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Consultation on proposed changes to legislation

Background

NHS England is inviting patients, NHS staff, partner organisations and interested members of the public to give their views on potential proposals for changing current primary legislation relating to the NHS in order to deliver the commitments set out in the Long Term Plan. Whilst it is possible to implement the NHS Long Term Plan without primary legislation legislative change could make implementation easier and faster.

NHS England wants to hear from as many people and organisations as possible. They intend to share feedback with other NHS bodies, the Parliamentary Health and Social Care Select Committee and the Department of Health and Social Care to further develop ideas.

As EDC members we have discussed the need for a diverse and inclusive leadership amongst those appointed as senior leaders and chairs and non-executives of NHS boards.

Discussion

If we look at the data of the appointments made up until 2002 The National Health Service Appointments Commission appointed 9.4 per cent from the black and minority ethnic communities and 4.2 per cent declared that they had a disability. Later data, for example from 2017[1], suggests that appointments for BME and disabled people onto NHS Boards has reduced, so Board leadership is significantly less diverse and inclusive than it was 15 years ago. Women make up almost three quarters of the NHS workforce, but are a minority of board members and very senior managers.

If we also look at the date from the report *Snowy White Peaks*[2] the report showed:

- That the proportion of London NHS Trust Board members from a BME background is 8%, an even lower number than was found in 2006 (9.6%);
- That the proportion of chief executives and chairs from a BME background has decreased from 5.3%; it currently stands at 2.5%.
- Two fifths of London's NHS Trust Boards had no BME members (executive or non executive) on them at all, whilst over half of London's Trust Boards either had no BME executive members or no BME non-executive members.
- There has been no significant change in the proportion of non executive BME Trust Board appointments in recent years, continuing the pattern of underrepresentation compared to both the workforce and the local population.
- The proportion of senior and very senior managers who are BME has not increased since 2008, when comparable grading data was available, and has fallen slightly in the last three years. The likelihood of white staff in London being senior or very senior managers is three times higher than it is for black and minority ethnic staff.

The data demonstrated that there remains a very significant gap between the composition of Trust Boards and also national NHS bodies and the rest of the workforce and the local population to whom services are provided. Research evidence suggested this may well adversely impact on the provision of services and denies the NHS the potential contribution a diverse leadership could make.

That research also suggests that NHS organisations which discriminate against black and minority ethnic staff may lose out as there is evidence of a link between diversity in teams (at every level including Boards) and innovation. At a time when the NHS needs to transform its care, lack of diversity may carry a cost in patient care for everyone and leadership bodies which are significantly unrepresentative of their local communities, such as NHS Trust Boards, will have more difficulty ensuring that care is genuinely patient centred – with resultant failings in the provision or quality of services to specific local communities that have particular health needs, including BME communities and patients. Where the organisational leadership better represents the ethnicity of staff, there is more trust, stronger perceptions of fairness and overall better morale of staff and higher levels of engagement.

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[1] From as yet unpublished NHS Confederation report `The need for Diverse Leadership',

[2] https://www.mdx.ac.uk/__data/assets/pdf_file/0015/50190/The-snowy-white-peaks-of-the-NHS.pdf.pdf

To make the best possible decisions, we believe senior leadership teams and NHS boards need to be made up of people with a mix of experience, qualities and skills. We need a significant amount of work to help improve the diversity of boards, and the development of the WRES and the WDES will help shine a spotlight on this issue. The Long-Term plan[3] sets out a specific commitment for each NHS organisation to set its own target for BAME representation across its leadership team and broader workforce by 2021/22. This makes a start on this agenda.

However, there are two substantive issues that the EDC believes has been instrumental in our regression in these areas:

- The independence of recruitment standards is something that has been lost with the merger of the TDA and the adoption of NED recruitment roles by executive Regional Directors, a task previously undertaken by independent teams who were not also tasked with executive performance. The EDC believes there is a potential conflict with the current model that has seen a distinct deterioration of diverse BME NEDS/Chairs since the abolition of the Appointments Commission and the emergence of the TDA and Foundation Trusts (FTs).
- In relation to FTs, The Kings Fund, in their paper written just before the emergence of FTs, warned of the likelihood of a reversal of progress on diverse Board appointments. CEs and chairs are increasingly highlighting the lack of diversity of FT Governors, that the existing skill specification (see Annex 1) leads to appointments to Boards being restricted to those with financial skills, and the potential for possible and actual negative impact this has had on diverse appointments.

Recommendation

To help address the declining numbers of senior leaders, chairs and non-executives from diverse backgrounds the EDC recommends that legislation should be amended so that either:

- An independent body is established to oversee senior NHS public appointments, with a specific and statutory goal to ensure senior and Board representation properly reflects the diverse nature of the local population, to provide specific development and support for senior leads, chairs and non-executives on equality, diversity and inclusion, and to help drive improvement through identifying good practice and opportunities for twinning with and being mentored by organisations that are more effective in addressing this deficit take place

Or

- Any new body being established (or merged) as a result of the changes to the new system architecture has a legal requirement to oversee senior appointments, to ensure there is a guarantee of independence and transparency in this process, with an additional requirement to ensure the body appoints or oversees appointment of people to senior posts and Boards that properly reflect their local populations.

And/or

- There should be changes to legislation to ensure that Governors demonstrate compliance with Public Sector Equality Duties as set out in 2010 Equalities Act.

[3] https://www.longtermplan.nhs.uk/

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Annex 1

What is the skill specification?

The chair role

Boards are led by the chair. Chairs need a range of skills to ensure board meetings are run effectively and that the board discharges its responsibility from a governance perspective. In addition, chairs need to have a vision for the organisation and be able to share this in a way that local communities understand. In short, they are ambassadors with boardroom competency who bring together their non-executives and hold the chief executive to account for performance. Often, they need good relationship building skills and since the Francis report the role of NHS chair, should include those whose values-based principles include openness, transparency, candour and strong patient-centred healthcare leadership.[i]

The non-executive role

The role of the non-executive directors in shaping, formulating and evaluating strategy is a recurring theme and important but from academic research on NHS Boards there is some evidence that this activity has been comparatively neglected on boards in the English NHS.[ii]

Technical Requirements

All those appointed to these leadership roles have to satisfy a number of technical requirements these are the Nolan principles, the Fit and Proper Person Test and a range of competences.

The Nolan Principles

Board members are expected to adhere to the Nolan Principles. These are

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

Fit and Proper Person

All those appointed are expected to meet the Fit and Proper Person test. The fit and proper person regulation (FPPR) requirements came into force for all NHS Trusts and Foundation Trusts in November 2014. The regulations require NHS trusts to seek the necessary assurance that all executive and non-executive directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role.[iii]

Competences

In 2006 the Secretary of State set out the following requirements from chairs and non-executives NHS Boards that they have the following specific set of competences amongst them.

- Finance experience in a large and complex organisation with the capacity to chair the Audit Committee and, ideally, a financial qualification;
- Governance experience; bringing experience of strategic planning, financial, risk and performance management;

- Commercial experience at senior level; bringing both governance and private sector expertise
- Voluntary sector or community service experience, with experience of regeneration, community development or service provision for disadvantaged groups;
- Specific expertise relating to the work of the organisation, such as consumer/customer focus, patient advocacy, market management, commissioning, contract management, local government, economic analysis and change management.

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

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[i] The Francis inquiry https://www.kingsfund.org.uk/projects/francis-inquiry-report?gclid=CjwKCAiAt4rfBRBKEiwAC678KZj7zCIXo-_0ax57hQYMa_dLjWI5jxTL37zVWZyEi9aKr2OQJn48WRoC4ZEQAvD_BwE

[ii] Towards a framework for enhancing the performance of NHS boards: a synthesis of the evidence about board governance, board effectiveness and board development. Health Services and Delivery Research, No. 1. 6. Chambers N, Harvey G, Mannion R, et al. Southampton (UK) 2013 https://www.ncbi.nlm.nih.gov/books/NBK259414/

[iii] Fit and Proper Person test https://www.nhsemployers.org/your-workforce/recruit/employment-checks/criminal-record-check/fit-and-proper-persons-requirement-for-directors

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Appointment Process for National Bodies

In the case of the NDPBs, appointments are made by ministers following the Code of Practice of the Commissioner for Public Appointments.

In particular

The health executive agencies: Medicines and Healthcare Products Regulatory Agency (Chair and 8 non-executives) and Public Health England (&chair and 3 non-executives). They employ their own staff and are allocated their own budgets.

Executive non-departmental public bodies: Care Quality Commission, (chair and 7 non-executives), Health Education England(Chair and 5 non-executives); Health Research Authority(chair and 4 non-executives) Human Fertilisation and Embryology Authority(chair and 13 non-executives), Human Tissue Authority(chair and 11 non-executives); NHS Blood and Transplant (chair and 9 non-executives); NHS Business Services Authority(chair and 5 non-executives), NHS Digital, NHS England, NHS Resolution, and the National Institute for Health and Care Excellence.

Advisory non-departmental public bodies: Advisory Committee on Clinical Excellence Awards, British Pharmacopoeia Commission, Commission on Human Medicines, Committee on Mutagenicity of Chemicals in Food, Consumer Products and the Environment, Independent Reconfiguration Panel, NHS Pay Review Body, Review Body on Doctors' and Dentists' Remuneration

Other advisory bodies: Accelerated Access Review, Administration of Radioactive Substances Advisory Committee, and The Health Service Safety Investigations Body, Morecambe Bay Investigation, NHS Counter Fraud Authority, NHS Improvement, National Data Guardian, National Information Board, Porton Biopharma Limited.

Professional Regulators: There are a number of other professional regulatory bodies these include the General Medical Council, Nursing and Midwifery Council, General Dental Council and the Health and Care Professions Council.