EQUAL OPPORTUNITIES TASK FORCE
OCCASIONAL PAPER NO 4

Health authority equal opportunities committees

King Edward's Hospital Fund for London

HEALTH AUTHORITY
EQUAL OPPORTUNITIES COMMITTEES

KING EDWARD'S HOSPITAL FUND FOR LONDON

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PREFACE

The King's Fund Task Force was set up to help health authorities to tackle racial discrimination by implementing effective equal opportunities policies. The Task Force decided that their first priority would be to provide guidance and advice about the development of policies to ensure equality of opportunity in employment.

The Task Force has so far published a model equal opportunities employment policy for the NHS, and guidance papers on equal opportunities advisers and ethnic monitoring.

This paper looks at the role of health authority equal opportunities committees and the part they can play in facilitating the implementation of an equal opportunities policy. It does not categorically recommend the setting up of equal opportunities committees but rather details the circumstances in which they can be useful and makes recommendations to improve their effectiveness.

There are two appendices. The first outlines the terms of reference and membership of four equal opportunities committees, three dealing with employment and one with service delivery. The second appendix lists some publications providing useful information relevant to the status, working and performance of health authority equal opportunities committees.

The paper was prepared by Laurence Ward, the Task Force project officer in 1988. Information was collected through interviews, by researching relevant literature, and reviewing the committees agendas, minutes and reports which the Task Force routinely receive. Those who agreed to be interviewed included chairmen and members of health authorities and of equal opportunities committees, health service managers, personnel staff, equal opportunities advisers and staff-side representatives, and others from outside the service. We thank them all for their time, invaluable expertise and support.

The paper was produced before the publication of the NHS White Paper *Working for Patients*. Although the new arrangements which the White Paper proposes may entail some changes particularly for members committees, the principal recommendations in this paper will remain relevant for all committees set up to achieve change in the equal opportunities arena.

1 INTRODUCTION

1.1 The manner in which an equal opportunities policy is formulated, adopted and implemented is usually dependent on the organisational and management culture already in existence in the health authority concerned. For this reason there are differences between health authorities in terms of who formulates the policy, how it is subsequently implemented, and its progress monitored.

1.2 Some health authorities see the implementation of an equal opportunities policy in employment as primarily a personnel management function, delegate responsibility through the district general manager to the director of personnel, and then let the personnel and training departments 'get on with it'. Others see equality of opportunity in employment and service delivery as essentially related, and achieving equal opportunities therefore becomes the responsibility of general management. The differences of approach lead to different decisions when it is decided whether or not to set up an equal opportunities committee, and when the terms of reference and membership of the committee are being considered.

1.3 There are now about 40 health authorities which have set up equal opportunities committees at district level. There are wide variations in the terms of reference, membership, methods of reporting, powers and performance of these committees. There are also differences in their names, structure and function. In some cases the name of the committee will give a clear indication of its function, whilst in others this is only apparent on examination of its terms of reference.

1.4 Some district health authorities have also set up committees at unit level to facilitate the implementation of equal access to the particular services the unit provides. In some cases such committees precede district-wide initiatives. In the employment field there are few committees at unit level; where they exist they have commonly been set up as a consequence of a district programme of action and are more dependant on district-wide initiatives.

1.5 Some regions have set up equal opportunities committees in relation to their own role as employers, and many of the issues raised in this paper will be relevant to them. At least one region has, together with staff-side, used the committee structure to progress equal opportunities in its districts. Although there are some formal similarities in the

region-district and district-unit relationships they are not sufficient to allow for meaningful generalisation to be made at this stage, and are therefore not included in this paper.

1.6 Although the paper deals mainly with health authority equal opportunities committees as they relate to racial equality in employment, many of the issues raised will be relevant to committees which deal with equal opportunities and/or access in service provision for black and ethnic minorities. Similarly, many of the issues relevant to committees with a race equality remit will be relevant to committees looking at disability and sex discrimination issues if they are set up separately. In practice most employment committees deal with equality of opportunity on grounds of race, sex and disability.

2 WHY SET UP AN EQUAL OPPORTUNITIES COMMITTEE?

2.1 There are considerable differences of opinion within and between health authorities about the efficacy of committees and working parties generally. One concern about members' committees, for example, is that they can encourage members to become inappropriately involved in operational management. Other committees and working parties can run into difficulties with regard to the roles and responsibilities of individuals on the committee, whether it be as managers, members, staff-side or black and ethnic minority community representatives. Difficulties can also arise with the way in which the committee is linked to the strategic and operational management process. The introduction of general management has brought such issues into sharper focus with its emphasis on line management and individual managerial accountability.

2.2 Most health authorities which have set up equal opportunities committees have done so because they generally use committees in their work. Thus an equal opportunities members' committee will exist side by side with standing committees such as finance, planning and personnel, and ad hoc committees for issues such as privatisation.

2.3 Some health authority equal opportunities committees have provided the forum for black and ethnic minority community representatives to have an input into health authority equal opportunities planning and implementation. In a number of cases health authorities have set up committees specifically to facilitate the process of consultation with representatives from black and ethnic minority community groups,

whilst at least one health authority involved black community representatives in an attempt to validate the committee's work. The issue of community representation is dealt with in chapter 5.

2.4 On occasion committees have been set up specifically either to check or to speed the process of change. One members' committee was set up because of concern by the health authority that management was proceeding too far and too fast. The committee modified and reduced the plans which management wished to implement. In another health authority the committee was set up to 'direct' management when the health authority members were concerned that their policy was not being implemented with sufficient diligence. This members' committee adopted a forceful style, seeking to ensure that the policy was implemented comprehensively and systematically.

2.5 Some equal opportunities committee members feel that their committee is little more than a talking shop and has been set up to give the appearance of action whilst in reality achieving little. This impression may be a consequence of the committee's constitution and its constrained powers, or because of its methods of working. Most health authorities committees, including equal opportunities committees, are advisory committees with no developed powers, and as such their role is necessarily limited. Equally, all equal opportunities committees operate on a consensus basis.

2.6 The work of some committees has led to the appointment of equal opportunities advisers. When appointed, advisers have in some cases helped to redefine and clarify the terms of reference, role and membership of the committee. Committees in turn provide support to advisers and backing for their work, and this can be an important part of their function. In some case committees have been able to assist the advisers in particular aspects of their work, either in providing advice or assistance in dealing with problems, or in identifying resources for general implementation or policy development.

Conclusion and recommendations

2.7 *Health authority equal opportunities committees are best set up, and work most effectively, when they are part of the way in which an authority generally works. Their advantages are that they:*

- *can involve those with expertise, experience and responsibility;*

- *give impetus to the formulation and subsequent implementation of the policy;*
- *demonstrate to all staff the importance attached to the policy;*
- *provide a forum for detailed debate;*
- *ensure that the policy is systematically implemented across all the health authority's units of management;*
- *allow members to become involved in issues that concern them; and*
- *involve community representation, and provide support for the work of equal opportunities advisers.*

2.8 *Committees should not be set up where they have no clear cut role or function, and where there is no commitment from the authority to the implementation of an equal opportunities policy. In these circumstances the existence of a committee is merely tokenistic.*

2.9 *Health authorities which are committed to implementing an equal opportunities programme of action, but who feel that committees are not the best way for doing so, should clearly identify and resource alternative ways in which the work otherwise done by a committee can be carried out. These could include greater priority and more management time and attention being given to objective setting, performance review and management delegation, the appointment of an adviser, some combination of these, or some other means.*

3 WHAT SORT OF COMMITTEE?

3.1 There are at least four types of health authority equal opportunities committee, all with inherent advantages and disadvantages. Local factors also affect performance.

3.2 First, some health authorities have set up equal opportunities committees as full member sub-committees of the authority, on a par with sub-committees such as finance and planning. These groups are always chaired by a member of the authority, usually someone with particular experience, expertise or interest in issues of race, sex and/or disability.

3.3 Secondly, some health authorities have used existing standing committees, such as the planning and administration member group, or the joint staff negotiating committee (JSNC), and added equal opportunities to their remit. Sometimes the task is formally delegated but in other cases the commitment of the chairman of the relevant committee leads to the issue being taken on board. These committees can deal effectively

with the issues because they are already established with clear methods of working, but they must determine from the start what proportion of their time will be allocated to the equal opportunities programme, and ensure that this is adequate. It may also be necessary to co-opt people on to such a committee because existing members may not be equipped with either the power or the knowledge to monitor effectively the implementation of an equal opportunities policy.

3.4 Thirdly, in some health authorities the equal opportunities committee is a sub-committee of an existing committee of the authority, usually the personnel committee or the JSNC. Such committees tend to attract less interest from members, have low level management involvement, and complex reporting mechanisms because of their distance from the full authority or the district general manager. They tend to have little authority or power to ensure that their recommendations are implemented.

3.5 Finally, in some cases health authorities have set up ad hoc committees with vague and general terms of reference. These include committees with a large number of black and ethnic minority community representatives and little representation from senior managers or members, and others that are 'management' committees with vaguely defined member involvement. These committees usually fail to achieve results.

Conclusions and recommendations

3.6 *The status of the equal opportunites committee compared to other committees of the authority will have important consequences for its work. Whilst a number of interdependent factors such as membership, methods of reporting and manner of working will affect performance, health authorities should ensure that the equal opportunities committee is given a status that demonstrates that the issue is being considered in a serious and comprehensive manner.*

3.7 *In most instances this will be achieved by giving responsibility to a full members' sub-committee of the authority. Where this is not feasible an existing standing committee of the authority may be allocated the task, but with a clear statement of how much time the committee will allocate to equal opportunities, co-option to ensure that the committee contains people with the relevant power and knowledge, and a review procedure to monitor progress.*

3.8 *Equal opportunities committees work least well where they are sub-committees of existing standing committees, and should not be set up where they have no formal status.*

4 TERMS OF REFERENCE

4.1 Committees have been given different roles in relation to the equal opportunities policy. They may be required to formulate or implement, or monitor the implementation of the policy. They also differ in terms of the groups – race, sex, disability – they cover, and in whether they consider service delivery or employment or both. It is therefore important that their remit and terms of reference are carefully thought through, and that the manner in which they link into existing management processes is clearly defined.

4.2 Some health authority members' committees have been set up solely to formulate the policy, with the subsequent implementation left to officers. In other health authorities, officers have formulated the policy together with an action plan which recommends the setting up of an equal opportunities committee. The authority has then approved both the policy and the action plan, and a committee has been set up to monitor the implementation of the policy.

4.3 Other health authorities, however, have given their committees responsibility for implementing the equal opportunities policy. This gives the committee an operational function which properly belongs to management. Although in many of the committees the line between policy and operational matters is often blurred, committees must not be given responsibilities which they do not have the power or resources to put into effect.

4.4 Health authorities have to decide whether to incorporate equality of opportunities in service provision or employment or both within the remit of the committee. Some health authorities have set up committees dealing with services first, seeing it as their priority to ensure that their services are adequate and appropriate to people from black and ethnic minority communities, whilst others have given priority to employment. At least one authority has expanded the terms of reference and membership of its employment committee so that it could begin to consider services.

4.5 Whilst there are clear links between equal opportunities in employment and service provision, authorities will find that there is a great deal of work to be done in each area. Committees are unlikely to be able to deal in sufficient depth with both and will tend to concentrate on the area which interests members most. Furthermore, the managerial input required for employment committees and service committees is different, as may be any outside experts involved. Bringing all these together is likely to result in an over-large committee. Two separate committees are therefore more likely to be able to deal with the different issues effectively. Links can be maintained by means of some shared membership, the circulation of papers and reports to the health authority.

4.6 Health authorities have also to decide whether the remit of the committee should encompass all the groups covered by the policy. Some health authority employment committees follow this course, whilst others have focused exclusively on achieving racial equality. Terms of reference relating only to racial equality enable more time to be devoted to this issue, and make sense for committees where equal opportunities service and employment issues are combined. However the similarities between the action required at the early stages of policy implementation to ensure equality of opportunity in employment for black and ethnic minority groups, women and people with disabilities make it sensible for the committee to have the wider remit. At later stages of policy development there may be a need to look at some issues separately and to decide on priorities for action. Local authorities which have set up separate committees for the different groups covered by the policy have encountered immense difficulties in coordinating the work of all the committees and linking in this work with existing management processes. Health authorities can avoid this mistake by co-opting people with the relevant expertise, and should not set up separate committees for all the groups covered by the policy.

Conclusions and recommendations

4.7 *Health authorities must decide what role the committee is to play in relation to the policy, ie whether the committee is to formulate the policy or to monitor the implementation of the policy. Committees should not be given an operational role with respect to the implementation of the policy.*

4.8 *We recommend that separate committees be set up for service provision and employment, and that employment committees have a district-wide*

role. Service provision committees should be based in particular units of management, with their work coordinated within a district-wide strategy and subject to regular review by the general manager and the health authority.

4.9 *We also recommend that health authority equal opportunities employment committees consider all the groups covered by the policy, at least in the initial stages of their work. We recommend against having separate committees dealing with race, sex, disability and other grounds of discrimination covered by the policy. Committees should co-opt experts in the different fields as the need arises.*

5 MEMBERSHIP

5.1 The membership of the committee will be largely determined by the terms of reference. Thus employment committees will include representatives from personnel and/or manpower departments, whilst committees on services are more likely to include unit general managers and service managers.

5.2 Committees have received different levels of officer support. In most employment committees the director of personnel, as well as unit personnel representatives, sit on the committee. It is important that senior officers are members of, and attend, the committee, to ensure that its recommendations have management backing and are effectively implemented. Committees dealing with service provision should also include a representative from the personnel department to provide expert advice on the personnel implications of their policies.

5.3 Most health authorities equal opportunities committees do not include representatives from departments such as planning, training, information or finance. All these play an important part in the successful implementation of the policy, as do other groups of staff such as nursing and medical personnel. Whilst involving too many departments and staff groups in membership would result in an over-large committee, departmental representatives should be involved as appropriate. Professional representatives such as medical and nursing staff should, as for personnel and member representatives, be of senior status and authority.

5.4 The health authority members who sit on equal opportunities committees are nearly always self-selected. They are usually members with

an interest, expertise or experience in equal opportunities issues. Where the chairman of the authority chairs the equal opportunities committee this brings momentum to the implementation programme, and again underlines the importance attached to the policy.

5.5 Health authority members on equal opportunities committees also have an important role in raising issues in relation to other items on the full authority agenda. Health authorities do not as yet ensure that all papers that go to the full authority include reference to the equal opportunities implications, and the members who sit on the equal opportunities committee are uniquely placed to raise these issues.

5.6 Members who are not openly supportive of equal opportunities policies should not be selected to serve on such committees. Their presence can have a negative effect in terms of both the progress and public relations aspect of the committee's work. Where the authority includes black or ethnic minority members it should not be assumed that they will necessarily have expertise or commitment to the implementation of equal opportunities policies, or that they will want to join the equal opportunities committee, rather than some other committee.

5.7 Committees with responsibility for formulating and monitoring the implementation of an equal opportunities employment policy need expertise which may not initially be available from amongst managers or members. Equally, health authorities may wish to involve staff and representatives from outside organisations in order to promote common ownership, which includes understanding of and responsibility for the policy. In many cases the JSNC and the local community relations council (CRC) have provided or identified appropriate representatives for these purposes.

5.8 Some health authorities have not included staff-side representation on their equal opportunities committee, and all consultation with staff representatives has taken place within the framework of the JSNC. Staff-side representation on equal opportunities committees is not a replacement for formal consultation but can facilitate that process, since many matters and potential problems will have already been ironed out in the equal opportunities committee, with staff-side representatives participating in the decisions taken there. The general practice followed for other committees may be the best determinant of whether or not, and in what capacity, staff-side are invited to join equal opportunities committees.

5.9 Black and ethnic minority community representatives have been invited to join equal opportunities committees not only to provide expertise and extend ownership of the policy, but also to ensure that there is black and ethnic minority representation in the group. There are few black or ethnic minority managers in the health service, and so where black or ethnic minority representation exists it is usually from staff-side, members or the community. Black and ethnic minority community representation can raise difficult and sensitive issues and it is essential that it is carefully thought through by all parties.

5.10 Black and ethnic minority membership is necessary if equal opportunities committees are to carry credibility, but membership must not be tokenistic. Members of black and ethnic minority community health groups are essential, for example, on committees examining equality of service provision because they have links with, and in some cases act as representatives or advocates for, actual or potential consumers of the authority's services. Similarly in the employment field, black and ethnic minority representatives should be selected for the expertise and influence they are able to bring and to fulfil an explicit role.

5.11 It is unfortunate that often the first, and in many cases only, contact health authorities have with black and ethnic minority community groups is in connection with their equal opportunities policy. Inexperience in consultation generally on the part of the health authority and lack of familiarity among the communities of health authority processes can lead to misunderstandings and frustrations which are then focused on the development of the equal opportunities policy. Health authorities could usefully provide introductory briefing for community representatives who are invited to join equal opportunities committees. This should include information about health authority structures and decision-making processes, and would ensure that representatives were clear about the committee's function in relation to the authority, the powers of the committee, the role they are expected to play, and the contribution expected from them.

5.12 It must not be expected that the existence of a committee, notwithstanding the involvement of black and ethnic minority community representatives, will provide sufficient consultation with communities or adequate expression of their concerns. Other means of regular consultation must be devised. In some areas this has been facilitated by the community health council (CHC) or CRC.

Conclusions and recommendations

5.13 *Health authority members with authority or with experience and expertise in equal opportunities should be chosen for the committee. It must not be assumed that black and ethnic minority members, where they exist, will necessarily have this experience. Members who are not clearly supportive of equal opportunities should not be invited on to the committee.*

5.14 *The director of personnel should be a member of the employment committee, and the relevant unit and service managers of service provision committees. The use of deputies should be avoided. The personnel department should be represented on service committees. Committees should also involve as appropriate representatives from the training, planning and finance departments, and senior nursing and medical staff.*

5.15 *Staff-side representation should be considered, particularly if it is the general practice of the authority to involve staff in committee work.*

5.16 *CRC representatives should be involved in employment committees if there is not adequate black or ethnic minority representation, or adequate expertise about equal opportunities, in the health authority. Representatives of black and ethnic minority community health groups will be essential for any committee dealing with service provision. These groups are commonly organised around particular services and should be included in service provision committees at unit level. Health authorities should provide introductory briefings for all community representatives before they take their places on committees.*

5.17 *Equal opportunities advisers must be members of the committee. Where they are required to service the committee they must be provided with the resources to do so effectively.*

6 HOW DOES THE COMMITTEE DO ITS WORK?

6.1 Committees work in different ways depending on the task in hand and the culture and organisational arrangements of the health authority concerned.

6.2 Some equal opportunities committees are badly serviced and unprofessional, for example minutes are not circulated to all committee members and agendas for meetings are often not available. Sometimes no clear method of working is discernible, responsibility for action is not

allocated or deadlines set. In some cases this reflects the importance attached to the issue. Agendas, minutes and reports are particularly important for committees dealing with race matters because of the possible anxieties and suspicions that frequently attach to these issues in health authorities.

6.3 Other committees have become involved in operational detail and have undertaken work on the implementation of the policy that properly is the responsibility of officers. Some committees, for example, have become involved in redesigning application forms, the detailed devising of monitoring procedures, and reviewing sources of recruitment; or have spent time discussing and evaluating the content of individual training programmes rather than reviewing the overall provision of appropriate training. Other committees have tried to become involved in individual complaints against the authority, or have formally visited units of management without clearly deciding on the form, purpose or value of the visits.

6.4 Some committees tackle issues only in units where there is a willingness to implement the policy. The progress across the authority is accordingly uneven. Furthermore the units that are most eager to implement the policy are often not the units where the most urgent work needs to be done. There is a case for beginning the work in units that are keen to implement the policy, in order to demonstrate early success and to allay the apprehensions there may be about the operational aspects of the policy. However the equal opportunities committee must ensure that a corporate strategy is followed, and not allow the implementation of the policy to become dependent on the commitment of individual managers.

Conclusions and recommendations

6.5 *Committees with responsibility for formulating a policy have achieved the quickest results when they have taken an existing policy, such as the Task Force model policy, policies developed by other health authorities, or in one case the South East Region Trades Union Council model policy, and used the Commission for Racial Equality Code of Practice as a base to draw up a policy and programme of action appropriate to their local circumstances.*

6.6 *Committees with responsibility for monitoring the implementation of the policy work best when they strategically review all the different aspects of*

the policy to ensure that they are implemented, systematically assessing the progress and difficulties of particular units of management. The committee might, for example, consider whether recruitment or promotion procedures have been reviewed throughout the authority, and whether agreed training programmes have been effected. The committee must receive regular ethnic monitoring analyses in order to assess the effectiveness of the policy and recommend future priorities, and has a particular role in ensuring that annual action plans agreed by the authority are carried out.

6.7 *Committees should also ensure that equal opportunities issues are raised in relation to other important items on the health authority's agenda, such as strategic planning, finance, training, personnel, manpower and service planning. This may be done by briefing relevant members, or by establishing a procedure whereby officers include the equal opportunities implications in all proposals submitted to the full authority.*

7 HOW DOES THE COMMITTEE REPORT AND TO WHOM DOES IT REPORT?

7.1 Equal opportunities committees' reporting mechanisms vary widely. Members committees with identical structures are in some cases advisory committees to the authority and in others advisory committees to the district general manager. In some instances it is not possible to define clearly whom committees report to or how.

7.2 There are in some cases complex reporting relationships, such as where the equal opportunities committee is a sub-committee of another committee, which may or may not report to the authority. A reporting relationship, for example, where the equal opportunities committee reports through the personnel committee to the director of personnel, who in turn reports to the district management board, and thus through the district general manager to the full authority, will cause delay. The more complicated the reporting relationships, the less likely it is that the committee will be able to bring about change.

7.3 Committees set up as advisory committees to the authority will constitutionally report to the full authority. There will normally be a formal report, at least annually, on their work. In some cases all the committee's minutes, as well as an annual report, go to authority members.

7.4 However the recommendations of committees which report to the district general manager, or the district management board, will not necessarily be considered by the authority. Progress will be affected by the commitment of the district general manager and the management board and the priority they accord to equal opportunities issues. In at least one case, the equal opportunities committee felt that the district general manager was not sufficiently supportive of their work and would have preferred a reporting line to the full authority.

Conclusion and recommendations

7.5 *Clear decisions must be taken about how the equal opportunities committee will report and to whom.*

7.6 *The district management board has a significant role in relation to the resource and staffing implications of implementing an equal opportunities policy, and it is necessary for any implementation proposals to be discussed with them prior to being submitted to the full authority. It may be useful for the district management board to receive minutes, or more regular reports from the committee than the annual report to the full authority.*

7.7 *It is however the responsibility of the full authority to ensure that their equal opportunities policy is implemented and that the work of the committee is effective. All equal opportunities committees must therefore have a direct reporting mechanism to the full authority.*

8 THE PERFORMANCE OF HEALTH AUTHORITY EQUAL OPPORTUNITIES COMMITTEES

8.1 It is difficult as yet to measure the performance of health authority equal opportunities committees. Most committees are relatively new, and no clear relationships have been established between factors such as membership, reporting lines, methods of working and the effectiveness of committees in ensuring the implementation of the equal opportunities policy. Some equal opportunities initiatives have taken place in health authorities because of the commitment of individual officers or members rather than because of an equal opportunities committee. It is clear that health authorities with good personnel policies and practices will find it easier to implement an equal opportunities policy than those

without them. Some health authorities have used existing management processes, such as objective setting and individual performance review, to further implementation of specific parts of their policy. However, in these circumstances also a committee can be useful in formalizing this process, and assisting in objective setting and resource identification.

8.2 There are some measures which can be used to assess the performance and effectiveness of equal opportunities committees. First, there are criteria that can be taken as minimal for functioning. These include matters such as the proper provision of agendas, minutes and reports, attendance, and the frequency of meetings. Some equal opportunities committees have never met, and others meet at irregular intervals. Attendance at meetings is relevant, in terms of both the number of committee members who attend regularly and whether junior staff frequently deputize for senior managers.

8.3 Secondly, there are criteria for effectiveness which include many of the wider structural and functional issues dealt with throughout this paper. Whilst it is not possible to determine the precise relationship between all these issues and performance, it is clear that committees with vague or inconsistent terms of reference, inappropriate membership or inadequate reporting lines are unlikely to be effective.

8.4 Thirdly, comparison with the performance of other committees can also be instructive, whether with other equal opportunities committees in the same or other authorities or with standing committees of the authority. Some health authorities have effective equal opportunities committees for services but ineffective committees for employment, whilst others have very effective committees on issues such as privatisation and very ineffective committees on equal opportunities.

8.5 However, there are other measures of the committee's performance which are the most significant. Chief amongst these is the time which it takes to get a policy formulated and/or the implementation programme in place. Some committees have taken less than six months to develop policies and action plans, whereas others have taken several years.

8.6 In the longer term, the only real measure of the work of the committee will be the degree to which it contributes to the elimination of racial discrimination and inequality and the promotion of equality of opportunity in the health authority. In employment, this will be quantifiable in terms of the numbers of black and ethnic minority employees and the

positions they occupy. At present the lack of data about the ethnic origins of health authority employees and job applicants makes it impossible for most health authorities to use these measures. They are however the only meaningful touchstone of success.

Conclusion and recommendations

8.7 *The main determinants of progress and of the committee's effectiveness are likely to be the commitment of the members, and particularly that of the chairman, to the policy; the seniority of the officers on the committee; the support there is amongst other managers and staff for implementing the policy; the degree to which good personnel policies and procedures already exist in the health authority concerned; and the ability of the committee to link in to existing management processes.*

8.8 *Committees should in particular ensure that the minimal criteria for functioning identified above are met. They must operate in a business-like way and should meet regularly, at least quarterly, and on dates that coordinate with meetings of the district management board and the health authority.*

8.9 *Committees must set realistic targets for what they expect to achieve in any year. Whilst initially these will relate to the formulation of a policy and oversight of its implementation, in the longer term the success of a committee will be judged by measurable change towards racial equality in the employment profile of the health authority. Committees should seek to ensure that quantifiable monitoring data becomes available as soon as possible. Committees should review their work annually, identifying problems and proposing appropriate solutions.*

8.10 *When they work well committees provide valuable assistance in formulating and monitoring the implementation of equal opportunities policies. The general management process must however be applied to equal opportunities as it is to other policies, and health authorities must ensure that committees do not become the sole focus of their work on equal opportunities. The responsibility for ensuring that an authority adopts an equal opportunities policy and that it produces results rests ultimately with the health authority as a whole and its senior management.*

The Task Force will be pleased to provide further advice and assistance on the setting up and working of equal opportunities committees, or on other aspects of the implementation of equal opportunities policies. Enquiries should be directed to the Task Force office, 14 Palace Court, London W2 4HT, telephone 01–727 0581, ext 2222.

APPENDIX 1 EXAMPLES OF HEALTH AUTHORITY EQUAL OPPORTUNITIES COMMITTEES

A: BASILDON AND THURROCK HEALTH AUTHORITY

Name and status
Equal opportunities joint steering group

Terms of reference
1 To review the content and nature of the authority's equal opportunities policy and promote its implementation;
2 to identify aims and objectives within the field of equal opportunities in employment;
3 to review employment practices, procedures and documentation, and endorse recommended modifications and developments where appropriate;
4 to monitor the effectiveness of the policy on the basis of the collection and analysis of relevant data on existing employees and job applicants;
5 to submit annual progress reports to the district health authority.

Membership
The group is chaired by the chairman of the health authority and comprises staff representatives (nominated via the DJSC) and managers drawn from across the range of functions and occupational groups within the district.

Frequency of meetings
Quarterly

B: LEEDS EASTERN HEALTH AUTHORITY

Name and status
Members' working group: equal opportunities.

Terms of reference
To determine the activities in achieving the objectives of an equal opportunities programme.

Membership
A working group of members along with appropriate officers and drawing on the expertise of the Commission for Racial Equality, the Community Relations Council and the City Council.

Frequency of meetings
Six times a year.

C: BLOOMSBURY HEALTH AUTHORITY

Name and status
Equal opportunities sub-committee of the personnel committee.

Terms of reference
1 To monitor the effective implementation of the authority's equal opportunities policy;
2 to consider proposals from management for further development of the policy and programme;
3 to advise the DHA through the personnel committee of actions required to enable the authority to fulfil its obligations under the non-discrimination legislation;
4 to establish consultative arrangements with representatives of local community organisations on equality issues;
5 to request reports of management on the operation of the policy;
6 to liaise with the finance committee on the financial implications of initiatives;
7 to submit to the personnel committee and the DHA an annual report on progress within the district;
8 to review existing personnel procedures and practices in the light of the policy;
9 adoption of new procedures and practices as they relate to the authority in its role as an employer;
10 to link the provision of equal opportunities to equal access to services;
11 to convene ad hoc working groups to examine procedures which may influence equal opportunities in employment;
12 to amend and update the authority's policy following consultation with the DJSC.

Membership
Chaired by the chairman of the authority. The committee includes five members, one representative each from the CHC, the local black community, women and people with disabilities. Officers in attendance include the four management board members with responsibility for equal opportunities and the equal opportunities adviser.

Frequency of meetings
Quarterly

D: HAMPSTEAD HEALTH AUTHORITY

Name and status
Joint DHA/CHC ethnic minorities working party.

Terms of reference
1 To produce a demographic profile identifying the ethnic minority groups living in Hampstead health district, and the pattern of disease and illness in these groups;
2 to identify the problems faced by local ethnic minority groups in gaining access to and in using health services;
3 to examine how the district currently delivers its services in the light of the problems identified;
4 to assess whether existing services need to be changed or improved so that they are more useful, appropriate and accessible to patients from ethnic minorities – this process to be assisted by the examination of existing examples of good practice;
5 to make specific proposals for developments;
6 to establish a vehicle to monitor progress, and to ensure that all future service developments take into account the needs of ethnic minority groups.

Membership
Three DHA members, three CHC members, one officer.

Frequency of meetings
Quarterly

APPENDIX 2 READING

DHSS. *Health Services Management: the membership of District Health Authorities*. HC(81)6.
DHSS. *Voluntary organisation representation on Joint Consultative Committees*. HC(84)9.
Chris Ham. *Managing Health Services: health authority members in search of a role*. Bristol, SAUS, 1986.
Allan McNaught. *Race and health policy*. London, Croom Helm, 1988.
National Association of Health Authorities. *Action not words: a strategy to improve health services for black and minority ethnic groups*. NAHA, 1988.
Ken Young and Naomi Connolly. *After the Act: local authority policy reviews under the Race Relations Act 1976*. Local Government Studies 10, 1, 1984.

Task Force publications

King's Fund Equal Opportunities Task Force. *A model policy for equal opportunities in employment in the NHS*. Occasional paper no 1. London, King Edward's Hospital Fund for London, 1987.
King's Fund Equal Opportunities Task Force. *Equal opportunities advisers in the NHS*. Occasional paper no 2. London, King Edward's Hospital Fund for London, 1988.
King's Fund Equal Opportunities Task Force. *Equal opportunities employment policies in the NHS: ethnic monitoring*. Occasional paper no 3. London, King Edward's Hospital Fund for London, 1989.

EQUAL O

CHAIRMAN

Thelma Golding	Chairman, Hounslow & Spelthorne Health Authority

MEMBERS

Dwomoa Adu	Consultant Physician and Nephrologist, Queen Elizabeth Medical Centre, Birmingham
Margaret Attwood	Manager of Organisational Development, Mid-Essex Health Authority
Bryan Carpenter	Director of Manpower, Plymouth Health Authority
Mary Coussey	Director, Employment Division, Commission for Racial Equality
Howard Fried-Booth	National Health Service Training Authority
Robert Maxwell	Secretary/Chief Executive Officer, King Edward's Hospital Fund for London
Kumar Murshid	Chairman, Tower Hamlets Health Authority Members' Equal Opportunities Committee
Asmina Remtulla	Health Visitors Association
Peter Westland	Association of Metropolitan Authorities
Peter Wormald	Director of Operations (Personnel), NHS Management Board

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Joy Gay	Information Officer
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