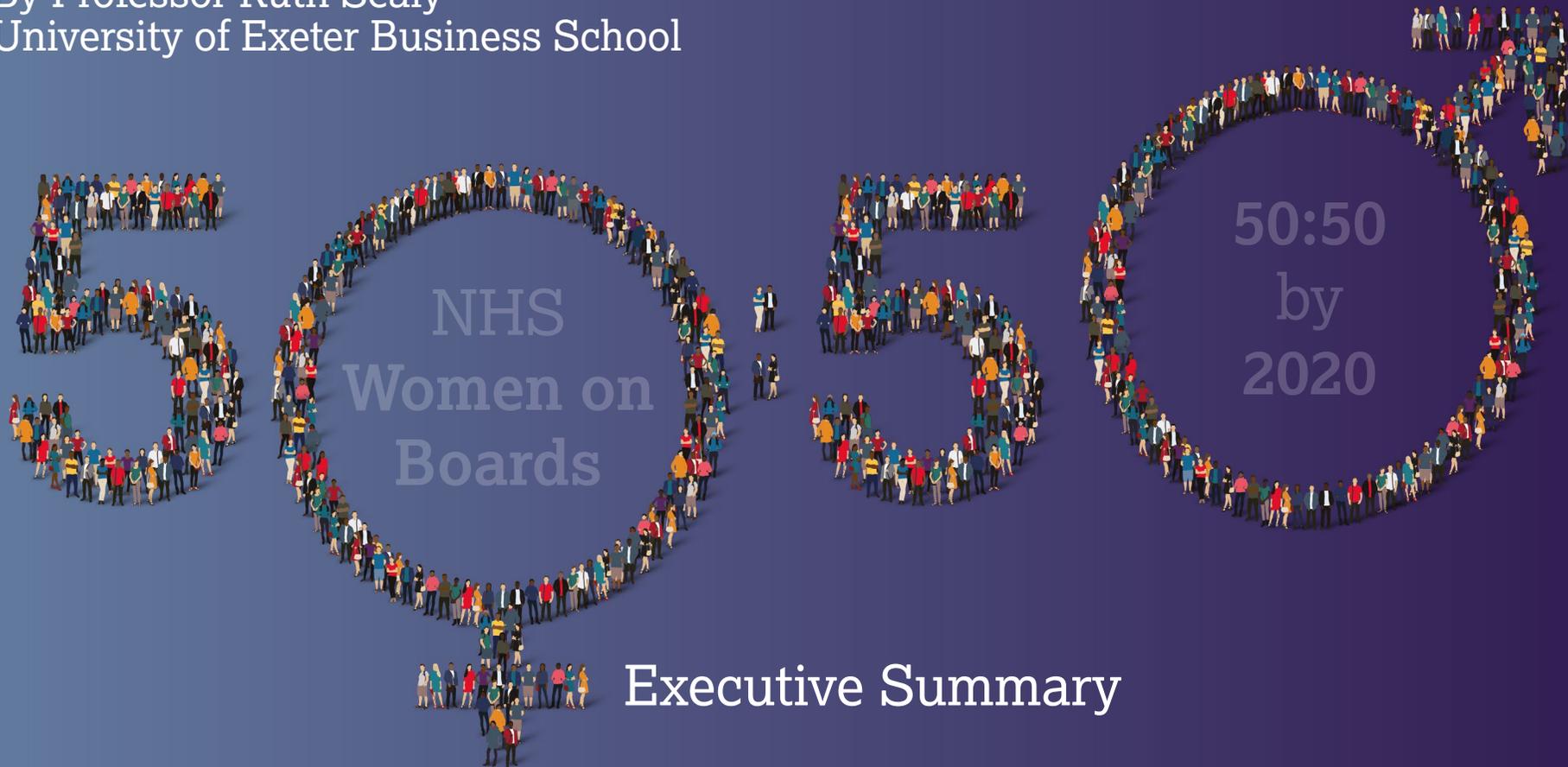


Action | The for equality | time is now

By Professor Ruth Sealy
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This research was led by **Professor Ruth Sealy**,
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for their excellent research assistance.

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 Leadership which lacks diversity is outdated and inexcusable in modern society.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.**



A handwritten signature in blue ink that reads 'Samantha Allen'.

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

SUMMARY OF REPORT FINDINGS

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.

This report 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 full report has four main sections (board data, interviews with chairs, medical directors (MD) and chief finance officers (CFO)) plus seven mini case studies, detailing actions chairs have taken to diversify their boards. 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.

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 trust 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. This figure has hardly moved since 2017 (38.3 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. **Chief executive and chief operating officer roles are gender balanced. However, as was the case in 2017, CFO and MD 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 useful insights regarding perceptions of barriers and potential solutions to making these goals more realistically attainable.
- **The proportion of female non-executive directors (NED) has increased**, but is still not sufficiently gender balanced, with no obvious supply explanation. Women now hold 40.9 per cent of NED roles, but only 37 per cent on ALBs. 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 to improve representation among NHS NEDs.**

We need 150 more executive and non-executive female directors (including 40 more female MDs and 50 more female CFOs) to reach gender balance across NHS trust and ALBs boards in England.

Interviews with chairs

From our board data, we identified the top 20 most diversified trust boards across England in terms of gender and ethnicity. We interviewed chairs from 13 of the 20, plus four others to ensure a good spread across regions, services and trust types (see full report). We took a behavioural approach to the 17 interviews to ascertain **why** they had diversified their board, **what** they had changed and **how** (see full report for detailed findings).

Motivations to diversify (why)

- **Board processes leading to better decision-making and effectiveness.**
- **Representation of community leading to greater legitimacy and better patient outcomes.**
- **Representation of staff leading to better talent management.**

The chairs spoke of three equally important motivations for and benefits of board diversity. Most ardently, the chairs talked about better board processes, how the composition impacts the dynamics, bringing better conversations, different perspectives, and new solutions proposed. They recognised the challenge of managing these differing perspectives, seeing their role as facilitating 'robust conversations' in order to arrive at the best decision-making.

Being representative of one's service users and community was discussed not as a nice to have, but as critical for the provision of the best and most effective care service. Concern was expressed that, from a patient safety point of view, ignorance of community issues without that representation may lead to failures in fundamental duties. Additionally, having representation on the board helps build legitimacy with the community, leading to better patient outcomes.

More than 75 per cent of NHS employees are female and overall almost one in five employees are from a BME background, rising to 40 per cent in some areas. Chairs felt it was imperative that leadership of their trust was representative of their staff. Reasons from staff included issues of being understood and having faith in board decisions, giving staff confidence in their work. Equally important was the aim 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.

Defining diversity (what)

Chairs with more diversified boards moved beyond just gender and ethnic diversity, taking a more holistic approach. They were concerned about other characteristics, such as sexuality, disability and age, 'life experience' with mental health, and functional diversity including allied health professionals on their boards. Overall, it was clear that **chairs with diversified boards moved beyond a tactical approach of compliance to one of strategic inclusivity, aiming for true cognitive diversity, proactively seeking and managing diverse skills, characteristics and experiences.**

Approach to diversification (how)

Approach

- o Intention
- o Purposeful action
- o Data
- o Determination

Chairs clearly articulated their belief that greater board diversity was not going to happen on its own. This awareness and understanding of systemic issues gave them permission for positive action towards purposeful composition. With detailed data, they were emphatic that diversification had to be managed explicitly and proactively, just like any other change process. Their attitudinal approach and personal commitment was notable.

Levers of change

- Community
- Search firms
- Governors
- Communications

A number of common levers of change were utilised to make their programme of change successful. Specifically, for NEDs, chairs discussed actively engaging with their communities' networks and using outreach exercises to find a broader range of candidates, such as through local business or Asian networks. With search firms, the key message was to be explicit about expectations of good quality diverse candidates, and being open to wherever the best talent was. In foundation trust appointments, chairs worked hard with their governors, providing diversity training specifically for the appointment process. They benefitted from the governors' community involvement and diverse networks, accessing a broader reach of candidates. Chairs also spoke of the importance of strategically communicating their intentions regarding diversity, often in non-traditional forms, such as their own social media use, to build the board's reputation and communicate the trust's values, persuading more diverse candidates to apply for roles.

Actions for change

- Appointment process
- Associate NEDs
- Adapting the executive appointment process
- Succession planning/talent management

Echoing the Lord Davies Review findings in the private sector, the main area effecting change to board composition was the appointment process. For example, areas included: rewriting the recruitment pack; stopping rolling appointments; recruitment training; diverse panels; purposeful shortlists; challenging interviewing techniques; and flexing criteria. Using multiple hires and the 'tie-breaker rule' allowed chairs to consider diversity holistically across their board. The successful use of the associate NED scheme was also recommended. Gender awareness and the different expectations and treatment of candidates was a focus of the appointment process for executive roles, but overwhelmingly chairs articulated the importance of proactive succession planning and strategic talent management. Spotting, encouraging, developing, and supporting candidates from middle through to senior management gave a more diverse pool of potential executives.

Other themes covered by the chairs' interviews included the importance of transparency in diversity data; dealing with issues of resistance and challenge within their own board or governors; the clarity of messages from NHS leadership; and the implications of diversity for integrated care systems (ICS) (see full report).

Case studies

The seven case studies throughout the main 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, embed psychological safety, 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.

Interviews with current and aspirant female CFOs and MDs

Interviews with 55 women currently in or aspiring to these board roles, provide useful insights regarding perceptions of barriers and potential solutions to making these goals more realistically attainable. As mentioned in the forthcoming report on the gender pay gap in medicine¹, women have made up the majority of medical school graduates for more than 25 years, but the system of medical careers was not designed for the needs of women. Many of the systemic issues identified by our interviewees have been predictable for a generation and are not going to fix themselves. Evidence shows 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 dichotomy². **If the NHS wants to optimise the contribution, and retain the majority of, its highly talented staff, then senior roles need to be manageable and accessible to the majority of the 21st century workforce.**

¹ Dacre & Woodhams. (forthcoming). Mend the Gap: The Gender Pay Gap in Medicine Review. Department of Health and Social Care.

² Walsh (2012), Not worth the sacrifice? Women's aspirations and career progression in law firms, *Gender Work & Organization*, 19(5), pp.508-531.

CONCLUSIONS

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 report³, 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.’⁴

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.

³ Dacre & Woodhams. (forthcoming), Mend the Gap: The Gender Pay Gap in Medicine Review. Department of Health and Social Care.

⁴ 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 of full report).

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 of full report). 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 of full report).

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 of full report).

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 of full report). 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 of full report).

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 of full report).

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 of full report).

“
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 read the full report [click here](#).

With thanks to:

- NHS Confederation and NHS Employers, Danny Mortimer, Samantha Allen, members of the network guiding group and Julie and Jess from the network team.
- Thank you to members of The King's Fund, Tracie Jolliff and her team at the NHS Leadership Academy, and the Faculty of Medical Leadership & Management who helped access some of the interviewees.
- **And finally, with thanks to all of our 72 interview participants (chairs, current and aspirant medical directors, current and aspirant chief finance officers) for being reflective and candid, and sharing your experiences with a view to making the NHS a better workplace and providing a better service for all.**



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