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Clinical Paper

NHS Trust Boards and Health and Well-being Boards: Do they play any role in the management of disparate levels of care for South Asian patients with Inflammatory Bowel Disease?

Farrukh A, Mayberry JF

Key words: NHS Trust Boards; Health and Wellbeing Boards; Disparate care; Directors; South Asians

Abstract:

Aims:

There is evidence of disparate levels of care for members of ethnic minority communities with inflammatory bowel disease in various NHS Trusts and Health Boards in England and Scotland. The purpose of this study was to investigate whether there was any association between the existence of disparate levels of care and the ethnic composition of the management boards of NHS Trusts and Health Boards. It also examined the ethnic composition of Health and Wellbeing Boards associated with these Trusts in England

Method:

NHS Trusts in England and Health Boards in Scotland, which had been involved in previous studies of disparate levels of care, were identified through a review of the relevant published papers. Health and Wellbeing Boards associated with these Trusts were then identified. Executive and non-executive membership of the NHS Trust, Health Boards and Health and Wellbeing Boards was determined through scrutiny of their web pages.

Results:

The proportion of Asians, who were executive officers, was significantly lower than the proportion who were non-executive board members both for trusts who offered disparate care ($z = 2.22$; $p < 0.03$) and those which did not ($z = 2.24$; $p < 0.03$). There was no significant difference in the proportion of Asians who were non-executive board members between the two types of trust. The proportion of ethnic minority members of English Health and Well-Being Boards, where there was evidence of disparate levels of care received by South Asian patients was significantly greater than on Boards where this was not the case. ($z = 2.8$. $p < 0.005$).

Conclusions:

The relation of these findings to disparate levels of care is unclear. However, it may point to a culture of tokenism, where either the members are not truly representative of underserved communities or they are unable to have any influence on local policy decisions. In either case there is an urgent need to develop better links with minority communities who are underserved so that issues can be effectively identified and remedied.

Introduction:

Over the last decade it has become apparent that a number of NHS Trusts in England have disparate levels of care when managing patients with inflammatory bowel disease[1-6]. This has been seen in South Asian, Afro-Caribbean and Eastern European communities[2,5,6]. There are also data that it occurs in Scotland, whereas information on minority communities in Wales and Northern Ireland is not collected in sufficient detail to allow an analysis[6]. However, it is not a universal phenomenon with 11 of the 29 Trusts investigated not showing evidence of disparate care. The reasons why it happened in the other 18 Trusts are unclear[4-6]. There is some evidence from research in other areas of healthcare that it may be linked to a reluctance on the part of management to take ownership of the issue[7]. Indeed, a study of the responses in three areas where such disparate care was identified from Trust's own data there was a denial of its accuracy and no action was taken[8].

The purpose of this study was to examine those Trusts reported previously to have provided disparate care and compare their management structure with that of Trusts where there was equitable delivery of care[3,5,6]. Health and Well-Being Boards are tasked with monitoring Trust's performance at a local level[9] and the composition of their management boards was also examined. These investigations were undertaken with a knowledge that "tokenism" has played a role in ensuring that there is apparently adequate representation of minority communities on decision making bodies[10]. Indeed, tokenism has been defined in healthcare as "the practice of making perfunctory or symbolic efforts to engage communities or patients"[10]. As early as 1969, Sherry Arnstein conceptualised a ladder of citizen participation with 8 steps representing increasingly significant levels of involvement in decision-making[11]. However, the reality of that ladder is yet to be seen

Nuffield Hospital,
Leicester LE5 5HY

Correspondence to: JF Mayberry
Email: johnfmayberry@yahoo.co.uk

in terms of a positive impact in the delivery of health care to ethnic minority communities. The token inclusion of some members of such communities on the management boards of NHS Trusts and Health and Wellbeing boards is more likely to lead to their assimilation[12]. Kanter has argued that in the workplace representation needs to reach a level of 15% to be effective[12].

Method:

NHS Trusts in England and Health Boards in Scotland, which had been involved in previous studies of disparate levels of care, were identified through a review of the relevant published papers[4,5,6]. In these studies, disparate care had been assessed through Freedom of Information Requests. These had included investigations of the proportion of patients with inflammatory bowel disease from various ethnic communities who had received biologic therapy and the expected and observed number of patients from these communities admitted to hospital.

For this study, Health and Wellbeing Boards associated with these Trusts were identified. Executive and non-executive membership of both the NHS Trust and Health Boards was determined through scrutiny of their web pages. Assessment of ethnicity was through consideration of names and from the content of published bios, including Trust's websites, Linked-in entries and publicly available information identified through Google searches including their standing as executives or non-executives. Chairpersons and Chief Executives were considered separately. A similar approach was adopted for membership of Health and Wellbeing Boards. White, Asian or Afro-Caribbean ethnicity of those members was determined from these web page entries. Although the majority of Asian executives and non-executive directors were South Asian, a small number were East Asian.

The Asian ethnic composition of Trust and Local Health Boards was compared between organisations where there was evidence of disparate levels of care for South Asian patients with inflammatory bowel disease with those where this had not been identified. A similar approach was used to compare Health and Wellbeing Boards. A non-parametric z statistic was used to compare population proportions of ethnic minority membership between Trusts providing disparate care and those providing equitable care[13].

Results:

Of the 29 Trusts and Local Health Boards involved in previous studies, 18 had shown evidence of disparate levels of care. The proportion of Asians, who were executive officers, was significantly lower than the proportion who were non-executive board members both for trusts who offered disparate care ($z = 2.22$; $p < 0.03$) and those which did not ($z = 2.24$; $p < 0.03$). There was no significant difference in the proportion of Asians who were non-executive board members between the two types of trust. In other words, the proportion of Asian professionals working in all Trusts and Health Boards was significantly less than non-executives. However, the proportion of non-executive board members who were Afro-Caribbean was significantly lower in trusts who did not offer disparate care ($z = 2.64$, $p < 0.008$) (Table 1)

Twenty-eight English Health and Wellbeing Boards were identified as being associated with the above NHS Trusts. Scotland does not have a directly comparable system. In three cases no publicly available information on membership of the board was available. The proportion of ethnic minority members of English Health and Well-Being Boards, where there was evidence of disparate levels of care received by South Asian patients was significantly greater than on Boards where this was not the case. ($z = 2.8$. $p < 0.005$) (Table 2).

Discussion:

NHS Trusts and Local Health Boards have a significantly lower number of South and East Asian professional executives than non-executive members. Both South and East Asian communities are also poorly represented amongst Chief Executives and Chairmen. Although the role of non-executives is to represent the local community, it is of some concern that where there is evidence of disparate levels of care, the proportion of members of the local Health and Wellbeing Boards was greater than where there were no such differences. This finding underlines the ineffectiveness of either Trust or Health and Wellbeing Boards having any impact on the care delivered by Trusts to poorly served communities.

The wider relevance of these findings to other English and Scottish NHS Trusts and Health Boards can only be speculative. The 29 Trusts and Health Boards were included in the original studies because they served significant ethnic minority communities. Of these 62% provided disparate levels of care across their populations with minority communities receiving poorer access to biologic therapies or more limited access to consultants and investigations[2,4,5]. The current trend to blame such disparities on the communities themselves provides little hope that the situation would be broadly different in other areas of the UK[14].

In March 2020, NHS England and NHS Improvement set an aspirational target to achieve 19% Black, Asian and Minority Ethnic (BAME) representation across all levels in the organisation by 2025. In October 2020 they adopted the BAME talent strategy to help achieve the 19% target[15]. However, both failed to appreciate that for there to be an effective representation of minority communities, it is critical that appointees at all levels come from those communities and share their cultural, social and religious values. When they do not, they become no more than tokens meeting political targets. In 2021, 12.6% (approximately 350 people) of all English NHS Trust board members were from a BAME background[16]. This report includes about 20% of such board members

The NHS Workforce Race Equality Standard Report for 2021 found that BAME were significantly less likely to

Table 1: Composition of Trust Board Membership

	Disparate Level of Care (n = 18)			Non-Disparate Level of Care (n = 11)		
	White	Asian	Afro-Caribbean	White	Asian	Afro-Caribbean
Chair & Chief Executive	34	1	1	21	1	0
Executive Officers	110	7	9	77	5	1
Non-Executive Members	113	20	14	72	15	1

Table 2: Health and Wellbeing Board Membership

Health and Well-Being Board	Total Membership (n)	Number of Asian Members (n)
Bristol	26	1
Hereford	No details	
Walsall *	8	3
Wolverhampton *	No details	
Luton *	5	3
Southampton *	11	1
Cambridgeshire & Peterborough *	9	0
Redbridge *	No details	
Havering *	10	2
Warwickshire *	18	1
Coventry *	18	3
Leicester *	28	9
Leicestershire *	22	5
Derby	6	0
Nottingham	26	1
Nottinghamshire	25	1
Bradford & Airedale	15	2
Birmingham	13	0
Sandwell	18	3
Lancashire	12	1
Slough	15	2
Richmond	8	0
Hounslow	9	0
Croydon	18	1
Essex *	28	2
Southwark	17	4
King's Lynn	2	0
Buckinghamshire *	20	1
Total	387	46
Mean (± SD)	16 ± 8	2 ± 2

• Trusts where there was evidence of disparate levels of care experienced by South Asian patients with inflammatory bowel disease

The proportion of ethnic minority members of English Health and Well-Being Boards, where there was evidence of disparate levels of care received by South Asian patients was significantly greater than on Boards where this was not the case. ($z = 2.8$. $p < 0.005$)

be short-listed for appointments and this has remained unchanged for the last 6 years[16]. Ferlie, *et al* [17,18] found that English NHS boards tended to endorse managers' decisions rather than make their own, although NHS boards have been re-structured and re-populated several times since that time. Thus, the fact that the proportion of executives who were of Asian origin was significantly less than those who were non-executives raises questions as to their potential to influence decision making within trust boards. The importance of managers taking ownership of issues was recognised by Salway, *et al*[7]. When this does not happen, change does not occur and the relative lack of South Asian executives able to promote change may be part of the explanation for disparate levels of care. However, this low level was also seen in Trusts where there were no issues with appropriate levels of care and so clearly other factors must play a role.

In a study of English NHS Trust Boards in 2015, non-executive members took an interest in what policy makers regarded as the most important policy and managerial issues, in a way that reflected their organisation's role in the wider health economy and their own role in governance activities outside board meetings[19]. In 2007 Nigel Hawkes, the Health Editor of *The Times,* described the role of non-executive directors in the following terms:

"Non-executive directors and chairmen and chairwomen, though I hate to say it, are treated sometimes as no better than useful pawns in a game whose goodwill, local knowledge, and devotion to public duty are exploited by the NHS until the moment comes to toss them aside."[20]

Narrowing health inequalities was one of the driving factors behind the creation of Health and Wellbeing Boards[9]. The evidence that this has been achieved with regards to under-served minority communities has not been demonstrated by this study. Their role was envisaged as:

Having a strategic influence over commissioning decisions across health, public health and social care, integrating services.

Involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care.

Bringing together clinical commissioning groups and councils to develop a shared understanding of the health and wellbeing needs of the community.

Through undertaking a Joint Strategic Needs Assessment (JSNA) drive local commissioning of healthcare[21].

Boards have a statutory duty to involve local people in the preparation of JSNAs and the development of joint health and wellbeing strategies. Overall the Boards involved in this study had a mean of 13% of members coming from a minority community. However, despite having significantly more Asian members, those Health and Wellbeing boards (HWB) linked to Trusts providing disparate levels of care have been ineffective in producing a change to the benefit of minority communities. Although it could be argued that these Boards have not been in existence long-enough to effect such a change, earlier work pointed towards their likely ineffectiveness[8]. A recent study by Visram, *et al*[22], which explored the relationships and interactions between HWB members and the public or their representatives, confirmed that meetings were carefully staged and scripted performances that tended to inhibit rather than enhance democratic accountability. A different study has raised questions as to the transparency with which Health and Wellbeing boards use research data on their local community and their exclusion of published qualitative literature suggests that gaining an understanding of the mechanisms driving health inequalities and how interventions to tackle this 'work' is not prioritized[23].

Healthwatch was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf. These organisations are funded by local authorities and have an input into the Health and Wellbeing Board. However, the disconnect between such bodies and local ethnic minority communities is well illustrated by a comment in the annual report from Healthwatch Leicester and Healthwatch Leicestershire:

> "The response to our survey from minority ethnic (BME) people was low and this limited our ability to analyse how the Covid-19 lockdown impacted on these communities. Therefore, to understand further the impact of Covid-19 lockdown on minority ethnic communities, we established 'BME Connect' – a platform for communities to come together to talk about the issues that matter the most to them."[24]

The concept that underserved communities will make use of an internet-based platform in contrast to completing survey forms points to a fundamental lack of understanding of the issues.

Institutional or structural racism was recognised within the NHS shortly after publication of the Macpherson report[25]. Although discrimination against staff is frequently reported, that experienced by patients receives considerably less attention. Nevertheless, the Public Sector Equality Duty (Equality Act (2010)) formed the basis for the statement in the NHS Constitution that:

> "Legal duties require NHS England and each clinical commissioning group to have regard to the need to reduce inequalities in access to health services and the outcomes achieved for patients."[26]

In 2013, NHS Improvement was tasked with issuing Provider Licences to Trusts and among the conditions is:

> "4 (b) reducing inequalities between persons with respect to their ability to access those services"[27]

However, in 2019 a British Medical Journal editorial discussed "decades of evidence of disparities in health outcomes related to ethnicity"[28]. It reported that: "The evidence is clear on the discrimination and prejudice against patients and staff from ethnic minorities. What is less clear is the appetite of health systems in the UK and around the world to tackle age-old health inequalities based on race and ethnicity." Indeed, there have been no reports of responsible organisations ever taking action on the basis of ethnic or religious discrimination.

There is an extensive network of statutory bodies[29] whose function is to ensure the equitable delivery of care to the communities that they serve. Over the last decade many of them have been completely ineffective in achieving this objective. It is unclear as to why this is the case. Where there are significant issues, South Asians make up a significant proportion of board members. However, whether they are representative of these underserved communities is open to serious question and their presence is more consistent with tokenism than a real attempt to address fundamental issues of inequality in the delivery of care.

REFERENCES:

1. Ahmed S, Newton PD, Ojo O & Dibley L Experiences of ethnic minority patients who are living with a primary chronic bowel condition: a systematic scoping review with narrative synthesis. *BMC Gastroenterol*. 2021; 21: 322. https://doi.org/10.1186/s12876-021-01857-8.
2. Farrukh A, Mayberry JF. Apparent discrimination in the provision of biologic therapy to patients with Crohn's Disease according to ethnicity. *Public Health*. 2015; 129(5): 460-4.
3. Farrukh A, Mayberry JF. Ethnic variations in the provision of biologic therapy for Crohn's Disease: a Freedom of Information study. *Med-Leg J*.2015; 83(2): 104-8.
4. Farrukh A, Mayberry JF. Patients with ulcerative colitis from diverse populations: the Leicester experience. *Med-Leg J*. 2016;84(1): 31–5.
5. Farrukh A, Mayberry JF. Apparent disparities in hospital admission and biologic use in the management of inflammatory bowel disease between 2014 – 2018, in some Black and Ethnic Minority (BEM) populations in England. *Gastrointest Disord*. 2020;2(2): 144–51.
6. Farrukh A, Mayberry JF. Evidence of on-going disparate levels of care for South Asian patients with inflammatory bowel disease in the United Kingdom during the quinquennium 2015 – 2019. *Gastrointest Disord*. 2022;4: 8–14
7. Salway S, Mir G, Turner D, Ellison GT, Carter L, Gerrish K. Obstacles to "Race Equality" in the English National Health Service. Insights from the Healthcare Commissioning Arena. *Soc Sci Med*. 2016; 152: 102–10.
8. Farrukh A, Mayberry JF. Does the failure to provide equitable access to treatment lead to action by NHS organisations? The case of biologics for South Asians with inflammatory bowel disease. *Denning Law J*. 2019;31: 77–91.
9. Colin-Thomé D, Fisher B. Health and Wellbeing Boards for a new public health. *Lond J Primary Care*. 2013; 5(2): 78–83.
10. Hahn DL, Hoffman AE, Felzien M, LeMaster JW, Xu J, Fagnan LJ. Tokenism in patient engagement. *Fam Pract*. 2017; 34(3): 290–5.
11. Arnstein SR. A ladder of citizen participation. *J Am Instit Planners*. 1969; 35: 216-24.
12. Kanter RM. *Men and women of the corporation*. New York: Basic Books; 1977.
13. Social Science Statistics. [Internet] Z Score Calculator for 2 Population Proportions. [cited 2022 Feb 9]. Available from: https://www.socscistatistics.com/tests/ztest/default.aspx
14. Sewell T, Chair. Commission on Race and Ethnic Disparities. The Report. [Internet]. London: Commission on Race and Ethnic Disparities; 2021. [cited 2021 Apr14]. Available from: https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities/foreword-introduction-and-full-recommendations.
15. Issar P, Bullers H. NHS England and NHS Improvement Board meetings held in common. NHS England and NHS Improvement 19% Black, Asian and Minority Ethnic goal progress. London: NHS England [cited 2022 Jul 2].
16. NHS Workforce Race Equality Standard. 2021 data analysis report for NHS trusts. London: Workforce Race Equality Standard (WRES); 2022. [cited 2022 Jul 2]. Available from: https://www.england.nhs.uk/wp-content/uploads/2022/04/Workforce-Race-Equality-Standard-report-2021-.pdf
17. Ferlie E, Pettigrew A. Managing through networks – some issues and implications for the NHS. *Br J Manage*. 1996;7(S1): S81-S99.
18. Ferlie E, Fitzgerald L, McGivern G, Dopson S, Bennett C. Public policy networks and 'Wicked Problems': a nascent solution? *Public Administration* 2011; 89(2): 307–24.
19. Sheaff R, Endacott R, Jones, Woodward V. Interaction between non-executive and executive directors in English National Health Service trust boards: an observational study *BMC Health Serv Res*. 2015; 15(470): 1-10.
20. Hawkes N. Being an NHS manager is a fool's errand. *BMJ*. 2007; 335(7632): 1239
21. The National Archives. Greater Manchester Archives and Local Studies Partnership. [GMALSP], [cited 2022 Feb 11]. London: The National Archives. Available from: https://www.nationalarchives.gov.uk/archives-sector/case-studies-and-research-reports/case-studies/commissioning-for-archive-services/greater-manchester-archives-and-local-studies-partnership/ (Accessed 11/2/2022)
22. Visram S, Hunter DJ, Perkins N, Adams L, Finn R, Gosling J, Forrest A. Health and Wellbeing Boards as theatres of accountability: a dramaturgical analysis. *Local Govern Stud*. 2021; 47(6): 931–50.
23. Kneale D, Rojas-Garcia A, Thomas J. Exploring the importance of evidence in local health and wellbeing strategies. *Public Health (Oxf)*. 2018; 40: (Suppl 1): i13–i23
24. Healthwatch Leicester and Healthwatch Leicestershire. *On Equal terms. Then and now. Annual Report 2020-21*. Leicester: Healthwatch; 2021. [cited 2022 Feb 12]. Available from: https://healthwatchll.com/wp-content/uploads/2021/06/Healthwatch-LL-Annual-Report-2020-21.pdf.
25. Collier, J. Tackling institutional racism. *BMJ*. 1999; 318 (7184): 679.
26. Great Britain Department of Health. Guidance: The NHS Constitution for England. London: Department of Health. [cited 2019 May 14].
27. Monitor: Sector Regulator for Health Services in England. The New NHS Provider Licence. London: Monitor; 2014 [cited 2019 May 14].
28. Kmietowicz Z, Ladher N, Rao M, Salway S, Abbasi K, Adebowale V. Ethnic minority staff and patients: a health service failure. *BMJ*. 2019; 365: P2226. doi: 10.1136/bmj.l2226.
29. Farrukh A. Discriminatory care and South Asian patients with chronic gastrointestinal diseases [PhD thesis]. Staffordshire: Staffordshire University. 187 p. [cited 2022 July 3]. Available from: http://eprints.staffs.ac.uk/7113/1/PhD%20Final%20Accepted%20version.pdf