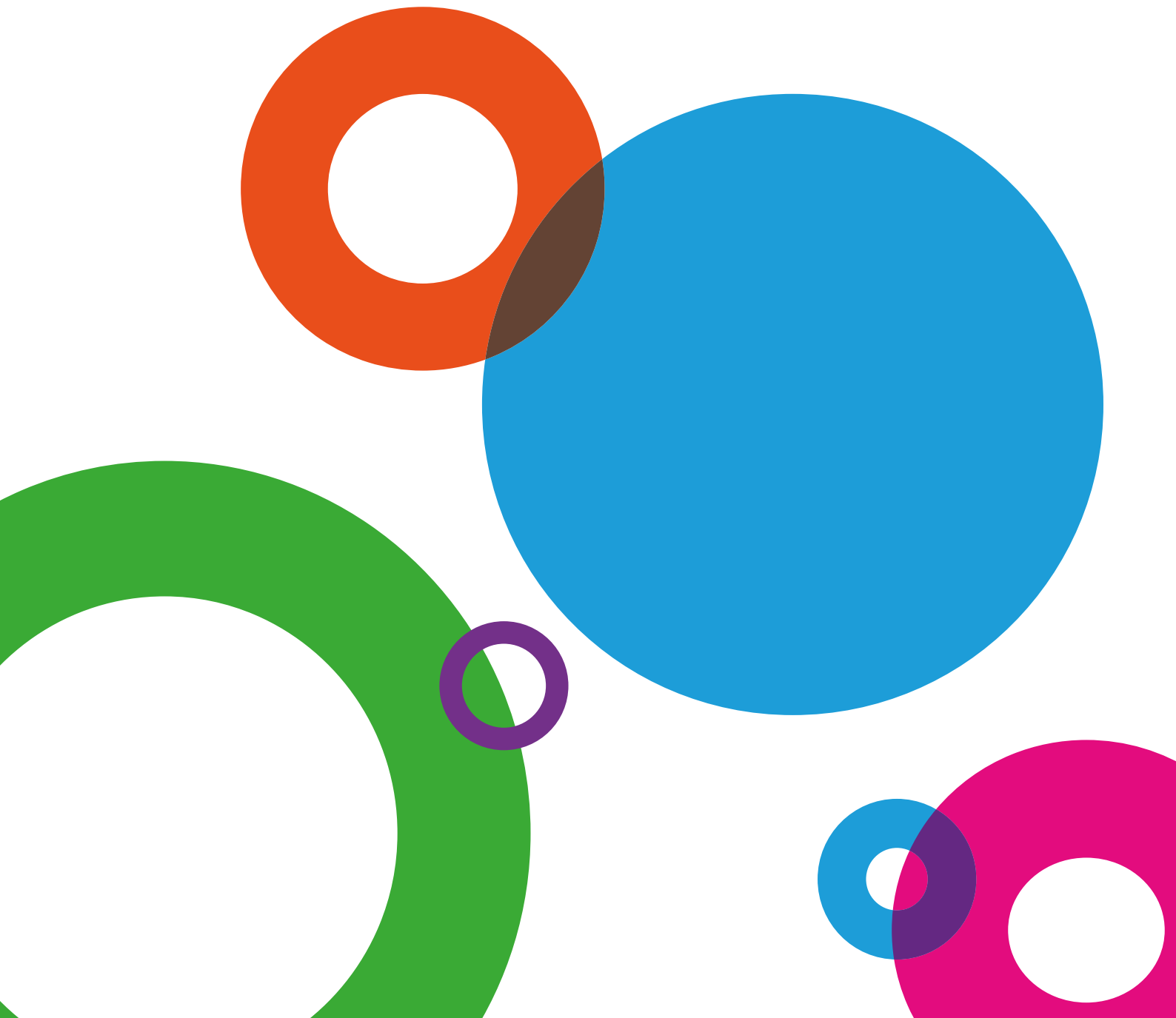




Chairs and non-executives in the NHS: The need for diverse leadership



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Executive summary

Diversity in leadership is important for the future of the NHS, particularly in light of the need to implement the new NHS Long Term Plan, which promotes greater integration between staff and expresses the need for transformational change across health services.

Equality, diversity and inclusion (EDI) is about having best practice in the governance of organisations and better engagement with the staff. For the NHS, this will lead to significant improvements in the standards of care delivered within its institutions. However, EDI is an area that the NHS needs to make significant progress in to reflect the spirit of the equality and diversity legislation and the NHS' stated ambition to create a more diverse leadership.

A critical part of the solution to these challenges is ensuring the chairs and non-executives on the boards of NHS organisations are competent and reflect the communities they serve and the workforce they govern. A diverse and inclusive leadership among those appointed to these board roles of NHS organisations will provide the tone of governance that is needed to:

- address the issue of staff feeling bullied and harassed
- develop the culture recommended by Sir Robert Francis¹ and Professor Don Berwick²
- motivate NHS staff to be caring and productive, and to provide more efficient and sensitive patient care.

This report examines the arrangements for the recruitment and appointment of chairs and non-executives within the NHS (NHS non-executives include chairs and non-executives). As the report demonstrates, the progress and gains made in the early 2000s towards a more diverse board leadership in NHS trusts (including foundation trusts) has gone into reverse or made no progress. As a community of leaders, chairs and non-executive directors are often not representative of the communities they serve and the staff they govern.

Since the early 2000s, there has been:

- a material reduction in the percentage of women in chair or non-executive roles on NHS boards. The percentage of women in these roles peaked at 47 per cent (for all chair and non-executives roles) in 2002. The latest intelligence from NHS Improvement, published in 2018, shows that 38 per cent of chair and non-executive roles are held by women (for all chair and non-executive roles).³ At the same time, there has been a parallel rise in the percentage of men in these roles. The differences are even greater for those in chair roles. Men peaked at 69 per cent in 2008 and men in chair roles today continue to be 69 per cent of all chairs in post. This growing gap contrasts with an NHS workforce that is dominated (at 77 per cent) by women.
- a reduction in the percentage of chairs and non-executives from a Black and Minority Ethnic (BME) background, despite today 19 per cent of the NHS workforce being BME. The percentages of people from BME backgrounds in these roles peaked at 15 per cent (for all chair and non-executive roles) in 2010. Today, 8 per cent (for all chair and non-executive roles) and 6 per cent of chairs are from a BME background. Data from the Workforce Race Equality Standard (WRES)⁴ confirms that in just under half of all NHS trusts (including foundation trusts) there are no BME board members.
- no progress in increasing the percentage of those who are disabled which tends to be about 5 to 6 per cent of all appointments.

This means that the gender gap for chair and non-executive roles has widened since 2002, ensuring the dominance of male non-executives on NHS boards. By 2017, the percentage of BME people in these roles was less than what was being reported in 2002.

This finding stands out in an organisation that is dominated by female employees and in which BME staff play key roles. It also contrasts with other public sector and commercial organisations that will have a smaller proportion of women and BME employees yet actively support and advocate for women and those from a BME background to apply for board and leadership roles.

In addition, the average age of those appointed is considerably older than the average age of executive directors, NHS staff and the wider population. As a consequence, there is an imbalance among the leadership of NHS organisations.

The reasons for these declines are not clear but two important factors appear to have had an impact. The first is the continuous change of those who are in charge of recruiting to these roles, starting with the abolishment of the NHS Appointments Commission, which oversaw appointments to a range of NHS public bodies, including NHS trusts.

The NHS Appointments Commission sought to make appointments which were independent from the executive, were gender balanced and reflected the need to promote a greater proportion of BME appointments, and opened recruitment to those with disability.⁵ It also provided a repository of knowledge on candidates and ongoing development of chairs and non-executives and published progress annually. Despite receiving parliamentary praise for the service it provided, the NHS Appointments Commission was dissolved in 2012. For a while responsibility for appointments was transferred to the NHS Trust Development Authority (TDA) and now resides with NHS Improvement.

The second important change involved the creation of foundation trusts. As foundation trusts are independent public benefit organisations, any appointments to their boards are no longer considered public appointments. Foundation trusts were therefore handed the autonomy to make their own chair and non-executive appointments without the oversight of an independent agency. This oversight instead became the responsibility of individual foundation trusts' council of governors, although in recent times some foundation trusts have invited NHS Improvement to the decision-making table. Given the move to foundation trust status has stalled, we are now left with a two-tiered approach to the appointments process for chairs and non-executive directors.

The report makes clear there are significant barriers to overcome if the chairs and non-executives on the boards of NHS organisations are to be more representative of the local communities they serve. These include:

- 'groupthink' decision making among independent board advisers, governors and executive search companies which use traditional networks to search for candidates
- lack of search programmes in place that target, foster and encourage diversity and inclusivity amongst candidates
- lack of transparent data (remuneration and appointees) which allows progress to be monitored
- selection criteria which is dominated by commercial and financial skills rather than the skills necessary for collaboration, transformation and engagement which are more important in securing strategic changes to services and fostering integration

- lack of fairness in the salary and conditions across boards, with foundation trusts' chairs and non-executives receiving considerably more for similar roles.

In order to help address the declining numbers of chairs and non-executives from diverse backgrounds, the NHS Confederation will bring health and care leaders together to develop and implement practical evidence based actions.

A series of recommendations are included in the report, including ensuring that an equalities and diversity framework is developed for the recruitment and retention of chairs and non-executives. This needs to be developed in conjunction with equality, diversity and inclusion experts, and representatives of those in non-executive roles and others to ensure that:

- future appointments and assessment of chairs and non-executives to NHS boards is diverse, inclusive and independent
- best practice methods for recruiting diverse chair and non-executive boards are used - this means changing present search and recruitment methods to seek out alternative candidates
- opportunities for 'twinning with' and being mentored by organisations that are more effective in addressing this gap take place
- a review of remuneration levels among chairs and non-executives takes place to ensure pay and conditions are even handed and incentivise those who are interested in such roles.

The benefits to the NHS of a more equal and diverse leadership are well understood. But if NHS organisations are to create a sustainable pipeline of diverse leaders that reflect the staff and the communities they serve, then the NHS must seek ways to accelerate this transition among chairs and non-executives. Such a diversification in the leadership of the NHS is more likely to champion patient and staff engagement⁶ and transform the culture of the health service for the benefit of patients.⁷

All figures in this report are rounded to the nearest percentage.

Introduction

Chairs and non-executives are important NHS leaders as their purpose as board members is to govern NHS organisations effectively, and in so doing build patient, public and stakeholder confidence in healthcare. Ensuring the boards of NHS organisations are diverse and representative of the communities they serve and the workforce they govern is a major priority for the NHS.

The NHS has an ambition that all NHS boards will be equal for gender and that the percentage of BME and disabled people on boards will be greater than at present. Despite this, there have been a number of recent reports that show the NHS will struggle to meet its equality and diversity ambitions.

This report examines the arrangements for the recruitment and appointment of chairs and non-executives within the NHS and assesses whether progress is being made towards achieving more balanced boards.

Other sectors

There is strong evidence for the positive impact that diversity and equality in leadership has on organisational performance and culture.^{8,9,10,11} This is the case across the private, not-for-profit and public sectors.^{12,13,14,15}

Boards across the UK and those with an international reach are seeking to create better diversity and promote women into board roles. A small number of companies actively seek to recruit skilled BME board members from a 'go to' database of names with the correct characteristics and background who are judged to be ready and able to perform such roles.

More generally, many executive search firmsⁱ and members of the Big Four accountancy companiesⁱⁱ keep lists, run courses and promotions and there are multiple networks advertising these roles. Among the tools and mechanisms put in place are specific skills courses in governance and finance, speed dating events between prospective candidates and employers, and mentoring and coaching and social/educational events. Others run campaigns in local settings and visit community groups targeting leaders and those with specific skills.

The NHS and progress towards achieving balanced boards

The need for organisational awareness and support of equality and diversity in NHS boards is set out in the English NHS Constitution, the UK Government's Equality Act 2010 and corporate guidance. Additionally, the NHS standard contract specifically requires NHS trusts to develop annual equality and diversity plans within equality delivery systems (EDS2).

The Equality and Diversity Council (EDC), which has joint chairs,ⁱⁱⁱ consists of senior decision makers and influencers in health. The EDC works to bring people and organisations together to realise a vision for a personal, fair and diverse health and care system, where everyone counts and the values of the NHS Constitution are brought to life.

A key measure is WRES¹⁶ – implementing this is a requirement for NHS commissioners and providers, including independent organisations, through the NHS standard contract. The impact of the WRES has been to provide transparency and data which can demonstrate and monitor progress (or lack of). It is a useful monitoring tool for NHS England/NHS Improvement and the Care Quality Commission.

i 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.

ii The 'Big Four' are KPMG, Deloitte, Price Waterhouse Coopers (PWC) and Ernst and Young (EY).

iii Simon Stevens, Chief Executive, NHS England and Joan Saddler, Associate Director, NHS Confederation and NHS non-executive.

A recent report, *A model employer: Increasing black and minoring ethnic representation at senior levels across the NHS*,¹⁷ outlines the ambitions set by NHS England and NHS Improvement for each NHS organisation to set its own target for BME representation across its leadership team and broader workforce. These ambitions are reflected in the NHS Long Term Plan. The strategy will provide accelerated, intensive support to local NHS organisations to increase the recruitment of BME staff at senior levels.

Paying attention to diversity and equality is a legal requirement. Furthermore, it promotes a culture of engagement which encourages the active and positive contribution of individuals to maintain and enhance the performance of organisations in supporting and encouraging high-quality and financially efficient care.

A range of factors may prevent people from applying or being appointed to a chair or non-executive role. These include a lack of awareness of the NHS system or of how the role works, and the perceived lack of potential (in themselves or others) to contribute. And some will not be able to take part as doing so may interfere with their own work or family responsibilities. Others may not consider the remuneration sufficient.^{iv}

iv Presently there are considerable differences between the pay and conditions of chairs and non-executives as foundation trust appointees receive greater levels of remuneration than those appointed to similar roles and responsibilities in non foundation NHS trusts. The remuneration received for non-executive roles has ranged from £7,000 to over 150,000 per annum.

How NHS chairs and non-executives are appointed

Boards are led by the chair. Chairs need a range of skills to ensure board meetings are run effectively and that the board discharges its responsibility from a governance perspective. In addition, chairs need to have a vision for the organisation and be able to share this in a way that local communities understand.

They are supported by their non-executive directors in shaping, formulating and evaluating strategy. However, there is some evidence that this activity has been comparatively neglected on boards in the English NHS.¹⁸ More details of the role of the chair and non-executives are included in Appendix 1.

Appointing the right chair and non-executives is therefore a critical task for all NHS organisations. According to the NHS Leadership Academy,¹⁹ the board selection process provides a defining moment in the development of an organisation. It is the opportunity to ensure that the right people with the right competencies are at the helm, providing leadership and governance that will secure the future of the organisation, fulfil the objectives of the business, and deliver sustainable benefits.

Responsibility for overseeing the appointment of chairs and non-executives to NHS organisations has been delegated to a number of different bodies since the early 2000s. These changes are set out in Appendix 2.

The critical changes that took place in the 21st century are the continuous changes to the structure of the NHS, and the abolishment of the independent agency that was charged with appointing chairs and non-executives. The NHS Appointments Commission which oversaw appointments to a range of NHS public bodies, including NHS trusts, was also charged with ensuring that chairs and non-executives had annual performance appraisals, received up-to-date training and full support for their board role and were briefed regarding policy expectations. It also actively sought to make appointments which were gender balanced and reflected the need to promote greater diversity and open recruitment to those with disability.²⁰

At the time of its creation, there was a widespread concern in the NHS that the necessary rigour of independence for chair and non-executive appointments was being compromised.²¹ But despite receiving parliamentary praise for the service it provided, the commission was wound up in 2012. Responsibility for the appointment of chairs and non-executives to NHS trusts now in effect resides with NHS Improvement's Executive who recommends all chair and non-executive appointments.

During this period another crucial change had an impact on the appointments process. The policy to move all NHS trusts to more autonomous foundation trust status meant that the commission gradually was stripped of and no longer retained oversight of chair and non-executive director appointments when foundation trusts started to form in 2004. Instead appointments became the responsibility of individual foundation trusts' Council of Governors. As foundation trusts are independent public benefit organisations, these appointments are no longer public appointments.

However, from 2015 the desire to move all trusts to foundation trust status has stalled, leaving a two-tiered approach to the appointments process, in which NHS Improvement oversees appointments to trust boards and foundation trusts determine their own appointments. Although for foundation trust boards in special measures, NHS Improvement will try to influence such appointments.

As we outline in the next chapter, the impact these changes have had on the number of chairs and non-executive directors from diverse backgrounds being appointed to NHS boards has potentially been significant.

What has happened to chair and non-executive appointments from diverse backgrounds?

Before looking at the results of the data, it is worth including some background on it.

The data to monitor NHS chair and non-executives (in England) is not reported in a standard format. The data that was reported changed under successive Department of Health Secretaries of State, and as the Equalities Act (from 2010) and the NHS Health and Social Care Act (from 2012) requirements were implemented.

From 2004, the NHS Appointments Commission slowly transferred its front-line NHS oversight role of chairs and non-executives to individual foundation trusts' council of governors as foundation trusts were created. In 2012, when the NHS reforms became law and the NHS Appointments Commission was dissolved, the oversight of chairs and non-executives of the remaining NHS trusts shifted to the NHS Trust Development Authority in 2012 and then NHS Improvement from 2016. As a consequence, the figures presented in this report have had to be sourced from archived annual reports, academic reports,²² recent NHS Improvement reports²³ and the WRES data.²⁴

Further, as trusts transitioned from NHS trust to foundation trust (between 2004 and 2012), the Appointments Commission provided initial support to the early aspirant foundation trusts on planning, preparing and recruiting chairs and non-executives. From 2006 till 2011, as its NHS oversight role reduced, its powers were extended to include chairs and non-executives of non-front-line NHS organisations. Until 2012, subject to competition and agreement of a fee, a foundation trusts 'council of governors could (and some did) appoint the NHS Appointments Commission to act as a recruitment agent for their chair or non-executives roles.

Data results

The data published shows that in April 2002, the percentage of women (for all chair and non-executives roles) was 47 per cent and shows a subsequent decline to 34 per cent (for all chair and non-executive roles) by 2008. In assessing the reasons for the continuing fall over this period, a survey commissioned by the NHS Appointments Commission in 2007 suggested that women failed to see adverts, were not confident of their competence, and thought the roles were taking too much of their time. Today the percentage in these roles are 31 per cent in NHS chair and and 38 per cent in all NHS (chair and non-executive) roles respectively.

In contrast the percentage of chairs and non-executives from a BME background rose. The percentage in post as a chair and non-executive peaked at 15 per cent by April 2010 .Today the percentage in these roles are 6 and 8 per cent in chair and (chair and non-executive) roles respectively.

Those who considered themselves to be disabled did peak in (chair and non-executive) in 2006 but afterwards the percentage remained relatively stable throughout the period at an average of about 5 to 6 per cent of all appointments.

After the NHS Appointments Commission dissolved and more NHS reforms were implemented from 2012 till 2017 such data was not routinely published. Today, in an NHS unitary board environment which reflects the foundation trust model, much that is reported about boards reflects executive and non-executive together. However, chairs and non-executives are important in their own right as NHS leaders as their purpose as board members is to govern NHS organisations effectively, to hold the executive to account and in so doing build patient, public and stakeholder confidence in healthcare.

The NHS Trust Development Authority released the number of chairs and non-executives appointed to NHS trusts and foundation trusts from 2006–2013. These figures show an average annual female (chair and non-executive) appointment rate of 34 per cent. During the same period the figures show an average annual BME (chair and non-executive) appointment rate of 6 per cent.²⁵

Two independent surveys of NHS boards, including arms-length bodies, reported in 2017 and 2018 that the percentage of women in NHS chair roles is just over 30 per cent, while women (for all chair and non-executive roles) is about 37 per cent.^{26,27}

The percentage of overall (chairs and non-executives) from a BME background is 8 per cent, although the data from WRES confirms that in just under half of all trusts there are no BME board members.²⁸

The percentage of non-executives with a disability is between 5 to 6 per cent. This has remained fairly constant during the last ten years.

The following graphs illustrate the trends on chair and non-executive appointments in terms of gender, ethnicity and disability.

Figure 1 shows the rising percentage of men in NHS board chair roles during the period from 2002 to 2017. This rose from 59 to 69 per cent of all chairs, while the percentage of women in chair roles fell to 31 per cent by 2008 and continues at the same level today. More in-depth analysis by NHS Improvement suggests that the gender imbalance is more likely in chairs and non-executives who are over the age of 55 years and those BME chair appointees have a greater proportion of women than white chair appointees.

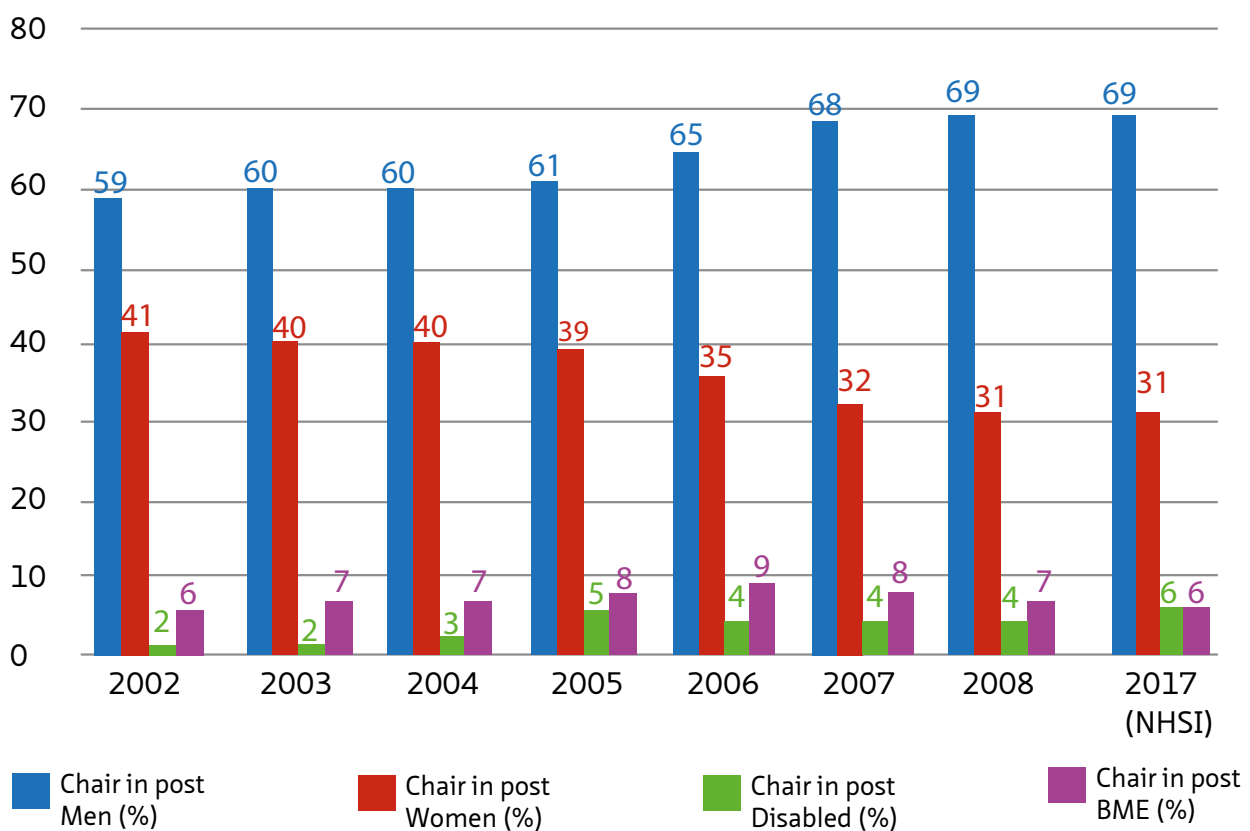


Figure 1: Percentages of NHS board chairs in post who are men, women, from a BME and disabled background from 2002 to 2017.^v

^v Figure 1: Data from NHS Appointments Commission accounts 2002–2008. No figures published 2009–2016. NHS Improvement 2017 figure was published in 2018.

Figure 2 shows the trends (for all chair and non-executive roles) from 2002 to 2017. The percentage of men in non-executive roles rose from 53 per cent to as much as 66 per cent and stands at 62 per cent today. Over the same time frame, the percentage of women in these roles fell to 34 per cent and stands at 38 per cent today.

This means the gender gap has widened from 2002 to 2017 resulting in the dominance of male non-executives on NHS boards.

Those appointed to those roles from a BME background showed some progress from 2005 to 2010, rising from 11 to 15 per cent of all appointees. But the progress reversed the next year.

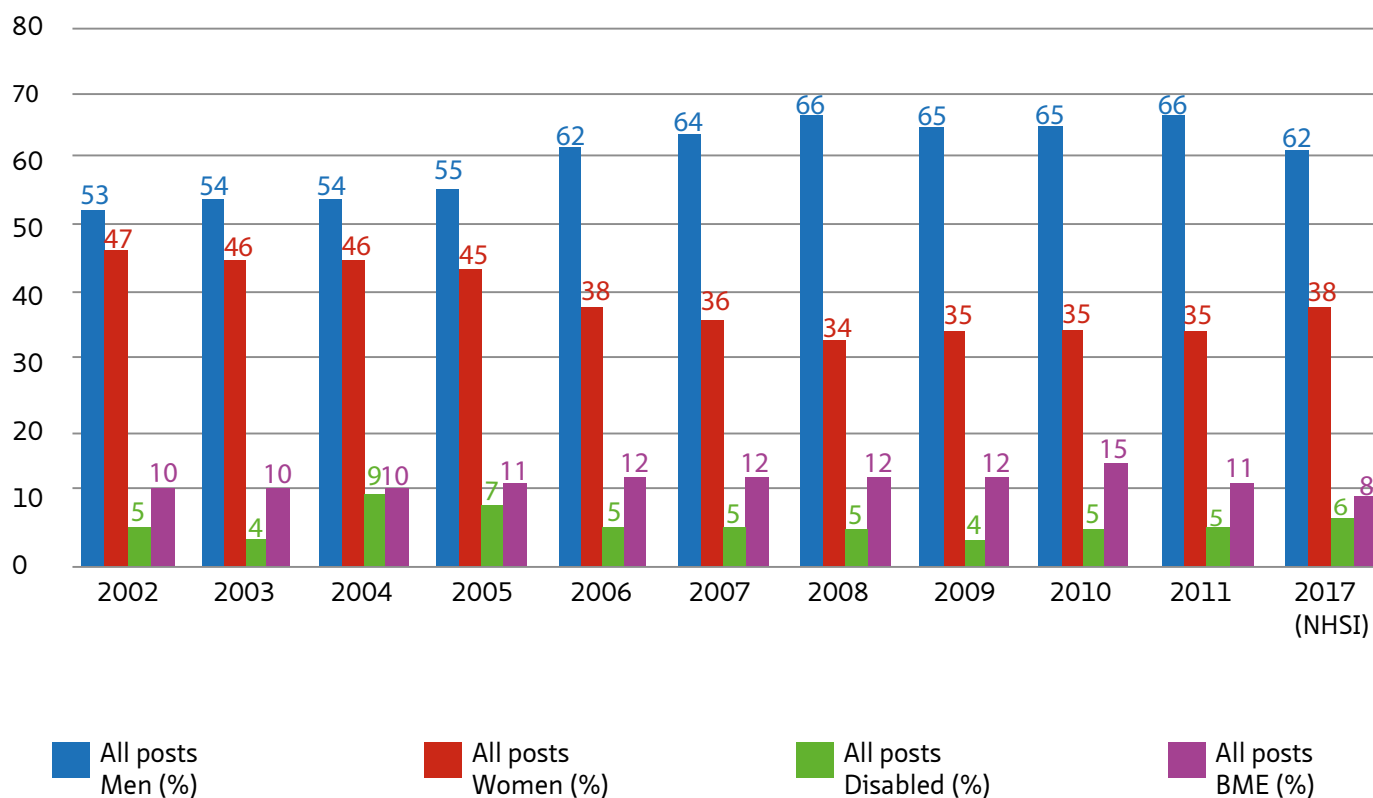


Figure 2: Percentages for all chair and non-executive roles who are men, women, from a BME and disabled background from 2002 to 2017.^{vi}

vi Figure 2: Data from NHS Appointments Commission accounts 2002–2011. No figures published 2012–2016. NHS Improvement 2017 figure was published in 2018.

The following two charts (figures 3 and 4) illustrate differences between non-executives, executives, the general population and NHS staff in employment for four of the protected characteristics (age, gender, sexuality and disability).^{vii}

Figure 3 shows that women are the dominant gender among NHS staff, and that non-executives characteristics do not match the NHS workforce nor the general population as the non-executive population has proportionally more men, fewer women, fewer BME and fewer disabled people in their group. Figures for LGBT are incomplete as the NHS has still to publish workforce statistics.

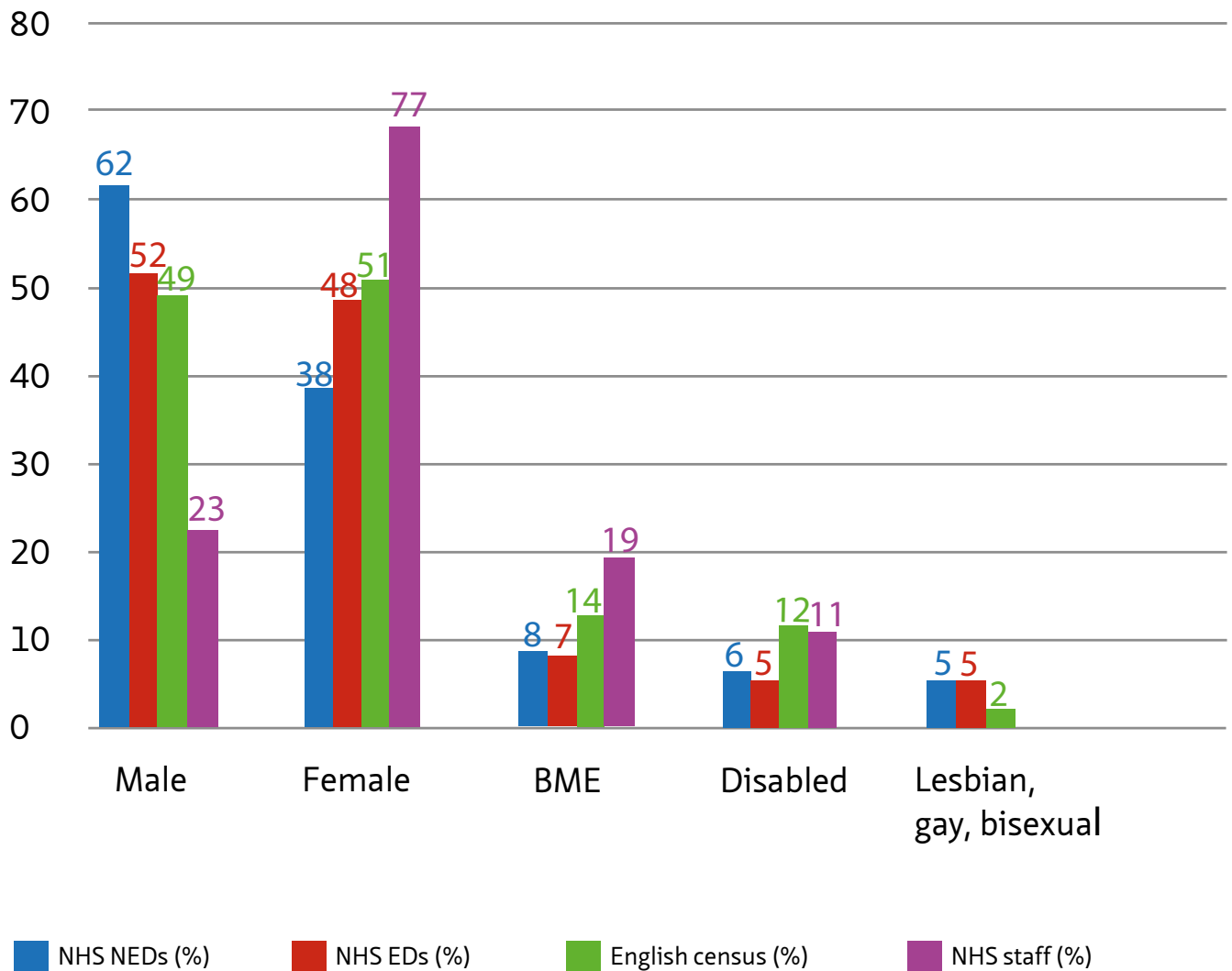


Figure 3: Percentages for all chair and non-executives who are male, female, from an BME, disabled and LGBT background compared to NHS board executives, NHS staff and the English population 2017.

^{vii} Protected characteristics include age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity.

Figure 4 shows that those appointed to these roles are much older than those who work in the NHS or those in the general population of England.

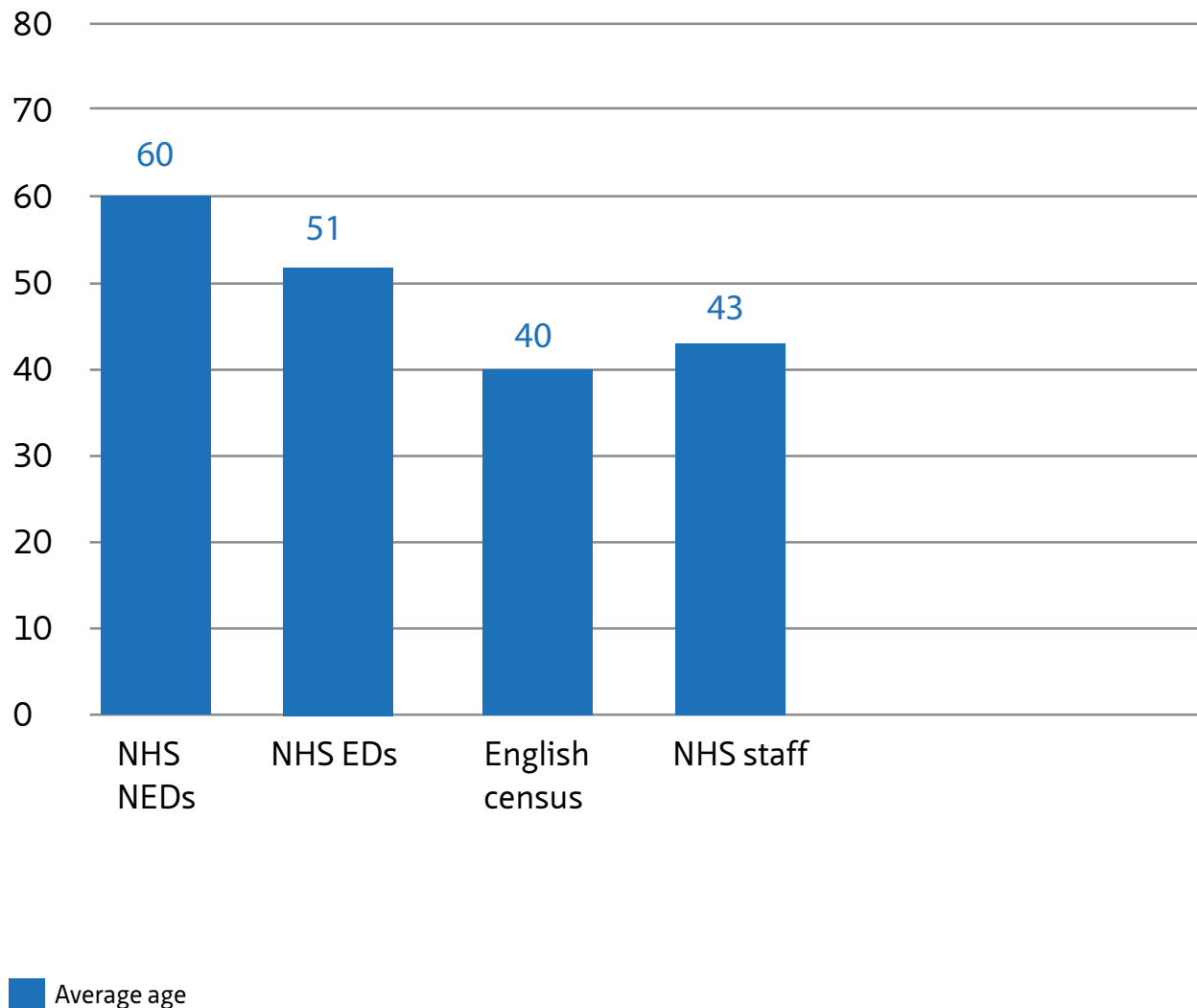


Figure 4: Average age for all chair and non-executives compared to NHS board executives, NHS staff and the English population 2017.

Conclusion and recommendations

The benefits to the NHS of a more equal and diverse leadership are well understood. They include the widening of the leadership talent pool, a better understanding of local communities and partners, minimising groupthink decision making and improved performance.

An inclusive leadership should help to motivate staff to be caring and productive, ensuring the NHS is able to address bullying and develop the culture recommended by Sir Robert Francis and Professor Don Berwick to provide higher clinical standards alongside delivering a greater sensitivity to patients and their families.

Despite best intentions to address the lack of a diverse leadership at national, regional and local level, there has been much concern that the NHS as an institution has failed to make enough progress on diversity.^{29,30}

One of the major areas of concern is a lack of diversity among chair and non-executive roles. As this report has demonstrated, the number of chairs and non-executives from diverse backgrounds on the boards of NHS organisations has steadily declined since the early 2000s.

More specifically, there has been a significant fall in the percentage of women in chair and non-executive roles from the start of the 2000s. This reflects poorly on an organisation that employs significantly more women than men.

The percentage of BME people in these posts is still considerably lower than it was in 2002 despite some improvement when the NHS Appointments Commission promoted such roles to BME communities. Furthermore, despite the opening up of appointments to those who are disabled the results show that progress in appointing disabled candidates has stalled.

The average age of those appointed is considerably older than the average age of those working in the NHS, than for executive directors and for the wider population. As a consequence, there is an imbalance among the leadership of NHS organisations.

Understanding the obstacles in recruitment and possible solutions

If NHS organisations are to create a sustainable pipeline of diverse leaders that reflect the staff and the communities they serve, then the NHS must seek ways to accelerate this transition among chairs and non-executives.

To become a chair or non-executive there are certain standard requirements, including skills, which are currently dominated by governance, accountancy and commercial experience. Although fiscal competence at board level is important, so too are those of valuing community engagement, workforce resilience and innovation – many of which were formerly included within non-executive criteria. These 'softer and more sophisticated' skills are important if we are to meet the transformation goals set out in the NHS Long Term Plan.

The challenge now is to find candidates that have the 'softer' competence, or who could gain it, in order to deliver more balanced boards that reflect the workforce and communities that NHS organisations serve.

NHS Improvement designed its NExT programme to address this challenge. It is a cadre of board-

ready and diverse candidates, but is small scale and only centrally promoted. It has had little impact on increasing diversity in the chair and non-executive community, which may be because the programme is small and the scale of the NHS challenge is considerable.

Overcoming the challenge may be hampered too by recruitment and accountancy advisors continuing to recommend candidates in the image of those that were heralded by Monitor rather than having embedded in their minds the images of candidates that the future NHS needs to embrace.

There is also the point that it is possible that suitable candidates are not able to commit the time or afford to take these roles. The emphasis by NHS regulators on accountancy qualifications, governance and commercial experience may have inadvertently reduced the non-executive talent pool. It was a concern that was expressed by non-executives from the BME communities who were in such posts when the NHS foundation trust model was rolled out.³¹

Approaches taken by other organisations

While the NHS has focused on appointing chairs and non-executives for business competence, other organisations have been more successful in meeting the diversity and inclusion challenge that mirrors the legislation and have found ways to find a better balance of non-executives for their board.³²

Among the differences found in these more diverse organisations is independent oversight of appointments to these roles (which is expected by the Commissioner for Public Appointments) which contrasts with the executive and governor oversight that dominates such appointments in the NHS. The use of outreach techniques to promote such roles locally and to community groups is also proving successful, as is actively seeking out specific pipelines of those with protected characteristics (age, female, disabled, LGBT and BME) to foster such candidates by providing a range of activities or development programmes that are local, specific and attractive to specific peer groups.

Such programmes promote, brief, refresh, train, encourage, mentor and coach and give exposure to real board work so that potential candidates are ready and able to step into these roles.

Those who are successful in championing diversity might usefully act as a 'twin and critical friend' to those in the NHS that are struggling to recruit chairs and non-executives that reflect the communities they serve and their workforce.

Indeed, a diverse leadership will be more able to handle the collaborative governance arrangements that are being taken forward in sustainability transformation partnerships (STPs) and integrated care systems (ICSs).³³ Such a diversification in the leadership of the NHS is more likely to champion patient and staff engagement³⁴ and transform the culture of the health service to provide better care for patients.

Recommendations

As this report has made clear, there are significant barriers to overcome if the chairs and non-executives on the boards of NHS organisations are to be more representative of the local communities they serve.

In the interest of better patient outcomes and better personal patient experience with the NHS, board leadership needs to be competent to govern and oversee NHS organisations. However, NHS chairs and non-executives in boards are insufficiently diverse presently to be as effective as they need to be. Inadequate diversity in the leadership risks demotivating staff further than they already are and will continue, unless rectified, to compromise patient outcomes and experience.

The non-independent nature of the appointment process, the inconsistent remuneration and rewards apportioned to NHS chairs and non-executives have resulted in an NHS that has gone backwards in diversity implementation. This is particularly concerning because its chairs and non-executives are considered important for giving the public confidence in the NHS.

This decline was noted by the NHS Appointments Commission in 2006 as foundation trusts became the preferred organisational model for provider trusts. For those with a BME background it is worse than, and for the disabled no better than, it was in the early 2000s.

The NHS must grasp diversity if the culture change that experts such as Sir Robert Francis, Professor Don Berwick and Professor Michael West recommend for the benefit of patient care is to happen.³⁵

The following recommendations are designed to focus attention on key areas where progress is needed:

- 1** The NHS Confederation is intending to bring health and care leaders together in the first instance to explore what can be done to address the declining numbers of chairs and non-executives from diverse backgrounds.
- 2** The chairs of NHS England and NHS Improvement should appoint a lead chair to work with the NHS Confederation to make recommendations to ministers for addressing the diversity deficit in NHS boards.
- 3** This group should oversee the development of an equalities and diversity framework for the recruitment and retention of chairs and non-executives across the NHS to ensure that:
 - future appointments and assessment of non-executives and chairs to NHS boards is diverse and inclusive, and independent
 - best practice methods for recruiting a diverse chair and non-executive community are used - this includes challenging and changing present executive search and recruitment methods to seek out diverse candidates
 - opportunities for twinning with and being mentored by organisations that are more effective in addressing this deficit take place
 - a review of remuneration levels amongst chairs and NEDs takes place to ensure the pay and conditions are even handed and incentivise those who are interested in such roles
 - a review of search firms takes place to ensure they are incentivised and can provide diverse short lists for NHS organisations.
- 4** Making use of the WRES data to allow progress to be monitored will aid routine monitoring. Suggestions for organisational targets for NHS boards have been outlined by the Model Employer strategy.^{viii}
- 5** The Leadership Academy and Regional Talent Boards should expand their role to include development and support for chairs and non-executives on governance and EDI.

Appendix 1: What is the skill specification for chairs and non-executives?

The chair role

Boards are led by the chair. Chairs need a range of skills to ensure board meetings are run effectively and that the board discharges its responsibility from a governance perspective. In addition, chairs need to have a vision for the organisation and be able to share this in a way that local communities understand. In short, they 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 of NHS chair, should include those whose values-based principles include openness, transparency, candour and strong patient-centred healthcare leadership.³⁶

The non-executive role

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 evidence that this strategic activity has been comparatively neglected on boards in the English NHS.³⁷

Technical requirements

All those appointed to these leadership roles have to satisfy a number of technical requirements. These are the Nolan Principles, the fit and proper person test and a range of competences.

The Nolan Principles

Board members are expected to adhere to the Nolan Principles.

- **Selflessness:** Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
- **Integrity:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity:** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability:** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
- **Openness:** Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- **Honesty:** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership:** Holders of public office should promote and support these principles by leadership and example.

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 NHS trusts 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.³⁸

Competences

In 2006 the Secretary of State for Health set out the following requirements from chairs and non-executives NHS boards that they have the following specific set of competences among them:

- **finance experience** in a large and complex organisation with the capacity to chair the Audit Committee and, ideally, a financial qualification
- **governance experience**; bringing experience of strategic planning, financial, risk and performance management
- **commercial experience** at senior level; bringing both governance and private sector expertise
- **voluntary sector or community service experience**, with experience of regeneration, community development or service provision for disadvantaged groups
- **specific expertise relating to the work of the organisation**, such as consumer/customer focus, patient advocacy, market management, commissioning, contract management, local government, economic analysis and change management.

In addition, NHS foundation trusts governance is red flagged if it has insufficient recent commercial experience and insufficient qualified financial expertise amongst its non-executives.

Appendix 2: Appointment process for NHS chairs and non-executives

National level: Appointments to national bodies

The Commissioner for Public Appointments provides independent assurance that appointments by ministers to the boards of public bodies are made in accordance with the government's Principles of Public Appointments and are true to its governance code. The appointments of chairs and non-executives to special health authorities or non-departmental public bodies or national roles are administered by the Centre for Public Appointments. They may (or may not) use executive search consultants to support the appointment process on behalf of ministers.³⁹

Since 2015 the Centre for Public Appointments in the Cabinet Office coordinates across government and promotes roles on the boards of public bodies to a range of candidates with diverse skills and backgrounds. The Centre for Public Appointments works with the Commissioner for Public Appointments who is committed to increasing the diversity of appointments through his role as a regulator and his work with the Public Appointments Assessors.

Roles are advertised and interview committees are made known well in advance and contain a chair and independent assessor. In recent years appointees to chair roles have been subject to pre-appointment parliamentary hearings.

Recent appointments have included the chairs and non-executives of NHS England and NHS Improvement.

Local level: Appointments to NHS trusts

Previously in the Department of Health (as it was then known), the arrangements for appointments to NHS trusts were delegated by the Secretary of State for Health to a separate NHS Appointments Commission in 2001.^{ix} At that time there was concern that the necessary rigour of independence for these appointments was being compromised.⁴⁰

Over the next ten years the NHS Appointments Commission remit was extended to include appointments to special health authorities and non-departmental public bodies. The NHS Appointments Commission was also charged with ensuring that chairs and non-executives had annual performance appraisals, received proper training and were given full support for their board work.

From the start the NHS Appointments Commission annual reports and accounts indicates that it sought to make appointments which were gender balanced and reflected the need to promote greater diversity and open recruitment to those with disability.⁴¹ There were special campaign and working groups set up to address these issues. In 2011, the national NHS intention plan was that all NHS trusts should become transformed into foundation trusts by 2016. This meant that from 2016 appointments to these roles were to be carried out by individual foundation trusts' Council of Governors. As these organisations are independent public benefit organisations these appointments are no longer public appointments. This proposed change meant that despite parliamentary praise for the service the NHS Appointments Commission carried out, it was dissolved in 2012.^x

ix The SpHA became the NHS Appointments Commission in 2006

x "The Appointments Commission provides recruitment services and related functions ... at reasonable costs, provides value for money and has built up considerable NHS expertise. The Commission has been a very valuable body for (the) Department of Health and the NHS over the last decade."

As a temporary measure, in the transfer of responsibilities under the Health and Social Care Act 2012, all remaining NHS trust appointments were delegated to the NHS Trust Development Authority, which was expected to be dissolved by 2016. However, since 2015 the transfer of all NHS trusts into foundation trusts has halted.

In 2019, the appointments process is delegated from the Commissioner for Public Appointments to NHS Improvement.⁴² Recruitment processes follow the Centre for Public Appointments code of conduct and appointments are made on merit and expected to reflect the Commissioner for Public Appointments stated objectives of promoting diversity.

Advisory assessment panels for these roles in the NHS trusts are established in line with NHS Improvement's policies and procedures and include an executive representative of NHS Improvement (for all chair and some non-executive appointments) and an independent person 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-executives candidates were independent of the executive.

In exceptional circumstances, appointments to these roles are made outside of the usual rules on the recommendation of an executive member of NHS Improvement when there is a need for specific skills or when there are unexpected vacancies. These appointments are limited in time and are usually subject to open competition rules at a later date.

The power to make, suspend and terminate appointments is delegated by the Secretary of State for Health and Social Care. By default, NHS Improvement is the Appointments Commission for NHS trusts and recently this reach has been extended to include influencing chair appointments to NHS foundation trusts that have licence breaches.^{xi}

Regional level: Appointments to CCGs, ICSs and STPs

NHS Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced primary care trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. There are just under 200 CCGs in England. They are described as membership bodies, with local GP practices as the members. They are led by an elected governing body made up of GPs, other clinicians including a nurse and a secondary care consultant, and lay members.

More recently the role of the lay members within CCGs is shifting into a traditional NHS non-executive role, but lay person membership has more flexibility than is found in NHS trusts.⁴³ The remuneration for the lay member role varies depending on the function that is carried out with some lay members receiving less than £10,000 and others more than £25,000 per annum.

As these lay roles are crucial in assuring proper governance within the CCG, NHS Clinical Commissioners, part of the NHS Confederation, has published guidelines for chairs which include a reminder about equality and diversity obligations.

At the regional level, STPs and ICSs are in different phases of development and have different population groupings. A number have independent chairs and others have yet to appoint to these roles.⁴⁴

xi Appointment of Oxford Universities Foundation Trust chair has a representative of NHS Improvement on its panel.

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About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of all organisations that plan, commission and provide NHS services. Our members are drawn from every part of the health and care system and join 500+ organisations connected to the NHS Confederation.

We have three roles:

- to be an influential system leader
- to represent our members with politicians, national bodies, the unions and in Europe
- to support our members to continually improve care for patients and the public.

All of our work is underpinned and driven by our vision of an empowered, healthy population supported by world-class health and care services; and our values of voice, openness, integrity, challenge, empowerment.

Equality, diversity and inclusion

Achieving diverse leadership is a longstanding priority for the NHS Confederation and we conduct a range of activities to support our member organisations, as well as the wider health and care system, to embed equality, diversity and inclusion into their work. We run two major networks that are helping local and national leaders to address the strategic and operational barriers to delivering greater diversity:

BME Leadership Network

Set up by the NHS Confederation in March 2019, it meets quarterly and seeks to:

- improve understanding of equality, diversity and inclusion and publish the benefits to help deliver better care for all
- improve and sustain the number of BME leaders working in the NHS
- profile the diverse range of BME leaders delivering solutions across the health and care system.

To find out more, email Joan Saddler at joan.saddler@nhsconfed.org

Health and Care Women Leaders Network

Delivered by the NHS Confederation and NHS Employers, this is a free network for women working across health and care.

It connects through events, masterclasses and tweet chats, and shares learning through podcasts, blogs, videos and key reports.

To find out more, email Julie Johnson at julie.johnson@nhsconfed.org



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