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Health Board Elections
and Alternative Pilots:
Final Report of the
Statutory Evaluation

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HEALTH BOARD ELECTIONS AND ALTERNATIVE PILOTS: FINAL REPORT OF THE STATUTORY EVALUATION

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The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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EXECUTIVE SUMMARY

0.1 This report describes the statutory evaluation of the NHS Scotland health board electoral and alternative pilot projects, arising from the Health Boards (Membership and Elections) (Scotland) Act 2009. It should be read in conjunction with the accompanying literature review that presents relevant research findings and experience from around [the world](#).

0.2 Parliament's declared legislative intent in passing the 2009 act was to increase local accountability and to address a perceived democratic deficit in wholly appointed Health Boards.

0.3 Two NHS boards, Dumfries and Galloway and Fife held elections for 10 and 12 members respectively. Two other boards, Grampian and Lothian explored alternative ways of recruiting and selecting 2 new appointed members each.

0.4 This evaluation shows that it is possible to successfully hold direct elections for NHS health boards. Members of the public are prepared to stand in considerable numbers. The electoral turnout was low. In general, those who stood showed similar characteristics to those who were appointed under the existing system; they are middle aged or older, mainly male, white and professional. However amongst those elected, approximate gender balance was achieved. It also appears that in some cases, reasons for standing in elections differ from those generally seen as motivating the seeking of board appointment. Specifically, a number of candidates, including some who were successful, stood on electoral platforms that were clearly driven by contentious local issues, for example, planned hospital closure or transfer of services.

0.5 This subsequently impacted the way board business was conducted. In one of the elected Boards, votes on issues became more common. Members were more likely to ask for their specific and sometimes dissenting contribution to be specifically recorded in the minutes. Dissenting opinions were more likely than previously to find their way into the press. By comparison, the impact of the alternative pilots was more subtle. This was probably a result of relatively few new members being introduced.

0.6 The costs of mounting the elections for the two boards totalled £773,256. For a number of reasons, it is not easy to accurately predict the cost of holding elections on a national basis, but a reasonable minimum estimate would lie in the range of £11M to £12M. Again the cost of rolling out the alternative pilots would be much smaller, about £224,000 per year, and £112,308 per appointment round, at 2010 prices.

0.7 This report provides in its Conclusion and Summary section an explanation of the advantages and disadvantages of three possible ways forward in terms of filling non-executive positions.

0.8 The current system has the advantage of being well understood, relatively cheap and allowing for the selection of individuals based on specific skills. However it is perceived as somewhat lacking local accountability and as being

responsible for generating boards that are not demographically representative.

0.9 The alternative pilots demonstrate possible ways of partially addressing the perceived weaknesses of the current system. Specifically, a broader recruitment process which makes clear that interest is particularly welcome from those traditionally underrepresented on boards undoubtedly has something to contribute. However the existing selection process that then follows initial long list recruitment needs careful reassessment, and probably modification, if this approach is to be fully effective in addressing Parliament's legislative intent.

0.10 Finally, direct elections have both considerable advantages and drawbacks. They directly address issues of local democracy and accountability and thus have the potential to change the way boards function through increasing the level of challenge to Chairs, Chief Executives and indeed the Scottish Government. One counter argument is that elected boards may not be able to function as effective corporate entities. We saw no evidence of this during the pilot period. The electoral pilots attracted large numbers of candidates. The general public did not turn out in large numbers to vote although those who were older were more likely to vote. Voter turnout amongst 16 and 17 year olds was particularly low reflecting perhaps the novelty of this group being able to vote for the first time. Many electors claimed they had inadequate information about Health Board elections. Furthermore the literature suggests that turnout may fall in subsequent electoral rounds. The process is costly in comparison to the existing system (whether it continues as is, or is amended in line with the alternative pilots). However, it could be argued that even an estimated cost of £12M (incurred every four years) is relatively modest in comparison to the budget of NHS Scotland as a whole.

0.11 The complex process of weighing these somewhat subjective factors means that the decision on which system to adopt is of necessity a political and parliamentary one rather than a technical one. However we hope our research findings will inform this decision by outlining the advantages and disadvantages of the different strategies and their costs (including the uncertainties surrounding those costs) as well as the possible impacts on the Boards, and resultant changes in the relationships between the Government, the Public and the NHS.

1 INTRODUCTION

1.1   Scotland has enjoyed the benefits of a National Health Service (NHS) since 1948. Throughout its existence the delegation of powers to geographically-defined boards has been a key feature of its management arrangements. The exact number and function of these local entities has varied, with hospital and community services being run separately at times. However, by and large the Scottish NHS has been characterised by stability, integration and an adherence to the founding principles of the NHS. In recent years this adherence has included a reemphasis of the concept of mutuality. Long-standing debates have continued around a number of issues. For example, there has been debate about how to balance a desire for local autonomy with the need to support rational regional planning. Governance arrangements have also come under scrutiny. Again, balance is a key issue with national imperatives and delegated managerial autonomy needing to be tempered with local community engagement and accountability. Central to achieving this balance is the way in which non-executive directors are selected/elected to boards.

1.2   Until the 1990s, appointments to boards tended to be in the gift of the UK government of the day. From 1995, the Nolan Commission reported on standards in public life, in the first of a series of reports that would enunciate clear principles for public sector activity and transform public sector practices, including the selection of board members[1]. Nolan principles and practices meant that nonexecutive directors had to be, among other things, selected on merit by panels with a substantial independent element (although ministers retained the ultimate power of appointment). Government and the public sector invested in formal appointment mechanisms designed to produce this independently validated, merit-based selection, including the Public Appointments Commissioner for Scotland and reformed mechanisms within boards for identifying merit and advertising board positions. In Scotland, 'unified boards of governance' for NHS services were created in 2000, but it was with the 2004 dissolution of NHS Trusts and Primary Care Trusts that the current structure of unified territorial Boards emerged. The current 14 territorial Boards have responsibility for the planning and delivery of almost all health care in their geographical areas, including public health. Whilst the 2000 and 2004 changes returned NHS Scotland more closely to its traditional organisational arrangements, it did not address what some perceived as the "democratic deficit" inherent in appointed governmental bodies. The rest of this chapter describes the introduction of electoral and alternative pilots as a means of seeking to address issues of engagement and accountability.

1.3   By 2010, the board of directors in each Health Board was made up of

- Between five and nine non-executive lay members: appointed by the Cabinet Secretary for Health & Wellbeing in a process overseen by Office of the Commissioner for Public Appointments in Scotland (OCPAS)

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[1] Available at http://www.public-standards.gov.uk/OurWork/Other_Reports_and_Research.html

- Non-executive stakeholder members: including a senior Councillor from each of the local authorities in the Board area; an Employee Director; the Chair of the Area Clinical Forum; and a University Medical School member (in the main teaching Health Boards)
- Executive members: senior managers within the Health Board.

1.4   The Health Boards (Membership and Elections) (Scotland) Act 2009[2] was introduced by the Scottish Government with the stated objective of improving public confidence in the health system. Prior to the 2007-11 Parliamentary session the Scottish National Party manifesto had contained a commitment to "Introduce direct elections to health boards" so that "at least half of health board members will be elected by the public."

1.5   This commitment was made against the backdrop of a number of high profile campaigns against NHS service reconfigurations.

1.6   The Christie Commission has suggested that enhancing public engagement and accountability should be a priority for Scotland's public services[3]. The legislation that enabled these pilots makes direct reference to both.

1.7   The Health Boards (Membership and Elections) (Scotland) Act 2009 follows several other measures that have aimed to increase public involvement and accountability in NHS decision making. Measures introduced by previous administrations include a statutory duty for Boards to involve the public in decision-making, encouraging Boards to establish Public Partnership Forums, the inclusion of representatives of Local Councils on Boards, and establishing the Scottish Health Council to promote greater public involvement in the NHS and support NHS Boards in improving their patient and public participation. Since 2007, as part of the agenda for a mutual NHS, the Government has introduced its NHS Quality Strategy, which has a "person-centred" ambition, the Participation Standard against which Boards self-assess how well they are doing in meeting its three specific elements and increased opportunities for members of the public to ask questions at their Board's Annual Review event.

1.8   The Health Boards (Membership and Elections) (Scotland) Act introduced direct elections to the Health Boards. It did so by allowing the Scottish Government to pilot direct elections to two of the territorial Health Boards, namely NHS Dumfries and Galloway and NHS Fife. The Act and supporting regulations required that

- Direct elections be held for new Non-Executive Directors
- These new members, together with Councillors nominated by Local Authorities and appointed by Ministers, form the majority of the members on each Health Board.
- All voting in the elections be postal
- The elections use the Single Transferable Vote system and the whole of each Health Board area form a single electoral ward

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[2]Available at www.uk-legislation.hmso.gov.uk/legislation/scotland/acts2009/pdf/asp_20090005_en.pdf
[3] Available at http://www.scotland.gov.uk/Resource/Doc/352649/0118638.pdf

- The franchise be extended to include 16 and 17 year olds in the pilot areas
- Candidates' campaign spending was limited to £250 each

1.9 In effect, these rules meant that NHS Dumfries and Galloway needed ten new elected members while NHS Fife needed twelve. The appointment of the Chair of each Health Board would continue to be a Ministerial one following the standard public appointment process. The Health Boards would remain accountable to Ministers and be required to comply with regulations and Ministerial directions.

1.10 Notices of election were to be published between the 15th and 22nd of April 2010. Members of the public were then able to put themselves forward as candidates for election until the 6th of May 2010. Candidates needed to live or work in the Board area, and a few senior NHS Executives and staff working closely with the Board were not able to seek election, but otherwise the eligibility criteria were similar to those for candidates for election to the Scottish Parliament or Local Councils. Between the 8th and 13th of May, Returning Officers in the pilot areas issued voting packs to eligible electors. The packs contained their ballot paper plus a booklet of 250-word candidate statements from each person seeking election. The poll closed at 4pm on 10 June 2010.

1.11 During the passage of the bill, Scottish Ministers also agreed to two alternative pilot schemes. These were to attempt to enhance the existing public appointment processes and increase the diversity of candidates applying to become members of Health Boards without direct elections. The alternative pilots were assigned to NHS Grampian and NHS Lothian. These Boards were each given two new Non-Executive Director posts, and the number of Executive Directors who were formal members of the Board was to be reduced. The Boards were to be allowed to innovate in the recruitment of applicants for these new non-executive positions, but the selection process was to follow Office of the Commissioner for Public Appointments in Scotland (OCPAS) guidelines.

1.12 The Act stipulates that the pilots must be evaluated, and a report on the evaluation laid before Parliament, before any decisions can be taken on whether any of the pilots will be rolled out across Scotland. The evaluation was commissioned by the Scottish Government in January 2010 and undertaken by a consortium which included London School of Economics Enterprises and the University of St Andrews. This report summarises the evaluation methods and results.

The report starts with a methods section (chapter 2) in which we lay out how we have responded to each of the aims of this statutory evaluation. In chapter 3 we explore how the elected and alternative pilots worked in practice. Starting with the elected pilots we cover the demographics of candidates and those elected, review data on turnout rates including comparing it to general election rates. We also here detail the processes involved in the alternative pilots. Chapter 4 explores the costs of these pilot schemes and seeks to extrapolate to a national level should the parliament decide to proceed with

their more widespread introduction. Chapter 5 explores the impact that these pilots have had on the functioning of NHS boards. In chapter 6 we present suggestions for improving the pilots should they be rolled out and in chapter 7 we conclude by looking at the relative advantages and disadvantages of each approach.

2   METHODS

The Scottish Government set us eight objectives for this research.

This section explains how we have addressed them.

Statutory Aim 1: Assess the level of public participation in Health Board elections

Candidate experiences

2.1   We wrote to all candidates for the elections, in both Dumfries and Galloway and Fife, asking to arrange a short interview prior to the election. We interviewed all candidates who consented. We discussed their background and motives for seeking election, their experience of the election process, and their expectations about their role if they were to be elected.

Voter turnout

2.2   We selected a random sample of 6000 names from the electoral register, 3000 from Fife and 3000 from Dumfries and Galloway. These samples represented roughly 1% and 2% of registered electors, respectively. We examined those electors' behaviour in three ways.

2.3   We sent a survey form to these electors' registered addresses within a few days of the election, and followed up with two reminders if required. Our survey attracted a 31% response rate, which is a fair response for a survey of this type. The survey asked electors whether they had voted in the Health Board Elections, and the General Election for comparison, and why (or why not). It also asked how much information they had about the two elections, gauged their level of interest in the two elections, and collected data on age, sex, ethnicity, education, length of residence in the Board area, disability, carer status, dependent children, general health and contact with the NHS. All forms were marked with an identifying number which allowed us to link electors' responses to their entry on the official marked register.

2.4   We then examined the entries for those 6000 electors on the marked registers for both the Health Board Election and the General Election. The identifying numbers on the forms allowed us to link returned survey forms with postcodes, and by comparing these postcodes with the Scottish Index of Multiple Deprivation we were able to test whether the responses were coming disproportionately from members of the sample of 6000 who were living in affluent or deprived areas. This gave us an indication of how far respondents to our survey were representative of the population. Examining the marked registers also enabled us to identify respondents who had not recalled whether they voted or not accurately.

2.5   Finally, we conducted in-depth interviews with 20 electors.

Young electors

2.6   These were the first Scottish elections in which 16- and 17-year-olds were eligible to vote. Recognising that young electors' experiences of the process might be distinctive, we paid particular attention to the views of 16- and 17-year-olds. No respondents to our survey who fell into this category responded to our requests to arrange in-person interviews. We therefore contacted some members of youth organisations and arranged focus groups with students in appropriate schools and colleges. These focus groups probed students' knowledge about the elections and views on how far they met the needs of young electors.

2.7   A total of eight focus groups involving 59 pupils were conducted: three in two secondary schools in Fife and five in two secondary schools in Dumfries and Galloway. We chose the schools that we approached with the objective of maximising the difference between their catchment areas. In Fife this was an affluent catchment area, and a catchment area with significant levels of deprivation. In Dumfries & Galloway, groups were conducted in a town centre school and a rural school. Students were in 5th and 6th year, and between 16 and 18 years old. Focus groups took place in class time, during the timetable slots allocated to Personal and Social Education or Modern Studies. Focus groups took place between November 2010 and February 2011. This was longer after the election than ideal, but delayed by the process of gaining ethical approval and agreement from schools.

Statutory Aim 2: Assess whether having elected members on Health Boards led to increased engagement with patients and other members of the public or improved local accountability.

Board interviews and observations

2.8   Interviews with Board members were a key component of our research strategy. Existing members were clearly in a strong position to observe any changes in how the Board operated, including increased engagement and improved accountability. We explicitly raised the issue of the relationship between the Board and members of the public in our interviews. Newly elected members were asked about their behaviour since being elected to find out whether they related to the local population differently from other non-executives in the past or their new colleagues. They were also asked specifically about what they perceived their relationship with the public to be, and to whom they saw themselves as accountable.

2.9   We interviewed members of the pilot Health Boards before the elections to establish a clear picture of how each individual Board was operating at that point. We interviewed both Executive and continuing Non-Executive Directors after the elections had taken place to find out what they thought had changed, and we interviewed all elected members at least once. We eventually interviewed most of the members who were in place both before and after the

elections, and all the elected members[4]. We also contacted key non-Board staff and stakeholders.

2.10   We regularly observed public Health Board meetings, as well as private events such as committee business and development sessions by negotiation with the Board Chairs. These observations informed our interviews.

2.11   In addition, we conducted selected interviews in Tayside Health Board to keep abreast of the kind of development in public and patient engagement taking place across the NHS.

Media monitoring

2.12   We reviewed press coverage of the pilot Boards between March 2010 and December 2011 to find out whether the pilots were having an impact on coverage. We used the NHS Scotland Media Monitoring database (www.media.scot.nhs.uk) to pick up coverage from the BBC, ITV, the national newspapers (the Sun, Daily Record, Scotsman, Herald, Daily Mail, etc.) and some of the local newspapers (the Courier, the Evening News, and the Press and Journal). This database also picks up some press releases from the Scottish Government and large charities. In both Dumfries and Galloway and Fife the local print media are highly fragmented, with many local newspapers covering individual communities. The media monitoring service does not cover these. We accessed print copies of these newspapers and made copies of articles that referred to the elections, discussed or quoted Board members, or raised issues that were relevant to our research.

Statutory Aim 3: Estimate the cost of holding the pilot Health Board elections and the estimated cost of holding future Health Board elections in all Health Board areas

2.13   We obtained figures for the costs of the pilots from the pilot Health Boards, the Dumfries and Galloway and Fife Returning Officers' staff, and the Scottish Government Public Appointments Unit. We consulted with experienced Returning Officers' staff, OCPAS assessors and civil servants for information on the details of election and public appointment processes and their cost implications. We have then estimated the cost of any national rollout based on the pilot figures. The details of our calculation are presented in the section on 'Costing'.

Statutory Aim 4: Review existing research evidence on elected health boards from elsewhere and draw out implications for the development of pilots in Scotland

2.14   We conducted a review of both academic and policy literature on elections to bodies analogous to territorial Health Boards in other jurisdictions. That review is being published alongside this report and contains its own methodology section.

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[4] A small number of Board members had to be excluded due to their personal circumstances, such as absence or ill health, and we did give the option of not speaking with us to any members who felt uncomfortable.

Statutory Aim 5: Examine the process of implementation of, and arrangements for, the pilot health board elections

2.15   We examined the voting materials and attended one of the counting sessions. We have examined media coverage of the Health Board elections, and interviewed Returning Officers' staff to gather their views on the implementation of the elections. We also invited candidates in the elections, key staff of the Health Boards, stakeholders and a number of voters to discuss the election process in their interviews

Statutory Aim 6: Impact of alternative pilots

2.16   Our examination of the alternative pilots was broadly similar to our approach to the elections, apart from the analysis of the election process and results. We observed Health Board meetings, committees and development sessions both before and after the new members were appointed. We monitored media coverage of the alternative pilot Boards, and surveyed applicants for the new non-executive posts [5]. We raised the issue of the alternative pilots with stakeholders. Perhaps most importantly, we arranged in-person interviews with existing members of these Boards to find out about any changes they had noticed over the course of the pilot, and interviewed the new members to find out about their personal experiences.

Statutory Aims 7 and 8: Strengths and weaknesses, costs and benefits of both the pilots and alternative pilots and implications for future models of rollout of elections and models for public engagement and involvement in NHS Scotland.

2.17   We have prepared a summary of what our respondents have seen as the key strength and weaknesses, costs and benefits of the pilots in this report. As requested, we have also included respondents' reflections on the execution of pilots so that, if Parliament does choose to roll out any of the pilots nationwide, improvements can be made based on past experience. We conclude by offering suggestions for improving the pilots. These are either ideas that were suggested to us during the course of our research and that we find plausible or they are ideas that arise from own experience and knowledge of the literature.

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[5] We could not contact applicants before the selection process had concluded, and attempting to interview all applicants after they were notified that they had been rejected was not felt to be appropriate. We did interview a few unsuccessful applicants.

3   SELECTION OF CANDIDATES

Elections

We have considered what kinds of people put themselves forward as candidates, which potential voters actually took part in the election and who was eventually elected.

Candidates

3.1   70 people sought election to the Board of NHS Dumfries and Galloway, 60 to the Board of NHS Fife[6]. The ballot papers and candidate statements sent to electors were therefore unusually long.

3.2   Our survey of candidates, to which 83 candidates (64%) responded, suggests that the demographics of the candidates were fairly similar in both Boards (Fig. 3.1). The candidates were overwhelmingly between 41 and 60 (36% of the total) or 61 and 80 (51.8% of the total). Dumfries and Galloway had one candidate who was over eighty, one under 19, and one between 19 and 40; Fife had five candidates aged between 19 and 40 but none over 80 or aged less than 19.

Figure 3.1: Age of candidates
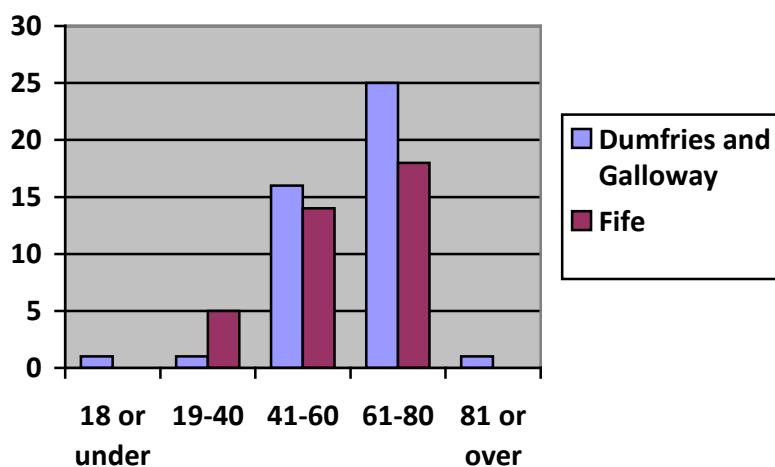
3.3   Most candidates were long-established residents of their Health Board areas, with 88% reporting they had lived there for over five years. Our responses indicated 71.1% were male and 96% were white (which means two candidates did not give information and one, in Fife, was not white). Five candidates (6%) had a first language other than English. The geographical distribution of candidates is indicated on the map, figure 3.2. This figure is based on the addresses printed on the ballot paper and therefore includes all candidates and not only those who responded to surveys.

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[6] Sadly, one candidate in Fife was killed in a traffic accident a few weeks before the election.

Figure 3.2: Geographical distribution of candidates
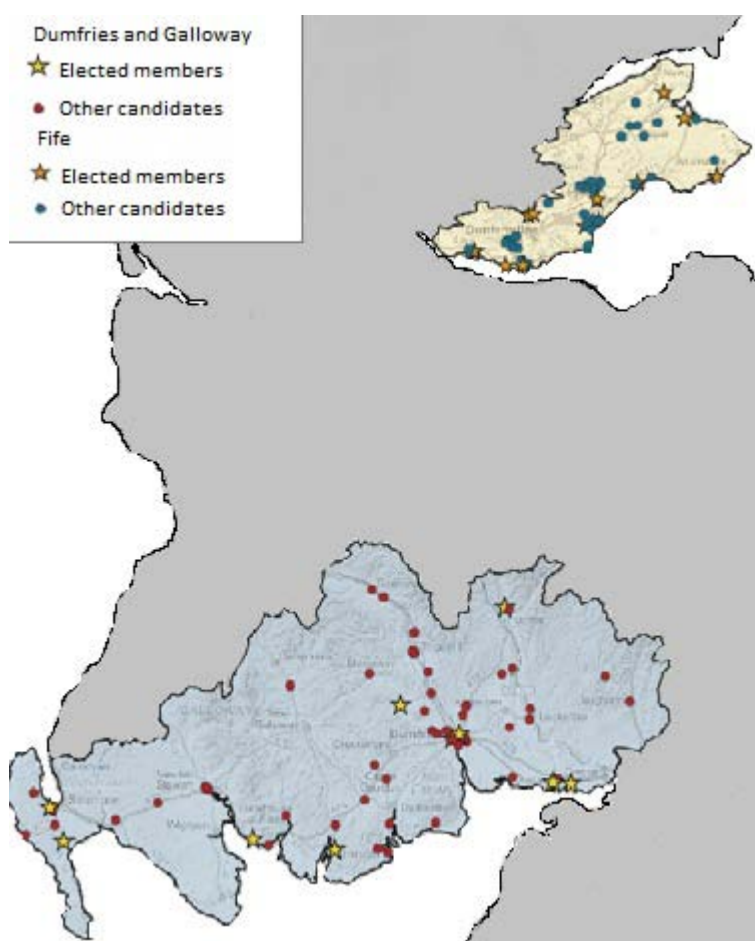
3.4   We interviewed every candidate who agreed to speak with us. While most were retired or semi-retired professionals or local politicians, applicants came from a range of different backgrounds.

3.5   There was a reasonably large group among the candidates who had sought appointment to public bodies before, or who had considered public appointments before but had recently retired and only now had enough free time to take a non-executive position. However, our interviews also suggested that many of the people who put their names forward would not have sought appointment to the Board through the traditional OCPAS-monitored procedure. Many candidates were unaware that non-executive positions on Health Boards were normally filled by public advertisement, and some believed that all members had to be invited to join Boards. A few were simply deterred by the current application system or believed they would stand no chance of being selected.

3.6   There was also variation in how candidates approached the elections. A few candidates, often those with experience in local politics, campaigned vigorously and used conventional tools such as pamphlets and door-to-door canvassing. However, most candidates did not campaign in this way and only a few reported receiving any support from political parties. The election was thus quite different from a local government election. Many candidates did not

take any measures to encourage others to vote for them besides writing a candidate statement for the booklet and answering any questions posed to them by acquaintances. Many others encouraged people they already knew to vote for them, but did not contact other members of the public. These candidates typically expected support from people who already knew them personally or by reputation. As their addresses were printed on the ballot papers, some also expected support from residents in their area who would want to vote for a local candidate.

3.7 There were a few factors peculiar to Dumfries and Galloway. In particular, there was a perception in some rural areas that the Board intended to centralise services in the larger towns. Some candidates in rural areas of Dumfries and Galloway reported that opposition to centralisation motivated them. Candidates in rural areas were also concerned that elected members who lived in the town of Dumfries should not dominate the Board.

3.8 Although many candidates were vague on the details of what a non-executive does on a Board of Governance, most seemed to appreciate the need to compromise with other members and to accept collective decisions after discussion and possibly voting (while formal votes of Health Board members are rare, many interviewees did seem to believe that votes would occur periodically). Despite concerns among some Board personnel and stakeholders that Non-Executive Directors with single-issue agendas (for example, opponents of local hospital closures) might refuse to compromise and obstruct Board business if they disagreed with a policy, most candidates presented themselves as willing to compromise if they found themselves in a minority.

Patterns of voter turnout

3.9 We obtained records of voter turnout in these elections from the Returning Officers. In Dumfries and Galloway, 22.6% of eligible electors voted in the Health Board election (returning 26,516 ballots). In Fife turnout was 13.9% (with 39,761 ballots returned).

3.10 Official records include the postcodes of all eligible electors in the two Board areas. This enables us to check whether turnout was concentrated in particular postcode areas, and also to compare turnout in deprived postcodes with turnout in affluent areas.

3.11 The percentage of electors who returned their ballot papers did vary significantly in different postcode areas in Dumfries and Galloway, as shown in the map below (3.3).

Figure 3.3: Turnout by postcode, Dumfries and Galloway
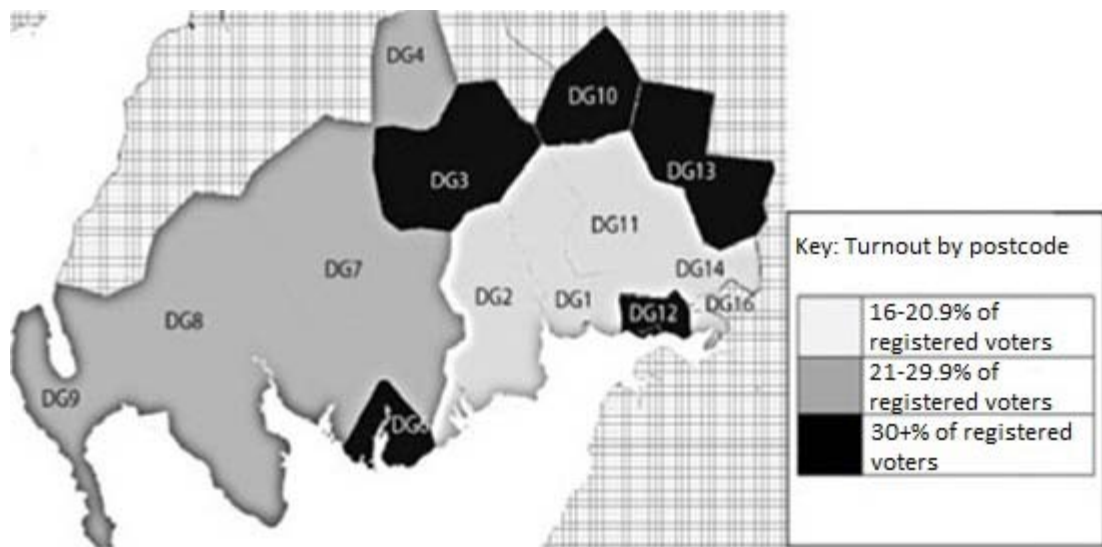
3.12   There was no clear pattern in Fife, where turnout varied only within a 5% range between 10.6% in FK10 (around Kincardine) and 15.9% (around Elie).

3.13   We also compared levels of turnout with postcodes' rankings on the Scottish Index of Multiple Deprivation (SIMD) (see Figure 3.4). This Index ranks clusters of postcodes according to their level of deprivation, from 1 (most deprived) to 6505 (least deprived) and is used by the Scottish Government in service targeting. In the graph below, deprivation ranking reduces from left to right. The leftmost bars represent turnout in postcodes which fell into the 500 most deprived clusters in Scotland, while the rightmost bars represent turnout in postcodes that fell in the 505 least-deprived clusters. The other bars represent turnout levels in postcodes falling into clusters ranked between the 501st and 1000th most deprived, 1001st and 1500th most-deprived, and so on. Blue bars give the turnout in Dumfries and Galloway; green bars the turnout in Fife. These figures ignore any postal votes that were sent to addresses outside the Health Board area.

Figure 3.4: Deprivation and turnout, board elections
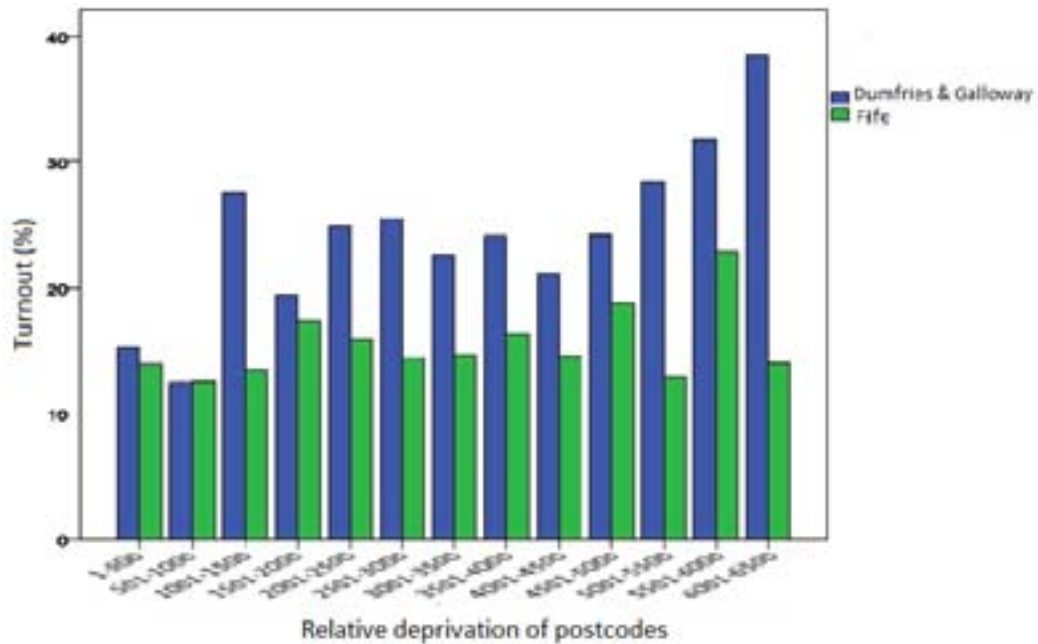
3.14 In Fife there was no statistically significant relationship between the SIMD rank of a voter's postcode and likelihood of voting in the Health Board election. Voters in deprived areas did appear to be less likely to vote in Dumfries and Galloway, but SIMD rank was an extremely weak predictor of likelihood of voting. The fact that this relationship appeared probably reflects the fact that turnout was very much higher than average in a few of the affluent areas of Dumfries and Galloway rather than electors in deprived areas being unwilling to participate. In general, it does not appear that residents of deprived postcodes were less likely to return their ballot papers.

3.15 For comparison, the figure below (3.5) repeats the analysis for the 2010 General Election, using a random sample of 3000 electors in each Board area[7]. While turnout overall was much higher in the General Election, the results for the Health Board do not suggest that there was a dramatically greater difference between deprived and affluent postcodes in the Health Board election.

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[7] General Election registers are marked by hand, so electors whose record was ambiguous were removed for this analysis.

Figure 3.5 Deprivation and turnout, general election
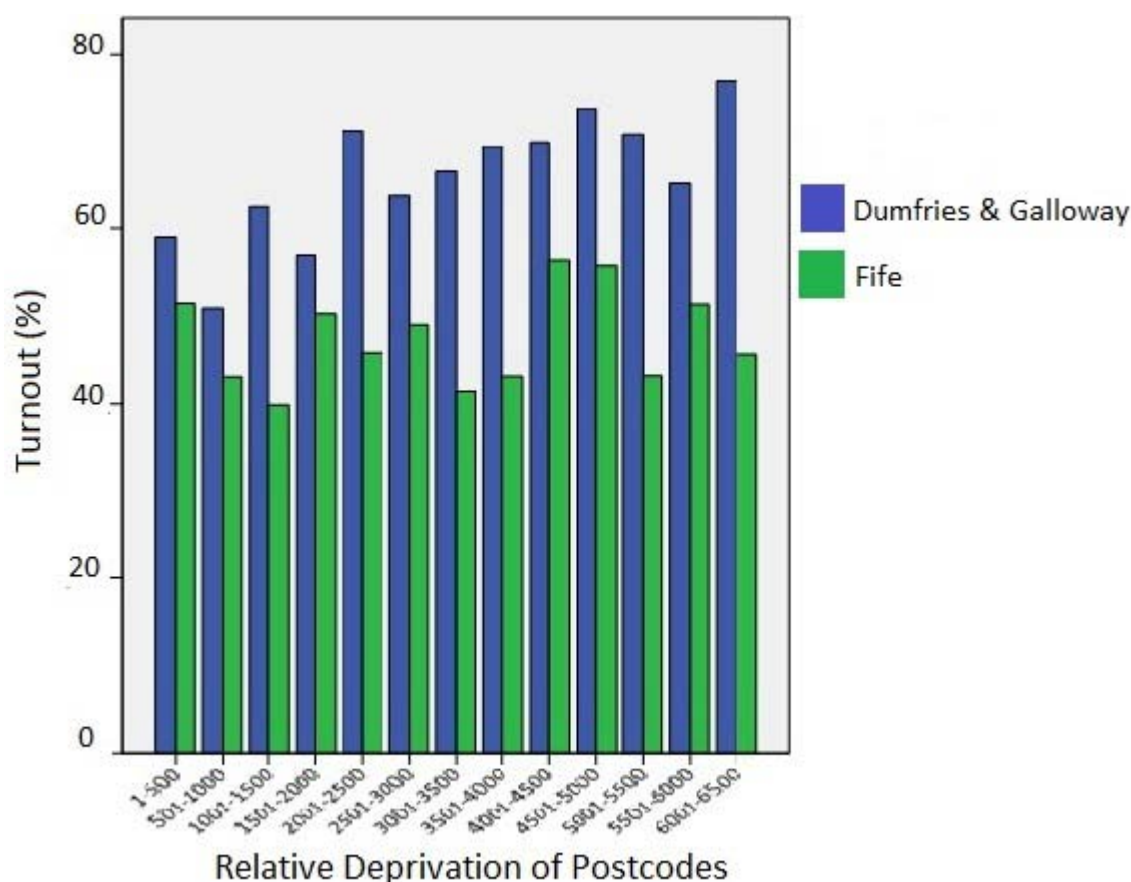
Survey of elector results

3.16   Our survey of electors in Dumfries and Galloway and Fife provided us with substantial demographic information about those who chose to vote, and not to vote, in the Health Board elections[8]. This goes beyond the information we were able to gather from official records, including information on gender, education and ethnicity. Because we found that there was a strong correlation between voting in the election and returning our survey, with voters much more likely to return surveys than non-voters, the figures reported here have been weighted to place increased emphasis on the responses given by non-voters.

3.17   Our analysis of this data indicates that age is by far the strongest predictor of whether an elector would turn out to vote in the Health Board election. Older electors, especially over-60s, were much more likely to return a valid ballot paper than younger electors in both Fife and Dumfries and Galloway. In

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[8] Note that these figures will differ from those listed in our interim report. The interim was based on raw survey data. The figures reported here were generated through a time-consuming process of refining the raw data. We have cross-checked voting reports with the Returning Officers' marked registers and used these to generate the statistical weighting applied to the survey responses. This compensates for the fact that respondents were more likely to have voted than the general population. The weighting should make the figures in this report more reflective of the true characteristics of voters and non-voters in the Health Board areas than figures derived from the raw data.

keeping with the pattern in the Returning Officers' figures, presented above, we also found that those electors in Dumfries and Galloway who lived in certain postcode areas were significantly more likely to vote. We also asked about respondents' length of residence within the Board area, sex, state of health, disability, whether the respondent was a carer, and whether they had dependent children, but we did not find that any of these characteristics significantly influenced the odds of voting in the Health Board election[9].

3.18   Based on our weighted survey results, it seems that an elector aged between 60 and 80 was more than twice as likely to vote as an elector aged between 18 and 40.

Health Board versus general election

3.19   Our survey asked voters both about whether they turned out for the General Election held just before the Health Board election, as well as the Health Board poll itself. This allowed us to test whether the characteristics associated with not voting in the Health Board election simply cause people to be disengaged from politics, or whether some of these electors were particularly deterred by something about the Health Board election.

3.20   Turnout in the Health Board election was much lower than in the General. Only a few of our respondents had voted for the Health Board but not in the General Election, and that group of respondents was too small for us to be confident about generalising from their characteristics. We did have many respondents whose records show had voted in the General Election but not the Health Board election[10], and we were able to compare their characteristics with those of respondents who had voted in both.

3.21   Electors who voted in the General Election but abstained for the Health Board were likely to be under 60[11]. Unsurprisingly given this age profile, they were also more likely to have dependent children, they were less likely to report that their lifestyles were "limited a lot" by disability, and on average they rated their health as better than respondents who voted in both elections. This reinforces our finding that older electors were particularly likely to vote in the Health Board election.

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[9] As we noted in our interim report, we did find that electors in Fife who described themselves as having "no formal qualifications" were much more likely to have voted. We are now confident that this finding represented a spurious relationship. Of 160 respondents who reported not having formal qualifications, 121 were over 60 and only three were under 40 (unweighted figures). Because over-60s were much more likely to vote than under-40s, regardless of their qualifications, this created an illusion that electors without qualifications were more likely to vote. Given the pattern of responses overall, it does not seem likely the lacking formal qualifications *explained* people's decision to vote. Similarly, an apparent relationship between being a regular patient and likelihood of voting in Dumfries & Galloway is complicated by the fact that older respondents were much more likely to vote and be regular patients.

[10] Records showed 729 respondents had voted in only the General Election, but the figures reported in this section have weighted those responses to take into account that voters were more likely to reply to our survey.

[11] The analysis shows 49.6% were over 60 as opposed to 59.6% of respondents; this figure is based on weighted results rather than the actual numbers of responses.

3.22   We already know that there are certain characteristics that make people less likely to vote in elections generally. Turnout in the Health Board elections was not only affected by these characteristics, but was much more heavily skewed towards older electors. Compared to respondents who had voted only in the General Election, respondents who reported that they had voted for the Health Board as well were more likely to be over 60 and had characteristics associated with being older.

3.23   The survey also revealed that, despite significant efforts by the Boards and Returning Officers to inform the local population about the Health Board Elections, many electors still felt ill informed about the elections. Table 3.1 shows responses to our survey question "How well-informed did you feel about the Health Board election?" It shows that many electors in both areas felt poorly informed, although electors in Fife tended to be less informed than their counterparts in Dumfries and Galloway.

Table 3.1: Did electors feel informed: board elections

	Dumfries and Galloway	Fife
"Not at all well informed"	27.1%	41.9%
"Not very well informed"	39%	39.8%
"Well informed"	29.4%	16.9%
"Very well informed"	4.3%	1.4%

3.24   Our survey form also offered respondents an opportunity to tell us why they had chosen to vote, or not to vote. When reviewing their responses we became aware that a significant proportion of non-voters were attributing their decision to limited information. We drew a random sample of 302 of the respondents to our survey who offered a reason for their not voting in the Health Board Election. Forty-six cited lack of information about the candidates, 6 lack of information about the role of Board members, and 48 a general lack of information about the election. Overall, a third of these voters attributed their decision not to vote to a lack of information. This suggests that electors' perception that they lacked information reduced the level of turnout. With regard to those who offered positive reasons for voting it seemed to come down to a feeling that that is simply what one should do i.e. it is a positive act of citizenship to vote and with these individuals this applied to both health board and general elections.

Timing

3.25   It is likely that the timing of the elections had a significant impact on the process. The closing date for candidate registration coincided with polling in the General Election. The election campaign took place against the background of post-General Election coalition negotiations. Proximity to the General Election affected candidates' experience. Several candidates who had past experience of campaigning for election mentioned that they had expected the first few days in which ballot papers were delivered would be the most fruitful for campaigning, but these coincided with the distraction of the General Election.

3.26   The coincidence between the Health Board and General Elections also raises counterfactual questions as to how campaigns for any future elections might differ if a rollout order is made. For example, while a few candidates did make use of political party labels there was relatively little activity by local branches of political parties in the Health Board elections. If this was partly a result of party members having focused their energies on the General Election campaign, it is possible that there could be greater mobilisation in any future elections. Therefore, while relatively few of the candidates campaigned as representatives of political parties this does not necessarily mean that the rules of the election discourage political parties from becoming involved. The relatively low level of partisan campaigning seems to have reflected inopportune timing of these elections from the point of view of party activists, coupled with self-restraint by political parties, which we cannot be certain would continue in the event of a national roll-out.

3.27   It is also possible that electors might be more available to digest information about future elections that did not coincide with a major national contest.

3.28   Electors were much less well informed about these elections than they were about the General Election. Comparing Table 3.1, derived from weighted responses to the question "How well-informed did you feel about the Health Board election?" with Table 3.2 shows the difference between the two elections. Voters felt much better informed about the General Election.

Table 3.2: Did electors feel informed: general election

	Dumfries and Galloway	Fife
"Not at all well informed"	4.5%	6.2%
"Not very well informed"	17%	19.8%
"Well informed"	62.5%	60.3%
"Very well informed"	16%	13.8%

3.29   While this may not be surprising given that the General Election was a very high-profile contest, survey responses and interviews with a selection of respondents suggested that the level of public awareness was also much lower than local elections. Electors' feelings of being under-informed about the choice facing them clearly played a part in reducing the level of turnout, and it seems plausible that the General Election distracted attention from the Health Board.

16 and 17 year old voters

3.30   The inclusion of 16 and 17 year olds as potential candidates and voters was an innovative element of the pilots.

3.31   Residents who were under 18 on election day but whose 16th birthday *fell on or before the 30th of November 2009* were eligible to vote in the election, which closed on June 10th, provided that their names appeared on the electoral roll. This was the first opportunity for people in this age group to vote in Dumfries and Galloway and Fife. Under normal circumstances 16-17-year-olds can be added to the electoral roll in advance of their 18th birthday, but in practice many 16- and 17-year-olds do not have their names added well in

advance of their 18th birthday. Despite the efforts made by the Returning Officers and their staff to encourage 16-17-year-olds to register before the Health Board election, it is possible that 16-17-year-olds were less likely to appear on the electoral roll than older residents. In Fife 4,484 16-17 year olds were registered while 2,421 were registered in Dumfries & Galloway.

3.32   Returning Officers' records showed that 12.9% of the 16-17-year-olds who were on the register in Dumfries and Galloway voted, with 312 ballots returned. Turnout among registered 16-17-year-olds in Fife was 7%, or 311 ballots. This means that those 16-17 year olds who were registered to vote were significantly less likely to vote than registered electors aged over 18.

3.33   In Dumfries & Galloway, the local authority's Youth Strategy Group had advised on communications efforts, with advertising concentrating on buses and local radio, and information sent to schools for their pupil intranet. In Fife, work with local youth groups (including the Big Shout and Members of the Scottish Youth Parliament) produced a DVD encouraging young electors to vote in the elections[12]. Copies of the DVD were distributed to schools around Fife and played in cafeterias.

3.34   Across both Board areas, young people in the focus groups had very little awareness or understanding of the elections having taken place. No one in any of the groups said they had voted, and most had no recollection of hearing about the election. The only exceptions to this were some young people who were members of political parties, or whose parents worked in the NHS. Notably, this lack of awareness also extended to the existence and purpose of board of directors of the Health Board. Several young people stated that they assumed the Board was for doctors and nurses. Most young people expressed much more enthusiasm for voting in the General Election, and attributed this to knowing the purpose of the election, and the perceived greater importance of the issues at stake.

3.35   Young people found the booklet of candidate statements over-long and unappealing; several suggested that a photo of the candidate would be more engaging. When the discussion moved to better ways of getting information to young people, a strong preference was expressed for a face-to-face presentation in school. Focus group participants were enthusiastic users of the internet and social media but pointed out that they would need prior understanding of the election; some felt that information on an election would not appeal when using social media: "that's not what you go on Facebook for, is it?" (M, Fife).

3.36   The potential for 16 & 17 year olds to stand as candidates was surprising to focus group participants. Views were divided, with some young people feeling that their peers would lack the necessary life experience for the role, and other arguing that they would be able to represent young people's different priorities and perspectives. Most said they would not seriously consider

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[12] The content is available at
http://www.nhsfife.org/nhs/index.cfm?fuseaction=nhs.pagedisplay&p2sid=6F221627-00B4-0FBC-D6E7FE1717963D1D&themeid=E44C37C3-5056-8C6F-C003CD63C15D8FF0

standing, citing a lack of confidence, or worrying that they would lack necessary medical knowledge.

Elected member characteristics

3.37   We interviewed all of the elected members at least once, and asked them to complete a survey so we could gain background information on them. With a few exceptions, we were able to gather demographic information from all of the members who were initially elected[13]. The new members who responded were all over 40, and 60% were over 60. However, none were over 80. All the new members who responded spoke Scots or English as their first language, all were White, and all had lived in the Board area for at least five years. Six men and four women were elected in Dumfries and Galloway, while six women and six men were elected in Fife. Of those who responded to our survey, in Dumfries and Galloway two elected members were carers and two were parents or guardians of dependent children. No members of NHS Fife fell into these categories.

3.38   The newly elected members who responded to our survey included several holders of advanced qualifications, as summarized in Table 3.3. The elected members tended to hold more advanced qualifications than the average for their local populations.

Table 3.3: Highest educational qualifications of candidates

	Fife	Dumfries & Galloway	Total
No formal qualifications	1	0	1
Standard Grades/O-levels/School leaving certificate	0	1	1
Highers/A-levels	1	0	1
College qualifications	1	4	5
Degree	2	0	2
Postgraduate	1	3	4

3.39   By way of comparison, the Office of the Commissioner for Public Appointments in Scotland (OCPAS) publishes a breakdown of the characteristics of people appointed to public bodies. OCPAS uses slightly different age categories than our survey, but by comparison their figures for 2010/11 show 57.8% of appointees were male, 96.6% were white, and 51% declared they were over 55 (with a further 25% aged between 46 and 55, 9%

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[13] For this section we have not included initially-unsuccessful candidates who were subsequently offered a seat on the Board after a resignation

between 36 and 45 with only 3% under 35)[14]. The candidate pool was therefore more diverse than the OCPAS appointments.

3.40   One distinctive feature in NHS Fife was the election of members who had previously been appointed to sit on the Board as non-executives, and who were compelled to resign when the elections were announced. In order to meet the statutory objective of having a majority of the Boards elected, the Scottish Government ended some of the existing Non-Executive Directors' terms of office before their original termination dates. In Fife, three of those members contested the election and all were elected, while one member chose not to seek election. None of the non-executives in Dumfries and Galloway who were removed from the Board in this way chose to contest the election.

3.41   The elected candidates' statements often referred to professional background, in many cases including previous experience in some part of the NHS or in the English NHS, which was confirmed in interviews.

Induction of elected members

3.42   Elected members received two days of joint induction training at the Beardmore NHS Conference Centre in Clydebank, and the two Boards that received elected members each organised two days of local induction at their own sites. This induction differed from the normal induction process for new Board members insofar as new members typically arrive as individuals or as very small groups. Introducing new non-executives as large groups made these dedicated induction sessions feasible. A number of new members stated that they found these sessions helpful; some commented that it was valuable to meet other elected board members and some others noted that the volume of information could be overwhelming.

Succession

3.43   The introduction of elections not only changed the initial selection process, but also introduced a new mechanism for replacing elected non-executives who left the Board before their term of office expired. As all candidates in the election were rank-ordered according to the number of votes they received, when members who were initially elected needed to stand down it was possible to substitute candidates who had initially been unsuccessful. As vacancies arose, vacated seats were offered to the initially unsuccessful candidates who had received the largest numbers of votes in the elections.

3.44   Two elected members of NHS Fife and one elected member of NHS Dumfries and Galloway were obliged to resign from the Board by the end of 2011. Norma Wilson applied for, and was appointed to, a senior management post within NHS Fife that appeared on the list of excluded positions in the Health Board (Elections) Bill. Jayne Baxter and Alis Ballance were obliged to resign because they were nominated as candidates for the Scottish Parliament.

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[14] http://www.publicappointments.org/publications/publication/115/ocpas-annual-report-201011 page 27

3.45 The succession procedure appears to have worked as planned. When the first member of NHS Fife resigned, the candidate who was ranked 13th in the election was able to take up the vacant position. With the next resignation, the candidate who had ranked 14th was able to take up the vacant seat. Similarly, the only resignation from NHS Dumfries and Galloway led to the candidate who had ranked 11th in the election results taking up the vacated seat.

3.46 The pilots did not encounter a scenario in which the candidate who was next in line was unable or unwilling to take up the post, or in which more than two elected members resigned. Such a scenario could potentially occur in future elections if a rollout order is made. The pilot gave us no information on how such a scenario would play out.

Exclusions

3.47 Two of these resignations from the Board were due to candidates for election to the Scottish Parliament being compelled to resign from the Health Board on submitting their candidacy. The prohibition on *candidates* for election serving on Health Boards did provoke some comments in a range of interviews.

3.48 Candidates for Parliamentary elections are required to sign a declaration at the time of lodging nomination papers stating that they are not disqualified from being a member of the Scottish Parliament. The Scottish Parliament (Disqualification) Order 2010 (S.I. 2010/2476) sets out many of the office holders who are disqualified, including "Chairman or any member, not being also an employee…of a Health Board…". Our understanding is that it has always been Scottish Government policy that Members of Parliament cannot sit on Health Boards, and that this extends to candidates for election to the Scottish Parliament. Any member nominated for election would need to resign from the Board before nominations were filed. This would apply to appointed and elected non-executives, and also to councillors nominated to the Boards. However, the policy had not been stringently enforced, leading some members to believe that they could stand for election to the Scottish Parliament and return to the Board if unsuccessful.

3.49 The Scottish Government's decision to tighten enforcement of this policy alongside the introduction of elections to Health Boards did put elected members who had committed to stand for election as representatives of political parties in a position that they found difficult. In effect, these members had to give up seats to which they had been elected. While this may have appeared in codes of governance, we found not all elected members were aware of the implications. We would recommend that implications of the policy be given a higher profile in the documentation issued to potential candidates.

Alternative Pilots

3.50 In addition to the two electoral pilots two boards were invited to try recruiting and selecting non-executive members in a somewhat different way. These two initiatives became known as the alternative pilots. The two boards involved were Grampian and Lothian. As in the elected pilots, the number of Executive Directors was formally reduced to five. However, these pilots added

only two additional Non-Executive Directors. Numerically, these pilots led to much less dramatic changes in the composition of the Boards, which would complicate any comparisons between the elected and alternative pilots.

3.51 In Grampian, the process for recruiting the two new members differed in that the vacancies were advertised more widely than in previous rounds, including a two-week advertising campaign on local radio, newspapers and distribution of flyers. The Health Board also took advantage of existing networks (such as voluntary sector bodies) to identify likely applicants, encouraged potential applicants who called the Communications office to apply if this seemed appropriate, and invited them to meet existing Board members to discuss the role.

3.52 In Lothian, the two members were recruited by very different methods. One of the new members was recruited by a mechanism similar to the Grampian pilot – a traditional competitive application open to all members of the public, but with a broader advertising strategy than in previous rounds and with possible candidates identified through voluntary sector networks. The other member was recruited from the office-bearers of Public Partnership Forums (PPFs). All office-bearers in the Lothian PPFs were invited to express interest in serving on the Board, and the selection panel chose from among those office-bearers who declared an interest using a conventional interview process.

Applicants

3.53 The Grampian pilot attracted 90 applicants for the two posts, a much higher number than such vacancies usually attract (the previous appointment round had attracted seven applicants). Not all of these applicants chose to give demographic information with their application, but of those who did 51 self-identified as White and four were from Mixed, Black or Asian backgrounds. There were 34 men and 24 women. The age profile of the applicants who gave this information is summarized in Table 3.4.

Table 3.4: Ages of Grampian applicants

Age Band	16-20	21-30	31-40	41-50	51-60	61-70	71+
Number of applicants	1	6	4	8	18	10	7

3.54 For the open competition, NHS Lothian attracted 30 applicants. Again, not all applicants chose to provide demographic information. Of those who did, all were White, and there were 12 men and seven women. The age profile of the applicants who gave this information is summarized in Table 3.5.

Table 3.5: Ages of Lothian applicants

Age Band	16-30	31-40	41-50	51-60	61-70	71+
Number of applicants	0	1	3	5	8	1

3.55 Eighteen office-bearers in Lothian PPFs expressed an interest in joining the Board; no demographic data was available from this selection.

3.56   We also conducted our own survey of applicants to Grampian and of members of the public who applied to Lothian's second (open) position. This survey received 26 responses from Grampian and 18 from Lothian, a rate that may have been reduced by the considerable time that elapsed between this survey and the deadline for applications. Our survey asked for information that is not gathered during the normal demographic monitoring of applicants. This asked about applicants' level of education, whether they considered themselves to be disabled, whether they were carers of adults or children, and whether English (or Scots) was their first language. We also asked if they had applied to join a Board of governance before.

3.57   This survey revealed further diversity among the applicants. Three applicants to NHS Grampian and two applicants to NHS Lothian self-identified as disabled, while five applicants to Grampian and two to Lothian were carers. One applicant for each Board reported that English (or Scots) was not their first language, while four applicants to each had dependent children.

3.58   With two exceptions in Grampian, all respondents had lived in the Board area for at least 5 years. Similarly, with a few exceptions respondents tended to rate their health as good (Table 3.6)

Table 3.6: Self-reported state of health, Grampian and Lothian applicants

Health	Grampian	Lothian
Very Good	10 (38.5%)	9 (50%)
Good	12 (46.2%)	7 (38.9%)
Fair	2 (7.7%)	1 (5.6%)
Bad	2 (7.7%)	0
Very bad	0	1 (5.6%)

3.59   In both cases, most applicants held degrees. The educational qualifications of the respondents are summarized in Table 3.7.

Table 3.7: Self-reported educational qualifications, Grampian and Lothian applicants

Qualifications	Grampian	Lothian
No formal	1 (3.8%)	0
Standard Grades or similar	1 (3.8%)	1 (5.6%)
Highers or similar	3 (11.5%)	0
College qualifications	1 (3.8%)	1 (5.6%)
University degree	11 (42.3%)	7 (38.9%)
Postgraduate	8 (30.8%)	9 (50%)
(no response)	1 (3.8%)	

3.60   Responses to our survey suggested one notable difference between the Boards: respondents who applied to NHS Lothian were significantly more likely to have applied (or been invited) to join Boards of governance[15] before than were applicants to NHS Grampian. Fourteen of the 18 respondents from

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[15] Not only NHS Boards, but also boards of companies and charities.

Lothian (78%) had applied to Boards of other organisations before this application, as opposed to only 10 of 26 respondents from Grampian.

3.61　It is worth remembering that neither the demographic monitoring as part of the application process nor our survey had a 100% response rate.

3.62　Thus, the alternative pilots do appear to have contributed to some increased diversity at the application stage. However, it is important to remember that selection from among these applicants continued to be made using a conventional OCPAS-approved method, based on a long application form and a competency-based interview. The alternative pilots formally changed only the process by which applicants were encouraged to submit forms to the Scottish Government and OCPAS for scrutiny. After that point selection progressed as normal, although the selection criteria for these appointments were weighted towards ability to provide a generalist perspective on the Boards' activities rather than possession of any specific technical knowledge (e.g. of finance or human resource management). In this respect the alternative pilots were very different from the elections. Elections recruited far greater numbers of potential non-executives and effectively bypassed the selection process normally put in place by the Scottish Government and OCPAS. If these methods were to be rolled out across Scotland, the conventional selection process would still shape the composition of new non-executive cohorts even if the size and diversity of the applicant pool were increased. The question of whether it would be possible or desirable to alter the Scottish Government and OCPAS selection process for non-executives technically falls outside the remit of this report. However there is clearly scope to do this should Ministers and Parliament decide that that would improve the appointment process.

Induction of alternative pilot appointees

3.63　The pilot appointees in both Grampian and Lothian received tailored induction and training similar to any standard appointed non-executive, delivered by the relevant Board. Due to the different timescales of these pilots, they were not present at the Beardmore induction sessions for elected members.

4   COSTINGS

Elections

4.1   The Health Boards and Local Authorities reported that the pilot elections and associated publicity cost £473,850 in Fife and £299,406 in Dumfries and Galloway.

4.2   The main costs of an all-postal election come from printing and posting ballot papers and counting the returns. The cost of running a direct election is therefore proportional to the number of people eligible to vote and the turnout. In principle, we can therefore estimate the cost of running similar elections across Scotland by multiplying the average costs of the elections in the two pilot areas to correspond to the population of Scotland. The two pilot areas had 403,139 registered electors, 10.36% of the electors in Scotland. Simply multiplying the costs of the pilot elections (£773,256) to correspond with the number of electors in Scotland suggests a total cost of £7.46m per election.

4.3   However, this assumes that turnout in a Scotland-wide poll would be the same as turnout in the pilot elections. Returning Officers were instructed to prepare for the election on the perhaps optimistic assumption of 60% turnout, so as to reduce the chance of the count being delayed by unexpectedly large numbers of votes. This would presumably be repeated in any future elections. However, the postal cost would vary depending on the actual level of voter turnout. This should be factored into our estimate. Given the large differences in turnout between Dumfries and Galloway and Fife, it is difficult to predict the turnout rate across Scotland. However if one assumes equal turnout across all board areas then we estimate the most basic cost of running the elections at different levels of turnout would range from £7.44M at 15%, through £7.73M at 30% and up to £8.13M at 50%. However, such estimates of cost do not allow for important issues of accessibility and security which we believe would be considered desirable in future elections. We deal with these issues in sections 4.8 to 4.9. Other additional cost factors are discussed in sections 4.9 to 4.15

4.4   Estimates assume that elections in all Health Board areas would be contested. The pilots attracted many candidates and it seems reasonable to assume that at least the first elections would generate enough interest to require a vote.

4.5   These figures reflect the cost of the election process. We have not included the additional costs of paying and training larger cohorts of non-executive members if their numbers were increased as a result of the elections.

4.6   There are several important caveats to these figures, which suggest that the figures would be a low estimate of the cost of direct elections.

4.7   Firstly, the pilot elections did not have the security features normally required for postal voting. In a conventional election, only electors who have registered for a postal ballot receive one. When requesting a postal ballot those electors give their date of birth and a sample signature. When they return a completed

ballot paper, they give another signature that is checked against the specimen to verify their identity. In the pilot elections, no signatures were required. As there is no national database of electors' signatures, in order to obtain a similar level of security Returning Officers would need to either create such a database or devise an alternative security check. While we saw no evidence of fraudulent voting in the pilot elections, if Parliament were to mandate a national rollout without security measures there would be an increased risk of fraudulent voting. We understand that when the Bill which led to these pilots was going through Parliament a representative of the Scottish Assessors estimated the cost of such measures at £1 per elector, which would imply an added cost of a little under £4m per election cycle. Thus this factor alone could increase the cost of an election to a total of somewhere around £11 to £12 Million. This and further factors articulated below make it likely that the cost of running these elections under normal conditions would significantly exceed the figures reached by a simple extrapolation from the pilot elections.

4.8 The second of these factors is translation. The ballot papers and candidate statements were delivered only in conventional print and in English. If elections were rolled out across Scotland there would need to be some mechanism for translation. There is no national database showing which electors do not understand English or have sight problems. Some mechanism would need to be put in place to ensure electors who needed translations or large print/tactile ballots and candidate statements would have access to them. This would inevitably add additional cost.

4.9 Thirdly, the cost for electronic counting is extrapolated from the outcome of negotiations between the Returning Officers and Opt2vote on this occasion. New payment structures would have to be negotiated were the elections to be rolled out nationally. There are only a few private companies specialising in the electronic counting of ballot papers that could fill this role in Scotland. The nature of their business involves bursts of high demand for personnel and equipment on election days. If elections occurred at points of high demand, Returning Officers might find it more difficult to obtain such competitive terms as they did for the pilots.

4.10 Fourth, in the pilots no attempt was made to create a register of 15-year-old attainers. This led to a large number of 16-year-olds whose birthdays fell on the wrong side of the 29th of November being ineligible to vote in the pilot elections on the 10th of June. If all 16-year-olds were to be eligible to vote in any future Health Board elections, then a register of 15-year-olds who would become 16 in the next year would need to be added to the annual canvass. Stringent privacy laws for under-16s may well imply a need to keep a separate register for those attainers, and there might be costs associated with this.

4.11 Fifth, ballots were printed in alphabetical order. There has been some speculation that this advantaged certain candidates over others because of the very large numbers of candidates who stood in the two pilot elections. We have no evidence to support this, but would advise that Parliament consider making some provision for the order of candidate names on ballot papers to be randomised if elections are rolled out. This would probably increase the

cost or complexity of printing ballot papers, as more print runs would be required (see 6.6 for more on this point).

4.12   Sixth, the low levels of voter awareness suggest that extra spending on publicity might be beneficial.

4.13   There would also be some unquantifiable costs in staff time to both the Returning Officers and the Health Boards. By their nature the elections introduced a large number of relatively inexperienced non-executives at one time, which created pressure on pilot Board officials to provide extra support.

4.14   The pilot elections increased the number of non-executive members on the Health Boards, leading to an added pay cost (and an unpredictable figure for extra expenses). The number of non-executives allocated to each Board is a matter for Parliament and the Scottish Government, but each additional non-executive would cost £8000 per year plus expenses, assuming that no pay was reclaimed from executives losing their Board status. If territorial Boards gained six non-executives on average (as in Dumfries and Galloway) the payroll cost would be £672,000 per year[16].

4.15   Note that we have not considered the possibility of paying members of Health Board Committees, a possibility raised by the Health Boards (Membership and Elections) (Scotland) Bill. We have not considered the possibility of extra legal costs were the result of a Health Board election ever to be challenged.

Alternative Pilots

4.16   The alternative pilots added only two new members to each Health Board. However, even taking into account the fact that the elections produced more new members the alternative pilots still had much lower costs.

Grampian

4.17   The major cost difference between the Grampian pilot and a conventional public appointment was an increase in advertising cost of £8022 for the Health Board area. The pilot also added two extra non-executives who are paid £8000 per year and can claim expenses; because of the NHS pay protection policy, the salaries of two executives who could otherwise have had Board status were not reduced.

4.18   The cost of the extra non-executives rolling out a similar advertising programme across Scotland would vary depending on the advertising techniques used and negotiations with individual media outlets. The cost of advertising will of course vary depending on the characteristics of the Board area: a square inch in a small local newspaper costs less than a square inch of a newspaper with a much larger circulation. On the other hand, newspaper and radio coverage does not necessarily map well onto the boundaries of territorial Health Boards, and media based in the major population centres within which advertising is expensive dominates many rural or suburban

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[16] Scotland has 14 territorial Boards, so if Boards gained an average of six non-executives the figure would be 14 x 6 x £8000 = £672,000 plus expenses.

areas. It is therefore difficult to predict the relative costs of comparable advertising campaigns in different areas precisely.

4.19   Given these variables, a reasonable estimate for the extra cost is simply to multiply the additional costs for the pilot by the number of territorial Health Boards in Scotland, giving a figure of £224,000 per year, and £112,308 per appointment round, at 2010 prices.

4.20   There would also be significant but unquantifiable opportunity costs in staff time to the Health Boards. For example, staff would need to spend time providing advice and encouragement to potential applicants when they could potentially have been working on other tasks.

Lothian

4.21   The costs of the open recruitment round in Lothian were similar. Recruiting a member from among the existing PPF office-bearers actually saved money, as there was no need to publicly advertise the vacancy; the Board simply wrote to them. Otherwise, the costs of selection in OCPAS assessors' time etc. would have been comparable with a conventional public appointment.

5   IMPACT

5.1   This section examines the impact of the pilots on how the Health Boards operate, with a focus on public engagement and accountability.

5.2   The pilots altered the mechanism by which non-executives were appointed to the Boards, and removed some senior executives' membership. It is important to be aware that these pilots were not the only changes taking place in the NHS over the two initial years of the pilots. Territorial Health Boards, including non-pilot Boards, continued to innovate. We had opportunities to discuss innovations that were unrelated to the pilots with staff of the pilot Boards and NHS Tayside. Clearly, there are many other factors that affect how Boards operate besides the institutional means of selecting non-executives. As the Higgs Report emphasises, "Effective boards depend as much on behaviours and relationships as on procedures and structures"[17]. Changes resulting from the pilots need to be seen in this broader context.

5.3   Changes must also be seen in light of traditional norms of Health Board behaviour, some of which came under pressure during the pilots. Throughout the pilots, but with particular effects in the early stages, some uncertainty was evident regarding the appropriate role that elected non-executives should play, and the extent to which this should vary from a standard appointed non-executive.

5.4   Chris Skelcher describes the three roles of Board members as:

* contributing an independent view and expertise;
* an 'internal role' focused on corporate strategy and performance monitoring;
* and an 'external role' dealing with stakeholders and the public[18].

In Scottish Health Boards, interviews suggest that the 'internal role' has been the focus of the non-executive workload. Broadly, the expectations of the Health Boards was that their boards of directors are corporate bodies with corporate responsibility (meaning that it is inappropriate to disown or speak out against collective decision) and do not engage in operational matters, which are the province of the executives. Board non-executive members, are seen to be responsible for governance, meaning monitoring performance (e.g. inspection of annual accounts) and deciding high-level strategy (e.g. approval of the budget and identification of the Board's overarching priorities). In this understanding, widely shared among our interviewees, it is not appropriate for non-executive directors to engage in operational issues, impugn collective decisions once they have been taken, or play a particularly visible public role. Additionally there is minimal opportunity for members to initiate or pro-actively raise issues for discussion, as their role is primarily one of scrutiny and holding to account. The Board as a whole is then accountable to the Scottish Parliament via the Scottish Government, a point made clear at the central induction for elected members.

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[17] http://webarchive.nationalarchives.gov.uk/+/http://www.berr.gov.uk/files/file23012.pdf page 17
[18] Skelcher, C. (1998) *The Appointed State*. p104

5.5　However several newly elected members stated that they felt an additional, or in a few cases primary, accountability to the public of their Board area. They felt this required greater activity within the external (public-facing) role, and accordingly greater emphasis on pro-actively contributing to Board decision-making. Where particular issues relating to this difference of perspective arose, with a key example being whether elected non-executives should hold 'surgeries' or public meetings, difficulties could arise. In Dumfries & Galloway, guidance was sought from the Scottish Government on whether this was an appropriate activity for elected non-executive members. The Government's position was that Boards themselves should decide. This context of uncertainty frames most of the following findings.

The Impact of new non-executive directors

5.6　This section summarises the impact of adding new non-executives by election or amended appointment processes.

Skills, experience and learning

5.7　Several of the elected members had served on boards of one kind or another, and some had experience within the NHS as clinicians. A small number had previously served on Health Boards, including three appointed members who had been removed from NHS Fife only a few weeks earlier to make way for newly elected members. However, interviews with existing personnel suggested that they saw many of the new members as having less experience in corporate governance than would be the norm for appointees who had come through a conventional selection procedure.

5.8　There was a general feeling that many new members' behaviour differed from established members' due to their relative inexperience. This was partly a normal part of adding new non-executives to a Health Board. Interviewees in Fife in particular had more difficulty in distinguishing the new members' behaviour from that of newly appointed non-executives they had encountered in previous years. Interviews with existing non-executives and members of all-appointed Boards further emphasised that new non-executives typically take several months, sometimes over a year, to develop in the role. What made the impact of these new members different was at least partly that ten and twelve of them arrived simultaneously. In our interviewees' past experience non-executives had arrived as individuals or in pairs and would take some time to become active members, during which time they would develop a sense of how the Board operated. With many new members being added at once this slow socialisation process was interrupted.

5.9　One dimension in which this relative lack of experience manifested itself was in the focus of new members' questions around the Board table. Several continuing members in Dumfries & Galloway expressed concern that elected members became too involved in operational matters (for example, engaging in long discussions about the technical specifications of new equipment to be purchased) at the expense of the strategic discussion that they expected to dominate Board meetings. Several of the elected members had backgrounds in medical practice, which gave them particular interests in areas which

established members considered to be more the 'operational' domain of professional managers than the kinds of higher-level aspects of Board business with which they would expect non-executives to concern themselves.

5.10   Similarly, the largely reactive role of scrutiny is conventionally fulfilled through careful reading of Board papers and questioning of Executive members. In both Fife and Dumfries and Galloway, some elected members expressed frustration about the lack of opportunity to make a pro-active contribution in the manner they had anticipated, finding Board meetings more focused on scrutiny and accordingly offering less opportunity for debate than expected. Closely related to this, a number of elected members expressed surprise or frustration at the extent to which Board activity and decision-making is circumscribed by central Government policy. Having been elected, they had expected Boards to have greater autonomy and thus more scope for decision-making.

5.11   The new members' questioning also tended to include more general queries (what several members referred to as "daft laddie" or "daft lassie" questions) than had been the case before the pilots began. Despite the informal moniker, "daft laddie" or "daft lassie" questions are often seen as helpful in a non-executive's role. Non-executive lay members are after all brought onto Boards precisely to question conventional wisdom within the organisation, and this seems to be an important part of the rationale for limiting their terms of appointment. Being willing to ask questions to which the answers seem obvious to longstanding NHS 'insiders' can be an important and constructive part of the role. On the other hand, too many might detract from strategic discussion and monitoring within a finite amount of time. The kinds of questions asked were different after the elections, but there was not a clear consensus among interviewees on whether this represented more rigorous and creative scrutiny or a diversion from important questions.

5.12   There was a general consensus that adding large numbers of new non-executives simultaneously put greater pressure on staff to provide appropriate support and training. This clearly had a significant opportunity cost for the Boards in that staff time spent on supporting new members could potentially have been used for other activities. On the other hand, adding the elected members as a large group did allow for some specialised, dedicated induction training when they arrived.

5.13   The variability of elected members' backgrounds and skills appears to be an inherent consequence of electing, rather than interviewing and selecting, non-executives. As such, it is impossible to guarantee that new members will arrive with all the skills needed to perform a corporate governance function. Elections prioritise other characteristics - electoral appeal - over the skills matrix previously used to identify the desirable characteristics of new non-executive directors. To some extent the alternative pilot model, which selected a new member from a Public Partnership Forum, also prioritises a non-skill-related characteristic – being a PPF office-bearer – over possession of particular skills. While the electorate may choose candidates with skills that are perceived to be required for Board roles, there is no guarantee that the

factors that make someone appealing to voters will always be matched with such skills. To some extent similar considerations apply to the alternative model, which selected a member of a PPF, where the pool of applicants was restricted to PPF office-bearers and skills were only one criterion for selection within that pool. On the other hand, an interview process can prioritise skills of corporate governance over other qualities. Thus, support and training beyond that normally required by new non-executives may well be needed for members who join Health Boards by these routes.

Board dynamics

5.14   Different elected members varied in their initial attitude to the existing Board. While there had been controversies surrounding the centralisation of services within Fife in previous years, the Board's general strategy was well-established by 2010. In Dumfries and Galloway, the election took place against a backdrop of campaigns against service reorganisation. In general, our interviews with elected members before they were elected suggested that they were open to being persuaded to other points of view and compromising with other Board members. However, some elected non-executives were felt to have arrived with a more confrontational attitude to existing members than others. Voters in several rural areas had concerns about small local hospitals being closed. Proposals to replace these 'cottage' hospitals, which were circulated before the beginning of the pilots, led some residents to believe a decision had already been made to centralise health services in the region. Candidates picked up on this. Where candidates who were elected saw their role on the Board as being primarily to represent electors who wanted to protect small local hospitals from the threat of closure, this could lead to confrontation.

5.15   In addition, the removal of several experienced non-executives combined with the addition of a large number of new non-executives was an unprecedented change in Board membership in Dumfries and Galloway. Trusting working relationships, which had built up over years, were broken up within a short time and understandably members took some time to build up similar working relationships with their new colleagues. In Fife, while the change was also unusually dramatic, there was a relatively greater degree of continuity in personnel due to formerly appointed non-executives winning election. Chairs of Board committees were initially allocated to experienced non-executives who had previously served on NHS Boards either in Fife or elsewhere. Important decisions on hospital provision had already been made, and contracts signed, before the pilot began.

5.16   Board agendas are circumscribed by legislation, and non-executives' opportunities to add specific points to the agenda are limited by the need to cover a fixed agenda within a limited time. Typically, within formal Board meetings non-executives react to reports from committees and officers rather than raising matters. There were notable deviations from this pattern in Dumfries and Galloway as several elected members wishing to raise issues of concern used the 'Matters Arising' or 'Any Other Business' sections of the agenda. These interventions became quite extensive. However over time, and

in particular with the departure of a particular elected member, this became less frequent.

5.17   One behaviour we observed in both of these Boards (which seemed to mark a distinction between elected and appointed members) was discussion about the minuting of individual contributions. Neither Board had traditionally produced verbatim minutes of Board or committee meetings; instead, minutes summarised the key points of discussion. In both Fife and Dumfries and Galloway some elected members were keen to have their personal contributions to discussions noted. This reflected some elected members being keen that they be judged based on their own personal performance, as well as the outcome for the Board collectively. Again, it is difficult to be certain of whether this reflected their having been elected – and therefore feeling that members of the public can hold them to account as individuals rather than parts of a collective – or whether new appointed members tend to share this feeling and lose it over time. In Fife the concern over minuting related specifically to a particular issue of governance (a question of whether one of the Board's committees was exceeding its mandate) whereas in Dumfries and Galloway similar concerns were expressed repeatedly in different contexts.

5.18   Not all changes in the dynamics of Board meetings were necessarily caused by the fact that new members were elected, as these pilots also led to other changes in the Boards' make-up. The elections also made both Boards significantly larger. In Fife especially, where the Board increased to 23 members plus several attendees, increased size was associated with much longer meetings. This resulted partly from elected members asking more questions and pursuing them for longer, but also from the simple increase in the number of people around the table. While the rationale for increasing the number of Board members is clear from the legislation, it is worth being aware that there is a cost to increasing numbers in that large Boards can become ponderous (as noted, for example, by the Higgs Report on corporate governance[19]). There are inherent costs to increasing the number of members, which need to be balanced against the benefits of introducing a larger number of different perspectives.

5.19   While elected members were seen as behaving differently from appointed members, interviewees were sometimes unclear on why this was. Differences could be attributed to their being elected, to their arriving in a large group (such that 10 or 12 members who were appointed to the Board simultaneously might have behaved in the same way), or to personal idiosyncrasies that might also have occurred in new appointees. There was a strong sense that the new members who were elected to the Board quickly developed a commitment to keep the Board operating effectively, even if they had not necessarily approved of all the Board's decisions in the past. Existing members had some concerns before the election that elected members might behave in ways that impeded the functions of the Board. After the elections, however, these continuing members perceived the new cohort as developing what one Executive Director referred to as a "social norm of non-executiveness" – a set of informal expectations about how it was acceptable

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[19] http://webarchive.nationalarchives.gov.uk/+/http://www.berr.gov.uk/files/file23012.pdf

(and unacceptable) for themselves and other non-executives to behave. New members continued to ask critical questions, and press for improvement on specific points, but this was done in a constructive manner comparable to the behaviours that we and our interviewees had observed in other (all-appointed) Boards.

5.20   Hence, while there were instances in which the new non-executives in Fife did behave differently from their predecessors, these instances need to be seen against a broader pattern of the new members being willing to compromise with each other and established members. The NHS Fife Board voted only once between June 2010 and the beginning of 2012, on a complex issue surrounding a General Practitioner in Balmullo's permission to dispense prescriptions (which had aroused strong feeling in the local community). A few of the elected members found themselves in the minority, but once the decision was reached they did not pursue the opposition further. By contrast, the Board in Dumfries and Galloway began voting regularly and on several occasions a dissenting member wrote to local newspapers after votes had been taken, arguing that a collective decision of the Board members was incorrect. Publicly opposing corporate decisions in this way represented a major departure from the norms of non-executive behaviour, although only a few of the new members engaged in such activity.

5.21   Most of our interviewees were unable to identify significant differences of approach between the new members in Grampian and Lothian and other non-executives that could be attributed to the selection process. While there was recognition that they brought assets from their own personal backgrounds and experience, and they were viewed positively as individuals, it was much more difficult to identify instances where their behaviour was very different from other non-executives' at similar stages in their appointments. This is probably unsurprising, as the process they passed through was very similar to the normal process for appointing non-executives from the application stage onwards. Interviewees also stressed that typically non-executives who join the Board in small numbers take several months, or even over a year, to develop fully into their new role and for their personal characteristics to begin to influence the overall dynamic. In later interviews, pilot appointees in Lothian emphasised that they had were encouraged and supported to attend particularly to a 'patients'-eye' perspective in their Board activities.

Impact on public engagement

5.22   All NHS Boards in Scotland have strategies for Patient Focus and Public Involvement, which are monitored and supported by the Scottish Health Council. Their PFPI or Participation practice is self-assessed against the Participation Standard, with levels reached and plans for improvement agreed by the Scottish Health Council. However, public engagement activities tend to be carried out at operational level, and in most cases have not been seen as the appropriate role for the Board of Directors. Most (pre-pilot) appointed non-executive members in the pilot Boards affirmed the importance of public engagement activities, but did not understand this as a central part of their own functions, which were understood as concerned with a more corporate vision of governance. This is not to say that appointed non-executive

members were not supportive of these activities, but they were understood as operational, not strategic functions. Existing appointed members said they occasionally received representations from members of the public, but that these would be passed on to the appropriate member of staff.

5.23   It would not, however, be fair to say that appointed non-executives were insulated from the general public. Appointed non-executive members who were currently or had previously served as CHP or CHCP Chair had more public-facing roles, including regular contact with Public Partnership Forums and other stakeholders. Where Boards had recently undertaken broad strategic consultations on contentious matters such as potential hospital closures, non-executive members had often represented the Board at public meetings. Annual Reviews are held in public, are generally somewhat better attended than regular Board meetings, and include an opportunity for members of the public to ask questions. All pilot Boards have a number of lay representatives on their committees of governance. Notably, a number of existing appointed non-executive members also saw their particular experience or skill-set being about the public (or consumer) perspective, as opposed to management or financial expertise.

5.24   During the pilot period, a number of changes were observed to the Board of Directors' roles in public engagement. Few can be directly causally attributed to the pilot itself: the pilot is only one part of broader moves for the Board of Directors to have a more public-facing role. Some changes were present across all pilot Boards. For example, in each Board there was discussion of how to increase public engagement with Board meetings, whether by making Board papers more accessible or altering meeting arrangements. Each pilot Board already had at least one meeting per year in an alternative geographical location within the Board area. In NHS Lothian, options discussed included webcasting of meetings and holding meetings in evenings. However in this matter, as in other discussions, many Board members expressed concern that there was a trade-off between measures to increase engagement and corporate effectiveness: for example, that non-executive members would feel inhibited in debate if the meeting was being broadcast, or that accessible papers may lack the degree of detail required to adequately hold executive members to account.

5.25   Other changes can be understood as more directly attributable to the pilot. In Dumfries & Galloway, as a result of occasionally heated debates about whether elected non-executive members should hold 'surgeries' in the style of an MSP or Councillor, a series of Board engagement sessions were planned. These were not perceived to have been a success by Board members, and were very poorly attended by the public. In Fife, some individual elected members who had committed to make themselves available to the public in their candidate statements did so by taking part in public events organised by the Board. They appeared alongside existing Board members and NHS staff. In both cases these meetings differed substantially from the kinds of private surgeries held by MSPs and Councillors. Several elected members did not wish to hold surgeries and did not see making themselves directly available to members of the public as part of their role. Most continued to channel any

feedback they received from members of the public to Health Board staff, as had been standard practice before the pilot.

5.26   Both existing appointed and newly elected non-executives were asked about whether they understood their role as representing the public. Across both appointed and elected members there was some variation in view. Appointed members were marginally more likely to say that they did not see themselves as representing the public on the Board. Instead, some saw their role as ensuring the effective operation of the organisation for the public. Several explicitly said that they felt the absence of pressure for re-election helped them to make difficult decisions without 'looking over their shoulder' at voters. However other appointed members were quite clear that they saw themselves as public representatives. Elected members told us they understood their role as including representing the public, but there was variation in whether this was seen as but one component of the non-executive role, or was its central purpose. Likewise, some members who felt very strongly rooted in a particular community (whether geographical or of interest) emphasised representing a sub-set of 'the public'. These differences in opinion were not merely semantic: the extent to which an elected member emphasised their role as a public representative made a difference to their preferences for engaging with the public (informally, or in arranged meetings) and taking a visible role in the media.

5.27   As with other potential effects, in both Lothian and Grampian the far smaller number of new members limited the extent to which the pilot could be expected to have an impact on public engagement. In Lothian, the member who was recruited through Public Partnership Forums continued to be a member of his PPF. This created opportunities for him to act as a direct link between the Board and this group of members of the public. However, he emphasised that views from the PPF mostly continued to be fed back to Board level in the usual way, via the CHP. While we can see a theoretical case for this model enhancing public engagement through strengthened and more direct ties between the Boards and PPFs, it is difficult to draw firm conclusions from a single appointment.

Media profile

5.28   One important finding from all our investigations, from the public survey to voter interviews to Board observations to interviews with Board members, is that Non-Executive Directors of Health Boards typically have a very low public profile. Apart from the Chairmen and Councillors nominated as stakeholder members, very few of the non-executives on any of the Boards would have been regularly mentioned in media coverage before the pilots began, or indeed familiar to members of the public through any other route. If changing the appointment process for non-executives is seen as a means of increasing public engagement with the NHS, then increased publicity surrounding non-executives' roles might be symptomatic of changes in the relationship between Board members and the public they serve. Accordingly, we summarise major changes below.

5.29   In Grampian and Lothian the new non-executives, like many existing non-executives, had virtually no media exposure.

5.30   The elected members in Dumfries and Galloway and Fife varied in how far they sought media attention and how much coverage they actually received. Most appeared in media coverage only immediately after the elections (when their success was reported) and did not attract significant attention thereafter. However, there were several exceptions.

5.31   In Fife, Arthur Morris' contributions at Board meetings were occasionally picked up, but this seems to be linked to his personal background as a surgeon and former BMA official (he was described in the Dunfermline Press of 1st September 2011 as "Board member Arthur Morris, a retired surgeon"). Dave Stewart was frequently quoted in the local press, usually in his role as Operational Division Chair. He had previously held this post as an appointed member of the Board and had also appeared in the local press as an appointee. Local newspapers did refer to him specifically as an "elected member". One unusually high-profile appearance after the pilot began related to some potentially inflammatory comments made in the December Board (reported in the Courier of 22nd December 2010) about the Board's relationship with Fife Council. Similarly, new elected member John Winton had enjoyed a high profile as a campaigner for services at Queen Margaret Hospital before the pilots began and continued to be quoted by journalists from time to time after he was elected. Some of this coverage suggested disagreements with the Board's policies, although our interviews suggested that the press coverage might have exaggerated disagreements. Neither members nor the Board can control the manner in which journalists report comments made during public Board meetings.

5.32   Similarly, in Dumfries and Galloway most elected members received very little media coverage besides announcement of their election. Those who did typically had some media profile before their election. For example, Alf Hannay was quoted in the Annandale Herald a few months after being elected (18th December 2011) and his criticism of the recruitment of a Public Health Consultant in one of the higher pay bands made the local BBC news on 11th May 2011. Mr Hannay was also willing to brief the press directly on the constraints imposed on the Health Board by government spending restraint (Dumfries and Galloway Standard 6th October 2010). However, it is worth bearing in mind that he had a local media profile as a Unison official (and indeed as a councillor several years earlier) before being elected (quoted in, for example, the Dumfries and Galloway Standard of 2nd June 2010).

5.33   A relatively high level of media interest in the elected members began with an article in the Dumfries and Galloway Standard on the 2nd of July 2010 reporting that anonymous new members had told journalists that they were unclear on their roles. The elected member who attracted most publicity in 2010 and early 2011 was Alis Ballance, who actively wrote to local newspapers disagreeing with collective decisions. Of all the elected members she had campaigned most explicitly on a platform of saving the region's community hospitals, and in office she maintained her commitments. Media coverage of Ms Ballance's role on the Health Board began when local press

picked up on a disagreement in the Board between elected members who wished to hold one-to-one surgeries with members of the public (Ms Ballance and Tommy Sloan), in the same way as local councillors do, and other members (reported, for example, in the Dumfries and Galloway Standard of 3rd November 2010). She continued to write to newspapers both in her role as Convener of the local Green Party (Dumfries and Galloway Standard 17th September 2010) and as an elected member of the Health Board. She called for community hospitals to be kept open in a letter to the Dumfries and Galloway Standard (15th October 2010) and arranged for a public lecture in her local community on how a Health Board decision to close community hospitals in Cumbria had been overturned (Dumfries and Galloway Standard 13th October 2010). Following a collective decision that Board Members should not hold one-to-one consultations with members of the public, but should instead participate in collective public engagement sessions of which she was highly critical, Ms Ballance felt obligated to hold individual surgeries. She was criticised for this by the Chief Executive in the press (Dumfries and Galloway Standard 11th February 2011).

5.34   Ms Ballance was obliged to stand down from Dumfries and Galloway Board when she decided to contest the 2011 Scottish Parliament election; in her resignation letter to local newspapers she cited "conflict" with the other members of the Board and accused Dumfries and Galloway of having "abused" the pilot elections (Galloway Gazette, 9th March 2011).

5.35   In both Boards, non-executives who previously had high profiles in the media seem to have retained media interest. This created both risks and potential opportunities for the Boards' communication with the media and, indirectly, the public. However, it is important not to overstate the increased media interest in non-executives. Even in the elected Boards, the members who were most commonly quoted in the media continued to be the Chairmen and the Executive Directors, along with other senior NHS staff.

Removal of executives' board status

5.36   Board members who remained in place over the course of the pilot typically portrayed the removal of two executives from Board-member Director status as either causing no appreciable change (as those Directors continued to attend meetings as before) or having a mildly negative effect on Board efficiency and transparency. There was concern at a lack of advance consultation, and the short notice given to the Boards when they were asked to reduce the number of Executive Directors also caused some complaint.

Assessing overall impact on pilot boards; understanding scale and context.

5.37   Elections to NHS Dumfries and Galloway were held against the background of major service redesign. This led to significant changes in the Board dynamic, particularly in the first twelve months of the pilot. Some elected members had explicitly campaigned on issues that were part of the Clinical Services Strategy regarding the future locations of secondary care in the region. In the first twelve months decision-making became noticeably less consensual and disagreements, which might previously have been discussed privately, were

debated in public meetings. In this period the Board was far more likely to take a formal vote on decisions than has been the case hitherto: many of these votes related to issues of Board procedure rather than substantive Board business. After the initial twelve months, and coinciding with the departure of Ms Ballance and a period of Board development work with an external consultant, Board meetings became less contentious.

5.38   In Fife, the impact was more subtle. Successful candidates had not stood on platforms that were at odds with the Board's existing strategy. There were some changes, including more extended Board meetings with more time devoted to discussion. Some new members did clearly develop personal interests in particular aspects of the service to which they were particularly keen to draw attention. The new members did seem to produce a greater diversity of views. There was disagreement among our interviewees as to how far this was a consequence of their being elected or whether appointing a large number of new non-executives could have changed the Board dynamic in similar ways. Decision-making remained more consensual than in Dumfries and Galloway. Only one formal vote was tabled in the course of our observation, and while several elected members voted against the decision that was eventually taken they adhered to the decision thereafter. Very few members of the public attempted to influence the Board by contacting elected members directly, and most of the non-executives who were approached referred members of the public who contacted them to NHS Fife's communications team, as had been standard practice before the elections.

5.39   The alternative pilots have shown that when Health Boards are given some latitude in advertising non-executive vacancies they can attract large and diverse bodies of applicants. The individuals selected in this way seem to have impressed both the selectors and their new colleagues. However, while they did see themselves as having a distinctive relationship to public opinion, there was only a subtle difference between their perception of their role and that of other appointed non-executives, who also saw themselves as fulfilling the role of an informed member of the public.

5.40   While the elections removed the Scottish Government and OCPAS from the selection process, the alternative pilots retained this element of selection. This means that the distinctive appointments process remained, possibly making some applicants uncomfortable. It also meant that while applicants were somewhat different, the appointments process remained the same except for the lack of specific skills as an objective in recruitment.

5.41   It is important to stress that the scale of the intervention in the boards with election pilots was greater than the scale of the intervention in the boards with alternative pilots. In both Grampian and Lothian, the pilot involved two non-executive directors on established, large, boards. In Dumfries and Galloway and Fife, the elections pilots changed half the board. It is to be expected that even without elections, such turnover might affect a board.

6   SUGGESTIONS FOR IMPROVEMENT

6.1   In the course of our research, many respondents made suggestions for improving on the pilots. We also had ideas of our own based on our experience and reading of the relevant literature. In this section we bring together, and offer a preliminary assessment of, suggestions that came up repeatedly. The majority of these relate to the electoral pilots. However this simply reflects the relative complexity and scale of change involved in the electoral (as opposed to appointed) pilots and does not imply a recommendation. The summary chapter that follows provides a balanced view of the advantages and disadvantages of each system.

Electoral pilots

6.2   We uncovered evidence that many voters found the number of candidates overwhelming. There was considerable concern that electors were either abstaining because they could not process so much information or were choosing candidates solely because they were already familiar with them, because they lived in the same area as the elector, or because their credentials were instantly obvious on a very superficial scan of the ballot paper. This may have disadvantaged some candidates and advantaged others. Many suggested that any future elections electors should be faced with fewer candidates.

6.3   This suggestion is problematic for several reasons. Firstly, any barriers erected to reduce the number of candidates would need to be equitable. Secondly, because it is difficult to predict the likely number of candidates in advance, the risk of having an unmanageable number of candidates needs to be balanced against the competing possibility of having too few candidates to offer voters a meaningful choice. When health board elections have been introduced abroad (as discussed in the attached literature review, and as seen in National Parks Scotland) there has been a general trend for the numbers of candidates to fall over time. This suggests that the numbers of candidates would decline naturally after any rollout. On the other hand, the possibility of having an overwhelming number of candidates if elections were held under the same rules as the pilot in the larger Health Boards is serious.

6.4   One potential solution that came up repeatedly was to divide Board areas into smaller 'wards' within which candidates would compete. For example, the NHS Fife area is currently composed of three Community Health Partnership (CHP) areas, and each of these could be treated as a separate ward[20]. However, dividing the Health Board areas into separate wards could have ramifications for the Boards' governance arrangements and perceptions of corporate responsibility. If some members were seen as having been elected by particular parts of the Board area, they could well perceive themselves to have a greater responsibility to the area that elected them. There would be a tension between such sentiment and their responsibility according to current

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[20] Dumfries and Galloway contains only one, very large, CHP.

the Code of Corporate Governance to act in the interests of the population of Fife as a whole.

6.5 The timing of the elections was not ideal. We understand that the Health Board elections were so close to the General Election because of a coincidence that was beyond Scottish Government or Health Boards' control, but that coincidence probably reduced the impact of the publicity campaigns and contributed to low public awareness. However, this problem is unlikely to arise again. As the UK Government has now moved to fixed-term Parliaments the Scottish Government should usually have ample advance notice of a General Election.

6.6 In our focus groups with young electors, several participants independently suggested that candidate photographs on the ballot papers or candidate statements would make the materials more appealing. Voters would presumably have a greater chance of recognising familiar candidates. The issue of how photographs on ballot papers affect voter behaviour has been examined by academics before and there is some evidence that photographs on ballot papers give an electoral advantage to certain demographic groups, such as younger candidates[21].

6.7 Ballot papers and booklets of statements listed candidates in alphabetical order by surname. A few respondents did suggest the possibility that candidates whose surnames gave them prominent positions on the ballot and among the statements gained an unfair advantage. There is some academic research on the effects of name order on election performance, which does tend to suggest that some positions on a ballot paper offer a modest advantage[22]. There are clearly many factors that attract voters to candidates, and these modest effects would probably not be enough on their own to elect candidates who did not win support for other reasons. It is important to remember that the elections referred to in the literature would not have involved such a large number of candidates and would have involved party labels, which are known to be an important cue for voters. It is not feasible for us to estimate how much of an impact name order may have had, but to dispel any doubt we suggest that it may be worthwhile to randomise name order on the ballot papers and candidate statements in any future elections. This would have cost implications.

6.8 There was some misunderstanding of the rules of the election. For example, we came across a few instances of voters and candidates who believed that they could only vote for ten (rank-ordered) candidates in Dumfries and Galloway and twelve in Fife because those were the numbers of seats available, rather than being able to rank-order all candidates if they wished. It is difficult for us to get a sense of how common such misunderstandings were and why they arose; it is possible that they always arise with STV elections and that we would find the same confusion in local government elections.

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[21] See, for example, Johns and Shephard (2011) 'Electoral Impact of Ballot Photographs' in *Political Studies* 59(3) pp636-658

[22] See for example Miller and Krosnick (1998) 'The Impact of Candidate Name Order on Electoral Outcomes' in the *Public Opinion Quarterly* 62(3) pp291-330

6.9   Voters appeared to have very little information about the role of non-executives on NHS Boards. Presenting electors with a brief introductory statement on the context of the election as well as the rules might help to disperse this information. Electors needed to be informed about the election either on the day their ballot papers arrived or beforehand as there were reports of some disposing of their papers on the day they arrived if they were unaware of the contest. Given the large volume of information being delivered to electors during the General Election campaign in April and May, information may not have been picked up; providing some alongside the ballot could reduce this.

6.10   A few candidates had reservations about their home addresses being printed on ballot papers. Some had held sensitive positions in the past and were concerned at being approached by former acquaintances. As far as we are aware there was no mechanism in place for candidates to stand without advertising their addresses. For example, candidates who had held judicial appointments, sensitive child protection roles, or who had previously been subject to harassment, may have legitimate grounds for wishing to conceal their address. We suggest such a mechanism be put in place in the event of a rollout.

6.11   One candidate complained that a statement had been printed incomplete, with a second paragraph missing. Ideally, candidates would be given an opportunity to see proofs of their statements before these were delivered to printers.

6.12   There were some minor practical issues around electoral registration. For example, the electoral registration rules obliged Returning Officers to send electors' voting packs to the addresses listed for them on the 1st of April 2010 register. This meant that *some* electors who moved to a new address between the cut-off date for this register (in early March) and the 10th of May *needed to specifically request that their ballots be sent to their new address, which would have been very inconvenient*. While a few electors inevitably find themselves in this situation at any election, the numbers might have been minimised had Registration Officers been able to use a more recent register. Similarly, the rules only allowed replacement ballot papers to be issued to electors who claimed they had not received a voting pack, or who claimed they had inadvertently spoiled the paper but could not produce evidence, within seven days of the voting deadline. Those electors had to wait *until the 3rd of June for their request for a new ballot to be acted on, even if this was reported in mid-May* and Returning Officers had no discretion to issue a new paper earlier. There may be an argument for relaxing the wording. We would recommend that the Scottish Government confer with Electoral Registration Officers on such issues if elections are rolled out across Scotland.

Appointment process

6.13   Recruitment and selection for the appointments took longer than initially envisaged, largely due to the unprecedented numbers of applications received, and this delayed the process considerably. As a result, some of the

new members did not join the alternative pilot Boards until November 2010. Ideally, systems would be put in place to speed the process.

6.14   There were some delays in getting feedback to applicants for the appointed pilots. Again, this was linked to the unusually high number of applicants. While the high level of interest generated may be an encouraging sign, if this were repeated in any rollout it would be beneficial if the Scottish Government were to slightly increase the resources devoted to administrative support of the selection process. This should allow officials to process applications at normal speeds despite a substantially increased workload.

6.15   It is worth noting that the alternative pilots altered the application process only up to the point at which applicants submitted their forms. From that point on, the Scottish Government Public Appointments Unit and the Office of the Commissioner for Public Appointments in Scotland (OCPAS) ran a conventional selection process. We were not instructed to evaluate any changes to the selection process beyond those made by the Health Boards as part of the pilot, so we are not in a position to say whether changes to the selection process might help to meet the Scottish Government's policy objectives. If encouraging greater diversity in the backgrounds of Non-Executive Directors of Health Boards is a policy objective, then there may well be scope for further study to find out how the selection process could enhance diversity.

7   CONCLUSION AND SUMMARY

7.1   In order to help Ministers and the Parliament to reach a way forward, this section lays out, in concise form, the relative strengths and weaknesses of each model based on the research reported here and the accompanying literature review. This section could usefully be read in conjunction with the executive summary. When comparing relative impact, it should be noted that the election pilots replaced approximately half of the membership of those two boards, while the alternative pilots involved many fewer non-executives relative to the size of the boards.

Current system

7.2   Strengths of the current system are that:

- it allows recruitment by skills (e.g. advertising for a candidate with specific expertise in finance);
- selects candidates who are primarily committed to a fiduciary role (i.e. who are seen and see themselves as trustees rather than representatives, delegates, or advocates);
- and it is well understood by the NHS, politicians, civil servants and the interested public.

7.3   Weaknesses of the current system include:

- its perceived democratic deficit
- and board demographics that are not wholly statistically representative of the general population.

Alternative pilots: Public Partnership Forum (PPF) recruitment

7.4   The strengths of the PPF recruitment model used in Lothian are:

- its very low cost;
- that it draws on a population with a demonstrated knowledge of and interest in the health board;
- and in common with other models it led to more accessible board papers

7.5   The weaknesses of the PPF recruitment model are:

- loss of the opportunity to use specific skill-based recruitment (e.g. recruiting specifically for financial expertise);
- the risk that it will duplicate existing board information flows;
- limited diversity compared to elections due to the use of the existing public appointments process;
- and limited diversity compared to elections due to the limitation of recruitment to existing PPF members, who are not necessarily statistically representative of the general population.

Alternative pilots: Wider advertising

7.6   The strengths of the wider advertising strategy used in Grampian and Lothian are that:

- its costs are much lower than those of elections;
- that it increases the diversity of the applicant pool;
- and that it creates the opportunity to raise the profile of the board and highlight opportunities for engagement other than board membership.

7.7   The weaknesses of the wider advertising strategy are:

- limitation of skill-based recruitment, as criteria are relaxed to encourage a wider range of applicants;
- and that the diversity of the actual candidates chosen for the board can be limited by the use of the existing public appointments process.

Elections

7.8   The strengths of the elections include:

- the creation of a new vehicle for boards to link to the general public;
- the creation of a new vehicle for the public to participate;
- more diversity of views about the NHS present on the board (e.g. candidates affiliated with specific hospitals were elected);
- an enhanced degree of challenge (e.g. recorded votes were taken, and elected directors sought to have their contributions recorded by name);
- increased attention to the role of the non-executives as a result of the need to induct a large number of new and diverse members;
- more approachable board papers, something not confined to the election pilot boards.

7.9   The weaknesses of the elections include:

- limited demographic broadening relative to the general population;
- limited use by boards as a way to find out about community preferences (no board eliminated any existing public and patient involvement mechanism that might have been considered duplicative after the elections);
- limited use by the public as a vehicle to influence boards (turnout, in the Scottish Board elections and the ones reviewed around the world, was relatively low);
- the financial cost of running the elections, which could be higher per-voter if rolled out across Scotland;
- the organisational cost of inducting a large number of new people, defining board member roles, investing heavily in board development, and diverting time of all concerned, but especially the Executive Directors and Chairs, towards board management;
- and the loss of the opportunity to engage in skill-based recruitment.