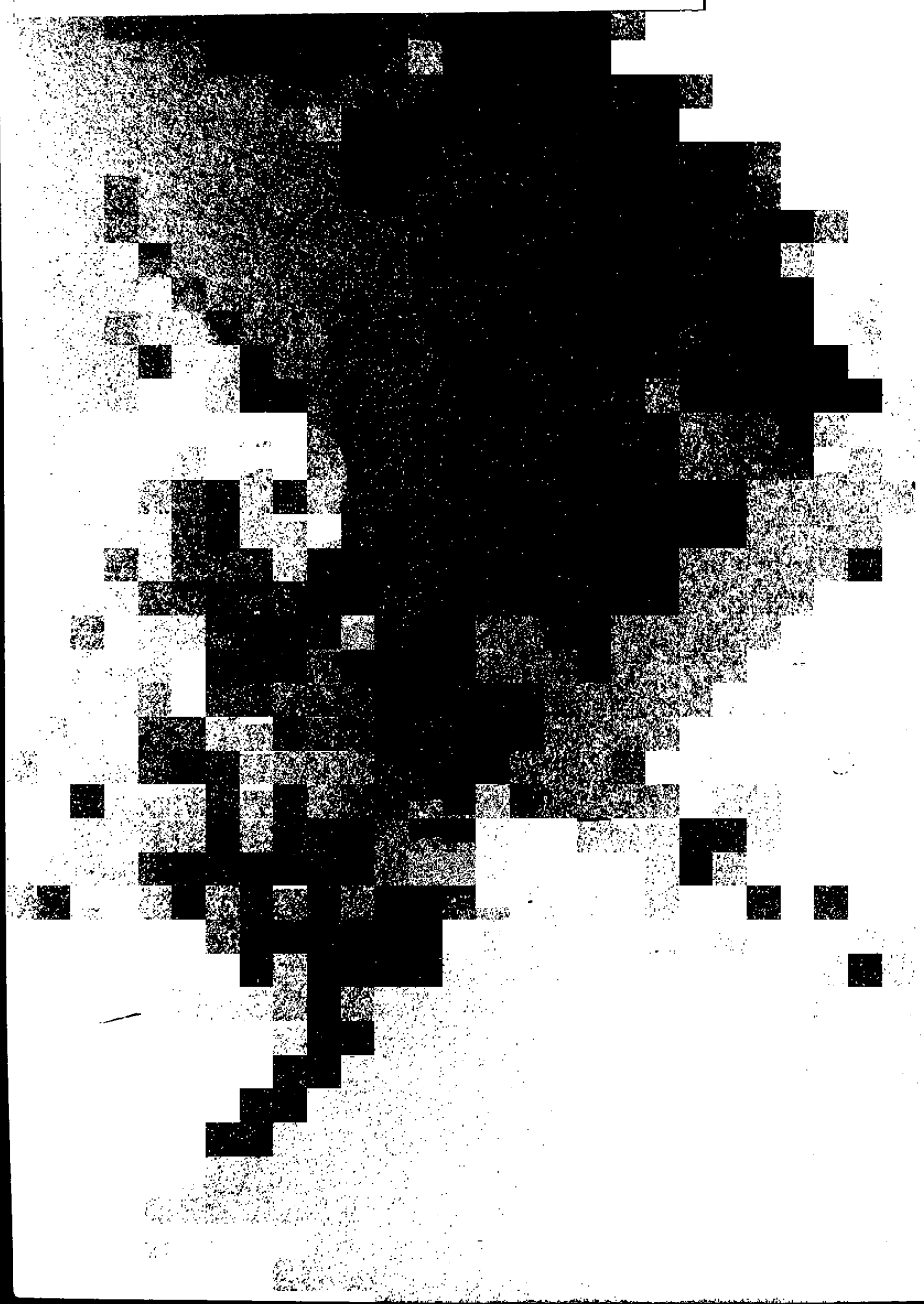
EQUAL OPPORTUNITIES TASK FORCE
OCCASIONAL PAPER NO 5

Ethnic minority health authority membership: a survey

King Edward's Hospital Fund for London



ETHNIC MINORITY HEALTH AUTHORITY MEMBERSHIP: A SURVEY

KING EDWARD'S HOSPITAL FUND FOR LONDON

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CONTENTS

1 INTRODUCTION

1.1 This paper presents the results of a Task Force survey of the ethnic origins of health authority members and the efforts which have been made by the health service to involve black and ethnic minority communities in membership. The Task Force undertook the survey because, whilst there was a widespread belief that black and ethnic minority members were under-represented, statistics were not available. Since its inception the Task Force has given firm guidance that health authorities must monitor the composition of their workforce as part of their equal opportunities policy, and believes that the same principle should apply to membership.

1.2 At present members of ethnic minority communities too often find that health services are either not easily accessible or are unresponsive to their needs. To improve this situation, the Task Force strongly takes the view that these communities must be fully involved in all aspects of the NHS, including its management. The Task Force therefore welcomed the report of the National Association of Health Authorities *Action not Words – a strategy to improve health services for black and minority ethnic groups*,[1] and would endorse their recommendation that involving members of black and ethnic minority communities in planning and managing services would result in greater equality of provision.

1.3 The Task Force was aware too that some health authorities were concerned that they were not representative of their local communities and had made attempts to nominate and/or appoint black and ethnic minority members. The Task Force has sometimes been approached for the names of potential members. However, health authorities have also reported difficulty in identifying suitable nominees, in getting them appointed, and in retaining the interest and the services of appointed black and ethnic minority members. The Task Force, with its remit to provide practical guidance on equal opportunities matters, thought that it would be helpful to publicize good practice. It also hopes that providing information about membership and appointment procedures will assist black and ethnic minority organisations in nominating potential members and will encourage individuals to put their names forward.

1.4 The remit of the Task Force is to help health authorities tackle racial

discrimination. The focus of the survey was therefore on the representation of black and ethnic minority members. The Task Force has however worked closely with the National Steering Group on Equal Opportunities for Women in the NHS and shares their concern that women should be adequately represented on health authorities. It therefore decided to collect information about the sex, as well as ethnic origin, of members. This also enabled the Task Force to examine whether both men and women from black and ethnic minority communities were adequately represented.

1.5 The survey was planned before publication of the white paper *Working for Patients*, which presages substantial change to authority membership and the introduction of self-governing hospital trusts. Examination of the white paper's proposals suggested that the survey would not only remain relevant but could be of enhanced significance. The overall reduction in the number of members and proposed changes in type of membership could lead to lower representation for black and ethnic minority groups. A bench mark against which future membership could be measured was thought necessary, and dissemination of methods which had proved successful in the past in achieving black and ethnic minority membership could be increasingly important. The recommendations which the Task Force makes as a result of the survey apply equally to the new health authorities and to hospital trusts.

2 SUMMARY OF THE REPORT

2.1 The report which follows provides information about the responsibilities of health authorities, the duties of members, appointment procedures and criteria for membership, both under the present system and under the proposals put forward in *Working for Patients*. The overall results of the membership survey are included in the body of the report, together with a summary of attempts made by health authorities to nominate and appoint black and ethnic minority members.

2.2 A chapter is included about membership nomination forms which the Task Force examined, and about the organisations invited to submit nominations. Some of the major issues raised during the survey are addressed, such as whether black and ethnic minority members are 'representatives' of their communities; whose responsibility it is to achieve a balanced membership; and weaknesses of the present nomination system so far as black and ethnic minority membership is concerned.

The report warns that these might be accentuated by the white paper proposals for future membership. Recommendations to appropriate bodies follow from the conclusions to the report.

2.3 There are three appendices. Appendix I provides the questionnaire and briefing note supplied to health authorities. The bulk of the survey findings are to be found in Appendix II, which includes the survey responses for each region and district. Appendix III reports the attempts which individual authorities had made, successfully or otherwise, to nominate and appoint black and ethnic minority members.

3 MEMBERSHIP: THE PRESENT SYSTEM

3.1 This section of the report describes the membership system in operation at the time of the survey and provides a background to the conclusions and detailed results reported in appendix II.

3.2 Overall responsibility for the NHS rests with the Secretary of State for Health who, with the NHS Policy Board, determines national policy. The operation and management of the health service rests with the NHS Management Executive, which reports to Ministers and the Policy Board. The provision of health care services is through 14 regional health authorities (RHAs) and 190 district health authorities (DHAs).

3.3 Each RHA and DHA has a chair and about 16–19 members. Chairs receive a part-time salary and members are paid expenses. The membership of both RHAs and DHAs comprises professional, local authority and generalist 'lay' members. There are normally four to six professional members, about four local authority members, and about eight generalist members. Professional members include medical, nursing and trades union representatives, and university members where the authority has teaching and research responsibilities. Local authority members may be elected councillors or others nominated by local councils. Generalist members can include anyone qualified for membership (see below) with an interest in health service provision.

3.4 The Secretary of State appoints the chair of both RHAs and DHAs, and RHA members. DHA members are appointed by the RHA.

CHAIRS

3.5 The Secretary of State appoints chairs after consultation with appropriate bodies and individuals, although this is not a statutory requirement.

The procedures adopted for appointing chairs are dependent to a certain extent on the preferences of individual Secretaries of State.

REGIONAL HEALTH AUTHORITIES

3.6 The 14 RHAs have responsibility for overseeing health service provision by DHAs, in accordance with national policies and objectives set by the Management Executive. They are primarily responsible for strategic planning, determining priorities, allocating resources to their DHAs, and monitoring their performance. RHAs themselves provide some services such as blood transfusion and ambulance services. They also recruit and employ consultant medical staff for DHAs, and can be involved in discipline and grievance matters relating to districts.

3.7 RHA members are appointed by the Secretary of State normally for a four year (renewable) term of office. About a third of RHA members are appointed from local authority nominations. The remainder are professional and generalist appointments. RHA members do not necessarily have to have had prior service as DHA members.

Appointments procedure

3.8 The National Health Service Act 1977 obliges the Secretary of State to consult before appointing RHA members. The law requires consultation with local authorities, universities, trades union and professional organisations, but in practice a wider range of organisations is included. The organisations approached for nominations include five representing women's interests – the Equal Opportunities Commission, the National Women's Commission, the Fawcett Society, the National Association of Professional Women and Soroptimists International. Two organisations representing black and ethnic minority interests are included – the Commission for Racial Equality (CRE) and the Overseas Doctors Association.

3.9 Although the Department of Health appointments unit writes annually to these organisations requesting nominations, they can be made at any time. Nor are nominations restricted to those formally consulted – *any individual or organisation can nominate potential members for all health authorities, including by self-nomination*. The department's appointments unit maintains a databank of nominees and will pass them to RHAs for consideration for RHA or DHA membership. There is a simple nomination form which seeks personal details of the nominee (name, address, occupation and so on) plus their experience of NHS, local authority, voluntary or other work.

3.10 The form does not ask for the sex or ethnic origin of a nominee. The department, and RHAs, are therefore unaware of the colour or ethnic origin of nominees except in so far as this can be deduced from their name. The sex of nominees is more easily ascertained from their name and designation (Mr, Miss, Ms).

3.11 All nominations are forwarded to RHA chairs who recommend a choice of potential RHA members to the Secretary of State. No guidance is issued to RHAs about selection and the method adopted depends on individual chairs. In practice, many of them interview nominees. Several organisations contacted about this paper suggested that greater consistency of approach, with clear guidelines for RHAs about selection methods, would be helpful.

DISTRICT HEALTH AUTHORITIES

3.12 DHAs are responsible for administering health services in their district, taking strategic policy and planning decisions and determining priorities in the light of local conditions. Members do not become involved in operational management but they are responsible for appointing senior managerial staff and monitoring their performance. The role and membership of DHAs is subject to the 1977 Health Services Act (amended in 1989) amplified by guidance in DHSS circular HC(81)6, *Health Service Management: The Membership of District Health Authorities*.

3.13 DHA members are appointed by the RHA for a four year (renewable) term of office. The professional members of DHAs include a hospital consultant, a GP, nurse and trades union representatives and a university nominee (where there is a medical or dental school in the district). About four members are nominated by local authorities and the remainder are generalist members. Nominations for DHA membership should be made to the chair of the relevant RHA.

Duties of members

3.14 The duties of members include attending authority, committee and other meetings; visiting health authority units/departments to meet with staff and patients; keeping an eye on services provided and the quality of care; sitting on appointments, disciplinary and other panels, including those dealing with complaints by patients; liaison with other bodies, including consultation and joint planning with local authorities; and a wide range of other duties in which members may be called upon to become involved either on a regular basis or from time to time.

Qualifications/Criteria for DHA membership

3.15 The members of a DHA should normally live or work in its area, although others with close associations with the health services in a particular district may be considered. NHS employees may not normally serve on the authority which employs them, nor can members serve on a Community Health Council (CHC) and an authority concurrently. Experience of management or administration in the public or private sector or of interest in particular health services, such as mental health, are looked for. Circular HC(81)6 draws attention to the need for a reasonable geographic balance and for younger members, and also advises RHAs to bear in mind 'a reasonable balance of age and sex . . . and, in appropriate cases, suitable representation of ethnic minorities'.

3.16 Members need to be able to give sufficient time to DHA work, normally about two to four days a month, some of which will be within normal working hours. Some employers allow time off with pay for members to attend to DHA business. Otherwise the expenses which members can claim allow for loss of earnings.

Appointments procedure

3.17 No central guidance is issued to RHAs as to selection procedures for DHA members, and these vary from region to region. Often the RHA chair will interview nominees. There is a statutory requirement (National Health Service Act 1977, Schedule 2) to consult professional bodies, trades unions and local authorities about potential membership, and circular HC(81)6 advises RHAs also to invite CHCs to submit recommendations for membership. In practice, many RHAs consult a wide range of local organisations and individuals. Some RHAs said that they included local Community Relations Councils (CRCs) and ethnic minority organisations in the consultation process. The names of individual nominees and self-nominees (see paragraph 3.9) will also be available.

4 SURVEY METHODOLOGY

4.1 A short questionnaire was sent in April 1989 to the chair of each of the 14 regional and 190 district health authorities in England. Special health authorities, whose members are appointed by the health minister, and authorities in Wales and Scotland which have different organisation, were not included in the survey. The questionnaire and briefing note which accompanied it are reproduced in appendix I.

4.2 The questionnaire asked chairs to specify the sex and ethnic origin of their health authority members, and to say whether their authority had made any specific attempts to find and nominate black and ethnic minority members. Those authorities which had made such attempts were asked to state the methods used and whether they had resulted in nominations and/or membership. It was left to chairs to decide, in the light of their circumstances, whether to ask members to self-classify their ethnic origins or to complete the questionnaire from their personal knowledge of members. Only one health authority said that it found this decision difficult. No complaints were received about the survey and no health authority reported difficulty in completing the questionnaire.

4.3 The survey was designed to minimise the time required of health authorities to respond. Follow-up enquiries were kept to a minimum. On one or two points this has resulted in incomplete data. Such instances are noted in the report.

4.4 Discussions were held with the Department of Health members appoints unit and with some black health authority members. The views of the National Association of Community Relations Councils, Greater London Action for Racial Equality and the Association of Community Health Councils in England and Wales were sought. The CRE was also approached for information. The Task Force would like to thank all those who contributed to the survey, particularly the health authorities which completed the questionnaire. It welcomed approaches from authorities which expressed interest in the survey and indicated that they would act on the results.

5 RESPONSE RATE

5.1 All but one of the 14 RHAs completed the questionnaire, as did 183 of the 190 DHAs, giving a response rate of 96 per cent. The authorities which did not participate in the survey were:

Region: Mersey

Districts: Doncaster, East Berkshire, East Birmingham, Huddersfield, Sheffield, West Norfolk and Wisbech, Worcester

We regret that these authorities, some of which are responsible for health service provision to substantial multi-racial, multi-cultural populations, did not respond to enquiries about an equal opportunities issue. We hope that they will nevertheless act upon our recommendations.

6 RESULTS OF THE SURVEY

6.1 This chapter provides an overall analysis of health authorities in respect of black and ethnic minority representation and their composition by gender. The results for individual regional and district authorities are presented in appendix II.

REGIONAL HEALTH AUTHORITIES

Membership: ethnic origins

6.2 All the RHA chairs were white. Seven of the 208 RHA members (3 per cent) were from black and ethnic minority groups. The ethnic origins, sex and type of membership of ethnic minority members are given in appendix II.

Membership: gender

6.3 There was one female RHA chair. Seventy-two of the 208 RHA members (35 per cent) were women.

Type of RHA membership by gender

	Men (%)	Women (%)	Total
Professional	44 (80)	11 (20)	55
Local Authority	28 (53)	25 (47)	53
Generalist	64 (64)	36 (36)	100
TOTALS	136 (65)	72 (35)	208

DISTRICT HEALTH AUTHORITIES

Membership: ethnic origins

6.4 All the 181* DHA chairs were white. Eighty-nine (3 per cent) of the 2974 members were from black and ethnic minority groups. There were 80 DHA members of Asian, Caribbean and African ethnic origin. There was only one region (Wessex) which had no-one from an ethnic minority group among its DHA members, although some other regions had very few and one other region (East Anglia) had no members of African, Asian or Caribbean ethnic origin.

* There was one chair vacancy and one chair did not specify ethnic origin.

Black and ethnic minority DHA members: gender and ethnic origins

	Men (%)	Women (%)	Total
Caribbean	12 (50)	12 (50)	24
African	4 (67)	2 (33)	6
Asian	39 (78)	11 (22)	50
Other	9 (100)	—	9
TOTALS	64 (72)	25 (28)	89

Black and ethnic minority members: type of membership by gender

	Men (%)	Women (%)	TOTAL
Professional	21 (84)	4 (16)	25
Local Authority	10 (67)	5 (33)	15
Generalist	33 (67)	16 (33)	49
TOTALS	64 (72)	25 (28)	89

6.5 The majority of black and ethnic minority professional members served in authorities in the Midlands and North of England – 19 of the 25 professional members were from the Northern, North Western, Yorkshire, Trent, West Midlands and Mersey regions. Local authority members were mostly from authorities in the South of England – nine of the 15 black and ethnic minority local authority members were from the four Thames and Oxford regions.

Membership: gender

6.6 One hundred and fifty-one of the 180* DHA chairs were male (84 per cent) and 29 were female (16 per cent). Two regions (East Anglia and Wessex) had no female chairs. The proportion of female chairs varied widely, the highest being in the Northern (5 out of 16), Oxford (2 out of 7), and Trent (3 out of 10) regions (all about 30 per cent).

6.7 Nine hundred and ninety-six of the 2959† DHA members (34 per cent) were women. The proportion of female DHA members varied from 39 per cent (North West Thames region) to 28 per cent (West Midlands region).

* There was one vacancy and two chairs did not identify their gender.
† One DHA supplied the ethnic origins but not sex of members.

Type of DHA membership by gender

	Men (%)	Women (%)	Total
Professional	618 (79)	163 (21)	781
Local Authority	507 (64)	290 (36)	797
Generalist	835 (61)	543 (39)	1378
TOTALS	1960 (66)	996 (34)	2956*

* Type of membership was not supplied for three members

7 POPULATION COMPARISON

7.1 The most recent Labour Force Survey[2] indicates that in Great Britain 51 per cent of the population are female and 49 per cent male, and that about 4.5 per cent of the population are from black and ethnic minority groups. Within the ethnic minority population, 51 per cent are estimated to be of Asian ethnic origin (including Indian, Pakistani and Bangladeshi), 21 per cent of Caribbean ethnic origin (including West Indian and Guyanese), 4 per cent of African ethnic origin, and 24 per cent from other ethnic minority groups.

7.2 The black and ethnic minority population is concentrated in certain areas, with 69 per cent of the ethnic minority population compared to 31 per cent of the white population living in metropolitan counties. The proportion of the ethnic minority group population in metropolitan counties is Greater London 15 per cent, West Midlands 13 per cent, West Yorkshire 7 per cent and Greater Manchester 5 per cent.

7.3 Details of the proportion of local populations of ethnic minority origin are available from one or more of the following sources:

- Office of Population, Census and Survey (OPCS) census statistics;
- Labour Force Survey HMSO (published annually);
- Ethnic Minorities in Britain: statistical information on the pattern of settlement, CRE;
- local authorities;
- the CRE and local CRCs.

8 SURVEY: CONCLUSIONS

Membership: ethnic origins

8.1 The proportion of black and ethnic minority RHA and DHA health authority members was about 3 per cent whereas the proportion of ethnic minority groups in the total population is in the region of 4.5 per cent.* There were no black or ethnic minority health authority chairs. The survey therefore indicated under-representation of black and ethnic minority communities on health authorities. The overall figures however hide greater inequalities. Many health authorities which serve areas with substantial multi-racial, multi-cultural populations had no black or ethnic minority authority members. Few had more than one such member.

8.2 Six of the 13 regions and 66 of the 183 districts which responded to the survey included black and ethnic minority members. However, only one RHA (North West Thames) and 17 DHAs had more than one such member. The 17 DHAs were predominantly in areas with significant black and ethnic minority populations in London, Birmingham, Bristol and the North West.

8.3 The proportions of black and ethnic minority DHA members of Asian and Caribbean ethnic origin roughly mirrored the proportions of these groups in ethnic minority populations. However, whereas members of Caribbean ethnic origin were equally divided between men and women, 78 per cent of members of Asian ethnic origin were men and only 22 per cent women. (The number of members of African and other ethnic minority group origins was too small to draw a reliable conclusion.)

8.4 The proportion of black and ethnic minority DHA members who were professional members (28 per cent) was nearly the same as the proportion of professional members in total (26 per cent). Black and ethnic minority professional members were however better represented in the Midlands and North of England than in the South. The proportion of black and ethnic minority members nominated by local authorities (17 per cent) was lower than the proportion of local authority nominees overall (27 per cent), and they were concentrated in the South of England. Conversely, the proportion of black and ethnic minority

* Population figure relates to Great Britain; the survey was of health authorities in England, for which separate ethnic breakdown figures are not available.

generalist members (55 per cent) was higher than this type of membership overall (47 per cent). Different demographic patterns must be borne in mind, particularly in looking at local authority and generalist membership. Many authorities do not have significant black and ethnic minority populations in their catchment area.

8.5 The under-representation of black and ethnic minority members underlines the responsibility for *all* members, and not only those from ethnic minority communities, to ensure that they are fully aware of the health care needs of their local black and ethnic minority populations, satisfy themselves that these are adequately met, and ensure that procedures are introduced for identifying and tackling racism and discrimination within the authority.

Membership: gender

8.6 Women too are under-represented on health authorities, with a female membership of 34 per cent against 51 per cent of the total population. The under-representation is accentuated amongst chairs, where only 16 per cent are women. This is despite efforts made by the department to increase the proportion of women on health authorities.

8.7 Whereas 34 per cent of all health authority members are women, a still smaller proportion of black and ethnic minority members – 28 per cent – are women.

8.8 The proportion of women DHA members who are local authority members (29 per cent) is similar to the proportion of local authority members overall (27 per cent). With generalist members, the proportion of women members is higher (55 per cent) than the proportion of generalist members overall (47 per cent). The proportion of women professional members (16 per cent) is, however, considerably smaller than the total proportion of professional members (26 per cent).

8.9 Many of the disparities reported reflect the discrimination and disadvantage which women and members of black and ethnic minority groups face in other areas of life. Greater effort by way of redress will be required by health authorities if their composition is not to compound, or even enhance, inequalities elsewhere.

9 ATTEMPTS TO NOMINATE BLACK AND ETHNIC MINORITY MEMBERS

9.1 Three of the 13 RHAs and 35 of the 183 DHAs which responded to the survey said that they had made attempts to find and nominate black and ethnic minority members. These figures include only those authorities which answered question 4 of the questionnaire affirmatively. Numerically the results of this part of the survey must be interpreted with considerable caution. Some authorities which said that they had made such attempts referred, for example, to the inclusion of the CRE amongst the organisations invited to nominate members. Other authorities, whose regional distribution lists showed that they did the same, answered question 4 negatively.

9.2 The main purpose of this part of the survey however was to identify which methods authorities had used to nominate black and ethnic minority members, whether they had been successful or not, and to identify good practice.

9.3 Overwhelmingly authorities relied upon the CRE and local CRCs to nominate black and ethnic minority members. The Overseas Doctors Association was the only other relevant national organisation regularly invited to nominate. Many authorities reported that these approaches had not resulted in nominations or appointments. In some cases, the Community Relations Officer had become a member of the authority.

9.4 Approaches to the CRE and CRCs were in the main restricted to inclusion in the list of organisations to whom the invitation to nominate was submitted. Some authorities had however made more specific contacts with their local CRC. These varied from personal requests to the CRC to submit nominations (rather than merely sending a circularised letter) to regular contacts with CRC members or officials to stimulate interest in health authority business. One authority held quarterly meetings with representatives of the CRC and other ethnic minority organisations, another circulated the agenda for authority meetings to the CRC. One chair had become a CRC committee member. Some, but not all, of these approaches had resulted in greater interest in nominating potential health authority members.

9.5 Only a few authorities had made contacts with black and ethnic minority community organisations other than the CRC. One authority had, however, written to all ethnic minority organisations in its area

requesting nominations, although without success. The chair of one authority attended conferences on equal opportunities issues, in part as a means of meeting potential nominees for membership.

9.6 Some authorities used press advertisements to invite nominations for membership. In at least one case this was a conscious attempt to ensure that the nomination process was made known widely to all sections of the public, but it had not been successful in attracting applications from among black and ethnic minority communities. Two authorities had used, or were thinking of using, ethnic minority publications for similar advertisements.

9.7 Authorities failing to attract black and ethnic minority nominations by other means had fallen back on personal contacts with individuals. These tended to be with 'community leaders', churches, local councillors and MPs. Some authorities relied solely upon such means. Whilst these methods appeared to be more successful in achieving black and ethnic minority membership, they restricted the range of individuals likely to be approached about nomination. Those authorities which reported success through personal contacts also appeared to be those most determined to achieve ethnic minority membership.

9.8 Only one authority reported that it had used its community health service contacts to seek to identify suitable black and ethnic minority nominees. This proved successful.

9.9 A number of DHAs which had made attempts to ensure that their RHA received black and ethnic minority nominations reported that no appointments had ensued. This complaint was also made by CRCs. Other authorities reported that although black and ethnic minority members were nominated and appointed, they had subsequently been obliged to withdraw, often because of heavy commitments to other organisations.

10 RHA NOMINATION FORMS

10.1 The Task Force obtained copies of the DHA nomination form from 10 of the 14 RHAs. These sought a fairly standard range of information, similar to that requested by the department's appointments unit. Besides personal details (name, age, employment and so on), the forms required some biographical information about nominees' experience in

public service, local authorities or voluntary organisations, and any particular field of interest in the health service. The forms examined were not complex or difficult to complete, although they differed greatly in their professionalism and the range of appropriate information they were likely to elicit.

10.2 The nomination form for one RHA could potentially deter some black and ethnic minority nominees. Listed with examples of appropriate voluntary sector experience were 'immigrant bodies'. The vast majority of black and ethnic minority voluntary organisations would not regard themselves as 'immigrant bodies'. Such terminology indicates a poor understanding of the nature of the black and ethnic minority populations (almost half of whom were born here) and would be regarded by many as offensive.

10.3 Only one nomination form, that of the North Western Region, asked for the ethnic origin of nominees. A section of their form, headed 'Monitoring of Appointments' stated:

> The Regional Health Authority is committed to the development of equal opportunities policies in relation to delivery of health services and to assist the Authority to monitor the nomination and appointment process, and for that purpose only, organisations or individuals making nominations are requested to complete the following question. How would you describe your ethnic origin (Please tick)

The categories listed were Afro-Caribbean, African, Asian, European (including UK), Other (please specify).

The RHA said that no objections had been received to the inclusion of this question and it was completed for most nominations.

10.4 A minority of the nomination forms were accompanied by some explanation of DHA membership. These varied from a photocopy of the statutory regulations listing disqualifications for membership, to notes specially prepared for potential members about the criteria for membership, duties of members and the time involved. In two cases, effort had been made to ensure that information was 'user friendly'.

10.5 No information sent to organisations and potential nominees specifically encouraged applications from black and ethnic minority communities. Only one authority (South Western RHA) included the reference in circular HC(81)6 to the need for suitable representation of ethnic

minorities in appropriate areas. Two RHAs' explanatory notes paraphrased the wording of the circular in pointing out that RHAs were required to bear in mind a reasonable balance of members by geography, sex and age, but omitted the accompanying reference to ethnic minority representation.

11 ORGANISATIONS CONSULTED

11.1 RHAs also provided lists of organisations consulted about membership. Besides professional bodies, these normally included a wide range of voluntary organisations such as the Red Cross, Age Concern, mental health and disability organisations, Townswomen's Guilds and Women's Institutes. Most of the voluntary organisations routinely consulted were from the traditional 'white' voluntary sector, and some are known to be concerned themselves about their under-representation within black and ethnic minority communities.

11.2 With one exception, consultation with organisations specifically related to black and ethnic minority interests was restricted to the CRE, CRCs, and the Overseas Doctors Association. One RHA included a local Afro-Caribbean Association. Not all RHAs consulted CRCs in addition to the CRE, and few consulted all their local CRCs.

12 CONCLUSIONS: SEEKING BLACK AND ETHNIC MINORITY NOMINEES

12.1 Although authorities relied upon the CRE and CRCs to provide black and ethnic minority nominations, in practice the CRE told the Task Force that they had made no nominations for health authority membership for two years. They are now revising their procedures. The CRE confirmed also that enquiries amongst a number of CRCs showed that they also had not put forward nominees. Some CRC officers said that they had ceased to put names forward because their previous nominations had been unsuccessful.

12.2 The CRE is a national organisation whose function is not to 'represent' black and ethnic minority communities. It has a legitimate interest in campaigning for adequate black and ethnic minority representation on public bodies. It should also use its extensive contacts

to nominate members to health authorities and take up any cases where it is told of reluctance to appoint black and ethnic minority members. On the other hand, the CRE has a wide range of responsibilities and cannot be regarded as the sole or prime source of black and ethnic minority nominations.

12.3 Nor can CRCs be regarded as the only local source of black and ethnic minority nominations. They also have wide-ranging duties and, in practice, receive a large number of similar demands for representation. Reliance on the CRE and CRCs for black and ethnic minority nominees will not only have reduced the total number of such nominations but will have restricted the range of nominees. Moreover, because the CRE and CRCs receive many similar requests, those they nominate are likely to have existing commitments. This may restrict the time which appointed members are able to allocate to health authority business and, irrespective of their interest or commitment, may mean that they are unable to attend meetings, devote adequate time to their duties, or have to withdraw.

12.4 If health authorities are not to be dependent on the CRE and CRCs, the alternative is to involve the wide variety of voluntary organisations which exist in black and ethnic minority communities, particularly in metropolitan areas. Some of them have been formed specifically to cater for the health and welfare needs of their communities. The local CRC should be able to provide details of such organisations. It is however the responsibility of health authorities to find out about such groups, make contacts with them and ensure that they are invited to submit nominations for membership. Regular contacts with such groups – which should in any case form part of any adequate system of assessing local satisfaction with health services – is more likely to yield nominations than a formal approach once a year.

12.5 Health authorities must ensure that organisations invited to nominate members are fully informed about the criteria for membership, categories of persons who are not qualified, the duties of members, the time likely to be required, frequency and times of meetings, the payment of expenses and possibility of employers granting paid time off work, and the potential for influencing the local provision of health care. The more that information of this kind is made readily available, the easier it will be for organisations to nominate people for health authority membership who are eligible to serve, aware of the commitment involved, and with a contribution to make to this aspect of public life.

12.6 Health authorities should also use their own contacts to identify potential members. One authority had successfully appointed an ethnic minority member through its community service provision. Many authorities employ significant numbers of employees from black and ethnic minority communities who also may have relevant contacts.

12.7 Nevertheless, authorities should be aware that a smaller proportion of the black and ethnic minority than white population may be in a position to offer themselves for membership. The Labour Force Survey confirms that black and ethnic minority employees are concentrated in a narrower range of occupations than white employees, and in lower paid jobs. They may find it more difficult to get paid time off from work or afford loss of earnings. Those who are self-employed are more likely to be working in small businesses which are less well established, and thus more difficult to leave. Authorities genuinely concerned to achieve black and ethnic minority membership may have to consider whether their present arrangements for meetings and the conduct of business are suited to the circumstances of all their local populations.

12.8 The need to provide information applies to the appointment as well as nomination stage. Black and ethnic minority communities are under-represented, not only on health authorities, but in public life generally. If the health authority is successful in drawing in to membership a wider range of individuals from ethnic minority communities, they may lack experience of similar bodies. Newly appointed members may require briefing about methods of conducting business, committee structures and decision-making processes additional to that normally provided. Ensuring that members fully understand the authority and their role will enable them to make their maximum contribution.

12.9 Effort must also be made to retain members from ethnic minority communities. Black and ethnic minority members, particularly if they are the only such members, may need support. Members who feel isolated or that their interests are marginalised may come to regard their appointment as 'tokenistic'. If they feel that the authority is not interested in their contribution or takes no action when legitimate concerns are expressed, they are unlikely to remain in membership. Finally, it would be unrealistic to expect black and ethnic minority members to continue in membership of an authority which is not perceived as seeking actively to implement an effective equal opportunities policy in both its employment and service provision.

13 ISSUES ARISING FROM THE SURVEY

Representation

13.1 Health authority members do not represent any section of the community. This was emphasized by several authorities in explaining the absence of black and ethnic minority members. Nevertheless some authorities clearly took a different view, referring to 'sufficient representation for the population' and seeking a member 'to represent ethnic minorities to replace a vacancy'.

13.2 It would indeed be impossible for one member to represent the interests of all ethnic minority communities. There is no reason why a health authority member of Caribbean ethnic origin should be any more knowledgeable about the culture and health care needs of the African, Asian or Chinese communities than a white member, yet this is commonly expected. The Task Force welcomed the comments of one DHA chair who pointed out that 'it is the duty of all members to look after the health care needs of all sections of the population'.

13.3 However whilst health authority members do not function as representatives, the composition of the authoity should reflect the community which it serves. An authority composed entirely of white members responsible for health service provision to multi-racial, multi-cultural communities will lack credibility. A number of authorities in responding to the survey rightly drew attention to their equal opportunities policy. Black and ethnic minority communities will however be sceptical about claims to be 'working towards equal opportunities in employment and service provision' if this is not seen to have taken effect amongst those who have ultimate responsibility for the authority's equal opportunities policy.

13.4 Ethnic minority members can moreover bring an essential extra dimension to health authority business. A health authority which has only white members may by default be failing to provide appropriate health care for all sections of its population. One RHA pointed out that it was only when their first ethnic minority member was appointed that they began to give real consideration to the implementation and effectiveness of their equal opportunities policy in respect of both employment and service provision, and to the composition of their DHAs. All black and ethnic minority communities share experiences of racism and discrimination, which includes the expectation that they should make do

with services which are planned, resourced and delivered with the needs of the majority white population solely in mind. Until all health authority members and managers take equal opportunities issues seriously on board, it may only be the presence of a member who is not from the majority white community which leads an authority to consider the relevance of its work to all its local communities and hence the overall effectiveness of its health care provision.

13.5 It is, furthermore, not only in areas with substantial ethnic minority populations that black and ethnic minority nominees should be considered. Many authorities said that black and ethnic minority membership was not relevant because their population was predominantly white; others claimed that the balance of their membership was right given the composition of their population. Some such authorities could have a tendency to regard black and ethnic minority members as 'representatives' and, therefore, not always consider their nominations by the same criteria as potential white members.

13.6 Other authorities pointed out that ethnic origin was not an issue since members were selected solely for their personal qualities and the contribution they could make to the authority's business. If however the possibility of serving in a health authority is not known to members of local black and ethnic minority communities, the possibility is lost that a particular skill may be obtained from amongst them rather than from a white nominee.

Membership: whose responsibility?

13.6 Many DHAs pointed out that the appointment of members was not their responsibility but that of the RHA, and one said that it was not their policy to nominate members. One RHA said that they were dependent on the department's appointments unit. On the other hand some authorities clearly regarded membership, and its composition, as their responsibility. One RHA had specifically drawn to the attention of selected DHAs their need to seek out and nominate potential ethnic minority members, and a significant number of DHAs in this and other regions had clearly made attempts to do so. As paragraph 9.9 has indicated, several DHAs said that they had put forward black and ethnic minority nominees who had not been appointed by the RHA.

13.7 Nationally, the Department of Health appointments unit should monitor the composition of health authorities and take appropriate

remedial action if overall representation of black and ethnic minority communities is inadequate. The unit also has particular responsibility for chair and RHA member appointments. It would be unreasonable, however, to expect them to seek out black and ethnic minority nominations for individual DHAs. Nor can this be left entirely to RHAs, which cover a wide geographic area. If an authority does not reflect its population, that is the DHA's problem. They have local knowledge and should make appropriate contacts to ensure that an adequate number of suitable nominations is available to the RHA from all sections of their population. They should also, where necessary, emphasize to the RHA the importance of making appointments from black and ethnic minority communities and RHAs should be receptive to this.

14 THE WHITE PAPER: CHANGES TO MEMBERSHIP

14.1 *Working for Patients* stresses that chairs and members of health authorities will continue to have a vital role in the management of the NHS. The proposals involve changes to RHA and DHA membership and envisage governing bodies for self-governing hospitals.

Regional and district health authorities

14.2 The new health authorities will be smaller and will for the first time include management members. Each authority will have five non-executive and up to five executive (management) members, with a non-executive chair. Local authorities will no longer nominate members. Authorities will not have a representational role and local community and consumer interests will be channelled through CHCs.

14.3 Chairs and other non-executive members of RHAs will continue to be appointed by the Secretary of State; RHAs will appoint non-executive members of DHAs. Non-executive members will be selected solely for the skills and experience they can bring to the authority, particularly in business, managerial and contractual fields.

14.4 Executive members of health authorities will include their general manager and finance director. Other executive members will be selected by the chair and non-executive members together with the general manager.

Self-governing hospital trusts

14.5 Each self-governing hospital or hospital trust will have a board of directors responsible for overall policy, performance and financial viability. The board will have an equal number of executive and non-executive members with a non-executive chair appointed by the Secretary of State. The chair and non-executive members will be appointed for four year renewable terms of office. Non-executive members will be selected for the contribution they can make to the management of the trust. At least two members will be drawn from the local community and appointed by the RHA. Other non-executive members will be appointed by the Secretary of State in consultation with the chair.

14.6 Executive members of hospital trusts will include the general manager, medical and nursing directors and the finance director.

Working for Patients: effect on black and ethnic minority membership

14.7 The effect of the white paper proposals will be to reduce the size and change the type of membership. Half of health authority and hospital trust members, the executive members, will be drawn from senior management of the NHS. No ethnic origin breakdown is available for this group. It is known, however, that black and ethnic minority managers are under-represented in the service as a whole, compared with the ethnic composition of the total workforce of the NHS or with the proportion of the population which comes from black and ethnic minority groups. There is no black or ethnic minority member of either the NHS policy or management boards; no black or ethnic minority regional or district general manager; not many black and ethnic minority members of regional and district management boards. It is likely, therefore, that there will be substantial under-representation of black and ethnic minority communities among health authority and hospital trust executive members.

14.8 It will be of correspondingly greater importance to ensure that black and ethnic minority non-executive members are well represented. Positive action will be required to ensure that this is achieved. Non-executive members will be selected for the contribution they are able to make to the authority, or the self-governing hospital trust, particularly in business, finance, management and contractual fields. The Labour Force Survey demonstrates that the black and ethnic minority population, and particularly black women, are under-represented in the types of occupation in which such experience is developed.

14.9 There are, however, practical steps which can be taken to ensure that black and ethnic minority involvement in the running of the NHS is not reduced. Firstly, non-executive members should be sought from the growing black business community. Some local authorities have black business development units. Other organisations invited to submit black and ethnic minority nominations should have their attention drawn particularly to the new criteria for membership.

14.10 Secondly, remedial action should be taken to address the under-representation of black and ethnic minority senior managers in the NHS. There are significant numbers of black and ethnic minority employees in the service. The Race Relations Act (Section 38(1)(2)) makes specific provision for training to be provided for employees from specified racial groups who are under-represented in particular kinds of work. Advantage should be taken of these provisions.

14.11 Health authorities should therefore realise that opening up their membership to nominees from black and ethnic minority communities is not a once-for-all matter. Developments such as are envisaged in *Working for Patients* means that continuing attention will be needed to the composition of the bodies which run the health service if it is to meet the needs and aspirations of the whole community, including black and ethnic minority groups, command their confidence and make full use of the knowledge and skills, as well as the drive and enthusiasm, which they have to offer.

RECOMMENDATIONS

The recommendations which follow relate to the Task Force remit of helping health authorities to tackle racial discrimination. Many of them may, however, be able to be adapted to the parallel field of ensuring equal opportunities on grounds of gender, and further guidance may be sought from the Equal Opportunities Commission.

The Department of Health

1 Include a question about ethnic origin, with an appropriate explanation, on their nomination form for health authority membership.
2 Monitor the composition of health authorities and the boards of directors of hospital trusts by ethnic origin and take remedial action if black and ethnic minority members are under-represented compared to their representation in the population.

3 Ensure that black and ethnic minority populations are appropriately represented amongst RHA members, health authority chairs, and on boards of directors of hospital trusts.
4 Include national black and ethnic minority organisations, in addition to the CRE and Overseas Doctors Association, amongst those invited to submit nominations for RHA membership and consulted about chair appointments.
5 Ensure that the proportion of black and ethnic minority health authority members is not reduced under revised membership arrangements set out in *Working for Patients*.

Regional health authorities

1 Include a question about ethnic origin, with an appropriate explanation, on their nomination forms for health authority membership.
2 Monitor the composition of DHAs in the region by ethnic origin and take remedial action if black and ethnic minority members are under-represented compared to their representation in the region and locally in individual DHA areas.
3 Where black and ethnic minority members are under-represented, either in individual DHA areas or in the region overall, make clear in any advertisements for nominations, in letters to nominating organisations, literature accompanying nomination forms and so on, that black and ethnic minority nominations will be particularly welcome.
4 Include black and ethnic minority community groups and all local CRCs amongst organisations invited to submit nominations for membership.
5 Supply information about membership to nominating organisations – about criteria for membership, duties of membership, time required to allocate and payment of expenses – in a 'user friendly' format.
6 Ensure that black and ethnic minority communities are appropriately represented amongst members they appoint to the boards of directors of hospital trusts.

District health authorities

1 Make clear to the department or appropriate RHA the authority's need for membership to reflect the ethnic composition of the local population and draw to their attention any inadequate representation of black and ethnic minority communities.
2 Compile a list of local black and ethnic minority organisations to be invited to submit nominations for membership and supply details to the RHA. Maintain regular contact with such groups and encourage them to submit nominations.

3 If black and ethnic minority members are under-represented compared to the local population, submit nominations from these communities to the RHA.
4 Consider whether the arrangements for authority business – time of meetings, payment of expenses and so on – are such as to enable all sections of the population to become involved in membership.

Hospital trusts

1 Ensure that black and ethnic minority communities are appropriately represented on the board of directors of the trust.

The Commission for Racial Equality

1 Seek information from the department about the composition of health authorities and hospital trusts by ethnic origin and draw to the attention of the Secretary of State any under-representation of black and ethnic minority communities.
2 Provide the department's appointments unit with a list of national black and ethnic minority organisations to be consulted about health authority membership.
3 Provide the department's appointments unit with nominations for RHA membership and chair appointments, on a regular basis.
4 Encourage CRCs to submit nominations for membership and to campaign with their DHA for appropriate black and ethnic minority representation.
5 Follow up this survey in two years' time to measure the effect of changed health authority membership proposals on levels of black and ethnic minority membership, and take action as appropriate.

Community relations councils

1 Ensure that the CRC is on the list of organisations invited to submit nominations for DHA membership, and submit nominations.
2 Provide a list of black and ethnic minority organisations to the RHA and request that they are invited to submit nominations for DHA membership in addition to the CRC.
3 Encourage local black and ethnic minority organisations to submit nominations.
4 If black and ethnic minority members are under-represented on the DHA, campaign with the RHA and the DHA for appropriate representation.

Black and ethnic minority organisations

1 Ask to be included on the RHA's list of organisations consulted about membership, and submit nominations.

APPENDIX I

KING'S FUND EQUAL OPPORTUNITIES TASK FORCE

Survey of health authority membership

BRIEFING NOTE

The Task Force

The Equal Opportunities Task Force was set up in 1986, funded jointly by the Department of Health and the King's Fund, to 'help health authorities to tackle racial discrimination'. The Task Force has published guidance about the development of equal opportunities employment policies and provides advice to individual health authorities. A list of Task Force members is attached. The Task Force works closely with the National Steering Group on Equal Opportunities for Women in the NHS and the National Association of Health Authorities (NAHA) Working Party on health services for black and ethnic minority groups.

The Survey

The Task Force is undertaking a survey to find out about black and ethnic minority membership of health authorities.

DHSS circular HC(81)6 on the membership of health authorities advised that a reasonable balance of members should include, in appropriate areas, a suitable representation of black and ethnic minorities. A recent report by NAHA 'Action not Words – A strategy to improve health services for black and ethnic minority groups', draws attention to the under-representation of black and ethnic minority health authority members, as well as the need for wider minority community representation on FPCs. There are, however, no statistics available.

The NHS white paper, 'Working for Patients', proposes changes to health authority membership. Authorities will need to ensure that black and ethnic minority communities are properly represented under the new arrangements. Our survey will establish the facts about present authority membership and provide a measure against which future ethnic minority participation can be assessed.

We are also asking about methods which have proved successful in attracting nominations from black and ethnic minority communities. Those health authorities which have made specific attempts to recruit black and ethnic minority members have met with varying degrees of success. We hope that this part of our survey will assist regional health authorities not

only to identify black and ethnic minority members for the new health authorities, but also with their new responsibilities for FPC membership.

Methodology
A short questionnaire is being circulated to each health authority seeking an ethnic breakdown of health authority membership, together with methods used to identify black and ethnic minority members and their success. Although the survey will report the position in health authorities, the information about the ethnic origins of health authority members will not identify individual members and will be used for statistical purposes only; names are not requested.

The results of the survey will be published to enable authorities to share their experience and to identify good practice. A copy of the publication will be sent to all health authorities. The publication will be directed also to members of black and ethnic minority communities encouraging their participation.

Queries
Any enquiries about the survey should be directed to Task Force staff, whose names are included on the list enclosed.

King's Fund Equal Opportunities Task Force
14 Palace Court
London W2

071 727 0581 ext 2222

QUESTIONNAIRE

Name of health authority .....

Please provide the following information about health authority membership as at 30 April 1989.

1 How many members are there on your health authority .....

2 Are any places vacant? If so, how many? .....

3 Please complete the following chart indicating the colour/ethnic group and sex of members of the health authority. *This information is for statistical purposes only and names are not requested.*

Type of membership	White		African		Caribbean		Asian		Other ethnic groups		Total	
	m	f	m	f	m	f	m	f	m	f	m	f
Chairman												
Professsional												
Local authority												
Generalist												
Totals												

(complete with numbers in each category)
m – male
f – female

4 Has your authority made any specific attempts to find and nominate black and ethinic minority members for the health authority? YES .....
NO .....
(tick appropriate answer)

5 If YES to question 4, please state briefly what these were, and indicate whether or not they succeeded.

a *Method used*

Resulted in nomination	*Resulted in membership*	*Unsuccessful*
.....	.....	..... (tick as appropriate)

b *Method used*

Resulted in nomination	*Resulted in membership*	*Unsuccessful*
.....	.....	..... (tick as appropriate)

c *Method used*

Resulted in nomination	*Resulted in membership*	*Unsuccessful*
.....	.....	..... (tick as appropriate)

6 Please use this space for any other relevant information or comments you wish to provide.

APPENDIX II

RESULTS OF THE SURVEY BY REGION AND DISTRICT

This appendix presents the numerical results of the questionnaire for each regional and district health authority.

Notes

1 The figures presented include both members and authority chairs.
2 The proportion of male and female members is calculated by each region and should be measured against the population comparison provided in paragraph 7.1.
3 The proportions of black and ethnic minority members within regions is not assessed. The numbers are small but, more significantly, the proportion of the population from black and ethnic minority groups differs widely for different districts. Each DHA should compare the proportion of their black and ethnic minority members with local population figures.
4 Those authorities which said they had made attempts to nominate/appoint black and ethnic minority members are shown. The methods they had adopted are described in appendix III.

REGIONAL HEALTH AUTHORITIES

Authorities which had made attempts to nominate/appoint ethnic minority members are indicated by *

Region	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Northern*	11	6	16				1	17
Yorkshire	11	6	16			1		17
Trent	12	7	19					19
E Anglian	12	4	15		1			16
N W Thames*	12	8	18	1	1			20
N E Thames	12	4	16					16
S E Thames*	11	7	17			1		18
S W Thames	11	5	16					16
Wessex	11	5	16					16
Oxford	12	5	17					17
South Western	12	6	18					18
W Midlands	13	5	18					18
Mersey	(non-respondent)							
North Western	8	5	12			1		13
TOTALS	148	73	214	1	2	3	1	221
	67%	33%						

7 ethnic minority members
5 male, 2 female
4 professional – East Anglia, Northern, North Western, NW Thames
3 generalist – NW Thames, SE Thames, Yorkshire

DISTRICT HEALTH AUTHORITIES

Northern region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Darlington	11	6	17					17
Durham	14	4	18					18
E Cumbria	12	6	18					18
Gateshead	11	6	17					17
Hartlepool	11	5	16					16
Newcastle	12	7	18			1		19
N Tees	11	6	17					17
N Tyneside	11	6	17					17
Northumberland	12	8	20					20
N W Durham	11	6	17					17
S Cumbria	8	8	15			1		16
S Tees	10	7	16			1		17
S Tyneside	13	4	16	1				17
S W Durham	12	4	16					16
Sunderland	12	4	16					16
W Cumbria	11	6	17					17
TOTALS	182	93	271	1		3		275
	66%	34%						

4 ethnic minority members
3 male, 1 female
2 professional – South Tees, South Tyneside
2 generalist – Newcastle, South Cumbria

Yorkshire region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Airedale	14	4	18					18
Bradford*	11	4	14		1			15
Calderdale	12	4	16					16
Dewsbury*	12	5	15			2		17
E Yorks	14	3	17					17
Grimsby	10	6	15				1	16
Harrogate	10	5	15					15
Huddersfield	(non-respondent)							
Hull	9	7	15	1				16
Leeds E	12	5	16		1			17
Leeds W	14	4	17		1			18
Northallerton	10	7	17					17
Pontefract	12	4	16					16
Scarborough	10	4	14					14
Scunthorpe*	13	5	18					18
Wakefield	11	6	17					17
York	13	5	18					18
TOTALS	187	78	258	1	3	2	1	265
	71%	29%						

7 ethnic minority members
5 male, 2 female
1 professional – Grimsby
1 local authority – Hull
5 generalist – Bradford, Dewsbury (2), Leeds Eastern, Leeds Western

Trent region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Barnsley	12	5	16				1	17
Bassetlaw	11	6	17					17
C Notts	12	5	17					17
Doncaster	(non-respondent)							
Leicester*	12	6	17		1			18
N Derbyshire	11	7	18					18
N Lincs	12	5	17					17
Nottingham	12	7	19					19
Rotherham	12	4	14			1	1	16
Sheffield	(non-respondent)							
S Derbyshire	10	8	17			1		18
S Lincs	9	9	18					18
TOTALS	113	62	170		1	2	2	175
	65%	35%						

5 ethnic minority members
5 male
3 professional – Rotherham (2), Barnsley
2 generalist – Leicestershire, South Derbyshire

East Anglian region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Cambridge	11	8	19					19
E Suffolk*	13	4	17					17
Gt Yarmouth	13	5	18					18
Huntingdon	9	8	17					17
Norwich	13	5	18					18
Peterborough*	12	6	17				1	18
W Norfolk	(non-respondent)							
W Suffolk	9	9	18					18
TOTALS	80	45	124				1	125
	64%	36%						

1 ethnic minority member
Male generalist member

North West Thames region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Barnet	8	9	17					17
Ealing	10	7	13	1	1	2		17
E Herts	12	6	18					18
Harrow	11	5	15		1			16
Hillingdon	12	5	17					17
Hounslow*	11	6	16			1		17
N Beds	11	5	15	1				16
N. Herts	11	5	15			1		16
N W Herts	9	7	16					16
Parkside*	9	9	17		1			18
Riverside	13	6	19					19
S Beds	9	7	15			1		16
S W Herts	10	8	18					18
TOTALS	136	85	211	2	3	5		221
	61%	39%						

10 ethnic minority members
6 male, 4 female
2 professional – Ealing, North Herts
2 local authority – Ealing, Parkside
6 generalist – Ealing (2), Harrow, Hounslow and Spelthorne, North Beds, South Beds

North East Thames region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Barking	12	6	18	d			18	
Basildon	11	6	17					17
Bloomsbury	13	6	19					19
City & Hackney	11	7	15		3			18
Enfield	13	4	17					17
Hampstead	10	5	14			1		15
Haringey*	11	5	15			1		16
Islington*	9	7	16					16
Mid Essex	12	6	18					18
Newham*	10	7	14		2	1		17
NE Essex	11	7	18					18
Redbridge*	8	8	15			1		16
Southend	10	7	17					17
Tower Hamlets*	16	3	18			1		19
Waltham Forest	11	6	15		1	1		17
W Essex	11	6	17					17
TOTALS	179	96	263		6	6		275
	65%	35%						

12 ethnic minority members
7 male, 5 female
1 professional – Haringey
4 local authority – City and Hackney, Hampstead, Newham, Waltham Forest
7 generalist – City and Hackney (2), Newham (2), Redbridge, Tower Hamlets, Waltham Forest

South East Thames region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Bexley	12	5	17					17
Brighton	12	5	17					17
Bromley	10	6	16					16
Camberwell*	14	5	17		2			19
Canterbury	10	8	18					18
Dartford	15	3	18					18
Eastbourne	12	5	17					17
Greenwich	8	9	16	1				17
Hastings	10	7	17					17
Lewisham*	14	5	17			1	1	19
Maidstone	8	7	15					15
Medway	12	6	18					18
S E Kent	11	7	18					18
Tunbridge Wells	11	6	17					17
W Lambeth*	10	8	16		1	1		18
TOTALS	169	92	254	1	3	2	1	261
	65%	35%						

7 ethnic minority members
4 male, 3 female
1 professional – West Lambeth
2 local authority – Greenwich, Lewisham
4 generalist – Camberwell (2), Lewisham, West Lambeth

South West Thames region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Chichester	10	6	16					16
Croydon	8	8	14			1	1	16
E Surrey	9	9	18					18
Kingston	11	6	16				1	17
Merton*	13	4	17					17
Mid downs	12	4	15			1		16
Mid Surrey	10	8	18					18
N W Surrey	10	8	18					18
Richmond	13	3	16					16
S W Surrey	10	7	17					17
Wandsworth	13	5	18					18
W Surrey	10	8	18					18
Worthing	14	5	19					19
TOTALS	143	81	220			2	2	224
	64%	36%						

4 ethnic minority members
3 male, 1 female
1 professional – Kingston and Esher
3 generalist – Croydon (2), Mid-Downs

Wessex region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Basingstoke	13	4	17					17
Bath	12	7	19					19
E Dorset	12	6	18					18
Isle of Wight	13	2	15					15
Portsmouth	15	5	20					20
Salisbury	11	7	18					18
Southampton	13	6	19					19
Swindon	12	6	18					18
W Dorset	10	6	16					16
Winchester	12	4	16					16
TOTALS	123	53	176					176
	70%	30%						

nil ethnic minority members

Oxford region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Aylesbury*	9	8	17					17
E Berks	(non-respondent)							
Kettering*	16	2	17		1			18
Milton Keynes	12	5	17					17
Northampton	14	4	17			1		18
Oxfordshire*	13	5	18					18
W Berks	11	7	17	1				18
Wycombe	10	8	18					18
TOTALS	85	39	121	1	1	1		124
	69%	31%						

3 ethnic minority members
2 male, 1 female
1 local authority – Northampton
2 generalist – Kettering, West Berks

South Western region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Bristol*	14	5	17		1	1		19
Cheltenham	10	7	17					17
Cornwall	13	7	20					20
Exeter	12	5	17					17
Frenchay*	12	6	18					18
Gloucester*	11	6	17					17
N Devon†			16					16
Plymouth	13	5	18					18
Somerset	11	7	18					18
Southmead	13	5	18					18
Torbay	12	6	18					18
TOTALS	121	59	194		1	1		196
	67%	33%						

2 ethnic minority members
2 female
2 generalist – Bristol and Western

† sex of members not given

West Midlands region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Bromsgrove	8	8	16					16
Central Birmingham*	13	5	16		1	1		18
Coventry*	11	5	16					16
Dudley	15	2	16			1		17
East Birmingham	(non-respondent)							
Herefordshire	14	4	18					18
Kidderminster	13	5	18					18
Mid Staffs	11	7	18					18
North Birmingham	12	5	16		1			17
N Staffs	16	2	18					18
N Warwickshire	14	3	17					17
Rugby	10	6	16					16
Sandwell*	15	2	15			2		17
Shropshire	17	3	20					20
Solihull	12	5	16		1			17
South Birmingham	12	5	16			1		17
S E Staffs	10	8	18					18
S Warwickshire	11	5	15			1		16
Walsall	14	3	14			3		17
West Birmingham	11	5	13		1	2		16
Wolverhampton	10	6	15		1			16
Worcester	(non-respondent)							
TOTALS	249	94	327		5	11		343
	73%	27%						

16 ethnic minority members
13 male, 3 female
5 professional – Central Birmingham, South Birmingham, Walsall (2), West Birmingham
4 local authority – Central Birmingham, Sandwell, West Birmingham, Wolverhampton
7 generalist – Dudley, North Birmingham, Sandwell, Solihull, South Warwickshire, Walsall, West Birmingham

Mersey region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Chester	13	4	17					17
Crewe	11	7	18					18
Halton	12	3	15					15
Liverpool*	13	6	18			1		19
Macclesfield	10	7	17					17
Southport	8	9	15			2		17
S Sefton	14	3	17					17
St Helens	14	2	16					16
Warrington	13	3	15		1			16
Wirral	14	4	18					18
TOTALS	122	48	166		1	3		170
	72%	28%						

4 ethnic minority members
4 male
3 professional – Southport (2), Warrington
1 generalist – Liverpool

North Western region

Districts	Sex of members		Ethnic origin of members					TOTALS
	m	*f*	*White*	*African*	*Caribbean*	*Asian*	*Other*	
Blackburn	14	4	16			2		18
Blackpool	12	6	18					18
Bolton*	10	7	16			1		17
Burnley*	14	4	17			1		18
Bury*	13	4	17					17
Central Manchester*	14	3	16			1		17
Chorley	11	6	17					17
Lancaster	11	6	17					17
N Manchester	12	3	14			1		15
Oldham*	9	8	17					17
Preston*	13	4	16				1	17
Rochdale*	11	7	17			1		18
Salford	14	4	17				1	18
S Manchester*	12	6	17			1		18
Stockport	10	7	16			1		17
Tameside	12	5	16			1		17
Trafford	10	6	15			1		16
W Lancs	11	5	16					16
Wigan	12	5	16			1		17
TOTALS	225	100	311			12	2	325
	69%	31%						

14 ethnic minority members
11 male, 3 female
6 professional – Blackburn, Bolton, Salford, Stockport, Tameside, Wigan
1 local authority – Burnley
7 generalist – Blackburn, Central Manchester, North Manchester, Preston, Rochdale, South Manchester, Trafford

APPENDIX III

ATTEMPTS TO NOMINATE BLACK AND ETHNIC MINORITY MEMBERS

1 This appendix records the attempts which authorities said that they had made to nominate and appoint black and ethnic minority members and indicates, where known, whether they were successful in achieving nominations and appointments.

2 Some authorities which did not respond affirmatively to question 4 of the questionnaire about specific attempts to find and nominate black and ethnic minority members qualified their responses or made other explanatory comments. Where possible, these are recorded in this appendix.

3 The report (see paragraph 9.1) warns that numerically this part of the survey should be interpreted with some caution.

REGIONAL HEALTH AUTHORITIES

Several regional authorities pointed out that RHA appointments are the responsibility of the Secretary of State and stressed their reliance on the department's appointments unit. Nevertheless three authorities said that they had made attempts to find or nominate ethnic minority members. The Northern and South East Thames regions had both consulted the CRE. The Northern Region had additionally invited the Overseas Doctors Association to submit nominations. The chair of the North West Thames Region found conferences on equal opportunities issues an opportunity to meet potential members. The chair of the South West Thames region was also said to be very conscious of the need for ethnic minority representation.

DISTRICT HEALTH AUTHORITIES

Northern Region

Whilst no authorities had made attempts to nominate potential ethnic minority members, several authorities drew attention to the low proportion of the ethnic minority population within their catchment area. One chair's personal concern about equal opportunities issues had led to taking up membership of the local CRC, but not so far to successful nominations for membership. Another chair acknowledged that this survey had reinforced the importance of the issue and would lead to further consideration of ethnic minority membership in future nominations. The RHA had sought nominations for DHAs from the CRE and the Overseas Doctors Association, and had also used their CHCs ethnic

minority community contacts as a source of black and ethnic minority nominations.

Yorkshire Region
Three authorities had made attempts to seek ethnic minority nominations and the RHA had done so for those districts with a significant ethnic minority population. Bradford health authority had made personal approaches to individuals without receiving nominations, but an approach to the local authority proved successful in achieving membership. Dewsbury and Scunthorpe had both made approaches to local groups. In the case of Dewsbury this included the CRC, the CHC and Asian community organisations supplemented by local interviews by the health authority chair. Unlike Scunthorpe, Dewsbury was successful in obtaining both nominations and membership. The RHA also contacted CRCs and other ethnic minority organisations on behalf of DHAs and advertised in the local Asian press. So far as they could tell, this had elicited no response so far.

Trent Region
One health authority, Leicestershire, had contacted potential ethnic minority members through informal approaches to associates concerned with Afro-Caribbean and Asian community services, which had resulted in both nominations and membership. The RHA stressed that they had followed the guidance in Health Circular HC(81)6 and sought to achieve a reasonable balance of DHA membership including, where appropriate, ethnic minority representation. They therefore consulted with a wide variety of voluntary organisations, including those concerned particularly with the health and welfare of ethnic minor ty communities.

East Anglian Region
Peterborough and East Suffolk districts had made attempts to identify potential ethnic minority members. Peterborough DHA contacted local minority group organisations unsuccessfully, but an approach to their MP produced a successful nominee. East Suffolk DHA unsuccessfully invited the local CRC to make a nonιnations, but had also used personal contacts of their chair. The chair of Huntingdon DHA stressed that although the local black and ethnic minority population was very small, they would welcome members regardless of their sex or race who could assist the authority in achieving their aims.

North West Thames Region

Two health authorities, Hounslow and Spelthorne and Parkside, had made attempts to nominate ethnic minority members, and North Hertfordshire were intending to do so. Hounslow and Spelthorne approached every known ethnic minority organisation in the borough without success, but an approach to their local MP for nominations resulted in a successful nomination at the second attempt. Parkside also approached local black and ethnic minority organisations, providing an introductory paper outlining the departmental guidelines on membership.

Ealing health authority stressed that in considering suitable members they were mindful of the need for balanced membership by sex and ethnic origin, particularly because of the ethnic composition of their local population. Harrow and Hillingdon health authorities pointed to the RHA's responsibility for membership, although Hillingdon said that the RHA trawl had been unsuccessful in identifying successful ethnic minority nominations. North Bedfordshire health authority felt that their ethnic minority representation was reasonable given the composition of their local population, although they had drawn the RHA's attention to the need for balanced membership and in particular to the need for female members. Barnet health authority said that members were selected from candidates offering themselves and no ethnic minority members had done so.

The RHA stressed that their chair regularly reminded the appointments unit of the need for ethnic minority representation. Ethnic minority organisations were contacted by the region particularly in those districts which had found difficulty in attracting minority group representation, but with limited success. In practice, the region found that success in identifying ethnic minority members was very much dependent on district chairs and MPs taking active initiatives.

North East Thames Region

Five districts had made attempts to identify ethnic minority members. Redbridge authority found that general advertising for members produced only one ethnic minority nomination, but that a successful nomination resulted from a specific invitation to the local CRC. Successful nominations in Newham, Tower Hamlets and Islington resulted from informal 'soundings', an approach to a local church leader and local community contacts respectively (in Newham after a positive decision had been reached to seek more ethnic minority representation). Haringey health authority had unsuccessfully approached individuals. Hampstead health authority, which

had not so far made any specific attempts, intended to commence local press advertising.

Three authorities, Barking Havering and Brentwood, North East Essex, and Basildon and Thurrock drew attention to the low proportion of their local populations from black and ethnic minority groups, the two former authorities stressing also that regardless of their sex or race members were appointed solely for the personal contribution they could bring to the role of the Authority. Enfield and Tower Hamlets authorities both drew attention to their equal opportunities policies, with Enfield particularly recognizing that the appointment of members should be consistent.

South East Thames Region

Three districts had made attempts to nominate ethnic minority members. In addition the RHA had made specific attempts in 1983, 1985, 1987 and 1989 to find ethnic minority members for Bexley, Greenwich, Lewisham and North Southwark, Camberwell and West Lambeth authorities. An ethnic minority member of the RHA had suggested that each DHA and CHC should have an ' ethnic minority dimension' to promote greater awareness of health service provision in a multi-racial, multi-cultural society and districts are reminded of the need to seek ethnic minority members when generalist vacancies arise. The RHA felt handicapped however by having no reliable method to assess the ethnic origin of nominees.

Lewisham and North Southwark and West Lambeth health authorities had invited nominations for membership through local black and ethnic minority organisations but described the results as unsuccessful (Lewisham) or only partially successful (West Lambeth). On the other hand, a personal contact by the chair of Camberwell DHA with a community group leader had resulted in membership. The RHA's approaches to the CRE and local CRCs resulted in one nomination in 1983 and five in 1985, none of which resulted in membership.

Three authorities, Brighton, Hastings and Maidstone, pointed to the low ethnic minority population within their areas. Lewisham and North Southwark DHA regretted that a former Afro-Caribbean member had been obliged to resign due to heavy local authority commitments.

South West Thames Region

One authority, Merton and Sutton, had achieved ethnic minority membership after a positive decision that this was required. Unfortunately the member's heavy commitments elsewhere led to resignation. Wandsworth

DHA, which also drew attention to previous ethnic minority membership, had received the nomination through their routine invitation to the CRC. The RHA stressed that their chair was looking for potential nominees and was very conscious of the need for ethnic minority representation.

Wessex Region
Although none of the DHAs had themselves made attempts to nominate ethnic minority members, several pointing out that their ethnic minority populations were very small, the RHA had included ethnic minority organisations amongst those invited to nominate candidates, particularly in relation to two districts with appreciable ethnic minority populations. The only nomination received had been unsuccessful.

Oxford Region
Three authorities, Aylesbury Vale, Kettering and Oxfordshire had made attempts to recruit ethnic minority members, all of them through the local CRCs. Although these had resulted in nominations, not all had been appointed to membership by the RHA and some members appointed had proved short-term. In the absence of ethnic minority health authority membership, Aylesbury Vale health authority sent agendas of DHA meetings to the local CRO and sought in this way to maintain close contacts with their ethnic minority populations.

South Western Region
Three authorities, Bristol and Western, Frenchay and Gloucester, had made attempts to find ethnic minority members, in some cases resulting in nominations but not membership. In Frenchay, public advertisements inviting self nomination were directed to both majority and minority groups in the local community, whilst Gloucester had approached both the local CRC and local councillors.

Bristol and Western had been more successful in relying on their chair's own contacts and knowledge of the local community. Several authorities drew attention to the low proportion of ethnic minority communities in their districts.

West Midlands Region
Three authorities had made attempts to nominate members, Central Birmingham, Coventry and Sandwell. Sandwell had asked the local CRC to make nominations direct to the RHA but had no feedback about nominations; Coventry had made informal local contacts, resulting in

nominations but not in membership. West Birmingham said that they had made no attempts since both the RHA and local authority who were responsible for membership were aware of the needs of their local community, but also stressed the responsibility which the authority as a whole took on board for catering for the health care and employment needs of local black and ethnic minority communities.

Mersey Region

Liverpool, the only authority in the region to have made attempts to find ethnic minority members, said that it had been their aim for the past ten years to recruit a cross section of their Inner-city community. They had contacted the local CRC, ethnic minority organisations and sought personal interviews and recommendations. This had resulted in four nominations, but only one successful membership.

Chester, South Sefton and St Helens and Knowsley authorities drew attention to the small ethnic minority populations in their areas – the latter stressing that although they had not specifically approached ethnic minority organisations about membership, they were committed to an equal opportunities policy.

North Western Region

Eight authorities had made attempts to nominate ethnic minority members. Several authorities, including Bolton, Bury, Burnley, Oldham, Rochdale, Preston and South Manchester, had used their local CRC and/or other local groups as a source of nominations, with success from time to time. Oldham had also approached the Magistrates Court. In two authorities the Community Relations officer had been a member of the health authority, including Bury who stressed that the absence of an ethnic minority member at any one time was not an indication that health services to ethnic minority populations were ignored. Central Manchester authority holds quarterly meetings with ethnic minority representatives and had found that this forum increased interest in membership. The RHA also had made approaches on behalf of districts to ethnic minority organisations and said that they took note of appropriate representation on each authority. They had recently revised their nomination form to include a question about the ethnic origin of nominees.

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2 Labour Force Survey 1987. HMSO, 1989.

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Equal opportunities advisers in the NHS. Occasional paper no 2. London, King Edward's Hospital Fund for London, 1989. Price £3.25
Equal opportunities employment policies in the NHS – ethnic monitoring. Occasional paper no 3. London, King Edward's Hospital Fund for London, 1988. Price £3.00
Health authority equal opportunities committees. Occasional paper no 4. London, King Edward's Hospital Fund for London, 1989. Price £2.25

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