Progress Under Pressure:

Health

Exploring diversity and inclusion in senior roles in health and associated sectors

CASTLE PEAK GROUP | Opencast

September 2026

“The start is showing interest. Understand where the learning is. Where the good practice is. Be curious. Be driven about it. And be prepared to take some risks.”

Sir Jim Mackey
Chief Executive of NHS England

Contents

Foreword

Welcome to the second edition of *Progress Under Pressure.*

In this report, we focus on the health sector, including NHS Trusts across the North East of England, as well as representatives of national bodies like the NHS Business Services Authority and NHS England, and related organisations like ambulance and fire and rescue services.

We set out to find out how diverse board and senior exec level teams were in these organisations, and the things that they were doing to embed inclusive practice in their operations and their recruitment.

This is a vitally important time to have diverse voices and lived experience around the board table, and taking the decisions which are shaping how the NHS is adapting to the challenges it is facing.

Health is never far from the public eye, and forever one of the top priorities for politicians and policymakers.

That ups the stakes, and can make organisations and their leaders risk averse.

But managed risk is important.

You have to do things differently to get different results.

What we find in this work is progress being made, but in a way that is still - perhaps - too slow, and too rigidly tied to the way things have always been done.

What isn't lacking is desire.

Everyone we spoke to recognised the value of diversity at board level, and the importance of inclusive practice across their organisation.

Boards were typically welcoming, but being an NHS non-executive director is not for the faint of heart - it is an entirely different beast to being a NED in almost any other sector, thanks to the legal responsibilities and the public scrutiny.

Lives are quite literally on the line, and it's not often a place for people to take their first steps into board level roles - even if they have relevant professional or personal experience and insight.

There are some structural things in the way of greater diversity, and there are some process things in the way too.

I hope this work plays a part in starting to clear away some of those barriers.

James Carss
Castle Peak Group
CEO

Opencast

The NHS is entering one of the most significant periods of transformation in its history.

Alongside the familiar challenges of demand, workforce, funding and performance, organisations across the health and care system are being asked to deliver a fundamental shift in how services are designed, delivered and experienced.

The ambition of the 10-Year Health Plan is clear: over the coming decade, the NHS will move from hospital to community, from analogue to digital, and from sickness to prevention. Each of these changes is substantial in its own right. Together, they represent a profound reimagining of how health and care services operate.

Technology sits at the heart of much of that ambition.

Across every sector, digital tools, data and artificial intelligence are reshaping how organisations operate and how people interact with services. Healthcare is no exception. The opportunities are significant: better access to services, more informed decision-making, improved efficiency, earlier intervention and more personalised experiences for patients.

But adopting new technology is only one part of the challenge.

Any organisation that has gone through significant change will recognise that transformation requires new ways of working, new capabilities and often new ways of thinking.

Success depends not only on the systems being introduced, but on the people shaping the decisions around them. As organisations navigate change, a diversity of perspectives can help leaders challenge assumptions, understand different patient, staff and community needs and make better-informed decisions.

That is something we have learned through our own growth at Opencast. As we've expanded, we've seen successful change depends on bringing the right mix of skills, experiences and challenge together from the outset.

The conversations captured in this report provide a valuable perspective on the leadership challenges facing the health sector as it navigates this period of transformation. They also show why transformation is more than just technology. It needs to be approached as a people, culture and delivery challenge.

Delivering the ambitions of the 10-Year Health Plan will require sustained leadership, collaboration and a willingness to learn from both inside and outside the sector. It will also require organisations to draw on the broadest possible range of experiences, perspectives and talents if they are to deliver services that truly reflect the communities they serve.

The insights shared here offer an important contribution to that conversation.

Harry Armstrong
Opencast
Managing Director - Business Development

Introduction

There has never been a time in the nearly 80-year history of the National Health Service when it hasn't been under pressure.

The health of the nation was crucial in the post-war era in which the NHS was established, as we rebuilt our economic and social fabric after years of conflict.

Today, health remains one of the most important issues in the eyes of the public, and will play a crucial role in addressing many of the challenges we currently face.

Politically, too, the NHS is never far from the limelight.

Over the next few years those leading our NHS Trusts will be adapting to a changing landscape as NHS England is merged into the Department of Health and Social Care, and as emphasis is shifted by the 10-Year Health Plan towards prevention of ill health, community - rather than hospital-led services, and a digital-first health service.

Getting these changes right will need the most talented people across leadership positions, operating at the best of their ability.

That means NHS governance needs to be inclusive, providing the right structures and support to make sure we have diverse voices around every board table, and on every committee.

Diversity in our decision-making will mean better outcomes, better efficiency, and a closer connection to the communities each Trust serves.

Lots of this is already embedded in the way the NHS works, but there is always more we can do.

This research paper looks to explore that, through insights gathered from conversations with more than a dozen current and former executive and non-executive leaders.

In it, we look at diversity around the NHS board tables now, and what the future may hold, alongside reflections on some of the specific challenges both immediate and on the horizon.

While much of what is discussed is universal, all of the participants in the research - even those in national roles - have a close link to the North East of England.

As such, those working in the health sector in that region - as well as in partner organisations in local and regional government, the voluntary sector and private business - will find the deepest insight in these pages.

01
Context

An NHS In Flux

The NHS is on the frontline dealing with many of the large social and economic problems facing the UK, and doing so while adapting to practically rolling reforms, reprioritisations and significant financial pressures.

The future of the NHS in England has been defined by the government's strategic 10-Year Health Plan - Fit For The Future.

It sets out three broad shifts for the NHS to make over the next decade:

01 From hospital to community

This will see a rise in neighbourhood services delivered outside of a hospital setting, and will require forming a closer link with the communities which are being served. The aim is to make the NHS feel like a more cohesive part of the safety net built around individuals, and it will be measured by a falling proportion of NHS spending in hospitals.

02 From analogue to digital

The government believes the impact of modern technology is yet to be felt in how people interact with the NHS. Central to this transition is the way in which the NHS app will be used in future, as a single point of entry into health services. However, this shift has a broader remit, looking at digital adoption within the NHS, and the future use of technology like AI to improve services.

03 From sickness to prevention

The NHS in its current guise mostly reacts to health problems as people present with them, meaning that - especially in more deprived areas - it deals with sickness rather than with health. A shift towards earlier intervention and preventing ill-health rather than responding to it, is a core tenet of the 10-Year Plan. It will require significant partnership with other bodies, including local authorities and the social care sector.

The 10-Year Plan also sets a direction for a more devolved NHS, where budgets are held at a Foundation Trust level, and decision-making happens locally.

Delivering this effectively will require leadership diversity.

National restructuring

Alongside the strategic plan for the future of the NHS, there is also significant restructuring happening nationally, with NHS England being merged into the Department of Health and Social Care.

This merger originated from an identification of duplication of roles between the two organisations, and will involve the loss or restructuring of thousands of jobs.

This will inevitably create uncertainty and complicate decision making and project delivery in the short term, while the new structure is established.

Regional Devolution

The future of the NHS is one of close working with partners from across the public, voluntary and private sectors.

Much of this collaboration will be defined by the landscape of devolution across the country - especially in the North of England.

While only Greater Manchester has a formal responsibility for public health as part of its devolution deal, there is a close connection between socio-economic aims and public health in all regions.

The connection to economic inactivity is a key one. In the North East, for example, long term ill health accounts for a third of economic inactivity (32.2%), or just under 140,000 people.

This public health aspect to economic potential limits growth, and partnerships with Combined Authorities will be a crucial relationship for the NHS over the next decade.

Greater Manchester is again the model for this, as the Live Well programme there has developed a multi-agency approach to improving public health, and is viewed as a 'prevention demonstrator' in partnership with DHSC.

Specific Health Issues

The NHS and wider health sector unfortunately can often find itself responding to challenges without the ability to set its own agenda.

These issues can be standalone, or symptomatic of broader structural issues within the sector.

For example, a national investigation is ongoing into maternity; there are inquiries open into Child and Adolescent Mental Health Services; the process of compensation is active following the infected blood scandal; and pandemic preparedness and response is still under scrutiny.

Ultimately, the NHS is under constant pressure, dealing with backlogs, waiting lists and significant challenges around staffing and resourcing.

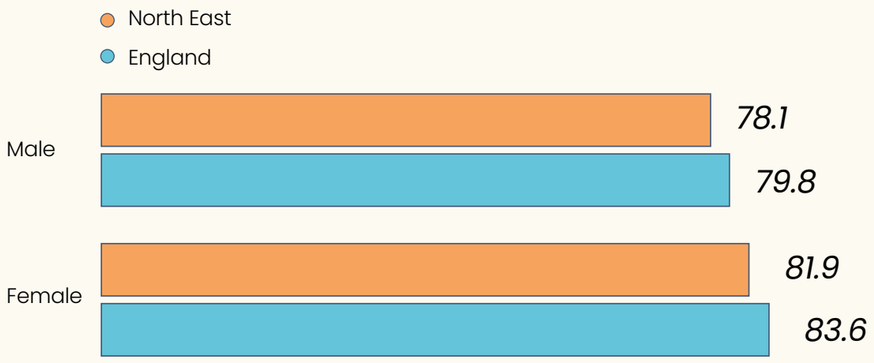
These require high-quality decision-making, and a connection to the communities which are being served, meaning diverse board and exec level appointments are crucial.

The North East Picture

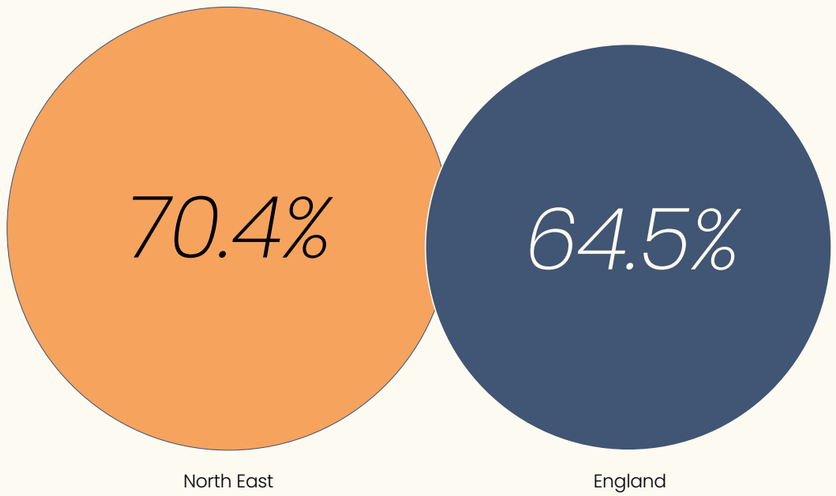
This research contains contributions from both a national and regional level, but those regional contributions centre around the North East's NHS trusts and related services.

As such, an awareness of the situation in the North East is important to appreciate the insights in context.

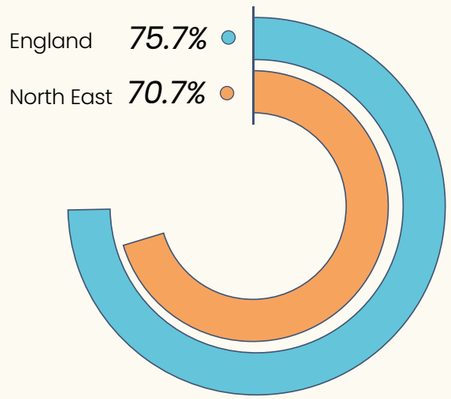
Life expectancy at birth (years) [1]



Overweight prevalence in adults



Percentage of people in employment



Children in low income families

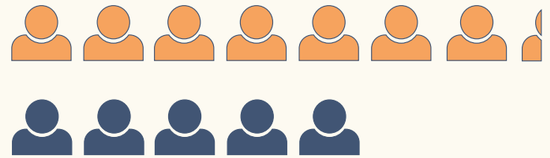
North East

24.4%

England

19.1%

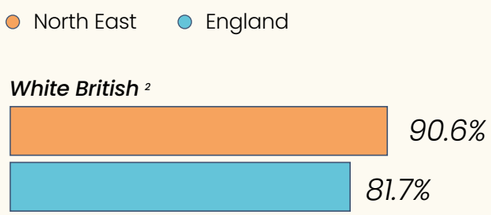
Hospital admission for alcohol-related conditions



737 *per 100,000 population*

504 *per 100,000 population*

Diversity



Level 3 or above qualifications [4]

North East	England
62.8%	67.4%

AB socio-economic grade [5]

North East	England
18.3%	23.5%

02

Insights

Diversity & Inclusion Then & Now

"I don't know if there's a committee or board meeting I've been to where we haven't spoken about equity and inequality and about trying to really think about what our decisions mean and what impact it will have on our mix and our demographics"

Across those spoken to, there was a consistent awareness of the importance of building a diverse and inclusive leadership within health sector organisations.

However, there was also a recognition that at board level, trusts were rarely - if ever - representative of the populations they serve.

While most contributors saw their organisations making progress in terms of board make-up - with quicker progress possible amongst non-executive directors - they were still often far from the ideal.

That's not to say issues of diversity are not well-served by boards, even without the visible representation of membership, as many trusts look for alternative ways to get diverse insights around the board table. For example, this can occur through the use of staff networks on protected characteristics or priority groups for inclusion, or through associate board positions.

"We do have staff networks and we do hear from those groups and they report up to board. So, even in those areas where we may be slightly lacking in diversity ourselves [as a board], we do have access to people who have the lived experience and who can share that with us."

Where diversity is limited around the board table, this can create two different but related dynamics.

The first is a sense of extra responsibility for those who do represent diversity of background, whether that's gender, ethnicity, LGBTQ+ identity or any other characteristic.

This can mean that individuals feel they need to speak up and champion diversity issues, regardless of their professional expertise or areas of formal responsibility.

"I wouldn't use the word burden. I mean, it's interesting to put it like that because I think some people do experience that as a burden. It's an extra responsibility."

A second dynamic has also been felt by senior leaders, especially those in an executive position.

Where an individual comes from a diverse background, it can sometimes result in others - whether consciously or not - tending to leave issues of diversity and inclusion to that person. This is something one contributor described as a feeling of others ***"taking their foot off the gas very slightly."***

This emphasises the importance of embedding diversity and inclusion practice across leadership, and ensuring joint accountability across functions rather than leaving the issue sat with any individual person or department.

Those issues notwithstanding, visibility and accountability of senior leaders is critical in diversity conversations, as is creating an environment where there is the psychological safety required for people to bring their whole selves to work.

"I do think that representation is key. People need to be able to see that there are people with protected characteristics in leadership positions, and that means people with protected characteristics have to be prepared to say things about their protected characteristics."

The safety required for those with protected characteristics to be visible relies primarily on organisational culture.

Many contributors spoke of a general feeling of an inclusive environment - both around the board table and within their organisations as a whole - but others also spoke of evidence suggesting that inequity continued to exist.

This included one trust where the data found those from Black or Asian backgrounds were more likely to be subject to disciplinary proceedings, and another where a senior leader in an operational position found themselves contesting a constructive dismissal case before action was taken.

Although board culture was generally considered inclusive and welcoming, there were some occasions where contributors mentioned expected ways to behave and conduct themselves which ran counter to inclusive practices by being too rigid. One likened this to feeling like they were "misbehaving" like a "naughty school child."

Rigidity of process and ways of working can prevent inclusive practice, and addressing this is a key component of successful cultures.

Building in appropriate flexibility and support to ensure that this does not become a limiting factor for individuals is vital, whether we are talking about gender, ethnicity, LGBTQ+ identity or disability or neurodiversity.

Overall though, the story amongst the organisations represented appears to be of progress, despite the pressure, but of a journey still ahead towards full diversity and inclusion.

"There have been some improvements, so now in our trust, there is some diversity. When we make decisions, we think about it. Inclusion is now on the agenda. It wasn't previously."

Executive & Board Recruitment

"We do have [redacted] structural bias in [redacted] recruitments and [redacted] promotions

Recruitment into senior roles is a balancing act of competing priorities.

Organisations are looking for professional expertise, relevant experience, cultural fit, certain personal characteristics, as well as looking for diversity of background, lived experience and decision making.

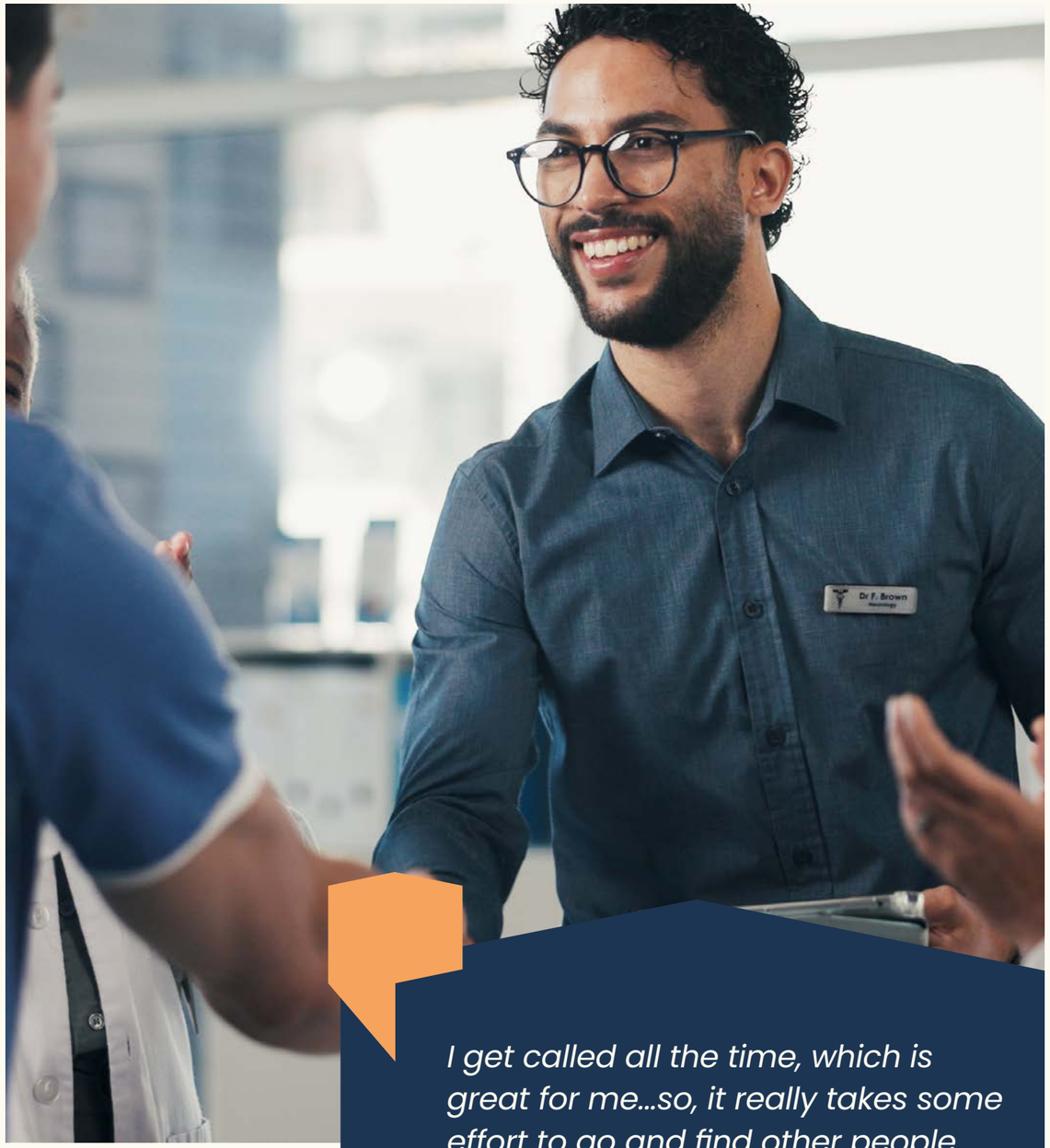
That juggling act is difficult, especially in a region like the North East, with a small population and business base, and therefore a smaller pool of talent to reach into.

Effective recruitment is an issue at all levels within the NHS, and in clinical and operational roles much success has been had with overseas recruitment, which has naturally widened the diversity across those functions.

There was a recognition amongst contributors that this emphasised the importance of diverse leadership, to reflect the wider workforce, and also brought up issues of community and the support provided to moving into the country and the region, as well as into the organisation.

Increased overseas recruitment was seen as an example of responding to talent pressures by doing something different, and the same logic stood for executive and non-executive board-level positions.

There was a feeling amongst contributors that too often the same techniques and processes were used, which resulted in the same outcomes.



I get called all the time, which is great for me...so, it really takes some effort to go and find other people. That's the search and selection piece, but it's also the marketing piece and it's the getting things out there."

Diverse shortlists

One contributor contrasts the approach in their NHS trust to their experience of private business, where recruiters might be tasked with compiling a diverse shortlist, or required to use non-traditional methods to market roles into different communities and reach different audiences.

These efforts would be what took a trust beyond what one contributor called being "well-meaning" and into tangible action to improve the situation.

Mentoring

"My fellow non-execs, who already have a lot on their plate and didn't need to welcome me and make me feel included, really made an effort to really help me get up to speed."

Mentoring and peer support was seen as critical in making board level recruitment or promotion a success.

A number of contributors in non-executive director roles spoke about the importance of support, both in terms of effective formal onboarding from the organisation, and familiarisation with board issues from fellow NEDs.

This helped overcome the large-scale nature of the job, in a sector dominated by jargon within complicated, multi-agency and multi-tier organisations.

"I would be getting the likes of me and a raft of other people and say 'the next time I appoint somebody, will you spend an hour with them?' Tell them what it's like and help them, and most people would say yes, so I think that's something that would help."

Shadow boards and staff development programmes

Likewise, there was seen to be a significant role for initiatives like shadow boards, associate NED roles, and for tailored and focused leadership development programmes.

"We put in place the shadow board where we had eight seats on it - four of them were open seats for our most talented senior leaders to apply for, and then the other four were for our BAME network, LGBTQ+, Women's and Disability and Neurodiversity Networks. That's been brilliant, having people around the board table from lots of lived experience groups sharing their views.

Shadow boards allow people to observe the functioning of the board, and perhaps engage in surrounding work, without the pressure of jumping straight into a board position.

From the individual's perspective, they gain valuable experience and confidence in how to operate in those roles, and from the organisation's perspective they are supporting the development of the next generation of board talent.

Associate NED roles work in a similar way, where a small number of associates are brought into the board setting without formal responsibility, but with the ability to attend board meetings, take part in discussions and observe the workings of the role.

Staff development programmes were seen as important contributors to diversity of promotion opportunities, however there was a risk that these were too generalised to have an impact on those from underrepresented groups.

Staff networks

Staff networks are an enabler of change across organisations, especially where they are structured in such a way as to provide a direct link between underrepresented groups and the board.

They can play a role in broadening diversity through supporting progression and addressing bias in the workforce, as well as by helping develop leadership programmes which are tailored to their communities.

"Each staff network has got a sponsor in the form of an exec. They feed challenges into the exec team that way, and the voices get elevated in terms of challenges, advice, guidance, anything that could be done."

Is NHS leadership a daunting place?

"A lot of the obstacles initially were me talking myself out of things. 'Gosh, I don't really know healthcare that much. I don't know the NHS.'"

An issue raised time and again during this research was the feeling that the NHS was not a good place to take on your first non-executive director role, or your first executive role if you are coming from outside of the health sector.

The weight of the responsibility is keenly felt, as board members are well aware of the significance of the NHS in the public eye, and the importance it has in people's everyday lives. That, coupled with very real regulatory responsibility, and the complexity of NHS Trusts means board level roles can be seen as daunting, which risks putting off those who are not directly familiar with the sector, or very experienced in NED roles.

"As a chair of an NHS trust, it's very easily a full-time job because although there's a real point of saying you're not to be operational, you're to be strategic - you're eyes on, hands off - but, when the regulator comes and looks at what you're doing, they expect you to have what is really an operational knowledge."

This is damaging both to diversity of backgrounds in board roles - defaulting towards older, typically retired, predominantly white men who have had senior health roles previously - but also to getting cutting edge technical and professional skills into the NHS from the private sector.

The difficulty in juggling the demands of NHS NED roles with full-time employment again means the talent pool becomes more limited.

"You got to cut your teeth somewhere. I think, having done it all over the place, it's a big ask to ask somebody to come in and cut their teeth on a NHS board position."

The reality is that some roles will be heavier asks than others, and NHS roles are almost inevitably going to be challenging positions due to the importance, complexity and public attention that are inherent with them.

However, that does not mean we can't do more to make them accessible. This could include working to demystify board responsibilities and processes, helping to improve understanding of them before people put themselves forward formally.

As well as some of the initiatives such as shadow boards, associate roles and leadership programmes listed above, there should also be consideration of how roles are structured and understood, and efforts made to reduce the barriers.

"The boards themselves are a bit of a dance. They're formal, you have a bit of debate, but it's all in public, so it's all very orchestrated and polite and careful."

Organisational Transformation

"The funding model for the NHS tends to prioritise putting a lot of the funding towards the dealing with things at acute hospital level rather than the preventative stuff and the community-based activity which avoids people going to A&E in the first place."

Leading an NHS Trust is akin to guiding a cruise liner into port in a storm.

They are huge organisations, carrying lots of inertia which makes changing direction a slow and gradual process, and if you're not careful then small mistakes can end up having big impacts.

Transformation and modernisation of the NHS isn't something which is just one process, it's dozens and dozens happening simultaneously across the country.

Changes in national policy can redirect funding, and change on-paper priorities, but culture, mindset and on-the-ground structures make those changes a reality.

The 10-Year Health Plan, for example, calls for a shift from treatment of sickness, to prevention of ill-health, but currently most money is pointing at acute hospital services which are under constant pressure.

"It used to be the case that it was a winter pressure and then it would ease in the summer, but now it's much more like all year round."

The change will also require the NHS and associated health organisations to work in partnership with others to deliver a more public health-focused set of services.

This will mean better integration with local authorities and the voluntary sector, as well as better information sharing with the public themselves to support behaviour change.

"We're doing an awful lot ensuring that it's not the NHS standing on their own now. We have to be working better with local authorities. We have to be integrating better with our patients and with the voluntary community sector."

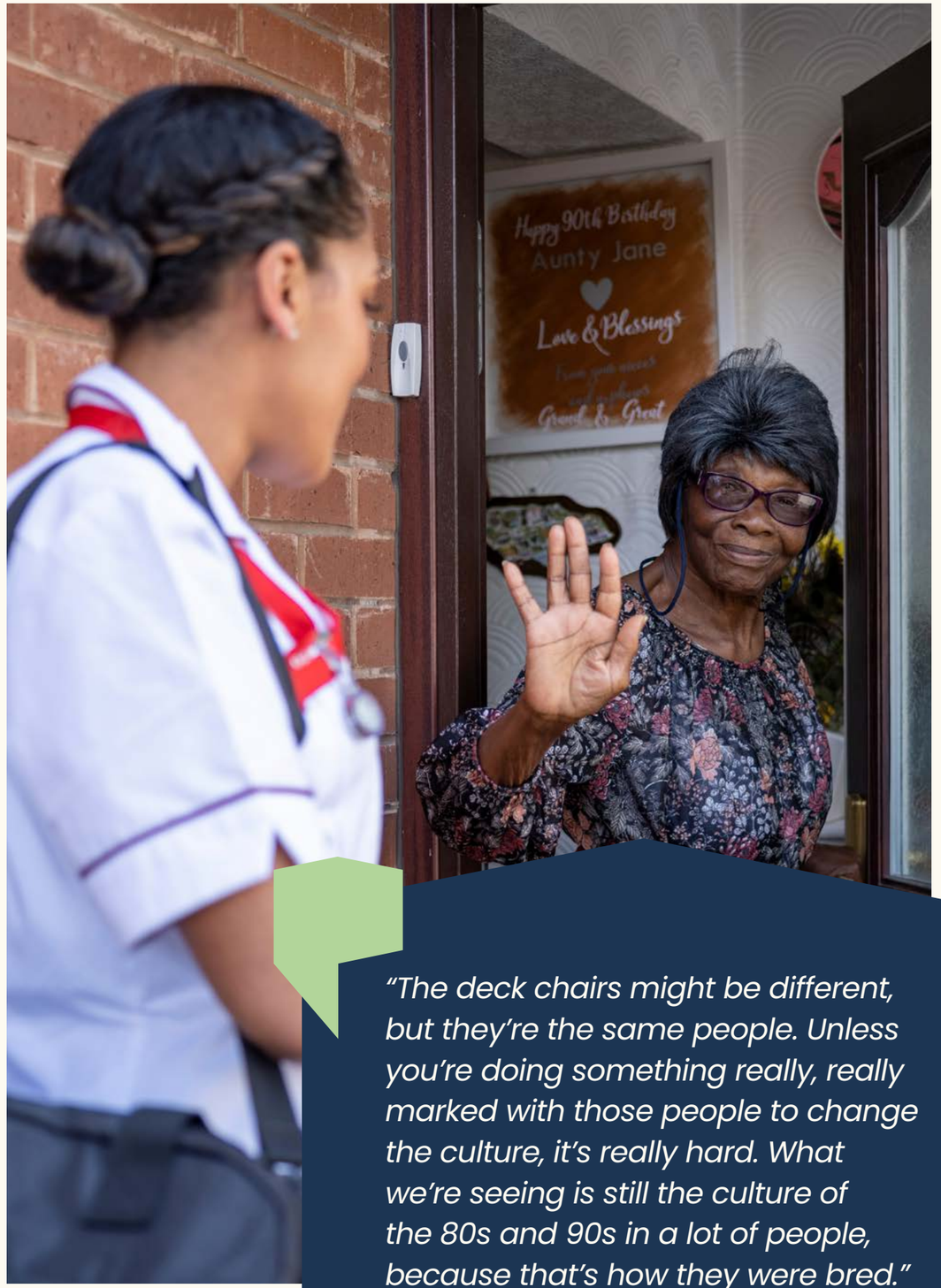
There will also be a need for internal transformation, looking at processes and structures as they are currently, and what can be done to improve performance.

One contributor drew a contrast between the NHS as an innovative investor in medical and surgical advances, and a comparatively lacklustre approach to modernising HR and management practices.

Several contributors called for changes in structures - for example the use of sub-committees to get expertise closer to leadership without the responsibility of full board positions. Other sectors like higher education were seen to be doing this more effectively than the NHS, as well as bringing in their student voice more impactfully than the NHS does patient voice.

Embedding diversity alongside organisational transformation adds an extra level of complexity, but also of opportunity.

One contributor talked about joining a board which had expressed a desire to increase diversity, but finding that there had been little thought given to what that meant in practice, and how the existing board and its members would be required to adapt.



"The deck chairs might be different, but they're the same people. Unless you're doing something really, really marked with those people to change the culture, it's really hard. What we're seeing is still the culture of the 80s and 90s in a lot of people, because that's how they were bred."

Community Representation

I think it's absolutely essential. I think we need people from a variety of different experiences and backgrounds to help us do this really well."

All contributors recognised the importance of properly representing the communities they serve, emphasising the value of diversity of thought and diversity of background alongside diversity of protected characteristics.

This was seen as part of an overall need to ensure boards and executive teams worked as effectively as possible to deliver the improved outcomes which were required.

There was also recognition that on-paper diversity did not fix all the problems, and that genuine understanding of lived experience, and of health inequality, were the ultimate aim - whether firsthand or through better data, evidence-gathering and feedback.

"Sticking somebody on the board because they hit a certain criteria is a million miles away from fixing what the underlying issues are about how we look after people and how we respect people and how we value everybody's opinion."

This brought out themes common across the diversity and inclusion agenda of avoiding tokenism, and the importance of ensuring that D&I is everyone's responsibility not just that of a particular lead or function.

Understanding and deprivation

Community representation doesn't just mean having a board which visibly looks like the people it serves, but also one which understands those people, and works to actively improve health outcomes for all - not just the most visible.

"It's absolutely critically important that we discuss health as a community and think about how we can improve health for all, not just for a smaller number of the community."

There was an awareness amongst many contributors that there were communities it was easier to reach, and easier to grasp the complexity of, and that it was important not to let these dominate NHS time and thinking at the expense of others.

One gave the example of diabetes, which is known to impact ethnic minority communities more prevalently, but where local services may not be tailored effectively to reach those groups for prevention or treatment.

"We're sitting in an area of high deprivation in my trust, and that leads to all sorts of problems in terms of A&E attendance. The cost of looking after people with multiple and complex needs, the co-morbidities, so we're also looking through the lens of socioeconomic status."

Deprivation, too, is an important factor.

Many contributors spoke about the need for board and exec teams to understand the impacts of socio-economic status on health outcomes. Diversity is a vital part of that, given the prevalence of those with a middle class, professional background on boards.

Visibility and Accountability

"We actively support things like Pride and Mela, and all of that is about making our services visibly accessible to all so that people naturally know they can turn to and rely on us."

Several contributors spoke about how their organisations work to be visibly inclusive within the community, to help build trust and accessibility.

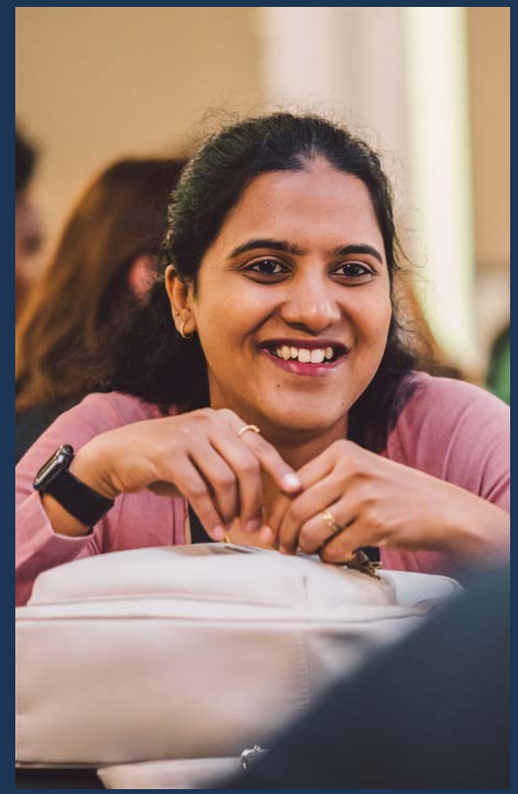
This visibility is a critical aspect of active community representation, and will have a knock-on effect on recruitment, retention and the sense of safety for those challenging ideas.

"I think we've got a wealth of culture there that we're not really learning from and cascading out."

When senior leaders take part in this, and are themselves actively visible, it can also help with direct accountability to the local community by making the processes of health sector leadership clearer too.

This connection and accountability was mentioned by one contributor in particular as something which was important, but which was often missing.

"There is something about having to be accountable to your local population that perhaps is what's missing."



Digital Transformation

"We've got an awful lot of work to do on fixing the basics, but we've also got the tension of this huge ambition that we built around AI."

Technology has transformed many aspects of our lives, and is an embedded part of how medical research and surgical procedures take place, but it has yet to be felt across health organisations as a whole.

The government has made a commitment for the NHS, and the services around it, to adopt technology and deliver services in new, more efficient ways.

Doing that means challenging existing processes and practices, and bringing in expertise which might not necessarily already exist in-house.

That is true on both the operational, executive side of organisations and in their governance structures.

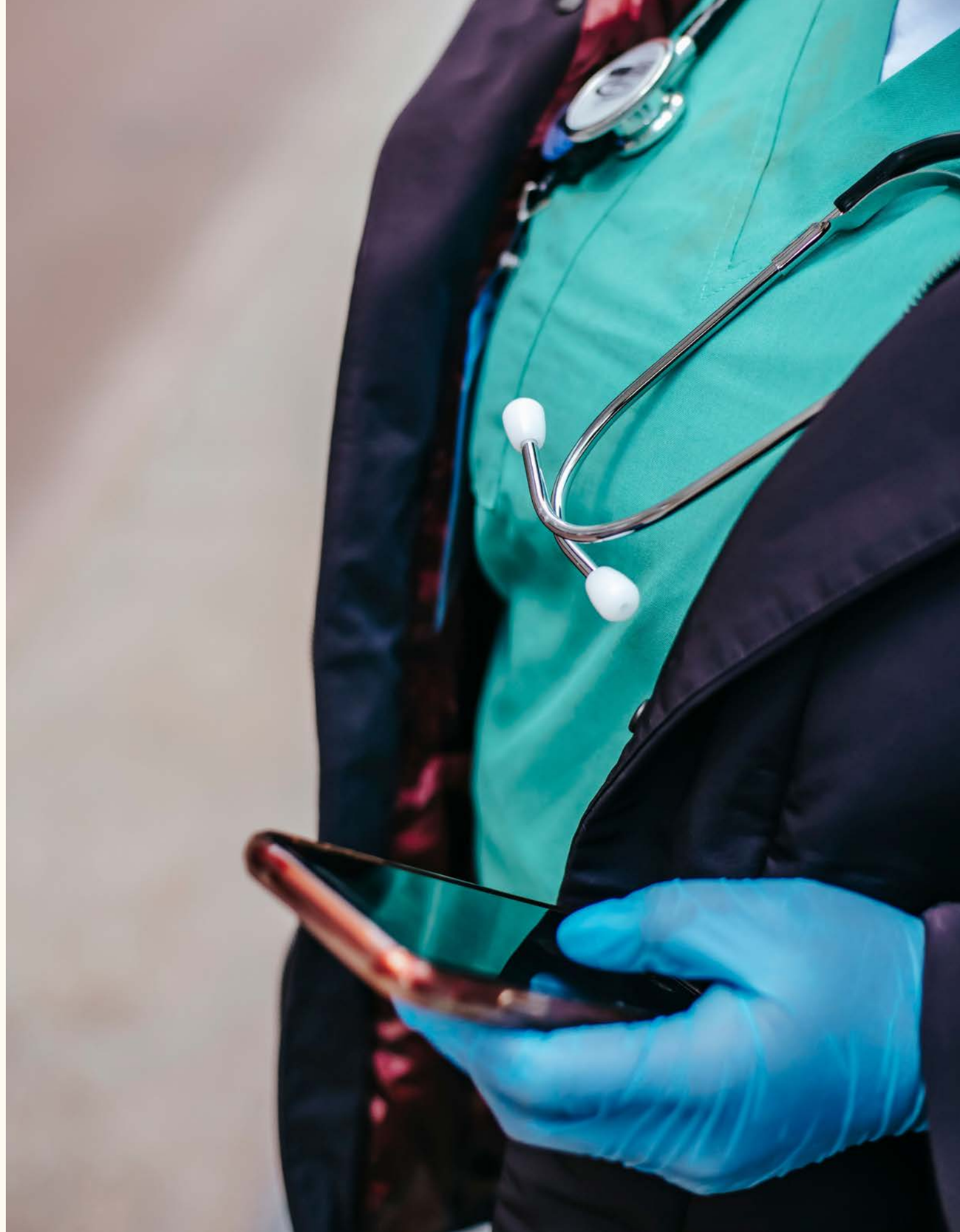
Contributors spoke of the importance of having the right expertise, and that these often came from outside the health sector, or with limited health sector experience.

"Having someone who was up to date and had had their hands dirty recently, they knew it was likely to be their first NED role and that they'd have to invest."

That comes with its own specific challenges, as individuals are required to get to grips with risk management and procurement processes within the sector.

Several contributors spoke about the particular challenges of non-executive director roles where a specialism in the tech sector was a core component, which meant a requirement for someone to have recent practitioner experience.

This meant a diversity of professional background, and often a younger voice than was typical meaning structures were required to offer support to someone likely to be a first-time NED.



Data and efficiency

"You tend to find it takes a whole month to scrape it all together, so you're looking at what happened last month and you're totally driving in the rear view mirror. The angle that I took on it was putting the platforms in place so that we could look at the data now rather than looking at what happened six weeks ago."

Digital transformation embeds itself into processes, and several contributors talked about the value of timely data and evidence in helping guide operational decisions and board accountability.

Often, this was a long-term process, where platforms were put in place, and efforts made to ensure data was collected and analysed promptly.

This was especially important where a delay in data analysis was then followed by a few weeks before a board meeting where a decision was made, following by a few weeks until the next one when feedback on a decision was heard.

Effective digital transformation means NHS organisations become far more agile, and are able to respond to issues - in particular those around patient satisfaction and outcomes - far more quickly.

Digital exclusion and customer service

"There's a disparity between those who are very digitally literate, know how to use the NHS app to sort appointments, to people that can't even use a mobile phone very well and still deal with phone calls all the time."

Several contributors cautioned on the drive towards digital-first communications and interactions with patients, pointing to concerns - quite acute ones in some parts of the region - around digital exclusion.

While single contact methods are simpler and cheaper for health organisations, it would not always be right for patients. One contributor referred to their 85-year-old father, and his struggle with using a mobile phone for regular contact with medical professionals.

Another referenced religious communities and a likelihood to avoid the use of technology on holy days.

Diversity in leadership, and a connection with and understanding of different communities and cultures is vital in building truly inclusive programmes.

Responding To The 10-Year Health Plan

If the funding moves towards treating people in the community, as opposed to following patient flows in hospitals, then I think you'll see quite a shift. The diverse voice just has to be at the heart of it, if we're really going to change the outcomes for the communities that we serve."

The government's 10-Year Health Plan for England was published in July 2025, and called for "a time for radical change – major surgery, not sticking plasters".

The three major shifts it outlines - from hospital to community; from analogue to digital; and from sickness to prevention - are each a significant undertaking.

Contributors recognised the huge challenges this presents, and the substantial effort it will require to deliver on these changes.

Collaboration

"I feel like the real measure of readiness for doing that is around those local relationships. Are person X from the NHS Trust and whoever from the ICS and whoever from the local authority actually joined up?"

Achieving success will mean working with partners in the public, private and voluntary sectors to address all the determinants of public health.

Contributors acknowledge the importance of building these relationships and developing organisational trust early in the process, but understood that some organisations were better placed than others at this stage.

"We're very much focusing much more on those wider determinants of health, and how, if we can manage that, that then protects us as an acute organisation to really perform and deliver what we need to."

As well as helping deliver the 10-Year Health Plan, these collaborations and cross-sector working was also seen as a route to improved performance on existing priorities - whether that was in acute care or broader public health.

A risk was the siloing - both internal and external - of responsibility, and several contributors noted a cultural challenge in this area to break down boundaries and encourage a view of patient and community outcomes in the round.

"The biggest challenge in health isn't the NHS. The NHS can't make people healthy. It can fix people when they're sick, but it can't make people healthy. The wider determinants of health are all about have you got a job? Have you got a home? Have you got friends and family? So it's something to do, somewhere to live, someone to love."

03

REFLECTIONS & RECOMMENDATIONS

Castle Peak's Reflections

There can be no question that the health sector - both the NHS itself and the organisations around it - have made big strides towards greater inclusion.

However, it's also true to say that despite the progress that has been made, and growing diversity in lower bandings, there remains work to be done in senior executive and non-executive roles.

Diversity at that level can be constrained in a number of ways, from the often-blamed candidate supply, to the recruitment process and appetite to taking a risk on those with less direct experience, or even board culture.

Those we spoke to for this research who represent protected characteristics largely - although not universally - felt welcome and respected on the boards they served, and as though their views, insights and professional expertise were valued.

But, all too often they told us they were the lone representative of diverse voices, amongst a group of straight, white men in their 50s or older.

In this way, direct diverse representation on boards in the NHS is still the exception rather than the rule.

Some characteristics we still don't know enough about, notably disability, neurodiversity and socio-economic background.

In many cases, where characteristics aren't visible, they aren't automatically disclosed - this would also include LGBTQ+ status, as well as those mentioned above - and the focus needs to be on psychological safety within the board room and the wider organisation to ensure people feel able to be seen.

That plays a vital role in showing what is possible, and in breaking down barriers.

Without that, as several contributors told us, potential board members look at the current make-up of the group and have to clear that visible diversity hurdle first.

That is coupled with the reality that sometimes the processes we put in place (and repeat time and again) in the name of fairness actually solidify inequity by producing similar outcomes each time.

These process design issues compound more structural issues around how the health sector can attract more diverse candidates, as well as help create a pipeline of board-ready talent.

Even with structural considerations, it is clear that process and risk still define appointments.

This makes sense. In organisations like NHS Trusts, the responsibilities are huge, and board members take on a statutory role - lives are quite literally on the line.

But, if you do things the same way you always have - including recruitment - then you will get similar results, or where there is progress, it will be slow.

Progress has been made, but as we respond to the pressures of now and of the decade ahead, it's time to push on and take the (managed) risk required to change faster and create a diverse, inclusive health sector leadership.

Chairs have a massive part to play.

They may not directly and unilaterally appoint their fellow directors - whether executive or non-executive - but they do shape role definitions, help choose search partners, help shortlist then interview candidates and contribute to appointment decisions.

They also help create board and organisational culture, and can positively challenge established structures and processes.

That's how we can make intent on diversity a reality, and bring lived experience directly into governance.

Opencast's Reflections

The NHS stands at a pivotal moment. Over the coming decade, it will be asked to make profound shifts in how services are designed, delivered and experienced. These are not simply operational or technological changes. They are changes in how the health system understands and serves people. In this context, the diversity of those shaping decisions becomes increasingly important.

Opencast

A key theme emerging from this research is the relationship between inclusion, representation and effective leadership. Greater diversity at leadership level brings a broader range of perspectives, experiences and constructive challenge into decision-making. Diverse leadership teams are better equipped to understand the different needs of the communities they serve, and to develop strategies and set priorities informed by varied viewpoints and lived experiences.

However, representation alone is not enough. The benefits of diversity are realised when organisations create environments in which different voices are heard, valued and able to influence decisions. Throughout this research, contributors highlighted the importance of moving beyond token representation and ensuring inclusion is embedded within leadership, governance and organisational culture.

Understanding the communities served by the NHS is a critical part of this. User-centred approaches encourage organisations to spend time with patients, carers, frontline staff and communities, listening to their experiences and understanding the factors that shape health and social care outcomes. Looking at services through the eyes of users provides valuable insights to inform decision-making, particularly when combined with a wide range of perspectives at leadership level.

Together, these findings show that diverse leadership and meaningful engagement with communities must go hand in hand. Both are essential if the NHS is to understand the people it serves and make better informed choices about its future.

The challenge now is not whether change is required, but how quickly we are prepared to embrace it. Progress will take time. There will be lessons learned, and organisations will need to adapt and refine their approach. But momentum only builds once movement begins.

The message from this research is clear: be ambitious, be courageous and start now. By embracing inclusive leadership and creating opportunities for a broader range of voices to influence decision-making, the NHS has an opportunity not only to deliver better outcomes, but also to create leadership teams that more closely reflect the diverse communities they serve.

Our Recommendations

Through the conversations had with contributors to this research, a number of themes have been uncovered, and approaches shared, which may support a push for greater diversity in senior executive and non-executive director positions.

Here are our recommendations for change:

1. **Empower chairs to 'be the change'** and shape their organisation's processes
2. **Specifically task recruiters with returning diverse shortlists**. Contributors told us there was value in giving clear briefs to recruiters which included returning diverse candidate shortlists, and also reviewing role descriptions to ensure they were accessible in both the language and the expectations that were being set for candidates
3. **Use diverse recruitment panels, and consider adjusting interview processes** to minimise unconscious bias and improve accessibility, including for people with neurodiversity
4. **Explore board-readiness programmes, which provide tailored leadership development support to those from diverse backgrounds.** Importantly, these programmes must be linked with genuine opportunities for progression
5. **Provide mentoring opportunities** where existing exec and non-executive directors work with those new to the role, to help them make an impact more quickly and effectively
6. **Conduct structural reviews to understand blockages for progression** and look at where alternative pathways should be provided
7. **Explore ways to get a broader range of issue-specific voices into the decision-making process,** by recognising where decisions have particular impact on certain groups, or where the board as it stands is lacking in certain characteristics. An avenue here could be the use of sub-committees for external voice, and more direct use of staff networks for workforce voice. This should only be viewed as an immediate way to address diversity issues which are being addressed long term
8. **Investigate ways to make board roles more accessible**, given the huge commitment required in the health sector - this should include looking at remuneration and the timing of board meetings to widen involvement

Final Words

The NHS, and the broader life and health sciences sector, are huge employers and Trusts themselves are anchor institutions in their area. They are capable of not only serving their community better, but shaping it for the better too.

They are vehicles of opportunity, and we have the chance to capture and formalise that so that leadership in the sector is based purely on merit, not on luck or privilege.

"I was brought up in Hebburn. Like a lot of people I know brought up in Hebburn, my family had nothing. Everybody had nothing. I've been fortunate enough to end up in a decent position in the boardroom but, I mean, honestly, it was luck."

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[4] *https://www.ons.gov.uk/explore-local-statistics/indicators/level-3-or-above-qualifications*

[5] *https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/approximatedsocialgradeenglandandwales/census2021#approximated-social-grade-asg-in-england-and-wales*

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