Action for equality | The time is now

By Professor Ruth Sealy
University of Exeter Business School

50:50

NHS Women on Boards

50:50 by 2020

UNIVERSITY OF EXETER | BUSINESS SCHOOL

Health & Care Women Leaders Network
Delivered by NHS Confederation

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FOREWORD

Authentic health and care leadership, based on breadth of thought, expertise and experience from multiple perspectives, is not just a lofty ideal we should strive towards. It is essential, overdue and needed now. Leadership which lacks diversity is outdated and inexcusable in modern society. It is the relic of a bygone era based on traditional comfort zones and power structures. Most importantly, it inhibits our ability to represent, understand, empathise with and fully meet the needs of the communities we serve.

In 2016 the then chair of NHS Improvement, Ed Smith, took on the role of diversity champion for NHS women. Adopting the approach Lord Davies took with the FTSE 100 and with the research led by Professor Ruth Sealy (University of Exeter Business School), Ed published the report 'NHS Women on Boards 50:50 by 2020. The report called for 500 more women on NHS boards by 2020.

So where are we now? The good news is we have made some progress but there remains much more for each of us to do. The seven case studies included in the full report demonstrate what is possible with the leadership, mindset and culture that creates the conditions to support women and black and minority ethnic (BME) leaders, both executive and non-executive, onto NHS boards.

The Health & Care Women Leaders Network is committed to the drive to increase the number of women on NHS boards. We are increasingly looking at leadership through an intersectional lens and therefore this report also considers BME representation on boards. The absence of a national data set that tracks each of the protected characteristics of NHS boards continues to be problematic.

Without the data it is difficult to hold leaders and the health and care system to account. Put simply, there is no consequence for not having a diverse board. As one leader said: "You will get a call if the finances go off track but no one calls if you aren't paying attention to diversity."

If it hadn't been for COVID-19 we would have published this report in March 2020. We considered delaying it further given the focus and effort now on the recovery and restoration across the NHS. However, given the findings in the report and the inequalities COVID-19 has cast further light on, we felt it imperative to share our findings now with NHS leaders.

I wish to thank Professor Ruth Sealy for her further research and writing the report. Also, Danny Mortimer, chief executive of NHS Employers, for his support to do this follow-up work, the Health & Care Women Leaders Network members, and the guiding group for the advice they gave.

I ask every leader and aspiring leader across the NHS to read the full report. The evidence within it and the case studies included demonstrate what can be achieved when leaders set clear goals for the diversity of their boards. However, whilst goal setting and the data is important to track progress it will be the mindset, behaviour, working conditions and culture shaped by those leading organisations and health and care systems that achieve diverse boards.

We need 150 more women in board-level positions to reach our goal. Taking action for equality and inclusion has never been more urgent and **the time is now.**

Samantha Allen
Chair, Health & Care Women Leaders Network
Chief Executive, Sussex Partnership NHS Foundation Trust

EXECUTIVE SUMMARY

The benefits of diverse leadership have been extolled extensively in academic and practitioner publications. This report focuses on the behavioural responses required of senior individuals within the NHS boardrooms to ensure real progress: the why, what and how of achieving boardroom diversity.

In 2016, Ed Smith, chair of NHS Improvement, agreed a target for all NHS boards to reach gender parity: '50:50 by 2020'. In 2017, board data was analysed to set a benchmark, and to determine areas where women's progress appeared to be blocked. It found three board roles where women were missing: non-executive director (37 per cent), chief finance officer (26 per cent) and chief medical director (24 per cent).

This report builds on and expands that work. It includes analysis of board-level data on over 3,000 directors across NHS trust boards in England and arm's-length bodies (ALBs), and over 70 in-depth semi-structured interviews with board chairs, directors, and women aspiring to directorship positions. Progress has been made, but there is much yet to do. Whilst the headlines of this report focus on the quantitative data for leadership diversity, the qualitative interviews highlight the mindset required of leaders to shift the culture towards one of inclusion. Inclusive leadership is requisite to reap the benefits of diversity and develop the compassionate leadership to which the NHS aspires.

The report has four main sections plus seven mini case studies, detailing actions chairs have taken to diversify their boards.

Board data

- Within a workforce that is 77 per cent female, the data reveals an overall increase in **women's representation on NHS trust boards in England to 44.7 per cent**, up by nearly 5 per cent from 2017. Data from 213 boards shows representation ranges from 15.4 per cent to 77.8 per cent.

- Using the European Commission's definition of gender balance of 40-60 per cent of each sex represented, 115 of the 213 trusts (54 per cent) are within this target.

- Data also reveals an overall representation of 8.9 per cent BME directors. Boards' ethnicity representation ranged from 0 per cent to 46.7 per cent, revealing significant regional differences within that figure.

- Across the 13 ALBs, the percentage of female directors ranged from 18.2 per cent to 66.7 per cent, with an average figure of 39.9 per cent. For BME directors these figures ranged from 0 per cent to 30 per cent, with an average of 10.5 per cent.

- **There were still 70 all-white NHS trust boards and six all-white ALB boards.**

- Overall, executive directors across NHS trusts in England and ALBS are gender balanced, with women holding 48.8 per cent of roles in trusts and 44.2 per cent in ALBs. On trust boards, this figure is skewed by the over-representation of women in nursing with 89 per cent of chief nursing officer roles being held by women.

- However, whilst **an increase of women holding medical director positions is revealed (29.0 per cent up from 24.6 per cent), we report a decrease in the percentage of female chief finance officer (25.3 per cent down from 26.3 per cent)**, despite both having majority female workforces.

- Women now hold 40.9 per cent of non-executive director (NED) roles, but only 37 per cent on ALBs.

- **We need 150 more executive and non-executive female directors (including 40 more female medical directors and 50 more female chief finance officers) to reach gender balance across NHS trust and ALBs boards in England.**

Interviews with current and aspirant female chief finance officers (CFO) and medical directors (MD)

Interviews with women currently in and aspiring to these board roles provide useful insights regarding perceptions of barriers and potential solutions to making these goals more realistically attainable. Women have made up the majority of medical school graduates for more than 25 years, but the system of medical careers is not designed for the needs of women. If the NHS wants to optimise the contribution, and retain the majority, of its highly talented staff, then highly career-oriented women, whether or not they have children, should not feel they have to choose between work orientation and non-work orientation. Senior roles need to be manageable and accessible to the majority of the 21st century workforce.

Interviews with chairs

Findings from the chair interviews increase our knowledge base of boardroom processes – the why, what and how of achieving boardroom diversity. Chairs demonstrate that **clear intent, backed up by purposeful action and determination, can successfully bring about requisite change**. Time and again, both through this research and that of several others cited in this report, we see that **accurate and accessible diversity data is a critical first step to change**. But, whilst diversity is having the different voices and perspectives present, inclusion is when those voices are fully heard. **Proactive talent management is imperative**. This again requires **purposeful shifts in culture and leadership**. Several of the chairs in this study have taken great strides towards inclusive cultures at board level and are also starting to embed that inclusion throughout their organisation.

As cultures become more inclusive, women and minority groups become more attracted to leadership positions. Many initiatives throughout NHS organisations have endeavoured to increase inclusivity, but this is extremely challenging if it is not led and role modelled from the top.

The chairs in our study also demonstrate that whilst clear direction from the national leadership is important, change at a local level is very much within the gift of individual chairs.

Case studies

The seven case studies throughout this report each focus on the actions of a chair in furthering the diversity on their boards. Examples include:

- how shifting board culture led to improved Care Quality Commission (CQC) ratings
- how to cultivate inclusive boards, orchestrate difference, avoid groupthink and produce better decisions
- understanding the motivations to change, including legitimacy, better talent management and greater board effectiveness
- paying attention to data in individual organisations and challenging chairs to own the requisite change
- completely overhauling every aspect of the recruitment process, internal and external, to move effectively towards more diverse and inclusive boards.

> "
> The NHS has always depended on the talents of a diverse workforce; However, we know that the experiences and opportunities that women, black and minority ethnic staff in the NHS face today are not always positive. Reading through these case studies I admire the candour of those who have shared their experience.
>
> Leadership isn't just about seniority or about a place on an organisational chart, though it's clearly a part of it. It's also using your position, influence and platforms to make improvements for your colleagues, staff, patients and your population. Collectively, each one of us has a part to play in creating a fairer, more equal NHS
>
> This reports highlights the progress we have made and how far we have to go. While it is important to look back at how far we have come, we must also take this opportunity to look forward and work for more.
>
> Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement and Chief Executive, NHS Improvement
> "

Summary of recommendations

National level

1. **Provision and use of data: Diversity data** on boards and senior management, and on appointment processes, **should be monitored, reported and made accessible** as a driver for reform.

2. **Implement national equality scheme:** a scheme similar to the Athena SWAN programme in higher education institutions should be introduced across NHS organisations.

3. **Diverse leadership for integrated care systems (ICS):** lessons from this report must form the basis of recruitment for collaborative diverse ICS leadership going forward.

4. **Accountability:** the well-led framework and CQC inspections should include specific reviews of board appointment processes, and whether chairs are proactively increasing diversity.

Chair and board directors (of ALBs and trusts)

5. **Diversity must become core business for all NHS boards:** diversity data should be a regular part of board information. Initiatives should have success measured and reported on. Directors should be accountable.

6. **Strategic inclusivity:** every board member should be able to explain their understanding of the importance of diversity, and what they are doing to improve inclusion within their own board and organisation. Boards need to move beyond a tactical approach of compliance to one of strategic inclusivity.

7. **Managing boardroom dynamics:** chairs should ensure boards have the psychological safety that allows difficult conversations. Chairs must demonstrate inclusivity and cultural competence as the culture will be set by their behaviours.

8. **Board appointments:** chairs should have explicit objectives, relevant to their organisation, to ensure board diversity (see section 3.5). There should be clear succession plans for CFO and MD roles.

9. **Lift as you climb:** all board directors should be proactive in helping to develop and encourage those at mid and senior levels through clear development plans linked to talent management and appraisal.

10. **Make the unknown accessible:** emerging leaders at mid and senior levels should be given the opportunity to experience board-level working. For example, through shadowing or observing an existing director joining board-level projects, and/or secondments, before deciding whether to aim towards the role.

11. **Scaffold the transition:** networks, professional bodies and organisational structures should support the transition to board roles.

Talent management for the 21st century

12. **Challenge leadership stereotypes and advocate new leadership styles:** chairs and other board members should explicitly challenge assumptions that stereotype leadership and its characteristics as masculine, or white, advocating more inclusive, compassionate, and collaborative styles.

13. **System-wide approach to actively managing talent:** better access to regular leadership training and guidance early on should be provided that enables women to develop authentic, competent leadership. All NHS England and NHS Improvement funded or commissioned programmes, including third party provided programmes, management training schemes and fellowships, should explicitly publish their participant composition by gender and ethnicity, with a commitment to 50:50 gender diversity.

14. **Encouraging different career paths:** recognition that rapid linear progression and mobility are not the only indicators of ambition to senior roles.

15. **Enable greater flexibility:** organisations should ensure that flexible working practices are in place to enable a range of work patterns, and that this is actively supported and role modelled by the most senior leaders. Presenteeism should be explicitly discouraged.

16. **Job shares:** all roles including board-level roles should be explicitly open to candidates who wish to job share. Job sharing should be seen as a legitimate and viable way of working, with appropriate systems and policies to enable and promote it.

SECTION 1: INTRODUCTION

In 2015, in collaboration with the United Nations and UN Women and sponsored by NHS Employers, a report led by Dr Penny Newman laid out a plan for gender equality across the NHS[1]. Accepting the business case (greater talent management and better decision-making, leading to better patient care and performance outcomes), the focus was on actions towards change. The conversation on gender diversity at leadership levels across other sectors in the UK had gained great volume in 2011, with the advent of the government-backed Lord Davies Review into women on corporate boards. Despite a decade of mainly in-house initiatives led by human resource managers, the proportion of women on the UK's largest listed corporate boards stood at just 12 per cent. Starting from a low base and with a working population of less than 50 per cent female, a target was set for the top 100 companies to move from 12 per cent to 25 per cent in just four years. Regular data reporting, mindset shifts in monitoring and regulation, and behavioural changes in activities such as recruitment and retention, were highlighted as necessary. The target was achieved in 2015 and Lord Davies recommended a higher target of 33 per cent, to cover boards and senior management of the top 350 FTSE[2] -listed companies by 2020.

In 2016, following the success of the Davies Review, and the publication of Dr Newman's UN report, Ed Smith (then chair of NHS Improvement) agreed a target for women on NHS boards of 50:50 by 2020, and an advisory group was formalised to suggest actions towards that target. In March 2017, the NHS Women on Boards 50:50 by 2020 report was launched, endeavouring to start a longitudinal dataset of board composition across NHS boards in England, to underpin the move towards gender-balanced leadership. This report builds on and expands that work, with data on over 3,000 directors across NHS trust boards and ALBs in England, as well as over 70 in-depth interviews with board chairs, directors, and women aspiring to directorship positions. From the board chair interviews, as well in-depth findings of their motivations for and approaches to diversification, we share seven mini case studies of change that chairs have engaged in, in order to diversify their boards. Whilst the headlines of this report focus on the quantitative data for leadership diversity, the qualitative interviews and case studies highlight the mindset required of leaders to shift the culture towards one of inclusion. Inclusive leadership is requisite to reap the benefits of diversity.

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[1] Newman (2015) NHS Women in leadership: Plan for action, NHS Employers
[2] Financial Times Stock Exchange

'It is not enough for the NHS merely to continue to champion the idea of inclusion and diversity. We must recognise our shortcomings in this area and listen to the experience of those who face exclusion and marginalisation to understand how to advance equality and diversity better. We need to develop leaders who have the knowledge, skills and behaviours to create and sustain cultures of compassion and inclusion. We must also urgently intensify our efforts to ensure our teams and organisations, particularly the senior leadership of the NHS, demonstrably reflect the diversity of the communities that they serve, including making progress against the ten-year leadership equality ambition that reflects the Prime Minister's pledge around race equality'
Interim NHS People Plan 2019

"

We need to look and learn from the UN - they have achieved 50:50 by 2020 and they did this through purposeful leadership. They recognised the benefits of doing this and made it a measurable goal.

Sam Allen, Chair, Health & Care Women's Leadership Network; Chief Executive, Sussex Partnership NHS Foundation Trust.

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In healthcare leadership, the case for diversity is well established. A report commissioned by The King's Fund cited research linking diversity, leadership, organisational performance, the quality of care and better use of resources[3]. However, a Future Focused Finance report revealed that only 30 per cent of 1,000-plus respondents believe that their organisation's board properly represents the community it serves. In 2015, the NHS Confederation and NHS Employers set up the Health & Care Women Leaders Network to raise awareness of barriers women face in the workplace; support women's career and professional development; and empower women to secure senior and board-level positions. Inclusion is core to the NHS Constitution, yet it remains one of the biggest challenges that health systems face[4]. An extensive literature review[5] commissioned by Tracie Jolliff, director of inclusion at the NHS Leadership Academy in 2017, provides the evidence base of the many challenges, structural and cultural barriers that such a large and disparate organisation faces in shifting from the old, homogenous command-and-control-style leadership to a more diverse and inclusive style. Positive inclusion is one of the key elements of compassionate leadership required to stimulate innovation in healthcare[6], and fundamental to the vision of what 21st century NHS leadership should be.

> **'In order to nurture a culture of compassion, organisations require their leaders – as the carriers of culture – to embody compassion in their leadership.'**
> (West, Eckert, Collins & Chowla, 2017)

Women have made up the majority of medical school graduates since 1991[7], and the total number of female doctors are expected to outnumber male doctors at some point before 2022[8]. The current NHS workforce is 77 per cent female. However, numerous reports over the past decade have outlined the multitude of additional career challenges faced by women in the medical profession, leading to a cumulative disadvantage[9] in their career progression[10]. For example, in 2012 Clare Marx, president of the Royal College of Surgeons, commissioned a report into the dearth of senior female surgeons. Findings showed that at qualification, female surgeons' ambition levels were equal to or even slightly higher than males[11]. However, measured again at three and five years post-qualification these had fallen off dramatically. The report authors attributed this change to the culture within surgery exacerbating the lack of belief amongst women that they could succeed in that career with authenticity.

More recently, the Independent Review of Gender Pay Gap in Medicine was commissioned by then Secretary of State Jeremy Hunt, amid the concern that the pay gap in medicine was substantial. Using workforce data, the analysis revealed figures of 19 per cent for most hospital doctors, 15 per cent for GPs and 12 per cent for clinical academics[12]. Much of this is explained through differences between male and female doctors in hours, grades, experience and Clinical Excellence Awards. Seniority gaps were explained by a combination of family and structural factors, with workplace cultures also accounting for women's lower level of experience. Evidently, there are many overlaps with other sectors and industries[13] and it is important to note that research is clear that male's and female's perceptions of such career barriers differ[14].

3   West, Dawson & Kaur (2015), Making the difference: Diversity and inclusion in the NHS, The Kings Fund.
4   NHS Leadership Academy, Building leadership for inclusion, [https://www.leadershipacademy.nhs.uk/resources/inclusion-equality-and-diversity/blfi-2/]

5   Bolden, Adelaine, Warren, Gulati, Conley & Jarvis (2017), Inclusion: The DNA of leadership and change, NHS Leadership Academy. [https://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2019/06/BLFI-Literature-review-Clear-Print-Version.pdf]

6   West, Eckert, Collins & Chowla (2017), Caring to change: How compassionate leadership can stimulate innovation in health care, [https://www.kingsfund org.uk/sites/default/files/field/field_publication_file/Caring_to_change_Kings_Fund_May_2017.pdf].
7   Department of Health, (2009), Deech report: Women doctors making a difference, report of the chair of the national working group on women in medicine.
8   Medical Workforce, The Kings Fund.
9   Newman (2011) Releasing potential: Women doctors and clinical leadership, NHS Leadership Academy.
10   Newman & Sealy (2013) Breaking down barriers for women doctors, Health Service Journal.
11   Peters & Ryan (2012) Fitting in and getting on: Understanding career motivation in male and female surgeons, Report for the Royal College of Surgeons, University of Exeter.
12   Dacre & Woodhams. (forthcoming). Mend the gap: The gender pay gap in medicine review. Department of Health and Social Care.
13   Jarboe (2013) (2015) A woman's place in public appointments, WomenCount.
14   Institute of Leadership & Management (2011) Ambition and gender at work.

In the private sector, the government-backed Davies Review (2011-2015) and Hampton-Alexander Review (2016-2020) have both been extremely successful in galvanising the conversation and action around increasing the proportion of women on publicly listed boards[15] and senior management[16] The previous decade had seen a number of reports and platitudes but very little change in the figures. In the wake of the financial crisis, increasing the numbers of women on boards in the private sector was seen as part of a broader shift towards more strategic and better performing boards, whilst simultaneously moving towards attracting and retaining the best people.

Previously, organisations lacking leadership diversity had assumed a supply problem of suitably qualified women or people from ethnic minorities. More recent diversity research data reframes the issue as one of demand, revealing systemic issues requiring multiple stakeholders and mechanisms to drive change in the diversity agenda[17] For example, in the private sector there was a substantive focus on the appointment process conducted between chairs and executive search consultants. Once the realisation is made that the problem is not one of supply, but of demand, then the solutions to that problem change.

In late 2017 and early 2018, consciousness of gender and racial issues exploded on a global scale through the social movements of #MeToo and #BlackLivesMatter. Also in the global sphere, in 2017, António Guterres became UN Secretary General, pledging to continue the fight for global gender equality (UN Sustainable Development Goal No. 5), declaring: 'The 21st century must be the century of women's equality.'[18] The UN itself achieved 50:50 by 2020 in its own leadership, with 90 male and 90 female directors.[19] There are now 18 female political leaders of countries across the globe, often focusing on innovative work for the betterment of society. For example, the collaboration between Scotland, Iceland and New Zealand (all led by women) focuses on shifting the main goal of economic policy away from purely wealth creation, which increases inequality, towards collective wellbeing. In addition, there has been extensive press coverage[20] regarding the assertion that countries with the lowest death rates from COVID-19 are proportionately more likely to be led by a woman (Germany, New Zealand, Taiwan, Iceland, Greece, Norway, Denmark, Switzerland, Finland).

The 2017 women on boards data collection aimed to establish a benchmark for trend data, and disaggregate what are often only average nationwide figures, in order to ascertain particular blockage points. **The report made six recommendations:**

1. Public reporting of gender balance data on boards and senior management should be mandated annually from all trusts, clinical commissioning groups (CCGs), ALBs and councils of Royal Colleges (RC).

2. Strong leadership on inclusive and balanced boards is required nationally and locally. An advisory steering group with constituents from the ALBs, RCs, employer bodies and independent experts should address the lack of understanding amongst some boards and support and bring energy to the goal.

3. A target of 50 per cent of all appointments made through executive search firms and the NHS in-house search functions between 2017-2020 to be female.

4. Further research to be led by NHS England and NHS Improvement (NHSEI) and NHS Employers to understand blockages in particular roles that fall well short of balance. Focus to be on actions to build capacity and progress.

5. Communication to boards about causes of imbalance and exemplars of corrective action taken should be enhanced.

6. Gender-specific learning should be built into NHS training programmes

15 Sealy, Doldor & Vinnicombe (2016), The Female FTSE 2016 Board Report: Taking stock of where we are, Cranfield School of Management.
16 Hampton-Alexander Review (2016), FTSE 100 has met the target of 33% women on boards, Accessed at: [https://ftsewomenleaders.com/].
17 Sealy, Doldor, Vinnicombe, Terjesen, Anderson & Atewologun, (2017), 'Expanding the notion of dialogic trading zones for impactful research: The case of women on boards research', British Journal of Management, 28, pp.64-83.

18 United Nations (2020), The 21st century must be the century of women's equality, [https://unric.org/en/the-21st-century-must-be-the-century-of-womens-equality/]
19 Statista (2020), Number of countries with women in highest position of executive power 1960-2020, [https://www.statista.com/statistics/1058345/countries-with-women-highest-position-executive-power-since-1960/.]
20 Forbes (2020), Are women better at managing the COVID-19 pandemic?, [https://www.forbes.com/sites/tomaspremuzic/2020/04/10/are-female-leaders-better-at-managing-the-covid19-pandemic/#10065b6628d4]

The Public Appointments Diversity Action Plan 2019 recommends better diversity data reporting 'to improve the consistency and reliability of the data that we hold about public appointments, so we can see where we are making a difference and where further focus is needed.'[21] This report highlights and updates NHS board data. NHSEI has committed to collect and publish data about senior leaders going forward, understanding that this is vitally important to support transparency and to improve diversity. Strong leadership on board diversity has been demonstrated by NHS Improvement chair Dido Harding and NHSEI chief executive Simon Stevens, and this report has been endorsed by Amanda Pritchard, chief operating officer, NHSEI and Prerana Issar, chief people officer, NHSEI. In addition, this report takes up the call for further research to understand blockages in particular roles that fall well short of balance. The 2017 report identified these as the chief finance officer, medical director and non-executive directors. This report focuses on actions to increase gender balance in these roles. Findings from the report will be communicated to all boards via NHS Employers and the NHS Confederation, to provide guidance on best practice to diversify boards.

In addition to updating the 2017 report on gender balance, this report also considers black minority ethnicity (BME) in board roles. The NHS is the country's largest employer of BME individuals and yet outcomes in recruitment, promotion, discipline and career progression are significantly worse than for their white counterparts[22] As the discussion about diversity becomes more sophisticated and inclusive, ethnicity is increasingly a necessary component in the conversation. Therefore, we include BME data in the board census and witness that it plays a significant part in the conversations with chairs.

We acknowledge that gender and ethnicity are only two dimension of diversity – others include race, disability, age, religion and sexual orientation. Whilst some of the challenges faced by women in their careers mirror those experienced by minority groups, it is important to note that women make up the majority of the population of the UK and a significant majority of the NHS working population, and for that reason addressing this under-utilisation of a particular talent pool is critical. Many women also make up the majority of those other minority groups.

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> **This report tells a powerful story of the ongoing challenges around gender equality, and highlights the fact that they become even more stark when faced by women from diverse backgrounds.**
>
> **We know and are committed to thinking and acting differently to make the NHS a true 21st century employer. Our ambition for a positive, compassionate, inclusive culture across our NHS has been strengthened by the publication of We are the NHS: People Plan for 2020/21 – action for us all. It sets out specific commitments about what needs to happen across our NHS to ensure we are inclusive, diverse and flexible. It also sets out what our people can expect in recognition of their efforts and what it means to be part of the NHS team – for example through enhanced health and wellbeing support and flexible working.**
>
> **NHS England and NHS Improvement has also made a clear commitment to ensure that our senior team is representative of the wider workforce at all levels. I applaud and encourage the efforts of everyone working for gender equality, and equality for all colleagues.**
>
> Prerana Issar, Chief People Officer for the NHS, NHS England and NHS Improvement
> "

21 H.M. Government (2019), Public appointment diversity action plan 2019, [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/812694/20190627-CO_Diversity_Action_Plan_FINAL-6.pdf]

22 Kline, R. (2015), Beyond the white snowy peaks of the NHS, better health briefing paper 39, Race Equality Foundation, [https://raceequalityfoundation.org.uk/health-care/beyond-the-snowy-white-peaks-of-the-nhs/]

CASE STUDY 1 – REVAMPING THE APPOINTMENT PROCESS
Lincolnshire Partnership NHS Foundation Trust: 42per cent, female; 25per cent BME

In planning the turnover of a number of both executive and non-executive roles over a couple of years, Paul Devlin, chair of Lincolnshire Partnership NHS Foundation Trust, decided: "The recruitment pack needed updating… [to move to] a values-driven recruitment process." Explicit about the organisational values, he wanted a board that would reflect and model such behaviours. For the chair, this could only be achieved with a good mix of gender and ethnicity.

With the executive roles, the chair enlisted support from the NHS Leadership Academy. He was explicit with them about his expectation that they sought to get diverse candidates, both in terms of equalities, but also background.

Recruitment materials were rewritten, including adverts and job packs, changing the language used quite specifically. For example, Paul states: "Rather than having bland 'we strive to be an equal opportunities employer' wording, actually identifying and explicitly saying, 'we welcome applications from these under-represented protected characteristics' and then listing them: so BME, LGBT. I know, from conversations with some candidates, it's that sort of subtle action which they recognised that oh yes, they get this stuff."

The chair also sent a covering letter to candidates that very explicitly talked about the importance of the trust values, what they are, why they're important to the trust and the expectation that the board members live and model these values. In addition, for executive candidates, the covering letter outlined that the trust was "seeking delegated leadership, a commitment to trusting people to be able to do what they do."

For the non-executive director (NEDS) roles, they did an analysis of what skills, knowledge and experience they had around the board table, working out what the gaps were for the kind of board they needed for the next few years. Said Paul: "We listed those specifically in the recruitment pack, literally on a table with bullet points." One example was they wanted somebody with a clinical background, "but we expressed that very clearly as clinical in the broadest sense, in a way that was more inclusive than we had done previously, expressly including allied health professionals." In addition: "There was stuff in there about commitment to working as part of complex teams and what that meant, and also we were, again, explicit around our commitments on equality and diversity, to our diverse communities and to the principles, those principles that the research backs up, that if you have staff who are able to bring their whole selves to work then they are generally happier people at work and generally do better work, and we get better services. So setting out that business case around equality and diversity was important for us."

The chair committed the board to NHS Improvement's NExT Director Scheme, principally targeting BME prospective NED candidates. The associate they took on was treated as if he was a fully resourced member of the board, with access to IT, etc. The chair also had regular one to ones with the associate, mentoring him, discussing behaviours in the meetings, and so on. Six months later, a vacancy came up, the associate applied in a competitive process and was successfully appointed as a full NED.

For both executive and NED posts, the trust has had much broader fields of candidate apply: "It made a big difference with the recruitment field we got," said Paul, with candidates saying that one of the things that really attracted them to the organisation was the commitment around values.

SECTION 2:
BOARD DATA FINDINGS

Data collection

In collecting the data for this report, we came up against the same issues we had in developing the 2017 report. Accurate, detailed diversity data on board composition (covering executive and non-executive roles) is still not available. Centrally available data on the gender composition of boards is not available at all. The Workforce Race Equality Standard (WRES) data, whilst undoubtedly a huge step in the right direction and extremely useful across the organisation, does not go into sufficient detail on board composition to understand where the actionable gaps are. In addition, there is no focus on gender in the WRES data. Whilst understandable in terms of wanting to focus that data on ethnicity, this hampers our understanding of issues as it prevents any analyses at an intersectional level, which we know from pay gap analysis is extremely important[23]

Transparent and available data is required for evidence-based decision making, ensuring that policies are based on fact rather than assumption.[24] Plans are afoot to make such a database available but unfortunately, this was not achieved during 2019. Therefore, data for this report was downloaded from public websites during December 2019 to January 2020. Our gender data is taken from public websites of each trust or ALB board, and we use the term 'assumed gender', as we are making a judgement based on photographs and names. We completely acknowledge that ethnicity cannot be satisfactorily measured by such simplistic methods and this then posed a dilemma for the commissioning team.

In the absence of complete accurate data, we asked ourselves which data would be most meaningful? For gender, we have detailed 'assumed gender' data from publicly available websites. For ethnicity, we could choose to use the WRES data, which is accurate as self-reported, but collected for a different purpose, and is limited in what it can tell us at trust board level, and ALB data is absent. It also presents very few comparable variables with the 'assumed gender' data. Alternatively, we could use the very crude 'assumed ethnicity' data, collected at the same time as the 'assumed gender' data. With multiple points of comparison, this perhaps gives a broader, more meaningful, if a little less accurate reflection of the status quo.

The discussion that ensued focused on how best to serve the purpose of the commissioned research, with both alternatives presenting imperfect solutions. In the end the decision was made to use the 'assumed ethnicity' data. Despite the crudeness and incompleteness of the data, we believe it gives a fuller illustration of diversity on trust and ALB boards today. We compared our 'assumed ethnicity' board data to the 2019 WRES data. Our figures, though taken six months later, were not dissimilar. The average trust board figure is 8.9 per cent BME ethnicity, which is just half a percentage point higher than the WRES data of 8.4 per cent. As a guide to the overall picture we believe it is representative.

The fact that such detailed and disaggregated data on any of the major dimensions of diversity is not readily publicly available continues to be an issue within the NHS and one that needs to be addressed.

The 2017 report included trusts, ALBs and CCGs. It was decided for this report to focus on trusts and ALBs, given the amount of change currently occurring in CCGs. The number of trusts has declined since 2017, as hospitals and services amalgamate. Our 2020 sample consists of 213 trust boards in England and 13 ALB boards, including data on over 3,000 board directors (2,865 from trusts and 143 ALB directors). The trusts employ over 1.27million employees, and the ALBs have a further 26,900 employees.

We acknowledge that gender and ethnicity are only two of multiple dimensions of diversity but are often visually the most salient.

Data was analysed by assumed gender, assumed ethnicity, board role, trust type, service type, board size, and region.

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23 Dacre & Woodhams. (forthcoming). Mend the gap: The gender pay gap in medicine review. Department of Health and Social Care.

24 Sealy, Doldor, Vinnicombe, Terjesen, Anderson & Atewologun (2017), Expanding the notion of dialogic trading: The case of women on boards research, British Journal of Management, 28, pp64-83.
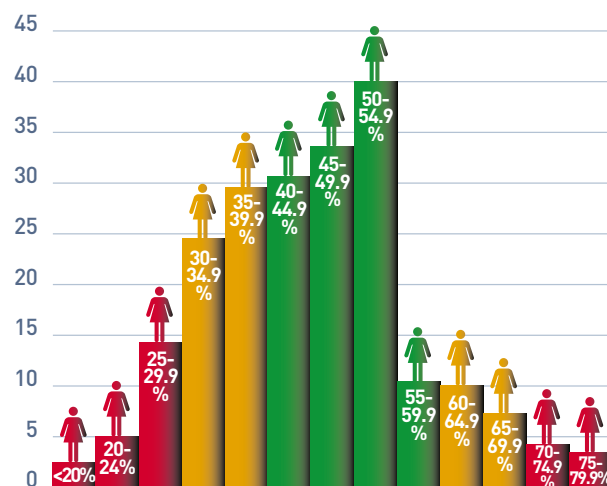
2.1
Key Findings

Across the 213 trusts, the **percentage of female directors ranged from 15.4 per cent to 77.8 per cent**. For the trusts, the average figure for women on boards is 44.7 per cent. This is an increase of almost 5 per cent on the 2017 figure of 42.6 per cent. For BME directors the figure ranges from 0 per cent to 46.7 per cent. The average figure is 8.9 per cent, which is slightly higher than the WRES data recently reported at 8.4 per cent. **By our calculations, 70 trusts still have entirely white boards**.

If we use the European Commission definition[25] of gender balance as having 40-60 per cent of each sex represented, then **115 of the 213 trusts (54 per cent) are within this target**.

However, 28 trusts (13 per cent) sit in the red zones (see Figure 1). There are three times as many trusts with less than 30 per cent compared to those with more than 70 per cent women directors.

25 European Commission, Gender balance in decision-making, [https://ec.europa.eu/info/policies/justice-and-fundamental-rights/gender-equality/gender-balance-decision-making-positions_en]

Figure 1: Percentage of women on boards across NHS trusts in England

Across the ALBs, the percentage of female directors ranged from 18.2 per cent (CQC) through to 66.7 per cent (Human Fertilisation and Embryology Authority), with an average figure of 39.9 per cent. This figure has hardly moved since 2017 (38.3 per cent). For BME directors these figures ranged from 0 per cent (six of the 13) to 30 per cent (NHS Digital), with an average of 10.5 per cent.

2.1.1
Regional differences

Data was analysed across the ten current NHS England regions: North West, North East, Yorkshire and Humber, West Midlands, East Midlands, East of England, London, South East Coast, South Central, and South West. Women on trust board figures ranged from 36.8 per cent (North East) to 47.1 per cent (South East Coast), with most (6/10) clustered around 44-46 per cent.

Figure 2: WoB by region

Figure 3: BME by region
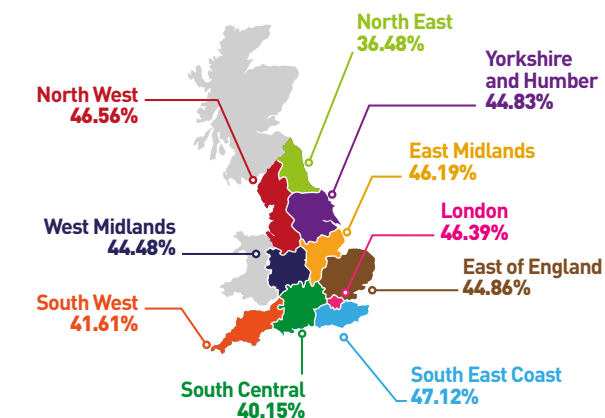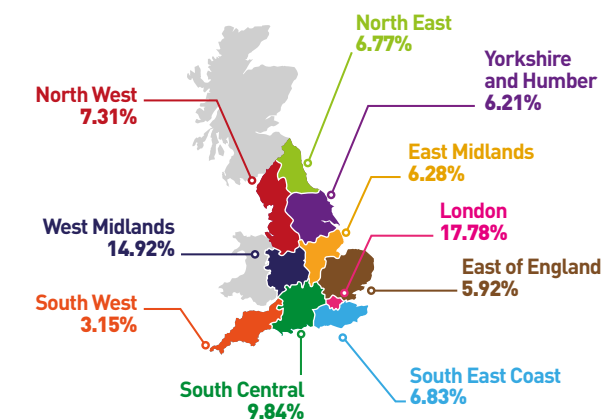

There were, however, significant differences in BME representation on boards across the regions, with London at 17.8 per cent BME and the South West at 3.2 per cent.

If we combined rankings for both gender and ethnicity by region, then London, North West and South East Coast score the highest and the North East and South West are ranked the lowest in terms of overall diversity.

2.1.2
Service type differences

More than half the sample (1,698 trusts directors) are on boards of acute trusts. In addition, there are acute and community, ambulance, community, mental health, and mental health and community types. As per 2017, ambulance trusts have the lowest percentage of women on boards with just 38.8 per cent (though this has increased from 35.7 per cent in 2017), compared to community trusts and mental health trusts, which have 50.5 per cent and 51.5 per cent women on boards respectively. For BME directors the lowest representation was on acute and community boards, with just 4.9 percent. The highest representation of BME directors was on mental health and community, with 9.4 per cent, and mental health with 15.5 per cent.

No difference was observed in the percentage of women on boards between foundation trusts and NHS trusts, both averaging 44.7 per cent. For BME directors there was a difference, with 8.8 per cent BME directors on foundation trust boards and 9.2 per cent on NHS trust boards.

Figure 4: Percentage of women on boards by service type

Ambulance 38.84%
Acute and Community 41.87%
Mental Health and Community 43.13%
Acute 43.29%
Mental Health 51.48%
Community 50.52%
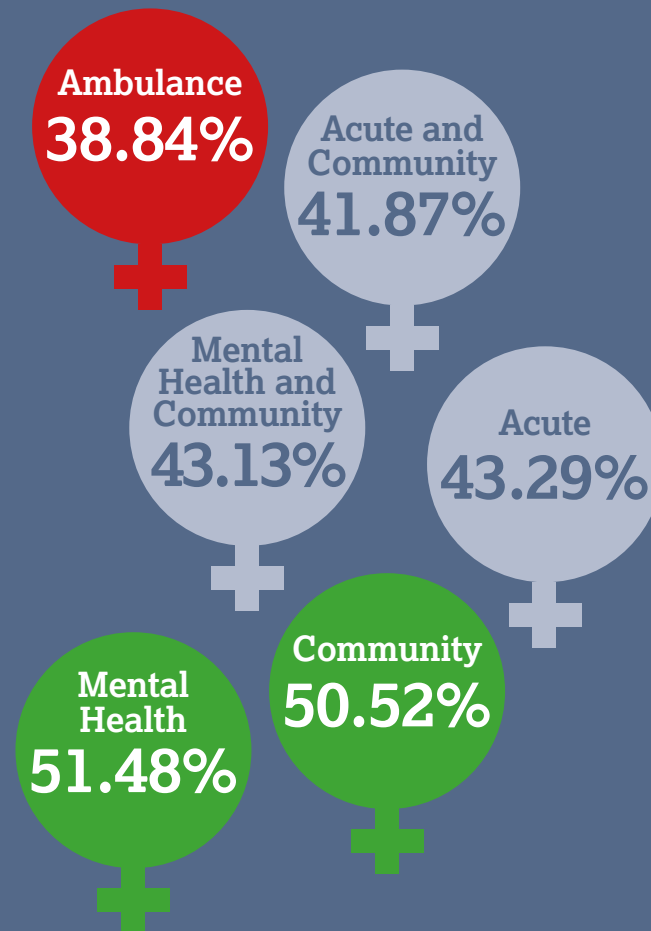
Figure 5: Percentage of BME directors on boards by service type

Acute and Community 4.90%
Community 7.30%
Acute 7.80%
Ambulance 8.30%
Mental Health 15.50%
Mental Health and Community 9.40%
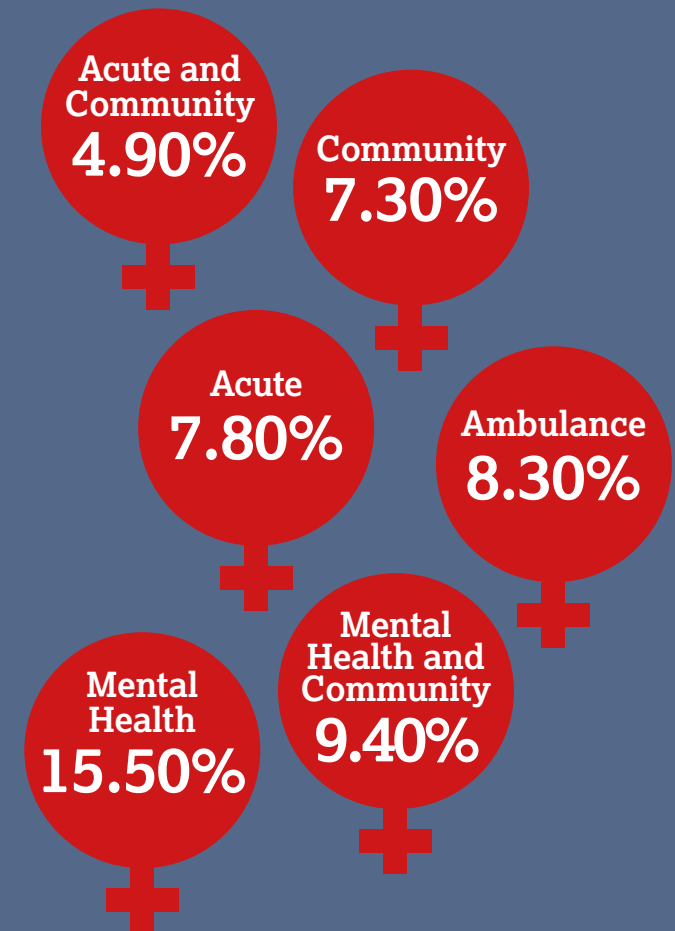
2.2
Board composition and key roles

Trusts and ALBs have similar board structures, with a mix of executive directors (EDs) and non-executive directors (NEDs), though the balance varies in the ALBS. For the trusts, the board size ranges from seven to 18 directors, with an average (mean and median) of 13. For the ALBs, the boards range from seven to 17, with a median of ten and a mean of 11 directors.

The average trust boards will have six to seven EDs and six to seven NEDs. The most common ED roles are:

- chief executive officer (CEO)
- medical director (MD)/chief medical officer (CMO)
- chief financial officer (CFO) (may also be deputy CEO)
- chief nursing officer (CNO)
- chief operating officer (COO)
- human resource (HR)/people and work development
- transformation/strategy/performance.

In NED roles, boards always have a chair and may also have a vice/deputy chair or senior independent director (SID), plus other NEDs

As from the findings in our 2017 report, the percentage of female executive directors is higher than that of the NEDs, in both trusts and ALBs. **Overall, EDs are gender balanced, with women holding 48.8 per cent of roles in trusts and 44.2 per cent on ALBs**.

These figures represent slight increases since 2017. However, on trust boards, **these figures are skewed by the over-representation of women in nursing with 89 per cent of chief nursing officer roles being held by women**.

For non-executive roles, women now hold 40.9 per cent of NED roles on trust boards but only 37.0 per cent on ALBs.

Figure 6: Women on boards by ED/NED

Role	Trusts		ALBs	
	Male	Female	Male	Female
Executive Director	704 (51.2%)	671 (48.8%)	29 (55.8%)	23 (44.2%)
Non-Executive Director	880 (59.0%)	610 (41.0%)	58 (63.0%)	34 (37.0%)

One of the findings from our 2017 report was that women and BME individuals were under-represented in non-executive roles. There is no justifiable explanation for this and as we had learned from the private sector research, this is often down to the chair and his/her appointment process. One of the recommendations from the 2017 report was to address this, alongside working with search firms. Therefore, section three of this report considers what chairs of the most diversified boards have done to achieve this. More recently, the NHS Confederation has established an independent taskforce to improve the diversity of chairs and non-executive directors in the NHS.

The taskforce is considering the recruitment processes and retention strategies needed to diversify the composition of NHS boards and governing bodies. The findings from section three of this report will be fed into the taskforce.

For the NED roles, women now hold 40.9 per cent. This is an increase on the 2017 figure of 37.4 per cent. Of 1,490 NED roles, 610 were held by women and 880 by men.

Overall, we need 150 more executive and non-executive female directors to reach 50:50 on trust boards. This figure should include 40 more female medical directors and 50 more female chief finance officers.

Across NHSEI trust boards, just 7.3 per cent of executive directors have an assumed BME ethnicity and 10.4 per cent of NED roles. As demonstrated in the regional board figures, we would expect to see wide variation across the different regions. On the ALBs, the ED figure is lower at just 6 per cent, but there is a higher representation of BME NEDs on ALB boards at 12.8 per cent.

Figure 7: Ethnicity on trust and ALB boards by ED/NED

Role	Trusts		ALBs	
	Assumed White Ethnicity	Assumed BAME Ethnicity	Assumed White Ethnicity	Assumed BAME Ethnicity
Executive Director	1,275 (92.7%)	100 (7.3%)	47 (94.0%)	3 (6.0%)
Non-Executive Director	1,335 (89.6%)	155 (10.4%)	82 (87.2%)	12 (12.8%)

2.2.1
Key roles

As can be seen from Figure 8, **CEO and COO roles (at over 45 per cent) are gender balanced**. This represents an increase in the percentage of female CEOs (from 42.6 per cent). In addition, just over half of all deputy CEO roles (52.2 per cent) are also held by women, which bodes well for future balance.

The proportion of female chairs has increased from 31.5 per cent in 2017 to 37 per cent on trusts and 38.5 per cent on ALB boards. In addition, a third of both senior independent director (SID) and deputy chair roles are currently held by women. The proportion of BME CEOs and chairs remains very low (2.4 and 5.2 per cents respectively), with the chief finance and operations roles also at under five per cent (see Figure 9).

Disappointingly, the female CFOs figure has decreased from 26.3 per cent in 2017 to 25.3 per cent (see Figure 8). This is an issue which we highlighted in the 2017 report and seriously needs to be addressed. See section five of this report.

Female MDs have increased to 29 per cent (up from 25 per cent), which is encouraging but still very low, given over 25 years of majority female medical graduates. Women MDs are well represented in community trusts, where 47 per cent of MD roles are held by women, and mental health trusts (41 per cent of MDs) but much less so in acute (28 per cent) and ambulance trusts (22 per cent). See section four of this report.

Given gender balance at CEO and COO roles, and MD roles in mental health and community trusts, we question why it is that women are less well represented in MD roles in acute trusts. We looked into the clinical specialisms of MDs in acute trusts to see how this impacts the poorer gender balance. There is no one requisite specialism route to MD. Currently, the most common specialisms for MDs in acute trusts are anaesthetics, surgery, and intensive care, which tend to be male-dominated, but between them they still only account for less than one third of the roles.

The percentage of MDs of BME ethnicity is 19.4 per cent overall, almost the same as the overall percentage of BME doctors[26]. Additionally, of the 64 female MDs, 14 are of BME background (21.9 per cent).

According to NHS statistics[27], one in five nurses is from a BME background, rising to 40 per cent in some areas, so it is notable that only eight women, (3.9 per cent of CNOs) are of BME background. In addition, it is important to note there are only 22 (just over 10 per cent) male CNOs, all of whom are white.

26 Figures from: https://www.nuffieldtrust.org.uk/chart/ethnic-profile-of-nhs-doctors-in-england-compared-with-total-population
27 NHS England, CNO black and minority ethnic (BME) leadership, [https://www.england.nhs.uk/nursingmidwifery/delivering-the-nhs-ltp/cno-black-and-minority-ethnic-bme-lead ership/]

Figure 8: Women on boards in key roles

Key role group	No. of female directors	% Female
CEO	97	45.5%
CFO	53	25.4%
Chair	78	37.0%
MD	64	29.5%
CNO	182	89.2%
COO	91	50.8%
HRD	102	67.6%

Figure 9: Ethnicity in key roles

Key role group	No. of BAME directors	% BAME
CEO	5	2.4%
CFO	10	4.8%
Chair	11	5.2%
MD	42	19.4%
CNO	8	3.9%
COO	7	3.9%
HRD	10	6.6%

Given the good gender balance in the CEO roles, we looked into their backgrounds to ascertain the varied career paths to this role for men and women.

- The largest group of CEOs has a background in NHS management, without a clinical or nursing background. This accounts for 29 per cent of CEOs (62 out of 213) and, of this group, only 31 per cent (19) are women.

- The second largest group has a nursing background, accounting for 24 per cent (51) of CEOs. A large proportion of these (78 per cent) are women. This, then, is the most common route for women to reach a CEO position, often via a COO or CNO role beforehand.

- 13 per cent of CEOs have a finance or accounting background (27 CEOs). Interestingly, given the low proportion of trust CFOs being women, 41 per cent (11 of the 27) of this group is female.

- The next largest group is CEOs who have clinical and related backgrounds (surgeons, anaesthetists, paramedics, pharmacists, psychiatrists, occupational therapists, etc.). They account for 12 per cent of CEOs. Of these, nearly half (46 per cent) are women.

- The remaining CEOs had varied backgrounds and were reasonably gender balanced, apart from civil servants, where seven CEOs with civil service backgrounds were all white males.

> "As a CEO of ELFT, I have personally seen the benefits to our organisation as the contribution of women at board level changed. I welcome the findings and practical recommendations in this report. The evidence is without dispute. Active inclusion of women on boards is right and just, it will also result in better outcomes for the people we serve.
>
> Dr Navina Evans, Chief Executive Officer, East London Foundation Trust"

CASE STUDY 2 – NO GROUP-THINK HERE: THE CHAIR'S ROLE IS ORCHESTRATING DIFFERENT PERSPECTIVES TO PRODUCE BETTER RESULTS
St George's University Hospital NHS Foundation Trust: 50 per cent female, 25 per cent BME

Gillian Norton, chair of St. George's University Hospital NHS Foundation Trust, knew from the outset that diversifying her board "was one of the things I had to do because the board didn't look very diverse when I arrived." She discussed using head-hunters for all advertised posts and asking for a focus on diverse candidates, including gender, ethnicity, disability, and age.

"I don't think it matters who the head-hunter is. The point is that you have to give them a clear brief... I think I've been more strident about this over time. And they've probably got better at it over time."

Gillian explains how she refuses to compromise on quality and vehemently rebuts the assumption that it would be necessary: "We would never have appointed somebody just because they fulfilled a particular protected characteristic... and the people [the head-hunters] brought back were of quality... they absolutely have to be up to the job. But I don't believe that that's not possible – a head-hunter that's doing their job properly can find people. They maybe just have to work a bit harder at it."

Interestingly, she also believes this has become a little easier over the past three to four years, as the benefits become better understood. "The societal debate is more rounded...and I think the public discourse is much more demanding of these kind of things." In addition, the chair felt there had been "a very clear message nationally...the message coming down from the regulator has been unequivocal – and rightly so, in my view. And so, I think, as well, the head-hunters have responded to that..."

The chair had always been clear on the effectiveness of a more diverse board, and she didn't have to persuade the rest of the board. "We all knew that we would be a better board for being a more diverse board in a whole range of ways." Gillian's main focus was on the quality of debate, "because you get a different range of views and experiences." Challenged on what those different experiences are, the chair articulated: "If you are a woman, even now, I would say you have to work harder, be more on the ball, be more persistent to get to senior levels than men have had to be in the past. So, the fact that I've had those experiences makes my experience different to a man... I've developed in a different way because of those things. If you think about somebody who's from an ethnic minority, they've often had to struggle much harder for acceptance, for opportunities – and so they bring a different range of experiences to the board. I would say the same about people's disability and sexuality."

With a diverse board, Gillian says, "You don't have group-think. It's my job to orchestrate people who are prepared to challenge appropriately and can bring to the debate widely different perspectives, so... I'm not interested in a bunch of people who all think the same. That's of no use to me at all. We've got a staff that have a huge mix of ethnicities and characteristics and experiences, and we need a board that, in some way, is remotely representative."

The chair is unequivocal: "You need to create as diverse a board as possible because it gives you a chance of coming to better decisions. I feel that really strongly. It's not easy, but careful and clever synthesis of those different perspectives produces better results."

SECTION 3:
INTERVIEWS WITH CHAIRS

One of the key findings from the 2017 report was the low proportion of women and BME individuals holding NED positions. From experiences in the private sector during the Lord Davies Review[28] we know that board chairs play a significant role in changing board composition. In late 2018, we learned of chairs making changes, having received a letter from one and seen discussion on social media from another, and so decided to capture some of the change processes occurring.

Between September 2019 and March 2020, we interviewed 17 trust board chairs (ten men and seven women). The 17 trust chairs between them chaired 12 mental health trusts (MH), six acute trusts , one acute and community trust (A&C), and one ambulance trust. Several of the chairs had chaired other NHS or public/third sector boards previously, and two currently chaired two trust boards. All had multiple years of board experience and were able to compare working on diverse and non-diverse boards.

From our board data we identified the top twenty most diversified trust boards by assumed gender and ethnicity. Chairs of 13 of those boards were included in our sample, in order to understand the why, what and how behind the successful diversification of their boards over the past few years.

Interviews lasted on average an hour, were recorded and professionally transcribed. This produced an average of just under 13 pages of transcript, and 6,780 words per interview.

The board size ranged from 10 to 17 with a mean size of 13.4 people. The percentage of female directors on the chairs' boards ranged from 31 per cent to 69 per cent, with a mean of 46.6 per cent. The percentage of BME directors ranged from 0 per cent to 43 per cent, with a mean of 21.3 per cent.

The following quotes are all anonymised from chair interviews and have been identified by gender, service and trust type. For example 'M.Acute.FT' is a male chair of an acute foundation trust; 'F.MH.NHST' is a female chair of a mental health NHS trust. The seven case studies across the report were also developed from the interviews and permission was sought from the relevant chairs to name them and their trusts.

> " The answer's leadership, now what's the question?
> M.Acute.NHST. "

"The changes we've made in the past couple of years have increased gender and ethnic diversity. And LGBT and disability diversity have increased in the last year."
F.MH.FT.

3.1:
Motivations to diversify (why)

The interviews revealed three equally important and clear motivations for and benefits of board diversity.

"Firstly, because the evidence is a diverse board makes better decisions... Two, I think it's really important that we reflect the communities that we serve and even if we don't have a diverse area, that we still act as an anchor organisation to show that we rate difference and recognise that difference is important in making us effective. The third reason is because, regardless of what your community looks like, your staff will always be diverse."
F.MH.FT

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28 Sealy, Doldor, Vinnicombe, Terjesen, Anderson & Atewologun, (2017), Expanding the notion of dialogic trading: The case of women on boards research, British Journal of Management, 28, pp64-83.

3.1.1
Board processes leading to better decision-making and effectiveness

Most ardently, the chairs talked about better board processes, how the composition impacts the dynamics and, most importantly, diversity bringing better conversations, different perspectives, new insights, lots of challenge, new solutions, new questions asked and new approaches proposed. They also recognised the challenge of managing these differing perspectives, seeing their role as facilitating 'robust conversations' in order to arrive at the best decision-making.

Chairs discussed how, from their experience, with gender-balanced boards: **"The level of testosterone around the table goes down significantly, especially amongst NEDs."**

Without that balance, competition rises and meetings can become 'gladiatorial,' with a lot of 'posturing and grandstanding.' Board members can become actors around the table, which…

can quickly become dysfunctional, as people become afraid to say 'I don't know' or 'I don't understand.
M.MH.FT.

[This] can lead to a cycle that can be quite destructive…

"It can affect relationships on boards. It leads to a point where people stop listening to each other."
M.Acute.NHST.

And that isn't really what you want when you're running a multi-million-pound business on which people's lives depend.
F.MH.FT.

A number of chairs were able to describe what has become known as 'group-think,' also referred to as 'nodding dog syndrome,' where important issues are not fully discussed. One chair described 'red pen decisions' as those decisions that are made too quickly. With diverse directors and more nuanced discussion, the impact and implications on wider audiences is considered more widely and a… **"decision made under pressure, doesn't come back to haunt you."**
M.Acute.NHST.

"To me the primary issue is cognitive diversity. You are trying to make sure that you have got people who think differently and bring different experiences of the world to the table. The more diverse a board that you can build, the more points of view you have."
M.MH.FT.

"I want what I call 'the polite revolution'…I want people who've got some alternatives…particularly at the start when they ask: 'Why do you do it this way?' I like that challenge…when someone has another look at things that have been blocked for a while, suddenly they become unblocked because someone looks at it in a different way or brings some different experience."
M.Acute.FT

3.1.1
Board processes leading to better decision-making and effectiveness continued

In response to a question about why women might bring different perspectives, one male chair summed up several chairs' views:

"I think it's a function of their lives, their journeys, their willingness to ask different questions on a very personal basis.... All too often, the route a woman takes to join a board will be different to the route a man will take to get to a board level ... all too often, her path to that position will have been tougher than many men around that table.... It impacts the conversation and makes a difference to the decision-making process...being able to see that issue, see that challenge, through a different set of eyes."
M.Acute.NHST.

Some chairs mentioned the importance of 'psychological safety' in the board and management teams, to make challenge acceptable and expected, which they could help develop by encouraging an inclusive culture and building relationships. This was an important part of their role as facilitators to allow that 'rich conversation' and 'robust discussions.'

> **I see my role as facilitation. Bringing out the best of the people on the board. Enabling everyone to speak. Everyone to have a voice.**
> F.MH.NHST.

"We need non-executives to be curious, to question, to challenge and to make their knowledge and networks available ...I'm pleased that we've created the conditions when we can have these sometimes quite heated discussions but once they're done, we come out with good results and everybody is okay after."
M.MH.FT.

In all, the chairs were unequivocal in their belief in and experience of the difference that diversity of skills, characteristics and experience made to their boardroom dynamics, and were conscious of their role in facilitating the discussions to get the best decision made.

"I've got over 30 years of non-exec director experience... and, from my experience, more diverse boards make better boards. I think the tone of conversations are different, I think the quality of the discussions, the perspectives, especially if a board is managed in a way that enables everybody to bring their whole self to those discussion. I think you get much better quality discussions, much better decisions and better outcomes. And it's based on experience, it's not based on reading other people's experience or research, but my own personal experience."
M.Acute.NHST.

3.1.2
Representation of community leading to greater legitimacy and better patient outcomes

Being representative of one's service users and community was discussed not as a nice to have, but was considered critical for the provision of the best and most effective care service.

"The more views we have, the more representative of the community, the better we will be at acknowledging the particular needs of the particular communities within our region."
M.Ambulance.FT.

Building on the argument that more diverse perspectives lead to better decisions, there was a real concern about ignorance of community issues without that representation.

"Diversity is essential in ensuring that you've looked at every angle... there are very rarely straight-forward decisions to be made... there are always nuances... what you need is a very balanced judgement. And so if you've got a community of people who've all come from the same space, all think the same way and all agree with each other, you're very likely to overlook something and make a big mistake. So, I think it's hugely important that we've got boards where you've got a range of views, a range of community experience."
F.MH.FT.

These communities may be based on many criteria such as ethnicity, religion, income or class, and for mental health trusts:

"There's an expectation... that's particularly strong in mental health services at the moment, that there will be people on the board to whom they can relate. And that's strong on our board."
F.MH.FT.

From a patient safety point of view, there was a concern that those who do not truly understand their local communities will fail in their fundamental duties.

"Organisations that do not understand their communities have strange decision-making behaviours that are exclusive... they don't see everything and therefore they will make poor decisions when actually health is the one thing that we need to be so alert and compassionate and inclusive about. Otherwise your performance as an organisation will be worse, which means you're harming and hurting and, in some cases, killing people."
M.MH.FT.

"I think in the delivery of safe effective care, having a diverse workforce is absolutely key... it is business critical for the NHS... and should be targeted towards reducing inequality and improving outcomes for patients. If we really are going to deal with population health, then boards need to be having quite sophisticated conversations about what outcomes are really important to local communities."
M.MH.FT.

Having representation on the board helps build legitimacy with the community.

> **Our [new NED]… being from an ethnic minority, Chinese background… gave us that perspective when we were looking at patient engagement matters in particular.**
> M.Acute.FT.

But it is not about representation for its own sake, it's about broadening our understanding of health issues across the diversity of populations in our society, to achieve better decisions made for better patient outcomes.

"If the state is going to be the primary insurer [of health], there also needs to be acknowledgements of the inequalities that people experience... If you don't have that reflected in some way round the table, then you are unlikely, in my experience, to be pulling the right data towards you and you are unlikely to be addressing some of those fundamental issues which seems to me to be the very point of your existence... I am not saying that the people sitting round the table then represent those groups, but I think by having those groups represented, you are more likely to be asking the right questions."
M.MH.FT.

3.1.3
Representation of staff leading to better talent management

More than 75 per cent of NHS employees are female and overall almost one in five employees (rising to 40 per cent in some areas) are from a BME background. The chairs discussed how they felt it was imperative that leadership of their trust was representative of their staff. Reasons expressed for this were recounted from staff conversations, including issues of being understood and having faith in the decisions made by the board, which gave staff confidence in their work. Another very important reason was that of achieving better talent management through greater retention of talented staff, and perceived opportunities that encouraged staff to aspire. Chairs were focused on optimising talent and capability.

"It's not only our service users who are very diverse. Our workforce is also very diverse. So, ensuring their wellbeing and the way that they operate is the only way we provide quality services. Ensuring that you've got people who are understanding what's going on with your staff groups, not simply the different professional groups, but people from different ethnic and other backgrounds, that is crucial. And people do take a view of what they can see at the top of a board. You know, is there anybody around the board table who looks like me? And, therefore, can I have the confidence that decisions they take will be bearing in mind my views and my expectations?"
F.MH.FT.

"If you are leading an organisation – most of us are leading organisations with around 2,000 up to 4,000 staff – I think if they are going to follow you, they need to feel that the board understands them and part of that is about them being able to see both cognitive and physical diversity around the table."
M.MH.FT.

Research tells us that perceptions of good and fair talent management impact staff engagement.

"So we recently appointed internally, the chief nurse, somebody who can tell her story and in this case it's a black woman coming through the system and being open about how it's not been easy... I think, gives a very important message. She's still got to be the best candidate!... But if her staff did not feel that the organisation appreciates her, they're not going to do the best job they can. And all the evidence is that best outcomes come from organisations where staff report themselves to be more satisfied."
M.MH.FT.

"If you look at those staff, who are not huge in number but who are identifying as having less satisfaction with the organisation, it's people from BME communities and people with disability and that's fairly consistent. We're working very hard with our networks to address that but I think it's also very important to signal and encourage people who are in senior positions to have people who are more representative of the workforce and to get people to talk about their own experiences."
M.MH.FT.

Particularly relevant to sections four and five of this report, considering the low numbers of female financial and medical directors, when discussing executive positions, one chair spoke of the need to:

"Encourage as many strong candidates to put themselves forward and, therefore, give us a good choice. But the importance of equality and diversity on the board, and the importance of equal opportunities within the workplace and having a board that understands the communities that we serve is something that I always talk to candidates about. And I think that is actually something that resonates in particular with women."
F.MH.FT.

"I think it is business critical, but I think we struggle to communicate it to people. I don't want young women to come into the NHS and look at the organisation and think, 'I can do better somewhere else.' That is a waste of our time and energy and it is a waste of their talent."
M.MH.FT.

> "These things matter, signals matter...when I talk to staff about it, people do say it really matters to them, to look at the board, to look at senior management, to see who's there.
> M.Acute.FT."

CASE STUDY 3 – MOTIVATIONS TO DIVERSIFY
East London NHS Foundation Trust: 40 per cent female, 53 per cent BME

Like several of her colleagues, Marie Gabriel, former chair of East London NHS Foundation Trust, was very clear about the three reasons to diversify. These reasons were board effectiveness, because "diverse boards make better decisions"; representation, to "reflect the communities that we serve"; and talent management.

Being representative of staff is both about legitimacy and talent management: "But actually it's really important for our staff to have people at board decision-making level that are reflective of them and understand their experiences," said Marie.

In both talent management and external appointments, the chair has taken "a very practical and robust approach". "Inclusive talent management has taken us a while to get it right," said Marie, but she now feels they are proactive in their succession planning.

When considering executive board roles: "We look at not just the next layer down but the next layer down beneath that... I can go through each of my executive directors and I would know the two or three people that are coming through. So, when [Name] left, he was our chief nurse, I knew that we had a black woman, a white woman and a white man all waiting and able, developed, enabled, been on Nye Bevan, coached, ready to be interviewed."

In appointing board directors: "It's about skills mix and experience but it's also about diversity and being clear and purposeful in that." Using a skills, experience and diversity matrix, she explained that: "It's really important that you proactively and openly say, 'This is what we need to shape our board and give us insight that we don't have in terms of how to be entrepreneurial, how to relate and engage with the Muslim community, how to relate and engage with the LGBT community, to maintain our board diversity.'"

For appointments she actively uses and expands her diverse networks both for current roles and also, for example: "Warming up two incredibly strong business women for future roles."

Like others, she was very clear about: "Choosing your head-hunters carefully and being explicit with them," regarding expectations. "...they understood that we wouldn't go forward unless we had a shortlist that was at least 50 per cent strong female candidates."

And when it comes down to final decisions between the last few best candidates, she was clear about looking at the board holistically in terms of creating the most diverse mix of individuals:

"When you're having a conversation about 'best fit' which you do, particularly if you've got candidates who are quite close, 'Well, actually this person will bring an insight that we don't have at the board, because of their experience or their set of characteristics, or whatever that is, which we need in the organisation.'"

3.2:
Defining diversity (what)

Chairs were aware of targets and some degree of measurement required for gender and ethnicity (through the 50:50 by 2020 target, or the Workforce Race Equality Standard (WRES) data collection), and so understandably these were the main considerations in terms of diversity characteristics. However, those with more diversified boards tended to take a more holistic approach. A number were concerned about other characteristics, such as sexuality, disability and age. Some were cognisant that there are multiple ethnicities and one is not representative of all. Within the mental health foundations, particularly for NEDs, there was a desire for individuals to have some 'life experience' with mental health. In addition, some chairs celebrated having allied health professionals on their boards. Overall, it was clear that **those with more diversified boards were not ticking boxes, but took a more inclusive approach, aiming for true cognitive diversity and varied perspectives on their boards, through combined skills, characteristics and experiences.**

"You have got to be really, really clear what it is you are looking for to build the capacity and capability of your board, through that cognitive diversity. I think that people appreciate you being explicit about the current balance of the board and your desire to achieve greater diversity."
M.MH.FT.

> "We've made a lot of progress on addressing gender balance and ethnicity. We also have a younger board member. The one that still remains too hidden, there isn't enough discussion about, I think, is the lack of disability on boards. It's not that you need one of everything, but you want that breadth of perspective from lots of different combinations, as varied as possible.
> F.Acute.FT.

3.3:
Approach to diversification (how)

In terms of how these chairs approached diversification of their boards, the first thing to note was that they absolutely accepted that becoming more diverse was not going to happen on its own, nor would it happen with a general 'wish' to be more diverse. This awareness and understanding of the issues gave permission for **positive action towards purposeful composition**. They were emphatic that this was something they had to manage very proactively, just like any other change process. They talked about being explicit, proactive, robust, clear, and very purposeful in considering their board composition. Whilst the mechanisms of change are outlined in later sections, it is important to note the attitudinal approach and personal commitment of those who have successfully diversified their boards.

"For me, if you're senior in your organisation, it's your job to try and make these things happen and be very explicit with colleagues about what the priorities are, and then making sure we do something about that. It takes real personal interest, discussing with people about those particular challenges that we've got and making sure that it crops up in conversations all the time."
M.Acute.FT.

3.3:
Approach to diversification (how)
continued

There was incredulity expressed by some that in the 21st century: "We are still having to argue for women to be represented equally in all our leadership roles in the public sector," (F.MH.NHST) and awareness of the slow pace of change regarding ethnicity. As nine of the 17 chairs were white males, they acknowledged their own positions of power and privilege and sought to use that for good.

> **Rather than going into rooms feeling guilty for being a white straight cis man, actually I go in feeling like I've got a real opportunity to be a powerful ally, where can I take my allyship? I've got an opportunity to be a really good ally, and that's what drives me.**
> M.MH.FT.

With that power came a frustration about others' lack of progress, and an approach of 'just making it happen.'

"So as a board we just got on with making it happen… There weren't special initiatives. We just found really good people who had never really been asked to do certain things before."
M.MH.FT.

"You've got to believe in what you're doing, not because it's some politically correct thing to do. This is a long-term commitment, but unfortunately I've heard some people use that as an excuse. No, it's not, it doesn't have to be a long-term thing, it can be done now. Once you've made the commitment, just do it. People will realise you mean it if you are explicit about it. The main factor is you should be judged on your results, so just get on with it and make it happen, so many people talk about it and then don't do it."
M.Ambulance.FT.

Their determination, leading by example, and commitment to change were clear:

"It's difficult, but it's not complicated. Is this important or not, and how much time do you personally spend in looking at it? And be very clear about what your own priorities are…you're just telling people very clearly, 'This is what we are about', and hunting people out, looking for people, encouraging people… Don't let it pass you by, these things matter hugely."
M.Acute.FT.

3.4:
Levers of change

There were a number of common levers of change that the chairs utilised in order to make their programme of change successful. These included **outreach into communities and networks; directed use of head-hunters; training and engagement of governors; and strategic communications about diversity**.

3.4.1
Community

Specifically for NEDs, chairs discussed actively engaging with their communities to find a broader range of candidates. They talked about working at getting into particular communities, such as through local business or Asian networks, proactively using and expanding their own and their directors' networks, as well as outreach exercises.

"**We use multiple avenues of communication in our communities… the local counsellors voluntary service, not only the CBI, but also Local Federation of Small Businesses, a network of Asian businesses… and a network of housing associations… these are really fruitful for finding people who have run organisations… who know all about regulation and raising funds and dealing with people with complex needs. So, you know, we've got a really good feel for where we will find people, and we've done very well in reaching them.**"
F.MH.FT.

Chairs talked about themselves and their directors using their networks to build relationships for the longer term as well as any immediate vacancies:

> So I will use my networks… I start that conversation quite early: 'Have you ever thought about NED? You'd be really good at it.' That doesn't mean to say they're guaranteed a role, but it does mean that you're actually touching people who would have never have thought about it… as a chair being aware of what you've got coming up and being aware that your networks are going to be incredibly important.
> F.MH.FT.

"**One of our governors** [Name] **had lots of contacts in the BME and Asian community. We set out to ensure that we got into diverse communities, through mosques and temples, into the Sikh community. We built up the networks. So actually, when we did start to replace NEDs we had a head start. We have three or four governors from the BME community, so we linked to those groups.**"
M.Ambulance.FT.

Some chairs talked about the need to be more creative in where they advertise, in order to reach a target audience, for example in rural communities. The chairs were all very clear, however, of the importance of demonstrating not only diversity but also inclusive environments:

"**Once people know you have a good reputation, that you are serious about hiring diversity and appointing people to senior positions who are diverse, then they want to be a part of it… It's sort of a tipping point, once you've got some really good appointments then more and more come.**"
M.Ambulance.FT.

"**You have got to use community networks and you have got to get those community networks to work for you to bring people forward, who are not the usual suspects … People need to know that this is somewhere that wants to be genuinely inclusive and diverse and that you are serious about it and know they can be their authentic selves in your organisation.**"
M.MH.FT.

3.4.2
Search firms

The key message from chairs was about being explicit and specific with search firms about their expectations of quality diverse candidates, being open to wherever the best talent was, but expecting that this often required asking these firms to work harder. However, as seen in the work to diversify private sector boards, such success was rewarded as chairs made a point only then to use those firms who got it, based on past results.

"It's about choosing your head-hunters carefully and being explicit with them. So, we tend to use [firm name]. They've got a really good record of equality, they work with me really well when I say: 'These are the skills, this is the type of experience that I need, go out and find me some people like that.'"
F.MH.FT.

"We give very clear guidance to the head-hunter working for us because it seems to me that if they don't actively look and connect with various bodies or groups where you would expect more diverse candidates, it's not going to happen.
M.MH.FT.

And as one chair said:

"It's one of those opportunities where we've got some power to influence, so we should be taking that.
M.MH.FT

Some chairs were very specific, for example:

"My ideal candidate would be a (local) GP... In talking to the head-hunter, I've made plain that we'd prefer to have a woman, than not, we'd prefer to have someone from an ethnic minority, than not, because (place name) is a very diverse borough."
M.Acute.FT.

The chairs were clear about selecting firms on the basis of :

"Experience of their track record of helping you achieve what you want to achieve."
M.MH.FT.

There was a clear message that the head-hunters should engage with the candidates proactively (see case study six), as sometimes women or minority individuals:

"Need to know that this is worth the investment of their time. There is something about being absolutely clear that it is their skills and their expertise that you are looking for, but also you have got a serious and convincing approach to diversity and inclusion that means that you are worthy of them investing their time in you."
M.MH.FT.

3.4.3
Governors

Governors play an important role in foundation trust appointments. Some chairs worked hard to bring the governors along with them on the diversity journey, including training around diversity and specifically the appointment process. There were also some instances where the constitutions needed to be changed to limit the governors' terms to nine years. However, chairs of diversified boards were clear about benefitting from the governors' community involvement and diverse networks, giving access to a broader reach of candidates:

> " My council of governors are really diverse and from all sorts of backgrounds and they get it… I don't need to explain to them why it is important… They get the need for different attributes and being reflective of the community. "
> M.Acute.FT.

Some chairs discussed the recruitment of the governors themselves and took the same purposeful approach as with the NEDs:

"I'm really clear in recruitment [of governors] about [the importance of] equality and diversity and inclusion. Working with different groups within your community when you know you're going out to get governors and say: 'Who do you know from your networks? We need some people who've got an understanding of traveller community in [county], who do you know from your networks that would be a good governor?' That way we have one of the most diverse councils of governors."
F.MH.FT.

However, a few chairs experienced some resistance from the governors depending on their own demographic background or their locality:

"…we've also got to bring the governors with us on the importance of diversity, which is something that I think the vast majority of them honestly believe in but sometimes maybe because of their own demographic background, it needs a little work."
M.MH.FT.

And so, chairs were willing to invest training and support, with several examples shared of how governors then became very active proponents of diversity in interview panels, Pride stalls, or race conferences.

"Not only do [governors] get diversity training as part of their induction specifically, but every time we're going out to recruit they have recruitment training, which of course includes diversity and inclusion, and how you make those candidates feel part of, comfortable at, the interview process, how you can actually engage positively with candidates."
F.MH.FT.

Whilst working with the governors to get their view on what skills, experience and connections were missing from the board, one chair expressed that she was:

"… something of a sceptic on assigning a number of people of colour, or women." However, it was apparent that she did not see that scepticism as being in conflict with actively diversifying the board.

"For the governors, it's what's missing in the team, who's the person who might then offer us something of that sort… You're gonna be very lucky if somebody comes along who's got everything that you want. But it's who's got the best potential match, and who's got something that's different to what you've already got on the board… My governors are quite smart. They've not made a bad decision yet."
F.MH.FT.

But, ultimately, the responsibility to diversify the board sits with the chair:

"I signalled to the governors that having a more diverse board was an absolute priority for me and I had no intention of chairing a board that carried on looking the way our board looked."
M.MH.FT.

3.4.4
Communications

In terms of reaching out to a more diverse range of candidates, a number of chairs realised the importance of communicating their intentions. They believed it was important that the communities know and understand who their hospital board are and what their intentions are regarding diversity. A number discussed communicating in non-traditional forms, such as their own social media use.

One chair said:

"**I don't believe you have to compromise on anything in order to get a diverse board, but I think you have to look in slightly different places, and you have to sell yourself a bit more. My experience is that actually people who come with those characteristics have choices.**"
M.MH.FT.

For both executive and non-executive recruitment:

"**How you promote your organisation both informally at meetings and using social media [can] show that this is the sort of organisation that genuinely welcomes diversity.**"
M.MH.FT.

And a number were clear that this was a reputation they could and should build:

> When people look at the trust recruitment now… they'll see we've got a diverse board and so we would hopefully be in an attractive place for women and people from other backgrounds who are not well represented amongst boards in the NHS at the moment.
> M.MH.FT.

It wasn't just about highlighting diversity (the numbers), but also the inclusive values:

"[social media] **is a very good way of promoting the things you're interested in… to connect with people in the NHS and local authorities and other organisations whose values are close to yours… It allows you to say convincingly, 'Yes, we are interested in you.'**"
M.MH.FT.

"**I think if you want people to come to you who have got the values** [you want], **then you've got to be able to portray that. My photo shows a boring old white male… but I also have got a view of the world that embraces diversity, not because it's the right thing to do, but because it actually makes the NHS function more effectively.**"
M.MH.FT.

But as illustrated in sections previously, community engagement was also a prime method for communicating the trust's values and intentions, persuading women and minority candidates to apply:

"**Lots of work so people knew who** [trust name] **was and what we stood for when we went out to look for NEDs… by reaching into communities, going to colleges, and for example we had started a student paramedic scheme, open to all sectors of the community … So the next time we advertised we got 75 applications, 18 of whom were really strong and appointable, 25 per cent representation from the BME community, so very good.**"
M.Amubulane.FT.

CASE STUDY 4 – SHIFTS IN BOARD CULTURE IMPROVE CQC RATING
Doncaster and Bassetlaw Trust Teaching Hospitals NHS Foundation Trust: 50 per cent female, 8 per cent BME

In November 2018, Suzy Brain England, chair of Doncaster and Bassetlaw NHS Foundation Trust, wrote to Professor Sealy at University of Exeter Business School to explain how she had diversified her board since 2017. At the time of writing, she had six male and six female directors, within which was "some low-level disability and two who would describe themselves as ethnically diverse." At the time of the 2017 report, the trust had all-male NED membership. The chair used the report to encourage the board and governors to change their practices, moving away from rolling NED appointments forward, to considering the skills mix required in an open competition. Having reached out to local businesses and other interested parties with some open events, they received over 40 applications for NED roles. Training the governors, applications were anonymised to focus on skills, knowledge and experience. Interview panels were gender balanced.

"It was in that first year of my appointment as chair that you published your welcome report 50:50 by 2020. I shared this report with the board and with governors…Using your report…governors agreed to an open and fair [appointment] process…and we not only have a much more ethnically diverse board but a true gender balance with a high level of skill and experience which is making a difference for our trust in what are difficult times for the NHS."

When asked to articulate these differences, the chair described how the diverse skills and experiences of the new NEDs helped reshape the organisation:

"The skill level is phenomenal and different… So my non-execs now ask good questions in board, they help me to have a very focused and probing board committee, where they use their skills, knowledge and experience from other roles outside of the NHS to be probing and to get the assurance that we need, or to help people to put actions in place… They'll buddy with an exec and have conversations and support them, my non-execs are coming in and adding value and sharing their experience… So we thought very hard about the range of skills and we got people with customer focus, people with regulatory, clinical, finance and accounting backgrounds. Having that range of skills, you know who to go to, to add value as we're reshaping and developing the organisation."

The chair explains how changing the board composition and culture has influenced the whole organisation, leading to better CQC ratings and improved staff survey results:

"I can tell you that since I wrote to you we have gone up from 'requires improvement' to 'good' on our CQC rating. We've had a massive increase in response from our staff about how they feel about working here in the staff survey, and all of the indicators we've improved on. Our four key objectives, we've had great feedback from patients and carers, and we are achieving our financial objectives in very, very tough times. Obviously, everybody works towards that, the whole team, but my non-execs have shown support, guidance, probing, asking the right questions, and helped us get over the line on all those things. By being personable, being present, knowing when to say thank you. That's a significant change in culture of the way the board as a whole operates."

3.5:
Actions for change

3.5.1
Appointment process

The main area discussed by chairs in terms of making actual change to their board composition was the appointment process. Chairs focused on different aspects of this, depending on where they felt they needed to make change. For example, areas covered included: rewriting the recruitment pack for values-based recruitment (see case study one); stopping rolling appointments (see case study four); recruitment training; anonymised applications (there was difference of opinion on this); gender-balanced panels; purposeful shortlists; challenging interviewing techniques; and flexing criteria.

> **Moving to an open and fair recruitment process gave ourselves the best chance possible to change the profile of the board as well as to change the skill set on the board.**
> F.Acute.FT.

> **I'm clear about getting the outcomes we need. If we anonymise we wouldn't know and it might not have the outcome that we want.**
> F.MH.FT.

3.5.2
Adapting the NED process

There were a number of examples where chairs had noticed that adapting their appointment process was giving them more diverse results. For example, flexing the process, multiple hires, and using the 'tie-breaker rule.'

One chair mentioned that they: **"Haven't used head-hunters for any of our NED appointments."** However, what they had done was: **"...reframe both the job adverts, the job descriptions, and flex in the interviews."**

"Because women look at those very carefully in my experience. And so, if you don't frame it in the right way, women who would be perfectly good candidates will make the assumption that they're not the right candidate... We try to be open about what fields people will have worked in. If you have to have worked in a large multi-national company at executive level, that will bring us a male/white shortlist. So, we've been quite successful in attracting diverse candidates when we've looked, for instance, at people who are running third sector organisations."
F.MH.FT.

Others are also aware of the importance of being able to flex and not always stick to rigid criteria:

"Youth is definitely a quality we would welcome... but in writing the spec, you're almost invariably saying you want someone who's got senior level experience. In the last process we had an application from a younger woman in her thirties who had a lot to offer intellectually, but who got cut out for that reason [her age]. I'm going to pay more attention to that next time."
M.Acute.FT.

"The problem with the mechanical process is that it can cut out some other very interesting individuals... who may not have as much operational experience, but have some really excellent ideas."
M.Acute.FT.

> **And sometimes the people that I want may not be the finished article, if we want a broader diversity, we don't just want retirees, but others who are currently in work, who bring a more up-to-date perspective and other interests. Now that means they may not have much time to give and so that conversation needs to be had, but it's a balance.**
> M.Acute.FT.

A number of chairs discussed multiple hires, either purposefully or opportunely. It allows them to consider diversity holistically across their board.

"I like to recruit in pairs... the balance of the board is more important than the individual attributes of the people... as well as being economical with effort, it allows you to look for a more balanced ticket."
M.Acute.FT.

"We were looking for one NED but were blessed with a tremendous shortlist... we were so impressed with [female candidate] and [Asian candidate] we took them both. They brought very, very different skills to the organisation. They're both very challenging! When you bring on really bright people... they're great assets to the organisation."
M.Acute.FT.

"We have never had to think 'if we've got more than one candidate who is appointable, well we'd better take that one to fill this target.' We always have been in a position where we've taken the best person, and as I said, could have appointed two or three diverse candidates."
M.Ambulance.FT.

"... if you're getting very good people, then let's think about this in terms of the overall balance of the board or the team, because as well as the individual skills people bring, their experience of life can bring diversity of thought as well as diversity in terms of characteristics and that to me is more likely to happen if you've got a mix of different genders, different cultural backgrounds."
M.MH.FT.

Many of the chairs discussed what is known as 'the tie-break provision' (EHRC, 2014), 'applicable only in circumstances where two or more candidates are assessed to be of equal merit and where only one has a protected characteristic (such as gender), which is underrepresented in the organisation or sector'[29]. The chairs talked about it in terms of what additional insight could one person bring over the other.

In one case of a female-majority board, this meant specifically choosing the male candidate:

"At our last non-exec appointment we had three men and three women and, you know, the three women were all appointable candidates. But, actually, I was able to say to my governing body, we currently have a female majority, so one of the things that's in [male candidate's] favour is he's a man."
F.MH.FT.

A number of the chairs explained how they talked this through with either governors or the rest of the panel:

"We had three strong candidates, a white woman who absolutely was a step above the other two. And the governors agreed with me on that. What we then had was [name], a black man, and another white man. Basically, both candidates were scored effectively the same and what I said to the governors was that, in terms of the diversity around the board table, both in terms of BME but also in terms of background, [name] is a social entrepreneur, working in the third sector. The other guy was an NHS NED, and I said, I've got one of him already, I'm not saying that's a bad thing but actually, let's go with the person who brings new and different."
M.MH.FT.

29 Equality and Human Rights Commission (2014), Appointments to boards and equality law, [https://www.equalityhumanrights.com/sites/default/files/appointments_to_boards_and_equality_law_22-07-14_final.pdf]

3.5.3
Adapting the executive appointment process

There was acknowledgement that in the past the NHS has not always put prospective executive directors through a rigorous recruitment process, with a sense that, particularly for MD roles, consultants decided 'whose turn it was.' Some chairs felt there was, therefore, a gendered element to this, that tended still to favour an 'old boys' network.'

> **I just think women don't engage in that sort of shenanigan or have that opportunity, if they ever wanted to really.**
> F.MH.FT.

However, there was also complaint that some systems attempting to bring in rigour and robust practices were eroding flexibility that allows a panel to ensure they get the best out of a candidate. Some of our chairs were external assessors/ panel members on other trusts' interviews and commented on poor practice they had witnessed, and had pointed out to those in charge:

"If I'm interviewing, I believe that you should be transparent, it should be robust, but it should not be rigid, it should give the candidate the opportunity to show how well they can perform, not how badly… By engaging them, put them at ease… questions that give them every opportunity to show us who they really are."
F.MH.FT.

One chair described his role in overseeing executive interview panels, with one female candidate that he had experienced as…

"strong and robust and clear, and that was positive." But one of the panel members had experienced her as **"abrupt and aggressive."** The chair said: **"I challenged it in the feedback session prior to the shortlisting for interview. I said, I think this is behavioural bias. If it had come from one of the guys you wouldn't have been batting an eyelid."**
M.MH.FT.

However, as acknowledged by the chair below, it's important to realise it is not just about appointing more diversity, the cultures need to be addressed as well:

"We are a majority BME workforce… We've moved to requiring more balanced and diverse panels to sit on all promotions. We've tried stuff around blind application sifting and so on… But it's a slow business and so we realised we need to be addressing the culture, as well as the individual, mechanical processes."
M.Acute.FT.

3.5.4
Associate NEDs (see also case study 1)

In addition to changes in the appointment process, a number of chairs discussed using associate NEDs, often an apprentice-type role, without voting rights. This allowed them the flexibility to take on slightly less experienced individuals and grow them into a role, either within their own or another trust board. In addition, there was praise for the NExT Director Scheme, initially launched in London, the Midlands and East England, specifically aimed at encouraging more inclusive board appointment processes, with a focus on women and BME candidates. Several of our chairs have used the scheme to bring on more diverse NED candidates.

"Since becoming chair I've initiated a governance review and I am looking to appoint two associate NEDs, looking to re-balance gender in these appointments."
M.Acute.NHST.

One of the benefits of the associate directors is it may enable a board to access different skillsets.

"I know of a chair recently who appointed someone who was in their thirties with digital experience, but they didn't really have some of the other criteria that you might traditionally look for with a non-exec and yet clearly they bring something very fresh and different. It is a way of not having to tick every single box."
M.MH.FT.

A number of trusts have been working together to develop associates to move on to full NED roles.

"We've been talking to other trusts, looking at how you can create more associate positions for people who may have an appropriate background but it's not currently strong compared to others... we could offer them experiences that would strengthen further applications for the NHS."
M.MH.FT.

"We also got involved with the Next Director scheme, we had three people through there. [Asian name] was a NexT Director, he is also much younger than the rest of us, so gives us that diversity as well."
M.Ambulance.FT.

3.5.5
Succession planning / talent management

Although acknowledging that executive director hires are the remit of the CEO, a number of the chairs were working closely with their CEOs on inclusive and proactive succession planning and talent management:

"... bringing in training for middle and senior managers. I call it 'shining a light' on people... give them another experience; show them that we're interested in them... One of our clinical directors (CDs), had never thought about becoming a CD... but because there was some attention shown, some discussions about what comes next... she's doing a great job as CD in one of our boroughs... And it was the actions of our chief executive to really look at how we could develop our senior clinicians into leaders, and we're reaping that benefit now."
M.Acute.FT.

A number went further than just the level immediately below the board (see case study 3), enabling chairs and CEOs to be developing internal talent, which they believed increases aspiration within their staff:

"[Female CEO] has been very good at promoting the leadership amongst female colleagues and actively recruiting excellent people... it creates a climate where there is expectation of women but also an acknowledgement amongst men in the trust that this is something that is healthy and good."
M.MH.FT.

"We have better ethnic and gender balance on the board... so it's working better in the organisation, much greater consciousness of ensuring that the minority staff that we do employ are well supported, they feel they're getting an equal stab at opportunities for promotion."
F.Acute.FT.

Many chairs raised the issue that leadership training was not started sufficiently early in the medics' careers and almost felt like a bolt-on. They suggested it was something that should be there from the start and a constant reminder. What this does is to allow the doctors to develop their leadership over time, which allows them to find their own style and authenticity in leadership. This issue was also raised in the interviews with current and aspiring female MDs (see section 4).

[We need to be] **looking at the early stages in somebody's career, at being able to think about or give them aspiration and map out what may be achievable for them if they wanted.**
F.MH.FT.

"[It's about] shining a light on someone, time and again. Those people will then apply for the next position and start moving up through the ranks. Give them time on leadership development, testing their leadership and their way of doing it successfully."
M.Acute.FT.

One chair even suggested the development of an app or similar technology that would be readily available for all NHS careers, to help individuals understand the range of options, at every stage. With particular reference to encouraging more women to consider the role of MD, the same chair suggested women need to be shown it is a realistic possibility:

"... because they don't dream that they can. I think women get so tied up with the responsibilities of just making the day work that sometimes they just don't have that five minutes to dream."
F.MH.FT.

In terms of action, a number of chairs saw an important part of their role as 'walking the wards,' talking to staff about their careers and roles within the organisation, and then creating opportunities to try out different roles.

"Meeting staff and actually celebrating the people we have with us, then getting them to think about their potential to take on leadership positions either formally or informally, and therefore maybe testing out and thinking 'I could actually do that senior position or I could get onto a board.' It is difficult to do but if you have an organisation that is committed to being different, it tends to encourage people to stay and try. "
M.MH.FT.

> With the next generation, it's about the quality of coaching that those individuals get, the quality of mentoring, the opportunities that they get to step outside of their current role
> M.Acute.NHST.

Amongst some chairs there was a recognition that development should not be considered a short-term objective, and that it may not even be their trust that benefits, but that this is just what good talent management should be.

"My view is that the four divisional directors... we should be helping them look at how, if they want to, they can move into different roles. Their line manager as the chief operative has done this as a number of them have applied for board-level positions. At this point [they] have not been successful, but again we've looked at what we can do to support them because too often when the trust has got good people, they try to cling on to them. It's understandable but not a good idea. We've got to be developing the people below them, who can come in and take on their roles and, again, that's probably about not asking them to do the whole thing but asking them to take on projects, and then find if it suits them, if they like it, what adjustments they need, what training. That's the other important thing... making sure people go on appropriate level training for development and women who it may have helped have not seen that. I think a good number of our executive team have been on The King's Fund courses."
M.MH.FT.

Finally, a few chairs mentioned consultant appointment panels, and the need for panel members to be more gender aware:

"I think probably the place to focus on is in the medical appointments ... I now sit on a lot of consultant appointment panels... I'd say the consultants who sit on those panels, it's less taken for granted that they should be really attentive to the gender issues and we're really on the watch out for not valuing people equally and so on... So that's where I'd start, that's where I'd really put effort in, over who's appointed to become a consultant and who's given excellence awards and so on."
M.Acute.FT.

3.6:
Resistance and challenge

It goes without saying that change will always encounter resistance, and our chairs acknowledged this frequently. However, confident that diversifying their board was the right course of action for their trust, they allowed for dissent, discussion and explanation, particularly around issues of 'representation' and 'best-fit'. They did this whilst being open to continuously learning about other people's perspectives and encouraging more sophisticated discussion around diversity and inclusion.

Not all the chairs we interviewed had trusts based in racially diverse areas, and some had governors who were resistant:

"I can't tell you how hard it is to get them to understand... what equality and diversity really means... 'Equality and diversity, we don't want any of that nonsense, do we?'... No amount of training or asking them to abide by a code of conduct, will get them to understand it naturally."
F.Acute.FT.

"But to increase our ethnic diversity you would have to have very targeted recruitment of those roles and our governors are obsessed with getting the right man for the job! They don't like anything that's targeted."
F.Acute.FT.

Chairs countered the locality argument in a number of ways, focusing on their region or on different dimensions of diversity:

"But in the south west, that also covers Bristol. So, the regions are so big now that there's nowhere that doesn't cover minority communities all over the country. But if you're not attracting diverse candidates, you're missing out on very excellent high-quality talent. The talent pool just expands. And we want the best person in post."
M.Ambulanc e.FT.

"But we have diversity in our patients...it may not be the most diverse county, but we provide a lot of services that are either regional or national. So, we have a secure service with mental health and we provide services to the prisons... So, BME does not just mean black. It could mean eastern European. It could mean people from diverse backgrounds. So, if I go into our prison service we have a lot of people from the eastern bloc in prisons. We have a lot of people from across the region, and that does include more diverse areas."
F.MH.NHST.

A number talked about having to address the 'best fit' or 'best man for the job' attitude. This came down to the chair having rehearsed explanations of how those attitudes are often anti-meritocratic.

"I did have a little bit of push-back from some NEDs around the table, ... those familiar arguments of 'oh but are we going to seen to be reverse discriminating?' So I had to do some work with the NEDs about why this is important, addressing some of that naïve stuff, like 'but we must get the right person for the job'... So then you have to explain 'of course we're doing that!' And in order to be sure we're getting the best person is to be taking account of their experience of our processes and, indeed, their life experiences that might mean actually we're unintentionally making it more difficult for people."
M.MH.FT.

A number of chairs did discuss the challenges they had faced particularly for non-executives, even when they had diversity amongst their executive directors.

> **It's proved really, really difficult to get people from different backgrounds to apply as non-execs. We haven't really, really cracked that one.**
> F.Acute.FT.

But most chairs believed in their 'will and determination' to make it happen.

"I also had to deal a little bit with the, 'but this is [county], it is quite difficult here'. I just had to go, 'well I don't believe that is the case'. My experience is, if you want a diverse board, you can have one... you just go out and get it... I do think there is an element about will and determination."
M.MH.FT.

"... Even if we don't have a diverse area in terms of a 50/50 for example, we still actually as an anchor organisation show that we kind of rate difference and actually even want to celebrate, recognise that difference is important in making us effective.
F.MH.FT.

Ultimately, it comes down to the openness to learn on the part of the chair, in order to develop a sophisticated level of understanding of the issues and a level of leadership that can hold the board, governors, and/or management team through the discomfort of conversations, acknowledging that things are not right and how to change the status quo.

"As a board, can you have very mature conversations, about what we mean by equality, what do we mean by inclusion? Can you hold a conversation about white privilege, and what does that mean, and other conversations like that in terms of gender and disability? So, really pushing the boundaries and challenging each other as to what our understanding is and how we might change that. And being prepared to deal with backlash, when you get responses such as 'what about the white people?' 'What about the men?' and not slamming the person down, but using it as an opportunity to say, 'Well actually what this means is,' and why we're having to do it and just use that opportunity to be able to explain why there's a need to address imbalance caused by discrimination and disadvantages."
F.MH.FT.

"I think we are still nervous about having an open dialogue about inclusivity. Because of how it makes some people feel. It makes some people feel guilt, and feel personally challenged, rather than looking at the systems and processes which have led to this, which make people unable to speak up, which have been a really important part of what we do, you know, really having people speak up. I think we've got to talk about the stories more. I think we've had too much emphasis on moral reasons, we've had to use academics' work about how equality and diversity, and the research you've done, leads to better decisions, leads to financial viability, leads to better quality. It's core to what we do."
F.MH.FT.

3.7:
Availability of data

One of the issues raised in the 2017 report was the need for readily accessible and up-to-date data on board and senior management composition of NHS organisations. Unfortunately, such data was still not easily available for this report. In the private sector, it was demonstrated that regular reporting on leadership composition at organisational, sectoral and industry level, provided the basis for policy and practical change. When questioned, our chairs were shocked such information was not readily available and called for it to be so.

"Yes, there definitely should be an accessible database. Because if you want to attract the best talent, these are very intelligent people, they want to know 'what does this organisation do? Do they really want to appoint diverse talent? Can I see people like myself succeeding in this organisation?' But this information should be easily and publicly available. The more information the better. 'Are my kind of people getting to the top?' We are delivering on this... The NHS should have nothing to hide... and maybe if there are some organisations that are not doing well here, this would help nudge them to do something about it."
M.Ambulance.FT.

What this data shows is some significant regional difference in aspects of diversity, and this highlights the importance of being able to disaggregate NHS data, not just deal in overall NHS averages. For example, one chair described **"pockets of super diversity"** in his city, but move out to the counties and he finds that **"Knowledge and awareness in engagement drops off very quickly and you get these questions like: 'I've never known a BME leader' or 'I've never served on a board where there's been a majority of women."**
M.MH.FT.

He continues that in some places:

"I notice you have quite a number of working class leaders with local accents and then other areas it seems like nothing's happened for 100 years and the way people talk and behave is the way I observed headteachers talked when I was a kid. They just talked down at you and exclude you and everything that you say."
M.MH.FT.

It is important to note these differences so that when leadership get together at a national level to discuss change, the variations are appreciated.

Another chair discussed using data to drive aspiration, at a county level, in discussion with chairs of other trusts:

"... analysing a trust's staff ratios by banding and saying: 'Given what we know about the diversity of your area, actually, this is the sort of diversity we should be seeing at those levels.' And, effectively, calling them aspirations for something like 2025. Using that data, I was able to do some work with the chairs of the other two trusts in [county] and for us to agree as chairs that we were going to take the same expectations about board engagement with the EDS3 to our respective boards. So, we were doing it as a [county] across the whole system, as one of the pilots around EDS3."
M.MH.FT.

This demonstrates that some chairs are collecting and using such data proactively, but without leadership and/or guidance, this is extremely unlikely to be the case across the whole organisation. **Not only is readily available, accurate data important for signalling intentions and ambitions, it is also requisite for making evidence-based decisions.**

"I thought we all had to submit our board data to NHSI so yes, it should be available. And the better organisations are doing proper analysis of all this kind of stuff themselves and it will be in board papers. But I agree with you, it's too hard to find it. It's like... everyone has to submit the gender pay gap data, you don't have to do the ethnicity one, but we've chosen to do it because these are things that matter to us and... we want to signal that we want to make the right kind of progress, so... yes, certainly, board composition data should be easily available."
F.Acute.FT.

3.8:
Messages from the top

There were mixed perceptions on how clear the messages from the top are regarding the importance of diversity, and also then how well these messages were disseminated down through regional and trust levels. Understandably, the two bodies most focused on were the (newly amalgamated) NHSEI and the CQC.

"I think we've got people now at the top [of the NHS] who do hold the right views. Dido Harding, as chair of NHS Improvement... has clearly got the right values for people... However, there may be a difference between what the top says and how other people behave... How do we translate good intentions into something real?... What is the proportion of men and women at regional directors? It's still quite a macho-type job... So there is getting practice and principles to be more aligned."
M.MH.FT.

One chair described the mixed messages about a desired change of leadership culture that wasn't then enacted from the top. He felt messages from the top of NHS England and NHS Improvement (Simon Stevens, Dido Harding) were: **"...being really, really clear about the culture, it's not about blame, it's about supporting people, it's about devolved leadership, really strong and positive."**

However, once the conversation turns to finance: **"...it's basically, 'we're really disappointed in you, 'we agreed to give you generous control and you haven't delivered have you?' The language was real old school command-and-control."** He mentioned the challenge of doing turnaround work by bringing in people regarded as a trusted pair of hands. **"And the risk is these are old school, 'do it my way or not at all.' And actually they also tend to be older white men."** The chair felt there was a risk of: **"...the work that's being done developing more inclusive leadership cultures being undermined by saying 'it's only about performance' and reverting to old school ways of working."** He felt a sense of responsibility: **"It's incumbent on us as chairs to push back at that.**
M.MH.FT.

> " Leadership culture is critical on this and NHSEI needs to practise what it's preaching from the very top, even when it's tough. And I know it's tough. ...Actually just pausing to have a conversation about, 'is this the right intervention?' would be useful from time to time.
> M.MH.FT. "

There was also criticism about messaging from the top about increasing diversity when not all the national bodies themselves are particularly diverse:

"This [board and senior management] **data should definitely be monitored, across the piece. But I think, at the moment, you would struggle to ask which of the national NHS bodies might credibly have a conversation about diversity on boards, given the very poor record that the national bodies themselves have."**
F.MH.FT.

As well as messaging, there was also discussion about possible levers to encourage or hold boards accountable towards more diversity. The CQC and its well-led criteria were mentioned by a number of chairs:

"The CQC has the ability to make this happen, they should say that you can never be 'outstanding' if you don't have good practice and process in place to ensure a more inclusive culture, have a really good approach to EDI. But I don't think it happens. I've never heard of anyone being called up on that... If you have targets and accountability and you make it happen, the culture will change to one where all groups can feel supported. The WRES is good, but it's what you do with the data and who is holding you to account for it."
M.Ambulance.FT

"Thinking about what levers do we have as a system to make sure that's right, this goes back to the leadership part. It's the oversight framework, the equality framework, the CQC and NHSEI. But particularly the senior leaders, how are we equipping them to be intelligent and able around inclusion and diversity? We've just got to stop... we've got to act swiftly and quickly when we have leaders who just don't get it ... Being really clear about what the expectation is, and that being a proper part of the recruitment processes that we have for our leaders. And actually [this should be] part of the objectives we set for chief execs, and therefore through them their team. And it's holding to account that you're not doing well here and what are you doing to improve?' Just as much as we do about money."
F.MH.FT.

However, again this was challenged by the view that the CQC itself was lacking in sufficient diversity.

"I think the argument that [NHS leadership] can't find ethnically and gender diverse candidates to ensure that they are practising what they preach is long since passed. [The CQC] – their own lack of diversity in the board room is problematic ... In their well-led inspectorate they have got people for whom this is a passion ...But when trusts are challenged on it during the well-led inspection, [their own lack of diversity] does have an impact." "
F.MH.FT.

There was a sense of frustration from some chairs regarding the leadership of trusts where no progress on diversity is being made.

> "
> **Nothing is going to change if we've had four or five years of talking about these issues at the top and you haven't even got to first base. These organisations are just better when they're inclusive and alert.**
> M.MH.FT.
> "

And there's a suggestion that questions should be asked of aspiring CEOs, chairs, and rising stars, as to whether they have a sophisticated understanding of the issues. The importance of appointing the right people to lead trusts in terms of their approach to and understanding of diversity issues was discussed by a number of chairs:

"...so the next group of people coming into these positions over the next few years should have mandatory training or some kind of extra testing beforehand, and we will be meticulous in trying to change the mix here, which wouldn't be popular in some respects, but I think the evidence base is just so heavy now. We've tried to do this politely for four years with damning evidence, somehow or other many organisations seem to have evaded it and some of the better organisations just seem to have got better. But others just haven't moved or have gone backwards."
M.MH.FT.

Understanding that not everyone instinctively understands diversity, one chair suggested support and training to better understand the issues. However, he was amongst others who also said that ultimately, chairs who don't engage with the need for diversity should not be allowed to stay in post:

"They will have talent in different areas that we need, so we've got to be inclusive at all times, but if there's a completely empty box, we need to do something to help people and these are not people without talent ...but some people in some professions in this country have been able to float up through decades without having to confront or understand anything."
M.MH.FT

He described how sometimes people have a revelatory experience and change, and so should be given a chance:

"But, if they're not willing to take the chance then I think we have to be stronger and say: 'I'm not sure you're fit for purpose here.' You know you're in an organisation that's 80 per cent workforce female and you don't seem to be able to articulate anything about that, or don't have conversations where you understand the significance of that and disability, or mental health. …Health to me is not transactional. It is by definition transformative every single hour. If you can't demonstrate you understand that then you're not the leader we need, really."
M.MH.FT.

There was a recognition that: "NHS Improvement is seeking to have more influence and to sit on interviewing panels for chief executive and chair appointments …"

But also a concern that NHSEI: "…needs to make sure that the people who are representing them are people who are then putting into practice their view that actually diverse boards are more successful boards. There's a focus on competence, but unfortunately this could be dangerous 'cause, you know, people potentially have a very set view of what a competent individual looks like and, so, you get back into an old way of thinking which doesn't actually help any of us."
F.MH.FT.

There were one or two exceptions to the perception that NHS leadership is engaged with the diversity issue. When asked what more could be done from the top, one chair said:

"I would welcome more engagement in this area of activity. I have found this thought-provoking and helpful, as an hour for me personally, in terms of thinking through my approach to board balance, and thank you for that. It is germane that it's the first time in six years that I've been, depending on how you look at it, either subjected to this or had this opportunity… And I would welcome a clearer focus and approach from the higher NHS about this."
M.A&C.FT.

But on the whole, most chairs were of the opinion that NHSEI should continue to proactively engage with the issue, giving chairs and CEOs active support, guidance and responsibility to make change, and ultimately accountability if they don't.

"I would argue that leadership shouldn't have to exhort us to [sort out diversity], because good boards would be trying to set those kind of standards for themselves. And, I think, for a lot of us, we've come from sectors that are far ahead in this kind of agenda… But, yeah, I think there's been good leadership from NHSEI about it and it's encouraged me… And I know it's encouraged other chairs as wel … And, if you can't get people to do things voluntarily, make sure they understand that a mirror will be held up to them and they might be found to be deficient in some respect." – F.Acute.FT.

3.9:
Implications for integrated care systems

A few chairs linked diversity with new styles of leadership specifically required for the forthcoming integrated care systems, focusing on cultural change, less competition, more cooperation, innovation and partnership models. It was unclear whether these changes in required skills were explicitly identified by NHS leadership and linked to diversity, but for some of our chairs the relationship was clear:

true cognitive diversity of perspectives, inclusive cultures and breadth of networks were seen as imperative for system working.

"I think there's a really interesting piece around the big changes coming with system working, which bring cultural challenges… which includes leadership culture … We're not good in the NHS at being explicit about having those conversations about culture and leadership, particularly when it's a bit difficult! Which is exactly the time we should be doing it. And I think we seem to sometimes be getting mixed messages from NHSEI.
M.MH.FT.

"I think there is an interesting opportunity coming up with integrated care systems. If we are going to start thinking about systems and group structures within systems and we are moving to a more cooperative and less competitive environment, allegedly, that might enable you to think about how you create your partnerships and networks across the local system and might enable you to then start thinking, 'where do your potential non-execs come from?"
M.MH.FT.

"You need balance on the board – you need people with political skills to understand how policy is developed and how the system of healthcare works… Hierarchical organisations can bring you efficiencies and control and all those things we know, but organisations are having to balance that need for control with the need for innovation and transformation… So, how do you recruit fantastic leaders who perhaps are different from the command-and-control models that the NHS has traditionally had? But, we've gone from having a time when what we recruited was people who came from a business world to run foundation trusts as standalone successful businesses, where what mattered was being able to run in a commercial sense. To now, the NHS requires you to work in partnership. We're now much more about population. Much more about place-based care…. looking for a new set of competencies… drawing people in who are used to working in a partnership model."
F.MH.NHST.

CASE STUDY 5 – CULTIVATING INCLUSIVE BOARDS FOR BETTER CHALLENGE
Birmingham and Solihull Mental Health NHS Foundation Trust: 69 per cent female, 31 per cent BME

"If people can bring their whole selves into the boardroom and trust it is a safe space to do that, they will perform better individually and collectively."

Creating an inclusive board culture is very important for Sue Davis, chair of Birmingham and Solihull Mental Health NHS Foundation Trust. Inclusion creates what is termed psychological safety, which, Sue explains, is: "A safe working culture, you know, feeling safe to challenge," and she believes this is how you get the best from people's diverse perspectives. The chair has experienced this as a particular concern from female executives, but from research we know this to be a function of being a minority. As with many of the other chairs interviewed, she has experienced that as you start to increase board diversity, this attracts more women and ethnic minorities to the organisation, "as a more attractive, safer place." However, faced with the 'challenge' of having a female majority on her board, the chair was pleased that the strongest candidate for the most recent appointment was a (black) male.

The chair recognises that: "Actually, there is a need to work on [creating a safe environment to challenge] in a proactive fashion. And not to assume that people join boards – especially if they're joining them for the first time – feeling comfortable about challenging their peers... without being criticised for challenging, and comfortable with the fact that they are going to be challenged."

She also spoke of orchestrating the board and "managing the airtime" with different characters wanting to speak more. She was very clear that if someone says something that somebody else had already said, that the point made is attributed to the original speaker. Women and minorities are far more likely to have experienced not having their voices heard and this is a chair's responsibility to manage, as well as to help develop those individuals.

One tool that the chair highlighted as very useful in this regard is the use of electronic board papers, which allows people to put a note on the board papers before the meeting: "I have encouraged people to put their questions on that format and everybody can see them before they get to the meeting... particularly a couple of newer board members have made use of that, and I think they found that helpful, so everyone is aware and there are fewer surprises."

In addition, at the end of the board meeting: "We do finish the day with a reflection session so that people can actually say: 'well, the way that was done didn't feel really quite comfortable.' And sometimes we have to agree, well, it wasn't comfortable, but it was necessary... But, actually, I think that has also helped people to come to terms with what are sometimes, you know, quite difficult situations that we have to debate and decide upon."

SECTION 4:
CURRENT & ASPIRANT FEMALE MEDICAL DIRECTORS

In the 2017 report, we identified a particularly low proportion of female MDs – just 24.6 per cent. This was disappointing given that women have made up the majority of medical school graduates every year for over 25 years. The figure has increased in 2020 to 29.5 per cent, which is welcome. However, this still represents only 64 MD roles held by women across England. This figure also remains significantly lower than the proportions of women in other board-level executive roles, such as CEO, COO and CNO. Conversations following the 2017 report with NHS leaders revealed a lack of concrete knowledge around why this might be. Therefore, for this report we wanted to investigate possible barriers and enablers to women reaching this important role. In order to do so, we interviewed women both currently holding an MD position, and those at levels below who may aspire to that position.

Between January and February 2020, we interviewed 35 current and aspirant MDs, from trusts across England. They came from four mental health foundation trusts (MH.FT), 16 acute foundation and NHS trusts (Acute.FT; Acute.NHST), six acute and community trusts (A&C), two community trusts (Comm.NHST), four regional roles (Regional) and three CCGs.

Two-fifths (14) of our sample currently hold an MD position and the remaining 21 participants were below that level in positions with titles such as associate MD, clinical director, divisional MD, clinical lead, deputy MD, and consultant. We refer to these participants as aspirant MDs (AMD), and a number of them had attended an AMD course or similar. Eight of the 35 (23 per cent) self-identified as BME.

Interviews lasted approximately an hour and were recorded and transcribed verbatim, with the participants' permission. Questions focused on their career path and decision points, and on their perceptions of the role of MD.

The section below considers the main themes emerging from the anonymised interviews, including the participants' motivations to be an MD; their career pathway to the role; perceptions and experience of challenges and barriers; and enablers to women achieving the MD role. In addition, as a number of our chair interviewees also opined on the dearth of female MDs, and are often involved in their appointments, we include chairs' explanations of the current situation and how it might be improved.

4.1:
Why be a medical director?

The women interviewed were attracted to the role of MD for patient-centred reasons, to be able to have the most impact. A clinical role offers the opportunity to improve life expectancy and enjoyment for one patient at a time; an MD can problem-solve and influence strategic decisions to get the best for a whole population of patients.

> Within our population there are pockets of people whose life expectancy is 84 to 90, who are sailing boats at 75… and then I've got residents whose probable life expectancy is 60… I can look after those individual patients as a doctor but I can't improve their health aspirations, and that's where, particularly at executive-level post… you've got the ability to potentially improve the health of a whole population.
> AMD.A&C.FT.

For those who have reached the level of MD, the job satisfaction of making a difference to all these patients is extremely high.

> "It's a job I love because in this position I can effect change… I can find things to unblock, find ways to make systems better, I can be part of the solution and that's what I really like. It took my previous job for me to realise that, actually, you have to be at the top to do it in a way that truly feels like you're [making a difference].
> MD.Comm.NHST.

The role requires vision and hard work, described as a challenging but rewarding job. MDs are always learning, working across disciplines and with other professions, which they reported enjoying. The nature of the role has evolved from hierarchical to strategic, with a focus on partnership and influence, and is now, as a board role, about leadership rather than management.

4.2:
Pathway to leadership

We noticed two patterns in how our respondents saw their career pathways. Current MDs looked back and saw their leadership development as incremental and, by the time they applied for an MD position, they felt just about prepared to take on the extra responsibility. But the women we spoke to who were less attracted to the role (currently one or two steps below it and considering their options) felt that going into leadership was perhaps too much of a step into the unknown after a relatively well-defined structure for progressing in a clinical career. These women often felt 'lost at sea' at this stage of their development, and wished to retain their clinical knowledge as much as possible – partly to retain credibility, but partly because, if what they saw as their venture into leadership did not work out, they would have to retrain to go back to clinical work. As a result, the MD role appears to be two time-consuming, high-pressure roles at once, and some aspiring MDs felt they would fail in one or both roles as a consequence.

"I'd be very hesitant to give up my clinical work, but I can also see that there gets to be a point where it's just too hard to do. You're not doing enough of it to feel like you're really sustaining your clinical knowledge and skills and the job and everything else is too much."
AMD.CCG.

These apparently conflicting perspectives on the step into this top role were reported by women taking very similar career paths in terms of leadership experience. They had taken on positions like roster or audit lead while doing mainly clinical work, followed by clinical lead, clinical director and then deputy or associate MD, learning strategic and leadership skills along the way. It may be the case that those who reach the stage of considering applying for an MD role without feeling prepared for it, are unaware of their leadership potential (see sections 4.3 and 6. recommendations).

Inspirational individuals played a significant part in many women's progression. Some aspired to work alongside a particular person, while several others applied for leadership roles as a direct result of encouragement from senior colleagues. Indeed, many suggested they would not have considered it if it were not for those 'taps on the shoulders,' which seem to bolster confidence and give women the permission to see their own potential.

"I was encouraged by one of the senior consultants in that team who let me know that he thought I'd be good at it. You don't get a lot of feedback so that was probably enough for me."
AMD.MH.FT.

4.3:
Challenges and barriers

4.3.1
Perceptions of the role

From one or two positions below MD, the role can look daunting, a 'big role.' Some of the women saw it as reactive and target driven, involving constant firefighting. Whilst accepting the role includes responsibility for significant clinical risk, the political aspects of a board role did not appeal to some. Clinicians consider it too removed from patients and staff, and it is seen as a risky, unsupported 'fall-guy' position:

> **There are advantages to doing the job at the end of your career, as in the ability to make brave decisions that may not fit in with local politics, both with a large and a small 'p'. And I think you have to recognise that sometimes it's the last job people do because of that political input.**
> AMD.A&C.FT.

Some of the MD interviewees said they believed that women may not come forward because they do not have a proper understanding of the role. Several deputy MDs made assumptions about extra hours on top of their current exhausting workload, but MDs themselves spoke of the advantage of having more control and flexibility in their work patterns. The day-to-day process of the role must be made more accessible; it would be useful to shadow or observe an MD before deciding whether to aim towards the role.

4.3.2
Family commitments and work / life balance

Having said that there are misconceptions about the role, MDs did acknowledge that it is **"all or nothing" (MD.A&C.NHST)**, and extremely time consuming. Many felt that their credibility was at risk if they did not retain some clinical work, so they effectively do two extremely stressful roles at once. Those who had not seen a job share in action felt that it was not possible to be a part-time MD.

The mothers we spoke to had largely built their career paths around family decisions and vice versa: - **"My generation, we didn't dare have kids until we were registrars" (MD.Acute.FT)** – and the majority had gone part time while their children were small. In some cases, working part time had meant they were taken less seriously and lost their voice in the organisation, finding it harder to engage in leaderful behaviours and decision-taking. They also struggled to recapture that voice when they returned full time, delaying their progression:

> **I want to be part of the process... I didn't want to be the, 'oh well, whatever, she's part time... she won't be at that meeting or doesn't need to do that'... It's a really important thing to think about when people** [go part time], **is how do you still have a voice?**
> MD.COmm.NHST.

Childcare and work/life integration in leadership roles were also an issue. MDs and AMDs spoke of long board meetings that would **"start at two and they would have no end point" (AMD.Regional)**, making it very challenging to plan childcare or school pick-ups.

Maternity, paternity and shared parental leave are also stumbling blocks. In surgery, participants described how a three-year PhD or other research sabbatical away from practice were not seen as an issue, but if a woman took a year off on maternity leave, she would be seen as having **"lost** [her] **ability to operate,"** **(AMD.Acute.FT).** If a woman's partner also works in the NHS then shared parental leave is likely to be frowned upon or his employer will be ill-equipped to manage it well:

> **We had one chap who took the second half of his wife's maternity leave and he got a lot of stick from his colleagues.**
> AMD.Acute.NHST.

"A friend's husband… wanted to take shared parental leave with their first and he managed it. But the system wasn't up for it, the system wasn't used to it, there was talk about him having to delay his CCT. "
MD.Comm.NHST.

4.3.3
Lone heroic leadership

In some trusts there is an absence of female role models in leadership, and those that do exist display more typically masculine leadership styles.

"If you said to anybody around here, you know, 'what's [MD] **like?' They'd say, 'oh my God, she's first in, she's last out – I wouldn't want her job.' So, you know, I'm role-modelling exactly the sort of** [style] **I don't want to role model. So, it's up to us. We are the only ones – it's the current crop of medical directors – we are the only ones that can actually make this look different. "**
MD.A&C.NHST.

Leadership style as an important issue was raised often. The NHS is struggling to shake off traditional 'heroic' leadership – both in terms of the 'unencumbered ideal worker', which disproportionately disadvantages women, and more traditional command-and-control styles.

"Although we have 'no more heroes' and all the rest of it, I still think people's theory in action is probably heroic leadership… as we try and shift it to a more collaborative, consensual leadership, you need to have clear leadership when it's important. So at some point you have to shift style, don't you?"
MD.MH.FT.

> **I think some of that's about the culture and the understanding of what being a medical director is. I think in a classic, hierarchical system you have to work really, really, really hard and you have to be known and you have to do the extra graft to get there… and I think it remains easier for men to do that.**
> MD.Comm.NHST.

Some of our interviewees felt strongly that heroic leadership styles may be perpetuated by the interview process, where good leadership based on 'soft interpersonal skills' is a lot harder to demonstrate, particularly for external candidates.

"What I do demonstrates I can facilitate change and build resilience in the workforce and commitment to be able to achieve better outcomes. I also know that I am not just here for the doctors and that a wide range of professionals and non-professionals would recognise me as a leader within the hospital. At interview that's harder to get across."
AMD.A&C.FT.

It is also hard for women to stake a claim on a leadership role when there remain some macho environments within some specialisms that hinder women's progression and make the role's setting less attractive to them.

There is very much a culture of 'suck it up', 'grow a pair'... and certain specialisms which are more bold and macho than other specialisms.
AMD.MH.FT.

Research shows that when employees experience leadership as 'someone who looks like me' they are more likely to aspire to and believe in their potential success in those roles[30][31] Without such role models, making those transitions is more challenging.

" Men – you know, they just come along, and say, 'well, of course I can be a medical director – why not?' Whereas women, you have to tap them on the shoulder and say, 'have you ever thought of being a medical director?'... You know, they kind of need more encouragement."
MD.A&C.NHST.

" If we developed more people at consultant grade, I think women would probably be more in touch with their leadership potential and would probably be more ready to apply for medical director posts."
MD.MH.FT.

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[30] Sealy & Singh, The importance of role models and demographic context for senior women's work identity development, International Journal of Management Reviews, 12(3), pp. 284-300.

[31] Peters & Ryan (2012) Fitting in and getting on: Understanding career motivation in male and female surgeons, Report for the Royal College of Surgeons, University of Exeter.

4.4:
Enablers

The interviewees discussed a number of enablers that either had helped them to the MD position or that they felt would help others to make that career step.

4.4.1
Gender-awareness in recruitment practices

Perceptions of leadership as masculine (discussed above) can be challenged in the recruitment process, starting with diversity training for recruiters. Participants felt the interview process was biased towards male styles of leadership, and women who display values-based leadership find themselves shut out. Women in the NHS (particularly BME women) are acutely aware of the prejudices they face, and, as is well-documented in academic research, either put themselves under pressure to fit into a system they feel does not fully recognise them, or they 'choose' not to apply (see case study 6).

"If you are really good and very brilliant as a man it's a fantastic thing, it's absolutely brilliant and people will rave about it. If you are all of those things as a woman, it comes across as overpowering and threatening and so you almost have to find a way to be all of those things but in a way that doesn't make people want to run out of the room. Rather than run out of the room, what they do is they lock you out of the room. They won't leave the room, they just make sure you don't get in."
AMD.Regional.

Even within a majority female workforce like the NHS, at senior levels, the stereotype of a typical leader remains male or displays masculine behaviours, and women who do not enact this stereotype are told that they **"lack gravitas" (AMD.Acute.NHST).** A developmental issue that often looks like a lack of confidence may be a result of implicit attitudes, along with loss of voice after maternity breaks and repeatedly not having one's voice heard. This can lead to women questioning their competence and hesitating to take the leap into the unknown that a board role represents. It could more accurately be described as a lack of awareness of their own leadership potential. What manifests as an individual's lack of confidence is commonly a failure of the system to encourage, which should be addressed with better feedback, development and support at senior levels.

As highlighted across the chairs' interviews, gender and ethnicity awareness in recruitment practices, at both consultant and board level, are often far from perfect, resulting too often in the perpetuation of the status quo.

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32 Walsh, Fleming & Enz, (2016), Give and you shall receive: Investing in the careers of professional women, Career Development International, 21 (2), pp193-211.

4.4.2
System-wide talent management and leadership development

An inevitable result of the reproduction of identical styles of leadership is the silencing of unique voices and inefficient utilisation of talent. As noted in the chair interviews in section 3 and below in 4.5, leadership should be developed and encouraged throughout the medics' careers, as well as a proactive board helping at mid and senior levels[32]. A system-wide talent management approach would enable women to discover and develop their authentic leadership styles, boosting the confidence of capable people at an early stage:

> **There should be an active programme of identifying [talent], through assessment, through whatever means rather than just waiting for people to come forward… which means that you don't always get the best people for the role… Get them into these leadership and management training programmes, and almost create a career pathway, a management career pathway for them.**
> AMD.A&C.NHST.

Female clinicians need to see leadership training opportunities embedded much earlier in their careers. The NHS does this well for nurses, who are encouraged to think about leadership and constantly developed with this in mind, and it shows in the statistics (see section 2), with high numbers of female CNOs and many nurses rising to CEO or COO level. Consultants are served less well in this area but find leadership training extremely useful when they take part.

"**[Leadership courses are] never or rarely put into consultants' job plans and they're not promoted because the hospitals obviously want you there for a service. I think that is probably something that should be brought out much earlier on in consultant careers. I know lots of nursing staff who've done these courses and not only have they been advised to go on them but they've also been paid to go on them.**"
AMD.Acute.FT.

"**That course was so very good, and I met a really good group of people that I'm in touch with, my learning set and who've been really supportive. It's been quite transformational, the best thing I've done in terms of professional development ever. But it was a complete accident that I found out about it.**"
AMD.Acute.FT.

Our participants recommended the Athena, Nye Bevan, King's Fund and Cambridgeshire and Peterborough NHS Foundation Trust (CEFT) programmes, among others, which give practitioners the skills and time to look inward and reflect on who they are and what they want from their careers.

Leadership courses focus on skills like relationship building, conflict resolution and listener collaboration, making female clinicians aware that some of the 'soft' skills they already possess increase their leadership potential. It is important that potential female MDs are confident in their own leadership style and qualities, especially when the MD position is held by someone with a different style who may not look at all like them. Leadership training identifies and focuses on these qualities, assuring women that they have something unique to offer.

" **The things that I've read in terms of leadership… It is your role modelling, your storytelling, your empathy, being able to convey a vision, and those things – they come from developing yourself, don't they?… A lot of what you do, you have it within you already.**
MD.MH.FT. "

'**Organisations are likely to strengthen the retention of their female professionals if they signal support through purposeful, long-term career development that provides a sightline to the top, and ultimately creates more female role models in senior-level positions. Organisations can also signal support through offering autonomy over how work is completed, and designing infrastructures of support to sustain professionals during mid-career stages.**'
(Walsh, Fleming & Enz, 2016, p.193[33])

4.4.3
More mentorship and sponsorship

MDs and deputy MDs said it was important to feel supported and that respected colleagues believe in them. Most mentioned a specific person (or sometimes a team of colleagues) that had acted as a mentor or inspiration in the early stages of their career, discussing their progression and offering advice:

"**Each and every single time that I've had a sort of boost or a jump, it's been because there's been somebody who reflects** [something] **back to you.**"
AMD.Comm.NHST.

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[33] Walsh, Fleming & Enz, (2016), Give and you shall receive: Investing in the careers of professional women, Career Development International, **21** (2), pp193-211.

> ❝ I think having a kind of senior…
> a mentor, a coach, has been
> really helpful.
> MD.Acute.NHST. ❞

This can be formalised as mentorship, but can be more like informal encouragement. The important thing is that it needs to be in place at every stage of a clinician's career. Without it, ambitious and talented women can feel isolated and lack direction. The CEO and chair of the board could have a role in shining a light on promising potential leaders, as a sponsor, and encouraging their development.

4.4.4
Make the role accessible

Some of the barriers to women's progression stem from perceptions of the role that may be incorrect, so accessibility and openness are key enablers:

"I'd say don't be scared of what you think it is… come and spend some time with one of us, come and understand what it really involves. A lot of it is around relationships and around people and around building trust, that's something classically that women do better and quicker than men."
MD.Comm.NHST.

> ❝ **"[We need an MD] 'My working day', you know, the sorts of things you look at, I find interesting.** [A female CEO of X hospital] **sometimes posts on Twitter what she's doing that day, and who she's meeting… and you know, what her day, what her diary is, essentially, for the day… What practically does it mean to do this role?"**
> AMD.CCG. ❞

This part of the solution does rely heavily on already overstretched women giving up more of their time, but we heard a great many aspiring MDs say that they would appreciate female MDs' top tips, the reality of the job day to day, and learning about their career journeys. To avoid placing more pressure directly on women, the CEO and chair should aim to make both the role of MD and the board of directors generally more accessible.

4.4.5
Job sharing

> ❝ I think a job share is an interesting concept… It would share the load and share the stress and share everything… From my perspective that would make it far more attractive. [As a deputy MD] **if you go up to medical director I don't know how that would facilitate being able to be a clinician as well.**
> AMD.Acute.FT. ❞

Job sharing is another potential enabler, allowing MDs to balance their board role better with clinical duties. However, the idea had not occurred to many participants, some of whom worked with MDs who even resisted having deputies. As discussed below in section 4.5.4, for most the idea of an MD job share is not about working less than full time, but about maintaining the balance between the clinical and leadership roles. The one participant who shared her role (as part-time clinical lead, not MD) said the opportunity to job share came about almost by accident.

"The clinical lead for the department stopped doing it and I actually ended up chatting to one of my colleagues and we decided we were going to job share it. So she worked part time, I worked part time, and actually what it seemed like at that time was like a division of labour, sort of joint responsibility, and it worked really nicely."
MD.MH.FT.

Sharing the role would lessen the pressure on women who are trying to perform multiple roles well, and this includes their role in the home.

4.4.6
Recognising family responsibilities

Other practical enablers for families include drop-in childcare facilities available for on-call clinicians, and private rooms should be available for new mothers to express milk. Meetings should plan realistic end times and stick to them. Other organisations implement rules about no critical meetings outside of 'core hours' of 9.30am–2.30pm. It is suggested that the NHS needs an **"Athena SWAN-type recognition of working hours for families, not just for women."** (AMD.Acute.FT.) This is also a recommendation in the forthcoming gender pay gap review[34]

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34 Dacre & Woodhams. (forthcoming), Mend the Gap: The Gender Pay Gap in Medicine Review. Department of Health and Social Care.

4.5:
Chairs' perspectives on the lack of female medical directors

In interviews with board chairs, we highlighted the low percentage of women MDs and asked for their explanations and suggestions on how to address the issue.

> **With the CFO and CMO roles, culturally we must be doing something that discourages them.**
> F.Acute.FT.

4.5.1
Historic stereotypes and images of medical directors

The chairs discussed a stereotype still prevalent for medical directors in a way that is no longer the case for other board roles, of a very hierarchical role and 'men in white coats.' We know from previous work on career ambition of female surgeons[35] that anyone not fitting such stereotypes has an uphill battle to convince themselves and others of their suitability.

"**I also think there may well be a bit of a historic thing about what we've always expected to see at senior clinical levels – men. Whether it's going back – 'men in white coats' – or whatever, that sense of expectation… as a woman and as a person of colour, you've really got to believe in who you are, the contribution that you make, your worth, and that's really, really important.**"
M.Acute.NHST.

Part of that historical image is the role of consultants in choosing the next MD, whereas today, of course, executive board directors are chosen by the board and/or governors.

> **You have to look at the history of medical directors in the NHS. It used to be buggin's turn you know. If you look at the number of female doctors who get platinum-level pay awards it's tiny compared to the number of men. So, there's a whole thing for the medical profession.**
> F.MH.NHST.

Another chair discussed the challenge of "**the power of the inherently in-bred consultancy body**" who could be "**incredibly powerful in dissuading the people they didn't want to stand from standing, you know, it's not your turn**" and engaged in "**active lobbying, saying you know, you're the one we want.**" One chair described how they had appointed internally a female MD, not the consultants' choice, who was then "**in a very exposed position**" despite all the board being fully supportive of her as the best candidate. The chair then enabled the new MD "**to appoint deputies who would support her and she now has a team within her directorate as well as total support from the board.**"
F.MH.FT.

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[35] Peters & Ryan (2010), Fitting in and getting on: Understanding career motivation in male and female surgeons, Royal College of Surgeons.

Similarly, another chair said:

> When I chaired an acute hospital and we went to appoint a new MD, there was a very strong sense of 'oh it has to be a surgeon.' In acute trusts there's still a hierarchy amongst the medics.
> F.MH.FT.

And another also commented on persistent stereotypes:

"There are some areas that it's still harder for women to get accepted, get recognised,… it would be interesting to do an analysis by specialty of trust… that should favour a mental health trust being better at [having more female CMOs]… Women have had a very strong role in psychiatry for a very long time… For myself, I remember when I moved out of a clinical role into executive director, talking to chief executive of an acute trust. He said, 'We normally think of it as a woman's job', because it was mental health and learning disabilities."
M.MH.FT.

For this report, we did disaggregate the female MD figures by trust type, confirming some of these perceptions. Women MDs are well represented in community trusts (where 47 per cent of MD roles are held by women), and mental health trusts (41 per cent of MDs) but much less so in acute (28 per cent) and ambulance trusts (22 per cent).

"If you look at women's careers in medicine they are less likely to move into managerial positions. They are also less likely to get the consultant pay, which is all through some ancient system which is really indecipherable. But we are actively encouraging our women consultants to step up."
F.MH.NHST.

4.5.2
Lack of continuous training

Many of the chairs talked about the anomaly, as they saw it, that doctors are not trained in and expected to take on leadership from the start of their careers. Comparisons were made with the Armed Forces, police and fire services, where leadership expectation is embedded early on. One chair described it as:
"An air gap between senior clinicians and senior leadership and management of NHS activity."
M.A&C.FT.

Senior clinicians were described as looking at board-level roles **"with complete disdain… with no interest to engage in activity which in their eyes has nothing to do with their roles as doctors."**
M.A&C.FT.

The lack of continuous leadership training throughout medics' careers means that 'doing leadership' is more of a new skill to add on at a late career stage.

"The trouble is medics don't always want to show they still need to learn something. It's quite hard. One of them said 'it's very difficult to come in and say you don't know anything about something."
M.MH.FT.

As the MD is such a senior role, a candidate needs to be confident and authentic in their own leadership style. This is very hard to acquire quickly, and disadvantages anyone for whom the dominant leadership styles throughout their career have been masculine or contrary to one's own.

"I think we always have to be looking at our recruitment policies and who has access to training, who demands access to training and opportunities, because there is absolutely no reason why the number of female CFOs and CMOs shouldn't reflect the balance pretty much the same as the balance in the whole of that area of the business. I also think there is something about the behaviours that we value… why are we focusing on how you promote yourself… saying that women need to be pushier… what are we valuing? Actually I want an NHS for the people who pause, reflect, think, act and maybe there is something about the behaviours that we value… the leadership styles that we are trying to develop and the way in which we both establish the right culture within organisations that we recruit for that culture."
M.MH.FT.

The chairs were also aware of the NHS's desire to move away from the old hierarchical command-and-control style of leadership, but that needed to be experienced and encouraged at all levels.

> **We need more leadership programmes run by the NHS, by other organisations and particularly to encourage people who would not normally have come forward, to go forward.**
> M.MH.FT.

"You need leaders who are operationally competent…but then look at how to develop good operational people into senior leaders…Goes back to 'shining a light' on someone, encourage time and again, those people will then apply for the next position and start moving up through the ranks."
M.Acute.FT.

One chair mentioned how in nursing:**"There is a range of things that people can do that take them into management and into commissioning, and into different fields, which enable them to come back and do leadershiproles of a different nature. But that really isn't there for the medics by and large, who have to specialise and are only recognised for their expertise in that specialism, which seems to close doors for medics rather than opening doors."**
F.MH.FT.

4.5.3
Clinical versus leadership roles

An issue raised above by the MD/AMD interviews and confirmed by a number of the chairs is the challenge of continuing clinical practice whilst in an MD role.

The lack of adequate leadership training and discomfort with the leadership role exacerbates the need to hold on to as much clinical practice as possible. The segregation of clinical and leadership practice turns off all but the most confident. Medics want and need to keep clinically up to date, both for themselves and their career – it is where their passion and expertise lies, what bolsters their confidence, and keeps doors open post-MD.

> " If I look at the chief medical officer, it's an unusual role and a very difficult one because basically, if you take it on you're 'going over to the dark side' as far as your colleagues are concerned. M.MH.FT. "

Chairs liked to encourage internal appointments, but realised that this could bring additional challenges to leading those who were previously peers. In discussing an internal promotion of a candidate, one chair acknowledged this:

"… she's extremely good and extremely enthusiastic. But it's quite interesting for medical directors, obviously she'd been an assistant medical director but, actually, in that role she's mainly been doing her own clinical work. And then pitching into what is really a 90 per cent managerial role at the very top level, to try and organise her peers, who are a herd of cats, so to speak, is a tremendously difficult step. However, she's doing very well."
M.Acute.FT.

There appears to be no fixed rule about how much clinical work an MD can/should do, and perhaps clearer guidance would help.

"A lot of it is driven by the individuals themselves and the agreements they have with the chief executive… I think that makes a big difference to them… so they've still got their hands on, they've still got their expertise in those areas. What it does do is put a huge amount of pressure on the leadership position that they've got and how much time they can devote to that… It's difficult, but we recognise it has real value for them and for us that they are practising clinicians right now as well as being in leadership roles."
M.Acute.FT.

4.5.4
Job shares and crafting the role

As there is no set way of combining the clinical and leadership aspects of the role, this actually allows flexibility for job crafting between the CEO, the chair and the prospective MD. Research shows that job crafting has positive benefits in terms of engagement and ownership[36]. Chairs described growing internal candidates into the role, through project-based work that gave candidates a taster of what it could be like. In addition, they described two main approaches to crafting the roles: job sharing and creating deputy roles.

"How do you tap into women who have got a wealth of experience and knowledge through the working NHS and actually give them the opportunity to take on wider things? Not necessarily to jump into formal management responsibility, which sometimes for very good reasons people don't want to do, but actually take on project work or particular areas on because that can actually help. People manage the transition into senior roles because they've taken on something that is very significant without having to take all the baggage and the administration that comes along with formal management roles."
M.MH.FT.

There was some discussion amongst chairs that the responsibilities of the MD role have increased over the years, with greater board governance and with the amalgamation of smaller trusts into much larger ones. Therefore, one sensible way to craft and support the MD role is the creation of deputy MD roles, which allows the MD to retain a fractional clinical role, whilst also enabling time for leadership duties.

"So we've created two deputy roles here, one for mental health, one for general health, and appointed two people to be deputy medical directors... One we brought in from the outside, one home grown... It also gives space to the medical director to do more in that very senior role.
M.Acute.FT.

Despite a belief amongst some of the AMD/MD interviewees that job share at this level was not possible, several of the chairs interviewed either currently have or had in the past an MD doing a job share. A number of chairs did say they had clinical directors, assistant/associate MD who were female who did not apply for internal MD roles and felt the reason may be not wanting to disconnect with the clinical role. Job share possibilities would make this much more attractive for those women and men who did not want to give up the clinical aspects.

"We had a job share as a medical director, a woman and a man... It worked for a long time. It was there for six years... It's what they chose to do and it was their proposal. They did different things as medical directors and they had skills that were complementary and both of them wanted to continue doing clinical work so it was a good solution and it worked really well, until [female name] got a national role and left"
F.MH.NHST.

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36 Walsh, Fleming & Enz, (2016), Give and you shall receive: Investing in the careers of professional women, Career Development International, **21** (2), pp193-211.

> "It would be good to see some more women job shares at senior level. I had two friends actually who did it as chief execs. Where it works well the organisation really benefits.
> AMD.MH.FT.

"These are really big roles... We had a male/female CMO job share... we should be looking at job shares more. My sense is that probably it's quite hard to do some job shares. People have done chief executive jobs shares in the past. It's hard work for the people, but it can be done very well."
M.MH.FT.

"At my other trust, we've got a joint medical director; one is a woman and one is a man. It works brilliantly. I mean, I just can't tell you how well that works. So, their skills are completely complementary. So, they've been able to, kind of, share the tasks between them … one does all the quality stuff, and one does all the efficiency performance stuff… When we were filling the post, we tried to head-hunt both of them onto our shortlist and neither of them was interested. And I think, that they're both physicians that still love doing physician-ing And the joint post enables them… they've got the job of their dreams really!"
F.Acute.FT

CASE STUDY 6 – APPOINTMENT PROCESS: GETTING THE BEST OUT OF CANDIDATES
North Middlesex University Hospital NHS Trust: 31 per cent female, 38 per cent BME

Cedi Frederick, chair of North Middlesex University Hospital NHS Trust, is no stranger to feeling like the 'token' candidate. As one of just 11 BME chairs across NHS England trusts, when he was initially contacted by head-hunters regarding the role: **"I immediately responded, 'Thanks, but no thanks.'...I genuinely believed they would not appoint a BME chair."** Luckily, the head-hunters persisted and were able to prove to Cedi that they had done their research on his executive and non-executive experience, knowing his reputation as someone able to deliver change and change cultures. They were able to persuade Cedi that his experience made him a very credible candidate.

"I think it starts with the head-hunters' approach...applicants from a BME background or women, a lot of them will carry all the negativity of their careers and their paths into that process, and perhaps they will go into that process lacking... perhaps not truly believing that they are a credible applicant... they have a little less belief in the process... and often, the systems we use do nothing to alleviate those concerns that people have."

Next, he ensures the interview panel are diverse. **"I've been asked the question: 'Why is it so important to have diverse panels?' So if you are a woman and you walk into a NED interview and the panel are all men, I think subconsciously, before you even open your mouth, you're gonna feel slightly disconnected. It's very difficult to have the empathy and the rapport that allows you to give your best in that process."**

He mentioned the importance of challenging colleagues: **"So asking 'So why didn't you think she was as good as the other candidate?' Asking that 'why' question can sometimes just spark a different conversation. It's not about being judgemental, it is about rapport. When you walk into an interview, it's about those first seven seconds, or whatever it may be, of connectivity."** He recalled an example where, as an independent panel member, he challenged his colleagues: **"Because the whole atmosphere in the room was very different from the first candidate, who was male, in terms of asking follow-on questions. The person really struggled to answer a question, so they were prompted.**

The next candidate was a female and the questions were short, sharp... I think the whole thing probably took twenty minutes less than the first interview, and I said to the panel, did they notice, and they genuinely looked nonplussed – 'Notice what?'... ' how you supported the first candidate to give the most fulsome answer he could, whilst you only accepted the first part of the answer that the second candidate gave, when you knew that she probably was struggling just to marshal her thoughts, and if you'd said to her, 'What about...?' she would have said, 'Oh, of course,' and carried on."

On paper it was a fair process, both candidates were asked the same questions, but: **"Subconsciously, they had just put the first candidate at his ease and the second candidate was obviously tense, obviously nervous... and no doubt the feedback to her would have been, 'Well, we're really sorry, but the other candidates were better.' Well, actually we didn't get the best out of this candidate."**

SECTION 5:
WOMEN'S SENIOR CAREERS IN NHS FINANCE

In this section we consider another board role identified in our previous report as having a very low proportion of women – the chief finance officer (CFO). In 2017, despite two thirds of the NHS finance workforce being female, just 26.3 per cent of CFO posts were filled by women. In this year's report this figure has declined further to 25.4 per cent. This represents just 53 women across England.

Why do fewer women than men make board level in NHS finance?

To explore this question, between December 2019 and January 2020 we interviewed 20 women working in senior finance roles across all regions of England. They came from three mental health foundation trusts (MH.FT), 13 acute foundation and NHS trusts (Acute.FT; Acute.NHST), two acute and community trust (A&C), and two CCGs. Twelve of the 20 currently operate at board level, with chief financial officer or director of finance titles. The remaining eight were heads of finance functions or deputy/assistant CFOs (ACFO). One of the 20 interviewees self-identified as BME. We asked about their career journeys, barriers and enablers, aspirations for the future and reflections on why fewer women make it to CFO level within the NHS. Interviews lasted approximately an hour, were recorded and transcribed verbatim, with the participants' permission.

All interviewees were deeply committed to the NHS as an institution, positive about the opportunities finance had offered them and the support they had received from colleagues. However, there are some cultural and structural barriers, highlighted below. We also consider potential solutions to these, as suggested by participants themselves.

> "With the CFO and CMO roles, culturally we must be doing something that discourages them."
> Chair F.Acute.FT.

5.1:
The ideal working pattern: long hours, limited flexibility

NHS finance was typically discussed as having a long-hours culture, compounded by a political culture of short-termism. Interviewees described organisations' attachment to a working pattern favouring presenteeism and demanding flexibility, which is not dissimilar to large finance organisations in other sectors[37]. For many women, the biggest challenge was then balancing work with caring responsibilities, such as children, partners or parents.

> "I think we haven't broken the reality of the expectations that you work long hours and that you're committed, body, mind and soul, to the job - that culture still exists."
> CFO.Acute.FT

Being able to take time out to meet non-work needs was not always easily achieved. Sometimes, this was framed as a personal choice and indeed many women who had succeeded to board level had partners or parents who took on childcare. Some had chosen not to have children. However, framing this as choice places the burden of flexibility entirely on the individual and fails to acknowledge the restrictive systemic practices[38]. Many felt demands of complete flexibility were one-sided, and there was limited flexibility from their employer. However, as non-clinical workers emerge from the COVID-19 lockdown, organisations and workers in all sectors and industries are re-thinking what 'normal' working patterns and modes may be in the future.

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[37] Atena & Tiron-Tudor (2020), Gender as a dimension of inequality in accounting organizations and developmental HR strategies, Administrative Sciences, **10**, pp1-24.

[38] Gronlund & Oun, 2018, In search of family-friendly careers? Professional strategies, work conditions and gender differences in work-family conflict, Community Work & Family, **21** (1), pp87-105.

"I've had those moments where I've felt you've got to be this completely flexible person but it's very difficult to be that completely flexible person when you've got children and a life outside."
CFO.MH.FT

"My second child had chicken pox and I'd only needed to take one day off in the whole thing of her having chicken pox. I would take it as annual leave and no problem. I got a roasting by email that I was going to miss the Friday meeting, because it was a core part of my role and I needed to be there in the organisation."
ACFO.A&C.NHST.

You don't see job shares at my level. You don't see a lot of flexibility. Part of my role is about being present.
CFO.A&C.NHST.

5.1.1
Enabling flexibility

The lack of flexibility in NHS finance may be due to the perceived need to be present to be accountable; the 24/7 business of caring and a legacy of 20th century (male-dominated) ways of working. However, there was a will to change it and several of the female CFOs were already thinking about how to facilitate this. Research in other professional contexts reveals that women refute the enforced choice of being either career oriented or family oriented[39]. Strategic career crafting demonstrates the possibility of integrating, nurturing and succeeding in their multiple selves[40]. Some were role-modelling different ways of working, consulting their teams on new ways of working and challenging the culture of presenteeism. The experience of lockdown and the slow recovery from COVID-19 is inevitably going to impact on ways of working going forward.

We found one example of a job share performed at a senior level, suggesting that sharing ideas across trusts would help facilitate confidence in creating more flexibility:

It's getting the culture that flexible working's okay and, actually, what we're judging people on is outcomes, not in terms of input.
CFO.Acute.FT.

"Are there other ways of delivering though that aren't just one individual? Can you have shared responsibilities? That's the sort of thing that I think would really need to happen to help women get that experience at that senior level before they then take that director of finance leap."
CFO.Acute.NHST.

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[39] Walsh (2012), Not worth the sacrifice? Women's aspirations and career progression in law firms, Gender Work & Organization, **19**(5), pp.508-531.
[40] Vidwans & Du Plessis (2020), Crafting careers in accounting: Redefining gendered selves, Pacific Accounting Review, **32** (1), pp32-53.

5.2:
The ideal career journey:
right place, right time

A related but more implicit challenge was the way in which an ideal career pattern was discussed. Finance careers in the NHS were seen as transparent and clearly structured. Positions are clearly banded and pay evaluated in an open way. However, this straightforward, linear progression framed some particular challenges for those with caring responsibilities, most often women.

One challenge was the need to be mobile, to gain the right experience and exposure. This was particularly at an advanced level, with the perception that internal promotion was not possible. Being mobile was seen to indicate ambition. This has become harder with the move towards fewer, larger organisations:

> It's very rare to move within a trust up to the role… I think sometimes it's because you do have to command so much respect, and control is probably the word.
> ACFO.Acute.FT.

One CFO recounted her disappointment from a conversation with a male board member who had offered to discuss career options with her (male) deputy. Her deputy's ambition was dismissed because he was not prepared to be as mobile as the board member thought he should be.

> "[Board member] **said, 'Oh, the thing is he's not as ambitious as I thought he was… because he wasn't prepared to move outside an hour's travel time'… I just thought I'm so disappointed… you're missing the point."**
> CFO.Acute.FT.

This perceived need to be mobile, whilst a challenge for everyone, was particularly so for those with families to care for. The boundary around moving (long commutes or relocation) was often a red line for many women, particularly those in dual-career families:

> **"It also impacts for women, though, particularly, because if the opportunities are less within your catchment area and you're having to think about commuting further to get that experience and get that job, that's really difficult when you've got a young family."**
> CFO.Acute.FT.

Also mentioned was the difficulty for women of sticking to a linear career structure that clashed with their own biology. For example, having children or the menopause. Some felt they had to 'cram their career in,' whilst others believed that it may now be too late:

> I needed to almost get to a certain level, to then feel I was safe having a baby and it wouldn't hamper my onward progress.
> CFO.Acute.NHST.

"That whole menopause thing also makes you just feel you're too old to do it now. Do I want to do this? My brain doesn't work, I'm too fuzzy, here come the bright young things, they can do it, it's that kind of thing."
ACFO.Acute.FT.

This was compounded by a sense that by not pursuing a quick and upwards progression, they were somehow signalling they were less ambitious. This suggests a very old-fashioned fixation with a masculine 'up-or-out'-type career model. Research in other sectors suggests that this 'tournament career model' results in less than optimal talent management [41]

"The feedback was it didn't look like, from my CV, that I was committed enough to be the finance director. Now, I'd not written on the CV that in my last five years I've been on maternity leave for nine months... but I thought that was fascinating, how long you're a deputy determines whether you're ambitious enough."
CFO.Acute.FT.

> I wonder, because I stepped away from it when it got really difficult [balancing my non-work life], I wonder if actually, at a later point in time, that will be something that then stops me from stepping forward.
> ACFO.A&C.NHST.

'The ability to manage careers more effectively, flexibly and equally must also be expected to improve opportunities for professional development, productivity and the quality of care. The NHS is suffering from an acute shortage of doctors, and we cannot afford to waste so much of the knowledge, skills and talents of our dedicated and committed workforce'
(Dacre & Woodhams, forthcoming [42])

[41] Martell, Emrich, Robison-Cox (2012), From bias to exclusion: A multilevel emergent theory of gender segregation in organizations, Research in Organizational Behaviour, **32**, pp137-162.
[42] Dacre & Woodhams. (forthcoming), Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England. Department of Health and Social Care.

5.2.1
Supporting women's career paths

Some more progressive CFOs were opening up the conversation about 'different ways of getting there' and challenging the idea that quick succession and geographical mobility are the only ways to show ambition. Some also suggested a more structured and strategic approach across trusts would help women gain valued experience.

"Also for women to be confident enough to say, 'do you know what? I'm going to stay at this level for another 12 months because, actually, it's really tough at the moment, my kids are really little.' But whilst I'm going to do that, what else, exposure, could I get to other things that would allow me to get interesting experience without having to take on more responsibility?"
CFO.Acute.NHST.

"I was on an aspiring finance directors' course about two years ago now and it was a really good course. Whole thing was meant to springboard you to an FD role, but they didn't at the end of it go: 'Ok now we've got 20 FD-ready people – where we going to put them? Can we offer secondments here? Can we do this? Can we offer that?' [What would help is] a really good development programme that was like: 'okay, right here with the skills you need. This is the mentor and actually here's your career progression sketched out, so what we've done is we've worked out all these ways where somebody else can do a secondment there."
ACFO.Acute.FT.

5.3:
Transition to CFO: tough at the top

A further challenge discussed by participants was the transition to becoming a CFO. Many noted it was a qualitative leap from previous roles in terms of the skills required (less technical and more leadership); focus (less accounting and more the whole organisation); and responsibility (the buck stops with them).

"The director…is the one that then when it all goes wrong, gets hauled off to the regional office or in terms of the NHS wider regulation, is the one who deals with the consequences of regulatory action against the trust, so it is different."
CFO.Acute.FT.

For some this was a fantastic step and they clearly relished it. And indeed, most participants were ambitious to have the influence that the role conferred. However, it is worth noting the difficulties some had experienced in making this transition. They talked about feeling isolated, not adequately prepared for their responsibility, and stressed. There appeared to be a lack of formal support for new CFOs:

"I basically didn't sleep for the rest of the year. I found it really hard. I definitely felt it was all on my shoulders. I didn't necessarily know where to go to for support, although the people in my organisation in the governing body were very supportive of me. Yes, it was really, really tough."
CFO.CCG.

> **It was like a baptism of fire… the time was hell you know we were working 'til midnight, didn't know what was coming.**
> CFO.MH.FT.

The ways in which these 'big and hard roles' are presented was sometimes seen as a potential disincentive to aspirants. Whilst our participants were keen to be challenged, develop their skills and make a difference, the fear of failing unsupported, of not being ready, combined with the perception of long hours, made some reticent:

"The last thing you really want to do is go to a really challenged organisation. You could be the best person in the world but you still can't turn it round, but then that's what sticks with you because everyone goes, 'oh she was there when this happened.' It is very much, especially the higher up in the NHS you get, it's very much on word of mouth and reputation and what you have delivered. It is quite hard and it can be quite relentless."
ACFO.Acute.FT.

"The scary headlines and things like corporate manslaughter and it puts the frighteners on people in terms of applying for roles."
CFO.MH.FT.

The role of CFO then presents something of a big transition. This is further exaggerated by the fact that there are fewer smaller trusts around to 'cut your teeth in' and perceptions of limited scaffolding or formal support once you are in those big roles.

"I think fundamentally one of the bigger problems is those nicer jobs or those baby jobs, those first CFO jobs are just not around anymore. So, you're almost set up to fail by taking one of the bigger ones before and people are just saying actually it's just not worth it."
ACFO.Acute.FT.

5.3.1
Scaffolding transition

For all the current CFOs, the one thing that helped with this transition was having a good network. This made them feel less isolated and more secure in asking for support. Some suggested the need to make this more formal; some talked about finding roles that would enable them to learn as a new CFO; and others mentioned putting structures and processes in place to help aspirant CFOs feel more prepared for the identity transition[43]. This is often called scaffolding – an external support system.

> So I think currently it's done informally, but I think there's a way that we could help people, by being more structured. I was thinking things like women's networks, finance director networks.
> CFO.Acute.NHST.

Interviewer: What would make you make that decision and make that leap because you say you're thinking about it the moment?

Respondent: I think for me it would need to be going into the right organisation, and by right organisation I mean two things: one that's not too challenging – you learn the skillset whilst doing it in a slightly safer environment, but also what I've realised now is it is really about, especially at this level, do you fit with the organisation and does the organisation fit with how you do things?
ACFO.Acute.FT.

> We've been running shadow board programmes, so for the next-in-line deputy directors and you know even the low deputy directors you know where people are really keen, where they've got talent, where t hey are the stars of the future.
> CFO.MH.FT.

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43 Ibarra & Barbalescu (2010), Identity as narrative: Prevalence, effectiveness, and consequences of narrative identity work in macro work role transitions, Academy of Management Review, **35** (1), pp135-154.

5.4:
The ideal candidate: toughness at the top?

Related to the above were the qualities seen as important to be a good CFO. The nature of the role demands a certain toughness, an ability to answer difficult questions from regulators and also to influence clinicians. Historically, the way in which this was done was described as 'competitive,' 'command and control,' 'adversarial,' an approach some suggested more typical of, and comfortable for, men.

"I think the way that the NHS has been set up in this commissioner/provider split has driven quite adversarial relationships between people and the focus of that is in the director of finance role, so everything escalates to directors of finance... I think sometimes women are less comfortable in that space than men might be, that sort of conflict."
CFO.CCG.

However, there was recognition of an increasing trend towards more collaborative approaches, influencing others through empathy rather than telling them what to do. This reflected the approach advocated by the HMFA's, Future-Focused Finance, and was seen to be 'a more female way' of operating.

"Future-focused finance has really been looking at what is the culture of finance, how do we develop really great leaders?... I think the nature of it means that it attracts females because it's a bit softer and it's got some fluffier relational aspects to it that I think make females particularly feel valued because it's about building teams."
CFO.MH.FT.

The gendering of these approaches does not necessarily reflect inherent biologically based differences. Participants were aware that male and female behaviours can be learnt through socialisation. What is more implicit is how certain situations might favour a certain way of doing things and who this benefits. Hence, being confident, talking oneself up and pretending to know things one does not, might be of particular benefit in going for jobs, interviews and difficult meetings, but are typically seen as male[44].

" I sit in meetings and I see men and I think I know you've absolutely no idea what you're talking about but say it with confidence such that... they almost blag it "
CFO.MH.FT.

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[44] Women in Whitehall: Culture, leadership, talent (2014), Cabinet Office & HayGroup, London.

5.4:
The ideal candidate:
toughness at the top? continued

As decades of research has shown, if women do display those more masculine behaviours, this is not considered positively and women are often actively penalised for it[45]

> Being seen to be ambitious actually wasn't always a positive thing. I think actually people were disparaging to me more because I was female. You know, that kind of description of being a bit of a ball breaker because you want to get where you want to go. Actually I'm not, I just want to progress.
> CFO.Acute.NHST.

Conversely, not knowing all the answers and showing humility were seen to be potentially of greater benefit in a more integrated and collaborative environment and were seen to be typically more female. A number of our chairs commented on the fact these more feminine approaches were readily seen by men and women in more diverse and inclusive cultures. They also suggested this was the leadership style required going forward in more integrated care systems and partnership models[46].

[45] Heilman & Okimoto (2007), Why are women penalized for success at male tasks? The implied communality deficit, Journal of Applied Psychology, **92** (1), pp81-92.

[46] Bolden, Adelaine, Warren, Gulati, Conley & Jarvis (2017), Inclusion: The DNA of leadership and change, NHS Leadership Academy. [https://www.leadershipacademy.nhs.uk/wp-content/uploads/dlm_uploads/2019/06/BLFI-Literature-review-Clear-Print-Version.pdf]

"If you think about the discussions about the sort of collaboration that we need now, if we're going to be really transparent of how we deliver care, it requires you to really be prepared to empathise, to really actively listen to other people and I think some of those are skills that are potentially more evident in women sometimes than men. It's something about having that humility, that you don't necessarily have all the answers... it's a huge generalisation but I do think that maybe women... potentially find some of that easier sometimes than men do."
CFO.CCG.

5.4.1
Challenging assumptions

Findings from the interviews do not suggest there is a right/wrong, or male/female way to be a good CFO. Rather they highlight that a number of qualities are shaped by broader societal assumptions as well as NHS contexts and specific cultures. It is important for leaders to reflect on these, and attempt to disentangle the person, the behaviour and the context. Hence it may be valid for both men and women to learn how to demonstrate confidence, and a willingness to admit doubt, but the more salient skill is knowing when to apply these. As highlighted in the chair interviews, it is particularly important to reflect on one's own assumptions when making recruitment decisions, judging behaviours and planning development courses.

More challenging is to change the culture at the very top. The political context means that whilst there is a trend towards collaboration there may well be a tension between what is said and what is practised. This was also echoed in some of the chair interviews:

"**The sort of feedback that you get is whether you'll be strong enough and that's interesting in that there's a spoken set of leadership qualities that the NHS says it wants and then there's the reality of what they seem to want when you're actually presenting yourself. The spoken set of characteristics and leadership qualities... and yet when you go into that process, that's not necessarily what people are looking for."** CFO.CCG.

" That relationship with the regulators is in itself quite demanding and can be quite adversarial, so I think definitely, if you were wanting to get people to feel more comfortable in senior roles in finance in the NHS then I think you need to improve that demanding culture coming down. CFO.CCG. "

These findings highlight the importance of an organisation purposefully setting its leadership culture and then actively managing that throughout the organisation.

'Every organisation has embedded unconscious assumptions about leaders and leadership... As these assumptions shape the way organisational members perceive, act and evaluate leadership... renewing the organisation's leadership concept is the most important role of leadership development initiatives (Turnbull James, 2011[47])

[47] Turnbull James (2011) Leadership in context Lessons from new leadership theory and current leadership development practice, The King's Fund

CASE STUDY 7 – CHAIRS LEADING CHANGE
Black Country Partnership NHS Foundation Trust: 55 per cent female, 45 per cent BME

Within his trust, Jeremy Vanes, chair of Black Country Partnership NHS Foundation Trust, is very conscious of making positive change through **"really, really paying attention to the data and listening to the stories,"** in his trust.

Driving change, he refuses to accept the 'just give it time' myth, giving examples from the US Navy to West Midlands firefighter schemes, where women are now equally represented. The chair accepted that there are regional differences in 'non-traditional leadership,' challenging the NHS not just to talk about averages and to gain more nuanced understanding of the data. Like others, he has experienced working in cities with public services led by women and BME individuals, but: **"Into the counties, knowledge and awareness drops off very quickly...it's like nothing's happened for 100 years...people just talk down at you and exclude you."** However, he refuses to accept this as an excuse for lack of change, particularly around board appointments. Speaking to a head-hunter, Jeremy recalls: **"I remember him saying 'We just don't get candidates from certain communities.' I said 'This call has just ended, I get them.' You just have to put yourself in contact with communities. I can't think of any community up and down the country that would not want to be involved with the NHS."** In talking about increasing the gender and ethnic balance on his boards, he said: **"There were no special initiatives. We just found really good people who had never been asked before."**

Where change is not forthcoming, responsibility lies with leadership. This chair suggested interventions such as at CQC well-led assessment level, as well as the appointment and training of trust chairs.

"The evidence base is just so heavy now. We've tried to do this politely for four years with damning evidence, somehow many organisations seem to have evaded it. Some of the better organisations have got better but others just haven't moved or have gone backwards."

A lack of progress should not be accepted at leadership level: **"Nothing is going to change if we've had four years of talking about these issues at the top and you haven't even got to first base... This needs to be driven more forcefully by the well-led conversation...there needs to be a test and I'd be very happy to trial, see if I can pass myself...we need to make these tests a bit harder, we really do, because you can see by some of these issues are actually going backwards."**

Understanding of diversity should feature strongly in the appointment process of chairs, with possible training and support given where required: **"They will have talent in different areas that we need, so let's be inclusive, but if there's a completely empty box, we need to do something to help people understand. Some people have been able to float up through decades without having to confront or understand any of these issues. ... I do think people need a chance. If they're not willing to take the chance then I think we have to be stronger and say: 'I'm not sure you're fit for purpose here.' You know you're in an organisation that's 80 per cent female workforce and you don't seem to be able to articulate anything about that or don't have conversations where you understand the significance of that and disability, mental health, the other issues that are really important to demonstrate to these organisations are good or better than public services. Health to me is not transactional. It is by definition transformative every single hour. If you can't demonstrate you understand that then you're not the leader we need, really."**

SECTION 6:
CONCLUSION AND RECOMMENDATIONS

The four main sections of this report (board data, and interviews with chairs, medical directors and chief finance officers) all contribute to our knowledge base of boardroom composition and processes, across NHS boards. In addition, they have helped uncover or confirm some key barriers to women's progression to board-level roles in finance and medicine. The aim is to highlight required behavioural responses going forward – the **how, what and why of achieving boardroom diversity.**

The board data reveals an overall increase in women's representation on NHS trust boards in 2020, across England to 44.7 per cent, with data from 213 boards ranging from 15.4 per cent to 77.8 per cent. Using the European Commission's definition of gender balance of 40 to 60 per cent of each sex represented, 115 of the 213 trusts (54 per cent) are within this target. It also reveals an overall representation of assumed BME ethnicity of 8.9 per cent. Boards' ethnicity representation ranged from 0 per cent to 46.7 per cent, recognising that there are significant regional differences within that figure. **There remain 70 entirely white boards.**

Across the 13 ALBs, the percentage of female directors ranged from 18.2 per cent to 66.7 per cent, with an average figure of 39.9 per cent. This figure has hardly moved since 2017 (38.3 per cent). For BME directors these figures ranged from 0 per cent, in six of the 13, to 30 per cent (NHS Digital), with an average of 10.5 per cent.

The proportion of female non-executive directors has increased, but across the NHS it is still not sufficiently gender balanced, with no obvious supply explanation. Interviews with chairs provide specific suggestions of best practice in how to actively diversify their boards for gender and ethnicity. This information will feed into the NHS Confederation taskforce.

In terms of gender representation, compared to community and mental health trusts, **the boards of acute and ambulance trusts are significantly behind in their figures.**

Overall, executive directors are gender balanced. This figure, however, is skewed by the over-representation of women in nursing, with 89 per cent of chief nursing officer roles being held by women. There are specific executive roles that are gender balanced, for example CEO and COO. However, as was the case in 2017, chief finance officer and medical director roles have poor female representation despite majority female workforces (CFO decreased to 25.3 per cent, MD increased to 29.0 per cent). Interviews with women currently in and aspiring to these roles provide some reflection and useful insights regarding perceptions of barriers and ideas regarding solutions to making these goals more realistically attainable. Trusts across England should aim to bring on 40 more female medical directors and 50 more female CFOs.

As mentioned in the forthcoming report on the gender pay gap in medicine[48], the system of medical careers was not designed for the needs of women. Given that the majority of medical school graduates have been female for more than 25 years, these systemic issues have been predictable for a generation and are not going to fix themselves. Evidence shows[49] that highly career-oriented women, whether or not they have children, are also highly committed to non-work spheres, and that assumptions about women being either family-oriented or career-oriented present a false dichotomy.

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48 Walsh (2012), Not worth the sacrifice? Women's aspirations and career progression in law firms, Gender Work & Organization, **19**(5), pp.508-531.
49 Dacre & Woodhams. (forthcoming). Mend the Gap: The Gender Pay Gap in Medicine Review. Department of Health and Social Care.

Overall, findings from the chair interviews, the highlighted case studies, and evidence external to the NHS, such as the United Nations, demonstrates that **clear intent, backed up by purposeful action and determination can successfully bring about requisite change.** Time and again, both through our own research and that of several others cited in this report, we see that **accurate and accessible diversity data is a critical first step to change.** The necessity of **system-wide proactive talent management is raised throughout all groups of interviewees.** There is currently no clear career path for doctors into leadership, and limited access or funding to leadership development training, which takes them away from the front line. Prior research reveals that unclear career paths tend to reinforce unfair advantages for men. This need for system-wide proactive talent management is similarly a strong recommendation in the forthcoming gender pay gap report[50], considering very different sets of data across the NHS, yet coming to several similar conclusions. Both sets of findings also concur with the Interim NHS People Plan 2019:

'To ensure we have effective leadership at all levels requires a more deliberate approach to talent management: identifying, assessing, developing and deploying individuals with the capacity and capability to make a difference in the most senior positions. We must support and encourage our best leaders to take on the most difficult roles, and we must create a pipeline of clinical and non-clinical talent ready to take on senior leadership positions in future. There is growing evidence that the best healthcare systems have strong clinical leadership at their heart – we need to make it easier for clinicians to pursue a career in management and leadership by building more structured career paths into such roles. Successful talent management is underpinned by collaboration, matching talent to service need, rather than competition'[51].

Whilst increasing diversity is having the different voices and perspectives present, inclusion is when those voices are fully heard. This again requires purposeful shifts in culture and leadership. Several of the chairs in this study have taken great strides towards inclusive cultures at their board level, and are also starting to embed that inclusion throughout their organisation. As cultures become more inclusive, women and minority groups become more attracted to leadership positions. Many initiatives throughout NHS organisations have endeavoured to increase inclusivity but this is extremely challenging if it is not led and role modelled from the top. The chairs in our study also demonstrate that whilst clear direction from the national leadership is important, change at a local level is very much within the gift of individual chairs.

50 Dacre & Woodhams. (forthcoming), Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England. Department of Health and Social Care.
51 Interim NHS People Plan 2019

Recommendations:

> **Knowing what must be done does away with fear.**
> Rosa Parks.

National level

1. The provision and use of data - Diversity data (at a minimum on gender and ethnicity) on boards and senior management (defined as direct reports to the chief executive and other board directors) **should be monitored, reported and made accessible**. In addition, anonymised diversity data on the director appointment process, including applications, shortlists, offers and acceptances, should be made transparent. The data should be held by NHS England and NHS Improvement (NHSEI) and updated annually (see section 2).

2. Implement a national equality scheme - A scheme similar to the Athena SWAN programme in higher education institutions should be introduced across all NHS organisations (see section 4.4). This is also a recommendation from the gender pay gap report.

3. Diverse and compassionate leadership for integrated care systems - Work must continue on developing appropriate collaborative leadership styles to take the NHS forward into successful system working as ICSs are established by April 2021. The lessons about appointment processes distilled from the interviews with chairs should be mandated by NHSEI and the independent chairs to form the basis of recruitment to all ICS leadership structures (see section 3.9).

4. Accountability - The well-led framework and CQC inspections should include specific reviews of board appointment processes with reference to whether and how chairs have considered and acted to improve diversity by protected characteristic (see section 3.8). In relation to gender diversity, particular attention should be paid to non-executive, CFO and MD appointments and talent management plans (see section 3.5).

Chair and board directors (of ALBs and trusts)

5. Diversity must become core business for all NHS boards - Diversity data, for example current figures, appointment and retention data, should be a regular part of board information. Any initiatives should have levels of success measured and reported on, as with any other change programme. Directors should be accountable.

6. Strategic inclusivity - Every board member should be able to explain their understanding of the importance of diversity, and what they are doing to improve inclusion within their own board and organisation. Boards need to move beyond a tactical approach of compliance to one of strategic inclusivity.

7. Managing boardroom dynamics - Chairs should ensure boards have the psychological safety that allows difficult conversations. Chairs must demonstrate inclusivity and cultural competence as the culture will be set by their behaviours.

8. Board appointments - Chairs should have explicit objectives, relevant to their organisation, to ensure board diversity (see section 3.5). There should be clear succession plans for CFO and MD roles.

9. Lift as you climb - There should be a proactive approach from board members to develop and encourage the development of leaders from diverse backgrounds at mid and senior levels (see section 3.5).

10. Making the unknown accessible - Emerging leaders at mid and senior levels should be given the opportunity to experience board-level working, for example through shadowing or observing an existing director, and/or joining board-level projects before deciding whether to aim towards the role. This is particularly important for aspiring MDs and CFOs from diverse backgrounds. In some circumstances it may be appropriate to create intermediate deputy or associate director roles in order to offer experience of board-level working ahead of a full board appointment (see sections 3.5, 4 & 5).

11. Scaffold the transition - New and aspirant directors should be encouraged to develop networks within and outside of their current organisation, for example, through their professional body (see sections 3.5, 4 & 5).

> " As you grow older you will discover that you have two hands: one for helping yourself and one for helping others.
> Maya Angelou. "

Talent management for the 21st century

12. Challenge leadership stereotypes and advocate new leadership styles - Chairs and other board members should explicitly challenge assumptions that stereotype leadership and its characteristics as masculine, or white, advocating more inclusive and collaborative styles.

13. System-wide proactive talent management - The talent management approaches being put in place across regions should explicitly address the deficit in diversity in MD and CFO roles. All NHSEI-funded or commissioned programmes, including third party provided programmes, management training schemes and fellowships, should explicitly publish their participant composition by gender and ethnicity, with a commitment to 50:50 gender diversity.

14. Encouraging differing career paths - Talent management programmes should explicitly recognise that rapid linear progression and geographical mobility are not the only indicators of ambition to senior roles. This is particularly relevant for potential CFO roles. A more structured and strategic approach across trusts would help women and leaders from diverse backgrounds gain valued experience.

15. Enable greater flexibility - Organisations should ensure that flexible working practices are in place to enable a range of work patterns, and that this is actively supported and role-modelled by the most senior leaders. Presenteeism should be explicitly discouraged. This is also a recommendation from the gender pay gap report.

16. Job shares - All roles including board-level roles should be explicitly open to candidates who wish to job share. Job sharing should be seen as a legitimate and viable way of working, with appropriate systems and policies to enable and promote it. This is also a recommendation from the gender pay gap report.

To access an executive summary of this report **click here.**

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  and providing a better service for all.**

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