civica

Turnout and behaviours in NHS Foundation Trust elections

2017

Membership Engagement Solutions (MES) was acquired by Civica UK Ltd, in December 2018. This publication was released prior to the acquisition.

Contents

FOREWORD

Brought in under the Health and Social Care (Community Health and Standards) Act 2003, the first foundation trust governor elections took place in early 2004 as the first ten foundation trusts were established. The mood - and the political interest amongst the public and staff - was high.

Today we have 152 foundation trusts and much has changed in health - and society in general.

Turn-out in elections is one measure, but only one measure, of the health of a democratic system. While turnouts have been falling in elections of all sorts over recent years, what is clear is that when people feel that voting will make a difference, then they will turn out to vote. This is borne out by the fact that, in those foundation trusts where the work of governors is seen as being influential and where work is put into making elections work, higher turnouts are achieved.

Our response to falling turnouts in elections should not be to question the need for democratic participation in our healthcare system; we very much need public involvement at a time of radical change where sometimes challenging choices need to be made. Nor should it be to despair at an apparent lack of interest.

We know that the public is interested in our NHS and we know that, where they feel they can be influential, they will participate. The challenge for the future is to continue to work to make the governor role relevant and influential, to put some real work into elections, but also to accept that the public will engage if they feel they have influence. Electoral turn-out will be one measure that we use to gauge the success of public engagement, but assessing the influence exerted by governors, members and the public will be of even greater importance.

Chris Hopson

Chief Executive
NHS Providers

NHS Providers

Executive Summary

Background

In 2011, MES, ERS and Monitor, the sector independent regulator as it was then named, published a joint report on membership recruitment and engagement in the NHS foundation trust sector since its inception in 2004 by analysing electoral behaviour over the period alongside trusts' recruitment and engagement activity.

Six years on, and given the changing landscape of the sector, we felt it was time to revisit this report and provide an update.

As such, analysis was carried out by MES and ERS with data from the 3,939 elections ERS have administered for 146 NHS foundation trusts from 2011 to June 2017 and 1.7 million anonymised public and patient membership records MES hosts on behalf of 168 NHS trusts and foundation trusts with the aim to:

- Explore turnout rates for governor elections and the number of candidates standing for election since 2011
- Take into account changes in the foundation trust landscape such as the 2010-2015 coalition government's Health & Social Care Act 2012, the argued growing fiscal crisis in the health sector and the introduction of electronic voting in late 2014
- Better understand the context of participation by building a portrait of the average foundation member, voter and governor.

Membership, voting and governor elections

As highlighted in our last report, quantifiably assessing how engaged members are is a difficult task. Members' participation in elections is, however, one indicator which can be used by trusts in assessing how engaged members are with the trust to which they belong.

This report has continued where the last left off by analysing foundation trust governor elections from 2011 to 2017 and exploring turnout rates, the number of candidates standing for election and the levels of uncontested and unopposed elections. Changes within the foundation trust landscape, such as the introduction of electronic voting in late 2014, have also been taken into account when assessing how electoral participation in the sector has (or has not) changed course since our last report in 2011.

Average governor election turnout rates have continued to decrease from 25% in 2010 to an average of 15% across all elections held in the first half of 2017. This does, however, represent a smaller decrease in turnout of 10% compared to the 23% drop seen from 2004 to 2010.

Average numbers of candidates per governor seat have also reduced slightly since 2010 (from 2.8 candidates on average per seat to 2.3 for January to June 2017), with contested patient elections having the highest number of candidates per seat, on average (2.8).

The number of uncontested or unopposed elections has risen to 58% in the first six months of 2017 from 47% in 2010, occurring more frequently in staff governor elections (65% of elections held) than patient (54%) and public governor elections (46%).

While electronic voting tools (online, telephone or text) have been utilised across a number of sectors since the early 2000's, the Foundation Trust Model Rules for elections did not allow for electronic voting until late 2014 following the efforts of a number of trusts who believed it may offer the twin benefits of reduced costs and greater accessibility in light of declining turnout.

As a result, since 2015 foundation trusts have increasingly been adding an online voting option (rather than telephone or text) on to their election methodologies and rules. The proportion of elections with an online voting option has increased from just 3% in 2014 to 98% in the first six months of 2017.

So far, on the relatively limited data we have, the simple addition of an online channel has not had a positive impact on turnout. Turnout was already heading downward and since the introduction of online voting, this decline has continued.

Looking at all elections with an online voting element since 2014, the despatch method of the voting instructions does, however seem to have a particular impact on turnout. The average turnout for elections where voting papers are posted out to all members allowing a response by either post or online (17%) is higher than for elections where voting papers are sent only to those members without an email address and all other members are sent voting instructions by email with the option to vote online only (13%). While we have observed that the latter has resulted in a lower average turnout, we can at this stage only speculate as to what this may mean.

While this could be an indication that voters are simply more likely to see and read a postal communication, the answer also lies in the wider context of a trust's member involvement and empowerment, or lack thereof. The elections and turnouts, whether postal, electronic or a mixture of the two approaches are only as successful, participation-wise, as the existing relationship between the trust and their members. Electoral behaviour is simply a barometer of other conversations, relationships and activity that has gone before.

Member, voter and governor profile

When considering governor election turnout rates, number of candidates per seat and the number of uncontested or unopposed elections presented elsewhere in this report, it is important to consider not just how many members are taking part in the election process, but what characteristics define them.

To this end, MES analysed over 1.7 million anonymised and aggregated public and patient member records across 168 NHS trusts and foundation trusts, looking at age, gender and ethnicity profiles and using CACI's Acorn socioeconomic data, to establish the current profile of members, voters and governors.

Members are more likely to be female (59%) and tend to be older, with around half aged 50 and over. Nearly three quarters of members are white, and just over half reside in postcodes which CACI's Acorn categories describe as 'Affluent Achievers' – representing some of the most financially successful people in the UK - or 'Comfortable Communities'- representing middle-of-the-road Britain.

Though female members still represent a slight majority of trust voters (53%), males are overrepresented as governors (52%) compared to their share of the public and patient trust membership (38%). Both voters and governors tend to be older still, with over three quarters of each group aged 50 and over, and are slightly less diverse than the trust membership.

According to their Acorn profiles, voters and governors are likely to be more well-off than the wider membership, with nearly half of trust public and patient governors categorised as 'Affluent Achievers' compared to around a third of voters and a quarter of members.

One would need to analyse the profiles of all members who stood for governor, not just those who were successful, to build a solid theory as to why governors in particular tend to be older, whiter and wealthier than the average trust members – is it predetermined by the types of individuals who put themselves forward or indicative of some other bias among the trust voters? We cannot say for sure at this stage, but just knowing which members take part and, crucially, which members do not take part can help to inform what may be done to not only increase turnout overall, but also make elections more inclusive.

Introduction

Objectives

In 2011, MES, ERS and Monitor, the sector independent regulator as it was then named, published a joint report on membership recruitment and engagement in the NHS foundation trust sector since its inception in 2004 by analysing electoral behaviour over the period alongside trusts' recruitment and engagement activity.

Six years on, and given the changing landscape of the sector, we felt it was time to revisit this report and provide an update.

As such, the research was designed to utilise the extensive datasets available to ERS and MES as providers of election and member engagement services to over 200 NHS organisations (including the majority of foundation trusts) and:

- Explore turnout rates for governor elections and the number of candidates standing for election since 2011
- Take into account changes in the NHS trust and foundation trust landscape such as the 2010-2015 coalition government's Health & Social Care Act 2012, the argued growing fiscal crisis in the health sector and the introduction of electronic voting in late 2014
- Better understand the context of participation by building a portrait of the average foundation member, voter and governor.

In this report, we have not sought to explore membership recruitment activity, as this has largely tailed off as trusts are either authorised or placed in a pipeline that over time indicates a slowdown in appetite for authorisation. We have also not replicated the many in- depth case studies of membership engagement of the last report, as we feel is this worthy of a full report in its own right at a future date.

Background and methodology

This report summarises the findings of extensive election and membership data covering 2004 to 2017 and builds on the findings presented in the 2011 'Current practice in NHS foundation trust member recruitment and engagement' report.

Building on the data from 2004 to 2010 featured in the last report, additional analysis has been carried out by MES and ERS with data from the 3,939 elections ERS have delivered for 146 NHS foundation trusts from January 2011 to June 2017 and the 1.7 million anonymised and aggregated public and patient membership records MES hosts on behalf of 168 NHS trusts and foundation trusts, representing 66% of the sector.

About Foundation Trusts

Foundation trusts are part of the NHS and were first established in 2004. They were designed to have greater freedoms than NHS trusts to run their own affairs, raise income and determine spend, and are not subject to central government control. They can use their freedoms to decide how best to deliver the kind of services that their patients and service users want. With these freedoms come important responsibilities; NHS foundation trusts are accountable for their own success or failure to:

- their local communities, through their members and governors;
- their commissioners, through legally binding contracts, to provide agreed levels of care which reflect the needs of their local communities;
- Parliament, through the legal requirement to lay their annual accounts before Parliament;
- the Care Quality Commission, through the legal requirement to register and meet the associated standards for the quality of care provided; and

- NHS Improvement (formally Monitor), as the independent regulator of foundation trusts.

Since our report in 2011, the landscape has changed dramatically. Whilst foundation trusts are an even bigger sub-set of the health sector's providers, the pace of travel from trust to foundation trust has slowed considerably. Our last report analysed all 131 foundation trusts as of 1 October 2010. There have been just 22 authorisations since then making a total in autumn 2017 of 152 .

The slowdown reflects the financial challenges in the NHS that started to increase, some may say exponentially, from 2012/2013. Foundation trust status a) became to some less appealing as the freedom to self-determine income and spend had gone, with no surplus money in the system for anything anyway, and b) became harder to achieve as trusts fell into even more precarious financial positions.

Political ambitions publicly stating that 'by 2012 [and then 2015] all trusts would be foundation trusts' kept altering and then became quieter. The Trust Development Authority (TDA) was created in the Health & Social Care Act 2012 to manage the application process for aspirant trusts through to foundation trust status, and performance manage the remaining trusts. In 2015, after three years of existence, it was announced that the TDA would merge with Monitor to form the new independent regulator (with a broader remit) NHS Improvement.

Alongside the financial challenges in the sector, other factors have contributed to the changing scene. The Mid Staffordshire NHS Foundation Trust scandal of 2008 led

to a full public enquiry; the Francis Report was published in 2013 and contained 290 recommendations for change. It shone a spotlight on the sector and created new (and needed) hurdles for foundation trust authorisation. Regulation of foundations trusts, and indeed all trusts, stepped up a gear and Care Quality Commission (CQC) visits became more frequent, often with little or no forewarning.

In 2011, the NHS Constitution was published by the Department of Health, partly in response to the events summarised above, setting out seven guiding principles of the NHS. On the face of it, the Constitution aligns with the foundation trust model, particularly principle 7:

The NHS is accountable to the public, communities and patients it serves.

The Health and Social Care Act 2012 made other significant changes that have influenced the course of the seven years since our last report. NHS England was created in 2013, taking over responsibility from the Department of Health for planning, budget and day-to-day operation of commissioning in the sector. This, in turn, has inevitably had an impact on the Provider side, including of course foundation trusts.

A lot has changed and in comparison 2004-2010 – the period studied in our last report – was relatively 'straight-forward'. Trusts were making great efforts to attain foundation trust status as the rewards seemed great and it was the consensus that this was the correct direction of travel.

In 2017, some NHS trusts can still be described as 'aspiring' for authorised foundation trust status but most are not. Existing foundation trusts show no signs of altering their status, and there appears to be no sign that legislation is set to change that state of play. Indeed, the foundation trust model and its governance has at its heart a tripartite relationship between staff, patients and public that supports fully the NHS Constitution's seventh principle and to that end – certainly from a public accountability argument – it would be surprising if there was a move away from this. The 2017 general election party manifestos had no indication of a change to the foundation trust model. Current discussion tends to be broader and centred around both how and how much to fund the NHS.

NHS trusts, even if no longer aspiring for foundation trust status are often, we find, sticking with the public membership and involvement philosophy set out in their original foundation trust applications. It still seems to be regarded as a good thing. How well trusts and foundation trusts are actually doing in this regard is up for debate, and there is unquestionably a mixed picture of activity. However, the principle of public accountability appears to be intact and perhaps, for some of the reasons mentioned above, stronger than ever.

Governor elections and participation are also a lasting indicator of the strength of the foundation trust model; not the only indicator but one nevertheless. This report therefore seeks to highlight any notable change these last seven years compared to the first six evaluated in 2011.

The membership and governor model

The concept of membership focuses specifically on delivering local accountability and was originally influenced to a large degree by the mutual sector – co-operative groups and building societies in particular.

All foundation trusts have a duty to engage with their local communities and encourage local people to become members of their organisations. Foundation trusts have to take steps to ensure that their membership is representative of the communities they serve.

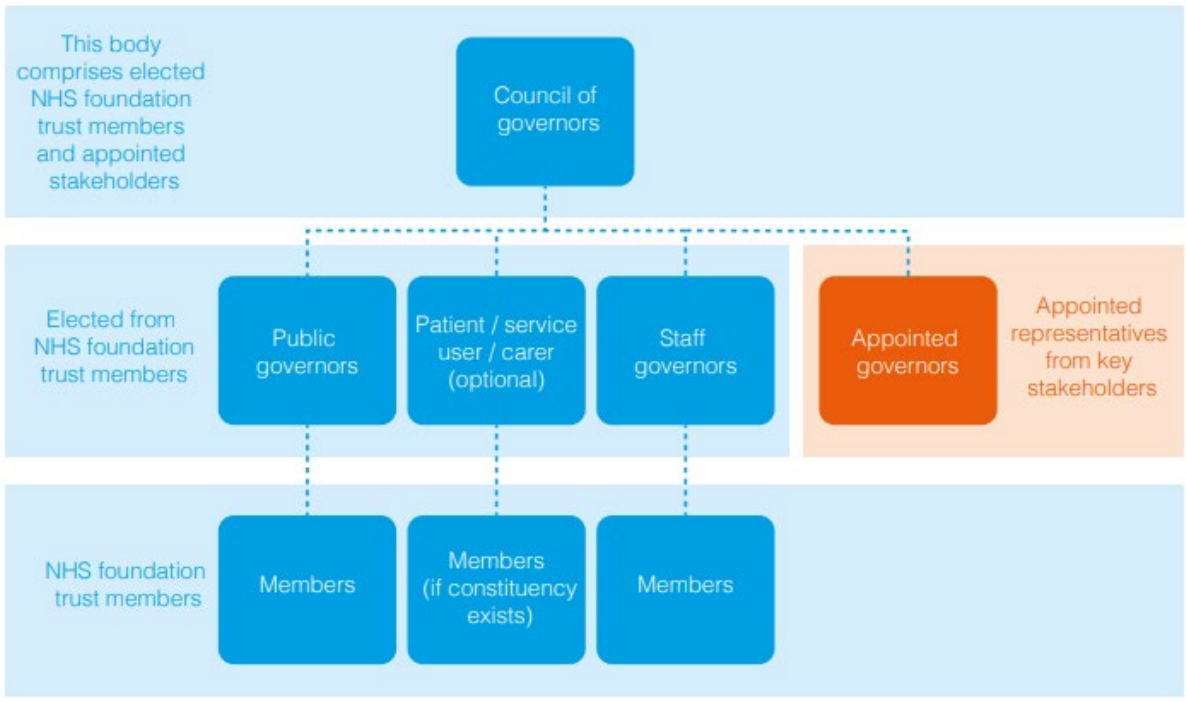
Anyone who lives in the area, works for the trust, or has been a patient or service user there, can become a member of an NHS foundation trust.

Members, who belong to various constituencies as defined in each foundation trust's constitution, can:

- Receive information about the foundation trust and be consulted on plans for future development of the trust and its services
- Elect representatives to serve on the board of governors
- Stand for election to the board of governors.

The board, or council, of governors works with the board of directors, which is responsible for the day-to-day running of the foundation trust, to ensure that the foundation trust delivers NHS care and acts in a way that is consistent with the terms of its authorisation. In this way, governors play a role in helping to set the overall direction of the organisation. The chair of the board of directors is also the chair of the board of governors.

Figure 1: A typical foundation trust member and governor structure



Source: Your statutory duties – a reference guide for NHS foundation trust governors (Monitor 2009)

Members belong to various categories, or ‘constituencies’ (as they are referred to electorally) as defined in each foundation trust’s constitution and can vote to elect governors or stand for election themselves within their constituency.

It is mandatory for foundation trusts to have staff and public members (at least 51% of the board of governors must be public governors and there must be a minimum of three staff governors). A proportion of every board of governors also includes appointed governors.

Membership, voting and governor elections

The following chapter provides an insight into foundation trust governor elections from 2011 to 2017, exploring election turnout rates, the number of candidates standing for election and the levels of uncontested and unopposed elections. Changes within the foundation trust landscape, such as the introduction of electronic voting in late 2014, have also been taken into account when assessing how electoral participation in the sector has (or has not) changed course since 2011.

As highlighted in our last report, quantifiably assessing how engaged members are is a difficult task. Members’ participation in elections is, however, one indicator which can be used by foundation trusts in assessing how engaged members are with the trust to which they belong.

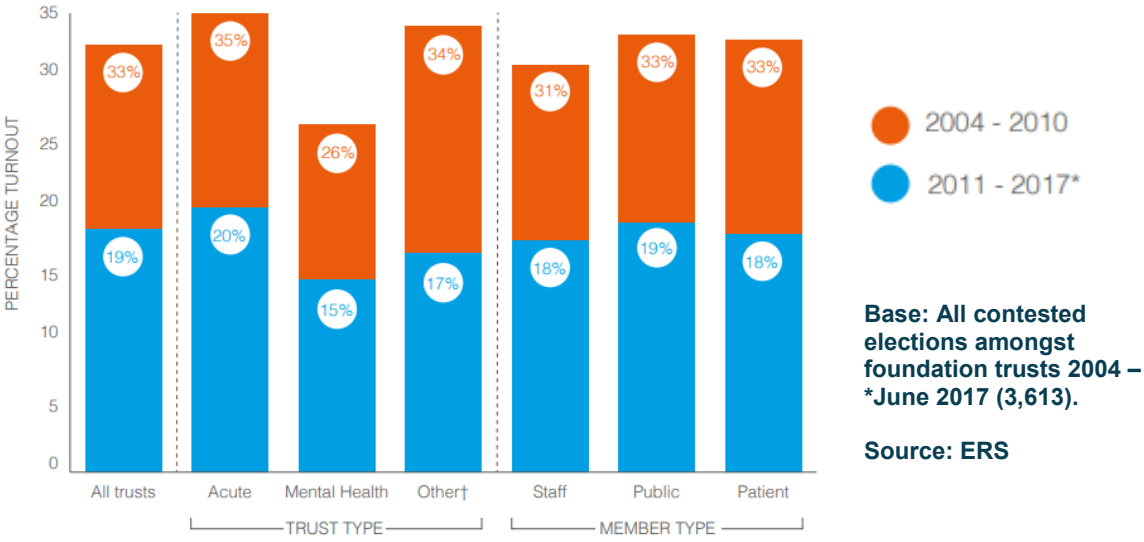
Please note that while all election data refers to authorised foundation trusts, in this particular section, the word ‘trust’ has also been used interchangeably for a more succinct read.

Election turnout

Based on data from 1,864 contested elections held by authorised foundation trusts between January 2011 and June 2017, the average turnout has been 19%, fourteen percentage points down from the average for 2004-2010 (33%).

Average turnout has been slightly lower in staff elections than in elections for public or patient seats, and average turnout for mental health trusts is lower than for acute or other trust types.

Figure 2: Average turnout by member and trust type



Base: All contested elections amongst foundation trusts 2004 – *June 2017 (3,613).

Source: ERS

Table 1: Number of contested elections by member and trust type

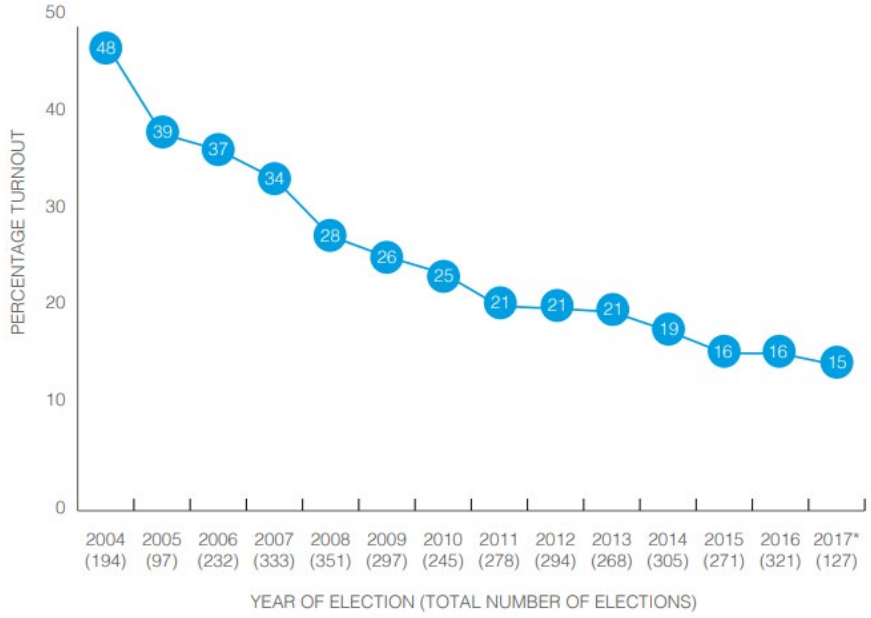
	All Trusts	Acute	Mental Health	Other†	Staff	Public	Patient
2004 – 2010	1,749	1,066	467	216	481	1,073	195
2011 - 2017*	1,864	1,219	545	100	484	1,275	178

†Other trust types include specialist, community (health and care) and ambulance trusts. These types have been combined due to the lower sample sizes for each.

Election turnout rates year on year

As observed from 2004 to 2010, average turnout has continued to decrease in the period from 2011 to June 2017. In 2011 foundation trusts undertook 278 governor elections and the average turnout rate was 21% and by 2017 the average turnout for the 127 elections held as of 30 June further reduced to just 15%.

Figure 3: Turnout since 2004

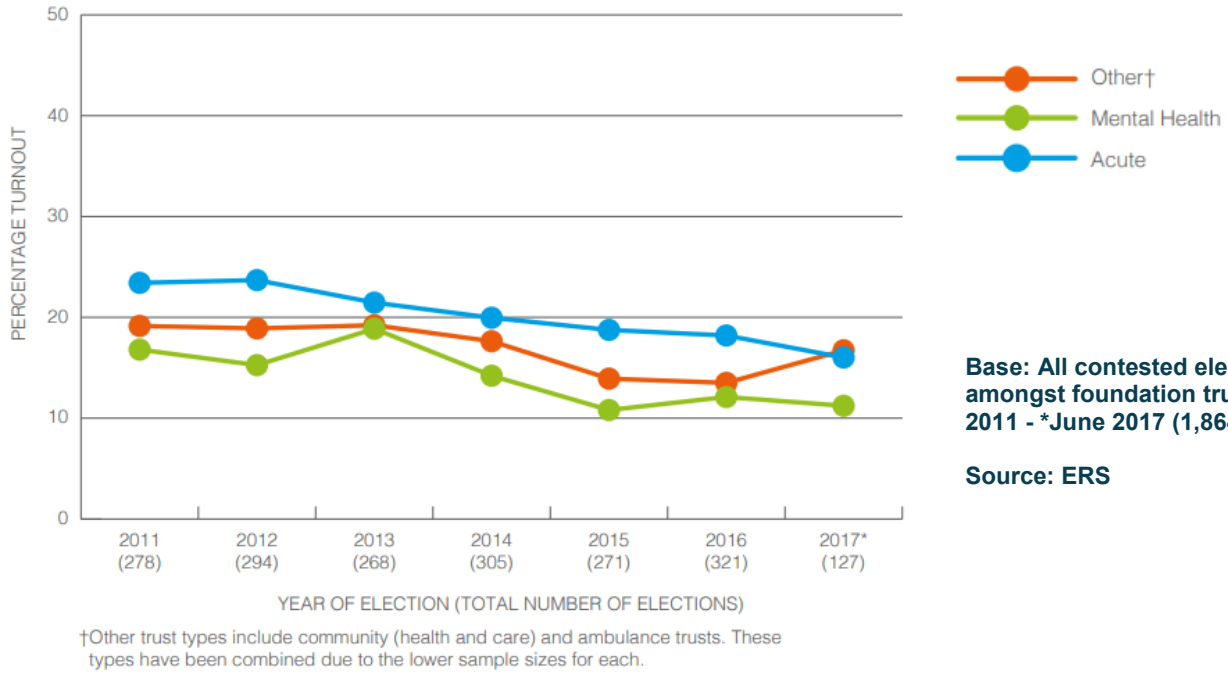


Base: All contested elections amongst foundation trusts 2004 - *June 2017 (3,613)

Source: ERS

The graphs below show that for 2011 to 2017 this downward trend is fairly consistent across all member and trust types. The average turnout for acute trusts does, however, consistently remain above average.

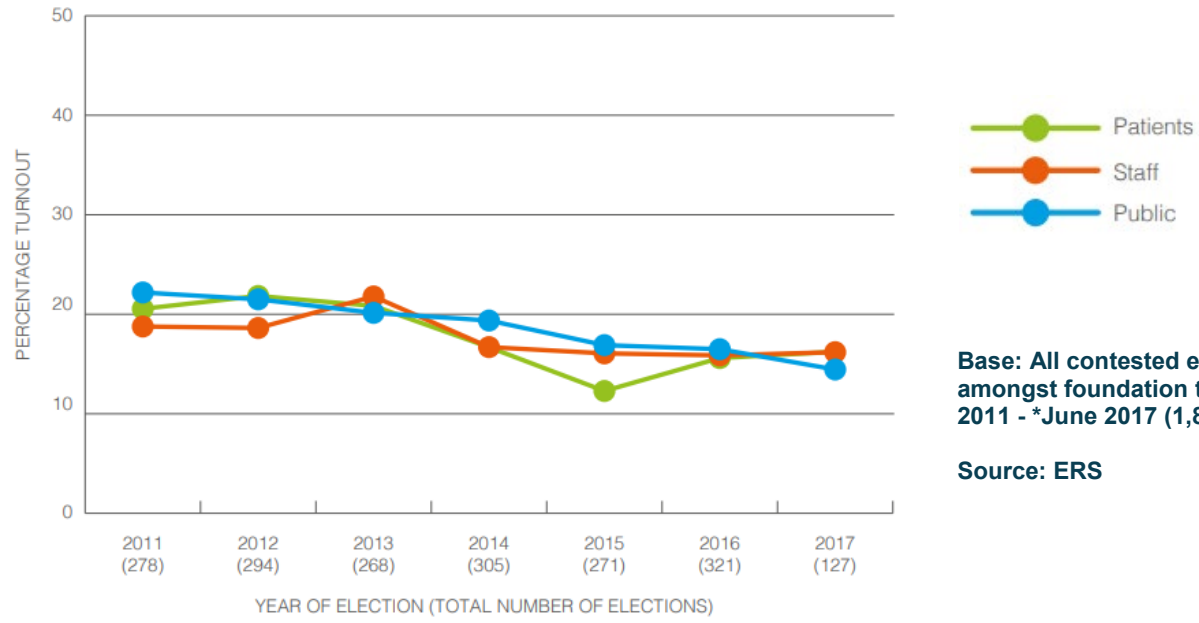
Figure 4: Average turnout by trust type



†Other trust types include community (health and care) and ambulance trusts. These types have been combined due to the lower sample sizes for each.

Base: All contested elections amongst foundation trusts 2011 - *June 2017 (1,864)

Source: ERS



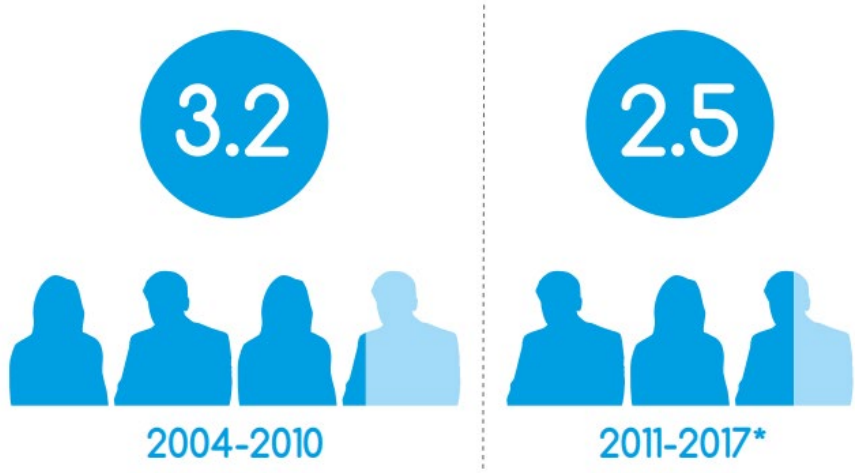
Base: All contested elections amongst foundation trusts 2011 - *June 2017 (1,864)

Source: ERS

Candidate numbers and vacancies

Beyond turnout, the number of candidates competing for a seat and the number of current governor vacancies may also be used as an indication of how well engaged foundation trust members are.

The average number of candidates per seat for all contested elections from 2011 to 2017 is 2.5, down from 3.2 for 2004 to 2010.

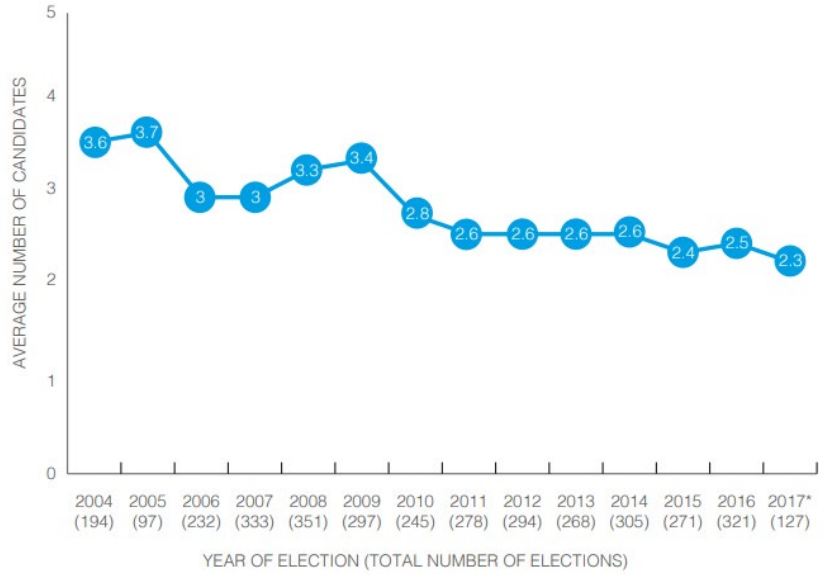


Base: All contested elections amongst foundation trusts 2004 - *June 2017 (3,613).

Source: ERS

Like turnout, the downward trend observed in 2011 has continued with the average number of candidates for contested elections decreasing to just 2.3 members per seat compared with 2.8 in 2010 and 3.6 in 2004.

Figure 7: Average number of candidates per seat since 2004

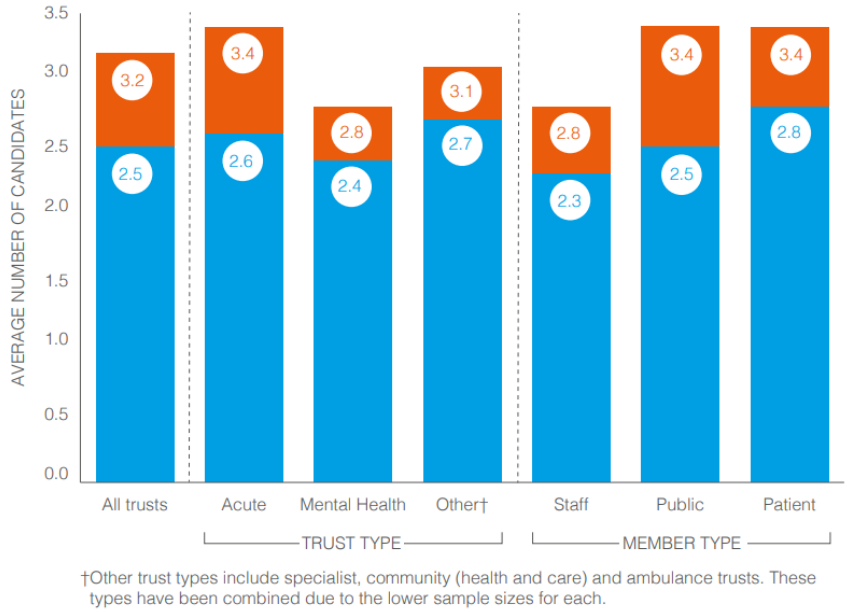


Base: All contested elections amongst foundation trusts 2004 - *June 2017 (3,613).

Source: ERS

Staff elections still tend to have fewer candidates with an average of 2.3 candidates per vacant seat compared to 2.8 candidates in patient elections from 2011 to 2017.

Figure 8: Average number of candidates per seat by member and trust type



†Other trust types include specialist, community (health and care) and ambulance trusts. These types have been combined due to the lower sample sizes for each.

Base: All contested elections amongst foundation trusts 2004 - *June 2017 (3,613).

Source: ERS

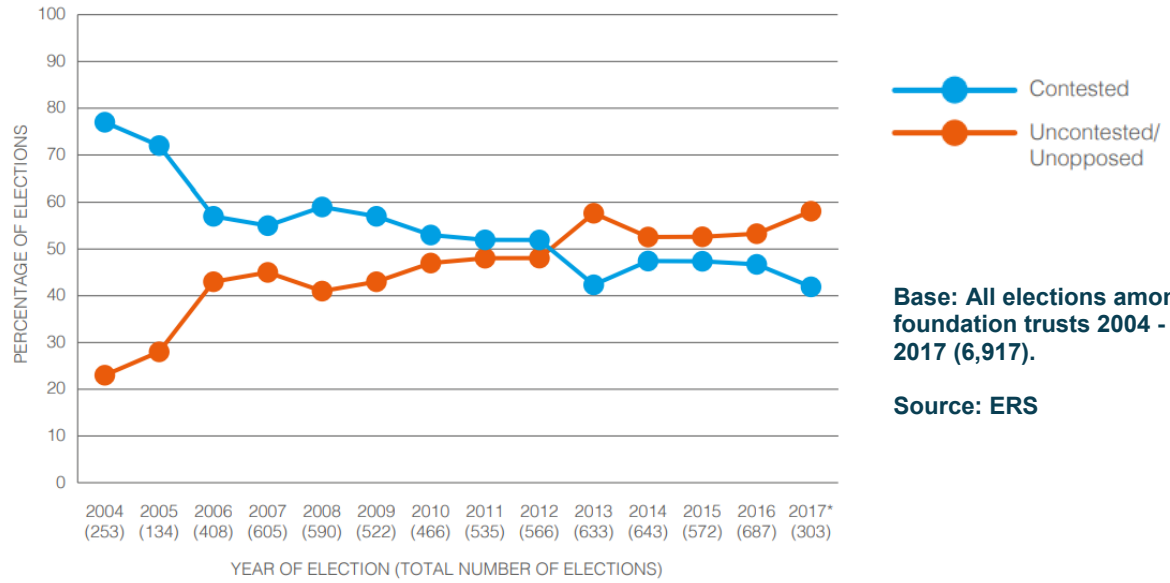
Uncontested elections

Another way to assess engagement is by looking at the proportion of uncontested or unopposed elections, that is to say elections where there are no candidates (and so no ballot takes place) or where there are fewer candidates than open seats (and so again no ballot takes place and a candidate is automatically elected).

This is important to consider in conjunction with the number of candidates per seat, as that only tells half the story. Though the number of candidates has decreased only slightly from 2011 to 2017, the number of uncontested/unopposed elections has increased substantially.

Of all electoral contests from 2011 to 2017 53% have been uncontested or unopposed representing a 12% increase since the 2004-2010 average. The number of uncontested or unopposed elections exceeded the number of contested elections in 2012, and has continued to increase.

Figure 9: The number of uncontested/unopposed elections since 2004

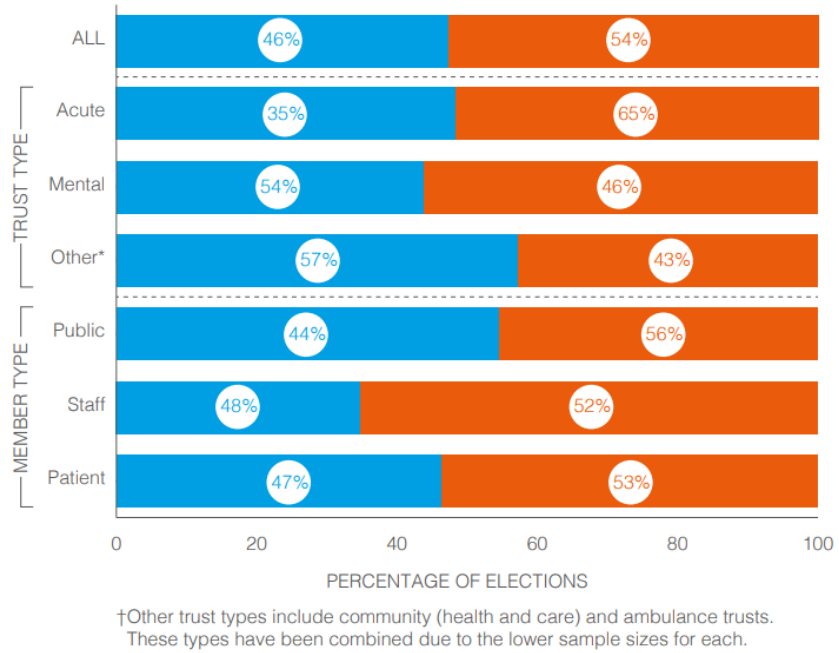


Base: All elections amongst foundation trusts 2004 - *June 2017 (6,917).

Source: ERS

The graph below shows that a slightly higher proportion of uncontested or unopposed elections can be found in mental health trusts and for staff elections.

Figure 10: Proportion of elections contested and uncontested/unopposed



†Other trust types include community (health and care) and ambulance trusts. These types have been combined due to the lower sample sizes for each.

Base: All elections amongst foundation trusts 2011 - June 2017 (3,939).

Source: ERS

Electronic voting – results and thoughts

Electronic voting tools (online, telephone or text) have been utilised across a number of sectors since the early 2000's. UK trade unions, for example, have used electronic voting in their ballots and non-statutory elections with increasing regularity since 2000. Building societies have integrated it into their AGM and Board electoral procedures for more than a decade, and associations and institutes started adding it as standard in the last 3-5 years, particularly as their member email data increased and digital communications became a greater focus of their activities and preferred tools. The vast majority of organisations currently using electronic voting provide their stakeholders with the opportunity to cast their vote online with very few providing telephone or text voting options.

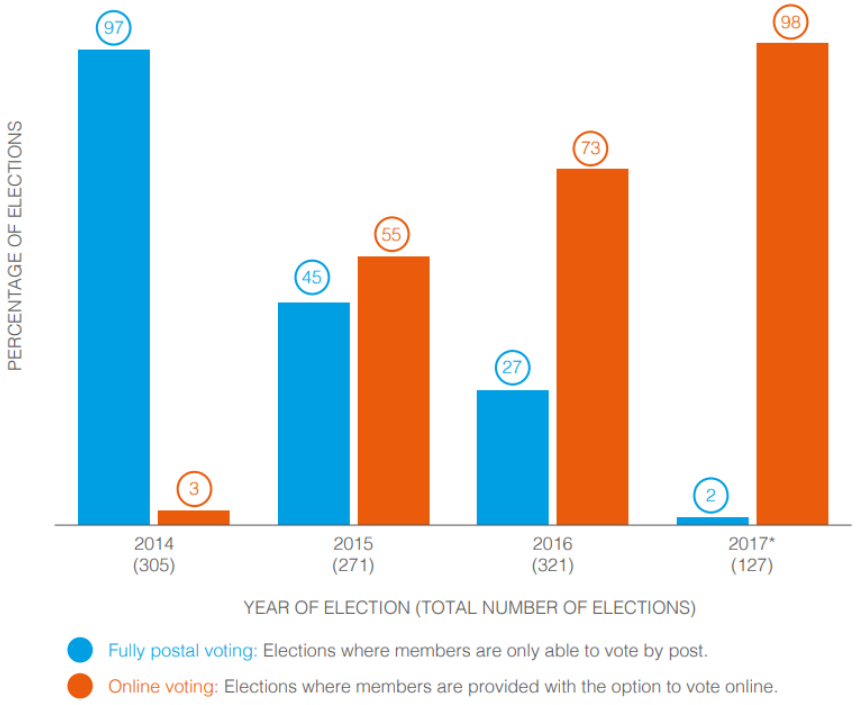
When the Model Rules for foundation trust elections were issued in 2003, there was no facility included to incorporate electronic voting. To that end, the first decade of foundation trust electoral activity – 2004 – 2014 – was solely postal voting.

With the declining average turnout showing no signs of changing course a number of foundation trusts sought a change in the model rules for elections, having seen organisations in other sectors incorporate electronic voting formats as standard and believing that it may offer the twin benefits of reduced costs and greater accessibility.

In late 2014, Lancashire Teaching NHS Foundation Trust ran a pilot designed to prove that electronic voting was viable, safe and beneficial. The pilot was deemed a success and later that year the foundation trust Model Election Rules, which had not been amended since their incorporation in 2003/04, were updated to allow for newer methods of voting to be included. Naturally, many foundation trusts had to change their individual constitutions, but this was a relatively straight-forward process.

Since 2015, trusts have increasingly been adding an online voting option (rather than telephone or text) on to their election methodologies and rules, primarily for cost saving reasons. Indeed, the graph below shows that in 2017 virtually all elections (98%) in the sector have an online component and so the updated provision in the model rules has without question been welcomed.

Figure 11: Postal and online voting since 2014



Base: All postal (510) and electronic (514) contested elections amongst foundation trusts 2014 - *June 2017 (1,024).

Source: ERS

So far, on the limited data we have, the simple addition of an online channel has not had a positive impact on turnout. Turnout was already heading downward and since the introduction by many trusts of online voting, this decline has continued.

There is an interesting aspect to the data that provides further insight: When foundation trusts use online voting there are two principal methods used to distribute voting instructions to their members – 1) posting voting papers out to all the electorate and allowing a response by either post or online (postal distribution), or 2) sending out voting instructions by e-mail to those members of the electorate with an email address enabling them to vote online only and posting voting papers to members with no e-mail address, (mixed distribution).

Figure 12: Turnout for electronic elections by distribution method

Base: All electronic contested elections amongst foundation trusts 2014 - June 2017 (514).

Source: ERS

What we have observed is that mixed distribution has resulted in a lower average turnout. What does this mean?

As pointed out previously, the data and time period is limited but is the indication that voters in these elections are more likely to see and read a postal communication than an email communication? Is information sent out via email lost in spam, or is it ‘missed’ or deemed less important held by many

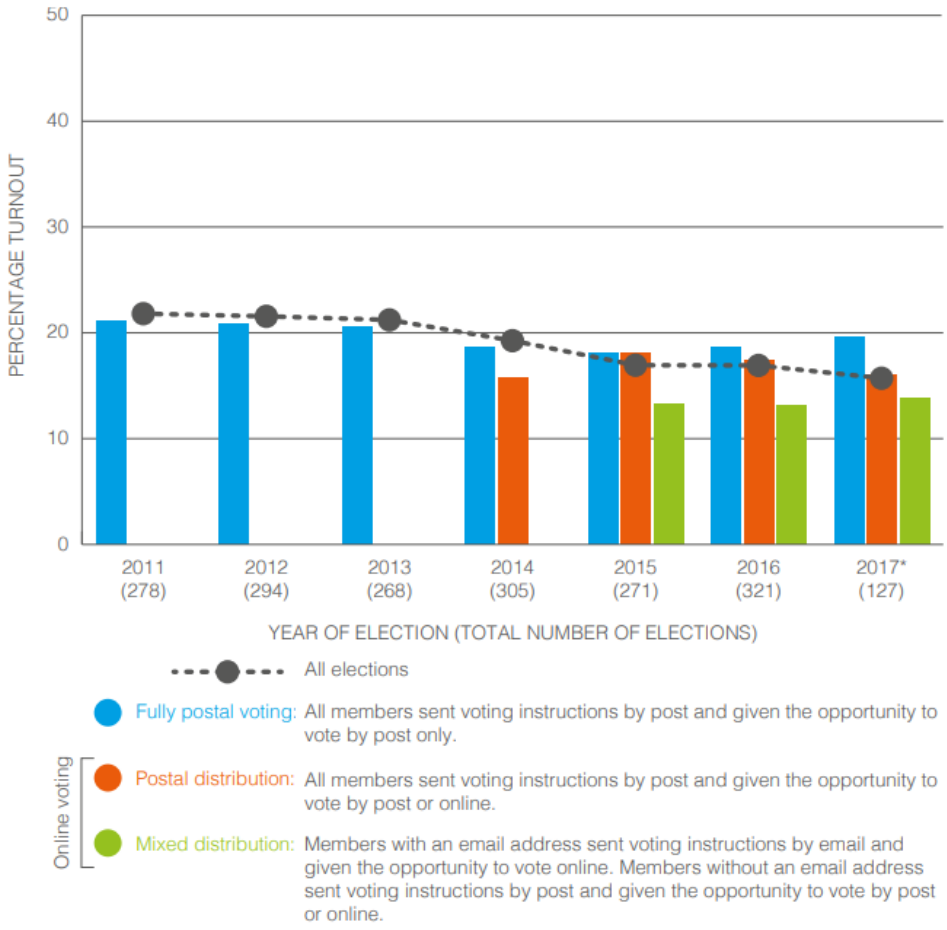
other email communications, from retailers, financial organisations and others? The figures are perhaps too marginal to solidly deduce this at this stage, but it is a possibility.

There is a school of thought that postal and paper communications create a greater impact, or at least a greater impact for certain topics. In 2014 Royal Mail's report 'It's all about Mail and Email' concluded the following:

- Consumers are feeling overwhelmed by the number of messages received and as such are more selective about the emails they choose to read
- Email is considered quick and informal
- Mail is considered authoritative and informative; as such it is more suited for communications where time is needed for consideration (e.g. elections where candidate statements should be read and compared).

Adding an online voting option in its simplest way – posting to all voters but allowing for a response online or by post – has a marginal benefit, however it can be said that the introduction of online voting is not, at least yet, reversing the downward trend of turnout. At best it could be postulated to have helped slow down the pace of decline, however that assertion is premature given the relative infancy of the format in this sector.

Figure 13: Turnout by voting and distribution method since 2014



Base: All contested elections amongst foundation trusts 2011- June 2017 (1,864).

Source: ERS

What is perhaps a fairer deduction to make at this point is that a mix of communications is needed and choice should be available. Postal communications and digital/email communications all have their place. Blending the two approaches and creating an intelligent, joined-up communications strategy for the election – for example a postal election mailing followed by a 'did you receive' email and reminder campaign – may be a better approach to take than emailing members with email addresses and assuming that they will have been looking out for that email and ready to vote. It

should also be considered that the quality of the electronic data (i.e. number of valid and current email addresses) is important too – most trusts know this and have for some years been improving the quantity and quality of their email data for members.

As mentioned earlier, one driver for trusts in adding online voting options has been the need to further reduce and control budgets. Online voting can undoubtedly help reduce costs – if postage costs, particularly despatch postage, can be reduced or removed along with print, paper and envelopes, then savings can be made. However, if this is at the expense of a higher turnout then the cost per voter could potentially go up, not down. Though is that how Trusts are assessing the spend vs value of their elections?

The two may well be mutually exclusive. Cheaper, functional elections can be run, but are unlikely to attract additional voters. Huge efforts can be made, however, with an election strategy involving both digital and postal communications, and it is quite likely this could add a few percentage points on to a turnout, though this does cost more. Trusts need to determine what the priority is – cost or turnout – and whether a lower turnout is subsequently weakening their governance. This brings into play a topic that has been a challenge since foundation trusts first came into being. It also highlights that when it comes to turnout, the election process itself is not the real story here, but rather wider member involvement.

Elections and turnout are a product of what has gone before. How are trusts using and involving their members and what is the 'sell' for membership? Do members receive regular communications, invites and are they involved in the trust in a meaningful way? Can decisions made in the trust evidence any influence from members? Are members informed and actively encouraged to participate? Or, are members hearing from the trust once a year, at election time, and presented with information about unfamiliar people, roles and uncontested seats in a way that does not inspire them to take part?

It is this area of member involvement and empowerment that some would argue needs the attention. The elections and turnouts, whether postal, online or a mixture of the two approaches are only as successful, participation-wise, as the existing relationship between the trust and their members. Electoral behaviour is simply a barometer of other conversations, relationships and activity that has gone before.

To sum up, turnout is only as good as a foundation trust's broader member engagement.

Members, voters & governors at a glance

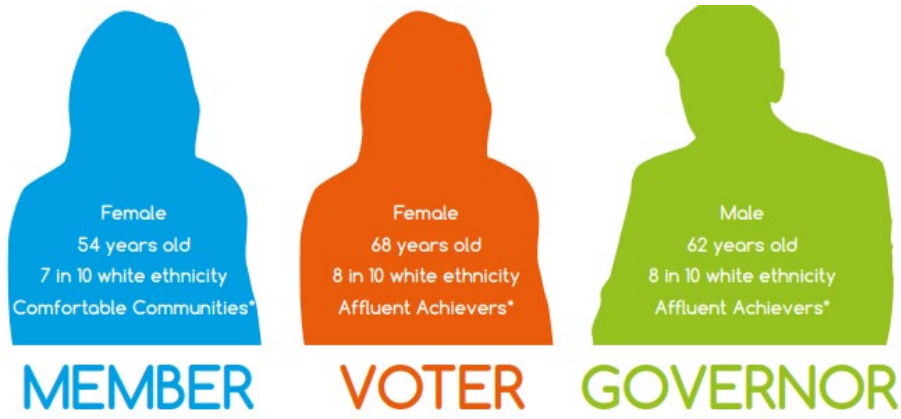
As established previously, all NHS foundation trusts have memberships, and each trust's membership must reflect the local population and community. The membership then has the opportunity to vote in elections held by the trust to elect a council of governors to represent their views.

When considering the turnout rates, number of candidates per seat and the number of uncontested or unopposed elections presented earlier in this report, it is important to consider not just how many members are taking part in the election process, but knowing what characteristics define them. Knowing which members take part and, crucially, which members do not take part can help to inform what may be done to not only increase turnout overall, but also make elections more inclusive.

The following chapter details MES' analysis of over 1.7 million anonymised and aggregated public and patient member records across 168 NHS trusts and foundation trusts, looking at age, gender and ethnicity profiles and using CACI's Acorn socioeconomic data, to establish the current profile of trust members, voters and governors.

Staff members were excluded from this analysis due to the different nature of their relationship with the trust - they join by nature of their employment rather than having been recruited to represent the local area population. Indeed many trusts choose to maintain their staff member records internally due to the more regular churn of staff than public or patient members. As such, MES hosts a lower proportion of staff member records and the records it does hold are far less likely to contain the demographics analysed in this section of the report. Similarly, appointed governors who take up a seat on behalf of local stakeholders have been excluded from this analysis, as they are not directly elected by the membership and trusts are far less likely to collect and hold the relevant demographic information for these individuals.

Figure 14: The average trust member, governor and voter



Base: Public and patient members (1,708,495), voters (48,462) and governors (1,228) – 10 July 2017

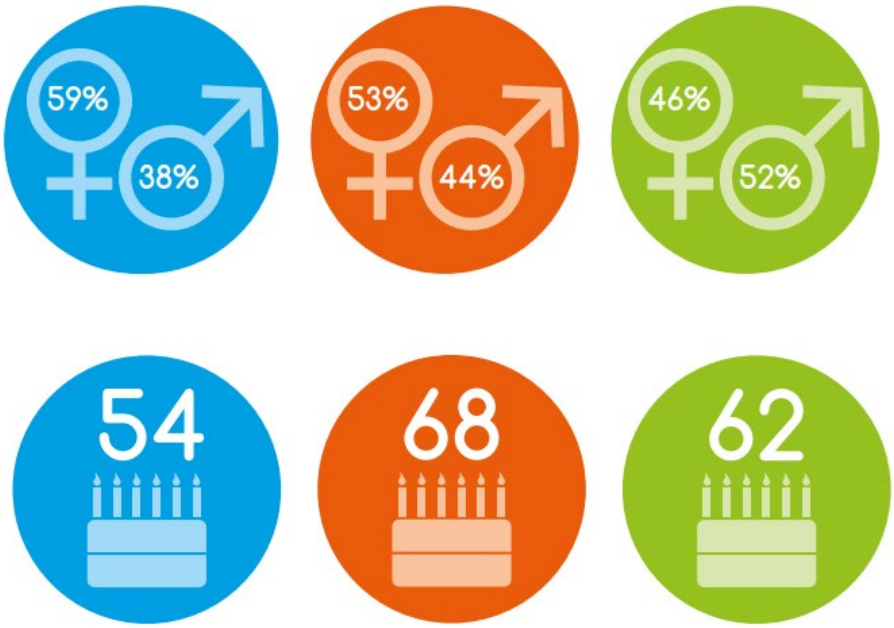
Source: MES & ERS

Age and gender profile

Trust members are more likely to be female and tend to be older, with around half aged 50 and over.

Though female members still represent a slight majority of trust voters, males are overrepresented among public and patient trust governors. Both voters and governors tend to be older still, with over three quarters of each group aged 50 and over.

Figures 15 & 16. Gender and average age of members, voters and governors



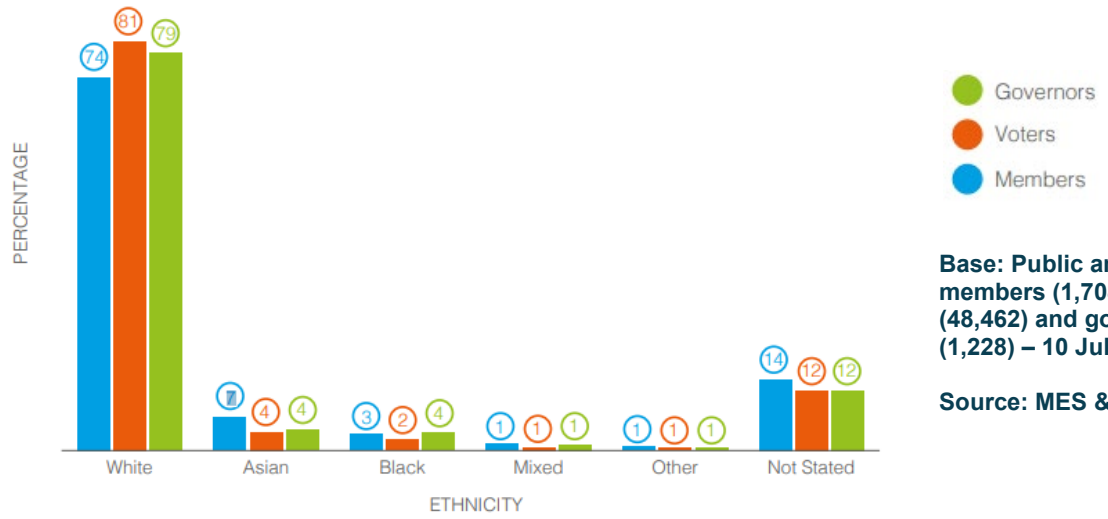
Base: Public and patient members (1,708,495), voters (48,462) and governors (1,228) – 10 July 2017

Source: MES & ERS

Ethnicity profile

Nearly three quarters of members are white compared to a slightly higher proportion of voters and governor (8 in 10).

Figure 17: Ethnicity profile of members, voters and governors



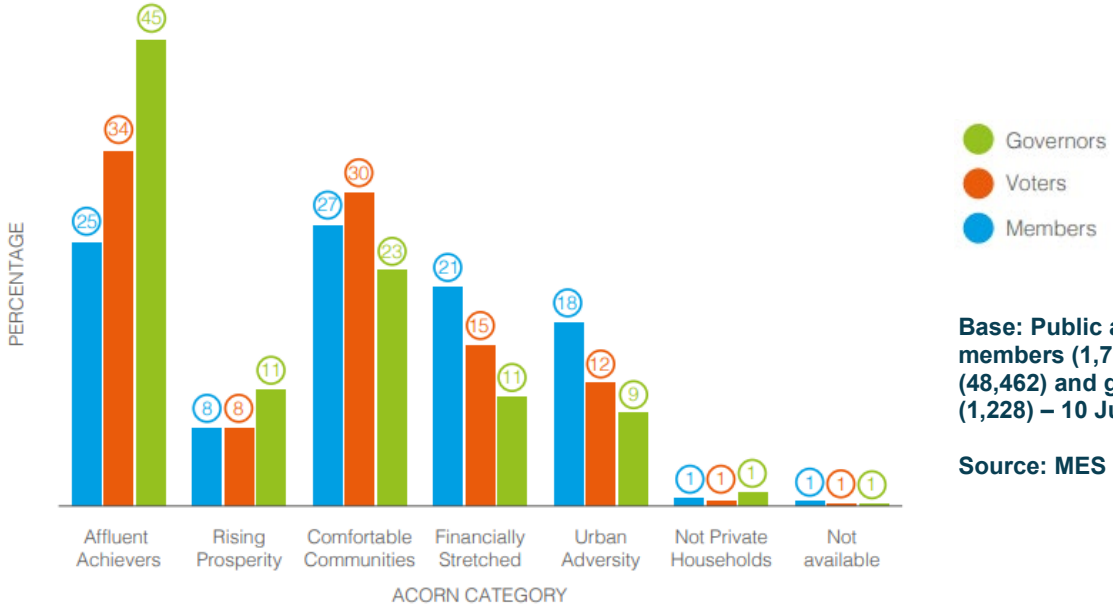
Base: Public and patient members (1,708,495), voters (48,462) and governors (1,228) – 10 July 2017

Source: MES & ERS

Sociodemographic profile

Acorn is a geodemographic segmentation of the UK's population. It segments households, postcodes and neighbourhoods into 6 categories, 18 groups and 62 types. By analysing significant social factors and population behaviour, it provides precise information and an in-depth understanding of the different types of people.

Figure 18: Acorn profile of members, voters and governors



Base: Public and patient members (1,708,495), voters (48,462) and governors (1,228) – 10 July 2017

Source: MES & ERS

Just over half of members reside in postcodes which CACI's Acorn categories describe as 'Affluent Achievers' or 'Comfortable Communities'. Voters and governors are likely to be even more well-off than the wider membership, with nearly half of public and patient governors categorised as 'Affluent Achievers' compared to around a third of voters and a quarter of members.

'Affluent achievers' are some of the most financially successful people in the UK and tend to be middle aged or older, predominate with many empty nesters and wealthy retired. A high proportion of these individuals are very well educated and employed in managerial and professional occupations. Usually confident with new technology and established at the top of the social ladder.

Those living in 'Comfortable Communities' represent much of 'middle-of-the-road Britain' – they may not be very wealthy, but they have few major financial worries. All life stages are represented in this category, from stable families and empty nesters to comfortably off pensioners and younger couples starting their lives together. Employment is in a mix of professional and managerial, clerical and skilled occupations and educational qualifications tend to be in line with the national average.

What does it mean?

One would need to analyse the profiles of all members who stood for governor, not just those who were successful, to build a solid theory as to why governors in particular tend to be older, whiter and wealthier than the average trust members – is it predetermined by the types of individuals who put themselves forward or indicative of some other bias among the trust voters?

However, just knowing more about trust members, voters and governors and taking a closer look at who and who is not taking part, can enable trusts to have more informed, meaningful conversations about how to better engage.

If older members are voting, could it simply be a matter of their higher likelihood of being retired and therefore having more time to take part in elections or stand for governor whereas their working age counterparts may not? If a trusts holds members events or lectures during the working day, might it be beneficial to hold a few in the evenings as well? Are trust communications engaging and concise enough to entice the member scanning through their emails on a lunch break?

These are the types of conversations that in themselves demonstrate not only a trust who is bothered about good engagement, but one which can hopefully effect change to see a difference.

Civica
33 Clarendon Road
London N8 0NW
Telephone: 020 8829 2330

Email: engagement@civica.co.uk
Twitter: @CivicaES
Website: www.civica.com/engagement