NHS Confederation

Action for equality in Wales and Northern Ireland: The time is now

Executive summary

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NHS Confederation

About us

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

For more information visit **www.nhsconfed.org**

The Health and Care Women Leaders Network delivered by the NHS Confederation, is a free network for all women working across health and care.

For more information visit **www.nhsconfed.org/womenleaders**

This research was led by Professor Ruth Sealy, University of Exeter Business School, with thanks to Julia Fernando for her excellent research assistance.

Our approach to language

Ethnicity is recognised to be a complex, multidimensional concept, often defined by features such as a shared history, common cultural traditions, shared religion, a common geographical origin, language and literature. It is a highly subjective classification that an individual is usually required to articulate into a simple category.

Following NHS Race and Health Observatory guidance (NHS Race & Health Observatory, 2021), where there is a need to refer to more than one ethnic group at a time, this report will use the terms 'black, Asian and minority ethnic', or 'ethnic minority' or 'black and minority ethnic' interchangeably, to reflect the varying views of stakeholders on language and representation.

Foreword

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Diversity in leadership roles can make a huge difference in setting the tone, focusing people on the same vision and priorities and epitomising the behaviours needed for success. Authentic and representative leadership across the health and care system therefore must not be seen as an obscure or tokenistic future goal.

The breadth of thought, expertise and experience that diverse boards can offer is critical in pushing forward system transformation to meet the needs of the communities we serve and achieve better outcomes for all patients and service users.

The NHS Confederation's 2017 report, NHS Women on Boards: 50:50 by 2020, collated data on the gender composition of NHS boards in England for the first time and examined the steps needed to reach gender parity by 2020. The follow-up report, Action for Equality: The Time Is Now, found that while progress had been made to increase the proportion of women in leadership roles, there was much more to do to meet the NHS's target of 50:50 representation.

This research was commissioned by the NHS Confederation's Health and Care Women Leaders Network, in partnership with the Welsh NHS Confederation and the Northern Ireland Confederation for Health and Social Care. It builds on the existing work by establishing a benchmark of boardroom diversity and inclusion relating to gender and assumed ethnicity across the NHS in Wales and health and social care in Northern Ireland. In total, 20 health and care organisations making up the respective systems in Wales and Northern Ireland participated in the research via a series of interviews with board chairs.

Its findings indicate that, both overall and individually, NHS boards in Wales are gender balanced and, on aggregate, have a nationally proportional representation from racial and ethnic minority individuals, although two of the 12 boards were entirely white. In Northern Ireland, while the aggregated figure is gender balanced, six of the eight boards are not, and seven of the eightboards were entirely white.

Although the relative gender balance of boards in Wales and Northern Ireland represents a positive starting point, it is clear this is a complex issue that cannot be boiled down to numbers alone. The 23 interviews carried out between May and August 2022 sought to more adequately reflect the realities of board representation, the challenges faced, understanding, beliefs, cultures and the nuances of inclusivity.

Interviewees were deeply passionate about the health service and fulfilling their public duty, and there was widespread acknowledgement that boards need to be representative of the communities they serve to ensure all voices are heard. But it is also vital to recognise that without a cultural shift, focusing on diversity alone risks becoming a mere formality exercise, which does little to benefit organisations or the seldom heard voices concerned. There is immense value in exploring and understanding the contribution and benefits of diversity of thinking across a range of characteristics, including age, disability, religious belief and sexual orientation.

Ultimately, as the Action for Equality report concluded in the English context, there is more to be done in both Wales and Northern Ireland. Transforming approaches to board and organisational composition and diversity must be led from the top of government, as well as by individual organisations, forming part of their strategic outlook. Attracting diverse applicants must entail an acknowledgement that the kinds of qualities, skills and experience we tend to value are often a result of opportunities afforded by privilege, whether related to individual characteristics or socioeconomic status. There is a need, therefore, to be explicit when developing targeted strategies to reduce barriers to attracting people from underrepresented groups.

We extend our thanks to Professor Ruth Sealy of the University of Exeter for her dedicated research and authorship of this report. We also wish to thank the Health and Care Women Leaders Network team, who played a key role in bringing this work to fruition.

We urge government officials and every leader and aspiring leader across the health and care system to read the report in full. The evidence and case studies within it demonstrate what can be achieved when leaders set clear goals for board diversity. However, while goal setting and data are important to track progress, it will ultimately be the mindset, behaviour, working conditions and culture, as shaped by health and care system leaders, that will achieve true board diversity.

This report will inform further conversations with governments on board governance and we know our members in Wales and Northern Ireland will work with their respective departments to support implementation of the recommendations set out here.

As health and care systems face unprecedented challenges and immense complexity, we will require imagination, creativity and fresh thinking to get to where we need to be. Diversity of thought and experience will be a key ingredient in getting us there.

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Executive summary

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This research set out to establish benchmark data for boardroom diversity across the health and care services in Wales and Northern Ireland. Twenty boards were involved: all 12 NHS organisations fromWales and eight from Northern Ireland. Data was initially collected from public sources (such aswebsites) and received directly from board chairs or board secretaries. In addition to establishing the composition of the boards, the researchers aimed to interview all board chairs in Wales and Northern Ireland to ascertain their approaches to boardroom diversity and inclusion. The research was carried out between May and August 2022, so the findings reflect the board composition at that time.

Data and board composition

Information and data on board composition and diversity are not easily accessible. Detailed and disaggregated data on board composition, including on major dimensions of diversity, should be publicly available.

Data was analysed by assumed gender, assumed ethnicity, nation and 'power roles'. In Wales we see NHS boards have each individually met the European Commission (EC) definition of gender balance (that is, at least 40 per cent of each sex present) and at a national level the percentage of black, Asian and minority ethnic directors is representative of the population. In Northern Ireland, although at a national level we see figures for board directors are gender balanced, only two of the eight boards hit the EC definition. The remaining six are split evenly between having excess men and excess women. Seven of the eight boards are entirely white.

Board chairs were then interviewed to investigate:

- their aims for board composition
- motivations for and barriers to diversification
- the strategic priority of diversity in their boardroom
- their approach to achieving inclusion on their boards
- the role of external actors
- succession planning
- the role of board evaluation and development.

All interviewees had extensive board experience across a range of sectors and roles and were overwhelmingly passionate about the health and social care service and doing their public duty. A significant proportion of all interviews was spent discussing the flaws and challenges of the independent members (IM)/non-executive director (NEDs) board appointment process and the chair's role therein.

However, analysis of the findings revealed that many of the issues raised regarding the appointment process stemmed from conflicting understanding of and approaches to diversity, as well as some major governance issues regarding the roles and accountabilities of chairs and their boards in relationship with the government and civil service.

Diversity issues

Levels of understanding and capability to address diversity were mixed across both nations.

Many interviewees focused on representation and tactical approaches, with concerns about tokenism and bias (or at best a lack of understanding). Examples of gendered cultures are still apparent in some instances. However, some did buy into the more behavioural arguments of better decision-making and outcomes, and therefore take a more strategic approach to diversity – not as an add-on, but as a means of helping themselves to address the enormous complexity of current challenges. For these individuals, diversity was focused not only on personal perspectives but also cognition, so included diversity of experience and expertise outside of the NHS, outside of their national or regional boundaries, and outside of the public/third sectors.

There was a divide between those chairs who felt they had opened the door and therefore diverse individuals should now come in, versus those who understood the need to change the systems and present roles and opportunities that were both attractive to underrepresented groups and worked in organisations which enabled underrepresented individuals to believe they could thrive and contribute. These differing paradigms of diversity lead to a lack of clarity about what behavioural approaches are acceptable (for example, the difference between the tie-breaker rule and positive discrimination.)[i]

Governance issues

There are some issues around the relationships between the chair and board and the government in both nations. These are blurring the lines of responsibility and accountability, often creating a very difficult environment in which good board governance can thrive.

Some very strong language was used by some chairs about the negative impacts of the blurred lines of responsibility on their own **'locus of control'** – the extent to which they believe they (as opposed to external forces) have control over the outcomes for their board and therefore organisation. Findings from an earlier large study of diligent and dynamic healthcare boards, and changes made following the Francis report on Mid-Staffordshire, clearly state that an **"enabler of improved leadership was the extent to which boards themselves believed that they were able to make an impact, rather than being policy victims."**[ii]

Prior findings such as these, plus the various reports and guides on good governance already published in the Welsh and Northern Ireland contexts, show that numerous improvements are needed to how governance is operating within the health service in practice. However, this also means there is already substantial good guidance out there for boards and governments to make use of.

[i] See: https://www.equalityhumanrights.com/sites/default/files/appointments_to_boards_and_equality_law_22-07-14_final.pdf.

[ii] Chambers et al, 2020, **Roles and behaviours of diligent and dynamic healthcare boards, Health Services Management Research,** Vol. 32(2), p. 103.

The appointment process

There was a lot of disquiet among the whole interviewee cohort about the logic behind and operationalisation of the appointment process of board members.

Empty seats, lack of a diverse candidate pool, use of headhunters, structural barriers of time and remuneration, problems with the application form, the interview process and the decision-making process, as well as the fundamental issue of the chair's lack of control of their board composition were all highlighted. A minority of chairs seemed to focus on the myth of choice as the reason for a lack of diverse applicants, rather than recognising that the barriers to such groups being appointed may be due to current procedures and attitudes.[iii]

Substantial research in the private and public sectors across the UK and elsewhere has shown that best practice methods to increase diverse recruitment usually require substantive changes to the current search and recruitment processes to find and appoint underrepresented candidates.

While many of the issues listed above relate to bureaucracy and process, more fundamental questions regarding the meaning and purpose of diversity and the expected role and responsibility of the Chair and board are significant influences. The bureaucracy and process issues can be attended to, but this may be futile to fundamental change without addressing the other two underlying questions.

[iii] NHS Confederation (2021) Strengthening NHS board diversity: A report by the independent taskforce on improving non-executive director diversity in the NHS.

Summary of recommendations

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Diversity

- **Champion boardroom diversity.**
  Any form of major change needs commitment from the top – the same is true for major change initiatives around diversity.

  As the leaders of the NHS health and social care services in Northern Ireland and Wales, the relevant minister/secretary and department should further champion boardroom diversity, with the clearly articulated motivations of:

  - better board processes leading to better decision-making and effectiveness
  - better representation of community, leading to greater legitimacy and better patient outcomes
  - better representation of staff leading to better talent management.

- **Develop understanding of diversity.**
  To develop diversity further, there is a need to engage appropriate trainers (such as the Equality and Human Rights Commissioner) to run interactive sessions with boards on developing understanding of diversity. Without knowing what diversity training exists, it is difficult to recommend. Online tick-box training courses in diversity rarely have substantive impacts on how people understand and approach diversity.

  An example of an **"extremely powerful"** exercise includes where members of an underrepresented group have a focused discussion about their lived experience in that organisation. Members of the majority group sit outside of the group listening in, without (initially) speaking.

- **Adopt key steps of major change programmes.**
  Training and awareness of the differing diversity paradigms that underlie our individual and organisational approaches to diversity would be helpful. Developing diverse and inclusive cultures can be approached like other major change programmes, with the four steps of strategy, objectives, intervention and accountability. These steps have been identified in prior research with chairs who have successfully diversified their boards, taking a strategic inclusivity approach to change.

Governance

- **Raise levels of understanding.**
  Training on roles and responsibilities of IMs/NEDs and how a unitary board functions effectively, including the importance of challenge, may be necessary. Ensure executives understand they need to leave that role at the door and become a board member while in the boardroom. This only has value if the governance system actually supports them.

- **Be clear on roles and showcase good practice.**
  Role clarity, such as a published organisation chart showing that the chair is the leader of the board (executive and non-executive) would help. Showcase examples of good practice and when relationships between the board and the government department are working well.

- **Provide robust evaluation at appointment stage.**
  Have 360-degree appraisals for the board and allow the use of leadership style profiling at appointment stage for NEDs and especially for chairs.

- **Undertake a board development programme.**
  The facilitated relationship-building (Two at the Top and Two in a Team) programme in Wales should be **"strongly encouraged"** for chairs and chief executives. Northern Ireland could replicate a similar programme.

- **Expand (and in Wales, reintroduce) the Boardroom Apprentice programme.**
  Boardroom Apprentice should be expanded to meet demand in Northern Ireland. Wales should look at replicating something similar, understanding what did not work in their earlier example and what the key enablers are in Northern Ireland.

- **Clarify the purpose of boards.**
  Health departments should consider what they want the role of the NHS board to be. Within governance frameworks, directors can take the role of monitoring and holding management to account; stewardship and supporting management; enhancing social capital and resources; representing the interests of all stakeholders; and reconciling competing power interests.[iiii] Once the purpose of boards is clear and accepted by all parties involved, the appropriate governance framework needs to be enacted, including changing processes that will drive genuine diversity of NEDs.

[iiii] Chambers, N.; Smith, J. Proudlove, N.;Thorlby, R.; Kendrick, H. & Mannion, R. (2020) **Roles and behaviours of diligent and dynamic healthcare boards. Health Services Management Research,** 33(2): 96-108.

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