The Tavistock and Portman NHS
NHS Foundation Trust

Board of Governors

Agenda and papers
of a meeting to be held

2pm – 4pm
Thursday 5th May 2011

Board Room
Tavistock Centre
120 Belsize Lane
London, NW3 5BA

Board of Governors

2pm – 4pm, Thursday 5th May 2011

Agenda

Preliminaries

1. **Chair's opening remarks**
   Ms Angela Greatley, Trust Chair

2. **Apologies for absence**

3. **Minutes of the previous meeting** — *(Minutes attached)* *For approval*

4. **Matters arising** — *For noting*

Reports & Finance

5. **Trust Chair's Report** — *For noting*

6. **Chief Executive's Report** — *(Report attached)* *For discussion*
   Dr Matthew Patrick, Chief Executive

7. **Finance & Performance Report** — *(Report attached)* *For discussion*
   Mr Simon Young, Director of Finance

8. **Governors' Reports** — *For noting*
   Governors (to be discussed after item 5)

Quality & Development

9. **Annual Plan** — *(Report to follow)* *For discussion*
   Mr Simon Young, Director of Finance

10. **Service Reports**

    a. **Education & Training** — *(Report attached)* *For discussion*
    Ms Trudy Klauber, Dean

    b. **SAMHS - Portman** — *(Report attached)* *For discussion*
    Mr Stanley Ruszczynski, Clinical Director of the Portman Clinic

11. **Membership Report** — *(Report attached)* *For discussion*
    Dr Sally Hodges, PPI & Communications Lead

Corporate Governance

12. **Corporate Governance Report** — *(Report attached)*

Ms Louise Carney, Trust Secretary *For approval*

13. Appointments – Governor Appointments to Committees & Groups *(Report attached)*
Ms Louise Carney, Trust Secretary *For approval*

Conclusion

14. Any other business

15. Notice of future meetings

Tuesday 24th May : Board of Directors
Tuesday 28th June : Board of Directors
Tuesday 26th July : Board of Directors
Thursday 15th September : Board of Governors
Tuesday 27th September : Board of Directors
Tuesday 25th October : Board of Directors
Tuesday 29th November : Board of Directors
Thursday 1st December : Board of Governors

Meetings of the Board of Directors are from 2.30pm until 5.30pm, and are held in the Board Room. Meetings of the Board of Governors are from 2pm until 5pm, and are held in the Lecture Theatre. Directors' Conferences are from 12.30pm until 5pm.

Board of Governors
Part I

Meeting Minutes, 2pm – 4.30pm, Thursday 3rd February 2011

Present:			
Ms Angela Greatley Trust Chair	Dr Robin Anderson Public: Rest of London	Ms Jennie Bird Public: Camden	Mr Robin Bonner Staff: Reps. of Recognised Staff Orgs. & Trade Unions
Ms Mary Burd Public: Camden	Ms Stephanie Cooper Public: Rest of London	Mr Adam Elliott Public: Camden	Ms Sara Godfrey Public: Rest of London
Mrs Amanda Hawke Staff: Admin & Tech	Ms Simone Hensby Non-Statutory Sector	Ms Jan McHugh Public: Rest of Eng. & Wal.	Ms Carole Stone Public: Rest of London
Mr John Wilkes Public: Rest of London			
In Attendance:			
Miss Louise Carney Trust Secretary	Dr Matthew Patrick Chief Executive	Mr Simon Young Director of Finance (items 7 & 9)	Ms Louise Lyon Trust Director (item 9)
Ms Trudy Klauber Dean (item 9)	Dr Rita Harris CAMHS Director (item 9)	Ms Susan Thomas Director of HR (item 9)	Ms Julia Smith Dir. Service Development & Strategy (item 9)
Dr Sally Hodges PPI & Communications Lead (item 10)	Mr Richard Strang Non-Executive Director		
Apologies:			
Mr Jonathan Bradley Staff: Clin., Academic, Snr.	Cllr Pat Callaghan Local Authorities	Mr John Carrier Primary Care Trusts	Chrissie Kimmons Public: Rest of Eng. & Wal.
Dr Caroline Lindsey Public: Rest of London	Prof. Steve Trevillion University of East London	Dr Aulay Mackenzie University of Essex	

Actions

AP	Item	Action to be taken	By	Immed
1	3	Miss Carney to amend minutes	LC	Immed
2	9a	Governors to comment on the Annual Plan via e-mail	BG	Apr 11
3	9c	Ms Klauber and Ms Godfrey to consider animation and gaming developments	TK	Sep 11
4	10	Miss Carney to circulate potential dates for Membership meeting	LC	Sep 11
5	11	Governors to comment on Trust Chair objectives via e-mail	BG	Apr 11

Actions **Agenda item** **Future Agendas**

1. Chair's opening remarks

Ms Greatley welcomed everyone to the meeting, include Mr Richard Strang, Non-Executive Director, who was observing.

2. Apologies for absence

As above.

3. Minutes of the previous meeting

AP1 The minutes were approved subject to some minor typographical

amendments.

4. Matters Arising

Ms Greatley noted that the review of the role of Lead Governor had been scheduled for discussion, but had been deferred in order to allow sufficient time for discussions on the Annual Plan. Ms Greatley suggested that this review be conducted by the Board of Governors' Performance Committee, who would then report to the Board of Governors. Governors to send any comments or questions to Miss Carney for the attention of the Committee.

Miss Carney gave a brief explanation of the role of Lead Governor, noting it was a statutory role required by Monitor, the regulator, that a Governor be identified who could be a conduit between Monitor and the rest of the Board of Governors in extreme circumstances where it was not appropriate to use the normal channels of Trust Chair, Chief Executive, or Trust Secretary. Ms Cooper noted that to date she had not contacted, nor been contacted by Monitor. Ms Greatley reminded Governors that the role of Deputy Chair of the Board of Governors had a number of responsibilities that included chairing meetings, sending information to Governors, and convening informal meetings of Governors and coordinate views. Mr Elliott noted that this arrangement allowed the role of Lead Governor to be insulated and used only in emergencies.

Mr Wilkes noted that the monthly bulletins sent to Governors from the Trust were intended as a conduit for information and updates from Governors, and invited Governors to review whether this system was working. To be discussed under "*Governors' Reports*" (item 8).

5. Trust Chair's Report

Ms Greatley contributed to the discussions under "*Chief Executive's Report*" (item 6) rather than hold a separate discussion.

6. Chief Executive's Report

Dr Patrick noted that the North Central Sector was experiencing significant unrest.

Dr Patrick noted that the Mental Health Strategy had been published on 2nd February, and £400m of funding had also been announced. Dr Patrick noted that many Primary Care Trusts were actively disinvesting from mental health in the difficult economic environment. Ms Greatley noted that she had written, along with the Chair of Barnet, Enfield & Haringey Mental Health Trust and Camden & Islington NHS Foundation Trust, to the Strategic Health Authority to express their concerns about this disinvestment. Dr Anderson suggested that there would be a great deal of disquiet within communities if service reductions lead to an increase in unmet needs or untreated conditions within the community.

The Board discussed the Health and Social Care Bill. Dr Patrick noted that the timing of reform was not ideal, as the NHS faced a shortfall of £20bn over three years, and the added complication of massive structural changes in the NHS was expected to add £1.2bn of costs. Dr Patrick also expressed concern over the pace of change, noting that there had been no pilots for reform. However, there were many elements of the Bill that could be positive, such as the involvement of primary care in commissioning. There may be other opportunities for the Trust to get involved in primary care work. It was noted that between 30% and 40% of GP patients present with mental health problems, and many GPs have little experience on how to deal with mental health problems.

7. Finance & Performance Report

Mr Young tabled an addendum to the Finance and Performance Report. Mr Young noted that data completeness was an important issue that the Trust needed to address, but he expected the Trust's Governance Rating to remain Green. Governors approved the auditing of the DNA indicator, noting that there may be a lot to learn from the audit, and that the audit may provide evidence to help sell the Trust's services in future. Mr Young highlighted that the mandated indicators do not apply to this Trust.

Mr Bonner queried the exception on data completeness. Mr Young explained that this related to recording the marital status of patients. The Trust was taking action to address this, but did not expect to reach 99%.

Mr Young explained that the cash balance was higher than expected due to the deferral of a major capital project. The cash balance was also high because the Trust would be carrying cash forward into 2011/12.

Ms Cooper noted that Mr Young's Report was a positive one in light of the environment in which the Trust was operating.

The Report was noted.

8. Governors' Reports

Governors discussed the most effective way of communicating with each other. Many Governors found the monthly bulletins helpful, as there are long gaps between Board meetings. However, others found short oral briefings at Board meetings more useful. It was agreed that it was important to remain flexible in communication methods. Mr Elliott suggested that Governors inform Miss Carney in advance of Board meetings if they have anything to report, for timing purposes. Dr Patrick agreed to post his monthly Chief Executive's Report to the Board of Directors in the Governors' Bulletin.

9. Annual Plan

9a. Introduction

Mr Young introduced the Annual Plan, highlighting the overall economic context in which the Trust was operating and its approach to the Plan's development.

Ms Greatley noted that the Board of Governors would next meet in May, by which time it would be too late to make significant changes to the Plan. Governors were invited to make any comments via e-mail.

AP2

9b. Patient Services

Ms Smith highlighted that the Trust was a small organisation with finite resources, and needed to be clear about the areas for development. Each Directorate has identified developmental areas. These areas included child and adolescent mental health services (CAMHS) early intervention work, children's Improving Access to Psychological Therapies (IAPT), criminal justice, complex medical conditions, medically unexplained symptoms, and the Big White Wall.

Dr Senior suggested that the Trust ought to be providing services that fit with the ambitions in primary care and targeting front line staff, including GPs and teaching staff. Dr Senior noted opportunities for training for primary care workers dealing with mental health concerns.

Ms McHugh noted that there were political preoccupations with local services in the North Central Sector, but queried national need. Dr Patrick noted that the Trust's local geographical footprint was very important, but nationally-provided services also provided a great opportunity for development, highlighting training, which was nationally provided, the Trust's Gender Identity Development Service, which was nationally commissioned, Big White Wall, which had a national, and potentially international brief, and e-learning.

Mr Bradley queried how the Trust pitched itself in the market, noting that some provisions are more expensive than others. Ms Smith commented that the Trust could not compete on price so must compete on quality. The Trust's staff are more senior, and so are more expensive. However, Ms Smith noted that the Trust had won a tender for its City and Hackney Service based on this model. Ms Smith noted, however, that the Trust must be clear within each market about its pitch.

Ms Cooper queried the developments around criminal justice. Ms Lyon explained that there were potential developments within the Portman Clinic, with forensic CAMHS, and offender management.

Dr Patrick concluded by noting that the Trust was a small organisation and that prioritising developments was very important. The Trust was operating in hugely unpredictable times, but must continue to invest in capacity and

capability, and look for new opportunities and new ways of working, whilst looking after the basics of what it does.

9c. Education & Training

Ms Klauber noted that just under half of 2012 income had already been secured. The Trust had done slightly better than expected with self-funding students, which was attributed to people trying to enhance their CVs during the economic downturn.

Ms Klauber highlighted the development of e-learning. Ms Klauber was considering "Tavistock essentials", such as public health issues, frequently asked questions for parents, and other such documents that help people see where they can go for help.

Ms Godfrey queried whether the Trust was developing any animation or gaming programmes to help address issues such as child abuse. Ms Klauber agreed to discuss this further with Ms Godfrey, but noted that the Trust needed to be realistic with its resources and not out-stretch itself. Ms Klauber noted that she would be getting small groups together to think about key modules to provide through e-learning.

AP3

9d. Quality

Ms Lyon explained that the Trust's Quality Report and Accounts would be focusing on access to information for patients; patient experience; and outcomes. Mr Elliott queried why patient experience and outcomes were separate priorities. Dr Senior explained that whilst there was much overlap, the methodology for both of these was very different, and highlighted the difference between clinical outcomes and patient-determined outcomes. Ms Burd commended giving outcomes such a high priority. Mr Bonner noted that one of the priorities for the Trust was maintaining its contracts, and suggested that outcome measuring would allow the Trust to show how it is making a difference.

Mr Bonner expressed concern at removing staff training from the list. Ms Lyon explained that whilst the physical environment and staff training were no longer explicit priorities in the Trust's Quality Report and Accounts, work to improve these aspects were still continuing.

9e. Productivity and Workforce

Mr Young explained that the Trust was operating within a tight financial environment, and was having to look in detail about how to deliver services with fewer resources. Whilst the Trust was hoping to reduce its costs through productivity savings, and natural wastage (i.e. not filling vacant posts), the Trust was developing a plan for voluntary and compulsory redundancies. Mr Young noted the importance of ensuring a plan was in place to deal with any redundancies. However, Mr Young highlighted the difference between planning and have a plan. Mr Young also noted that

discussions would be taking place with staff side.

10. Annual Plan – Membership

Dr Hodges highlighted the importance the Trust was placing on ensuring its membership was properly representative of the community it serves, and also on engagement with its membership. Dr Hodges noted that membership had a dedicated agenda slot at each Patient and Public Involvement Committee meeting. An Assistant Psychologist, Keith Mahon had been appointed to focus on Member engagement and quality.

Ms Greatley reminded Governors that she had met with Stephanie Cooper, Dr Hodges, and Miss Carney to give consideration to membership issues. Ms Cooper noted that the Trust would like positive ideas and input from Governors on Membership issues.

Ms McHugh suggested that one obstacle to the Trust's membership strategy is that Members think the Trust wants something from them, and the Trust ought to promoting what Members get from the Trust. Ms McHugh suggested talking to Members about why they joined in the first place, and using that as a base upon which to engage with them.

AP4 Dr Hodges invited Governors to meet with her and Mr Mahon to discuss Membership ideas. Miss Carney to circulate potential dates.

11. Trust Chair Objectives

AP5 The objectives were noted. Governors to e-mail any comments to Ms Greatley, Mr Bostock (Senior Independent Director) and Miss Carney.

12. Any other business

Miss Carney circulated a brief from the Foundation Trust Governors' Association noting that their host organisation had changed from the King's Fund to Capita.

Miss Carney reminded all Governors that they must complete their mandatory Information Governance Training by the end of March 2011.

13. Notice of future meetings

Noted.

Board of Governors : May 2011

Item : 6

Title : Chief Executive's Report

Summary :

This paper covers the following items:

1. Introduction
2. Productivity
3. NHS Reforms
4. UCL Partners
5. And Finally…

For : Discussion

From : Chief Executive

Chief Executive Report

1. Introduction

1.1 I wanted to begin this month's report by letting the Board of Directors know that Trudy Klauber, Dean and Director of Academic Services, has announced that she is standing down from role. Trudy has always planned to step down mid-way through her second term of office, and she and I have been discussing the timing of this for some while. Trudy has been in role now for seven years.

1.2 The plan is that recruitment of a successor will begin after Easter, with a new appointment in post by the end of August at the latest. Trudy will then work with her successor to ensure a smooth and stable transition.

1.3 In the meantime, Trudy will continue with her role, which is of particular importance when the NHS and university sectors are experiencing so much change and instability.

1.4 After the end of the year, Trudy intends to remain working in the Trust, returning to her original clinical and training role alongside Trust-wide roles.

1.5 In another senior staff change, Marcus Evans, Head of the Nursing Discipline, has been appointed as interim lead for the Adult Directorate. This will initially be for a period of three to four months to enable Marcus to work with Louise Lyon, Trust Director, and the Directors of the Adolescent Directorate and the Portman Clinic in reviewing how best to organise these services.

2. Productivity

2.1 As highlighted in my last report to the Board of Directors, the budget for next year requires that we identify a further £500k of cost reductions / savings in the current financial year.

2.2 Work is already underway on a program to identify these savings, while ensuring that all of our services are organised in such a way that they can be delivered with a slightly smaller staff group. I believe that there will also be opportunities to genuinely improve the way in which we deliver some services across the Trust.

2.3 The Programme Board is being chaired by Simon Young, Director of Finance, and comprises Louise Lyon, Trust Director, Rita Harris, CAMHS Director, and Susan Thomas, Human Resources Director, in

addition. These latter three will be leading work streams focused on specialist and adult services; CAMHS; and central directorates and services respectively. The former two work streams will be looking at training and education, clinical services, consultancy and research within those areas.

2.4 Alongside this work I am organising a series of Trust-wide staff meetings. The first two of these will be held in May, with later dates in June / July. These meetings will not only provide an opportunity for us to discuss the work underway, but importantly an opportunity for sharing the strategy and planning incorporated into the Annual Plan, ensuring that all staff are familiar with our direction of travel as an organisation. While much of this planning originates locally within directorates, it is not always the case that everyone is familiar with the contents of such plans.

2.5 The voluntary redundancy and early retirement scheme made available to staff last month has now closed to expressions of interest. While some firm applications have already been received, a number of staff are still waiting for their quotes. To ensure that all applications are dealt with equitably, none will be considered until after Easter.

3. NHS Reforms

3.1 The Prime Minister has announced a break in the progress of the Health Bill through Parliament, allowing for a 'listening exercise' to be undertaken. The expressed aim is to gather suggestions and opinions as to how the Bill can be improved. It has been made clear, however, that no change is not an option, and that there should be no halt in the implementation of many of the Bill's major objectives, including the development of GP consortia, the establishment of an NHS Board, and the dissolution of Primary Care Trust's and Strategic Health Authorities (although the timetable for the latter has been put back slightly).

3.2 The Government is establishing an NHS Future Forum, which will review the Bill in response to expressed concerns. The membership will comprise for the main part senior NHS clinicians, with charity, third sector, patient and managerial representation. The Forum will report to the Prime Minister and Deputy Prime Minister along with Health Secretary, Andrew Lansley.

3.3 In the meantime, the Royal College of Nursing, at its annual conference, passed a vote of no confidence in Andrew Lansley. The RCN has expressed very significant concern about planned reforms from the outset.

4. UCL Partners

4.1 On 4th April, I joined the first meeting of a group convened under the mental health theme of UCL Partners. This multi-disciplinary group is chaired by Professor Fonagy, the theme Director, and will be looking at the development of a values-based approach to mental health and wellbeing. This work builds on the work of Michael Porter in the United States, and will look not only at individual benefit but family, group and community benefit, from the perspectives of those most directly affected by mental health difficulties as opposed to clinicians and professionals. I think that as a Trust we have a good deal to contribute on these matters.

4.2 This work will run alongside a group being co-chaired by Professor Alessandra Lemma (of the Tavistock and Portman), looking at the outcomes and mechanisms of change associated with psychological therapies (broadly defined).

5. And Finally…

5.1 On 8th April, two important events were held at the Trust. The first was a national conference on the development of payment by results for Child and Adolescent Mental Health. The conference was organised and chaired by Simon Young, who chaired the London project board for this work before it became a national project. Over 100 people attended.

5.2 Alongside this, the Trust held a learning day with the British Red Cross. The Trust has recently agreed a Memorandum of Understanding with the Red Cross and will be offering some of our trainees and staff the option of placements with Red Cross refugee services. The project, led on our side by Sarah Davidson, Philip Stokoe and Jo Stubley, is an exciting one that offers benefit to the refugees with whom the Red Cross is in such close contact, as well as to both organisations and their staff. For us, as a specialist mental health trust, such partnerships are essential if our contribution is to be made available to those most in need in places and in ways that facilitated access.

Dr Matthew Patrick
Chief Executive Officer
April 2011

Board of Governors : April 2011

Item : 7

Title : Finance and Performance Report

Summary:

The Trust's draft accounts for 2010/11 report a surplus of £145k, virtually in line with the Plan of £145k.

Monitor's Financial Risk Rating for the third quarter was 3, in line with the rating for our 2010 Annual Plan. The governance rating was green. These ratings are expected to be maintained for the fourth quarter.

Cash balances remain satisfactory, and higher than Plan.

For : Information

From : Director of Finance

Finance and Performance Report

1. Compliance with Authorisation

1.1 This Foundation Trust was authorised by Monitor, the NHS Foundation Trust regulator, with effect from 1 November 2006. Its terms of authorisation[1] are an eight-page document together with six schedules, of which the first is our Constitution. Two amendments have been added to the terms of authorisation since 2006, and all six schedules are updated regularly.

1.2 Monitor uses two rating mechanisms to assess the risks that a Foundation Trust will breach its terms of authorisation or its statutory obligations. These two ratings are based on the Annual Plan submitted in May each year; and on the information provided in-year, usually quarterly. The principles and details are set out in the document "Compliance Framework 2010-11" published by Monitor[2]. Details were also set out in this report in November 2010, and are not repeated here.

1.3 This Trust's recent and current ratings are shown in the table below:

	2009/10 Quarter 4	2010 Plan	2010/11 Quarter 3	2010/11 Quarter 4
Governance	Green	Green	Green	Green *
Financial Risk	4	3	3	3 *
Mandatory Services ‡	Green	n/a	n/a	n/a

* = expected rating, based on our Quarter 4 performance

‡ = now included in the Governance rating

1.4 The surplus in 2009/10 was higher than Plan, which increased several of the metrics and led to the rating of 4. We have nor repeated this level of surplus. Our current performance leaves a significant safety margin before the financial risk rating would fall to 2.

1.5 For the governance rating, we continue to meet the requirements for all these indicators with one exception. This is the target to achieve 99% completeness in the collection of seven items of patient data. This failure does not by itself prevent us from retaining the Green rating, and we do not expect to be seen as at risk of breaching our terms of authorisation.

1.6 Our aim and expectation, in line with Plan, is to maintain the current ratings.

---

[1] http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory/tavistock-and-portman-nhs-foundation

[2] http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/compliance-frame-0

2. Income and Expenditure

2.1 The draft accounts for 2010/11 were completed on 21 April, as required, and sent to Monitor and to our auditors. The results for the year are shown in the table below.

2.2 The draft accounts show a surplus for the year of £145k, virtually in line with the Plan of £150k. Income and expenditure are each some £800k (2.5%) below budget.

2.3 The financial position for future years remains challenging, and the Trust is working on actions to deliver the productivity improvements of 5% per annum which are part of our Plan. A separate update on the 2011 Annual Plan will be presented at this meeting.

	2009/10	2010/11	2010/11
	Actual	Plan	Draft Accounts
	£000	£000	£000
Income			
Patient Services	13,342	14,560	14,297
Education and Training	15,091	16,065	16,204
Consultancy	1,206	1,658	1,256
Research	129	327	148
Other	531	586	462
Total Income	30,299	33,196	32,367
Expenditure			
Pay	23,061	26,015	25,156
Non-pay	5,686	5,636	6,232
Reserves		462	
	28,747	32,113	31,388
EBITDA *	1,552	1,083	979
Depreciation	(563)	(509)	(512)
Bank Interest	18	20	15
Other Finance Costs	(1)	0	(4)
Dividend (to the Dept of Health)	(355)	(446)	(333)
Retained Surplus	651	148	145
EBITDA* as a % of income	5.1%	3.3%	3.0%

* = Earnings before Interest, Tax, Depreciation and Amortisation

3. Cash

3.1 The total in the Trust's bank accounts at 31 March was £4.7m, which was £3.2m higher than Plan. This was also significantly higher than the previous forecast, due to unexpected advance receipts of £1.1m.

3.2 The balance is expected to reduce gradually but to remain satisfactory through 2011/12, subject to achieving the planned income and expenditure. The balance could reduce to £1.6m by March 2012.

3.3 Since becoming a Foundation Trust we have arranged a borrowing facility in order to safeguard our liquidity in the event of short-term difficulties, but there is no current intention to use this.

4. 2010/11 Annual Plan – Objectives

4.1 The 2010/11 Annual Plan approved in May[3] set out the Trust's vision and key strategic priorities for the next three years. It also set specific objectives for each year in the areas of clinical quality, service development, workforce, capital and estates, operational and financial effectiveness, legal and governance matters and regulatory compliance.

4.2 The Assurance Framework is designed to monitor progress on the objectives for the current year; the risks to achieving them; and how these risks are being managed, including the controls, assurances and action plans in place. The Assurance Framework for 2010/11 was approved by the Board of Directors in June and was last reviewed at the meeting in February. The Board noted the action plans relating to meeting our financial targets for future years; maintaining the quality of care and of our education and training; and continuing to develop and launch new services. These plans are all to be included in the 2011/12 Annual Plan.

Simon Young
Director of Finance
27 April 2011

[3] Also on the Monitor website, at the same reference as for [1] above.

Board of Governors : May 2011

Item : 9

Title : 2011 Annual Plan

Summary:

The Governors were consulted at the last meeting on key aspects of this year's Annual Plan.

This paper provides an update on the Plan, which is due to be approved by the Board of Directors on 24 May and submitted to Monitor by 31 May. This update includes the 2011/12 budget and an outline of the proposed financial projections for the following two years.

For : Discussion

From : Director of Finance

2011 Annual Plan

1. Introduction

1.1 A paper on the 2011 Annual Plan was discussed at the last meeting of the Board of Governors, in February. This covered the economic and political context, and four significant areas of our Plan: Patient services; Education and Training; Quality; and Productivity and Workforce.

1.2 At that meeting, the Governors were supportive of the direction taken by the Trust in the Plan. Points made in the discussion have been taken into account in developing the Plan further. Objectives for staff mandatory training have been re-instated in the quality priorities for 2011/12.

1.3 The Plan will be submitted to Monitor at the end of this month, in the form of text and a detailed financial template. It will be reviewed by them "to assess the risk of ongoing compliance with Terms of Authorisation (both financial and governance), and the overall quality of planning."

2. 2011/12 Budget

2.1 The budget for 2011/12, the first of the three years covered by the Plan, was approved by the Board of Directors on 29 March. It is summarized in the table on the next page.

2.2 Our costs have risen by 2.5% on average, mainly due to annual pay scale increments (though most staff are receiving no cost-of-living increase this year) and the 1% rise in national insurance contributions. On the other hand, all patient service contracts were reduced by 1.5% in value, in line with the national 4% efficiency requirement. Some contracts have also been slightly reduced in activity levels, but the overall reduction was less than our earlier projections. The national training contract value has been reduced by 3%.

2.3 In order to meet the 4% efficiency target and these other changes, the budget includes significant cost reductions which have already been identified and implemented; and a further £500k of productivity savings which are to be identified by early July and then implemented.

2.4 A voluntary redundancy scheme is being operated in order to facilitate these productivity savings. Applications are due to be considered later this month. A firm estimate of the costs will be

made at that stage, for inclusion in the Plan. These restructuring costs are likely to change the budgeted £150k surplus to a non-recurrent deficit for 2011/12 only; but such costs are excluded from the calculation of the Trust's financial risk ratings, which should not be affected; and the projected cash balances remain sufficient.

	2010/11 Budget £000	2010/11 Actual (Draft) £000	2011/12 Budget £000
Income			
Patient Services	14,560	14,297	13,776
Education and Training	16,065	16,204	16,228
Consultancy	1,658	1,256	1,508
Research	327	148	167
Other	586	462	559
Total Income	33,196	32,367	32,238
Expenditure			
Pay	26,015	25,156	25,321
Non-pay	5,636	6,232	5,952
Productivity Savings			(500)
Reserves	462		431
	32,113	31,388	31,204
EBITDA *	1,083	979	1,034
Depreciation	(509)	(512)	(509)
Bank Interest	20	15	11
Other Finance Costs	0	(4)	0
Restructuring Costs ‡	0	0	‡
Dividend (to the Dept of Health)	(446)	(333)	(386)
Retained Surplus	148	145	150
EBITDA* as a % of income	3.3%	3.0%	3.2%

* = Earnings before Interest, Tax, Depreciation and Amortisation
‡ = See 2.4. To be included in Plan when submitted to Monitor

3. <u>2012/13 and 2013/14</u>

3.1 The national efficiency targets are expected to be at least 4% in each of the next two years. We are also projecting some further reductions in contract activity levels.

3.2 At the same time, we are continuing to aim for growth, and investing in staff time to achieve this growth in key areas of potential, as set out in the February papers and discussion.

3.3 The aim is to deliver a similar surplus of £150k (0.5% of income) each year, with a contingency reserve. The 4% targets will necessitate continuing improvements in productivity over the period. These savings will be included in the Trust's financial projections.

3.4 Except in a "downside" scenario with more significant income losses and little or no growth, it is not expected that the savings would require significant further redundancies.

Board of Governors : May 2011

Item : 10a

Title Education and Training Report

This paper sets out for Governors:

1. An update on the role of the Dean
2. New Commissioning Arrangements for Workforce Education and Training
3. An update on our forecast for 2011-12 and on the e-learning project

For : Discussion

From : Dean of Postgraduate Studies/ Director of Education and training

1 The Dean

1.1 I shall be stepping down from my role as Dean of Postgraduate Studies and as Director of the central directorate, Education and Training, in the summer. I shall work with my successor to hand over both these roles during the autumn term and will then go back to a combination of clinical and teaching work, full time in C and F. I have very much enjoyed this challenging and important central role, but, after one full term of five years, and a second of two years, with much regret, I have decided that it is time to hand on the joint role. I have had the privilege of working closely with central directors, and with the directors all four service directorates and of being a member of the Board of Directors. I have learnt a lot, and have thoroughly enjoyed the challenge of working across the Trust and with so many interesting and exceptional colleagues. The loss will be painful, but I look forward to taking on a Trust-wide role playing a part in ensuring the continuity of our culture of training people to focus on the relationships they make with colleagues, and most of all with patients, paying attention to detail and not flinching from negative and painful encounters, which often enable us to be most effective in helping people to manage their lives and relationships a bit better.

1.2I have made my announcement in order that the appointment process for the next Dean and Director of Education and Training can proceed in a timely fashion.

2 Commissioning Education and Training for the Healthcare Workforce

2.1 The DH has just ended its consultation on proposals for major changes in education commissioning in the NHS. They have proposed a small Executive, Health Education England (HEE) , which will undertake national commissioning. Most education and training commissioning will be done by Skills Networks led by Employing Trusts, with membership to include GP Commissioners, professional representatives and representation from Academic Health Science Centres (AHSCs). The Trust is working closely with UCL partners, our local AHSC and their Health Innovation Education Cluster (HIEC). The Trust has been involved in the consultation process with NHS London, who took a major role in trying to coordinate Trusts, Universities, Training & Education Providers (Tavistock and Portman NHS FT and the Royal Marsden), the Deanery and medical education providers, Royal Colleges, NHS workforce planners, and the NHS London support teams for both commissioning and provider support and management. We have also responded separately to the consultation and have encouraged professional disciplines within the Trust to make their own responses.

2.2 There are a number of uncertainties, and some dangers related to the DH proposals.

2.3 The Trust holds a national training contract, which is funded by top-slicing the funding to the strategic health authorities. We have assumed that this arrangement would continue with Health Education England, but they will not be familiar with the contract in the way that NHS London has come to understand it and to see it as a very valuable contract in terms of value for money and of the measurable high quality of provision.

2.4 Skills Networks will be small local groups linked to the philosophy that local GPs and others will know what they need to commission and will have funding and legal authority to make contracts. This does not cover small, specialist education and training. Indeed, it is felt to be a threat to small professional groups such as systemic and child psychotherapists and clinical psychologists, for example, as well as dentists, dental nurses, specialist community nurses and allied health professionals). Localism could mean that very small numbers of people with particular skills might be overlooked unless there is some kind of overview, either regionally or nationally.

2.4.1 The skills and resources to support commissioning and contract management will still need to be provided by managers with expertise. NHS London could provide such services in London. London NHS education feels threatened because a proportion of what it provides is training to staff who move out of London soon after qualification. London's size also means it provides a lot of specialised training linked to specialised clinical services – including the T and P and Great Ormond street Hospital for example.

2.4.2 Workforce planning information is, for the first time, to be provided as a mandatory requirement by every Trust which ought to make close working relationships with CWI (Commission for Workforce Intelligence), who are responsible for ensuring continuity of supply. This could represent a threat to those professions who have not yet sufficiently developed the evidence base for their approaches, especially if they occupy higher AfC bandings at a time of cost improvement and service redesign linked with funding cuts. In the psychological therapies, for example, it might be an opportunity for training lower graded therapists to deliver specific and particular treatments, leaving very few senior staff that can assess, triage, supervise or support the lower banded workforce. Turnover in psychological therapy services is already high and this is not a service quality improvement for patients.

2.4.3 The consultation process has consolidated the Trust's relationship with senior figures in NHS London. We await the outcome.

2.4.4 NHS London's proposal involves teams such as those they have developed supporting the GPs and others, and envisages a pan-London skills network which is likely to commission most training outside that of nurses and doctors, and one or two larger professional groups. The Trust might see itself as working on its national contract with HEE and finding a place on a pan-London Skills network and one local one such as North Central London for example if the NHS London design is accepted.

3 Update on Education and Training's current situation and the e-learning project

3.1 We are in negotiation with NHS London to agree a new five year national contract which should afford some security at a time of uncertainty. Our first discussions have gone well. We expect efficiency savings to be imposed, as they have been for the current financial year, but NHS London has indicated its appreciation of the quality and variety of what we offer, and our ability to plan to re-invest income on new projects, while we have steadily increased our recruitment over the past five years and we expect to maintain the level in the coming three years.

3.2 Our commissions for Continuing Personal and Professional Development for NHS workers in London have been reduced in line with approximately a 20% cut in funding to each Trust for the coming academic year. The commission for 2011-12 is £217,000 compared with £266,000 in 2010-11. This includes funding for CPPD for our own bands 5-9 staff.

3.3 We are expecting to maintain recruitment levels in the coming academic year, but we expect more students to enrol for our wide range of continuing professional development opportunities rather than an increase in demand for our long academically validated postgraduate and professional doctorate programmes. HEFCE funding will diminish for postgraduate programmes such as ours over the coming three years, but we hope that our professional doctorates with UEL will be revalidated as research degrees, which might protect a part of the funding at a higher level.

3.4 We have plans to expand training in psychological therapies (for which we have succeeded in obtaining research funding with partners), to proceed with the first year of our joint Infant Mental Health School, and to offer training for the Children's IAPT which now has a draft curriculum and competencies, soon to be published.

3.5 e- and blended learning project

3.5.1 Professor Stephen Briggs is leading this project, in which the Trust has invested £100,000 in 2011-12 to develop its staffing and to purchase essential software, hardware and training to be used to develop a range of training to meet the requirements of a workforce whose funding and day release time is currently highly restricted.

3.5.2 We are beginning to build a record of the income from video-linked national and international supervision and teaching; although this will not be a major income source, it will grow steadily as part of directorates income growth planning.

3.5.3 Our major planning is to create a team which will include an experienced e- and distance learning academic to help us to avoid some errors, and to work with IT, a newly appointed project manager and administrator and staff specifically deployed by the directorates to develop a series of new e-products to include:

- high quality lectures, podcasts and talks as "tasters" on our approach, our shared understanding of human development, personality development and introductions to psychoanalysis, systems, organisational dynamics and development, management and leadership. These will be used as marketing and will also, we envisage, contribute to raising the Trust's profile in public health and wellbeing.

- Modules of current courses will be developed blended learning with e –components, talks, reading and written assignments, alongside weekend or blocks of face to face teaching – delivered at the Trust, perhaps as twilight or weekend teaching, (like mini OU summer schools). We shall seek academic accreditation and develop pathways so that students can build an MA in Professional Development through a combination of such modules and, possibly some longer attendance at the Trust. Some teaching could be delivered by accredited staff in e.g. Leeds, Bristol, Liverpool, Oxford where we have links already.

- We shall work with new ideas for a jointly delivered MA, perhaps with the broad title MA in Emotional Health and Wellbeing

3.5.4 We do not expect to generate high income in the first or second year, but we shall set clear targets to monitor developments and potential income and expect to report on progress to the Management Committee and to the Boards of Directors and of Governors.

Trudy Klauber
Dean, 27th April 2011

Board of Governors : May 2011

Item : 10b

Title : Service Report – Portman Clinic

Summary:

The Portman Clinic is a specialist NHS outpatient psychotherapy clinic offering treatment for adults, adolescents and children with problems of criminality, violence, sexual deviation and anti-social personality disorder. It has a national catchment area. Clinical staff members are all consultant-grade psychotherapists and are qualified as psychoanalysts or psychoanalytic psychotherapists (child or adult), and have a core professional training in psychiatry, clinical psychology, social work, probation or nursing. Senior, experienced post-graduate trainees and honorary clinicians also undertake clinical work under supervision.

Direct and indirect patient services offered by the Clinic include assessment for psychotherapeutic treatment (individual, group, couple and family); extended assessment and psychodynamic formulation to inform the patient's local service-based treatment programme; consultation and advice to the professional network involved with the patient; risk assessment reports; reports to criminal or family courts, tribunals and inquiries; and consultancy and supervision to individuals, teams and institutions. The Portman Clinic is committed to developing outcome monitoring and research on the treatments and services that it provides. The Portman Clinic also offers continuing professional development programmes and post graduate training courses for professionals.

Mr Stan Ruszczynski, Clinical Director of the Portman Clinic, will attend the Board of Governors meeting to discuss some of

the current issues and development plans at the Clinic.

For : Discussion

From : Clinical Director, Portman Clinic

Board of Governors : May 2011

Item : 11

Title : Membership Report

Summary :

This report highlights the Trust's plans for Membership.

Governors are invited to consider how the Trust might develop its Membership, focusing in particular on Governor-Member engagement.

For : Discussion

From : Patient & Public Involvement and Communications Lead

Membership Report

1. Membership Plans 2011/12

1.1 Develop the opportunities for patients / public to get involved with the work of the Trust through voluntary work

1.2 Encourage patients' views through Members' contribution to the Members Newsletter

1.3 Increase the number of relevant small scale surveys on issues meaningful to patients, such as the environment

1.4 Increase the number of events that patients and local public can attend and contribute to

1.5 Increase numbers of younger Members and the input of younger Members by developing aspects of the Membership that will be of interest to young people, such as linking with schools and local youth groups

1.6 Increase the range of committee work that Governors can get involved with

1.7 Membership Plans 2012/13

1.8 Develop the range of Member-led / Member-developed events

1.9 Increase the number of patients / Members involved in service developments as advisors

1.10 Have a proactive recruitment drive for Governor elections around Black and Minority Ethnic (BME) involvement and younger people representation

Capsticks

The Healthcare Business Inside Out

Who's the governor?

A changed governance regime for NHS foundation trusts

The Health and Social Care bill proposes fundamental changes to the way NHS foundation trusts are governed and managed.

The changes mark a move away from collective responsibility of a board to individual responsibility for each director. At the same time, the duties and responsibilities of governors are significantly increased.

These changes in responsibility are introduced at the same time as the financial safety net for foundation trusts and Monitor's Compliance Framework is removed. In the future, there will be no soft landings or loans on favourable terms.

This will mean a radical shift in management dynamics and responsibility as board members and governors take real responsibility for the direction and transactions of their NHS foundation trust.

Governors – their new role

In future, Monitor's compliance framework will be removed (except for a two year transitional period for some foundation trusts).

To balance this change, governors are given significant duties and real approval powers.

The most important change is that the council of governors is given express statutory duties to hold the non-executive directors individually and collectively to account for the performance of the board and to represent the interests of the foundation trust's members and the public as whole.

Under the current Act, governors appoint the chair and non-executive directors of a foundation trust. The new express duty to "hold non-executives to account" will encourage governors to use their existing powers so as to performance manage non-executives. This raises interesting questions about the role of the chairman as chair of both the council of governors and board of directors and whether this dual role could give rise to conflicts.

There are no express provisions about how non-executives are to be held to account. So, constitutions may need to be changed to allow for ongoing monitoring to allow governors to discharge their new duties.

Governors will be able to require directors to attend a meeting to obtain information about their organisation's performance and that of its directors. They may (like shareholders in a company) vote on motions at such meetings. If, for example, governors pass a motion of "no-confidence" in directors, then they would (using their existing powers) be entitled to remove the non-executives.

Governors do not currently have powers to remove executive directors but any vote about the performance of the directors will need to be published in the annual report (and might encourage executive directors to resign if they have been criticised).

This extended role for governors raises interesting questions around fiduciary duties, liability and insurance. Many governors are likely to require significant training in order to understand and be able to discharge their duties. Indeed, the impact assessments published in relation to the bill suggest significant initial and ongoing training and advice needs – and this is no surprise in the context of Monitor's devolved duties.

Monitor will be one source of guidance, establishing an independent panel to give advice to governors. The proposals envisage this as "an authoritative source of advice" in response to governors' concerns about constitutional and governance issues.

More than half the governors' council would need to approve a referral to this panel, so referrals would likely occur only in relation to material areas of concern. This might mean that the foundation trust will need to provide much more by way of ongoing support and advice to its council of governors.

Constitution and members

Monitor will neither check whether a constitution complies with statutory requirements nor need to approve changes. This means that a foundation trust (like any private sector provider) will need to make sure that its constitution is and remains legally compliant.

Again to balance the loss of this oversight role, governors and members gain approval rights in relation to constitutional changes.

For example, the governors and the board of directors must approve any proposed changes to a constitution (the approval of more than half of each forum being required to implement a change). In addition, if a change to a constitution affects the powers and duties of governors, more than half of the members of a foundation trust must approve the change at the next meeting. If they don't approve the change, the change will be ineffective and must be reversed.

All foundation trusts will be required to hold an annual public meeting for their members. This marks a significant change from

current practice. At that meeting, the board of directors must present the accounts, auditor's report and annual report. This move of power back to governors and members might mean that NHS foundation trusts 'look and feel' much more like the mutual or co-operative form on which they were initially modelled.

Transactions

In the new world, Monitor will no longer review significant or material transactions.

NHS foundation trusts may choose to state that some types of transaction are "significant" in their constitution. If a foundation trust chooses to do this, then it will need the consent of more than half of the council of governors to proceed with the transaction.

Bearing in mind the hurdle this consent will impose upon complicated transactions, it will be interesting to see how many foundation trusts decide to include this right for governors.

However, the consent of more than half of the governors will always be required for any merger, acquisition or separation of the NHS foundation trust. Unlike "significant transactions", this is not an optional requirement. This means that, in practice, responsibility for signing off any merger or acquisition moves to the directors and governors.

Directors

At the same time, directors will have individual responsibility to promote the success of the foundation trust so as to maximise the benefits for the members as a whole, and the public. This duty echoes statutory duties of directors of companies.

This is a move away from collective responsibility of boards and will mean that each board member will have individual duties. More importantly, board members may also face personal liability (with claims for financial losses) under insolvency legislation where a non-designated provider continues to trade when likely to become insolvent. The awareness of this will make directors stop and think even more than before when entering into transactions.

There are also express duties for each director to avoid conflicts of interest but, importantly, there is a carve-out from the duty if the issue in question has been authorised in accordance with the constitution. It will be important to make sure that constitutions are written so as to take advantage of this provision.

A new but familiar landscape?

The emphasis on internal governance and governors is interesting. Compare it to the regulation of listed companies or charities of similar size to foundation trusts. In contrast to the proposals for foundation trusts, both listed companies and charities are subject to significant ongoing external compliance requirements. This only throws into sharp focus the importance of the role of governors, and their training and resourcing, from here on.

Despite these changes in governance, NHS foundation trusts move firmly back within the Department of Health's 'line of sight' in relation to their forward plans and accounts. These must be sent to the Secretary of State and fall outside Monitor's new remit. In addition, the Secretary of State may make orders about the content of annual reports of foundation trusts.

This new reporting requirement is coupled with the right of the Secretary of State to make changes (by statutory order) to the voting rights of directors, members and governors. This means the Department of Health retains the power to change all of these new governance arrangements at any time.

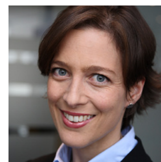
Conclusion

These monumental changes mean that the central checks and balances for transactions – historically provided by Monitor – will be removed. This, at the same time as the financial safety net for foundation trusts that run into financial difficulties becomes unavailable. What remains unclear is whether Monitor (or even the Secretary of State) will impose additional requirements or special approvals as part of its licensing regime or by order.

Please click here for further commentary on NHS foundation trust financial powers and central control, and here for further discussion of the implications of the proposed failure regime for NHS providers.

The Bill also proposes significant changes to competition law and NHS services. Capsticks is hosting a conference on this topic. For more information please click here.

For more information, please contact Sharon Lamb and Toby Newman.



Sharon Lamb
Partner
020 8780 4874
sharon.lamb@capsticks.com

Toby Newman
Senior Lawyer
020 8780 4671
toby.newman@capsticks.com

Board of Governors : May 2011

Item : 12

Title : Corporate Governance Report Addendum

Summary:

Governors Chrissie Kimmons and Jan McHugh have both resigned their seats as Governors for the Rest of England and Wales sub-class of the Public Constituency.

According to the Trust's Constitution, should vacancies arise during a term of office, the unsuccessful candidate with the highest number of votes at the last stage of the count shall be deemed elected and shall hold office until the end of the original term. If there are no candidates available, then a by-election shall be called provided there is at least a year and a day remaining from the announcement of results until the term of office expires.

The Rest of England and Wales seats were elected without contest, as only two candidates (Ms Kimmons and Ms McHugh) were nominated for the two seats. There are therefore no unsuccessful candidates to automatically elect.

The current term of office for Governors will end on 31st October 2012. The Trust would expect to announce the results of the by-election well before 30th October 2011, which would provide the successful candidates by at least a year and a day left of the term of office.

For : Noting

From : Trust Secretary

Board of Governors : May 2011

Item : 13

Title : Governor Appointments to Committees & Groups

Summary:

Recent discussions have highlighted a wish from more Governors to get involved with Committees and Groups within the Trust. The paper below outlines proposed amendments, and invites Governors to nominate themselves to sit on these Committees / Groups.

For : Approval

From : Trust Secretary

Governor Appointments to Committees and Groups

1. Introduction

1.1 In February 2010, a paper was presented to the Board of Governors outlining Committees of the Board of Governors, for approval, and inviting Governors to nominate themselves to sit on these Committees.

1.2 At the same meeting, Governors were invited to nominate themselves to sit on various other Trust Committees and Groups.

1.3 Recently, discussions have highlighted that more Governors want to be involved in Trust work than was initially anticipated. Committee and Group chairs have been consulted, and have agreed, where appropriate, to increase the number of Governors on Committees / Groups.

2. Board of Governors' Committees

2.1 When the Terms of Reference were drawn up for Governor Committees, it was agreed to require a Governor from each of the Constituencies, to ensure that all members and interests were properly represented.

2.2 However, in practice, it has been difficult to ensure all positions are appointed to.

2.3 It is proposed to increase the number of Governors required to four Governors, and where possible, one from each constituency, with a quorum of two Governors in addition to the Committee Chair.

3. Trust Committees and Groups

3.1 More Governors than initially anticipated have expressed an interest in working on Trust Committees and Groups. Chairs have been asked to consider inviting more Governors to sit on Committees and Groups, where appropriate.

4. Appointments to Committees and Groups

4.1 Non-Executive Director Appraisal Committee

4.1.1 Current Members: Robin Bonner; Carole Stone

4.1.2 Vacancies: 2

4.2 Board of Governors' Performance Committee

4.2.1 Current Members: Robin Bonner; Adam Elliott

4.2.2 Vacancies: 2

4.3 Members' Newsletter Editorial Group

4.3.1 Current Members: Sara Godfrey; Chrissie Kimmons

4.3.2 Vacancies: 1

4.4 Patient & Public Involvement Committee

4.4.1 Current Members: Stephanie Cooper; Simone Hensby

4.4.2 Vacancies: 1

4.5 Equalities Committee

4.5.1 Current Members: Jonathan Bradley; Mary Burd

4.5.2 Vacancies: 1

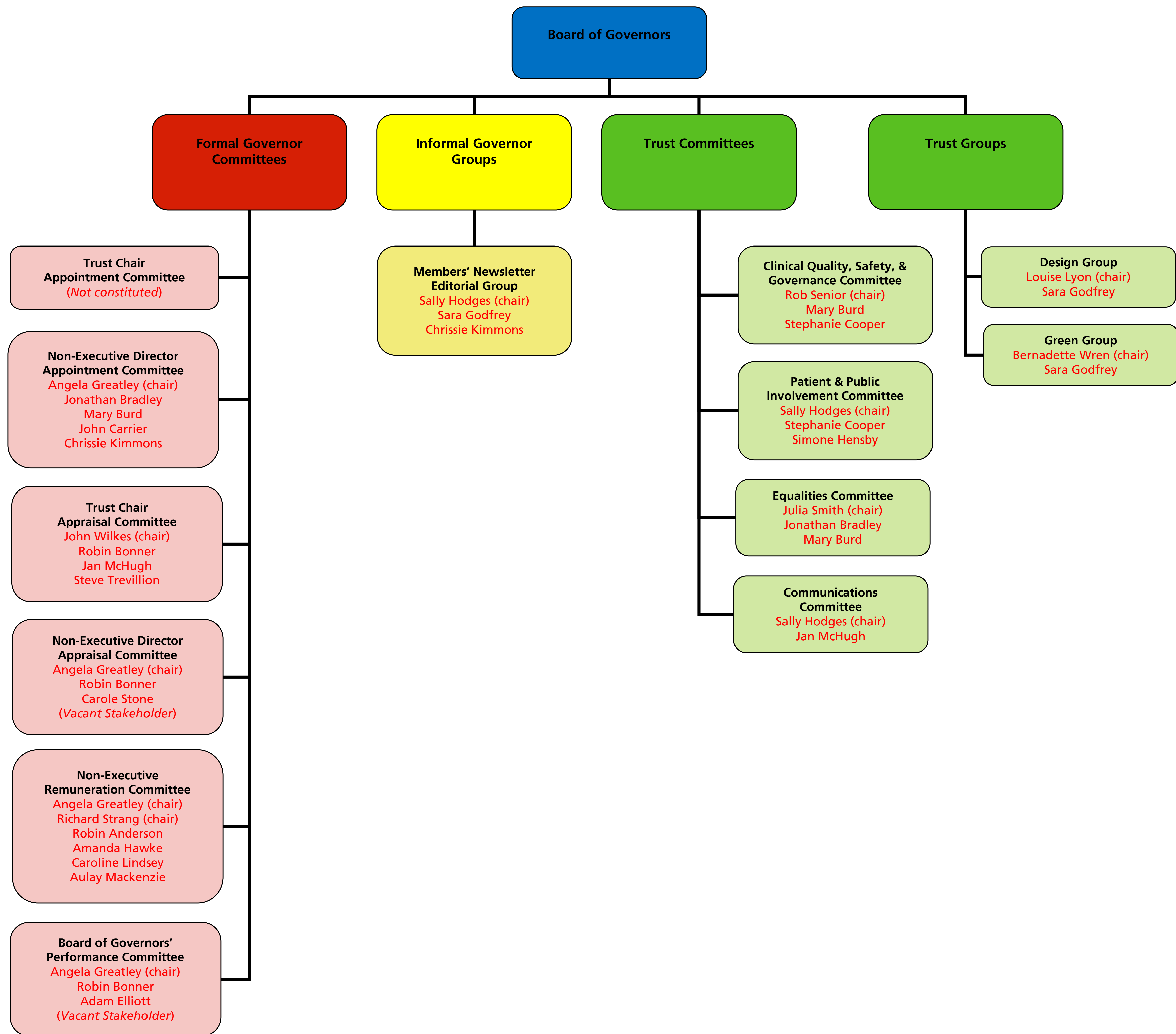
4.6 Communications Committee

4.6.1 Current Members: Jan McHugh

4.6.2 Vacancies: 2

5. Conclusion

5.1 Governors are invited to nominate themselves, either in writing to the Trust Secretary prior to the meeting, or at the meeting itself if they wish to join this Committee. Should more than two Governors nominate themselves, a vote shall be held.



Board of Governors
Formal Governor Committees
Informal Governor Groups
Trust Committees
Trust Groups
Trust Chair Appointment Committee
(Not constituted)
Non-Executive Director Appointment Committee
Angela Greatley (chair)
Jonathan Bradley
Mary Burd
John Carrier
Chrissie Kimmons
Trust Chair Appraisal Committee
John Wilkes (chair)
Robin Bonner
Jan McHugh
Steve Trevillion
Non-Executive Director Appraisal Committee
Angela Greatley (chair)
Robin Bonner
Carole Stone
(Vacant Stakeholder)
Non-Executive Remuneration Committee
Angela Greatley (chair)
Richard Strang (chair)
Robin Anderson
Amanda Hawke
Caroline Lindsey
Aulay Mackenzie
Board of Governors' Performance Committee
Angela Greatley (chair)
Robin Bonner
Adam Elliott
(Vacant Stakeholder)
Members' Newsletter Editorial Group
Sally Hodges (chair)
Sara Godfrey
Chrissie Kimmons
Clinical Quality, Safety, & Governance Committee
Rob Senior (chair)
Mary Burd
Stephanie Cooper
Patient & Public Involvement Committee
Sally Hodges (chair)
Stephanie Cooper
Simone Hensby
Equalities Committee
Julia Smith (chair)
Jonathan Bradley
Mary Burd
Communications Committee
Sally Hodges (chair)
Jan McHugh
Design Group
Louise Lyon (chair)
Sara Godfrey
Green Group
Bernadette Wren (chair)
Sara Godfrey

Elections to Committees & Groups

Non-Executive Director Appointment Committee		
This Committee has four (4) Governor seats (where possible, two Public, one Staff, and one Stakeholder). There is currently one (1) vacancy. Please vote for each type of Governor in order of preference, i.e. put a number "1" by your first preference of Public Governor, a number "2" by your second preference of Public Governor, and so on, and do the same for Staff Governors and for Stakeholder Governors.		
Governor	Robin Anderson	
	Robin Bonner	
	~~Jonathan Bradley (already a member)~~	———
	~~Mary Burd (already a member)~~	———
	~~John Carrier (already a member)~~	———
	Stephanie Cooper	
	Adam Elliott	
	Sara Godfey	
	Amanda Hawke	
	Chrissie Kimmons	
	Caroline Lindsey	
	Aulay Mackenzie	
	Jan McHugh	
	Carole Stone	
	Steve Trevillion	

Non-Executive Director Appraisal Committee		
This Committee has four (4) Governor seats (where possible, one Public, one Staff and one Stakeholder). There are currently two (2) vacancies. Please vote for each type of Governor in order of preference, i.e. put a number "1" by your first preference of Public Governor, a number "2" by your second preference of Public Governor, and so on, and do the same for Staff Governors and for Stakeholder Governors.		
Governor	Robin Anderson	
	~~Robin Bonner (already a member)~~	———
	Jonathan Bradley	
	Mary Burd	
	John Carrier	
	Stephanie Cooper	
	Adam Elliott	
	Sara Godfey	
	Amanda Hawke	
	Chrissie Kimmons	
	Caroline Lindsey	
	Aulay Mackenzie	
	Jan McHugh	
	~~Carole Stone (already a member)~~	———
	Steve Trevillion	

Board of Governors' Performance Committee		
This Committee has four (4) Governor seats (where possible, two Public, one Staff, and one Stakeholder). There are currently two (2) vacancies. Please vote for each type of Governor in order of preference, i.e. put a number "1" by your first preference of Governor, a number "2" by your second preference of Governor, and so on.		
Governor	Robin Anderson	
	~~Robin Bonner (already a member)~~	———
	Jonathan Bradley	
	Mary Burd	
	John Carrier	
	Stephanie Cooper	
	~~Adam Elliott (already a member)~~	———
	Sara Godfey	
	Amanda Hawke	
	Chrissie Kimmons	
	Caroline Lindsey	
	Aulay Mackenzie	
	Jan McHugh	
	Carole Stone	
	Steve Trevillion	

Members' Newsletter Editorial Group		
This Group has three (3) Governor representatives. There are currently two (2) vacancies. Please vote for each type of Governor in order of preference, i.e. put a number "1" by your first preference of Governor, a number "2" by your second preference of Governor, and so on.		
Governor	Robin Anderson	
	Jennie Bird	
	Robin Bonner	
	Jonathan Bradley	
	Mary Burd	
	Pat Callaghan	
	John Carrier	
	Stephanie Cooper	
	Adam Elliott	
	~~Sara Godfrey (already a member)~~	———
	Amanda Hawke	
	Simone Hensby	
	Caroline Lindsey	
	Aulay Mackenzie	
	Carole Stone	
	Steve Trevillion	
	John Wilkes	

Patient & Public Involvement Committee		
This Committee has three (3) Governor representatives. There is currently one (1) vacancy. Please vote for each type of Governor in order of preference, i.e. put a number "1" by your first preference of Governor, a number "2" by your second preference of Governor, and so on.		
Governor	Robin Anderson	
	Jennie Bird	
	Robin Bonner	
	Jonathan Bradley	
	Mary Burd	
	Pat Callaghan	
	John Carrier	
	~~Stephanie Cooper (already a member)~~	——
	Adam Elliott	
	Sara Godfrey	
	Amanda Hawke	
	~~Simone Hensby (already a member)~~	——
	Caroline Lindsey	
	Aulay Mackenzie	
	Carole Stone	
	Steve Trevillion	
	John Wilkes	

Equalities Committee		
This Committee has three (3) Governor representatives. There is currently one (1) vacancy. Please vote for each type of Governor in order of preference, i.e. put a number "1" by your first preference of Governor, a number "2" by your second preference of Governor, and so on.		
Governor	Robin Anderson	
	Jennie Bird	
	Robin Bonner	
	~~Jonathan Bradley (already a member)~~	———
	~~Mary Burd (already a member)~~	———
	Pat Callaghan	
	John Carrier	
	Stephanie Cooper	
	Adam Elliott	
	Sara Godfrey	
	Amanda Hawke	
	Simone Hensby	
	Caroline Lindsey	
	Aulay Mackenzie	
	Carole Stone	
	Steve Trevillion	
	John Wilkes	

Communications Committee		
This Committee has three (3) Governor representatives. There are currently three (3) vacancies. Please vote for each type of Governor in order of preference, i.e. put a number "1" by your first preference of Governor, a number "2" by your second preference of Governor, and so on.		
Governor	Robin Anderson	
	Jennie Bird	
	Robin Bonner	
	Jonathan Bradley	
	Mary Burd	
	Pat Callaghan	
	John Carrier	
	Stephanie Cooper	
	Adam Elliott	
	Sara Godfrey	
	Amanda Hawke	
	Simone Hensby	
	Caroline Lindsey	
	Aulay Mackenzie	
	Carole Stone	
	Steve Trevillion	
	John Wilkes	