NHS Confederation

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

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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 NHS Confederation's Health and Care Women Leaders Network, is a free network for all women working across health and care.

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

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.

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Foreword

Foreword

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.

Samantha Allen
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Overview and introduction

Overview

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 from Wales and eight from Northern Ireland. Data was initially collected from public sources (such as websites) 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.

Introduction

"The ambition of all those working in the health system is to create the best outcomes for the communities served. Research shows that diversity improves the quality of decision-making by teams, delivers higher quality outcomes, which in turn aids staff recruitment and retention." So stated the NHS Confederation's 2017 report, NHS Women on Boards 50:50 by 2020,[1] which focused on establishing a benchmark census of gender diversity in England, with data on a total of over 450 boards and over 6,000 individual directors.

In 2020, the NHS Confederation published a second report into women on NHS boards in England, entitled Action for Equality: The Time Is Now.[2] The report repeated a census of boardroom diversity on 213 trust boards, with over 3,000 directors, and interviews with women medical directors and finance directors. Interviews were also conducted with chairs of NHS organisations in England's most diverse boards in terms of both gender and ethnicity (averaging over 40 per cent women directors and over 20 per cent of directors from ethnic minorities), focusing specifically on how and why they had achieved such diversity.

The report included recommendations at a national level around the provision and use of diversity data, as well as accountability for diversity issues. For the chairs and directors, better and more active use of diversity data from the organisation in board meetings was recommended, as well as moving away from a tactical approach of diversity compliance to one of 'strategic inclusivity'. For chairs, there was also a need to develop and demonstrate inclusivity and cultural competence, with a focus on the culture of the board as well as then pushing that down throughout the organisation.

In June 2022, the Messenger review of NHS leadership[3] in England acknowledged that there is much yet to do to create a more diverse leadership across the NHS, with tangible action and changes needed to ensure this happens. The report pointed to staff from minority groups still not being provided with the support they need to progress to leadership roles and the need for greater commitment to act on improving diversity in senior leadership, including making equality, diversity and inclusion a core aspect of the inspection regime.

These are just three of the many reports and reviews within the NHS over the past six years that have pointed to the need for greater diversity of skills, characteristics, knowledge and experience required to ensure the most effective boards in the most challenging of times.

In 2017, the Good Governance Pocket Guide for NHS Wales Boards[4] acknowledged that all health systems across the developed world face increasing demand and cost pressures, with a unique blend of responsibilities and challenges for leadership. The guide stated that 'leaders will have to navigate high levels of uncertainty and anxiety, listening and engaging with the views of the public, service users, staff, partners and other stakeholders, and charting a way forward which is in the public interest'.

This was before the COVID-19 pandemic and in 2024, the NHS across the United Kingdom faces a plethora of additional challenges, including excessive waiting times; long-term staff shortages; and financial precarity. In addition, the pandemic highlighted significant inequalities, generally for many marginalised groups and particularly for ethnic minorities, both in terms of the experiences of employees working for the NHS and the health outcomes for patients accessing NHS healthcare. The pandemic highlighted the need for inequalities to be addressed across all public services.

The health and care services in Wales and Northern Ireland sit within the remit of devolved governments and so face their own specific national policy contexts. In 2016, the government in Northern Ireland agreed to an ambition of gender equality for all public boards, that by year end 2020/21 equality of all posts held would be 'reflected both in board membership and at chair level'.[5]

In 2014, the Welsh Government supported the campaign for gender balance of 50:50 by 2020 for women and men in public life. In 2020, the government introduced a Diversity and Inclusion Strategy for Public Appointments in Wales,[6] with an ambition to increase the number of disabled people, black, Asian and minority ethnic, and other under-represented people in appointments to boards by 2030 so that boards reflect the communities they serve, therefore improving decision-making. More recently, the Welsh Government has committed to a focus on anti-racism as well as the 2020 diversity strategy to support Reflecting Wales in Running Wales.[7]

Therefore, this report was commissioned to take a snapshot of the diversity, specifically gender and ethnicity, of all NHS boards in Wales and Northern Ireland, as well as ascertaining the views of board chairs as to some of the enablers and barriers to creating diverse and inclusive boardrooms.

> "Inclusive and diverse boards are more likely to be effective boards, better able to understand their customers and stakeholders and to benefit from fresh perspectives, new ideas, vigorous challenge and broad experience. This in turn leads to better decision-making."
> **Lord Mervyn Davies,** 2011[8]

Board data

> “Actions must be underpinned by robust data and data analysis. Internationally, those countries that perform well on gender equality almost universally produce regular, accessible and engaging data and evidence that maps gender equality.”
>
> **Senedd Research,** 2018[11]

Board data

The availability of data on the demographic composition of boards has been found to be a crucial first step to monitoring diversity in organisational leadership and accessible diversity data is a critical first step to change, both in the private[9] and public sectors.[10] The first challenge encountered when seeking to analyse board diversity data for NHS boards in Wales and Northern Ireland was that these data do not currently exist.

In attempting to collate the data from public sources – for example, the website for each organisation – we found the data to be incomplete and often inaccurate or out of date in almost all cases. Therefore, after each chair interview and having ascertained that the information we had was incorrect, we wrote to each chair requesting accurate board data. In reporting our findings, we are using the term 'gender' to denote how the individual board director is presenting their gender as confirmed by their name, their photograph (where available) and confirmed by the chair. We completely acknowledge that ethnicity should not have to be measured by such simplistic methods and this then posed a dilemma for the commissioning team, who are interested in the proportion of racial minorities.

Terminology used was also raised by a few chairs and in this report, we will use the term black, Asian and minority ethnic, currently accepted in the NHS, fully acknowledging that these terms do not satisfactorily describe the wide range of different ethnicities. We also acknowledge that gender and ethnicity are only two of multiple dimensions of diversity that are often visually the most salient.

We did not collect data on disability or any other protected characteristic (although it was raised in some interviews), and therefore this, plus the very small number of black, Asian and minority ethnic directors, precludes any analyses at an intersectional level. A number of chairs did raise the issue of **"non declared"** status of some characteristics (such as disability, sexuality), which may be an area for future discussion.

The fact that such detailed and disaggregated data on any of the major dimensions of diversity is not readily publicly available continues to be an issue within the NHS and one that needs to be addressed, reflecting the findings of earlier NHS reports in England (2017, 2020).

Board data was analysed by assumed gender, assumed ethnicity, board role and nation. Unlike previous NHS research on English boards, we did not disaggregate the data any further for two reasons. Firstly, the number of boards we are considering is very small, making it difficult to reasonably make claims about statistical significance. Secondly, while the aim is to encourage this data to be readily available to the public, it is not the intention of this report to pass judgement on individual boards.

Across Wales and Northern Ireland, we analysed data from 20 organisations. The board size ranged from 11 to 23 in Northern Ireland and 11 to 24 in Wales. The mean board size in Northern Ireland was just over 15 whereas in Wales it was just over 19. The total number of board members across all 20 organisations in our sample was 353.

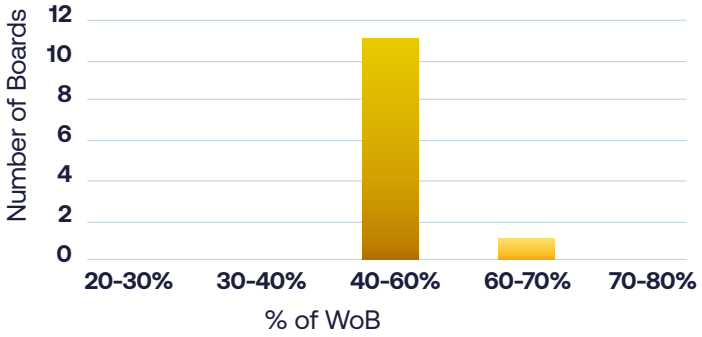
> "An ideal number should not prevent spaces on a board being made available for additional less-experienced members to join."
> **NIAO Board Effectiveness Guide,** 2022[13]

A recent report by the Northern Ireland Audit Office recommends that, depending on the complexity and size of the organisation, board size should be in the region of 8-15.[12] Wales and Northern Ireland have had integrated health and care systems for over a decade. Therefore, many of the boards we were analysing are significant in both size and complexity (for example, the organisation may have a budget of over £1 billion and over 10,000 employees). There is a recommendation that the board size needs not to overburden the members of the board, which findings suggest in reality is an issue to balance.

The European Commission (EC) defines gender balance as having 40-60 per cent of each sex represented.

Across the 12 NHS boards in Wales, the percentage of women directors ranged from 47.1 per cent to 60.9 per cent, with a mean of 52.8 per cent. Eleven of the 12 boards fall within the EC definition of gender balanced, with the 12th falling just outside, with 60.9 per cent women directors (see Figure 1).

Figure 1: **Gender Balance on Wales Boards**



NHS boards in Wales do not use the term non-executive director (NED), but instead refer to those individuals as independent members (IM). The mean figure for women executive directors was 54.8 per cent and for IMs it was 52.2 per cent (see Table 1).

Table 1:

Proportion of women directors in Wales Boards

All Directors	Executives	Non-Executives
52.80% (122/228)	**54.80%** (63/115)	**52.20%** (59/113)

Proportion of ethnic minority directors in Wales Boards

All Directors	Executives	Non-Executives
5.10% (10/198)	**5.70%** (6/104)	**4.20%** (4/94)

Proportion of women directors in NI Boards

All Directors	Executives	Non-Executives
54.70% (66/122)	**64.80%** (35/54)	**46.30%** (31/67)

Proportion of ethnic minority directors in NI Boards

All Directors	Executives	Non-Executives
<1% (1/122)	**0.00%**	**1.60%** (1/67)

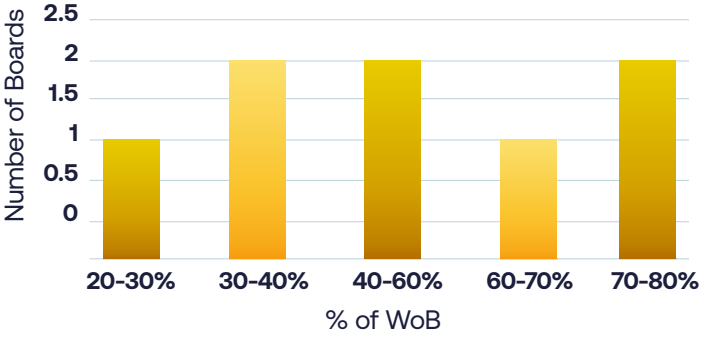
From the data we received, the percentage of black, Asian and minority ethnic board directors across all 12 boards was 5.1 per cent, with 5.7 per cent executive and 4.2 per cent IMs.

Overall and individually, the NHS boards in Wales appear to be 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, across eight boards, the percentage of women directors ranged from 27.3 per cent to 78.3 per cent, with a mean of 55.7 per cent. However, while the aggregate figure is gender balanced, only two of the eight boards fall within the EC definition of gender balance, with three boards having 20-40 per cent women and three having 20-40 per cent men (see Figure 2). The mean figure for women executive directors was 64.8 per cent and for non-executives it was 46.3 per cent (see Table 1). As far as we could tell from the data provided, the percentage of black, Asian and minority ethnic board directors across all eight boards was less than 1 per cent, with no executive directors and only one NED.

Overall, while the aggregated figure across Northern Ireland is gender balanced, six of the eight boards are not, and seven of the eight boards were entirely white.

Figure 2: **Gender Balance on NI Boards**



Board composition and key roles

We analysed what are sometimes referred to as the 'power' roles on the board, by gender and racial diversity. These roles are the chair, the chief executive (CEO), the chief finance director/officer (CFO) and the medical director.

In Wales, again using the EC definition, we found gender balance among the chair, CEO and CFO roles (see Table 2). This is very positive. In NHS England there remains a dearth of women CFOs, despite over two-thirds of finance workers in NHS England being women, so it was good to see this is not the case in Wales. However, the percentage of women holding medical director roles was only 25 per cent, which is disappointing given that women have made up the majority of medical school graduates since 1992.[14]

Three of the 11 medical directors in Wales (27.3 per cent) for whom we have data are from a black, Asian minority ethnic background, which is encouraging.

In Northern Ireland, none of the 'power' roles fall into the EC definition of being gender balanced. We note an excess of women in both CEO and CFO roles (62.5 per cent and 75 per cent) but a dearth of women in medical director and chair roles, at only one third of each. However, it should be noted that considering just eight boards, the numbers are so small that just adding or subtracting one person significantly changes the results. There are no individuals from a black, Asian and minority ethnic background in any of the 'power' positions.

Table 2:

Proportion of women directors holding power roles in Wales Boards

CEO	CFO	MD	Chair / Vice
50.00% (6/12)	**41.70%** (5/12)	**25.00%** (3/12)	**60.00%** (12/20)

Proportion of ethnic minority directors holding power roles in Wales Boards

CEO	CFO	MD	Chair / Vice
0.00%	**0.00%**	**27.30%** (3/11)	**0.00%**

Proportion of women directors holding power roles in NI

CEO	CFO	MD	Chair / Vice
62.50% (5/8)	**75.00%** (6/8)	**33.30%** (2/6)	**33.30%** (3/9)

Proportion of ethnic minority directors holding power roles in NI

CEO	CFO	MD	Chair / Vice
0.00%	**0.00%**	**0.00%**	**0.00%**

The interviews

The interviews

Prior academic research across sectors,[15] the private sector experience from the Lord Davies review into women on boards,[16] and the numerous Codes of Governance[i] would all suggest that board chairs play a significant role in determining the composition of their boards. Therefore, we set out to interview the chairs of all 20 organisations in Wales and Northern Ireland to ascertain their approaches to boardroom diversity.

We conducted 23 interviews in total. Chairs of 19 of the 20 NHS boards were interviewed plus the vice-chair of the 20th board, as the chair was unavailable. Eleven of the 20 chairs were men. In addition, we interviewed three individuals with extensive board and governance expertise to get a slightly broader overview. Interviews occurred between May and August 2022 and were all conducted online, using either Zoom or Teams platforms. They lasted between 50 minutes and 1 hour and 20 minutes. They were recorded and transcribed, generating over 200,000 words on over 300 pages of data, with a mean of just over 9,500 words per interview.

The chairs

All interviewees had extensive board experience across a range of sectors and roles and were overwhelmingly passionate about the health service and doing their public duty. The chairs ranged in their tenure on their current NHS board, with some in their first term and some coming to the end of their second.

> “The chairperson is the cornerstone of the board and is expected to bring valuable credentials and a personal commitment to the role (MWM Consulting, 2009). Frequently the chairperson is perceived to be the single biggest determinant of a board’s effectiveness. He or she has the primary role in determining the focus of the board, setting the tone for discussions and influencing the composition of the board. Care and attention should therefore be taken when appointing the chairperson.”
>
> **NIAO Board Effectiveness Guide,** 2022[17]

[i] For example: Financial Reporting Council UK Code of Corporate Governance 2018.

Findings from the interviews centre around three key areas, which will be elaborated on in subsequent pages:

1. The meaning and purpose of diversity - understanding of this was very mixed across all boards in both nations. While some excellence was demonstrated, there were also some simplistic conceptualisations of diversity with tactical rather than strategic approaches to its operation.

2. Governance and government - the relationships between the chair and the board on one hand, and the Department of Health, minister and civil service on the other varied considerably. The issues varied slightly between the two nations but impacted on responsibility and accountability of the chair and board in both countries.

3. The appointment process - one of the main points of focus to come out of almost all the interviews from both nations was that, in practice, assumptions regarding the role of the chair being responsible for the composition of the board were questionable. Dissatisfaction was expressed by a number of chairs about multiple aspects of the appointment process and their role within it. Discussion about various aspects of the appointment process took up a substantial portion of every interview. The variation in conceptualisation of diversity and the issues of governance from relationships with government both played into and impacted the operationalisation of the appointment processes.

Explaining diversity, paradigms and positive action

Explaining diversity, paradigms and positive action

Workforce **diversity** refers to varying characteristics of individuals, which may be visible (such as gender or race) or invisible (such as sexuality or religious belief). There are nine diversity characteristics protected in law by the 2010 Equality Act. These are:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation.

Boardroom diversity often also refers to human capital characteristics such as skills, knowledge, and experience.

Though often used interchangeably, diversity is considered distinct from **inclusion**.[18] On the one hand, a diversity strategy can be operationalised through changes to organisational policies or applied targets, with the clear aim of increasing the number of group members with distinct characteristics.

By contrast, an inclusion strategy concerns 'the extent to which each person in an organisation feels welcomed, respected, supported and valued as a team member'[19] and relies more on voluntary practices[20] and a sense of belonging embodied by all members of the organisation.[21] Thus, organisational policies and targets may provide a structure for addressing issues of diversity, but without full engagement from the individuals concerned, the extent to which such strategies lead to a culture of inclusion may be limited.

Establishing a difference between **equality** and **equity** is also key to the success of any diversity and inclusion strategy. The Equality and Human Rights Commission defines equality to be 'ensuring that every individual has an equal opportunity to make the most of their lives and talents'.[22] However, equality in practice can overlook the varying structural challenges faced by organisational members. Equity, on the other hand, considers difference and seeks to create the conditions for removing the specific barriers each organisational member faces, to achieve 'fair treatment in access, opportunity and advancement for all individuals'.[23]

Individuals and organisations are often described as being 'on a diversity journey', referring to the level of their understanding of such issues and the approach taken to addressing them. In academic literature these are defined as diversity paradigms[24] and can be described as follows:

Diversity paradigms

Discrimination and fairness approach – focuses on the moral imperative to equal opportunities, opening the door and treating everyone the same; may be described as 'gender/colour blind', which ignores power, status and privilege; this does not lead to diversification of culture.

Access and legitimacy approach – acceptance of difference, using diversity to gain access and legitimacy in markets and constituent groups – the business case is the dominant motivation.

Integration and learning approach – understands and values differences, learns new insights from cognitive diversity and integrates cultural competences to create inclusive cultures.

Findings 1: The meaning and purpose of diversity

The meaning and purpose of diversity

Meaning/conceptualisation

"Do we know what we mean by diversity?"

The understanding of and approaches to diversity varied in levels of sophistication across all interviewees. There were some individuals in both nations who clearly demonstrated an advanced understanding of the value of inclusive cultures on their boards and in their organisations, and the continuous reflective work required to achieve such inclusion. However, there were a number of interviewees who struggled to define diversity beyond 'counting heads' of different categories of people.

While representation, which was continually referred to in the interviews in both nations, is a very important starting place, it is vital to recognise that without culture shifts, this can become a **"box-ticking exercise"** which, while satisfying external demands, does little to benefit either the organisation or the groups concerned. Because **"being demographically diverse is not the same as being able to be culturally diverse,"** some interviewees suggested **"there is more work to be done to understand the contribution and the benefit you can get from that more diverse thinking."**

Representation and voices

Motivations for pursuing greater board diversity were also varied, revealing differing diversity priorities among chairs. The majority focused on representing all voices as a moral imperative – a sense of obligation to an established standard of equality and fair representation. National policy and targets set by governments are likely to have influenced this. For example, in 2020 the Welsh Government launched a strategy to support Reflecting Wales in Running Wales, with the aim of aligning workforce diversity in public bodies to the demographics represented in the broader Welsh population, and in June 2022 the Welsh Government launched its Anti-racist Wales Action Plan.[ii]

Focusing on representation is a starting point on the diversity journey, and it should be acknowledged that according to the data collected for this report, Wales' very purposeful focus on representation has paid off in terms of achieving gender balance on each of the NHS boards, and that at an aggregate level the representation of ethnic minority directors across the boards reflects the national figures.

In both nations, emphasis was placed on board membership needing to be **"representative of communities served"** to ensure **"all voices are heard"** by health and social care providers, recognising that for particular populations **"their voice is seldom heard."**

However, while representation may initially seem a laudable goal, when pushed, chairs acknowledged that having representation on the board of all service users' voices was unrealistic and problematic, particularly for already large boards. Chairs were divided over the characteristics they deemed a priority for achieving better board representation.

As mentioned above, at the time of the interviews, the Welsh Government had recently launched its anti-racist campaign, so this was front of mind for Welsh chairs.

[ii] See: https://gov.wales/anti-racist-wales-action-plan

Across both nations, discussions about diversity centred predominantly on gender, race and ethnic minority, socioeconomic status or class and disability. There was a greater consideration of religion given by Northern Ireland chairs, with reference to **"our troubled history."** Unless pushed, few interviewees considered representation of the LGBTQ+ community.

However, while the majority of chairs discussed board-level representation targets against the diversity of the community served, there was very little mention of the impact of achieving board diversity in relation to the demographics of workforce, and any impact this may have, for example on talent management.

Many chairs acknowledged the impossibility of hearing all voices through board diversity alone and proposed other means through which they either aimed to, or already did gain access to these perspectives. Stakeholder engagement, such as patient participation groups and community outreach, were discussed as means through which **"marginalised"** voices could be **"brought on board, going out into the communities and listening to them as to what they feel are the issues."**

However, while there was a clear focus on the importance of representation, **only a few boards examined the extent to which greater board diversity translated into more inclusive cultures.** For example, while gender balance may have been achieved numerically in boards in Wales, there were still a number of comments from interviewees about the **"gendered cultures"** in the boardroom and organisations.

There was some discussion about women's career progression within the NHS being particularly challenging, with a lack of appropriate mentoring and sponsorship that is always required at the senior career stages. This is part of the larger shift required towards more inclusive organisational cultures across the NHS.[iii] Prior research across NHS boards in England made a number of recommendations on women's career progression to executive levels, such as medical director and finance director.[25]

Several chairs struggled to articulate the difference between representation and advocacy, which most agreed was not the role of a board director. Using 360 appraisals of its chair, however, one board was able to evaluate its success in bringing not only diversity, but a climate of inclusivity to its board. The chair commented while difficult to receive, the feedback was very useful to learn that some board members felt they were **"not given their space to speak"** and the 360 feedback helped them going forward to **"ensure that I am including everybody and everybody's voice is heard."**

But discussing such initiatives was the exception, not the rule. **The topic of inclusion was raised only by a small minority of chairs in this study and there was limited agreement regarding how representation and inclusion of all voices could be achieved in practical terms.**

[iii] See: NHS Academy programme on Building Leadership For Inclusion.

Tactical approaches to diversifying boards

Several chairs struggled to demonstrate a real understanding of whether and why they wanted a diverse board, beyond the diktat of government policy. They declared a desire for representation, while in the same breath raising concerns about such goals being **"tokenistic."** Several chairs across both nations expressed concern that representation goals risked becoming **"a tick-box activity"**.

There was a shared perception from some chairs that board roles are inherently insufficiently attractive to diverse applicants, without understanding their role in maintaining or changing that perception. For example, one chair was able to see the role of **"attraction"** in bringing in talent generally but did not apply this to diversity. The chair understood that **"if the board has got a good strategy in place, if the vision is good, that pulls people into the organisation as well, because if it's visible enough and if it is attractive enough, people want to work in that organisation,"** but did not make the connection between having a strong diversity strategy and attracting more diverse directors to the board.

This same chair was strongly opposed to tailoring job adverts to attract diverse groups on the basis that it might **"exclude other potential candidates,"** without acknowledging that the current adverts may also be excluding the very groups all chairs purported to want. Private sector experience and recent NHS England reports[26] point to the need to 'demystify the role of the NED and make accountabilities and competences clearer' alongside the use of 'creative and media-savvy positioning and advertising' and 'networking into specific underrepresented groups in the community or through professional networks' as standard procedure to increase the diversity of the candidate pool.

Finally, there was a sense among some that consideration of diversity in the current health sector climate was important but rather more 'nice-to-have' than a strategic priority. Even if personally they believed it to be important, **"the headspace"** or the knowledge to work out how to do it was not there.

Perspectives and outcomes

Transcending the moral imperative, a minority of chairs did discuss board diversity as a means to achieving better outcomes for all patients. Diverse board membership was believed to bring a **"diversity of thought"** to the table, to **"enable really good decision-making,"** facilitate different perspectives and helpfully challenge the status quo. For some interviewees this appeared almost as a nice-to-have, whereas for others there was a real sense of urgency, recognising a need for change which was **"much more utilitarian."**

For a few there was an understanding of the need for **"diversity because we're facing unprecedented complex and immensely difficult challenges in healthcare and we haven't got a chance of solving those problems unless we bring all the brains to the party. And that means thinking differently... We really, really need a mix and a blend of different people, different experiences to have a chance of solving those problems."**

This diversity of thought was also felt to come from board members who brought different perspectives from their experiences working in non-health sectors, which most, but not all, interviewees agreed was a good thing.

There was an understanding that if most IM/NEDs had **"spent their life in the NHS"** that **"it becomes difficult to challenge perceived thinking."** Some chairs welcomed IM/NED **"endeavours to actually get you to see differently,"** particularly if they perceived a lack of constructive challenge in board-level decision-making.

They understood the value of those with very different experiences **"different opinions, different views, and it's that difference that allows us to offer a scrutiny and challenge, particularly as [IMs/NEDs] to the work of our exec directors."** These chairs understood this might require more management of the board dynamics by themselves, but that **"with diversity of experience and insight we'll have more arguments, you're going to get different perspectives, but you're going to get better decisions."**

Struggling to take a strategic approach to diversifying boards

Despite several chairs agreeing that increasing board diversity was a strategic priority, there were scarce examples where a clear strategy was in place to address gaps in this regard (for an exception see Public Health Wales Strategic Equality Plan 2020-24[27]). For example, chairs stated that they had difficulty attracting diverse applicants, but few exploited opportunities to make specific requests or use positive action at various stages of the appointment process.

Previous research in the private and health sectors has shown that there is much work to be done to encourage minority candidates to apply for roles that have previously been seen to be the exclusive domain of particular groups (such as white and middle class). This was only overtly recognised by a few interviewees. The quote from one interviewee hones in on how obtaining particular skills and qualities that are recognisable in boards are often a function of privilege.

> “There’ll be nothing on paper that says if you come from an ethnic minority background, you can’t be an [NED/IM]. But the kinds of qualities, skills and experience we value come about because we have opportunities that are related to our privilege. Whether that’s because we are male or white or highly educated or successful in a commercial sense. Those are the people who end up in in these kinds of roles. So the sort of exclusion that people from ethnic minority backgrounds find in regular working life then simply replicate themselves in this kind of subset of it. So if those barriers exist for people below the board level, then they don’t suddenly disappear at board level, they just replicate it.”

There appeared to be a lack of understanding between **positive action** and **positive discrimination.** One interviewee pointed out that most chairs acknowledge they need to change the way services are delivered to reach particular groups, and so questioned why they could not **“learn from what we do in our normal work anyway”** and take the same approach to attracting board candidates. Using the example of significant differences in life expectancy depending on where people live, one interviewee described the accepted practice of using different approaches to reach different populations.

> So the way we provide our services, it's not positive discrimination, is it? It's positive action to actually reach the people. We call them hard to reach, but they say we're hard to reach. They're not hard to reach. We're hard to reach. So why can't we take that into this [diversity] arena? That's what I just don't understand, if we really want more diverse boards.

To summarise, levels of understanding and capability to address diversity were mixed across both nations. Many 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 perspective but also cognition, so included diversity of experience 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 that they had opened the door and therefore diverse individuals should now come in, versus those who understood the need to **"build a better mousetrap and the world will beat a path to your door."**[iv] 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).[v]

[iv] This quote is a phrase often attributed to Ralph Waldo Emerson in the late 19th century, though it is believed to be a misquote.

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

Findings 2: Governance and government

> The significance of effective boards in the current climate of change and transformation cannot be emphasised enough; they are a key component to the successful operation of any organisation through the provision of high-quality support and constructive scrutiny of the executive team.
>
> **NIAO Board Effectiveness Guide** 2022[28]

Governance and government

The main focus of this report and all 23 interviews conducted was boardroom diversity. However, we know from prior research in the private sector – including publicly listed companies and large professional service firms – and on the NHS in England that transformational change in approaches to board and organisational composition and diversity need to be led from the top of the organisation and be part of its strategic outlook.

In the health service, leadership diversity is important to champion staff and patient engagement, transforming cultures for the benefit of patients,[29] with sub-optimal board composition increasing risk of patient safety issues.[30] In addition, within the private sector, a lack of leadership diversity and inclusion are increasingly being seen as governance risk factors to optimal effective board functioning by institutional investors and other stakeholder groups (as part of what is now termed ESG – environmental, social and governance concerns).

A number of our interviewees declared themselves to be **"passionate about governance"** and believed that **"good governance can really improve the delivery of public sector."** Therefore, in asking about both the board appointment processes (covered extensively below) and strategic focus, it was not surprising that crossovers to other governance and board effectiveness issues emerged.

Relationships with government departments and civil servants

In the 2022 Northern Ireland Audit Office report, the comptroller and auditor general specifically points to the important role of boards and 'the importance of having more truly independent high calibre of non-executive members... to bolster scrutiny and challenge' as well as the importance of having 'an open and trusting relationship' between the chair and the minister.[31] However, from the chair interviews, it is apparent that this was not their perception of how the system worked in Northern Ireland.

At a high level, a number of chairs in Northern Ireland suggested an absence of positive working relationships between themselves and the Department. Several believed this to be underpinned by a lack of appreciation for the work of the board, the roles of the chair and NEDs. Multiple examples were given of behaviours which were believed to be **"dismissive"** of the chair and/or board, indicating their **"perceived irrelevance."**

Several chairs spoke of a lack of interest or engagement from above, for example, no one ever attending a board meeting or **"picking up the phone to discuss the issue."** Several chairs referred directly to the case study highlighted in the NIAO 2022 report of the Regulation and Quality Improvement Authority (RQIA) whole board resignation as indicative of these issues, how their own situation is **"writ large about departments, boards, chairs and chief executives not understanding their respective roles and responsibilities."** There were multiple references to decisions that were taken on their behalf **"for which actually the responsibility will lie with us. You know, you can start to see where there's a real breakdown then in effectiveness."**

Multiple chairs in both nations, but particularly in Northern Ireland, used terms such as **"micro-managed, command and control"** and **"powerless"** to describe the **"parent-child relationship"** they had with the Department/civil service. There were also examples given in Northern Ireland of the careers of those who had challenged the system having been adversely impacted. This highlighted one of the problems of such a small community of boards and directors, **"there's a price to pay for stepping outside the system"**.

Chairs in Northern Ireland also referenced the structural issues surrounding the appointment process as further evidence of the lack of prioritisation of NEDs and the board – for example, the length of time NED roles remained unfilled; the lack of credence given to chairs' requests for particular skills; the failure to recognise the realistic workload of the roles; and the **"paltry stipend"** provided for them.

Northern Ireland chairs referred to another earlier report by the Innovation Lab, where civil servants and chairs had worked together on how to improve governance. Recommendations were apparently made and well-received, **"but then we did the Northern Ireland thing and it sat on the shelf."** One of the main recommendations was **"the revamping of the relationships with the departments,"** to be reformed and **"rather than being the parent-child relationship,"** it should be more of a partnership, **"[moving] away from this whole sponsor language because that reinforces the child."** Although health is the last department to reorganise in this way, encouragingly, discussions are now ongoing around partnership relationships. One of the challenges identified by a number of the chairs, however, questioned **"whether they know how to change their behaviours."**

In Wales, several interviewees referred to the small size of the nation and the fact that **"everyone knows everyone,"** and that relationships with the Department and minister were critical. There are challenges in relation to governance and lines of responsibility, with the minister talking directly to chief executives, the **"governance can sometimes get a little bit blurred."**

A Welsh interviewee, contrasting the situation of NHS governance in England, described the closeness as **"there's no clear water between the politics and the provision."** This then becomes problematic regarding the time horizon considered for longer-term strategic decisions, with clear conflicts of interest, as politicians are motivated by electoral cycles.

In both countries, the fundamental purpose of NHS boards was questioned. One chair's experience left them feeling deceived by the illusion that boards have the power **"to make a difference"** suggesting that this scepticism about the board's role had almost become accepted.

However, if governments want these boards to behave as fully-functioning unitary boards of substantial organisations (several had budgets of around £1 billion and over 10,000 employees), accepting the level of complexity that every health organisation faces these days, then interviewees argued that **"actually, we need a completely different sort of take on what it is that boards of directors need to be able to do."**

Interviewees wanted acknowledgement that **"that requires a different blend of experience, whether that's professional or lived experience of insights or, you know, different perspectives."** Chairs suggested that governments do need the benefit of fully-functioning unitary boards to run health and care **"because the problem space gets bigger and bigger and more and more complex."** They pointed to the challenge of hiring **"the same sorts of people"** who are **"boxed up in one corner of it"** and are challenged then to produce **"more diverse thinking."**

Several interviewees pointed to:

- appointment processes that led to the recycling of individuals
- both the appointment process and the structural issues of time and meagre stipend restricting potential candidate pools
- the closeness of the relationship to government, reducing the capacity or motivation to drive the innovative creative solutions required to address the complex challenges NHS organisations face.

Such criticisms of IM/NED roles being filled with **"the same old people who are at the tail end of their careers"** has long been identified as a governance issue in the private sector, since the Higgs review on the role of effective non-executive directors in 2003.[vi] As one chair said **"experience is important, but it has to be blended with other experiences. Otherwise, the experience isn't being refreshed and reinvigorated and renewed and regenerated."**

The challenge of persuading others to make such changes was acknowledged by another chair, who stated, **"you need the diversity in order to have the different conversations; you need to have the different conversations in order to get the diversity."**

[vi] Available at: UK National Archives.

Responsibility and accountability

> “Ambiguity can cause frustration and consequently hamper the effective operation of the board. Failure to understand or apply roles and responsibilities is a real risk to boards.”
> **NIAO Board Effectiveness Guide** 2022[32]

Good governance is dependent on chairs, boards, chief executives and the government department understanding **“roles and responsibilities and relationships and understanding what governance is.”** Interviewees from both nations raised important issues regarding a lack of clarity around roles and responsibility.

In Northern Ireland, a number of chairs raised issues regarding their role and relationships with the executives. Chairs believed, often based on past experience and in line with governance best practice, that they had responsibility for the whole unitary board. However, the chief executive negotiating and communicating directly with the Department of Health or the Permanent Secretary, rather than via the chair, confused lines of accountability.

Several chairs discussed the role of the executives, objecting to but understanding that when a department is dismissive of the chair, NEDs and the board, **“why would a career executive pay attention to the chair, when actually his or her career is entirely in the hands of the Permanent Secretary?”** Several chairs expressed the view that such poor relations curtailed their ability to discharge their responsibility from a governance perspective.

The Department of Health Permanent Secretary is also chief executive of the Health and Social Care system in Northern Ireland. Several chairs questioned how the chief executive of each board could be responsible to the chair and board and simultaneously to the Permanent Secretary, without completely undermining the role of the chair.

As one chair said: **“No one ever explained to me what the governance implications of that were, despite me writing on a number of occasions and never getting a reply... Technically, I am the chair and the board technically on paper is responsible. But the way the system works – the way the system actually works – is that if there’s an issue, a significant issue, clinicians go directly to the minister.”** This makes lines of responsibility and accountability in reality very unclear, as emphasised in the NI Audit Office guide to good governance and other similar publications across sectors.[33]

Although reported as less of an issue in the Welsh interviews, in the Wales Good Governance Guide,[34] the organisational chart of the board also shows IMs reporting to the chair, and executives reporting to the chief executive. The chair then reports directly to the minister and the chief executive reports directly to the NHS Wales chief executive, revealing a lack of clarity around the chair's responsibility for the whole board, meaning **"lines of accountability can get very blurred."**

One impact of this is that it splits the board, creating a schism between the executive and non-executive roles, which is not how effective unitary boards should operate. One chair discussed the **"fractious relationships"** between the executives and NEDs/ IMs when they had become chair, a real sense of **"them and us,"** and how the chair had to work very hard to get all the directors to understand what their roles were and how they fit and work together in the board, supported by the chair. **A suggestion was made about training new board members on how unitary boards operate. But as pointed out, this only has value if the governance system actually supports it.**

All the chairs have had extensive experience in various leadership positions in the public, private and/or third sector and understood the importance of good working relationships **"with others in important positions for actually working out solutions and delivering."**

Drawing on their prior board experiences, chairs articulated that **"with the vastness of the organisation"** there were plenty of tactical issues for them to be concerned with, but that **"in terms of the strategic conversation, it's happening somewhere else and we can try to influence it...but I just do not think that accountability structures are as transparent and as effective as they might be."**

This lack of clarity around their strategic roles and **"messy accountability"** was raised multiple times. But as one chair pointed out **"they and we know what's wrong, we keep getting reviews and reports, but nobody seems brave enough to really address it."**

In Wales, examples of dysfunctional accountability were described, with a chair describing, for example, **"unrealistic targets being dictated, not agreed."**

As one chair in Northern Ireland pointed out, the result of the lack of clarity around responsibility and accountability is that **"you throw a wet blanket over the creativity and the innovation and the adaptability of the system."**

Such sentiments about the state of governance in Northern Ireland were ubiquitous, with almost all chairs critiquing the way the system currently operates. When asked about potential change, concerns were repeatedly expressed that the system is **"very embedded."** However, as one interviewee mentioned **"if three major inquiries show anything, it should be that something in the system is not working, that governance is not working."**

There was, however, hope expressed that the appointment of a new Permanent Secretary in Northern Ireland (in April 2022) could create opportunities to improve the current culture. One chair optimistically described how, within three months, they had already had three conversations with the new Permanent Secretary.

"It's the difference leadership can make. In terms of setting the tone, in terms of focusing people on the same priorities, in terms of symbolising the behaviours that you want to symbolise, and so I do think that leadership can make a terrific difference. And you know, I've given you examples of where things haven't worked. I could, if we had another hour, give you examples of things that do work, when people all do get on the same page" said one chair, describing excellent working relationships with universities and citing the best respiratory COVID-19 outcomes of anywhere in the UK.

Notwithstanding the challenges with relationships, a number of chairs described how, despite their frustration, they were still driven to make things work better. They noted that they endeavoured to circumnavigate the system, trying to make changes within their organisations, working closely with other chairs. But overall, the frustration won through with the sense that **"Chairs are not appointed with the sort of terms and conditions that allow us to do the job that we really could do to help."**

Board evaluation and development

In both Wales and Northern Ireland, chairs are required to complete an annual evaluation of their board, with a given template. For this research, we asked chairs, aside from the template, what was important to them in the evaluation of their board and how they judged the board's effectiveness. Given the depth of their experiences, most chairs chose to go beyond the stipulated template and introduced **"more sophisticated evaluation."**

For example, one chair described how, on another public sector board, they had external evaluators and described a **"really comprehensive review"** with 360-degree reviews of each board member. They then replicated this on their own board. Another confessed to having **"largely plagiarised a lot of what good governance in NHS England are doing – they have board maturity, and are more sophisticated and interactive. We each scored ourselves and then shared the results. They were very helpful discussions."** Another interviewee described: **"a self-assessment under the Well-Led Framework which they don't use in Wales, but we did."**

The stipulated template did not cover the executives. However, a number of chairs believed they should be appraising the whole board, despite this potentially being problematic: **"how can I give somebody an appraisal when I'm not their line manager."** In several cases, however, the chairs pushed through their inclusion of the whole board and were clear that this was an important part of board development.

There were different ways of doing this. For example, in Wales, two interviewees discussed getting each executive and one IM to discuss their self-assessment together and then also reflections of the chair and CEO. The chair and CEO also reflected on each executive and IM. Two other boards also brought in specialist external board evaluators, appreciating their expertise: **"the process is about having a really open and frank conversation about what's working, what's not working, doing a structured reflective piece over the last year, where are there pinch points and things we could have done better."**

Governance guidance suggests that board composition and diversity, and the impact that this has on board dynamics and decision-making, should be a part of a board's evaluation of itself. Few of the chairs made those links directly; there was more focus on good working relationships between all board directors and their roles, without reference to diversity characteristics specifically. This revealed their emphasis on getting some basics working first, as well as the social complexity of boards and that diversity characteristics are just one facet, which in themselves should not be expected to make significant changes.[35]

While most chairs appreciated the benefit of conducting reflective elements of evaluation, there were several comments made about the **"somewhat box-ticking nature"** of the formal board evaluation template. When probed, this often referred not to the template, but to the lack of engagement or quality feedback from the Department, particularly in Northern Ireland. This directly contravenes the NIAO (2022) recommendations which state that ministers should provide feedback on the chair's report, requiring them to engage in conversation with the chair.

Across both countries, a few chairs were very consciously and actively reflective about the inclusivity or otherwise of their board dynamics. One chair shared their frustration at the lack of initiative taken by some of their counterparts. The chair pointed to reflective practice as necessary to improve inclusive board dynamics and processes. Another chair concurred: **"Reflection on board dynamics is essential, fundamental to building the board."**

In responding to questions about board evaluation, several chairs also discussed board development, making the point that board development should not just be about knowledge and skills, but also individual development. For example, one board in Wales had **"NHS Providers to do some work on challenge on a unitary board, to move away from the idea of a stakeholder board."**

Another chair spoke of engaging the Equality and Human Rights Commissioner to do **"some very insightful development sessions with the board"** regarding diversity. Several chairs also discussed the value or potential value of using psychometric tools. As discussed below, several chairs in both nations considered this should be used at the appointment stage, but given this was not the case, they either used or wanted to use this in board development.

In Wales, one interviewee described the success of a facilitated board development programme called Two at the Top and Two in a Team, provided by NHS Leadership Academy, which focuses on developing relationships, behaviours and better-quality discussions. It pairs the chair and CEO, or an executive and appropriate IM (such as the CFO and an IM with finance experience), and works with an external facilitator on their roles, constructive relationships and responsibilities. The interviewee felt passionately that implementing such developmental programmes should be more strongly encouraged by government and was the responsibility of the chair.

Some discussed how they were in the early stages of thinking about developing the board's understanding of its culture, its influence on the rest of the organisation, and the role of diversity therein. Culture is sometimes perceived to be intangible and hard to influence, but in his recent book, psychologist John Amaechi simplifies this to state that people make choices and choices makes culture.[36]

In the private sector, the Financial Reporting Council's 2018 update of the UK Corporate Governance Code[37] places significant focus on inclusive cultures, with boards encouraged to regularly assess and monitor culture.

The Guidance on Board Effectiveness.[38] published in support of the Code gives examples of how to do this. **"We say that's an important area but we've yet to venture into it. We signed up to the behaviours that have come from our workforce, we started to get into allyship, but we're not clear yet what role the board has beyond that, in terms of culture change. So that's the next stage for us."**

Diverse chairs and NEDs/IMs impact the tone of governance[39]. **Comments from a few chairs would suggest that board culture could be an area for further board development, which might benefit from some facilitated support.**

In summary, in both nations there are issues around the relationships between the chair, the board and the government which are blurring the lines of responsibility and accountability, often creating a very difficult environment for good board governance to thrive. Some very strong language was used by some of the chairs about the negative impacts of this 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 a large study of diligent and dynamic healthcare boards, and changes made following the Francis report on the Mid-Staffordshire inquiry, 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.'[40]

That research also looked at relationships between various board practices and impact variables and found that higher Care Quality Commission ratings in England were associated with a strong sense of the board and chair holding the executives to account. In addition, boards with a stronger locus of control also 'maintained a focus on strategy and had a stronger quality outcomes propensity'.

Prior findings such as these, plus the descriptions given in our interviews by the board chairs of the reality of how governance is operating within the health and social care service, would suggest that the various reports and guides on good governance already published in the Welsh and Northern Ireland contexts are not being implemented. Urgent focus should be given to removing perceived barriers to this, clarifying roles and responsibility.

Case study: Boardroom Apprentice

> To be honest with you, this was an idea I had six years ago and I asked a few people to give me help and we went to goodwill. We pulled this together and it worked and it's just grown since then, which is brilliant.
> **Eileen Mullan**

Eileen Mullan, chair of Southern Health and Social Care Trust, has dedicated her time to helping Northern Ireland improve public/third sector board succession by launching the Boardroom Apprentice. This is a 12-month **"learning, development and placement"** programme targeting younger, diverse, new aspiring public and third sector board members, with three pillars:

1. A non-decision-making role on a public board, providing hands-on experience
2. A suite of learning days, building skills, knowledge and understanding
3. Support from a dedicated person on their host board.

The programme provides application form training, workshops on CV-writing and generally helps applicants identify the experiences and skills they can transfer over to a board role. The programme has been a success in terms of generating applicant interest in public board:

> I have more people wanting to do it than I have host boards available to provide that opportunity.
> **Eileen Mullan**

In 2022, 277 participated in the programme, which has received over 1,000 applications since it was launched six years ago. Boardroom Apprentice actively targets underrepresented groups with a view to increase diversity on boards, **"get them at an earlier age"** and **"move the board member role from aspiration to reality."** The programme is also deemed a success by other board chairs:

> I do think one of the steps that Eileen has taken on the Boardroom Apprentice is a really good way of getting diversity, getting skills, and getting to the younger members.
> **Northern Ireland board chair**

> So we work with the apprentice to make it work for them, and we try to give them experience in as wide a selection of committees as we can.
> **Northern Ireland board chair**

A follow-up tracker of the first three cohorts showed that over 50 per cent of apprentices were sitting on public or third-sector boards. The positive impact of the programme is also reflected by the number of Northern Ireland chairs who discussed the mutual gains through hosting apprentices:

> "The young woman we got this year has been superb. Absolutely I could not have chosen better."
> **Northern Ireland board chair**

> "I'm a big fan of the Boardroom Apprentice scheme. My first boardroom apprentice that I mentored, she's now the vice chair of [a public sector forum] two years on. She was great!"
> **Northern Ireland board chair**

Overall, Northern Ireland chairs agreed that hosting apprentices and particularly those from minority backgrounds brought "**fresh perspectives**" and "**opens up those boards to really think differently as well.**" A Boardroom Apprentice UK Pilot has launched in 2022 and will run for two years, supported by the Secretary of State for the Department of Levelling Up, Housing and Communities, and the Cabinet Office.

Findings 3: The appointment process

The appointment process

A substantial portion of all interviews was spent discussing the appointment process. In both nations, the commonalities are that board chairs and NEDs/IMs are appointed by **"the minister"** and the process is handled by a public appointments body. The process includes an advertisement being published, applicants completing a form, initial applications going through **"the sift,"** with those **"ticking the boxes"** being asked to interview. The chair convenes an interview panel, notes on each candidate are taken to determine **"those above the line and those below."** These are sent to the minister to determine the successful candidate.

There was a lot of criticism in both nations regarding various aspects of the appointment process. Chairs overall conveyed a sense of **"limited agency"** and **"inhibited power"** in the selection and appointment of board members, contributing to a number of challenges in achieving greater board diversity. Issues on both the meaning of diversity and board governance fed into some of the problems highlighted with the appointment process.

Empty seats

One of the most serious issues about the appointment system in both nations was that it had led to a number of boards having "empty seats" for NED or IM roles.

Chairs expressed grave concerns about prolonged periods with empty seats and governments' lack of understanding of the negative impact on governance, the board's ability to function, board committee quorum, and key tasks such as succession planning.

"There is just inactivity in appointing... Even before the Northern Ireland Executive collapsed, the post had been vacant for quite some time. And that, that is not good for good governance." Chairs in both nations described their public appointments bodies as **"unfit for purpose,"** whose **"inefficiency"** was felt to hamper attempts to strategically plan board succession.

In Northern Ireland, the sense of **"limited agency"** in the appointment process was more pronounced. Given the high involvement of the public appointments body in this process, it is unsurprising that chairs shared deep concerns around the continued absence of an appointed commissioner for public appointments. At the time of the research, interviewees said the post had been vacant for over 18 months (and remains vacant at the time of publication) and they believed an appointment process took place in 2021 but was ultimately unsuccessful. Without a commissioner in place, there is no one in authority to advance board appointment decisions. **"Our department is really behind on appointments because we're all sitting with gaps."** Chairs expressed a sense of powerlessness to appoint and reported multiple empty seats on their boards.

In addition, Northern Ireland chairs described challenges in succession planning due to the impact of directors' board terms ending simultaneously. This can have the extremely detrimental impact of losing **"a lot of that expertise"** and intellectual capability simultaneously.

Chairs' attempts to address gaps, for example by trying to extend a board member's term, were met with inflexibility by **"senior officials at the department,"** even immediately after the pandemic: **"We were still struggling with the pandemic in a big way. And I felt the oversight of the board was critical. And having vacant seats was not good... but again they rejected my request to extend that person for a year."** Chairs also pointed to the **"extra demands"** these enduring vacancies then placed on remaining board members, pressures they believed were poorly acknowledged and understood by government.

In Northern Ireland some felt the capacity of the Department to resolve the issue was illustrative of the lack of priority for boards and their chairs.

In Wales, multiple chairs attributed empty seats on boards more to the public appointments unit being historically under-resourced. However, even with additional staffing, interviewees lacked confidence: **"Unless they improve their processes, I believe that the reputational damage for the way we try and employ these independent members and the way in which they are told what their responsibilities are... is in need of radical overhaul now."**

One or two chairs from both nations suggested pooling application processes, running **"competitions"** for multiple boards and/or to create a bank of NEDs/IMs. This has been tried successfully in other areas and sectors[41] and is the purpose of initiatives such as Boardroom Apprentice in Northern Ireland, and the NexT Director scheme in England,[vii] particularly focused on underrepresented groups.

One chair of a new organisation described creating a board from scratch and had a more positive experience purposefully interviewing many more candidates than in the normal system, as they were endeavouring to create a team. Research shows that undergoing multiple simultaneous hires often enables more diversity[42] precisely because there is a focus on creating a team rather than comparing individuals against each other. In other areas, chairs consider their board skills matrix and diversity mix to inform their recruitment.

[vii] See: https://www.england.nhs.uk/non-executive-opportunities/improving-non-executive-diversity/next-director-scheme-supporting-tomorrows-non-executives/

Reaching candidates and broadening the candidate pool

A number of chairs agreed that when recruiting with diversity in mind, careful consideration must be given to how roles are communicated in job adverts, as well as **"who gets to see them."** Interviewees were critical of the Public Appointment Bodies' ability to ensure visibility of job adverts among diverse audiences. In both nations, boards predominantly used public adverts in regional newspapers or posted on social media platforms such as LinkedIn. They believed using an open approach would help reach a greater number of applicants.

However, a number of chairs expressed frustration and a lack of understanding as to why few diverse candidates applied. A number of Wales chairs discussed more proactive approaches to reach more diverse audiences. A common strategy was to **"not rely on the government's website, which is quite hidden from ordinary people"** but to leverage existing networks to promote the job advert to a more diverse network membership.

Only a few chairs saw it as part of their remit to make the role or organisation **"attractive"** or to better explain it to non-traditional candidates, despite several chairs stating **"I don't know why people don't apply."** A number of interviewees explained it was due to structural reasons of remuneration and time (see below).

Interviewees from both nations spoke of the size of the country as a reason for the **"shallow applicant pool"** and **"recycling"** of board candidates, as **"it's quite a closed pool... And really, it's the same people sloshing around. Albeit they may pop up with different job titles in different organisations at points in time."**

A couple of chairs discussed going wider geographically to look for NEDs/IMs, but some chairs in Wales questioned this as **"the health system in Wales is completely different"** from that of England.

Some chairs, aware of the challenges, were keen to respond proactively, wanting to have input to reach appropriate candidates. Frustration was raised where the public appointments body was not being proactive, nor were they allowing the chairs to be proactive in the appointment process.

When questioned about this lack of flexibility and barriers to changing the situation, a number of interviewees gave similar responses regarding the process having to be standardised across the system, not allowing for individual chairs to take individual actions. This had been explained to them as **"arguments about equality. Which is quite interesting. Because I think it has the opposite impact because you keep getting the same sort of people."**

This brings back discussions about the meaning of equality and diversity and assumptions that in order to be fair, everyone has to have exactly the same experience of the appointment process. But this assumption is built on the premise that everyone is starting from the same place of opportunity, which was nicely pointed out as incorrect by one interviewee: **"There isn't much diversity amongst us, not just in demographic terms, but also in terms of career experiences, educational experiences. We're all pretty similar to each other, and so it's easy to recognise. So I think those are constraints that have a limiting effect for others. It's a structural issue and so we keep on doing the same thing. You know we keep on seeing that sort of cycle of recruiting those people who look and sound and have the same experience that we have."**

Headhunters were used by some boards as a way to address these challenges, accessing **"harder to reach groups"** and reducing the time boards would otherwise have to spend on the search. Some chairs described decisions regarding whether to use a search firm (and if so which one) as the responsibility of public bodies and government, a decision which is **"not ours to take."**

However, the use of headhunters was criticised by some chairs who perceived the costs as unjustifiably **"wasting money"** given the existing financial pressures and budgetary constraints, **"when we should be more than capable to run an exercise ourselves."**

And there were questions regarding headhunters' effectiveness at bringing diverse candidates, based on a belief that such firms also just recycle their preferred candidates. Certainly, prior research into increasing board diversity in the private sector has shown a changing role of progressive search firms taking on the boardroom diversity challenge and becoming **"accidental activists."**[43] Prior research with NHS England chairs discussed successfully using particular headhunters with proven track records in finding candidates from underrepresented groups.[44]

Structural barriers

Almost every interviewee in both countries raised the issues of remuneration and the stated time commitment required to fulfil board roles as completely inadequate.

The majority of interviewees clearly articulated how the low remuneration (which has not increased in a decade) and the reality of six to eight days per month for a IM/NED role (as opposed to the four days mentioned in adverts) hampered diversity efforts.

Examples were given of how it would preclude highly skilled younger and in-work individuals, people from the private sector, those with caring responsibilities, and perpetuated the most likely candidates to be retirees **"with a decent pension."**

And although the chairs were all very clear about their own motivations of public service and **"giving back"** one chair described their stipend as laughable for the three to four days a week they worked, with the responsibility for an organisation, many of which have turnovers of over £1 billion and over 10,000 employees.

Another chair described the department as **"duplicitous"** for advertising posts as one day a week **"You cannot do the basic governance and oversight of a £1 billion business in one day a week."**

Several interviewees also expressed discontent with the remuneration in both Wales and Northern Ireland (approximately £9,000) being substantially less than an equivalent role in England (£13,000- £16,000), despite the organisations in England often being smaller.

A few chairs also presented remuneration as another area over which they were powerless, particularly regarding reduced leverage with high potential candidates from the private sector, believing it to limit the applicant pool generally. This contributed to the general sense of helplessness regarding recruitment as **"we can't change the things that we need, and we cannot appoint or decide on who you like and what you want to offer."**

The application form

A clear message from chairs in both nations is that the application form is rigid, inaccessible and perhaps even exclusionary of the diverse individuals it is seeking to attract. Common complaints include the amount of time taken to complete the form, rigidity in criteria and language inaccessibility for those where English is not their first language and for those not familiar with the public sector.

Related to its inaccessibility, chairs described a high incidence of poorly completed application forms which triggered a great deal of frustration for some, as well as a recognition that perhaps better guidance could be offered.

Some chairs were more reflective and endeavoured to understand the challenges some people have with the forms, explaining that **"we're required to stick to fairly rigid criteria about personal statements submitted with applications, covering a number of bases, key criteria that needs to be demonstrated, personal statements that are required length...and so on, which normally not all candidates comply with those sorts of requirements and that's, I think, served to disadvantage some people."**

To address these issues, a number of chairs suggested either changing the application form to render it more accessible or **"we need to offer people training on doing this"** to better understand and successfully complete an application. Another suggestion made was that **"everybody who applies for an IM/NED role for the first time, I think they need a mentor."** However, some chairs who had wanted to offer such mentoring were discouraged from doing so, in the name of equality and everyone getting the same treatment.

Despite this and the constraints of the current appointment process, a number of chairs demonstrated proactively working around the guidelines. A number of chairs **"mined"** their own networks and/or encouraged their board to **"reach out to all its networks that you know are in any way diverse. So we try to bring people to attend...we try to bring the opportunities to the people."** A few chairs admitted to mentoring candidates to bring diversity: **"I particularly focus on women on boards, and also women with a disability and have been successful in helping people get on to other boards."**

Others recognised that a more diverse candidate **"might be someone that you need to do a lot of work with and help and support and mentor. But if you don't do that sort of... positive discrimination, then you don't actually move anything."** However, this was felt to be **"under the radar"** of the public appointments body.

More than one chair in both nations suggested a fundamental overhaul of the process, with more proactive roles proposed for the public appointments bodies, proposing they run **"briefings"** that could **"be at a local or a national level to assist candidates to understand the process"** as well as ways of adapting the current system.

As an example, they proposed the use of psychometrics and/or occupational psychologists in the process. One chair relayed their experience of having done this for another organisation, seeking more diversity, making the form, the process and the assessment more accessible.

The interview: competence, values and potential

Mixed opinions were expressed by interviewees about the current interview process, with much dissatisfaction with its inflexibility. One chair highlighted that anyone who got **"over the line"** demonstrating competences in the interview could be placed on their board, regardless of how much or little prior board experience they had. One chair suggested within the current system, that the Public Appointments Body take on inexperienced individuals for NED roles, but onto smaller public sector boards with a £1-2 million budget. **"It would train them in a smaller board first of all, before then launching them into this kind of size of budget and complexity."**

Some chairs identified the focus on fixed competences in the interview process that disallows candidates who are judged to have the right values, considerable potential and/or other desired skills. In Northern Ireland there was significant praise for the Boardroom Apprentice programme, set up pro bono by a current chair. In Wales, a form of apprentice programme had been tried a few years earlier, which was mostly described as unsuccessful. However, several Wales interviewees were interested to learn more about the success of the Northern Ireland Boardroom Apprentice, seeing it as a potential way of expanding the potential IM pool.

Who makes the decisions on board composition and succession?

In Northern Ireland, when describing the appointment process, chairs commonly referred to a step in the process called the **"pen pick."** Once all shortlisted candidates are interviewed, chairs describe the final step to appointment as **"at the minister's discretion."** The minister's decision, Northern Ireland chairs report, is heavily guided by a summary of each candidate composed by a member of the Public Appointments unit.

Strong frustration was expressed around this issue. Opinions were voiced that it was **"ridiculous"** that civil servants who are not working in a delivery organisation, and likely have no experience of how the board functions in practice, are penning the recommendations. One frustrated chair pointed to the futility of following a fair and inclusive interview process, only to end with a **"subjective decision"** from the minister. A small number of chairs mentioned successful court challenges to some previous appointments as indicative of what they deemed to be a failing system.

In almost all other sectors, including in NHS boards in England, a key role of the board chair is to manage board composition, succession and evaluation.[45] Several chairs in this research, particularly in Northern Ireland, felt prevented from doing this: **"There is no opportunity for a chair to create a team. Or to create the resources and the skill mix that they have to start off with."** The current appointments system is preventing chairs from constructing their board as a team, as they are blocked from requesting particular skills or experiences that they feel would benefit the board and therefore the organisation.

By contrast, in Wales, some chairs believed they did have greater influence over the final decision, describing being **"very clear on who is and who is not above the line. And who is the preferred candidate."** However, there was a lack of clarity regarding the legitimacy of this within the system.

Some chairs in Wales highlighted the additional challenge of having specified non-executive roles, which they felt made it even harder for them to consider diversity requirements.

For example, of the IM's backgrounds **"one has to be finance, one has to be local government, one has to be third sector and now one has to be digital and...Given the specificity and the number of the roles, it's really tricky to try and cover all aspects of diversity and inclusion around the board table through board membership."** However, some felt they were able to **"do [diversity] through advisors' networks, that type of thing as well to make sure that we get inputs because it's simply not possible with the number [of board members]."**

In terms of board composition, particularly in Northern Ireland, interviewees questioned whether there was an authentic desire for board diversity from the department. There were several comments about the lack of diverse appointment panels, relevant diversity training, or meaningful conversations about what needed to change systemically to increase the diversity of both applications and appointments.

In summary, there was a lot of disquiet among the whole interviewee cohort about the logic behind, and operationalisation of, the appointment process of board IMs/NEDs. Empty seats, lack of diverse candidate pools, use of headhunters, structural barriers of time and remuneration, problems with the application form, the interview process, the decision-making process, and the fundamental issue of the chair's lack of control of their board composition were all expressed. A minority of chairs focused 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 caused by current procedures and attitudes.[46]

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 manifest themselves through bureaucracy and process, the meaning and purpose of diversity, and the expected role and responsibility of the chair and board have significant influence. The bureaucracy and process issues can be attended to, but this may be futile to fundamental change without addressing the other two underlying issues.

Conclusion and recommendations

Conclusion and recommendations

This research set out to establish benchmark data for board composition of 20 NHS boards across Wales and Northern Ireland.

Data and board composition

The first finding was that 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 EC definition of gender balance (i.e. at least 40 per cent of each sex present) and at a national level the percentage of black, Asian and ethnic minority 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/NED 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 in this research.

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).[viii]

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."**[47]

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.

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

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.[48]

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.

Recommendations

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.[49] 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.

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