Equality and diversity in health governance systems: are we getting it right and are there lessons from COVID-19?

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Abstract

The COVID-19 pandemic highlighted major challenges in governance and inequalities particularly among those from Black, Asian and minority ethnic (BAME) groups. This paper focuses on the BAME community and explores this through a governance lens, with particular reference to the representation and functioning of boards involved in healthcare and building a transparent culture. To illustrate this, the paper utilises a series of structured reflective questions with model answers termed Right Question, Right Answer and links to the Centre for Quality in Governance (CQG) Maturity Matrix. This article highlights the need to improve diversity and accountability of health and care organisations to their staff and local population. For governance to be effective, it must be aligned and comply with healthcare system regulations to ensure improvement of legislative acts and standards. The paper aims to inform government policy by moving from rhetoric, or merely describing challenges, to action and change by increasing accountability.

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Introduction

In recent years, the UK health and care system has been under pressure to manage increasing demand on a background of financial constraints and workforce pressures. Additionally, there have been several high-profile serious failings within the NHS, which are well summarised in a Scottish Academy paper.[1] This summary report stresses the need to move away from merely describing the problem with failure to learn from the past, to a more structured approach that improves governance and accountability. Greater attention to inclusion and diversity within all governance structures must now be addressed. The recent UK government report by the Commission on Race and Ethnic Disparities[2] concluded that structural racism no longer exists in the UK. The report has been heavily criticised, particularly in relation to health and social care, with significant concern that it will result in worsening systemic health inequalities.[3] The COVID-19 pandemic has not only increased the strain on all health and care systems but has further emphasised endemic inequalities. Specific population groups experienced poorer outcomes during the pandemic including the elderly, male gender, care home residents, those with specific comorbidities or chronic conditions, high-exposure occupations and in particular those from lower socio-demographic backgrounds and ethnic minority groups.[4,5] Frontline health and care staff who responded to the challenge have also been affected physically and mentally with a disproportionate impact on those from Black, Asian and minority ethnic (BAME) groups.

In relation to organisational governance, numerous reports confirm underrepresentation of BAME groups on boards and management structures.[6,7] This problem continues despite the growing recognition of the important relationship between diversity and system performance. More diverse leadership

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Table 1 UK regulatory Acts and codes that apply directly to governance of the NHS

Legislative Act	Description
UK Health and Safety at Work Act 1974[25]	Duty of employers to ensure safety, health and welfare at work of their employees and to make sure their activities do not endanger others.
Management of Health and Safety at Work Regulations 1999[26]	Sets requirements of employers to manage health and safety under the Act. Main employer requirement is to carry out risk assessments, i.e. a careful examination of what, in a workplace, could cause harm to people, so that measures can be identified that eliminate or significantly reduce risk of harm.
Health and Social Care Act 2012[27]	Legal duties pertaining to health inequalities in England. Includes specific duties for all relevant health bodies including the requirement to have due regard to reducing health inequalities.
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20[28]	Enforces a statutory duty of candour: to be open and honest when things go wrong. The regulator in England is the Care Quality Commission (CQC) and in Scotland it is Health Improvement Scotland (HIS). Organisations risk criminal sanctions (fines and/or possible deregistration) if they fail to comply.

teams are associated with improved financial performance[8,9] and healthcare outcomes.[10,11] While the COVID-19 pandemic was an opportunity for rapid clinical innovation,[12] it should also be a catalyst for positive change in governance structures and behaviours with improved inclusivity, transparency and accountability in order to improve staff wellbeing and patient experience and outcomes. Creating representative governance models is fully consistent with the Institute for Healthcare Improvement (IHI) Triple Aim,[13] which describes an approach to optimising health system performance through improving the health of populations, enhancing the experience of care for individuals and reducing the per capita cost of healthcare. This is particularly the case by organisations adopting the 'fourth aim', which recognises the need to value staff[14] by improving wellbeing for all staff and service users. Fundamental to this is ensuring that governance structures are representative of the staff and local population. Many organisations, including universities, the NHS and police, are now attempting to address BAME inequalities across their organisations as part of this agenda.[15] Travis describes governance as being about 'how things are done' rather than the common health policy focus of 'what should be done'.[16]

This paper discusses inequalities and diversity under three headings: the lessons learnt from COVID-19, the perspective of NHS regulation and then health system governance. The authors put forward a Right Question, Right Answer approach to explore BAME representation and involvement in health board structures as a potential mechanism to assess and improve equality, diversity and inclusion (EDI) at all levels of governance from macro, to meso, to micro.[17]

COVID-19: health inequalities and health governance lessons

The World Health Organization (WHO) defines health inequalities as 'differences in health status or in the distribution of health determinants between different population groups'.[18] The COVID-19 pandemic has further highlighted known concerns around health inequalities, particularly in relation to the BAME community, including access to health and care and associated outcomes. During COVID-19 in the UK examples included the availability of personal protective equipment (PPE), as BAME health and care staff were less likely to voice concerns, and importantly population outcomes, with emerging evidence suggesting excess mortality in patients and staff from BAME populations.[4,19,20]

The government-commissioned Public Health England (PHE) report *Disparities in the Risk and Outcomes of COVID-19* (2020)[4] described the risk as 'disproportionate' for those with Asian, Caribbean and Black ethnicities. Individuals of Bangladeshi origin are twice as likely to die if they contract COVID-19, compared with white Britons.[4] Other BAME groups also have an increased risk. Similarly, a recent Intensive Care National Audit and Research Centre report[21] showed BAME groups were more likely to be critically ill from COVID-19.[18,21] Of the UK healthcare workers who died from COVID-19, those of BAME origin were disproportionally affected (93% of doctors, 71% of nurses and 55% of other health workers),[22] but BAME groups on average represent only a fifth of the NHS workforce.[23] The reasons for the inequality in outcomes are currently being studied.[24] In the next section, we further explore inequalities in the context of regulation and transparency.

Inequalities and NHS regulation

In the UK (recognising variation exists between the four devolved nations), all NHS boards sit within a national regulatory framework including legislation to protect staff and patients, to ensure health and safety standards are met, and health inequalities and harm are reduced (Table 1). Regional or hospital boards are responsible for the design, delivery and performance of healthcare and healthcare settings for their

local population and are required to report to government with monitoring by the designated health regulatory bodies (such as the Care Quality Commission and Health Improvement Scotland).

All UK countries have specific legal duties and responsibilities to reduce health inequalities. Importantly, all health and care staff, and their employers, have a duty to act in accordance with the fundamental standards of care, below which care must never fall. At times, however, employer expectations may conflict with the professional duty of care, for example through unsafe working environments (e.g. inadequate PPE),[29] excessive workloads, or remobilised staff being asked to fulfil tasks for which they did not feel trained or competent. All three examples occurred during the COVID-19 pandemic with variation in the provision and distribution of effective PPE and related guidance,[30,31] staff burnout[32] and remobilisation of staff including the use of medical students to support areas with healthcare staff shortages.[33,34] PPE shortages and excess workloads were not unique to the UK[35] and these have been linked to staff mental and physical wellbeing.[36,37,38] BAME nursing staff experienced greater PPE shortages.[39] As the COVID-19 pandemic begins to subside there will be inevitable independent reviews, which must critically examine the decision-making and risk analysis within governance systems to mitigate against such variation and inequalities. All health and care organisations must ensure adequate records and be able to exhibit learning. The proposed new integrated care systems (ICS) in England as statutory bodies with partnership boards provide an immediate opportunity to develop fairer, more focused responses to inequalities in outcomes and opportunities based on place. In July 2020 NHS CEO Sir Simon Stevens called for each NHS board to publish an action plan showing how over the next five years its board and senior staffing will in percentage terms at least match the overall BAME composition of its overall workforce, or its local community, whichever is the higher.[40]

Governance and BAME: from rhetoric to action

In this article, we argue that the recognised problems of inequalities must be acknowledged and then resolved at all levels of the health and care system. This will require a concentrated effort by leaders, the governing bodies (and place-based systems of care) to demonstrate within their governance assurance framework that they have an effective and diverse leadership with accountability to resolve or minimise health inequalities, thus moving from rhetoric, or merely describing the challenges, to action with measurement and monitoring of compliance and improvements.

One beneficial approach is to improve organisational transparency.[41,42] Organisational transparency means sharing information (good and bad) routinely with employees and patients, while working collaboratively to identify solutions and building trust in organisation–stakeholder relationships.[41] The more informed staff, patients and the local population, the more they have a sense of ownership and belonging and can add value.[43] Transparency also implies visibility into the functions of the organisation for the stakeholder groups. This is best achieved through institutionalising transparency in organisational policies and articulating these practices through well-defined processes. For example, boards should have full disclosure with open publication of the makeup of the board in relation to gender, ethnicity and diversity. This should include equal pay reporting, which for example became mandated in law within California (2021) with information to be filed annually by employers.[44] Other opportunities for organisational transparency include comparative analysis and publication of internal and external job application success rates by gender and ethnicity. NHS BAME staff networks have an important role in holding boards to account and pushing for transparency. For example, the NExT Director scheme by NHS England is a development programme created and designed to help find and support the next generation of talented people from groups who are currently underrepresented on NHS boards. The Seacole Group is a network of BAME non-executive directors in the NHS who have a clear vision: that NHS boards reflect the ethnic diversity of patients and communities they serve.

Transparency remains a challenge for healthcare systems. Whistleblowers from the health sector outnumber those from all other sectors at employment tribunals and were the largest group giving evidence to the All Party Parliamentary Group for Whistleblowing.[45] A common theme was the absence of transparency, with perceived lack of accountability of those investigating concerns. This is consistent with a theme of this article that staff from BAME backgrounds are disproportionally affected. BAME doctors are more than twice as likely to undergo disciplinary proceedings and be referred to the GMC.[46,47]

The GMC *Fair to Refer?* report 2019 provides guidance based on a study of the patterns of disproportionate referral to the GMC of non-white doctors.[47] The paper describes challenges for BAME doctors and provides a further example of the need to improve equality, diversity and inclusion at all levels across the NHS. The report made four recommendations; three are generalisable and the first is a specific issue that applies to international medical graduates (IMGs) starting work in the NHS:

1. Providing comprehensive support for doctors new to the UK or the NHS or whose role is likely to isolate them (including SAS doctors and locums).
2. Ensuring engaged and positive leadership more consistently across the NHS.
3. Creating working environments that focus on learning and accountability rather than blame.
4. Developing a programme of work to deliver, measure and evaluate the delivery of these recommendations.

These recommendations emphasise the aim to improve wellbeing prospects for all staff and service users, including

Table 2 Example key questions for assessing and improving board equality and diversity

Do the board and executive team reflect the composition of local population/staff demographic in terms of age, gender and ethnicity?
Do we collect and analyse staff numbers with a BAME background in relation to overall staff demographic for: permanent staff, temporary staff, locum staff?
Do we analyse BAME staff comparators in relation to the overall demographic: salary, seniority, successful job applications both internal and external, complaints including whistleblowing, sickness levels?
What plans do we have in place to improve BAME staff opportunities and safety?
Have we conducted a deep dive or internal audit review to verify these details and progress against any action plans and risk registers?
How have BAME staff and their families fared with COVID-19 infections/shielding/recovery/deaths?

career development for staff, through a focus on BAME as a mechanism to improve equality and diversity for all.

Improving board diversity: Right Question, Right Answer

Evidence from many sectors including health suggests that diverse boards, both in terms of gender and ethnicity, make better decisions.[8,9] Recent NHS data, however, show BAME groups remain underrepresented at board level with only 7.7% of board members being from BAME groups although they make up 19% of the workforce. The variation is even greater on NHS boards in England, where 45% have no BAME members.[7] Indeed, most of those in senior NHS positions are overwhelmingly white and male, a phenomenon dubbed the 'snowy white peaks of the NHS'.[48]

Several reports suggest a more proactive approach to risk assessment and management[1] is now necessary to tackle inequalities, particularly with the planned public inquiries, where boards and staff members will be required to show they acted reasonably and in the light of evidence. Both improvements and mistakes will have occurred during the COVID-19 pandemic. Boards should be at the forefront of this learning with a culture of urgency and transparency. Appointing archivists to document decisions or adopting a rapid deep-dive approach are two mechanisms to explore this, with board chairs and members encouraged to ask the right questions that lead to assurance that management have the capacity and competence to improve, if necessary highlighting how this affects other programmes and priorities.[49] This Right Question, Right Answer approach can be used across all board activities as needed and linked to assessments of board maturity, such as the Centre for Quality in Governance (CQG) Maturity Matrix (https://cqg.org.uk/) or similar instruments.

Adopting a series of targeted reflective questions allows a board to undertake a critical self-assessment to explore its collective and current understanding of its position in relation to board strategy including equality and diversity across the health care system.

Here we describe this approach to improve the understanding of the BAME community as a whole, recognising their role as a lever for change. We describe a Right Question, Right Answer approach, which uses key questions (Table 2), with examples of good and less good answers (Table 3). This should be linked to generic governance review instruments

Table 3 What are the questions we must ASK and ANSWER?

Key questions	Poor answers	Better answers
1 Do the board and executive team reflect the composition of local population/staff demographic?		
	Unfortunately, we can only recruit from those who apply, and candidates tend to be white males.	We recognise the need to better reflect our stakeholders and have actively sought to recruit from BAME and other underrepresented groups. We have had some success but are looking at offering associate roles.
2 Do we collect and analyse staff numbers with a BAME background in relation to overall staff demographic for:		
a Permanent staff	Yes. Data is collected but not made available to the board on a regular basis unless called for.	Yes. Data is collected and made available to the board on a regular basis. Our HR/staff committee has analysed the data and made recommendations for improvement.
b Temporary staff	No	
c Locum staff	No	

Table 3 continued

Key questions	Poor answers	Better answers
3 Do we analyse BAME staff comparators in relation to overall demographic:		
a Salary	Yes. Data is collected but not made available to the board on a regular basis unless called for.	Yes. Data is collected and made available to the board on a regular basis. Our HR/staff committee has analysed the data and made recommendations for improvement.
b Successful job applications both internal and external		
c Seniority	No	
d Complaints including whistleblowing	Only if information is volunteered by complainant.	
e Sickness levels	Yes. Data is collected but not made available to the board on a regular basis unless called for.	
4 What plans do we have in place to improve BAME staff opportunities and safety?		
	We are an equal opportunities employer and candidates are judged on merit. Our safety procedures have won awards for compliance with national standards.	We have started a campaign to actively recruit BAME groups to senior positions and put succession planning in place for all staff. In future we will actively screen staff with higher risk profiles and ensure hazardous duties are avoided.
5 Have we conducted a deep dive or internal audit review to verify these details and progress against any action plans and risk registers?		
	No, reporting is adequate and proportionate.	Yes, first review highlighted some gaps in data collection, which we have rectified. Future study will highlight areas for action.
6 How have BAME staff and their families faired with COVID-19 infections/shielding/recovery/deaths?		
	We do not collect that information systematically.	We recognise that BAME groups have suffered disproportionately and have created an action plan to make improvements for the future. Progress will be provided against the planned trajectories to equalise numbers for infections/shielding/recovery/deaths.

as well as data (as outlined in the questions) with appropriate measures and targets[50] with the aim to repeat at defined intervals to assess progression. This approach helps to define a transparent and learning culture rather than defensive postures. It can further aid boards in critically and openly assessing their current position and outlining strategy to improve linked to agreed timelines and audit points.

Conclusion

This paper has explored inequalities in relation to NHS board governance using the backdrop of COVID-19 and the impact on the BAME community as an opportunity for change. The Right Question, Right Answer approach combined with assessments of board maturity provide a simple, transparent and reproducible approach. We outline this for EDI, where board underrepresentation, workforce shortages and diversity remain challenges.

The approach described can be adapted to all aspects of board governance and supports moving from rhetoric to action and measured improvements. The authors put forward a series of recommendations (Table 4), which will help ensure effective, diverse and inclusive organisational governance.

Table 4 Recommendations for inclusive and effective governance

Improve and document wellbeing prospects for all staff and service users, including career development for staff.
Develop a problem-based approach to management, working together with frontline staff to find and test appropriate evidence-based solutions.
Improve the use of data within boards, to utilise it effectively with appropriate targets and stop the 'sin of omission' that permits inaction or ineffective action.
Ensure board constitution and succession planning reflect the BAME makeup of their catchment area and staff complement.
Implement recording and risk assessment systems incorporating appropriate behaviours. This would include challenging and pursuing why some groups of patients or staff are disproportionally affected by illness, complaints, grievances, disciplinary actions, whistleblowing, career opportunities, pay inequalities and dismissals.
Develop effective approaches to actively engage staff in change programmes and to listen and respond to staff concerns to overcome marginalisation of individuals who voice concerns. 'Just doing my job' is a common refrain from those who whistleblow.
Address lack of equality and diversity in board structures and processes and the need for acknowledgement that institutional racism is a problem that must be tackled. The Right Question, Right Answer approach could provide a mechanism for boards to critically assess their current position and aspirational goals in terms of organisational diversity. Diversity in gender, ethnicity and nationality has been shown to benefit a team in terms of productivity.

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