

# Strengthening NHS board diversity

A report by the Independent Taskforce  
on Improving Non-Executive Director  
Diversity in the NHS

June 2021

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# About

This report explores the steps needed to strengthen the diversity of NHS boards in England.

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

To find out more, visit [www.nhsconfed.org](http://www.nhsconfed.org) and follow us on Twitter @NHSConfed

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# Foreword



**Prerana Issar, Chief People Officer  
NHS England and NHS Improvement**

Our NHS People Plan and recent Workforce Race Equality Standard findings signal that we need to increase the representation of people from black and minority ethnic backgrounds within our NHS board leadership group if we are to build a healthcare system focused on the needs of the communities we serve. As part of that effort, it is timely that we re-double our efforts to transform the way we recruit our non-executives. It is with this in mind that I welcome the independent task force's report and the practical recommendations it provides to every board on how it can strengthen the diversity of its board team. As the report acknowledges, progress is already being made and we will use this report as we continue to move forward.

We know that with commitment, practical guidance and support, progress is possible. In the last year the proportion of black, Asian and minority ethnic non-executive directors (NEDs) on NHS trust Boards has increased to 16.8 per cent. However, this figure is just 11.1 per cent across all NHS trusts and foundation trusts. We have partnered with the Seacole Group and the newly established Disabled Directors Network; we are delivering the second cohort of the Aspiring Chair Programme of which 80 per cent of the intake are from diverse backgrounds, and we continue to expand our

NExT Director Programme positive action scheme to support new diverse aspiring NEDs. Together, these programmes have created a pool of 115 leaders who are being developed to fill chair and non-executive director (NED) positions respectively.

We also know from our next generation NED work that both the talent and interest in NHS roles is out there. We need to demystify the role of an NHS NED and make the accountabilities and competence clearer. We also need to ensure that our recruitment search strategies reach into the communities we serve and that the recruitment process itself is more transparent. We will work together to help boards strengthen their performance in this area:

1. We will introduce guidance for succession planning to enable board chairs to review their board's skill and diversity mix and to inform future recruitment.
2. We will provide a common set of job descriptions and competencies for the recruitment and development of non-executives.
3. We will provide dedicated guidance and support for boards on how they can strengthen their diversity.
4. We will run a campaign to attract a new stream of diverse NED applicants and establish a compact for executive recruiters, which will ensure that they are able to work with us to achieve our ambition.
5. We will establish a talent pool of next generation NED candidates and support their readiness for board appointments. We will also provide a confidential feedback mechanism for candidates to register their experiences, good and bad, from the appointments process.

These commitments will build on work already underway. The COVID-19 pandemic has presented the NHS, and its partners, with the greatest challenge it has ever faced and shone a harsh light on inequalities in the health of the population. Significant challenges face health and care as we recover. Insightful, reflective and sensitive leadership has never been more important as we continue to strive to ensure fairness and equality in healthcare.

This report sets out the findings of the work of an independent taskforce, comprised of leaders from across the NHS, focused on the need for more equal and diverse leadership by non-executive chairs and directors on NHS boards and how to achieve this goal. I would like to say thank you to the members of the independent task force for their time and commitment resulting in this report on such an important topic.

# Key points

Chairs and non-executives are an important NHS leadership group. As independent board members, they hold the executive to account and in doing so build patient, public and stakeholder confidence in the NHS.

- The NHS Confederation report *Chairs and Non-Executives in the NHS: The Need for Diverse Leadership*, published in the summer of 2019, showed that there was insufficient diversity in those appointed to these roles in the NHS.
- In 2020, to support the diversity ambition of the NHS People Plan 2020/21, NHS England and NHS Improvement's director of leadership and lifelong learning, Jacqueline Davies, and the Chief People Officer of the NHS, Prerana Issar, asked the NHS Confederation to identify ways to increase chair and non-executive director diversity in the NHS.
- An independent taskforce was commissioned to research and review approaches and methodologies for non-executive recruitment. Chaired by Dame Clare Gerada and Joan Saddler OBE, the taskforce delivered a report detailing a roadmap for recruitment and appointment of diverse non-executives. Good practice was identified which has successfully enabled the appointment of women, black and minority ethnic, disabled and LGBTQ+ candidates into NHS non-executive director roles.

- The taskforce's membership included chairs, non-executives and chief executives from across the NHS. Despite difficulties caused by the COVID-19 pandemic, work continued remotely. Best practice literature on board diversity in the UK was sourced. Executive search firms (ESFs), chairs and non-executives presently in roles, or who had been candidates in the recent past, took part in surveys, focus groups, one-to-one interviews and roundtable discussions. The outcome of these activities was then considered by taskforce members.
- The findings confirm that the appointments process is not independent or transparent. Job descriptions, interview and assessment processes are not the same. Appointment processes are not independent nor transparent. Governors, regional and local executives and ESFs are very influential in the decision-making, either because it is their responsibility, they are on interview or stakeholder panels, or because their views are sought during the assessment process.
- Important vehicles for change are commitments from the top, starting with national commitment and NHS boards. Public transparency is essential. Published league tables that use data to rate organisational or individual performance have been impactful elsewhere and could be adapted for the NHS as a tool to motivate and stimulate progress.
- ESFs are important gatekeepers to these roles, supporting their NHS clients to find suitable candidates. ESFs all follow similar procedures, as shown in the roadmap in Appendix 1. Most of their activity is one-off and reactive, although they do provide access to databases and search facilities, and have market knowledge. All stated that diversity was an important consideration when selecting board candidates.
- Diversity in these NHS board roles was often hampered because of the rigid candidate criteria (finance, commerce, governance or previous NHS experience), unrealistic



expectations in terms of time commitment (for those in employment) and the time constraint imposed on the search period by individual organisations. Such requirements limit the pool of candidates they can find. However, the chairs and non-executive we talked to think some of the pools of candidates on offer from ESFs fail to access candidates from underrepresented groups. ESFs that specialise in finding candidates from underrepresented groups stated that to have good sources, but candidates had little experience working with the NHS.

- Clear expectations, the use of standard procedures such as job descriptions, independent assessment processes, creative and media savvy positioning and advertising, networking into specific underrepresented groups in the community or through professional networks and the use of transparent data would help. In the commercial sector, ESFs have agreed targets, codes of conduct and accreditation processes for women.
- Long-term contractual relationships (compact) between ESFs and the NHS that are performance dependent would help to stimulate competition, clarify and standardise expectations and motivate ESFs to collect data. This could be made public, build up databases with pools of candidates from underrepresented groups and support succession planning, training and development initiatives to support more appointments from underrepresented groups.
- The present initiatives being trialled in the NHS to increase the percentage of underrepresented groups into these roles will not shift the numbers soon. There is evidence of individual boards improving their quota of diverse board numbers. Target setting, training, coaching and development programmes and individual awareness in leaders helps. However, even though individual chairs and ESFs can make a difference, it is a one-at-a-time process. For many it will be a box-ticking exercise that will be done once one more person from an underrepresented group

is appointed to each board. Raising awareness and persuading and training leaders and decision-makers about the value of diversity will therefore continue to be important and necessary across the NHS.

- The chairs and non-executives that we talked to believe there is a sufficient pool of diverse candidates for these roles, but ESFs report that some candidates consider these NHS roles to be unattractive and can find more fulfilling roles elsewhere.
- In addition, many who put themselves forward are eliminated by the current decision-making process, as ‘chemistry and fit’ tend to override diversity, which results in ‘more of the same’ people in these NHS board roles.
- Consequently, the chairs and non-executives interviewed want to see an independent NHS appointments process set up for NHS chair and non-executive director (NED) appointments based on merit, which would streamline and regularise the appointments procedure and provide transparency. Publicly reported progress and performance from this process will give underrepresented groups the data they need to build peer and stakeholder pressure.
- The move to system working and putting integrated care systems (ICSs) on a statutory footing provides an opportunity for the NHS to reset, change the appointment process and appoint diverse leaders. ICSs will have new responsibilities and accountabilities across the system and the NHS organisations that sit within their remit.

# Acknowledgements

NHS England and NHS Improvement's non-executive talent and appointments team has been at the helm of the central effort to promote equality, diversity and inclusiveness in those appointed into these roles.

Many thanks to those chairs and non-executives from the NHS Confederation's networks who took the time to fill in the survey and engage in case studies and debate.

We would like to thank the partners and consultants from the executive search firms who gave their time willingly to discuss their views on these issues and to be part of the roundtable discussion.

# Introduction

A more equal and diverse leadership in chairs and non-executives appointed to NHS organisations will mean patients, communities and staff will have a leadership that is more reflective and sensitive of the communities it serves. Such a diversification in the leadership is more likely to transform the culture for the benefit of patients and champion patient and staff engagement.<sup>1</sup>

In the light of the COVID-19 pandemic, which has disproportionately harmed those from underrepresented groups, particularly among health and care staff, there is a greater urgency than before to address equality, diversity and inclusion (EDI) in the NHS.

In 2020, to support the diversity ambition of the NHS People Plan 2020/21, NHS England and NHS Improvement's director of leadership and lifelong learning, Jacqueline Davies, and NHS Chief People Officer, Prerana Issar, asked the NHS Confederation to identify ways to increase chair and non-executive director diversity in the NHS.

Chairs and non-executives are an important NHS leadership group. As independent board members they hold the executive to account, and in doing so build patient, public and stakeholder confidence in the NHS. The NHS Confederation report [Chairs and Non-Executives in the NHS: The Need for Diverse Leadership](#), published in the summer of 2019, showed that there was insufficient diversity in those appointed to these roles in the NHS.

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There is a greater urgency than ever before to address equality, diversity and inclusion in the NHS.

This project builds on the findings and recommendations of that report:

- Review executive search approaches, tools, standards, and methodologies for non-executive appointments that have successfully enabled the appointment of women, black and minority ethnic, disabled and LGBTQ+ candidates into NHS roles.
- Review executive search agencies known to work widely across the NHS and other bespoke agencies to establish their approaches to successful recruitment and appointment of diverse candidates.
- Survey 20 diverse NHS NEDs and aspiring but as yet unsuccessful NED applicants. Understanding their experience of the appointments process and to identify required success factors supporting effective recruitment and appointment of leaders from diverse backgrounds.
- Deliver coaching and support to up to five chairs actively seeking to diversify their non-executive team.
- Review practical strategies and processes to enable appointment of a targeted number of diverse non-executives as part of a challenging trajectory of improvement. To include options for compacts on ways of working and incentivising recruitment agencies.
- Deliver a report detailing a roadmap for recruitment and appointment of diverse non-executives offering options for implementation.

# What methods were used to find answers?

## Project oversight

An independent taskforce, co-chaired by Dame Clare Gerada and Joan Saddler OBE, who are respectively the co-chair of the NHS Assembly, and director of partnerships and equality for the NHS Confederation, was put together to oversee the project. Its membership includes chairs and chief executives from across the NHS (see Appendix 2).

The project was launched during February 2020 by the chair of NHS Improvement, Baroness Dido Harding. After an initial interruption because of the difficulties around the COVID-19 lockdown, the independent taskforce conducted its work during the autumn and winter of 2020/21.

## Board recruitment practices

A review of the methods that increased diversity in board appointments was refreshed from the original report. These insights informed the one-to-one activities, discussions and roundtables that took place with executive search firms (ESFs, which are an important gatekeeper) and with the group of chairs and non-executives that took part in the project. The findings from these activities were then considered by members of the independent taskforce.

## Interviews and surveys

During the pandemic, interviews, surveys, discussions and roundtables were held remotely. Twenty-two NHS chairs and non-executives, and 18 senior partners and consultants from executive search firms on the official government supplier list, took part. Their views and experience of the present appointment process was used to shape the recommendations.

## Roundtable

A roundtable, consisting of several ESFs and members of the taskforce, discussed how a compact between the NHS and ESFs could be constructed to improve the percentage of people from underrepresented groups being appointed to NHS chair and non-executive roles.

# What is the NHS context for increasing equality, diversity and inclusion?

Equality, diversity and inclusion (EDI) is about having best practice in the governance of NHS organisations and better engagement with the staff. EDI is an area that the NHS still needs to make significant progress in to reflect the spirit of the equalities legislation and the stated ambition of the NHS to create a more diverse leadership.

In future, the governance by NHS boards, their composition and compliance with EDI expectations will be under greater scrutiny. The COVID-19 pandemic has made the NHS's performance more visible to the general public. It has highlighted the worsening impact of the virus on those from BME and marginalised communities. Consequently, almost nine in ten leaders now believe the NHS must deliver a step change in how it cares for diverse and marginalised communities.<sup>2</sup>

In the NHS People Plan 2020/2021,<sup>3</sup> specific targets for addressing EDI in the NHS are outlined. The ambition is that NHS boards become more aligned with the population, communities they serve and the workforce they employ. The plan states that: "NHS leaders have stepped up to this challenge, there is more active role modelling of compassionate, and inclusive leadership and ...there is a strengthening of the role of BME staff networks in decision-making."



COVID-19 has challenged NHS staff morale. There has been loss of life and significant illness in some staff. Despite much support for the action taken by the NHS,\* there has been criticism too regarding the UK preparedness for this pandemic.

## Legislative changes

There are legislative proposals in the pipeline that, if enacted, will change the way the NHS is organised. These proposals include the formal merger of the NHS England and NHS Improvement regulators, which are to an extent already operating as one leadership team (NHSEI).

At a local level, a bringing together of NHS trusts and foundation trusts (FTs) is underway. There are chairs and non-executives and chief executives and directors who have joint or in-common roles across these separate legal NHS entities. The future healthcare models favour merging institutions with shared specialisms, such as mental health or acute and specialist services. Other models include pulling all health services (mental health, acute and community) into settings across communities or localities.

Sustainability and transformation partnership (STPs) have in effect become integrated care systems (ICSs), where collaboration and partnerships between local NHS bodies will become statutory. Their purpose is to secure health services for their population. These ICSs are in place in a shadow form and are in effect replacing clinical commissioning groups (CCGs) as they come together. An ICS board would include representatives of NHS providers, primary care and local government, as well as a chair, chief executive and chief financial officer. Much of present-day NHS England national commissioning functions could then be delegated to the appropriate local ICS once this legislation comes into force. ICSs will have new responsibilities and accountabilities across the system and the NHS organisations that sit within their remit.

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If enacted, legislative proposals will change the way the NHS is organised.

\* The NHS has adapted to the challenge of the virus by using digital processes such as online, visual, email or phone consultations. It has created surplus Nightingale hospitals; it has made use of leading-edge science, and set up testing and vaccination for whole communities.

# What has worked elsewhere?

To increase diversity hiring in boards, the guidance published by the Equality and Human Rights Commission (EHRC)<sup>4</sup> recommends that accountability for diversity must be consistent and led by the board. It recommends that the hiring process follows standard procedures, is proactive about seeking out different sources of suitable candidates and uses a range of recruitment methods to reach the widest possible pool of candidates. These sentiments are echoed by advisers and regulators right across the public, charity<sup>5</sup> and commercial sectors.

It goes on to say that selection criteria should specify measurable skills, experience, knowledge and personal qualities. Clients need to provide a clear brief, including diversity targets to the ESF tasked with finding candidates, and consistently assess candidates against the role specification. Those in post need to be in these roles for a limited time.

Actions that have been suggested as useful include:

- create specialist networks, mentoring and coaching support and development opportunities for the underrepresented groups
- enlist people with life experience, seeking potential candidates from the professions, such as law or accountancy, or the public, not-for-profit, voluntary or academic sectors
- specify in advertisements and marketing materials that candidates from underrepresented groups are encouraged to apply

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Accountability for diversity must be consistent and led by the board.

- use specialist social media or job bulletins as an advertising medium.

Lord Davies produced his report on Women on Boards in 2011,<sup>6</sup> which made ten recommendations on how to increase the number of women on the boards of FTSE 350 companies. Later that year the EHRC conducted further enquiries. It concluded that ESFs assess candidates on their ‘fit with the current board’ rather than just the skills they possess.<sup>7</sup>

Due to the white male-dominated nature of boards, and despite the efforts of the 30 per cent club,\* whose mission is to bring more women into board positions, many female candidates continue to be disadvantaged.

ESFs collaboratively drew up a voluntary code of conduct (Appendix 3) to address the challenges relating to increasing the appointment of women on FTSE 350 boards. The code sets out seven key principles of best practice that should be followed, ranging from action when accepting a brief from a company to induction. The code also covers succession planning over the medium term; the setting of diversity goals; how the client brief can be defined to balance experience with relevant skills; the value of diverse long lists of candidates; and support during the selection process.

In 2014, an enhanced and graded accreditation process<sup>8</sup> was put in place to acknowledge those ESFs which are at the forefront of helping boards to enhance their gender diversity. The increased criteria include meeting the requirements of the voluntary code but also making numerical targets and showcasing their materials and websites to promote gender diversity. Specified data is collected and, alongside qualitative analysis, is used to determine the rating level of the ESF. These codes are summarised in Appendix 3.

\*For more information on the 30 per cent club, see [http://www.30percentclub.org.uk/equalityhumanrights.com/sites/default/files/research-report-85-gender-diversity-on-boards\\_0.pdf](http://www.30percentclub.org.uk/equalityhumanrights.com/sites/default/files/research-report-85-gender-diversity-on-boards_0.pdf)

By 2015 the percentage of women directors in FTSE 350 companies had doubled. The last Davies Report was overtaken by the Hampton–Alexander Review (HAR) in 2016.<sup>9</sup> The review adopts a voluntary business-led approach. This sets recommendations for FTSE 350 companies to improve the representation of women on their boards. A progress report is published annually.

The 2019 HAR report states that there are now only two FTSE 350 boards that have no women on their board and 42 that have only one woman on their board, which is an improvement on the Davies report of 2011.

The processes used to shift this percentage upwards have included data transparency, government oversight and competitive league tables. Despite this progress, the percentage of women in board roles is not yet at the hoped-for 30 per cent target and the top role of the chair continues to be male dominated.<sup>10</sup>

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The top role of chair continues to be male dominated.

The 2017 independent Parker Review<sup>11</sup> highlighted the lack of BME appointments in boards. Only nine BME people (9 per cent) held top positions in the FTSE 100. A target was set for every company listed on the FTSE 100 to have at least one BME director by 2021. Three years later, the updated 2020 report shows little progress, and there have been calls for the Hampton–Alexander Review to be extended to include BME groups.

Independent research reported by Tulsiani<sup>12</sup> compared the voluntary mechanisms adopted by the UK with the legislative mechanisms of other countries. This research found that while women have been encouraged by the published findings of the UK reviews, the legislative approach has been more effective at increasing the number of women at board level.

# What has worked in the NHS?

A greater percentage of women and those from BME groups were in NHS chair and non-executive roles when the appointment process was managed by an independent body, the NHS Appointments Commission.<sup>13</sup>

Unpublished data held by the centrally based NHS England and NHS Improvement appointments team confirms that more of the board candidates longlisted and shortlisted in the past year came from a BME background and/or were women.

Professor Ruth Sealy's 2020 report for the NHS Confederation's Health and Care Women Leaders Network<sup>14</sup> shows a marginal increase in the percentage of women who hold NHS non-executive and chair roles, at 41 and 37 per cent, respectively. This is about 3 per cent since the NHS Confederation report published in 2019.<sup>15</sup> The percentage of those who hold NHS non-executive and chair roles and who disclose their ethnicity as BME stands at 10 and 5 per cent respectively, which shows a rise in those holding non-executive roles but a fall in those who are in the chair role.

Chairs of the newly formed oversight organisations, such as integrated care systems, continue to be overwhelmingly white men. Of the 42 areas, 14 chairs are women and five are from a BME background (data at May 2021).<sup>16</sup>

This means that the present system is continuing to have insufficient impact on getting people from underrepresented groups into these roles.

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Chairs of the newly formed oversight organisations continue to be overwhelmingly white men.

Today, the appointment process for chair non-executives does not follow a standard procedure across the NHS. Foundation trust governors carry out their own autonomous appointment system, while NHS trusts (non-foundation trusts) and ICS appointment systems involve oversight from NHSEI regional executives. NHS trust appointments are standardised and subject to annual external audit and regulated by the Commissioner for Public Appointments for compliance with the Cabinet Office Code of Governance. There is also guidance produced by NHSEI on the recruitment process for ICS leaders. From time to time, NHSEI regional executives may be involved in, and have influence over, the appointment of a chair in a foundation trust, or request that an foundation trust chair be appointed as a joint or co-chair of another trust.

Most chair appointments will use ESFs to support the process. Sometimes an in-house HR team will support the process. The recruitment roadmap of this process is outlined in Appendix 1.

# NHS chair and non-executive requirements

All those appointed to these leadership roles must satisfy several technical requirements. These are the Nolan Principles,<sup>17</sup> the fit and proper person test and a range of competences.

The Nolan Principles are a standard expectation for those in government leadership roles in the UK, whereas the fit and proper person regulation (FPPR) requirements came into force in November 2014. These regulations require health service bodies to seek the necessary assurance that all executive and non-executive directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role. In November 2019, as recommended by the Kark review<sup>18</sup> into concerns that the FPPR process was insufficient, ministers accepted that all NHS chairs and board directors should meet specified standards of competence to sit on the board of any health-providing organisation and that a central register should hold this information.<sup>19</sup>

Chairs need a range of skills to ensure that the board discharges its responsibility from a governance perspective. In 2019, a domain framework for the NHS provider chair was published.<sup>20</sup> This framework emphasises the following competences: strategic, partnerships, people orientated, professional acumen and outcome focused. The NHS People Plan published in 2020 emphasises the need for those competences to strengthen oversight of equality, diversity and inclusion.

Chairs must visibly and consistently demonstrate a commitment to developing and maintaining a healthy organisational culture and environment built on trust, openness, honesty, integrity and inclusivity, and which promotes collaborative, system-level leadership that is focused on the best interests of all patients and service users, and the wellbeing of all staff.

Chairs are ambassadors with boardroom competency who bring together their non-executives and hold the chief executive to account for performance. Often, they need good relationship-building skills and, since the Francis report, the role should include those whose values-based principles include openness, transparency, candour and strong patient-centred healthcare leadership.

The role of the non-executive director in shaping, formulating and evaluating strategy is a recurring theme and important, but recent academic research on NHS boards has tended to suggest that this strategic activity has been comparatively neglected on boards in the English NHS.

The newly appointed independent chairs, mandated by NHS England and NHS Improvement, for integrated care systems (ICSs) have responsibility for the future of the health and care systems within their region, to improve the health and care of the population covered by each respective system. Their role is to oversee greater partnership working between the NHS and local authorities, engaging with a range of stakeholders to maximise the benefits of collaborative working, shared decision-making and effective governance. ICS boards will have new responsibilities and accountabilities across the system, and the NHS organisations that sit within their remit.

In addition, the chairs shape the approach to partnership development and help lead the way to improved health, care and wellbeing, so that people can live healthier lives and get the care and treatment they need, in the right place, at the right time.

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ICS boards  
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system



# The present appointment system in the NHS

In 2021, all appointments to these roles in foundation trusts are carried out by individual foundation trusts' council of governors. As these organisations are independent public benefit organisations, these appointments are no longer public appointments.

All NHS trust chair and NED appointments are delegated from the Secretary of State for Health and Social Care to NHSEI and regulated by the Commissioner for Public Appointments. The present process is overseen by NHSEI's non-executive talent and appointments team and is regarded as an exemplar. NHSEI's recruitment processes comply with the Governance Code on Public Appointments and are regulated by the Commissioner for Public Appointments. They are made on merit and processes must reflect the Commissioner's stated objectives of promoting underpinning principles of responsibility, selflessness, integrity, merit, openness, diversity, assurance and fairness.

Advisory assessment panels for these roles in NHS trusts are established in line with NHSEI's policies and procedures, and in compliance with the Code of Governance, include an executive representative of NHSEI (for all chair and some non-executive appointments). All panels include an independent member (who is independent of NHSEI and the NHS trust to which the appointment is to be made) with experience of recruitment at a senior level. This is a change from the pre-2012 arrangements in the NHS Appointments Commission in which the assessors of chair and non-executive candidates were independent of the executive.

More recently, the NHSEI central non-executive talent and appointments team has taken steps to promote and showcase the importance of equality, diversity and inclusion in the NHS. It has run awareness programmes and is collecting data about those who are recruited which it intends to make public.

It has enhanced its capacity to train and get ready more diverse candidates through its centrally run Aspirant Chair Programme<sup>21</sup> and NExT Director Scheme<sup>22</sup> and commissioned programmes with ESFs. It supports chairs' annual appraisals and monitors all chair and non-executives' annual performance appraisals. The NHSEI non-executive talent and appointments team is small in scale and relies on the support of local decision-makers, such as chairs and governors and regional NHSEI directors, to achieve the ambitions of NHS People Plan and EDI strategy.

# The opinion of NHS chairs and non-executives

In 2019, Professor Ruth Sealy discussed how to improve diversity in NHS boards with a selected group of NHS chairs. Several common themes emerged from the research. Diversity is a leadership issue that needs to be driven by the board:

- Implementing diversity is incredibly challenging if it is not led and role modelled from the top.
- Greater diversity at board level should increase the organisation's ability to engage with the workforce but can be challenging or disruptive to the present-day order of things. Staff welcome diversity because it gives them faith in board decisions and builds confidence in their work.
- Diversity needs to become embedded throughout the executive and non-executive leadership and into the organisation's culture.
- Diversity needs accurate and accessible data. Collecting and publishing this data is a critical first step to monitor progress.

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Diversity needs accurate and accessible data.

Chairs reported that they used a range of tactics to reach out and find more diverse candidates. They also supported their governors and ensured they were trained in diversity. Many updated their materials and communication media to make them more easily understood by candidates.

## The independent taskforce

In 2020, the independent taskforce surveyed, engaged and discussed these issues with a mixed group of chairs, non-executives and candidates using a case study approach. Several themes emerged from this work.

Chairs and non-executive directors felt encouraged by the opportunity the NHS Long Term Plan<sup>23</sup> and its companion the NHS People Plan 2020/21<sup>24</sup> bring to encourage diversity on boards.

Lack of progress could arise because diversity was not a key priority with some NHS executives, particularly those who are struggling with day-to-day NHS demands.

EDI must be an important issue not just for chairs and non-executives but a required competence for all NHS leaders.

There is a lack of standardisation and consistency in the present recruitment, selection and appointment process. The recruitment mechanisms are lengthy, biased and influenced by those with vested interests.

An independent oversight of the recruitment, selection and appointment of chairs and non-executives will lead to a process that is systematic, standardised and transparent.

NHS boards must be held accountable for collecting, monitoring and reporting outcomes that are underpinned by clear key performance indicators, and that show EDI in the context of service delivery, remuneration and appointments. The data set should be agreed, collected and published in a timely fashion.

Chairs and non-executives suggest that real progress can only emerge when the executive leaders in the NHS are part of a “collaborative journey, sharing a mutual ambition, and urgency to create the conditions necessary, particularly an independent

process that will deliver improved diversity on boards”. They also said: “There is too much of a tendency in the NHS for inclusion to be a virtue... We need to focus more on it as a competence.”

They believe it to be a myth that people from underrepresented groups do not apply for board roles in the NHS through choice, rather than admitting that there are barriers to such groups being appointed because of present procedures and attitudes.

All trustees and board members who took part in these discussions were from the NHS and some had non-NHS appointments. Their areas of expertise included change management, coaching, governance, commissioning, customer delivery, finance, patient advocacy, health prevention, local government services, mentoring, organisational development, performance management, public health, strategic planning, risk management and support services for disadvantaged groups.

It is a myth that people from underrepresented groups do not apply for board roles in the NHS through choice.

# The opinion of executive search firms

Executive search firms (ESFs) are key stakeholders in changing the landscape of diversity on boards. The present roadmap of an NHS chair and non-executive search process outlined by ESFs is included in Appendix 1.

It consists of the following stages: being contracted to do the task; getting a client brief; putting together a candidate profile; searching for candidates (internal, within existing databases, and external, tapping into other sources); advertising and marketing the roles; longlisting; screening and interviewing candidates; shortlisting; client interviews; referencing, contract negotiation; placement and follow up.

The role played by ESFs varies, as aspects of the executive search service they provide will depend on the client's budget and preferences, and whether it is a role that is attractive. There are occasions when ESFs act as recruiters of last resort if the NHS inhouse service has failed to recruit.

“Diversity is a very important subject.”

“It's my job to persuade my client and the governors about being aware of equality and diversity.”

These statements came from the one-to-one and roundtable conversations held with ESF partners and consultants who work with and place chairs and non-executives onto NHS boards.\*

There was heightened awareness of the need for greater diversity in NHS chair and non-executive appointments. Their principal areas of focus were gender and BME. Other protected characteristics such as disability or sexuality were often not disclosed and therefore the data held for these groups is not so reliable. However, all claimed to target these groups.

All reported meeting equal opportunities legislative requirements and continuously monitoring and collecting data about the diversity their candidates. Recent unpublished data held by some of the ESF consultants confirms that more of the board candidates longlisted and shortlisted in the past year came from a BME background and/or were women. Views were also expressed that women may be less likely to be considered if the priority was to recruit a BME candidate, due to stark under-representation of this group.

Equalities impact assessment tools were not in use. Artificial intelligence (AI) and other tools that could neutralise descriptions, language and presentations were under consideration by some of the ESFs.

Interview processes for chairs and non-executives varied but often included full day events with stakeholder and discussion groups. Being able to communicate and engage with diverse groups of local people such as governors, medical staff, porters, ministers and MPs was considered a necessary skill.

\*Executive Search Firms recruiting to these board roles include Gatenby Sanderson, Harvey Nash, Hunters, Korn Ferry, Spencer Stuart, Odgers Berndston, Russell Reynolds, Saxton Bampfylde, Veredus and NHS 'in-house' scheme. Audeliss Limited; Green Park; Miles Advisory LLP; CRG Tech. Those highlighted took part in the project.

Apart from a set of technical skills, and in line with the NHS values, those appointed to these roles needed to have the correct set of behaviours and norms to fit in with the specific organisation that was recruiting. The academic business literature concludes that concepts such as ‘chemistry’ or ‘fit’ may shape boards to be more of the same, and that word of mouth and personal networks restrict candidate pools.<sup>25</sup>

ESFs described how difficult it can be to persuade NHS decision-makers to think more broadly and to embrace change. In their experience, groups blocking the movement to more diverse boards of chairs and non-executives included foundation trust governors, stakeholders, NHS chairs or influential decision-makers at a regional level. Others pointed out that the recruitment process was slow and caused candidates to drop out.

Many believe that NHS organisations will continue to recruit as they do at present. They have experienced some decision-makers paying lip service to diversity, recruiting one person from an underrepresented group in order to tick the diversity box, and then reverting to business-as-usual behaviour.

The NHS is not the preferred choice for candidates from underrepresented groups. Reasons given by some board-ready candidates to decline an NHS board opportunity include better rewards elsewhere, the time commitment needed in the NHS, which is much more than stated, and the personal reputational risk when patient care or monetary control fails. Others were put off by NHS images, descriptions and reports that showed present boards and organisations dominated by white men with qualifications and experiences that were unfamiliar to them. Presenting diversity in NHS organisations is important, as candidates from these groups look for such evidence.

All ESFs described urgent requests from chairs and NHSEI for candidates with previous board experience, NHS knowledge and/or financial and commercial acumen. The pool of candidates with

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‘Chemistry’ or ‘fit’ may shape boards to be more of the same.



these skills, and that are available at short notice, limits the number of diverse candidates that ESFs can put forward. Many ESFs are still trying to create a pool of candidates with wider backgrounds.

Creative ways that were being explored by ESFs to source and develop diverse candidates from middle management includes the building of networks and thought leadership programmes. ESFs deliberately widen the scope of the search to look for those with achieving and risk-taking backgrounds, such as entrepreneurs and professionals. ESFs are building links to conferences, events and settings to promote EDI.

The lack of a consistent job description for chair and non-executive roles in similar organisations is an issue. There is one for an NHS chair, a recently prepared model chair competency framework which is on the NHSEI website.<sup>26</sup> It will need to be adapted when the new NHS legislation is enacted.

Most of the ESFs interviewed work with regular clients and are happy to do so. This can help them anticipate and support succession planning, but most agreed that much of the work of the ESF in the NHS is time-limited, bespoke to an individual brief and not compatible with succession planning. Many encourage feedback from the client and from candidates in new roles. ESFs may signpost such candidates to coaches or expert support organisations to prepare them for their new NHS board role.

Purposeful expectations, common data collections and clarity about diversity goals would be welcomed by the ESFs. The independent taskforce believe that an explicit compact between ESFs and the NHS would be beneficial. The NHS would be able to standardise recruitment procedures and job descriptions, and train assessors in diversity. ESFs could invest more in developing databases for candidates from underrepresented groups. The NHS/ESF relationships could be firmed up over time so that ESFs were better prepared to support succession planning in these roles.

# Conclusion

The COVID-19 pandemic has disproportionately harmed health and care staff and those from underrepresented groups. As such there is now a greater urgency to embrace diversity in the governance of the NHS. Those who took part in our discussions believe that while clear direction from the national leadership is important, change at a local level is presently dependent on the intent and commitment of individual chairs. Awareness-raising programmes for those in these roles (NHS chair, non-executive, governor) on EDI is important and should continue.

The independent taskforce has concluded that present chairs and non-executive appointment processes need to be refreshed and be independent. If NHS organisations are to create a sustainable pipeline of chairs and non-executives that reflect the staff and the communities they serve, then continuing with the present non-standard procedures for recruiting and appointing chairs and non-executives will not achieve that ambition soon.

The taskforce would also like all NHS board members to be accountable for diversity at board level, with a greater commitment from those in executive roles.

The NHS must consider how to present and make these board roles more attractive. Otherwise, board-ready people from underrepresented groups will take up alternatives where the monetary and personal rewards are greater.

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Chair and non-executive appointment processes need to be refreshed and be independent.

Appointments need to be separated from those who have a vested interest to shape boards to be more of the same. The use of word of mouth and personal networks are common in the NHS, but this restricts the pool of candidate. ‘Chemistry’ or ‘fit’, ‘good enough’ or ‘one of us’ discussions are still in use today. Such habits and judgments restrict diversity.

ESFs use common recruitment processes (see Appendix 1). Chairs and non-executives think the candidates on offer from ESFs are too restricted and that ESFs fail to access enough candidates from underrepresented groups. ESFs claim that the specified criteria for these NHS roles, and the bias of those who make the appointments, restricts the number of candidates from underrepresented groups that are successfully appointed.

Succession planning by the ESFs and the NHS to build links and seek alternate networks would help to build up databases of candidates from underrepresented groups. Sources to tap into include specific community networks, entrepreneurs, academics and the professions.

The involvement of ESFs in NHS chair and non-executive appointments may benefit from a transparent compact with the NHS. This compact should set out expectations of behaviours, data collection and set targets for underrepresented groups who are shortlisted and appointed. Progress against expectations would then be monitored, with results published annually. The present codes of conduct used in the commercial sector may be a basis to explore such a compact and lead to an accreditation process for those ESFs that do well in the recruitment of underrepresented groups.

In the UK, there is a lot of government and specialist guidance and instruction on how to get more women and those from BME communities into board roles. They suggest that the important vehicles for change are leadership, public transparency,

government regulation, league tables and peer pressure. Such performance mechanisms could be adapted for the NHS as a tool to stimulate chair and non-executive board appointments from underrepresented groups.

As a motivator for change, these mechanisms could be used to recognise and reward NHS leaders who are able to get candidates from underrepresented groups into these roles.

# Recommendations for the NHS

The independent taskforce's recommendations support a phased implementation over 18 months of these actions to take on board ministerial requirements and expected legislative changes. It acknowledges that NHSEI's non-executive talent and appointments team has already begun to adopt some of these recommendations and update its processes.

## Immediate actions

Commission and establish:

- **Regular awareness-raising programmes for those in these roles (NHS chair, non-executive and lay people) on EDI.** The purpose of these programmes should be to continuously build lived experience and cultural intelligence in those occupying these roles.
- **An independent appointment process that actively encourages candidates to come forward from as wide a cross-section of the community as possible.** The organisation appointed should be independent of the NHS, have the expertise and capacity to host this process, be able to incorporate the recommendations of the Kark review and other ministerial requirements, be publicly transparent and should have the support of NHS leaders.
- **An independent review process to evaluate the programme and to demonstrate impact.**

## Within the short term

- **Negotiate an agreement between NHS England and NHS Improvement and the host of the independent appointment process.** This would facilitate, engage and involve NHS bodies and ensure the accountability for the independent appointment process programme, its objectives and its results are transparent. Within this, establish a confidential ‘hotline’ for NED candidates to raise concerns about a recruitment process.
- **Publish the data for 2020 held by NHSEI on the protected characteristics of those who applied, are longlisted, shortlisted, interviewed and are appointed to these roles.** The data set should be made publicly available annually and include the range of competences. Data should include appointments to all chair and non-executive roles in the NHS and meet the ministerial agreements for the enhanced FPPT, as recommended by the Kark review.
- **Draw up, consult and publish descriptions and expectations for ESFs and determine who are qualified to meet the NHS EDI requirements of these chair and non-executive appointments.**

## Within the medium term

- **Draw up, consult and publish role descriptions that reflect the nature and expectation of the task at hand, regularise the roles, clarify time commitment and monetary reward. All descriptions to be framed in an inclusive and open way.**
- **Conduct a competency review to ensure that access to these roles can come from as wide a cross-section of the community as possible and that those appointed meet the statutory requirements, can govern a board and are empathetic to the issues of EDI.**

- **Oversee, streamline and make transparent search and selection procedures to embed diversity and equality and ensure the right candidates are appointed.**
- **Negotiate a compact with the ESFs appointed that clarifies the data that needs to be provided, the behaviours of the ESFs and expected targets. This compact could be used to establish accreditation.**
- **Establish a visible reward system to celebrate progress in diversity in NHS organisations. Use a competence framework based on annual diversity data collection from boards to judge chair and non-executive performance in diversity.**
- **Establish a diverse pool of experts to support and advise integrated care systems with the appointment of provider and system chairs to increase diversity.**

## Within the long term and ongoing

- **Ensure succession planning arrangements are in place for replacing an organisation's chair and non-executives.**
- **Introduce regular and local campaigns/programmes to promote chair and non-executive NHS roles to wider groups and networks. Using images that show women and those from BME backgrounds are part of the NHS leadership group. Promoting case stories from candidates from diverse backgrounds, encouraging those with other underrepresented characteristics (such as disability) to feel welcome in these roles. Seeking out and building networks with communities or those in professional, business, voluntary or patient groups.**
- **Negotiate the power to recommend removal when the person's EDI performance is not up to the required standard.**

- **Provide national and locally provided EDI induction, training and coaching programmes for newly appointed chairs and non-executives.** These programmes should provide essential NHS knowledge and contemporary lived experience of EDI within the NHS and its partners.
- **Provide national and local EDI training and coaching programmes for all chairs and non-executives in post.**
- **Provide enhanced templates for individual chair and non-executive performance reviews that enable reviewers to give credit for good EDI performance and that identify where EDI skills need to be developed.**



# Appendix 1: Present recruitment roadmap for chairs and non-executives involving executive search firms\*

This is based on document and process reviews, and interviews with executive search firms in 2020.

Recruitment steps	Activity	Comment
	Client invites ESFs to a meeting to discuss roles and asks for cost and presentation.	
Recruitment proposals from ESFs	ESFs pitch competitively.	This stage may not be required if the ESF is already seeking roles for the client or has been involved in succession planning for that client.
Preferred supplier is appointed		
Detailed role description drafted, rewritten and agreed with client	At present there are no standard NHS job descriptions available for these roles.	The criteria most asked for are finance, experience of the NHS, governance, commerce and previous board experience.  But there may be explicit instructions such as no more of a specific background.  NHSEI has published a chair role job description.

\*In-house recruitment will forgo research for candidate, expect advert response or NHS networks.

Recruitment steps	Activity	Comment
<p>Organisation description, documents and images drafted, written and chosen by client</p> <p>Timeframe to recruitment will be agreed</p>	<p>At present many documents used by NHS organisations will not have welcoming images for EDI candidates.</p> <p>This may take nine months.</p>	
<p>An outline timetable of the process will be agreed</p>	<p>Shortlist and longlist dates; progress meetings; in-house interview dates and final panel interview slotted into client's diaries.</p>	
<p>Marketing campaign and advertising process agreed</p>	<p>This may include a specific website for the role and social media links.</p>	
<p>Adverts written and designed</p>	<p>Posted in appropriate sites including social media with closing dates.</p>	
<p>Researchers in the ESF will be deployed to conduct a search for the role</p>	<p>They will do keyword searches of internal databases, and get in contact with previous clients, NHS opinion formers will be asked to suggest candidates.</p>	<p>They will pay particular attention to any candidate highlighted by the client.</p> <p>Often researchers are independent suppliers to several ESFs.</p>
<p>Researchers will call, talk to and invite these candidates to consider the role</p>	<p>Pointing to where the information is held in the web.</p>	<p>And if there is no interest from specific or preferred individuals ask for recommendations from them.</p>
<p>Researchers will keep in touch with any preferred applicants showing an interest and who seems to fit the brief</p>	<p>They may have email and or phone exchanges.</p> <p>An informal telephone call may be arranged with the client.</p>	<p>It is important for the ESF's reputation that there is a reasonable number of candidates who have applied for the role.</p>

Recruitment steps	Activity	Comment
<b>Submission deadline</b>	As a minimum, applicants will have to write a supporting statement as to why this role and submit CV and referees.	All will fill in equal opportunities monitoring questions.
<b>CV review and supporting statement review</b>	From the applicants, the ESF eliminates and puts forward recommendations to the client and applicants are reduced in number.	The client has final say. Unsuccessful applicants may or may not be informed personally by the ESF, depending on the number of applicants.
<b>Longlist</b>	ESF interviews the rest of the candidates and a report is written regarding candidates' suitability and whether recommended for shortlist or not.	There may be email and/or phone exchanges during this process. The ESF will seek to keep the most suitable candidates interested in the post.
<b>Final shortlist announced</b>	ESF informs those going forward and explains the next stage of the process.	Unsuccessful candidates will be informed of failure and may receive an offer for feedback
<b>Interview process</b>	Final panel assessors determined by the client. The interview process may also involve visits, stakeholders' meetings and rarely a psychological assessment	The ESF keeps in touch with the candidates and the client till the final interview. Often acts as an observer in the final panel. Panel members in non-foundation trusts will be nominated by NHSEI and will include a preferred executive.
<b>Referees, DBS and Fit and Proper Person are checked</b>	These checks may be done in-house although ESF may do this on behalf of clients.	
<b>Appoint or reject</b>	Recommendations of the panel are put forward to the appropriate decision-making body.	

Recruitment steps	Activity	Comment
Feedback	Unsuccessful candidates get feedback from the client or the ESF.	
Candidate takes up role		Sometimes this will not happen, and a second-choice candidate or new search is commenced.

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# Appendix 2: Membership of the independent taskforce

## Co-Chairs

- Dame Clare Gerada, Co-Chair, NHS Assembly
- Joan Saddler OBE, Co-Chair, Equality and Diversity Council; Director of Partnerships and Equality, NHS Confederation

## Members

- Jagtar Singh OBE, Chair, Coventry and Warwickshire Partnership NHS Trust
- Mark Lam, Chair, Barnet, Enfield and Haringey NHS Trust and East London Foundation Trust
- Dr Kathy McLean, Chair, University Hospitals of Derby and Burton NHS Foundation Trust
- Sam Roberts, Director of Innovation and Life Sciences, NHS England and NHS Improvement
- Adam Doyle, Chief Executive Accountable Officer, Sussex and East Surrey CCGs

- Richard Stubbs, Chief Executive, Yorkshire and Humber Academic Health Science Network AHSN
- Dr Robina Shah, MBE DL JP FRCGP (Hon) Project Adviser and Former NHS Foundation Trust Chair
- Dr Maureen Dalziel, Former NHS chief Executive and Chair

## Support

- Kelly Ireland, Special Adviser to the Chief Executive, NHS Confederation
- Wayne Farah, BME Leadership Network Facilitator, NHS Non-Executive Director

The taskforce launch event was supported by Prerana Issar, Chief People Officer, with keynote contributions from Dido Harding, chair of NHS Improvement and Niall Dickson, then chief executive of the NHS Confederation.

# Appendix 3: ESF codes of conduct

## Voluntary code of conduct

There is a voluntary code of conduct in place for executive search firms (ESFs) with the commercial sector. This code first emerged from the ESFs as a result of the 2011 Davies Report, which highlighted the lack of diversity and paucity of women board members in FTSE 350 companies.

As ESFs are the key gatekeepers to board appointments, it was a good response by the industry to the report. The purpose of the Standard Code is to specifically address the lack of gender diversity on corporate boards and to discover best practice for the related search processes.

The criteria and behaviours expected from the ESFs includes their role in supporting the client and in identifying and supporting candidates. Their role is outlined under clear expectations as follows: succession planning; diversity goals; defining briefs; long lists; candidate support; supporting candidate selection; induction; embedding best practice; and signalling commitment.

It has about 50 ESFs as members.

## Enhanced code of conduct

In 2014, an enhanced code for ESFs was put in place. This enhanced code of conduct requires greater standards. To become accredited, the code requires performance/output standards, as well as qualitative components.

- At least 40 per cent of their FTSE 350 board appointments have been to women.
- To have supported the appointment of at least four women to FTSE 350 boards.
- To have a proven record of helping women to achieve their first board appointment.

It acknowledges those firms at the forefront of helping boards enhance their gender balance, with a strong track record in promoting gender diversity in the FTSE 350 and having done much to fuel the progress on FTSE 350 boards.

It has about ten ESFs as members.

Greater details are provided on the internet.\*

\* [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/208464/voluntary-code-of-conduct-for-executive-search-firms.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/208464/voluntary-code-of-conduct-for-executive-search-firms.pdf)

\* <https://www.gov.uk/government/publications/enhanced-code-of-conduct-for-executive-search-firms-accreditation-process>



# Definitions

**Fit and proper person test:** All those appointed are expected to meet the fit and proper person test. The fit and proper person regulation (FPPR) requirements came into force for all NHS trusts and foundation trusts in November 2014. The regulations require health service bodies to seek the necessary assurance that all executive and non-executive directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role.

**The Disclosure and Barring Service:** Helps employers make safer recruitment decisions each year by processing and issuing DBS checks for England, Wales, the Channel Islands and the Isle of Man. DBS also maintains the adults' and children's Barred Lists and makes considered decisions as to whether an individual should be included on one or both lists and barred from engaging in regulated activity.

**Underrepresented groups:** In the UK, often defined as those groups with protected characteristics under the Equality Act. The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. NHS diversity focus has been on women and those from black and minority ethnic (BME or BAME) communities. Women and these communities make up a high percentage of NHS employees.

**Regulators:** NHS Improvement, NHSI & NHS Executive, NHSE, these bodies often come together under NHSEI to signify their joint working.

**EDI:** Equality, diversity and inclusion

**ESFs:** Executive search firms

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