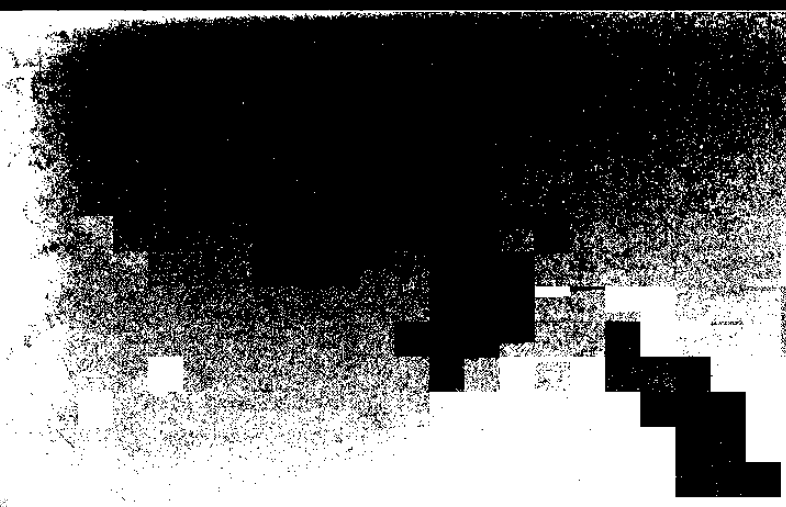

EQUALITY

ACROSS THE BOARD

NATIONAL ASSOCIATION OF HEALTH AUTHORITIES AND TRUSTS–KING'S FUND CENTRE WORKING PARTY ON BLACK AND ETHNIC MINORITY NON EXECUTIVE MEMBERS

A JOINT VENTURE

National Association Of
nahat
Health Authorities And Trusts

KING'S FUND CENTRE

EQUALITY ACROSS THE BOARD

NATIONAL ASSOCIATION OF HEALTH AUTHORITIES AND TRUSTS–KING'S FUND CENTRE
WORKING PARTY ON BLACK NON EXECUTIVE MEMBERS

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FOREWORD

Non-executive members and directors on the boards of NHS authorities and Trusts have a vital role to play in today's health service. They provide strategic leadership and bring their personal skills, experience and judgement to the management of their authorities and Trusts.

I am committed to increasing the proportion of people from idfferent black and ethnic backgrounds who are appointed as chairmen and non-executive members, so that they can play a full part in the management of a service in which the whole community has an interest. Appointments must be made on merit alone, but we must make the best use of all available talent, and do more to attract people from different cultural backgrounds.

This joint NAHAT/King's Fund Centre report is therefore particularly helpful. It contains a host of valuable advice on how to make progress on appointing more people from ethnic minorities, and I welcome it warmly.

Baroness Cumberlege
1993

MEMBERS OF THE WORKING PARTY

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Yasmin Gunaratnam, Researcher to working party

This report was funded by the Department of Health

ABOUT NAHAT AND THE KING'S FUND CENTRE

The National Association of Health Authorities and Trusts (NAHAT) is the representative body for family health services authorities and health authorities. It also has in membership the majority of NHS trusts and GP fundholders. NAHAT's primary role is to express the collective views of its membership on important national issues affecting the NHS. In developing and furthering the interests of healthcare it aims:

- to foster co-operation and communication between NHS authorities, government departments, local authorities and other organisations concerned with health matters;
- to educate and inform the public about the achievements and needs of the NHS;
- to promote research, education and the exchange of information within the NHS;
- to advise government and professional bodies on issues relating to the NHS;
- to investigate specific problems of concern to its membership.

NAHAT is financed by its members organisations and generated income.

The King's Fund Centre is a service development agency which promotes improvements in health and social care. We do this by working with people in health and social services, in voluntary agencies, and with the users of these services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences, information services and publications. Our aim is to ensure that good developments in health and social care are widely taken up. The King's Fund Centre is part of the King's Fund.

DEFINITION OF TERMS

The working party uses the collective term 'black and ethnic minority' in this report to refer to people of racial or other minorities in this country who may be disadvantaged because of their racial background. The working party was aware that terminology is a very sensitive issue and that there is no single accepted term. However, it felt that the Chief Medical Officer in his report *On the State of the Public Health* for the year 1991 provided a useful definition:

People of African, Caribbean and Asian origin widely refer to themselves as 'black'. This term underlies a common experience of life in this country among people whose skin colour is not white, but who live in a white majority society. The term 'ethnic minority' refers to the many people from minority communities who do not identify themselves as 'black', for example, Chinese, but who, because of their ethnic origin, language, cultural or religious differences, share a similar experience to 'black' people.

The term 'racism' is used in the report to refer to historical and institutional processes that are based upon treating black and ethnic minority people less fairly because of their racial identity.

INTRODUCTION

THE LOW NUMBERS OF BLACK AND ETHNIC MINORITY PEOPLE ON NHS BOARDS

The 1991 Census data[1] was the first specifically to collect information on ethnicity. It found that 5.5 per cent of the British population is made up of black and ethnic minority communities. While this overall percentage masks substantial regional variations, it is clear that NHS boards do not reflect the racial or gender composition of their local communities: The facts speak for themselves:

- the overall percentage of black and ethnic minority non executives of health authority and trust boards is 3 per cent
- out of **1531** non executive members of regional health authorities (RHAs), NHS trusts and special health authorities (SHAs) in March 1993, (with 30 vacancies) **only 45** are from black and ethnic minority communities. At present there are no accurate figures for DHAs
- out of **534** appointed chairs (with 16 vacancies) of health authorities and trusts **only four** are from black and ethnic minority communities, of which two chairs are from FHSAs, one trust and one DHA (three of these chairs are men)
- there are no black and ethnic minority chairs of RHAs
- there are no black and ethnic minority chairs or non executives of SHAs.

THE NAHAT–KING'S FUND CENTRE INITIATIVE

At a meeting in November 1992, NAHAT (National Association of Health Authorities and Trusts) and the King's Fund Centre drew together over thirty black and ethnic minority non executive members of NHS authority and trust boards. The meeting was held to address concern at the low numbers of black and ethnic minority non executives on boards throughout the country. There was real concern by some black and ethnic minority members attending the meeting around issues of discrimination and discriminatory practice. Several individual non executives spoke about their experiences of racism on NHS boards. The experiences ranged from feelings of marginalisation and isolation to one member recounting how some of his fellow white board members resigned in protest on his appointment.

At the meeting, it was agreed that a working party should be established to examine and put forward strategies to increase the number of black and ethnic minority people on NHS boards.

THE NAHAT–KING'S FUND CENTRE WORKING PARTY

The joint working party met for the first time in March 1993. Its members were chosen to reflect a cross-section of geographical, authority and trust interests. The terms of reference for the working party were to make recommendations on:

- how to find potential members
- how to overcome barriers to their appointment
- how to support them to make a full contribution on NHS bodies.

AVOIDING TOKENISM

From the outset, working party members were clear that tokenism should not play a part in the appointment of black and ethnic minority non executives. Candidates for board positions should only be appointed because of their quality, calibre, expertise and the positive contribution they are able to bring to the board. The working party felt that there was no shortage of such people from black and ethnic minority communities. It is in the interest of the NHS to make the best use of human resources to enhance the overall expertise of the board.

REPRESENTATION

The representational role of health authority and trust members is a somewhat complex point. At one level, the government has been clear that a member's role is not to represent any section of the community. However, it also recognises that the composition of a board should reflect the communities it serves. In 1991 William Waldegrave, the then Secretary of State for Health, said in an address to Bristol Race Equality Council[2]:

'I want to ensure ... that we appoint as members of health authorities, people from a wide range of backgrounds ... . We need people with close links to the communities they serve. One way by which we can ensure that the needs of the ethnic minority communities are fully taken into account is to consider good, suitable candidates from those communities for health authority appointments.'

KEY ISSUES

The working party identified a number of key issues to guide its work. Many of the issues had been raised by black and ethnic minority members at the NAHAT-King's Fund Centre meeting in November 1992. The issues are as follow:

Racism and discrimination

From the initial meeting in November it was generally accepted that although there were many factors which played a significant part in the low numbers of black and ethnic minorities people on NHS boards, racism and discrimination were important underlying issues which needed to be tackled within the NHS. It is important that overt and covert forms of discrimination are sought out and addressed.

Providing equality of opportunity should be concerned with removing unfair structures, policy, discriminatory practices and oppressive behaviour. Clear messages and strategic action to promote equal access and opportunity will also serve to enhance the corporate image of the NHS within local communities.

Bringing the board closer to local communities

In order to be able to serve local communities effectively it is important that all board members have experience of and links with different sections of the community. An added dimension to the personal skills of black and ethnic minority members is the unique knowledge and insights gained from their experience of their communities.

Appointment on merit

There is no shortage of able black and ethnic minority people who can serve on boards and make a positive contribution to the NHS. Appointments should be made on merit alone and not just as a token gesture to ensure a 'black face' on a board. In being clear about its recruitment criteria and the valuing of a diverse range of experiences and skills, the NHS will also enable the recruitment of black and ethnic minority people in other sectors.

Avoid marginalisation

Black and ethnic minority people on boards can easily become the sole focus of ethnic minority interests. There needs to be corporate responsibility for these issues and an acknowledgement of the wider experiences and qualities of black and ethnic minority members if they are to make effective contribution.

Commitment to the issues

All board members have a responsibility for ensuring that the needs of all sections of the community are taken into account, irrespective of the size of local black and ethnic minority populations. It is even more important that their specific health needs are not overlooked.

Equal access and opportunity

Present methods of recruitment to boards fail to maximise the use of a wide range of talents across black and ethnic minority communities. Black and ethnic minority women and working class people, for example, may experience additional forms of discrimination. Recruitment procedures should aim to cast a wide net, recognise a diverse range of experiences and skills and provide opportunities for all black and ethnic minority people.

Leading from the top

It is important that there is a greater number of black and ethnic minority people at all levels in the NHS, particularly in senior positions. Efforts should be made to encourage the recruitment of more black and ethnic minority people on the Policy Board, at the Management Executive and Department of Health and as executive directors of health authorities and trusts. By having black and ethnic minority people in paid employment in leadership positions within the health service, the NHS will be able to give clear signals that it values the contribution of able black and ethnic minority people. This will have the added benefit of encouraging able and well-qualified young black and ethnic minority people to see possible and achievable career paths in the NHS for themselves.

THE COMPLEXITY AND INTER-CONNECTION OF ISSUES

Seeking to increase the number of black and ethnic minority non executives is a complex issue which also relates to areas of health service provision and management which are outside the remit of the working party. However, the working party feels that it is important that the NHS acknowledges the implications and impact of black and ethnic minority representation on boards for:

- building alliances with local communities to enable the NHS to meet *Health of the Nation* targets and to achieve health gain
- the need to co-ordinate and develop strategic programmes on equity and race in employment practices
- the development of consumer sensitive services
- the demonstration of equity and equality in health care.

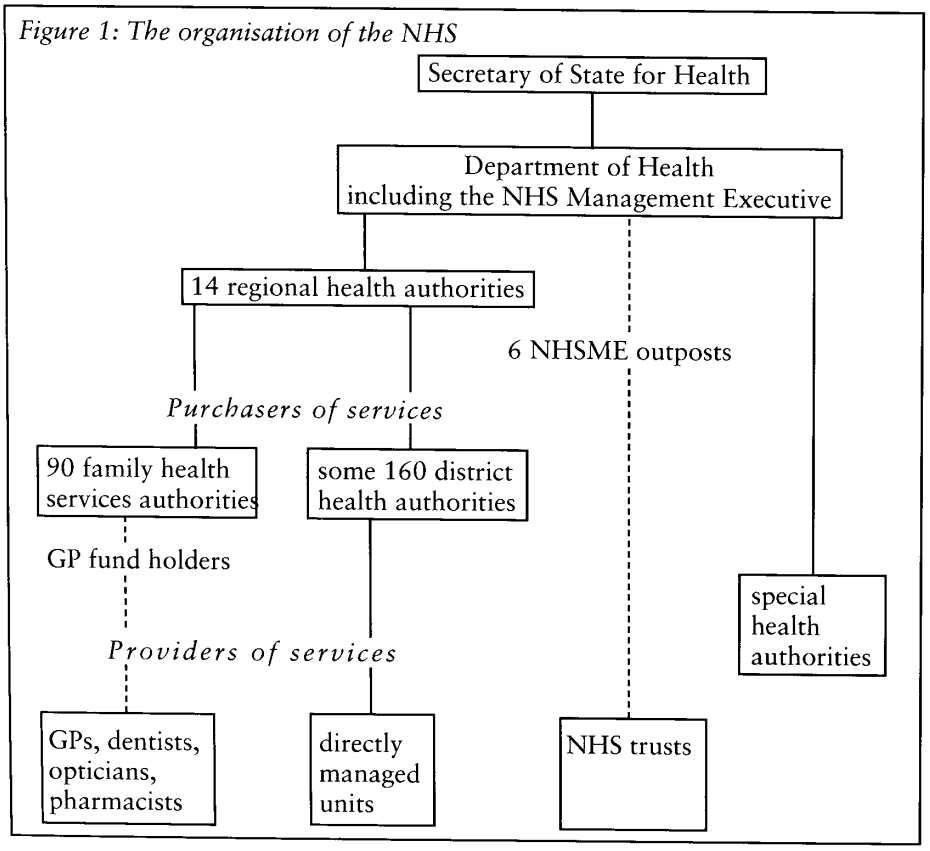
SECTION ONE: THE APPOINTMENTS SYSTEM

THE ROLE OF THE SECRETARY OF STATE

Overall responsibility for the NHS lies with the Secretary of State for Health (see Figure 1). The Secretary of State is also responsible for appointing:

- all chairs of RHAs, DHAs, FHSAs, SHAs and NHS trusts
- the non executive members of RHAs and SHAs

Figure 1: The organisation of the NHS



- a number of non executives of trusts, including a person drawn from the relevant medical school in the case of a trust with teaching responsibilities.

THE APPOINTMENT PROCESS

Generally speaking, Regional chairs take the lead in recommending suitable candidates for ministers to appoint to health authorities and trusts. NHSME officers advise on these recommendations before ministers make their decisions. The views of MPs are also sought on some appointments. There are only broad criteria set centrally for identifying potential candidates. RHAs are, on the whole, free to establish their own recruitment and selection priorities.

Each RHA keeps a central database on which the details of potential candidates are held. Candidates' details can come from a variety of sources, including the Public Appointments Unit, the NHSME Health Appointments Unit, MPs, organisations and from people who nominate themselves. Many of the nominations are fed, via the NHSME Health Appointments Unit, into the regional databases for consideration when suitable vacancies arise. Some regions advertise for candidates, although there is no formal requirement for them to do so.

RHAs are responsible for appointing:

- the non executive members of DHAs and FHSAs, and

- two of the non executive members of trusts.

DHAs and trusts also put forward nominations to the Secretary of State and to regions for consideration.

Table 1 overleaf summarises appointments made to NHS boards.

THE ROLE OF CHAIRS AND NON EXECUTIVE MEMBERS

Chairs

The position of chair is a non executive one. Their main role is to encourage non executives' contributions, develop a team approach and corporate identity for the whole board, communicate effectively with the public and staff and represent the health authority or trust to other organisations. Chairs are expected to devote about three days a week to NHS business. They are entitled to receive remuneration, which is banded to reflect the level of responsibilities involved.

Table 1: The composition of and appointments to NHS authorities and trusts

	FHSA	RHA	DHA	NHS trust
Chair appointed by	Secretary of State	Secretary of State	Secretary of State	Secretary of State
Non-executives on the board	5 lay members appointed by RHA, 4 professional members appointed by RHA	5 appointed by Secretary of State, including an FHSA chair and a member who holds a post in a university with a medical or dental school	5 appointed by RHA. Teaching districts to include a member who holds a post in a university with a medical or dental school	Up to 5 including at least 2 appointed from local community by RHA. Rest to be appointed by Secretary of State, including a person from the relevant medical school where a trust has teaching responsibilities
Executives on the board	Chief executive	Up to 5 including chief executive and finance director	Up to 5 including chief executive and finance director	Up to 5 including chief executive and finance director, medical director, senior nurse

Non executives

These are expected to share corporate responsibility for policy and decision-making within the authority or trust and are also responsible for holding executives to account. They are expected to bring an independent judgement to bear on issues of strategy, performance, resources (including key appointments) and standards of conduct. Non executives receive remuneration and are expected to spend an average of two days a month on NHS work. However, in practice many non executives say that they can often devote four days or more a month.

SECTION TWO: CURRENT APPROACHES TO RECRUITMENT

INFORMAL WORD OF MOUTH RECRUITMENT

A survey carried out by Warwick University[3] and the experiences of black and ethnic minority members at the NAHAT-King's Fund Centre meeting (November 1992), show that new board members are often recruited informally, through word of mouth, by chairs and chief executives. Since many chairs and chief executives are middle class, white men, it can be difficult for a diverse range of people to be included in what is essentially an 'old boys' network'. However, the working party recognised that an increasing number of white women are being appointed as chairs and executive directors.

The pattern of recruiting 'in one's own image' and excluding people who are not a part of established networks can ensure the maintenance of an elite 'inner circle'. Such practice is inappropriate; it also goes against recognised good practice in employment (CRE, code of practice for employment[4]).

It is important to recognise that efforts to increase the numbers of women and black and ethnic minority people on NHS boards need to be based on principles of equal access. This means not simply replacing the old boys' network with an 'old girls' network', for example, but establishing genuinely equitable recruitment practices.

NOMINATIONS

In instances where some health authorities and trusts consult with outside organisations in seeking nominations, black and ethnic minority people may still find themselves excluded.

- Many authorities consult senior managers in large-scale commercial companies and professional bodies. However, the Labour Force Survey[5] indicates that black and ethnic minority people are unlikely to be found in management positions and are concentrated in a narrower range of occupations and in low paid jobs. This situation exists due to a number of different factors, one of the more significant being discrimination in the employment market.

Occupational position is only one indicator of performance and ability. Accordingly, it should only be one of several variables taken into account in recruitment processes.

- A King's Fund survey in 1989[6], found that many of the voluntary organisations that were consulted by RHAs 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.

CONSULTATION WITH BLACK AND ETHNIC MINORITY ORGANISATIONS

The King's Fund survey found that in the few cases where health authorities had actively tried to consult with black and ethnic minority organisations, consultations were restricted to the Commission for Racial Equality, local race equality councils and the Overseas Doctors' Association.

The CRE and its local councils receive many similar requests for nominations. The existing commitments of those already known to the CRE, who are often involved in a range of community activities, can restrict their availability.

BARRIERS TO RECRUITMENT: A SUMMARY

- Old boys' network
- Vacancies not widely advertised
- Lack of NHS profile and information on board membership within black and ethnic minority communities
- black and ethnic minority people do not want to be token gestures
- Few or no role models
- Discriminatory recruitment practices and inappropriate selection criteria.

SECTION THREE: THE NUMBERS OF BLACK AND ETHNIC MINORITY NON EXECUTIVES ON NHS BOARDS

NON EXECUTIVES IN 1991

According to a 1991 survey by Warwick University[3] of the members of boards of regional, district and family health services authorities:

- authorities do not reflect the composition of the population at large, particularly in terms of gender and ethnicity
- membership is highly concentrated around late middle age
- a majority of non executives hold company directorship and are active in the public sector or in voluntary activities
- more than 99 per cent of chairs are white.

AN OVERVIEW OF THE CURRENT COMPOSITION OF NON EXECUTIVE MEMBERS BY ETHNICITY

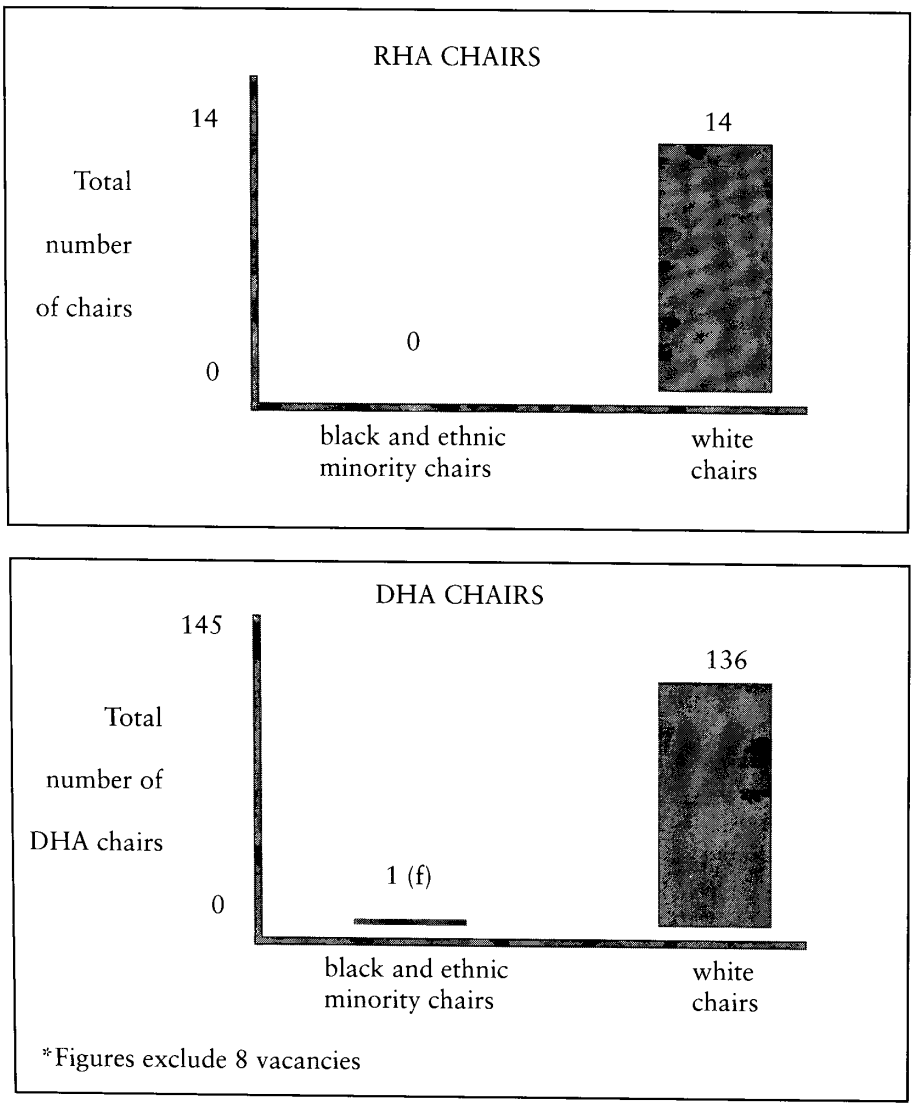
The following bar charts show the current numbers of black and ethnic minority chairs and non executive members for RHAs, DHAs, FHSAs, NHS trusts and SHAs. However, information on the numbers of black and ethnic minority non executive members for FHSAs and DHAs was incomplete at the time of writing and therefore has not been included in the report.

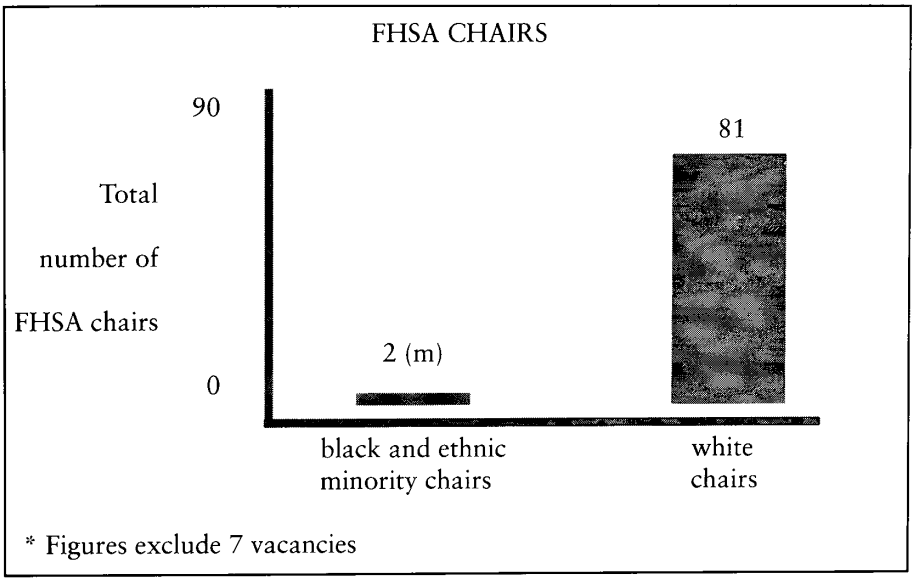
The figures were collated using the most recent information from the NHSME Health Appointments Unit (March 1993) and information given to the working party by regions. It should be noted that the Health Appointments Unit is continually updating its data and consequently figures for vacancies and appointments are subject to variation. Information on the gender of black and ethnic minority chairs is represented in brackets, where 'f' denotes female and 'm' male.

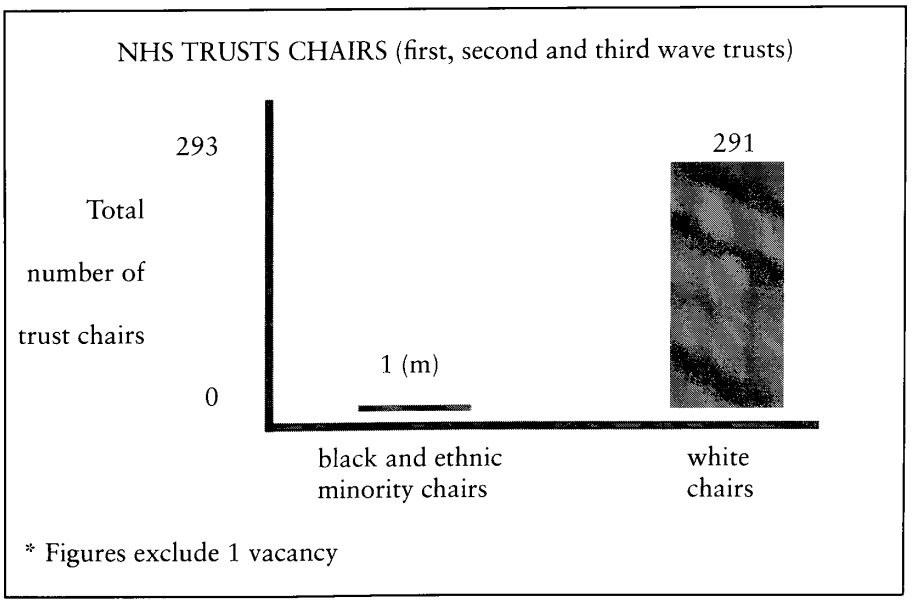
THE VITAL POSITION OF CHAIRS

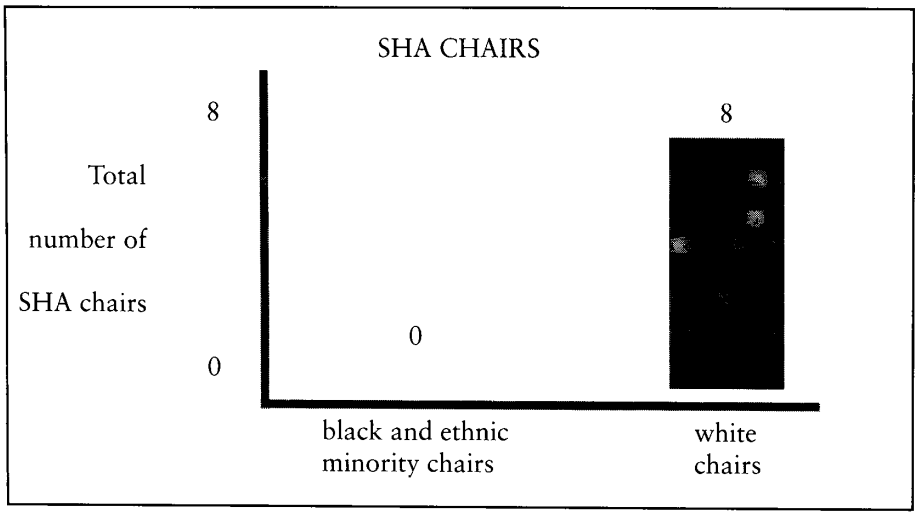
The chair's role in providing leadership to a health authority or trust and in acting as its spokesperson is one of critical significance and high profile. While the numbers of black and ethnic minority non executives generally are low, the number of black and ethnic minority people who occupy the vital position of chair is relatively even smaller.

Figure 2: Black and ethnic minority chairs




FHSA CHAIRS
90
Total
number of
FHSA chairs
0
2 (m)
81
black and ethnic
minority chairs
white
chairs
* Figures exclude 7 vacancies

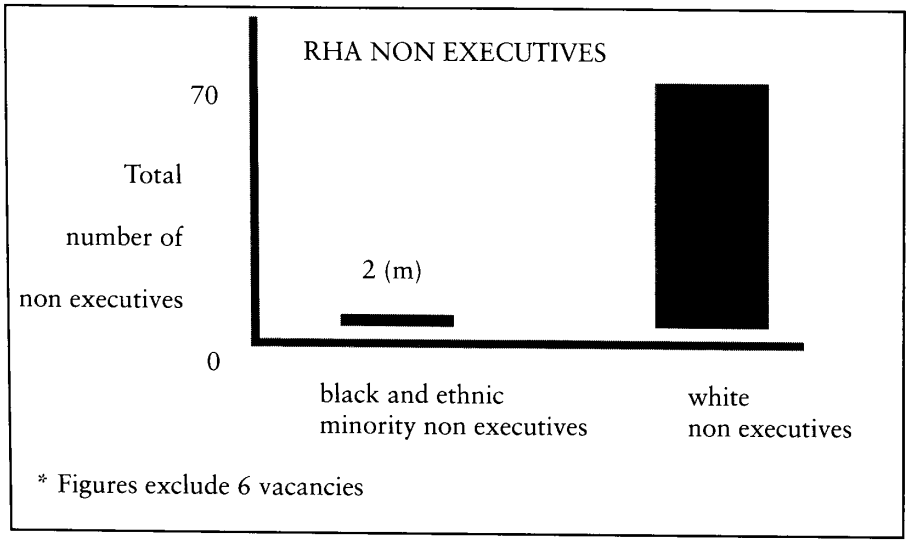

NHS TRUSTS CHAIRS (first, second and third wave trusts)
293
Total
number of
trust chairs
0
1 (m)
291
black and ethnic
minority chairs
white
chairs
* Figures exclude 1 vacancy

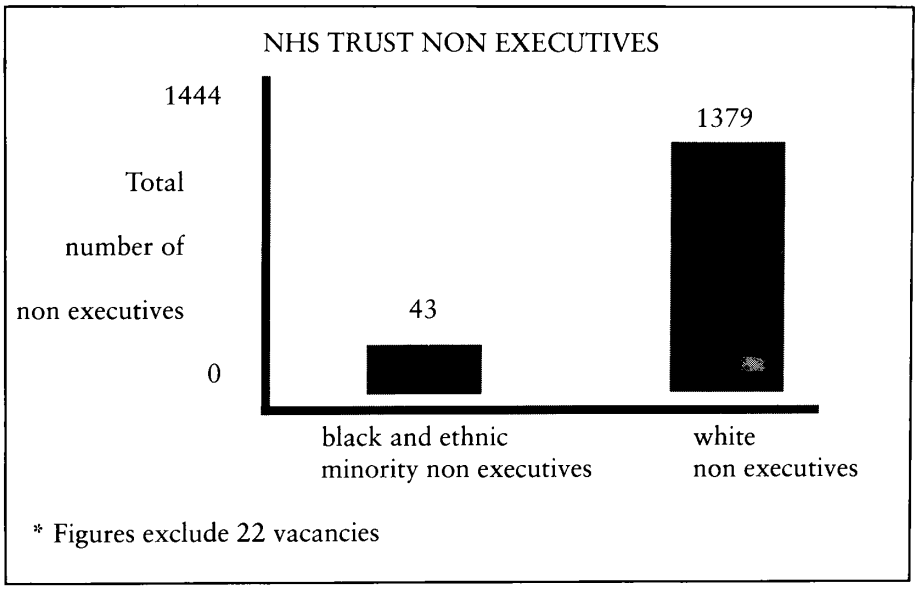


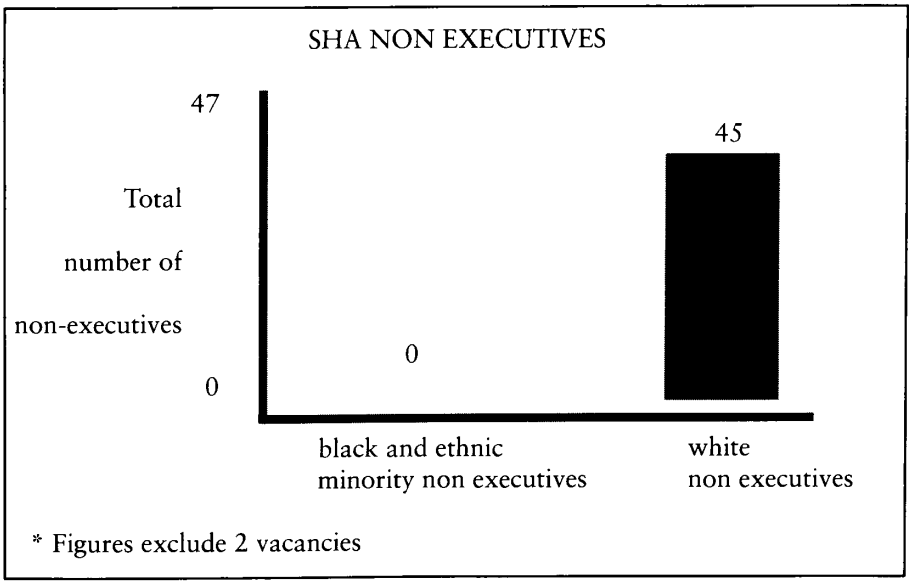
BLACK AND ETHNIC MINORITY NON EXECUTIVE MEMBERS

The bar charts below show the numbers of black and ethnic minority non executive members for RHAs, NHS trusts and SHAs. At the time of writing the Health Appointments Unit was in the process of updating the details of black and ethnic minority non executives for DHAs and FHSAs and information for these authorities was incomplete, and is therefore not included in this report.

Figure 3: Black and ethnic minority non executive members




NHS TRUST NON EXECUTIVES
1444
Total
number of
non executives
0
43
1379
black and ethnic
minority non executives
white
non executives
* Figures exclude 22 vacancies


SHA NON EXECUTIVES
47
Total
number of
non-executives
0
0
45
black and ethnic
minority non executives
white
non executives
* Figures exclude 2 vacancies

TRUSTS OVER TIME

Table 1: Trust non executives by first, second and third wave trusts

	Total	White	Black and ethnic minority (figures in brackets as a per cent of total excluding vacancies)	Vacancies
First Wave	273	256	9 (3.5 per cent)	8
Second Wave	490	473	10 (2.1 per cent)	7
Third Wave	681	650	24 (3.6 per cent)	7

The latest figures show a slight increase in the percentage of black and ethnic minority non executives, from 3.5 per cent on first wave trusts to 3.6 per cent on third wave trusts. However, it should be noted that the number of black and ethnic minority non executives on second wave trusts is relatively lower at 2.1 per cent.

IMPORTANT ISSUES

It is important to remember when considering these figures that the numbers for black and ethnic minority chairs and non executives obscure individual authority and trust variations. There are still many authorities and trusts which have no black and ethnic minority members on their boards. Some of these are also serving areas with significant local black and ethnic minority populations.

Clearly the number of black and ethnic minority chairs is very low. Of equal concern is that none of the eight Special Health Authorities has black and ethnic minority chairs or non executive members on its board. However, it should be noted that most, if not all, of the SHAs will shortly become trusts. This may offer the opportunity to recruit more widely from diverse sections of the communities that the SHAs as they become trusts will serve.

SECTION FOUR: CURRENT INITIATIVES BY REGIONAL HEALTH AUTHORITIES

RHAs were invited by the working party to provide information about the numbers of black and ethnic minority chairs and non executive members in their region, their appointments procedures and any initiatives they had taken to encourage the recruitment of black and ethnic minority non executives.

Responses were received from all of the 14 RHAs. Of these, ten RHAs were able to provide the working party with some information on the numbers of black and ethnic minority non executives in their region. The main findings from the regional responses show that:

- many RHAs said that they consulted with MPs, chairs, existing non executives, general managers/chief executives and the Public and Health Appointments Units in seeking nominations
- of the five RHAs that said they maintained a database of nominees, all five said that they monitored the gender of nominees. Three said that they had implemented ethnic monitoring of their databases
- three RHAs were able to provide figures for the number of black and ethnic minority nominees on their database and a fourth RHA provided an approximate figure for its black and ethnic minority nominees
- three RHAs mentioned advertising board vacancies in the local media; however, one of the RHAs said that it had last advertised in 1987/88
- two RHAs said that they had targeted information on non executive membership at local black and ethnic minority organisations.

Two RHAs referred to the relatively low numbers of black and ethnic minority communities in their local population as being related to the small number of black and ethnic minority people on boards in their region.

SPECIFIC APPROACHES

The following examples are of the three RHAs who responded to the working party detailing initiatives that had been specifically developed within an equal opportunities framework.

South West Thames RHA

Provided details from its recent recruitment drive for the chairs of ten fourth-wave prospective trusts. Ethnic monitoring of applications showed that out of 192 applications there were four black and ethnic minority applicants who recorded their ethnic origin.

The RHA produced guidance notes for the trusts suggesting a suitable appointments process for non executive members. The notes detail the importance of:

- a role specification and person specification
- local awareness-raising and advertising through community groups, events and local media
- advertisements which encourage applications from women and black and ethnic minorities
- panel interviews which encourage the involvement of at least one woman and a black or ethnic minority person.

The RHA also organised two open days about the role of non executives and trusts which were scheduled to take place between formal advertising and the closing date for applications.

South Western RHA

Has recently examined its appointments process. This had included the establishment of three 'short life' working groups, one for DHAs, one for FHSAs and one for trusts. The groups have examined and agreed essential criteria for achieving a balanced mix of non executives in relation to age, gender and ethnicity.

North West Thames RHA

Has built up a database of nominees for non executive appointments. In particular, the region has built lists of women and people from black and ethnic minority communities. There are currently 558 names on their list of potential candidates, 273 of whom are women and approximately 40 are people from black and ethnic minority communities. The region is currently working on a membership package to send to all potential candidates.

THE NEED FOR STRATEGIC ACTION

The working party noted a range of initiatives taken by regions to increase the numbers of black and ethnic minority non executives on boards. Some RHAs are clearly working to encourage the recruitment of more black and ethnic minority non executives. However, there were no clear indications that comprehensive and strategic measures had been taken to address the recruitment of black and ethnic minority members. There are real opportunities for RHAs to address this issue.

In further responses, some RHAs attributed the lack of black and ethnic minority people on their boards to the relatively small proportion of local black and ethnic minority communities in their areas. The size and demography of local black and ethnic populations should only be one factor used to inform the development of equitable recruitment strategies. It is the responsibility of all boards to ensure that all local communities have access to information about board membership and that recruitment initiatives target suitably qualified individuals. Black and ethnic minority members should not serve in a representative capacity but because of their experiences and skills.

There are also real opportunities for RHAs to formulate measures aimed at supporting black and ethnic minority executives once they have been recruited. For example, initiatives can be taken to address discrimination faced by women and black and ethnic minority members. The process of enabling full participation and addressing feelings of marginalisation clearly also have benefits for all board members and corporate governance.

SECTION FIVE: CURRENT NATIONAL INITIATIVES

While there is still progress to be made, the working party was encouraged to see that some positive steps have been taken by some organisations to enable the wider recruitment of black and ethnic minority members. Examples of positive initiatives include the following.

THE PRIME MINISTER'S INITIATIVE

In October 1991, at the launch of Opportunity 2000, the Prime Minister announced a new government initiative aimed at increasing the number of public appointments held by women and black and ethnic minority people. All government departments were asked to develop a strategy to bring about improvements and to set goals for improving performance. They were also required to put a junior minister in charge of setting objectives for increasing the number of women and black and ethnic minority people holding public appointments.

THE CABINET OFFICE – PUBLIC APPOINTMENTS UNIT

The Unit maintains a 'Public Appointments List' of people willing to be considered for public appointments. The Unit's role is advisory and it puts names forward to government departments for the several hundred vacancies each year.

The Unit has stated that it is keen to encourage more nominations from black and ethnic minority people. It is in regular contact with the Home Office, the Commission for Racial Equality and appropriate professional and community organisations in its efforts to seek more nominations. Ethnic monitoring of public appointments was introduced in 1992.

The first statistics published earlier this year in *Public Bodies 1992* showed that, at 1 September 1992, 2 per cent (820) of approximately 41,000 appointments listed were held by black and ethnic minority people. Significantly only 158 appointments were held by black and ethnic minority women.

THE DEPARTMENT OF HEALTH

As part of the Prime Minister's initative, the Department of Health has made a commitment to secure more nominations for appointments for women and black and ethnic minority people. In addition, the Department has recently set a specific goal to increase the proportion of black and ethnic minority members of NHS boards to 4 per cent by September 1996. The Department has a database of appointees including details of ethnic origin, which will enable progess in appointing more black and ethnic minority people to be monitored. The Department has also stated that it will:

- carry out a survey on, and promote, ethnic minority representation on health authorities and trusts
- secure more nominations for appointments from women and black and ethnic minority people through collaboration with national women's organisations, black and ethnic minority groups, industry and professional bodies
- establish a database of existing black and ethnic minority appointments and a pool of possible future black and ethnic minority members.

SECTION SIX: MAKING THE CHANGE

This section of the report details a strategy for enabling the wider recruitment of black and ethnic minority people on to NHS boards. The working party believes that the whole range of organisations in the NHS and individual chairs and board members have a responsibility for and a part to play in this strategy.

WOOING BLACK AND ETHNIC MINORITY COMMUNITIES

A Canadian report on 'Working with Volunteer Boards'[7] likened the recruitment of board members to a courtship. It states:

Each party wants to be attractive to the other, yet wants to know 'what's in it for me?'.

A starting point for the NHS in recruiting more black and ethnic minority board members is to establish a strategic information campaign. The campaign should aim to inform black and ethnic minority communities about a range of health service issues and also aim to make board membership an attractive option.

black and ethnic minority communities need to be kept in constant touch with both strategic and local changes. They need to know about the roles of regions, purchasers, providers and FHSAs and about the respective roles of NHS boards and non executive members.

Health authorities and trusts must actively sell themselves to potential black and ethnic minority candidates, so that candidates are clear about what they can contribute and also about 'what's in it' for them.

PROACTIVE NETWORKING

In order to reach a range of potential black and ethnic minority candidates, health authorities and trusts should establish and maintain links with a variety of black and ethnic minority community, business and cultural organisations. A recent study of black volunteering[8] found that:

agencies which had links with black groups were more likely to have black involvement than those with no such links.

Authorities and trusts can work with organisations to encourage nominations. They can also work with the groups to advertise vacancies and provide information about the health service to local communities. However, in advertising vacancies it is important that expectations are not raised and that clear information is given about the actual number of vacancies available and the type of person required.

TARGETING SERVICE USERS

Efforts can be made to seek nominations from health service users. Information about authority and trust membership and vacancies can be displayed and made available in primary care, secondary care and community health services.

CORPORATE INVOLVEMENT

The whole process of recruitment and selection needs to be opened up, so that chairs involve non executive members in recruitment planning and decision-making. Sir Duncan Nichol, in a speech to a NAHAT conference in February 1993, elaborated on and referred to the theme of corporate governance detailed in the recommendations of the Cadbury Report[9]:

'I think we need to look very carefully at whether we have embedded our non executive contribution..., whether we have... been absolutely clear about those fundamental contributions of the non executive member, the non executive member who "should bring an independent judgement to bear on issues of strategy, performance, resources, including key appointments and standards of conduct". I think we need to do more to develop, to train, to help our non executive members in this regard.'

ESTABLISHING FORMAL RECRUITMENT AND SELECTION PROCESSES

There is a wealth of experience in 'good practice' around equal opportunities in recruitment and selection procedures in employment. Indeed, health authorities and trusts have themselves established and developed procedures to enable fair recruitment in their employment practices. There is a real opportunity for boards to use the best of good practice procedures to enable wider and more equitable recruitment.

RECRUITMENT AND SELECTION PROCEDURES

Job description

In order to break out of the informal and often *ad hoc* approach of word of mouth recruitment, boards that have not already done so must create job descriptions for chairs and non executives. The job description should be a broad statement of the purpose, scope, duties and responsibilities of the particular post. It should include an indication of the time commitment required and also state that training will be provided. It is important that there is sufficient information about the role of board members in order to:

- provide clear information about the purpose of the job and the responsibilities that go with it; and
- provide enough information to enable potential candidates to make decisions about whether to apply.

Skills and abilities

Both the board and potential candidates need to be clear about the skills and qualities that are required of chairs and non executive members. This can be done through drawing up a person specification, which describes the range of skills, abilities and knowledge required.

Information can also be given to candidates which profiles the skills of a range of existing board members. However, this may be undesirable in instances where boards are entirely made up of white, professional men.

In some ways this is perhaps the most important stage in the process, since it is usually at this stage that the criteria against which individuals are subsequently assessed are first identified.

Applications

It is generally recognised that standardised application forms are good practice mechanisms for recruitment, because they enable 'like for like' comparisons between candidates. Application forms should not be too restrictive in the categories of information sought but should restrict enquiry to the skills and abilities needed to perform the job.

The self-nomination form used by the Department of Health can provide a good framework from which to develop application forms for board membership. It is clear and straightforward and provides opportunities for candidates to provide information on:

- a section where applicants can indicate their racial or ethnic group
- any direct experience of caring for any dependants (for example, disabled people or children)
- educational and professional qualifications
- time available (per week/month/year)
- present occupation and position (if any)
- previous jobs/positions (paid or unpaid), including positions in the voluntary sector and membership of central and local government committees.

Advertising

Advertising in the local and black and ethnic minority media can be an effective way to raise awareness and/or to highlight particular board vacancies.

Advertisements for board membership should use clear and jargon-free language and should include:

- a description of the role of the chair/board member
- a clear specification of the personal qualities and experiences required
- an indication of rewards, not only remuneration but also personal benefits such as satisfaction and opportunities to learn new skills
- an indication that applicants will be informed about the outcome of their application
- a statement of commitment to equal opportunities and/or a statement encouraging application from black and ethnic minority people.

Job advertisements are only one way of advertising. Authorities and trusts should also consider using the expertise of their public relations specialists to develop links with the media. Further options for raising the profile of board membership can include:

- ❑ existing black and ethnic minority non executives giving interviews about their work to local newspapers and radio stations
- ❑ articles about board membership in local and ethnic newspapers and in community newsletters.

Selection processes

Authorities and trusts should endeavour to establish selection processes such as interview panels for potential candidates which include women and black and ethnic minority people. The reliability and validity of an interview can be improved by:

- ❑ ensuring that interviewers have received training in interviewing techniques, equal opportunities and legal requirements
- ❑ the use of job-related questions
- ❑ following an appropriate structure.

Feedback to candidates

It is important that a formal system is established for both processing and responding to expressions of interest and formal applications. At the very least potential candidates need:

- ❑ acknowledgement of their interest/application
- ❑ to know if their details are to be kept on a register for future appointments
- ❑ to be informed if their application was successful or not successful.

TRAINING

New black and ethnic minority non executive members can often come on to a board with little previous experience of public appointments or of the NHS. This, together with the fact that authorities and trusts are developing new roles which require new expertise, can be particularly disorientating.

Chairs should therefore regularly address the training needs of all their non executives. They should also take specific steps to ensure that new board

members fully understand the role of the board and their place within it. Chairs have a vital role to play in ensuring that each board member can make a full individual contribution to the corporate work of the board. A full training strategy for board members will need to include:

- ❑ Preparation training – opportunities should be created to provide recommended reading and, where possible, training to familiarise new board members with the health service *before* they take up their positions.

- ❑ Induction training – newly appointed members should receive some form of induction into their role and the wider role and structure of the NHS.

- ❑ Continual training – all board members should have access to continual and regular training events which will enable both the maintenance and improvement of corporate goverance. In this instance training can take a variety of forms and can include opportunities to meet and share experiences with members of other health authorities and trusts and local organisations.

DEVELOPING A POSITIVE ORGANISATIONAL CULTURE

Once black and ethnic minority members have been recruited on to boards it is important that consistent efforts are made not only to retain them but also to maximise their effectiveness. This is where a positive organisational culture, which includes how people interact with each other and styles of working, can play a vital role. Elements of a positive culture can include:

- ❑ genuine partnership and power sharing between board members

- ❑ the valuing of a diverse range of skills, experiences and opinions

- ❑ an openness to listen and respond to feedback

- ❑ mutual respect and support.

PROFILES OF SOME EXISTING NON-EXECUTIVE MEMBERS

The following profiles provide an indication of the calibre and the range of experience of existing black and ethnic minority non executives. The working party believes that positive and strategic action by the NHS is needed, rather than tokenism, to tap into the talent in black and ethnic minority communities.

RHA non executive

Experience and background - an African-Caribbean man who is a barrister. He previously served on an FPC and spent seven years as a district councillor. He is also an executive member of Sickle Cell Anaemia Relief (SCAR).

DHA non executive

Experience and background - an Asian woman. Previous experience as a local government officer and as a community worker in a variety of black and ethnic minority community organisations. Mother of two school-age children. Speaks three languages. Previously member of a CHC and FPC.

FHSA chair

Experience and background - an African-Caribbean man with experience as a director of a small business and as a senior partner in a management consultancy. He has served as a chair for a local black business organisation and the local African-Caribbean development agency. He has been involved in a variety of national working parties, including the Social Security Advisory Committee and the Home Office's Ethnic Minority Business Initiative working party.

NHS trust non executive

Experience and background - an African-Caribbean woman. Qualified as a registered nurse in 1964 and went on to become director of nursing services. Previous experience as a member of the Health Education Authority, English National Board and FHSA.

SECTION SEVEN: RECOMMENDATIONS

The NHS is a major employer of black and ethnic minority people. It is well placed to take the lead and provide a good practice model for other organisations in implementing innovative and strategic equal opportunity measures. In order to initiate and implement such change, co-ordinated action is required at all levels.

MINISTERS

It is important that ministers give clear indications about the priority for increasing the number of black and ethnic minority people on NHS boards and in senior positions within the health service. Initiatives can be taken to:

- issue written guidance to RHAs on developing strategic action to increase the recruitment of black and ethnic minority non executives and on measures to combat discrimination on boards.
- consult regional chairs about setting goals for the recruitment of black and ethnic minority non executives.
- publish annual figures on the number of black and ethnic minority non executive members on NHS boards.
- support the forthcoming 'Race for Opportunity' which will be the race equality equivalent of the Opportunity 2000 initiative. Ministers should also make plans for how the goals of the initiative can be achieved within the NHS.
- set targets to increase the number of black and ethnic minority people in senior management positions within the NHS, NHSME and DoH.
- establish mechanisms to enable black and ethnic minority people to take part in NHSME and DoH internal committees, task forces and working groups.

THE NHS, NHSME AND DOH

It is important that black and ethnic minority people are represented at board level and in senior management positions within the NHS, NHSME and DoH.

Setting an example at management level will serve to back up ministerial commitments, avoid accusations of tokenism and make it clear that the NHS is committed to equality.

Corporate race initiative

Ministers should establish a race initiative with the aim of drawing together the different strands of race equality measures and initiatives that are currently taking place throughout the NHS. The initiative should have corporate responsibility for promoting and overseeing the development of good practice in all race-related issues ranging from board membership to employment and service provision.

In order to be effective the initiative will need to have both management power and adequate resources. Ideally the person leading the initiative should report diectly to the NHSME Chief Executive and be part of the NHSME board.

In relation to NHS boards the initiative should have specific functions which include:

- ❑ advising ministers on reviewing nomination and appointment procedures for non executive members
- ❑ providing advice to individual health authorities and trusts on implementing equitable recruitment and selection procedures
- ❑ monitoring initiatives to increase the number of black and ethnic minority non executives
- ❑ establishing links with a range of national and local black and ethnic minority organisations
- ❑ holding a national database of black and ethnic minority nominees and non executive members.

Key general functions of the initiative could include:

- ❑ raising the profile of race equality issues within the health service
- ❑ pioneering and supporting the implementation of positive action programmes for black and ethnic minority people, such as fast-track management programmes

- disseminating and promoting good practice throughout the service
- monitoring the implementation and progress of race equality initiatives through performance reviews and management contracts
- working collaboratively with regions and trusts to formulate good practice measures in race equality.

The initiative would play a central role in establishing core standards in recruitment and selection for non executive members and in establishing a national database.

Core standards in recruitment and selection

The NHSME should provide guidance to all health authorities and trusts aimed at establishing core national standards in the recruitment and selection of non executives. The core standards should reflect the guidance detailed in the 'Codes of Practice' issued by the Commission for Racial Equality and the Equal Opportunities Commission. Such core standards should also include:

- establishing local information campaigns with professional PR specialists, the local and black and ethnic minority media, professional journals and local newsletters and bulletins. The campaigns should be aimed at providing information about the NHS, the role of boards and of non executive members.
- encouraging authorities and trusts to build links with a variety of black and ethnic minority organisations, local community health councils, professional bodies and women's organisations in order to generate nominations.
- producing job descriptions, person specifications and application forms which recognise a diverse range of skills, experiences and backgrounds.
- establishing local databases for nominations which record ethnicity, gender and disability.
- requirements that short-lists for appointments include black and ethnic minority candidates and that an explanation should be given where no such candidates have been short-listed.
- establishing selection and interview panels which involve existing non executive members, and where possible at least one woman and one black or ethnic minority person.

Database

The Department of Health's database should include mechansisms for record-keeping and monitoring of ethnicity, gender and disability. The database should be used by ministers to monitor the outcomes of positive action initiatives and to compare the performance of different health authorities and trusts.

By monitoring ethnic origin and gender, ministers could also ensure that recruitment and selection procedures are providing equal opportunities. Nominations and appointments should be monitored to ensure that recruitment strategies do not discriminate against different black and ethnic minority communities or against black and ethnic minority women.

HEALTH AUTHORITIES AND TRUSTS

All health authorities and trusts have a responsibility for enabling the recruitment of black and ethnic minority non executives. However, we begin this section by highlighting the specific responsibilities of RHAs which relate to their central role in recruitment and appointment procedures for non executive members of DHAs, FHSAs and trusts. We also recognise that information in this section will be relevant to NHSME Outposts.

RHAs

Regions should play an active part in setting a framework and climate for ensuring the wider recruitment of black and ethnic minority non executive members. Using their position, RHAs can encourage the development of a variety of local initiatives:

- regional chairs will need to encourage and support the development of strategies – with targets and time scales – for increasing the number of black and ethnic minority people on NHS boards throughout the region.

- regional non executive members must designate responsibility for co-ordinating and overseeing recruitment and selection processes for non executives to a senior manager.

- regions should co-ordinate strategic information campaigns and recruitment drives which seek to increase nominations from black and ethnic minority people.

- it is essential that regions establish processes to address and examine any alleged discrimination faced by black and ethnic minority non executives at board level and in carrying out their duties.

- regions should consider approaching other local agencies such as local government committees and school governors to share information on recruitment processes and to examine the feasibility of a joint database for nominations.

- regional annual reports should detail progress towards the achievement of targets.

- regions should set targets within management contracts (DHAs and FHSAs).

Trusts

- trusts should show who the non executive directors are and how they intend to monitor recruitment of black and ethnic minority directors in their business plans.

THE NATIONAL HEALTH SERVICE

Chairs

The working party believes that all chairs should play an active role in ensuring the full participation of board members and the full functioning of the board. Chairs should therefore ensure that there are provisions to meet the training needs of all board members.

It is also important that chairs regularly consult black and ethnic minority non executives to discuss their feelings of satisfaction/dissatisfaction with board affairs. Chairs must ensure that black and ethnic minority non executives are able to contribute their skills and expertise fully to the board.

Positive action

All health authorities and trusts must look at new methods for seeking out and enabling more black and ethnic minority people to come forward as potential non executive members. Boards should consider implementing positive action measures to recognise and develop transferable skills and make use of potential. Such measures could include the following schemes:

- Mentoring schemes – if potentially suitable candidates have been identified who lack experience of board procedures and affairs, boards should consider setting up mentoring schemes. This may involve the potential candidate being paired up with an experienced board member who will brief the candidate on their role. Opportunities should also be provided for the 'shadowing' of the member at appropriate board meetings and business.

- Pre-appointment training – boards should consider establishing a programme of training for a range of potentially suitable candidates who lack certain skills and knowledge. The training programme could cover such issues as committee skills, public speaking and financial analysis. The programme could also provide advice to candidates on opportunities to gain the appropriate skills, for example, through becoming involved in local community activities.

Dealing with discrimination

While it is outside the remit of the working party, it is believed that the NHS needs to acknowledge and address issues around covert and overt discrimination. To ensure effective working throughout the system it is important that all non executives understand the different ways discrimination can manifest itself. Greater understanding can help to remove barriers to both the recruitment and retention of black and ethnic minority non executives and ensure active progress towards equality. Initiatives that should be taken to address discrimination include:

- ❑ all board members should be provided with training on equal opportunities and the statutory requirements of anti-discrimination legislation
- ❑ all boards should regularly monitor and review their recruitment and selection of black and ethnic minority people
- ❑ all boards should consider establishing exit interviews for board members who resign to identify and address any experiences of discrimination or perceived marginalisation.

Getting managers on board

Executive directors should be provided with opportunities to receive training on race equality as it relates to a range of issues in employment practices and service provision. Training on race equality should be seen as a part of their mainstream training activities.

Executive directors should be encouraged to seek out good practice in race equality, not only in the health services but also in other parts of the public sector and in other countries.

CONCLUSION

In conclusion, the working party was heartened to see that the NHS is beginning to develop initiatives to promote the recruitment of more black and ethnic minority non executive members. However, as the latest figures show, few members on NHS boards are from black and ethnic minority communities. Strategic action to redress the situation is limited.

While authorities and trusts have made some progress, there are many boards which are predominantly white and male. The situation must change, otherwise we do a disservice to both the NHS and the community at large. There is a particular challenge for ministers in setting an agenda for change. However, all authorities and trusts need to develop plans and strategies to bring about real and consistent change. They also need to make board membership an attractive option for black and ethnic minority people.

The determined pursuit of equal opportunities makes a critical contribution in management terms. It is not about political correctness, it is about efficiency and effectiveness. It is also about equity, equality and empowerment in health terms. There needs to be a concerted move away from rhetoric and towards action. We hope that this report will provide a realistic framework to support that action.

Tapping into a wider pool of talent can ultimately only ensure the improvement of decision-making and leadership across the NHS. These opportunities are too great to ignore.

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There is no shortage of people from black or ethnic minority communities who could make a positive contribution to NHS boards, yet few board members are from these communities. This situation must change, otherwise we do a disservice to both the NHS and the community at large.

Equality Across the Board sets out a framework for action, showing what could and should be done by ministers, health authorities and trusts in order to tap into a wider pool of talent which will improve decision-making and leadership across the NHS.

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