

# NHS Women on Boards



By Professor **Ruth Sealy**  
*University of Exeter Business School*





## FOREWORD

When I was asked by groups of senior women to represent them as a diversity champion for the NHS, and to accept the challenge of 50:50 by 2020, I was both delighted and somewhat scared!

We had no data to tell us where we are today or indeed where we have come from. The expanse of the NHS eco-system and its hundreds of boards is vast. The nature of the work in those organisations is very different across trusts, clinical commissioning groups and arm's-length bodies. However, we have made a very good start with this initial report and the work that has been done to date: There is a baseline and some thoughtful analysis of the data, there are some recommendations for leadership and those who source board candidates to consider and act upon; there is a future programme of work to do to enrich the dataset, to report on progress and to research the knotty issues of increasing both demand for, and supply of, candidates to lead to achieving the 2020 target.

We make no apology for adopting the approach that Lord Davies took in his work on the FTSE 100, which is now being led by Sir Philip Hampton and Dame Helen Alexander. No apology – because his approach has led to substantial progress.

Our approach and recommendations can do so as well if they are embraced by the leaders of systems and of individual organisations across the NHS. I hope that they are, and I commend this report to NHS colleagues.

In doing so, I am very grateful to the advisory board for their support and engagement and to Professor Ruth Sealy, of Exeter University Business School, who has carried out much of the work and has written the report based on her research and experience of working with Lord Davies. I also wish to thank Janice Scanlan at NHS Improvement, who has collated data from many sources to enable a good baseline for NHS trusts.



**Ed Smith**

CBE, FCA, CPFA, Hon DUniv, Hon LLDs  
Chair, NHS Improvement

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*I'm pleased that the NHS has embraced the target for 50 per cent women on its boards by 2020, and look forward to seeing increased transparency and hearing more about progress in the next year.*

*Prime Minister Theresa May August 2016*



”

## EXECUTIVE SUMMARY

Demographic data was collected for boards of trusts, clinical commissioning groups (CCGs) and arm's-length bodies (ALBs). Across 452 organisational boards, the proportion of female-held seats ranged from 8.3 per cent to 80 per cent, and the overall average was **41.0 per cent**.

In order to be gender balanced, **NHS boards in England need another 500 women**. The overall number of women holding seats needs to increase from 2,500 to 3,000 between now and the end of 2020 – that's an additional 125 per year. The proportion of women on boards across trusts was **42.6 per cent**; on CCGs was **39.5 per cent** and for ALBs was **38.3 per cent**.

If we use the EU Commission's definition of gender parity of at least 40 per cent of each sex on each board, then **53.8 per cent of all the boards** have achieved this. However, there are still 209 boards that do not meet that target. Given that 77 per cent of the NHS's workforce is female, if we use a more stringent definition of between 45-55 per cent of each sex, then just **34.1 per cent** of boards achieve this and there are almost 300 organisations who need to pay more attention to their gender composition. The scale of the task to reach 50:50 is stretching, but doable: just over one more woman per board.

There are no significant regional differences in the proportions of women directors across the trusts (41-43 per cent) and no differences between NHS trusts and foundation trusts (both 42 per cent). However, when we looked at service-type differences, ambulance trusts had the lowest proportion at 35 per cent. This is interesting given that recent King's Fund research showed that the ambulance trusts also had the highest levels of perceived discrimination.

For the CCGs, the Midlands region had a noticeably lower proportion of female board members (36 per cent compared to 40-41 per cent).

Across trusts, executive roles are more or less balanced between men and women. However, there is a real imbalance in certain roles. While the percentage of female chief nurses was very high (85 per cent), the figures for chief finance officer and medical directors were disappointingly low (26 per cent and 25 per cent). The non-executive directorships were also unbalanced, approximately one-third women, two-thirds men. This was also mirrored by ALBs, both the executive and non-executive roles had these proportions. There are no obvious supply-based reasons for any of these discrepancies.

On CCGs, although almost 40 per cent of chief/accountable officers were female, the figures for chair and vice-chair were very low at 15-16 per cent. Given that 70 per cent of the CCG workforce is female, these figures are very disappointing.

Gathering relevant data for trusts, CCGs and ALBs proved very challenging and this must be the first task. Without accurate data, we cannot know that we are addressing the right issues. There must now be a concerted effort to collect and utilise a detailed longitudinal dataset across all of the boards. While there will be some sector-specific issues, the pattern of the working population's gender balance to board balance is not dissimilar to publicly listed boards in the private sector. Much can be learned from best practice in other sectors to build capability and progress.

**This report makes a number of recommendations. The focus must now be a call to action to drive up the proportion of women on NHS boards to reach gender balance.**



## INTRODUCTION

The ambition of all those working in the health system is to create the best outcomes for the communities served. Research shows that diversity improves the quality of decision-making by teams, delivers higher quality outcomes, which in turn aids staff recruitment and retention. It also supports a climate where people work more productively as envisaged in the *NHS Developing People Improving Care framework*.

The leaders of the health and care system developed the *Five Year Forward View* to deliver an ambitious programme of reform. We know that this will continue well into the next decade to meet the changing needs of our population and is impacted by technologies and innovations as well as new workforce models. Within this, the partner organisations have committed themselves and the NHS to becoming a better employer: to improve the way they recruit and develop their workforce, becoming truly inclusive.

As far as gender equality in leadership is concerned, despite women making up three-quarters of the workforce, there is some way to go.

In the private sector, the government-backed *Davies Review* was extremely successful in galvanising the conversation and action around increasing the proportion of women on FTSE<sup>1</sup> publicly listed boards.<sup>2</sup> For the previous decade, there had been a number of reports and platitudes but very little change in the figures. The context of the *Davies Review* was one of extreme uncertainty and financial volatility, in the wake of the financial crisis, with a focus on poor decision-making in the boardroom. 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. Diversity was also being seen by increasing numbers as requisite for success and reputation, especially in attracting and retaining the best people.

“*Inclusive and diverse boards are more likely to be effective boards, better able to understand their customers and stakeholders and to benefit from fresh perspectives, new ideas, vigorous challenge and broad experience. This in turn leads to better decision-making.*  
*Lord Mervyn Davies, 2011*”

<sup>1</sup> Financial Times Stock Exchange

<sup>2</sup> Sealy, Doldor & Vinnicombe (2016) *The Female FTSE 2016 Board Report: Taking stock of where we are*, Cranfield School of Management, UK.

<sup>3</sup> Davies (2011) *Women on Boards*. Accessible at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/31480/11-745-women-on-boards.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/31480/11-745-women-on-boards.pdf)

Detailed quantitative and qualitative data about the characteristics of board directors, the turnover of board positions, the percentage of new appointments going to women, the appointment process, and women's career aspirations, meant that decisions regarding the *Davies Review* approach to increasing the proportion of women on boards were evidence based. For example, data showed that we did not, as was commonly believed, have a supply problem of educated, experienced senior women in the workforce available for non-executive directorships. Once the realisation was made that the problem was not one of supply, but of demand, then the solutions to that problem changed.

Certainly in the private sector there was a substantive focus on the appointment process conducted between chairs and executive search consultants (ESCs). With encouragement from Lord Davies, a small group of high-profile ESCs, who between them carried out approximately 85 per cent of board appointments in the largest FTSE listed companies, put together a voluntary code of conduct<sup>4</sup>, outlining how they (as identified gate-keepers) would work towards ensuring greater diversity of new board appointments. They were strongly encouraged to have a broader dialogue with their clients regarding director specifications and to support them through the appointment process.

**Clare Panniker, Chief Executive  
Basildon and Thurrock University Hospitals NHS Trust, Mid Essex Hospital  
Services NHS Trust and Southend University Hospital NHS Foundation Trust**

*I took up my first NHS board position back in 1997 and my first CEO role in 2003. Having started out my career as a student nurse at St Mary's Paddington I didn't imagine that my decision to move out of nursing into management (taking 3 years out to do a business degree) would result in such progression.*

*Looking back there was a lot I didn't know but I had a couple of really influential role models and women who were willing to take a risk with me. Unusually at the time, the board at the Whittington had a female CEO, finance director and HR director, and in particular, Jane, the CEO, saw something in me that she was keen to help develop. She gave me opportunities not just in the roles I took on but in development - mentors, programmes, study tours etc.*

*Later it was another woman, Christine, who encouraged me to apply for my first CEO role. The encouragement and belief shown in me by strong but feminine leaders helped me appreciate that I could be values driven and successful and do it my way.*

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<sup>4</sup> Accessible at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/208464/voluntary-code-of-conduct-for-executive-search-firms.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/208464/voluntary-code-of-conduct-for-executive-search-firms.pdf)

In healthcare leadership, the case for diversity has also been well established. However, a recent *Future Focused Finance* report reveals that only 30 per cent of 1,000+ respondents believe that their organisation's board properly represents the community it serves. It is therefore easy to comprehend how any negative attitudes or behaviours based on diversity dimensions experienced by staff in hospitals, are likely to be replicated towards patients. Another report, commissioned by The King's Fund, cites research linking diversity, leadership, organisational performance, the quality of care and better use of resources<sup>5</sup>.

Women have made up the majority of medical school graduates since 1991<sup>6</sup>, and the total number of female doctors are expected to outnumber male doctors at some point before 2022<sup>7</sup>. The current NHS workforce is 77 per cent female.

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 in their career progression<sup>8,9</sup>. There are several overlaps with other regions and industries<sup>10,11</sup> and it is important to note that, as in other sectors, male and female perceptions of these barriers differ<sup>12</sup>.

Despite this knowledge, we lack robust and complete figures for women on NHS boards in England and we have no data regarding tenure, turnover or appointment rates. Despite calls for similar thorough data to be collected and reported in the NHS to allow longitudinal data and a greater understanding of the issues and blockage points, no such data collection has yet occurred.

The private sector achieved a doubling of women on board figures in less than five years. In-depth interviews with 34 key stakeholders (FTSE chairs, chief executive officers, executive search firms and subject-matter experts) in 2015, identified that the following had been key drivers of change<sup>14</sup>:

- setting targets that are ambitious yet realistic
- monitoring progress against targets every six months, with detailed analytics
- effective championing
- multiple stakeholder engagement.

While acknowledging that the initial target of 25 per cent for publicly listed boards is low in comparison to what we want to achieve in the NHS, the starting point was much lower (12.5 per cent) and women comprise a minority of the working population.

The success of the *Davies Review's* use of targets has been recognised in the private sector and across the world. A multitude of large corporations (banks, law firms, professional service firms, publicly listed companies) are now using publicly stated diversity targets. This is not just at board level but, recognising the need to strengthen their female talent pipeline, many organisations have introduced gender/diversity targets at several levels below the board as well<sup>15</sup>. The government-backed *Hampton-Alexander Review* (2016) has accepted the target recommended by the Davies Review and academics of 33 per cent women for boards, executive committees and their direct reports by 2020.

We acknowledge that gender is only one dimension of diversity – others include race, ethnicity, disability, age and sexual orientation. While 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.

<sup>5</sup> West, Dawson & Kaur (2015), *Making the difference: Diversity and inclusion in the NHS*, The Kings Fund.

<sup>6</sup> Deech Report (2009) *Women doctors making a difference*, Report of the Chair of the National Working Group on Women in Medicine October 2009, Department of Health

<sup>7</sup> Medical Workforce, The Kings Fund

<sup>8</sup> 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, UK.

<sup>9</sup> Newman (2015) *NHS Women in leadership: Plan for action*, NHS Confederation

<sup>10</sup> Jarboe (2013) (2015) *A woman's place in public appointments*, WomenCount, Wales.

<sup>11</sup> Newman & Sealy (2013) *Breaking down barriers for women doctors*, Health Service Journal, 15th July 2013

<sup>12</sup> Institute of Leadership & Management (2011) *Ambition and gender at work*, February 2011

<sup>13</sup> Newman (2011) *Releasing potential: Women doctors and clinical leadership*, NHS Leadership Academy

<sup>14</sup> Vinnicombe, Doldor, Sealy, Pryce & Turner (2015), *Female FTSE Board Report 2015: Putting the UK progress into a global perspective*, Cranfield School of Management, UK.

<sup>15</sup> See Sealy, Doldor & Vinnicombe, *Female FTSE Report 2016 for numerous case studies*

## METHOD

As has been mentioned, despite multiple reports from various arms of the NHS during the past decade, no accurate and complete figures were available for the boards of NHS England. During 2016-17, several requests were made over time to establish the data for trusts and CCGs. In addition to name, role and sex of each board member, we also requested age and tenure, with end-of-term dates for roles where this was relevant. This research and longer-term project would significantly benefit from this additional data to build up a depth of understanding of NHS boards, through the establishment of longitudinal trend data. We know from the private sector that the regular reporting of data and understanding of the trends across time were key to implementing the right actions. For example, by understanding the average tenure rates and the gender balance of new appointments, we were able to identify what the target appointment rate for female directors needed to be in order to make substantive change. With only a snapshot of cross-sectional data, it is difficult to evidence and understand the bigger picture of board appointments and tenure.

Initially, there was resistance to supplying such data and so the majority of data in this report are from the public domain.

We need greater encouragement for boards and their support teams to respond to data requests from NHS Improvement and NHS Employers, given the current emphasis on transparency.

For the trusts, the majority of data in this report was collected in the autumn of 2016, from trust websites where the gender is 'assumed data'. Subsequently, questionnaires have been sent out to all company secretaries and individual board members, and with their co-operation, NHS Improvement is now starting to collate a full data set of these directors, which will be regularly updated.

Some of the data is here but, as yet, this is an incomplete dataset, and this is noted in some findings that follow.

Of the 207 CCGs, only 19 completed the questionnaire sent, and we would like to thank them for their co-operation. However, the majority of CCG data collated for this report was taken in February 2017, from websites, LinkedIn and other publicly available sources.

For the ALB sample, we have data from NHS Improvement, NHS England, the Care Quality Commission, Public Health England, Health Education England, the National Institute for Health & Care Excellence, and the Department of Health, collected in autumn 2017.

*“ We must continue to learn from the evidence of the difference women can and do make when able to make board-level contributions. Women on boards bring new skills and new ways of thinking, they enhance governance, work more collaboratively and ask different questions. It is a strategic priority for the makeup of boards to more closely reflect the population they serve. Moves to normalise women’s positions on boards are key to the future of the NHS and will bring benefits for all. The progress to date is excellent but as yet the aspiration of 50 per cent women on NHS boards by 2020 will not be achieved unless there continues to be transparency, focus and effort, nurture and encouragement in the NHS. I fully support the recommendations of the report.  
Clare Marx CBE DL FRCS, President, Royal College of Surgeons* ”

## **Alison Hill, Non-Executive Director, Royal Berkshire Foundation Trust**

*My involvement in running organisations began in representational politics as a medical student. Within two years, of qualifying, I was elected to the GP's national committee of the BMA. How did I do that? Being young, female and passionate made me unusual. Being able to think and write clearly and being blessed with a strong voice helped to make an impact.*

*Once there, I was mentored (by older men mostly - there were few women role models) in effective committee behaviour and chairing skills, and trained in negotiating and media skills. I ended up chairing the main national policy-making conference for GPs. Those dozen years taught me how to work in a high-level team and how to lead change but, in a very traditional organisation, I needed the authority invested in the role to help me do this.*

*My second career anchor in health policy led to work in the Department of Health, in NHS management and as a frontline clinician.*

*With this experience, I learnt to make pragmatic strategic decisions: the best way to test a strategy is to ask the people who will put it into practice.*

*After I retired from my practice, I went back into NHS management as PCT medical director. Despite the fact that I had years of board-level experience running practices of various sizes, strategic planning and policy-making at local, regional and national level, managerial operational and governance experience, I was excluded from an executive role on the grounds there was already one doctor (female) on the board. There were actually more women than men, but it seemed that my women colleagues on the board were struggling to make an impact and were valued more for the height of their heels than for the relevance and wisdom of their interventions.*

*At my retirement, the opportunity to serve as a NED came quickly, post-Francis, in an acute foundation trust board. I had most of the requisite skills: I knew how to read between the lines of board papers and to ask questions of and about data.*

*I understood the tensions of working in a policy and regulatory context that was complex, bureaucratic and contradictory. But I was unprepared for the task of balancing financial performance against service performance in a complex organisation. A more detailed induction into the role would have helped.*

*More and more women have the broad perspectives, decision-making skills and ambition to work at board level, but not enough of them are there. What helped me? I was given responsibility and plenty of opportunities when young, to learn to make sound decisions in a group. I grew to understand the role of the board as a strategic leader, the importance of knowing the business of the organisation, of respecting and supporting the staff. Leadership can be lonely; support networks are key, trusted mentorship and coaching, essential. Boards need to invest in operating effectively as a unified body, respecting each member, learning to work creatively with different perspectives.*

## FINDINGS

We have data for 6,118 board members across 452 boards. This sample includes 238 trusts, seven arm's-length bodies (ALBs) and 207 clinical commissioning groups (CCGs). The average board size of our sample is 13.5 members, with a range of 5-23. ALB average board size is 13.4, trusts 12.9 and CCG 14.3 persons.

Trusts and ALBs have similar board structures, with clearly defined executive (ED) and non-executive (NED) roles, with the latter having an advisory capacity and being more involved in strategic and governance oversight. In the analysis below, we frequently combined findings from trusts and ALBs, due to their similar structures and roles.

CCGs are membership bodies with a combination of primary care providers, secondary care representatives and lay members. The main clinical lead role may also be the accountable officer (akin to a chief executive) or the chair. There will also be a finance lead, a chief nurse and sometimes a chief operating and/or commissioning officer.

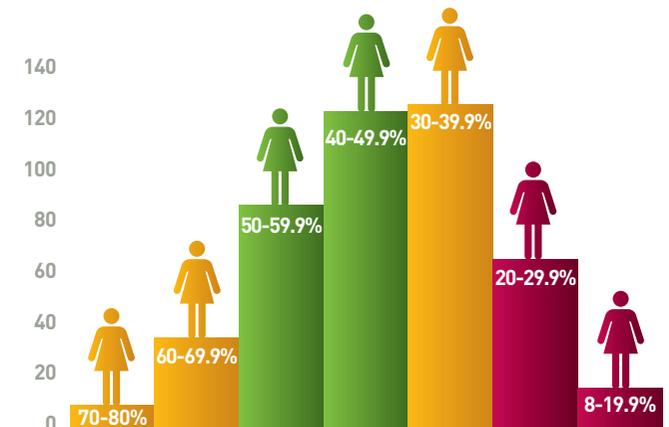
Across 452 organisational boards, the percentage of women ranged from 8.3 per cent to 80 per cent, and the overall average was 41.0 per cent. Put very simplistically, women currently hold 2,529 of the 6,118 board seats we have data for. In order to reach the 50:50 target which would be 3,059 seats, **NHS boards in England need an additional 500 seats held by women.** Unfortunately, without tenure, turnover and appointment rate data of men and women, we cannot tell how many women are actually needed to increase the absolute number. We could say that we need an additional 125 women each year from 2017 to 2020.

Across the trusts, the percentage of women on boards was 42.6 per cent, on the CCG boards it was 39.5 per cent and the ALBs 38.3 per cent.

If we define gender balanced boards as having between 40-60 per cent members<sup>16</sup> of each sex, then 53.8 per cent of all the boards have achieved this (see Figure 1). While this is encouraging, it still means that over 200 boards (209) in our sample are not gender balanced.

Our target is that NHS boards in England are 50:50 by 2020. We accept, of course, that for each board this is not always possible to achieve as a constant, and so if we look at how many boards are truly balanced at between 45-55 per cent of each gender, the figure is lower at 34.1 per cent, meaning almost 300 boards (298) are not yet hitting the target.

Figure 1:  
**Number of trusts, CCGs and ALBs with varying percentages of women on boards**



**NHS boards in England need an additional 500 seats held by women**

## Regional differences

We found no significant regional differences in the percentage of women on trust boards (see Figure 2) or CCG boards (see Figure 3). Anecdotal conversations had suggested that such differences existed, but data suggests that this is an urban myth.

Figure 2:  
Percent of women on trust boards (WoB) by region

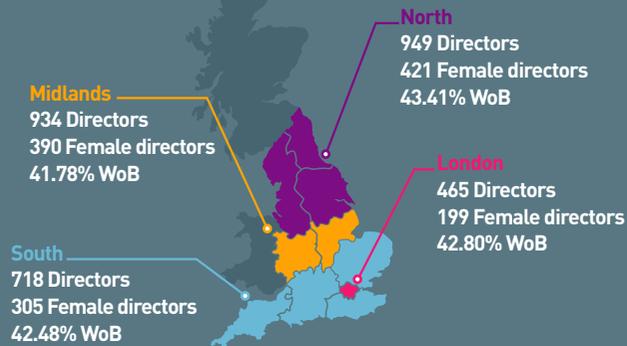
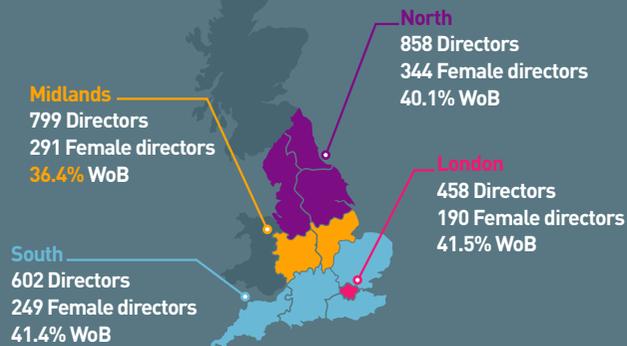


Figure 3:  
Percent of women on CCG boards (WoB) by region



Most of the CCG regions have a similar percentage of women on boards (WoB), with the exception of the Midlands. It may be worth future research investigating if there is any correlation here with the proportion of BAME<sup>17</sup> doctors also in this region.

## Differences by trust and service type

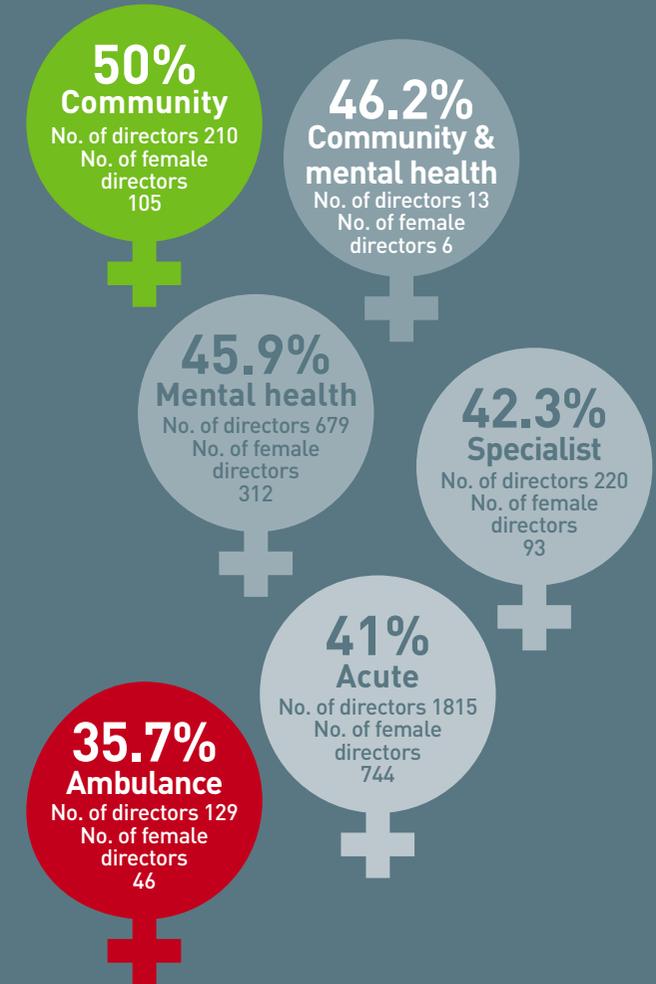
As illustrated in Table 1, the percentage of WoB is almost identical across the two trust legal structures.

Table 1:  
Percent of WoB by trust type

Trust Type	No. of directors	No. of female directors	% WoB
Foundation	2055	878	42.7%
NHS trusts	1011	428	42.3%

Among service type, community trusts exactly hit the 50 per cent target and ambulance trusts have the lowest figure (see Figure 4). There will undoubtedly be a range of reasons for this variation. However, it is worth noting that West et al.'s 2014 report on diversity and inclusion in the NHS, across service types, noted that the levels of discrimination experienced by staff were also highest in ambulance trusts.

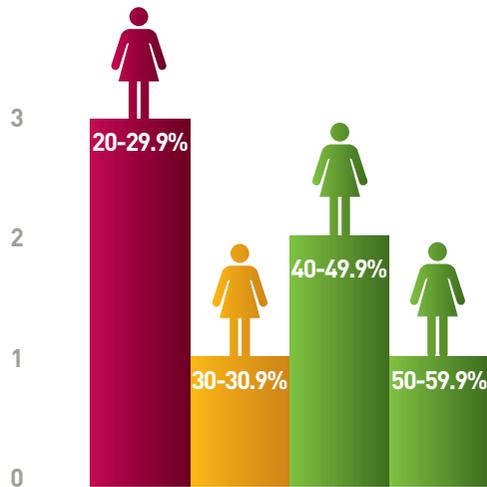
Figure 4:  
Percent of WoB by service type



## Arm's-length bodies

Notably, just 36 of the 94 ALB directors across seven boards are women, making the overall percentage of WoBs in ALBs 38.3 per cent - lower than the trust and CCG figures. There is, however a range from 23.1 per cent to 50.0 per cent (see Figure 5).

Figure 5:  
Varying percentages of WoB across ALBs



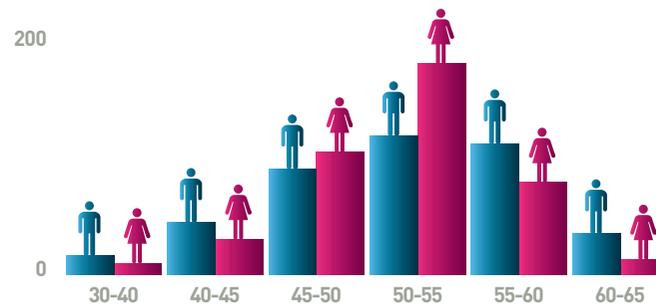
## Age and tenure

### Trusts

(The data for trust's age and tenure is based on responses to NHSI's 2017 provider board membership and diversity questionnaire from approximately 70 per cent of all roles.)

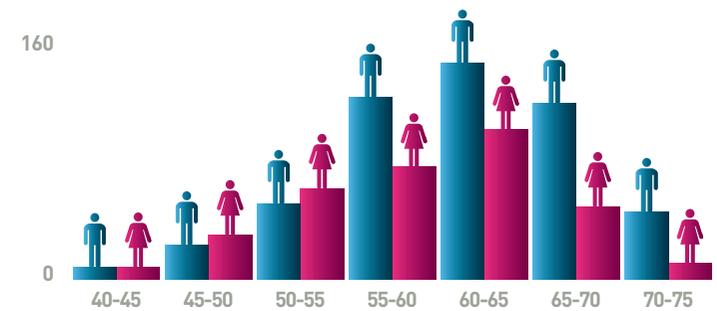
Women executives outnumber men in the 45-50 and 50-55 age groups (see Figure 6). However, this figure then drops off significantly after 55. This spike is possibly due to the majority of chief nurses retiring at this age.

Figure 6:  
Male and female executive director ages  
The number of women in executive positions peaks significantly in the 50-55 age group



The number of both men and women in NED roles increases by age group through to 60-65, but from age 55-60 there are considerably more men than women.

Figure 7:  
Male and female non-executive director ages  
Whilst there are slightly more women NEDs under age 55, over 55 are far more likely to be men



Non-executive directors are generally taken onto boards for terms of up to four years, which may be renewed. Since the *Higgs Review* of 2003<sup>18</sup> into the role and effectiveness of non-executive directors, there has been a focus on limiting the number of years NEDs remain on the same board. Maximum terms are important as a NED's independence may become compromised after so many years within one organisation. These data show how many NEDs are approaching the end of their terms, having served at least six years on the board. Figure 8 reveals that there may be good opportunities to make a positive impact on gender balance on trust boards towards the end of 2017 and the beginning of 2018, when a number of male terms come to an end. This information should encourage boards and those assisting them with candidate search to focus activity on strong and diverse candidate slates, which may result in more female NEDs.

Figure 8:  
**NED gender profile by board end date**<sup>19</sup>  
(qualifying period: 6 years of more in office at Board End Date)



Looking at board end dates for chairs in office for six years or more (see Figure 9), there are opportunities during 2017 and 2018 to make a positive impact on gender balance by rejuvenating these board positions, and we would strongly encourage this.

Figure 9:  
**Board chairs gender profile by board end date**  
(qualifying period: 6 years of more in office at Board End Date)



## Clinical commissioning groups

With a sub-sample size of just 101 CCG board members, the average age is 54 years, with a range from 35.6 to 75.8 years.

Data regarding those on fixed terms (sample size of 149) shows an average expected tenure of 3.6 years, with a range of between six months to 7.4 years. For those board members without expected term dates (sample size 77), the average tenure is currently 3.2 years, ranging from 0.8 years to 7.9 years. The majority were just under four years, reflecting the formation of the CCGs in April 2013.

## Arm's-length bodies

We have included data for seven ALBs, but as yet, full data (including age and tenure) for only two. We have 94 directors, with names, board roles and 'assumed gender' for all. We have age data for just 24 and tenure for 51. The average age is 58, with a range of 44-75. Based on six ALBs (excluding the Department of Health), the expected average NED tenure is 4.5 years, with a range of 3-10 years.

<sup>18</sup> Available at: <http://www.ecgj.org/codes/documents/higgsreport.pdf>  
<sup>19</sup> Note: to prevent individuals from being identified, any data series with fewer than 5 responses has been excluded

## What roles do men and women hold on boards

We compared the roles that men and women hold on the boards in the sample. Initially we looked at executive director (ED) roles versus non-executive director (NED) roles on trusts and ALBs. On trust boards, we found very little difference in the proportion of women and men holding ED roles (See Table 2). This is greatly encouraging and in stark contrast to the research on publicly listed boards, where despite the recent increase in female directorships, the percentage of female EDs remains around 10 per cent (*Hampton Alexander Report, 2016*).

However, what is notable is the discrepancy between the proportions of men and women holding NED roles on trust boards. We currently have no health service data as to why that should be. The role of the independent NED is incredibly important in terms of good governance. However, data from the private sector and around the world usually point to a combination of biased advertisements and appointment processes. We need to know more about what is happening in the appointment process and what proportion of new appointees are going to women. Therefore, we would strongly encourage conversations with chairs and any executive search firms used to identify candidates as to how they can seek to rectify this difference.

In the private sector, with proactive management from a number of stakeholders, the percentage of female-held NED roles on FTSE 100 boards was doubled from 15.6 per cent to 31.4 per cent from 2011 to 2015. A similar increase of 15 percentage points is needed in NHS boards in England.

Table 2:  
**Executive & non-executive roles by gender on trust boards**

Role	Male	Female
Executive director	781 (51.9%)	723 (48.1%)
Non-executive director	977 (62.6%)	583 (37.4%)

On the major ALB boards, women and men are roughly split one third/two thirds for both ED and NED roles (see Table 3). Given the more balanced proportion of women holding ED roles across the trusts (ie an equitable pipeline supply), we need a greater understanding of why these women are not making it up to these major roles in equal numbers as men.

**Future substantive qualitative research should be conducted into career paths and choices for women and men leading to major executive roles.**

Table 3:  
**Executive & non-executive roles by gender on ALB boards**

Role	Male	Female
Executive director	28 (60.9%)	18 (39.1%)
Non-executive director	31 (64.6%)	17 (35.4%)

## Key roles

We looked at the key roles held by men and women across the 452 boards.

In the 245 ALB and trust boards, the percentage of female chief executive officers is encouraging, but should not lead to complacency. The senior independent director (SID) is often considered a chair-in-waiting role, so increasing the proportion of women holding SID roles may in future lead to increases in female chairs (see Table 4). The percentage of female chief nurses reflects the nursing population, and the chief operating officer and human resources director roles are also majority female. The roles which reveal a disappointingly low proportion of women are the chief financial officer and medical director roles.

Table 4:

### Key roles held by women on trust and ALB boards

Key Role	No. counted in sample	No. held by women	Percent of women
Chief executive officer (CEO)	242	103	42.6%
Chief financial officer (CFO)	228	60	26.3%
Chair	241	76	31.5%
Medical director	240	59	24.6%
Chief nurse	212	181	85.4%
Chief operating officer (COO)	167	89	53.3%
Human resources director	119	75	63.0%
Senior independent director	89	33	37.1%

### More female medical directors needed

The medical director role is concerned with leading both the profession and governance, driving cultural change, delivering on quality and addressing the improvement challenge. The medical director is a strong clinical voice on the board of the organisation. Given the almost equitable numbers of female and male executive directors on trust boards, the low proportion of female medical directors is both surprising and disappointing.

In a report by the former Trust Development Authority/Monitor in 2014, two of the five main findings of a survey of male and female medical directors included a desire for: clearer training and career pathways both to and beyond the medical director role; a means of identifying the medical directors of the future, and making it a clearer career option that more people will consider.

### More female chief financial officers needed

Figures from a *Future Focused Finance* report show that 62 per cent of the NHS finance workforce is female, and yet our data reveal that just 26.3 per cent of trust and ALB finance directors are. This figure is an increase from the NHS finance first census in 2009<sup>20</sup>, which was 21 per cent, but at less than one percentage point increase per annum, it will take over a generation to reach gender balance at the top of this majority female field.

In 2016, the Treasury commissioned a report into women in finance, headed up by the CEO of Virgin Money, Jayne-Anne Gardia.

The report produced some clear recommendations about women in finance, a number of which could be taken up by the NHS for its finance employees.

Since 2009, Future Focused Finance has been collecting data on this group of employees and has identified a need to address concerns about working practices (eg. lack of flexibility or job-share) at senior levels. Interestingly their research suggests that these fears may be unfounded as the difference between the proportion of women and men working more than their statutory hours is not great (58 per cent vs 65 per cent). One recommendation would be to set a target for a certain proportion of all new CFO appointments to be women. This figure should be based on an assessment of the talent pipeline in finance and communicated strongly to search firms, used in the appointment process, by chairs and CEOs. Previous research in the private sector shows that sometimes search firms could work harder at ensuring a more gender-balanced slate of candidate and in supporting those less obvious candidates through the appointment process (EHRC Report, 2012)<sup>21</sup>.

“ We recommend that every financial services firm operating in the UK be encouraged to publish its own inclusion strategy and targets on an annual basis – and that progress against these internally generated targets be reported. We recommend that this strategy is driven at executive committee level by a senior member of the committee, responsible and accountable for its design, executive and success. And we propose that success against these internal measures forms part of the annual bonus outcome of all senior executives. Jayne Anne Gardia, CEO Virgin Money ”

<sup>20</sup>HFMA and NHS Finance Skills Development (FSD)

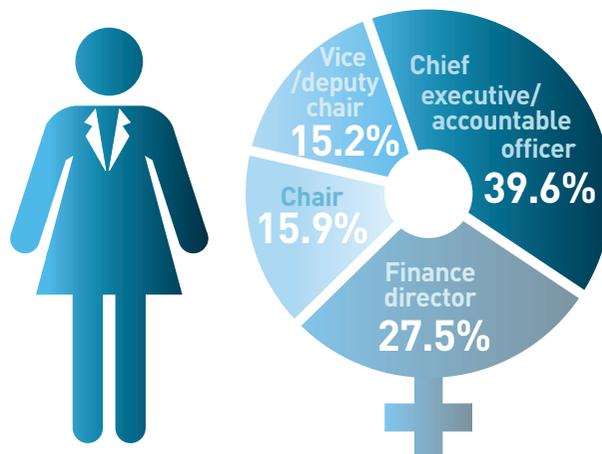
<sup>21</sup>Doldor, Vinnicombe, Gaughan & Sealy (2012) Gender diversity on boards: *The appointment process and the role of executive search firms*, Equalities & Human Rights, Commission, | Research Report 85, London.

## Key roles on CCGs

The clinical commissioning groups are responsible for allocation of significant amounts of the NHS budget to NHS trusts and to the independent sector where the majority of people are employed. Prior research<sup>22</sup> shows us that 70 per cent of the CCG workforce is female, with the majority of GPs being women. As 69 per cent of doctors training to become GPs are female (GMC, 2015), this proportion is consistently increasing. In 2014, NHS England reported on a sample of 85 per cent of CCGs that 63 per cent of CCG governing members were male and that 74 per cent of GP leads were male.

We are conscious that CCG websites may not always be entirely up to date and that there is a lack of consistency of member roles and descriptions across them. Therefore, for this report we have focused just on the clearly identified leadership positions of chair, chief executive/accountable officer, finance director, and vice/deputy chair.

## Percentage of women holding roles



Clearly these figures are disappointingly low and highlight the challenges for CCGs in considering the diversity on their governing bodies. This is something we would expect them to be taking into consideration when making appointments in future given the significant opportunities to develop and retain talented senior women in the system supporting the delivery of the Five Year Forward View.

“*There’s no magic about getting a good gender balance – just dogged repetition of what a high priority it is and a determination to seek out strong women candidates who could hold their own against any competition.*

*Sir Nicholas Montague, Chair of Council, Queen Mary University of London<sup>23</sup>*”

<sup>22</sup>NHS England (2014), Clinical commissioning group workforce equality & diversity profile, including governing body members and GP leads  
<sup>23</sup>WomenCount, (2016), “Leaders in Higher Education 2016”

## CONCLUSIONS AND RECOMMENDATIONS

This report has endeavoured to start the collection of a complete and longitudinal dataset on the board composition of NHS trust, ALB and CCG boards in England, with a view to contributing to the overall aim to achieve gender-balanced boards - 50:50 by 2020.

We need an additional 500 female-held board seats by 2020. If we use the EU Commission's definition of gender parity of at least 40 per cent of each sex on each board, then there are still 209 boards that do not meet that target. Given the gender split of the NHS's workforce, if we use our own definition of between 45-55 per cent of each sex, then there are almost 300 organisations who need to pay attention to their gender composition. The scale of the task is stretching but doable: 1-2 more women per board. However, there is a real imbalance in certain roles. While we have a very high percentage of chief nurses, we need more specific research and data on why there is a dearth of women in other roles, (particularly chief financial officers and medical directors). Are women applying and not getting jobs, or are they not applying? If not, do we have a supply problem, or is it a demand problem? Where we know we don't have a supply problem in terms of availability of competent women eg for non-executive director positions, what is not attractive and/or what is not being recognised?

A very helpful meeting was convened in January 2017 with all the major search firms operating in the NHS, and a number of actions were agreed:

- search firms will find ways of sharing candidate information so that the pool of applicants can be strengthened
- programmes will be supported that increase the interest of potential non-executive directors in particular
- training will be offered to governors to assist their role in recruiting to board of director positions
- In the summer of 2017, NHS Employers and NHS Improvement will publish a code of best practice based on the discussions, which will guide chairs and chief executives and search firms.

In addition, it is incumbent on board chairs to insist that they get top-quality female candidates from their search firm or other sources, providing a broad search covering private, public and tertiary sectors.

“  
*The success of women in different areas of society is interconnected, the success of women in one strata can reinforce success of women in another, creating a virtuous cycle.*  
**Professor Nadkarni, Cambridge Judge Business School**<sup>24</sup>  
”





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