



Women in clinical commissioning leadership

A case for change

Despite increasing numbers of women in the NHS and wider health sector, representation at senior leadership level remains low. Historically, arguments in favour of greater equality have focused on fairness, however, there is now clear evidence which shows that organisations with women on their board outperform those without, especially in two key areas; financial performance and organisational excellence.

NHS Clinical Commissioners (NHSCC) and its membership believe that gender inequality must be urgently addressed in order to realise these benefits for CCGs. This briefing outlines the scale of the problem of gender imbalance within clinical leadership in the NHS and recommends a series of next steps to address this for CCGs, NHSCC and NHS England, as well as the wider health system.

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Introduction

It is widely accepted that diversity in the NHS is to be encouraged.¹ As far back as 1999, the Department of Health created an NHS Equality and Diversity Council.² Most organisations have equality and diversity leads,³ and NHS England speaks of its central commitment as being “high-quality care for all”.⁴

So firm is the belief in the virtues of diversity in healthcare that the need for it is enshrined in legislation. The Equality Act 2010 includes a specific equality duty for public sector organisations, requiring “due regard” to the need to advance equality of opportunity for all.⁵

The reality, however, is that when it comes to gender equality in the NHS there is still a long way to go.

At NHS Clinical Commissioners (NHSCC), we believe that this gender imbalance must be urgently addressed. This briefing outlines why change is so necessary and so urgent. It also explains what NHSCC, CCGs and NHS England can do to grow the number of women in clinical commissioning leadership.

Why does equality matter?

The sense that equality is positive is often rooted in a sense that ‘it is the right thing to do’. Surely it is only fair to ensure people are not discriminated against on the basis of their gender, sexual orientation or religious beliefs? The importance of ensuring the NHS represents the diverse communities it serves is also stressed.⁶

These arguments are right and proper. But the case for equal gender representation in our health service leadership goes beyond them. This is not just a moral issue. It is a performance issue. And it is one commissioners need to be taking seriously.

In 2007, management consultancy McKinsey published its first *Women Matter* report.⁷ Its conclusion: corporations with women on their boards perform better than those without. Statistically, significant research showed this to be the case on two separate metrics – financial performance, and organisational excellence.

The research also showed that performance significantly increased once a critical mass of female representation was reached: specifically, at least three women members out of ten on management committees.

This ‘rule of three’ is a contention which has been backed up by much subsequent research.⁸ There is no reason to believe it does not also apply in an NHS context. Yet we are often a long way from this magic number in healthcare organisations.

Efforts to improve gender balance

That is not for want of recent efforts to bring attention to the issue. These include specific attempts to increase female representation in clinical leadership, at both local and national levels:

- Since 1999, The King’s Fund has run the Athena programme that is “designed to support women to fulfil their potential as public sector leaders.”⁹
- In 2008, the British Medical Association (BMA) published *Women in Academic Medicine: Developing equality in governance and management for career progression*.¹⁰ The report noted that, while the number of women entering medical schools had greatly increased, “they remain under-represented in some crucial areas like surgery; the university medical sector and at senior levels throughout the whole profession”. The BMA subsequently established a Women in Academic Medicine Group.
- Also in 2008, the chief medical officer asked Baroness Deech to chair an independent National Working Group on Women in Medicine. The resulting report, *Women doctors: making a difference*, was published the following year. It highlighted that, while the number of women admitted to medical school had grown from 24.4 per cent of the total admissions in 1960/61 to 56.2 per cent of admissions in 2008/09, women remained under-represented in senior posts.¹¹
- That same year, the Royal College of Physicians commissioned and published *Women and Medicine: The Future*.¹²
- In 2012, the NHS Leadership Academy published a report authored by Dr Penny Newman – entitled *Releasing Potential: Women Doctors and Clinical Leadership*¹³ – as well as guidance on building diverse boards.¹⁴
- In 2013, *Health Service Journal (HSJ)* published its first list of the most inspirational women in healthcare.¹⁵ It also ran a survey, to which more than 1,000 people responded, on the opportunities for, and obstacles to, female leadership in healthcare.¹⁶
- At the beginning of 2014, a group of doctors at Sheffield Teaching Hospitals NHS Foundation Trust joined with academics from the University of Sheffield to create Sheffield Women in Medicine (SWIM).¹⁷ Among its aims: “To promote culture change within the healthcare system to achieve gender equality.”¹⁸
- Also in 2014, the Faculty of Medical Leadership and Management (FMLM) launched its Women, Leadership Action and Advocacy Group.¹⁹ In association with the NHS Leadership Academy, the FMLM had previously published a paper offering ‘top tips’ to support and develop female medical leaders.²⁰

- In December 2014, The King's Fund – in collaboration with the FMLM, BMA, Medical Women's Federation and the Royal College of Surgeons – held its Advancing Women in Medicine Summit.²¹
- In September 2015, HSJ and NHS Employers launched its Women Leaders Network. Among the stated aims: "to scrutinise and challenge bias against women on health and social care boards".²²
- Dr Penny Newman – in collaboration with UN Women – is currently preparing to publish a new paper entitled *NHS Women in Leadership: Plan for action*.²³

The Medical Women's Federation, meanwhile, has been promoting the personal and professional development of female doctors since as far back as 1879.²⁴

The scale of the problem

Despite all these efforts, the problem of lacking gender balance at senior levels of the NHS is still acute. It is the case that:

- 77 per cent of the total NHS workforce are women²⁵
- 47 per cent of all doctors practising in the NHS are female²⁶
- Of practising hospital and community doctors who qualified in the United Kingdom, 49 per cent are female²⁷

...and that:

- 70 per cent of the CCG workforce are women²⁸
- 52 per cent of GPs are female²⁹
- There has been a 46 per cent increase in the headcount of female GPs since 2004, while male headcount has decreased by 4.7 per cent.³⁰

Yet it is also the case that:

- 63 per cent of CCG governing members are male³¹
- 74 per cent of CCG GP leads (GPs who lead a particular workstream) are male³²
- 4 CCGs have no female members on their governing bodies³³
- Only 22 per cent of CCGs have three or more female GP leads³⁴
- 29 CCGs have no female GP leads at all.³⁵

When one considers the next generation of GPs, it is clear this sort of situation is simply unsustainable. Of GP registrars (those training to become GPs), a striking 68 per cent are female.³⁶

Diagnosing the problem

There are likely to be multiple and interlinked explanations for the lack of gender diversity in health leadership generally, and in CCG leadership specifically.

In September 2015, NHSCC and MSD held a roundtable discussion at which senior female clinicians in commissioning were invited to share their views on the obstacles. This discussion was supplemented by separate conversations with those from other organisations. Among the numerous issues identified were:

Unequal processes

It was felt that selection processes for some CCG clinical leadership positions may favour men. Specifically:

- The election process for clinical chair roles was felt to be less attractive to women than men.
- The requirement of some CCGs that all governing board members are GP partners. Only 42 per cent of these senior GPs are female.³⁷ Salaried GPs on the other hand – who constitute almost a quarter of the GP workforce³⁸ – are 71 per cent female.³⁹
- The portrayal of roles. It was felt that if the primary purpose of a role was advertised as being to secure financial savings, it was more likely to attract men. Talking of building collaborations and strong working relationships to increase efficiency might be more inclined to attract female applicants.

Lack of support

It was felt there was a real lack of support for potential female clinical leaders in CCGs. This includes, but is likely not limited to:

- A failure to spot, nurture and manage female talent. It was argued that potential female clinical leaders are not spotted early enough. Even if they are identified, a lack of role models, mentoring, leadership development and clarity on possible career routes stymie progression. It was felt many women have the belief that leadership roles are difficult and incompatible with family responsibilities and the responsibilities of practising medicine. Existing female leaders felt this was a mistaken perception, but that the lack of role models means it is a difficult misconception to shift.
- A lack of peer support networks, particularly among sessional GPs.
- A traditional lack of support for GPs returning from maternity leave. Returners' programmes are improving, but it was felt this had historically been a real problem.

These issues are all symptomatic of a broader NHS culture which limits the progression of women to the highest levels of leadership.

The actions we all need to take

It is incumbent upon all of us working in the health system broadly, and clinical commissioning specifically, to take action now to address this gender imbalance in leadership. A failure to do so is not just a failure of fairness: it is a failure that will impact on performance, and on long-term sustainability.

Actions we at NHSCC will take

At NHS Clinical Commissioners, we know we have an important part to play in increasing female representation in clinical leadership. It is a role we are ready and willing to take. We pledge to:

- Ensure NHSCC champions the case of female leaders and clinicians in our work and publications.
- Work with MSD to develop an offering to our membership that includes mentorship and buddying.
- Encourage and support women and women clinical leaders on our board.
- Develop close working relationships with groups and forums seeking to advance the cause of women in senior health service positions. This will include The King's Fund, Medical Women's Federation, FMLM and BMA. The linking of NHSCC's work in this area with other organisations will enable joined-up end-to-end solutions to be developed.
- Champion the cause of women in clinical leadership on a national platform, as a member of the *HSJ* Women Leaders Network.
- Work with other groups, including the FMLM, to publicise a refreshed and updated list of top tips for empowering women in clinical leadership. In producing this document, NHSCC will highlight and showcase examples of women in clinical leadership roles.
- Consider developing a quality mark for those CCGs that actively promote female clinicians across a range of CCG clinical leadership roles. A range of criteria could be developed similar to the Athena SWAN scheme for science, technology, engineering and mathematics (STEM) departments in universities.

We challenge the following to also take action:

The whole health system

There are numerous groups making valuable contributions to progressing the number of women in clinical leadership. To ensure clarity of voice, we believe these groups should ensure they work together to progress their common aim and increase the impact of their excellent work. This includes the FMLM (and specifically its Women's Leadership, Action and Advocacy Group), The King's Fund (not least through its Athena programme), Medical Women's Federation, British Medical Association Women in Academic Medicine, and *HSJ* and NHS Employers' Women Leaders Network.

CCGs

To effect real change and increase the representation of women in clinical leadership – consequently boosting diversity and performance – CCGs may wish to consider:

- Measuring where they are now, and developing a plan for the future
 - CCGs should begin by ensuring they understand their current position: how many women are in clinical leadership posts locally?
 - On establishing a baseline, targets could be set for future improvement and plans established to boost the number of women on governing boards and committees such that it reaches the rule of three (ideas for specific actions follow). CCGs might also consider appointing a champion for female clinical leadership in their organisation, while buddying and mentoring schemes could also be actively supported.
- Reviewing appointment processes, including the language used in job adverts
 - Research suggests women are less inclined to apply to jobs if adverts include phrases linked with male stereotypes (including “assertive”, “independent”, and “analytical”).⁴⁰ It has also been suggested women do not apply for jobs unless they are confident they meet 100 per cent of the requirements specified (and that men will apply if they meet 60 per cent).⁴¹ CCGs should therefore consider whether the wording used in adverts for clinical leadership posts is in danger of actively discouraging female applicants.
 - In our research for this briefing, we spoke to numerous female clinical leaders who felt the election process common for senior CCG posts was likely to discourage women. CCGs should consider whether alternative or modified appointment processes would increase the number of women seeking clinical leadership posts.
 - We suggest CCG member practices could also valuably take similar actions.



“It is incumbent upon all of us working in the health system broadly, and clinical commissioning specifically, to take action now to address this gender imbalance in leadership”

- Ensuring salaried GPs are engaged with CCG decision-making
 - 71 per cent of salaried GPs are female,⁴² yet it is unclear how many CCGs have allocated places on their boards for salaried GPs. We urge CCGs to consider how they can best utilise the expertise of these GPs. Since salaried GPs will be involved in daily decision-making for patients in their local area, they should also be able to influence decisions for patients in the wider locality. Research from 2012 suggests many are willing to take on this role: 60 per cent of surveyed salaried GPs said they would contribute more to commissioning if they had more support to do so.⁴³
 - CCGs might consider setting up a salaried GP group. This would allow individuals in these roles to feel more connected, and to share opinions and expertise more easily.
- Working with organisations such as the FMLM to develop a talent management plan that identifies, supports and develops women who have the potential to be the clinical leaders of the future
 - CCGs should ensure they have identified as wide a pool of talent as possible and that flow through the system is adequately maintained and resourced. This includes succession planning.
 - It would be beneficial to understand why individuals choose to leave the system: exit interviews could be conducted with any CCG member – and preferably any GP – who chooses to leave his or her post.

NHS England

We believe NHS England should:

- Ensure women and women clinical leaders are appropriately represented on national platforms and at public events.
- Appoint a champion for women in clinical leadership. This individual would be tasked with driving the agenda internally and giving the issue a national focus.
- Commission women-specific leadership development programmes in partnership with the FMLM or other organisations. By directly commissioning this resource, NHS England can demonstrate its commitment to promoting women in leadership and clinical leadership and create new female leaders.
- Regularly publish data on the representation of women in clinical leadership, to include a review of those in the early stages of their career who have shown interest in leadership roles and analysis of the gender profile of GPs working in leadership roles.

If all parties take action, we firmly believe the number of women in clinical leadership can be boosted – and performance along with it.

Acknowledgements

NHSCC and MSD offer thanks to the following individuals for their valuable input:

- Anne-Marie Archard, head of the London Leadership Academy
- Dr Debbie Frost, chair, NHS Barnet CCG
- Dr Tim Moorhead, chair, NHS Sheffield CCG and board member, NHS Clinical Commissioners
- Dr Jane Povey, deputy medical director (primary care and public health), Faculty of Medical Leadership and Management
- Rosamond Roughton, director of NHS commissioning, NHS England
- Rachel Snow-Miller, senior programme lead – primary care commissioning, NHS England
- The team at MSD – Tracey Franklin, director of human resources, UK and Ireland; Sam Little, head of healthcare access; and Sarah Roper, healthcare access
- Julie Wood, chief executive, NHS Clinical Commissioners
- Claire Read, the commissioned writer of this briefing.

Very special thanks to Dr Penny Newman, medical director, Norfolk Community Health and Care NHS Trust for early access to her forthcoming paper on NHS women in leadership and for additional input.

Empowering women clinicians in commissioning is an initiative made possible through collaboration between NHSCC and MSD.

Contact us

For more information on the issues covered in this briefing, please contact office@nhsc.org

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Notes

NHS Clinical Commissioners is the only independent membership organisation exclusively of clinical commissioning groups.

Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We're giving them a strong influencing voice from the front line to the wider NHS, national bodies, government, parliament and the media. Our networks provide members with the opportunity to share experience and expertise; and provide information, support, tools and resources to help CCGs do their job better.

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