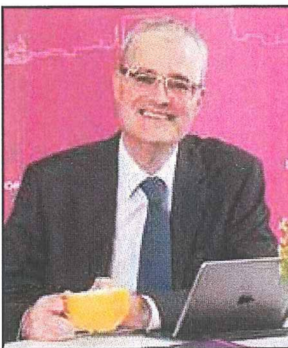
December 2015

# NHS Women in Leadership: PLAN FOR ACTION

**PENNY NEWMAN**
**In collaboration with UN Women**

## DANNY MORTIMER
### CHIEF EXECUTIVE, NHS EMPLOYERS



The NHS employs over one million women and is the largest employer in the UK. We are facing a period of enormous change over the short and long term. These changes will require significant alterations to our workforce in terms of roles and responsibilities and will be influenced and shaped both by the needs of our communities and by huge advances in technology and healthcare provision. This context and the necessary NHS response is clearly described in the NHS Five Year Forward View, published in autumn 2014.

To quote my colleague, Rob Webster, the NHS is 'made of people'. We know that – from our own experience and from the seminal research of Michael West and his colleagues – the workplace experience of those people makes a profound impact on those they care for. We also know that all too often we fail to ensure that all the talent available to the NHS is used to the full benefit of the communities, citizens and patients we serve. For an organisation that largely employs women, any failure to make best use of their talents should be of particular concern to leaders across the NHS.

This report sets out a comprehensive and compelling model for organisations to begin to look at a particular aspect of their workforce development and leadership – and I would encourage them to do so. This should then also trigger a more comprehensive overview of all aspects of gender equality – in terms of both workforce and service delivery. The role of women on boards is business critical to the NHS – and we must make true gender equality our business.

## CLARE MARX
### PRESIDENT, ROYAL COLLEGE OF SURGEONS

At first glance, there are so many women who are currently presidents of the Royal Medical Colleges that one could be forgiven for thinking that gender inequality in NHS leadership roles is a thing of the past. But as I look behind at the medical leadership pipeline, it looks very similar to the one I followed. I wonder if it is just my specialty, surgery. That's not what the evidence shows even though we, the surgeons, have further to go than most.

This report is important. The messages and actions we take away from reading it will help us ensure that we do more to enable all those who give so generously of their skills and commitment to the NHS, to have a chance in achieving their full potential. By bringing about change in the gender diversity of leadership, the service will benefit from the differing skills that change brings to the table.

This report challenges the organisations for whom and with whom we work to show sustained commitment to addressing gender inequality by measurement, provision of enabling infrastructure and committing to leadership development.

Women can't do this on their own; we need men as champions for change. We are equal partners in the great NHS endeavour, ensuring high-quality, compassionate care for our patients. Let's not waste the energies of another generation of women who wish to give their best.

## PHUMZILE MLAMBO-NGCUKA
### UN UNDER-SECRETARY-GENERAL AND EXECUTIVE DIRECTOR, UN WOMEN

On 27 September 2015, just after the General Assembly adopted the new 2030 Agenda for Sustainable Development, the Secretary-General of the United Nations addressed more than 70 heads of state and government at the first-ever Global Leaders' Meeting on Gender Equality and Women's Empowerment. He asked for "direct and tangible commitments to policies and action that will secure true gender equality throughout the world".

Globally, 2015 has seen a surge in awareness of the benefits for everyone that come from engaging women, equally and at all levels. This holds true whether we look at the performance of institutions, the durability of peace accords, or the health of families. This is borne out by global research and backed by well-articulated arguments. However, making enduring change in the face of entrenched stereotypes and cultures is not easy.

We know that in all countries and institutions, increasing the contribution of women in leadership starts with strong advocacy from the top, with a consistent emphasis on equal representation at decision-making levels, systematic review of organisational culture, and continuous monitoring. In both the NHS and the UN system, there is a rich talent pool from which to draw dynamic and skilful senior women managers and build institutional behaviour change. Daunting as it might sometimes seem, we must make a start. If not now, then when?

Demonstrating his personal commitment to gender equality, Secretary-General Ban Ki-moon has appointed more women to senior positions than all previous Secretary-Generals combined, has established rigorous systems and processes at all levels of the organisation (gender mainstreaming) and regularly reviews progress through the UN System-Wide Action Plan (UN-SWAP), the accountability framework instigated in 2012. With the formation of UN Women five years ago, the UN further underlined its dedication to achieving gender equality and women's empowerment.

The NHS has many similarities to the UN system: both are highly respected institutions serving the public interest, both are focused on sustainability with limited resources and competing demands, and both are complex structures that include multiple diverse organisations. In both, women remain under-represented in leadership despite the need for the brightest to meet major challenges. The NHS has an additional multi-billion business imperative for improved organisational performance, decision-making, productivity and care in order to meet patients' needs – to which tackling gender equality, and rigorous monitoring of progress can contribute.

This report provides an opportunity for joint work to promote gender equality, engaging both men and women, drawing on our experience of effective change processes and tools within the UN system, and sharing lessons learnt from the work globally on women's empowerment. As both of our organisations strive to be role models for others, and to justify the trust placed in us, together we must act on the evidence, modify our institutional processes, organisational cultures and individual mindsets, and step it up for planet 50:50 by 2030.

## PARTNERS

We acknowledge the need for gender equality in the NHS and partner organisations, support the recommendations of this report and pledge to champion and address gender equality among wider diversity issues.

Royal College of General Practitioners

Maureen Baker
Chair, Royal College of General Practitioners

Department of Health

Dame Sally Davies
Chief Medical Officer, Department of Health

Royal College of Surgeons
ADVANCING SURGICAL CARE

Clare Marx
President, Royal College of Surgeons

Public Health England

Duncan Selbie
Chief Executive, Public Health England

Sally Davies
President, Medical Women's Federation

Faculty of **Medical Leadership** and **Management**

Peter Lees
Chief Executive and Medical Director, Faculty of Medical Leadership and Management

Danny Mortimer
Chief Executive, NHS Employers

The King's Fund

Vijaya Nath
Director, Leadership Development,
King's Fund

Quality. Delivery. Sustainability.

Kathy Mclean
Medical Director, Trust Development Authority

NHS Clinical Commissioners

The independent collective voice of clinical commissioning groups

Julie Wood
Chief Executive, NHS Clinical Commissioners

Jane Cummings
Chief Nursing Officer, NHS England

# FURTHER ACKNOWLEDGEMENTS

Thank you to all those who participated in the interviews for generously giving their time and expertise. In addition, my gratitude goes to the King's Fund and Vijaya Nath, director of leadership development, for hosting the Advancing Women in Medicine Summit on 16 December 2014 and to other colleagues on the organising committee from the Faculty of Medical Leadership and Management, Medical Women's Federation and British Medical Association. Particular thanks goes to Clare Marx, president of the Royal College of Surgeons (RCS). Without the summit and generosity of Ms Marx and the RCS to act as host to Ms Aparna Mehrotra who was invited as guest speaker, there might not have arisen the opportunity to work with UN Women. Thank you especially to Ms Aparna Mehrotra for role modelling and providing the opportunity and privilege to work with UN Women on this important agenda. Finally, thank you to NHS Employers and in particular its chief executive, Danny Mortimer, and head of equality and diversity, Paul Deemer, for their encouragement and support in the production and distribution of this report. This report was launched at the HSJ Women Leaders Network event on 3 December 2015 and we are grateful to HSJ for its support.

**Dr Penny Newman**

Dr Penny Newman is a GP and consultant in public health, medical director at Norfolk Community Health and Care NHS Trust, and associate at Health Education East of England. She is author of the report *Releasing potential: Women doctors and clinical leadership* published by the NHS Leadership Academy in 2012, and was a member of Organising Committee of the Advancing Women in Medicine Summit. Penny is a National Innovator Accelerator Fellow, an initiative led by UCL Partners, NHS England and the Health Foundation to contribute to the delivery of a commitment made in the NHS Five Year Forward View and create the conditions and cultural change necessary for proven innovations to be adopted faster and more systematically by the NHS. She runs a network for women doctors Inspiring Women Leaders in Medicine and coaches female colleagues. Please email **penny.newman1@nhs.net**

**Aparna Mehrotra**

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# EXECUTIVE SUMMARY

## Introduction

In September 2015, the United Nations approved Agenda 2030 and ambitious new sustainable development goals (SDGs) which replaced the United Nations 2000 millennium development goals (MDGs). Within the SDGs, goal 5 was dedicated as a standalone goal: to achieve gender equality and empower all women and girls. In acknowledgement that no goal could be properly achieved without the participation and perspectives of half of the world's population, its women, gender equality was also embedded into almost all other goals. Overall, the SDGs cover women's equal rights, health, education, leadership representation and equal pay, achieved through stronger policies and legislation.

Agenda 2030, which was negotiated and approved by all member states, constitutes a blueprint for the immediate future. Its goals are expected to be achieved in the next 15 years, by 2030, and for which all sectors of society will be expected to mobilise, with the health sector being no exception.

This paper was written in collaboration with UN Women to promote gender equality and explore the application, in part or in whole, of its new UN System-Wide Action Plan (UN-SWAP) to the NHS. In particular, in alignment with SDG 5 and the belief that equal representation of women in decision-making enhances outcomes, it recommends a series of next steps to accelerate progress.

As well as consideration of the UN approach, the report is based on a detailed review of evidence and qualitative interviews with 12 senior NHS leaders who were sent prior information on UN-SWAP to assess its application to the NHS. In the process, a range of actions to increase the number of women in leadership across the NHS and improve the talent pipeline have been identified (see pages 20–22, 27–29).

Barriers to career progression are covered more in a previous report by the author *Releasing potential: Women doctors and clinical leadership* and are broadly applicable to all professions.

## Women in leadership in the NHS

The NHS seeks to respond to complex 21st century challenges facing healthcare including a £30 billion funding gap, the urgent need to improve the quality of care, significant problems with staff recruitment and retention, and the need for more skilled leadership.

As part of an ambitious programme of reform needed to deliver the changes required, NHS England has committed the NHS, in its Five Year Forward View, to becoming a better employer, to radically alter the way it plans and trains its workforce and to provide non-discriminatory opportunities.

The majority of NHS staff are women (77 per cent), on which the service depends. Yet women make up only 36 per cent of chief executives, 26 per cent of finance directors and 24 per cent of medical directors. In 211 clinical commissioning groups (CCGs), the workforce is mostly female (70 per cent) while women make up only 37 per cent of governing body members and 26 per cent of lead GPs.

The under-representation of women in NHS leadership, pipeline issues of horizontal differentiation into lower level and female-friendly roles, and bottlenecks in certain groups, for example, finance and medicine, all have significant implications for the quality of service and financial bottom line that

merits specific attention. Medicine, in particular, has an unequal distribution of female doctors between specialties and relatively few female leaders.

Evidence is now accumulating showing that promoting gender equality similar to other sectors, and across the globe, can help the NHS address the challenges it faces through:

- improving organisational performance, decision-making and innovation
- increasing productivity with improved recruitment and retention
- increasing access to the widest talent pool
- meeting patients' needs
- becoming an exemplar employer
- meeting global and national legislative requirements.

But action that focuses on individual women's development alone is insufficient. Growing international evidence suggests that the complex systemic cultural and societal barriers that impede female career progression will only be addressed by system change.

## Learning from the United Nations system

In the UK, successful system-wide interventions to improve the representation of women in senior leadership include the Davies report in the private sector, and Athena SWAN awards for women in scientific academia. In October 2015, Lord Davies reported the number of women on boards in FTSE 100 companies had more than doubled from 12.5 per cent to 26 per cent since his first report (2010). He recommended the voluntary target be raised to minimum of 33 per cent for the next five years. This is just below the 40 per cent set by Viviane Reding, vice-president of the European Commission, and has been achieved without the need for quotas as companies recognise the need to strengthen their own talent pipeline.

The United Nations (UN) system, made up of 32 different entities, is another example from which the NHS can learn. There exists an inverse relationship between seniority and representation of women, similar to the NHS, and a multi-pronged approach has been adopted to gender equality and women's empowerment across all the UN system entities and their mandates. This multi-pronged approach includes the following points.

1. A legal and conceptual framework (see Appendix 1 on page 33–34) which includes the policy of gender mainstreaming to ensure all policies and programmes address women's as well as men's concerns and experiences so that both women and men benefit equally.
2. The adoption of temporary special measures (see Appendix 1 on page 33–34) to attain and sustain equality of women in every sphere, including at each stage of the staff selection process, which are complemented by policies and practices intended to promote a facilitative organisational culture conducive to the retention of women staff.
3. A wide range of actions incorporating gender specific goals (50:50) supported by legislation and actively backed by senior leaders, setting and monitoring annual targets for each level in the staffing structure, creating a network of champions in the middle layer architecture, ensuring impartial appointment processes, running exit surveys to gauge organisational culture, creating flexible work arrangements and publishing data and analysis on gender. The HeForShe campaign aims to engage more men as advocates for equality.

4 The new UN System-Wide Action Plan (UN-SWAP) constitutes the first uniform framework to systematically measure progress across all UN entities. It requires organisational responses to six key functional clusters and 15 performance measures relating to accountability, results-based management, oversight, evaluation and monitoring, human and financial resources, capacity assessment and development, and coherence and information management. In three years, the progress has been registered across almost all indicators.

## Action recommended for the NHS

The 12 senior leaders interviewed all recognised that more women are needed in senior leadership roles to meet current challenges and that the talent pipeline needs to be improved. They stressed the need for a different leadership style, improved board effectiveness and increased recruitment, retention and productivity – all of which can be addressed by increasing women's contributions and reducing barriers to their advancement.

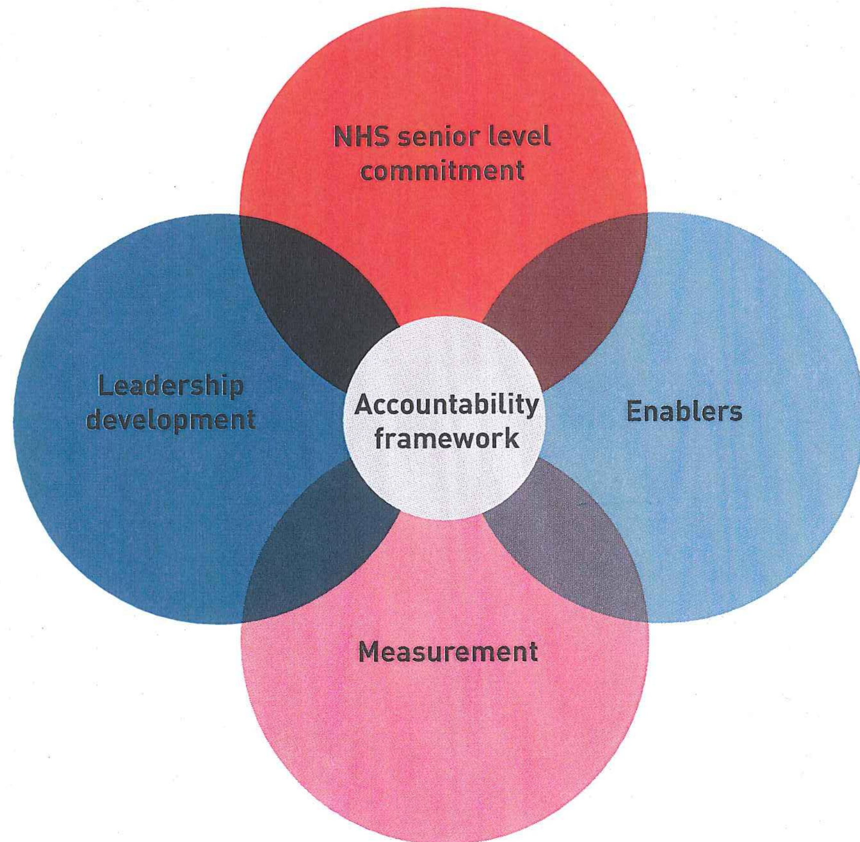
However, although there was consensus on the need for action, views differed on the degree of urgency and approach based on a business and/or moral case – achieving change through a compelling narrative outlining the positive contribution of women similar to the Davies report, and/or an accountability framework equivalent to the Workforce Race Equality Standards and UN-SWAP. Fear of disadvantaging men and other protected groups, and the view that women themselves did not want to be seen as a needing 'remedial action' led to reservations about positive action. A few reported that the problem had mostly been addressed, unsubstantiated by data. High-level leadership and open debate are required to address these different views, given the complexity of the issue.

Despite these qualms, all senior leaders interviewed had clear ideas on what was needed. Recommended action for the NHS included the creation of a guiding coalition, identifying a national champion, accurately measuring board membership by gender, setting aspirational targets, and creating a framework for action including leadership development, improved flexible working, returner schemes and other enablers (see Figure 1 on page 11). Few senior leaders were aware of the full range of options as recommended by UN Women, indicating a need to learn from other sectors.

Much can be learnt from the UN system approach to gender equality. The UN-SWAP provides many benefits to the NHS as a common language, framework, and way to measure progress shown to increase representation of women in leadership. However, given the lack of clear direction and shared understanding, the general sense of the interviews was that the timing is not yet right for UN-SWAP to be considered fully as a lever for change in the NHS.

The first step is for senior leaders representing the NHS as a whole, to agree that the under-representation of women in NHS leadership and talent pipeline is a priority before legislative changes make it a requirement. This report provides information on what must be done at a system, organisational and individual level once this has been agreed, including full consideration of UN-SWAP when work commences.

## Figure 1: Actions recommended by NHS leaders to increase female representation in senior roles




- 50:50 goal, senior champion(s), task force and strategy

- HR policies including talent management, flexible working, appointment panels/shortlists, returner schemes, bias awareness training
- Infrastructure, for example, crèches
- Showcasing
- Investment

- Identify gaps, good practice and monitor improvements

- Review of leadership: what's valued
- Board development
- Women-only programmes
- Coaching, mentoring and sponsorship

## Recommendations

The following recommendations are based on the range of actions identified from the interviews and informed by UN Women.

A successful strategy involves a multi-pronged approach including but not limited to the following.

1. **Focus**: the NHS must adopt a focus on the equal representation of women and their advancement at all levels, including at board level or equivalent, to meet the workforce challenges it faces.
2. **Champion**: a high-level champion should be appointed, much as Lord Davies for industry, with a compelling narrative outlining the positive contribution of women and the business case for action.
3. **Task force**: a system-wide task force should be created to inform and support the high-level champion (inter alia) and to strengthen implementation.
4. **Mandate**: the Department of Health should include gender equality and all its appropriate manifestations within the Mandate of NHS England.
5. **Monitoring and accountability**: as a priority, data should be recorded and published to benchmark and track improvement. In addition, a broader system of monitoring and accountability should be developed. Such a framework may be built on the Workforce Race Equality Standards and the UN-SWAP, and should be piloted in a few selected NHS organisations.
6. **Organisational culture**: shifts in organisational culture constitute the bedrock of sustainability and progress. Issues of organisational culture should be systematically identified and effective plans and practices developed to address them such as organisational and exit surveys, unconscious bias training and promotion of flexible working. Higher decision-making levels, such as boards and executive teams deserve special focus.

# INTRODUCTION

The NHS provides healthcare free at the point of use to the UK population and, similar to healthcare globally, faces a significant financial challenge (circa £30 billion). Recent high-profile reports, such as those looking into care at Mid Staffordshire hospital, have indicated that quality of care can be variable and the culture needs to change.

To address these challenges requires an ambitious programme of organisational reform driven by local and national leadership rather than further legislative change as described in NHS England's Five Year Forward View. It also requires a modern workforce and for the NHS to become a better employer, supporting the health and wellbeing of frontline staff, providing safe, inclusive and non-discriminatory opportunities, and supporting employees to raise concerns.

This paper was written by Dr Penny Newman following Ms Aparna Mehrotra's invitation as speaker at the Advancing Women in Medicine Summit, at the King's Fund on 16 December 2014, and as guest of the Royal College of Surgeons (RCS).

Given the UN's global mandate on equal representation, the aim was to consider whether achieving greater gender equality could help the NHS address its challenges and if so how this could be promoted through the use of the new UN System-Wide Action Plan (UN-SWAP) outside the UN system. The opportunity exists for the NHS to develop an NHS-SWAP accountability framework as pioneer for other countries in health or other public sector areas.

Since September 2015, ambitious new sustainable development goals (SDGs) have been adopted by world leaders at the United Nations General Assembly which are applicable to all for the next 15 years. A key focus of the SDGs is on achieving gender equality and empowering women, ensuring equal opportunities for leadership and the creation of sound policies and legislation. Commitment of all member states to the SDGs strengthens the case for the NHS to reconsider its approach.

This report is the result of semi-structured interviews with 12 senior leaders from national organisations across the NHS (see Appendix 2 on page 35). Interviews were held between January and May 2015 following circulation of a consultation report providing background NHS data and information on the UN approach.

This paper is written for UN Women, all those interviewed and other senior NHS leaders, to help address the leadership gap, improve the talent pipeline and hence improve the quality of care for patients. It covers:

- what the data and evidence tells us
- action undertaken by the UN to address gender inequality within its own system
- what NHS leaders say
- what the NHS could do
- recommendations for the NHS.

# WHY IS GENDER EQUALITY IMPORTANT IN THE NHS?

## The under-representation of women

It is national policy that NHS boards should be representative of the communities they serve and that this is likely to benefit the planning and provision of services. There is increasingly robust evidence that a diverse workforce, in which all staff contributions are valued, is linked to good patient care.

However, data indicates that although women are the majority of graduates, for example, 60 per cent to 70 per cent of management trainees over the past three years, they are significantly under-represented in current NHS senior leadership. The NHS is composed of 77 per cent female staff and yet women make up only 36 per cent of chief executives, 26 per cent of finance directors, 24 per cent of medical directors, 69 per cent of human resources directors and 87 per cent of nursing directors (where women make up 89 per cent of nurses overall).

While some progress has been made in increasing the representation of women as chief executives, it has been limited – women still tend to migrate to posts in community health, children's, women's and mental health services. And only two out of ten chief executives of the Shelford Group, containing the largest teaching hospitals, are female.

Out of 211 CCGs authorised in April 2013 and responsible for two thirds – £66 billion – of health service spend, the workforce is mostly female (70 per cent) while women make up only 37 per cent of governing body members and 26 per cent of lead GPs.

The composition of higher national bodies is given in Table 1 below revealing women make up between 29 per cent and 58 per cent of board members (average 41 per cent).

### Table 1: Gender representation on national NHS bodies

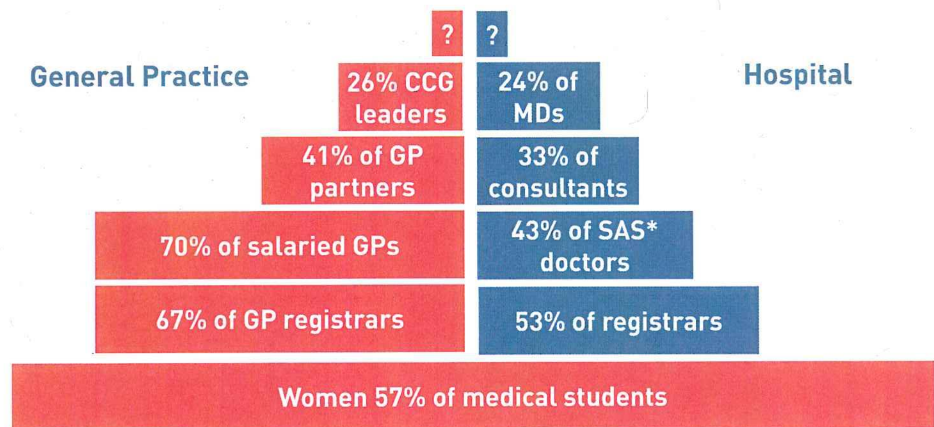
| | Executive | | Non-executive | | | |
|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | All | % women |
| NHS England | 5 | 3 | 6 | 2 | 16 | 31% |
| Monitor | 6 | 4 | 9 | 2 | 21 | 29% |
| Trust Development Authority | 6 | 4 | 2 | 3 | 15 | 47% |
| Health Education England | 8 | 11 | 3 | 3 | 25 | 56% |
| Public Health England | 11 | 7 | 5 | 2 | 25 | 36% |
| Academy of Royal Colleges | 6* | 2 | – | | 8 | 33% |
| GMC | 4 | 4 | 4 | 7 | 19 | 58% |

* The Board of Trustees oversees the overall governance of the Academy. The gender composition of Academy Council of Presidents of the member Colleges and Faculties was unavailable.

Women, however, predominate at the levels before very senior managers:

- Bands 8a to 9 (senior clinical and managerial) – 31 per cent men and 69 per cent women
- Bands 5 to 7 – 17 per cent men and 83 per cent women
- Bands 1 to 4 – 19 per cent men and 81 per cent women.

## Figure 2: Proportion of medical workforce who are women




*SAS Staff and Associate Specialists.

**Source: HSJ Women's issue 2013, Health and Social Care Information Centre 2013, NHS England 2013 Clinical Commissioning Group Workforce Equality and Diversity Profile.**

Doctors make up 11 per cent of the NHS workforce yet have a disproportionate influence, particularly on CCGs. While there is no shortage of women doctors in the pipeline, they continue to be the most poorly represented group, a trend requiring specific attention (see Figure 2 above).

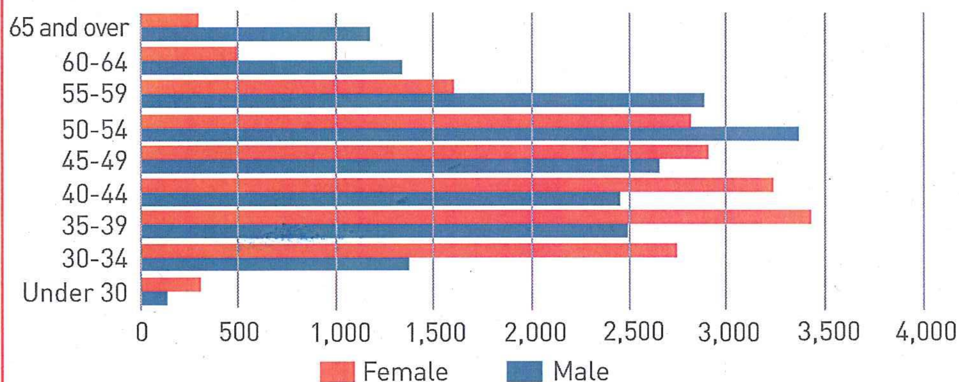
- Women have been the majority of entrants to medical schools for over two decades and will soon be the majority of qualified doctors.
- Women currently make up 41 per cent of GP partners and 33 per cent of consultants. There is a wide variation between specialties, for example, they are under-represented in surgery (11 per cent consultants) and emergency medicine (30 per cent consultants) and are more likely to choose paediatrics (49 per cent consultants) and psychiatry (40 per cent consultants).
- Women are over represented in lower-level roles, for example, as salaried GPs (70 per cent).
- Women doctors are most under-represented in board equivalent roles despite the need for medical leadership, for example, as trust medical directors (24 per cent) and as lead GPs on CCGs governing body (26 per cent).
- Although established to ensure GP input into the commissioning of healthcare, 29 CCGs have no female medical representation.

In particular, the relatively few female GP leaders (and hence role models), and limited development opportunities for salaried and locum GPs, are of particular concern given the changing demographic of general practice to a more female, part-time and sessional workforce (see Figure 3 below).

Internationally, women make up about 42 per cent of the estimated global paid working population. Within the health sector, in many countries women comprise over 75 per cent of the workforce, making them indispensable as contributors to the delivery of healthcare services. However, as in the NHS, women still tend to be concentrated in the lower-level health occupations, and to be a minority among more highly trained professionals.

The reasons for the under-representation of women are complex and include a 'cumulative disadvantage' that women encounter over the course of their careers. Obstacles include individual and organisational attitudes, or subconscious bias, career and appointment structures and processes, and limited opportunities for flexible working. In surgery, for example, a perceived lack of 'fit' with current leaders, impacts on women doctors' motivation to join and remain in the specialty.

**Figure 3: GP by gender and age**




**Source: General and Personal Medical Services, England 2004–2014, as at 30 September 2014; Health and Social Care Information Centre (HSCIC), published March 2015.**

## Comparison with other sectors

This under-representation of women in senior positions is seen across all sectors in the UK, and points to systemic cultural and societal barriers preventing the attainment of gender equality.

In 2012, women occupied on average 30.9 per cent of the most senior positions across 11 key sectors, including business, politics and policing. The armed forces and judiciary had the fewest women in top posts – 1.3 per cent and 13.2 per cent respectively – while secondary education had the most at 36.7 per cent. The NHS has a comparative advantage to these other fields in rectifying gender imbalances, given it has a larger pool of women entering the pipeline.

It is becoming widely recognised by governments, and organisations themselves, that organisations are missing out. Targets to increase the number of women on boards have been set for many countries across Europe. Since the original

publication of the Davies report in 2011, female representation in the boardroom has increased from 12.5 per cent and 7.8 per cent, to 26.1 per cent and 19.6 per cent on FTSE 100 companies and FTSE 250 companies respectively. The number of all-male boards have reduced from 152 to 15, and 550 more senior women have been appointed. In October 2015, Lord Davies raised the voluntary target to a minimum of 33 per cent to be achieved within the next five years. This is just below the 40 per cent set by Viviane Reding, vice-president of the European Commission, and has been achieved without the need for quotas as companies recognise the need to strengthen their own talent pipeline.

In the UK Senior Civil Service (SCS), a report commissioned by the Cabinet Office looked into the blockages impeding talented women from succeeding and sets out five key recommendations to transform the quality of the leadership, culture and talent. These include establishing a more inclusive leadership climate, reducing variability in leadership capability so that the best talent can prosper, clarifying accountability for leadership behaviour, publishing data on gender diversity as a driver for reform, and further developing positive action initiatives for women, such as greater access to mentoring using non-executive directors.

## Benefits of gender equality

Why has the NHS been impervious to these developments? The case for gender equality in the pipeline and at board level or equivalent has six key dimensions:

- improving organisational performance and decision-making
- increasing productivity
- accessing the widest talent pool
- meeting patients' needs
- being an exemplar employer
- meeting global and national legislative requirements.

### Improving organisational performance and decision-making

- Gender diversity at board level has been shown to increase financial and organisational performance.
- Diverse top teams benefit from improved decision-making, innovation and creativity, better governance and less 'group think'.
- A 'critical mass' of three or more women in top teams is needed to bring about the type of cultural change the NHS is being asked to make.

### Increasing productivity

- Research by McKinsey demonstrated that the additional productive power of women entering the workplace since the 1970s, accounts for about a quarter of GDP in the USA through increasing workforce participation and skill.
- The NHS is currently experiencing recruitment and/or retention problems, for example, in nursing, medical specialties such as general practice and emergency medicine, in science and technology, and in top leadership posts. A third of NHS providers have at least one board-level position not permanently filled.
- The NHS needs to tap into the productive power of women, achieve better return on investment, and anticipate increased caring responsibilities of both male and female staff given changing parental responsibilities and an aging population.

### Accessing the widest talent pool

- Organisations need to be able to draw from the widest possible range of talent and ensure ambitious well-qualified women are encouraged to lead.
- As leaders, women outperform men on 360 degree feedback criteria and research suggests women make safer decisions; women doctors are less likely to be referred for performance issues and receive fewer complaints through the GMC compared to male colleagues.

### Meeting patients' needs

- There is increasingly robust evidence that a diverse workforce, in which all staff contributions are valued, is linked to good patient care.
- Women offer a broad range of life and work experience that can help ensure services meet patients' needs. For example, women are estimated to be responsible for about 70 per cent of household purchasing decisions which impact on health, including diet.
- The leadership of the NHS can better mirror the people it serves.

### Being an exemplar employer

- The ambition of the NHS to be at the forefront of healthcare innovation and delivery is undermined by a lack of women in senior decision-making.
- Other staff, including black and minority ethnic groups (many of whom are women), and men, are likely to benefit from a focus on gender equality given the wider impact of any changes to reduce bias.

### Meeting global and national legislative requirements

- Gender equality is a basic human right. There will be increasing pressure on member states from the UN to consider special measures for women to accelerate achievement of gender equality in relation to the SDGs, including on the UK government. SDGs include, among others, goals to achieve gender equality and empower women, ensure women's effective participation and equal opportunities for leadership at all levels and to adopt sound policies and enforceable legislation to promote gender equality.
- All organisations in England are required to comply with the 2010 Equality Act, which requires equal access to employment regardless of gender.

## MEASURES IN PLACE TO ADDRESS LEADERSHIP DIVERSITY IN THE NHS

As the ethnic diversity of NHS bodies at senior level is similarly poor, so far measures to address workforce and leadership inequality have mostly targeted diversity as a whole and/or the leadership development of black and minority ethnic (BME) groups. A recent report, *The snowy white peaks of the NHS*, led to an outcry at the lack of BME leadership and a new Workforce Race Equality Standard for the NHS has since been developed. The standard is viewed as the first phase of Workforce Equality Standards that will cover all equality groups, including gender.

The NHS Leadership Academy considers diversity within all its programmes and has specifically targeted aspiring BME leaders through the Breaking Through and, more recently, the Ready Now programmes.

The Equality Delivery System (EDS2) supports NHS organisations to improve their performance for all characteristics given protection by the Equality Act 2010, and to help meet the public sector equality duty. Two of its four overarching goals focus on 'a representative and supported workforce' and 'inclusive leadership'. EDS2 was mandated in the NHS standard contract for providers in April 2015, and features in the CCG Assurance Framework for commissioners.

Targeted programmes for women include the NHS Women's Unit to increase the number of women in senior management (1992); the King's Fund's Athena programme for aspiring female leaders; four national reports on women doctors' careers (2006 – 2012); and the Equality Challenge Unit's Athena SWAN Charter to advance the careers of women in science, technology, engineering, maths and medicine (STEMM) in research and academia through recognition awards linked to research funding (2005). NHS Employers and the Health Service Journal (HSJ) have recently launched the Women Leaders Network, a community for leaders and emerging leaders, which aims to achieve fair representation of women on boards of health and social care organisations.

# WAYS UN WOMEN COULD SUPPORT GENDER EQUALITY IN THE NHS

## Learning from the UN system

Women account for 42 per cent of staff in the UN system, and there exists an inverse relationship between seniority and representation of women, similar to the NHS. In order to meet the requirements set out in Article 4 CEDAW (see Appendix 1 on pages 33–34) the implementation of temporary special measures has been put in place to attain and sustain equality of women in every sphere, including at each stage of the staff selection process, which are complemented by policies and practices intended to promote a facilitative organisational culture conducive to the retention of women staff.

More specifically, a multi-pronged approach has been taken which provides lessons for the NHS. These include:

1. **A legal and conceptual framework** (see Appendix 1 on pages 33–34) – the policy of gender mainstreaming ensures all policies and programmes address women's as well as men's concerns and experiences so that both women and men benefit equally.
2. **Identification of goals, supported by legislation** – the goal of 50:50 has been set at all levels, in all occupational groups, and has been legislated by the UN governing body, the General Assembly of 192 Member States.
3. **Senior level support** – over the current Secretary-General's (SG) two terms, the representation of women in the UN system has increased more than under all prior SGs combined.
4. **Setting and monitoring annual targets** – targets at each level in the staffing structure has propelled progress, shone the spotlight on gaps and success at each level and allowed tracking of career advancement.
5. **A network of champions** – created across and within institutions in the middle-level architecture and located in all departments and offices of the UN, champions include a dedicated position to coordinate the network and report to the General Assembly and Secretary-General (Focal Point for Women).
6. **All shortlists must include women** – for decision-making positions at the highest level, the SG requests lists of three names, of which one must be a woman. The women not selected are then placed on a roster from which they may in the future be selected for similar functions at that level.
7. **Positive appointment practices** – any female candidate who is deemed to meet the qualifications delineated in a job description must be listed in the final shortlist. If equal or better qualified must be selected because there are imbalances at that level of appointment and in that occupational group, assessment is undertaken against a job description and not candidates against each other.
8. **Gender balanced interview panels** – ensure full consideration of women and impartiality in assessments. The Focal Point for women participates in selection as observer with a voice but not a vote to ensure women, like men, are recruited equally on their potential and not solely on past records.
9. **Organisational culture** – the key component of sustainability and annual organisational surveys and exit surveys gauge and address organisational culture systematically.

10 **Flexible working arrangements** – have been created to meet demands and realities of child and elderly care.

11 **Publication of reporting and analysis** – reports from the Secretary-General to the General Assembly on Gender Mainstreaming and on the Improvement of the Status of Women are published annually. These include data, trends analysis by department and office, recommendations and conclusions.

To improve equality in organisations external to the UN system, UN Women adopts multiple strategies which cannot be fully listed here. Most relevant to the NHS is the HeForShe campaign that aims to engage an initial ten governments, corporations and universities around the world in activities to achieve gender equality through encouraging greater participation of men.

## Description of UN-SWAP accountability framework

Building on the above, since its inception two years ago, actions have been brought together through the UN-SWAP which constitutes the first unified and uniform accountability framework to systematically measure progress related to gender equality and women's empowerment across all the UN system entities and their mandates.

UN-SWAP has been used as a lever for change enhancing capacity and system-wide performance by:

- including corporate processes as well as institutional arrangements at the individual entity level in its scope
- establishing a common understanding and aspirational guides
- encouraging focus, shared responsibility and coherence
- setting out minimum reporting requirements
- enabling comparison of results between organisations and of future performance expectations over time
- facilitating an analysis of strengths and weaknesses across the system and hence resources required
- promoting leadership and direction.

The UN-SWAP includes consideration of six key functional clusters and 15 performance indicators based around accountability, results-based management, oversight, evaluation and monitoring, human and financial resources, capacity assessment and development, and coherence and information management. UN entities self-assess and report against a rating system consisting of five levels for each performance indicator: exceeds requirements, meets requirements, approaches requirements, missing, and not applicable.

Indicators are set out on page 22 and here:
**www.unwomen.org/en/how-we-work/un-system-coordination/promoting-un-accountability**

## UN-SWAP performance indicator

### Strengthening accountability

1 Policy and plan – organisations are required to have an up-to-date gender equality and gender mainstreaming policy.

2 Gender responsive performance management – assessment of gender equality and the empowerment of women is integrated into core values of organisations and/or competencies for all staff.

### Enhancing results-based management

3 Strategic planning – central strategic planning documents of the organisation should include specific outcomes/expected accomplishments and indicators on gender equality.

4 Monitoring and reporting – organisations should report on gender equality results in relation to their central strategic planning document and ensure that all key organisational data is sex disaggregated.

### Establishing oversight through monitoring, evaluation and reporting

5 Evaluation – gender dimensions are sufficiently integrated into evaluations of projects and programmes.

6 Gender responsive auditing – risks in relation to gender are assessed during annual risk planning cycles.

7 Programme review – programme quality control systems should fully integrate gender analysis.

### Allocating sufficient human and financial resources

8 Financial resource tracking – a financial resource tracking mechanism is in use to quantify disbursement of funds that promote gender equality and the empowerment of women.

9 Financial resource allocation – a financial benchmark for resource allocation for gender-related mandates is set and met.

10 Gender architecture – dedicated staff devote at least 20 per cent of their time to promoting gender equality in each organisation, there is a gender balance or equal men and women within the organisation at every level and the organisation has sufficient staff and resources to meet mandate.

11 Organisational culture – harassment and discrimination policies are in place; the organisation has developed facilitative practices such as maternity leave, paternity leave and flexible working policies; and surveys are undertaken to monitor and analyse workplace cultures.

### Developing and/or strengthening staff capacity and competency in gender mainstreaming

12 Capacity assessment – organisation-wide assessment of the capacity of staff in gender equality is carried out. Based on results, a capacity plan should be established.

13 Capacity development – staff at all levels receive ongoing mandatory training on gender.

### Ensuring coherence/coordination and knowledge information management at the global, regional and national level

14 Knowledge generation and communication – knowledge on gender equality is systematically documented and publically shared and communication plans include gender as a key component.

15 Coherence – UN agencies are to participate in inter-agency networks on gender equality and women's empowerment.

## First steps towards effective gender mainstreaming in the UN system

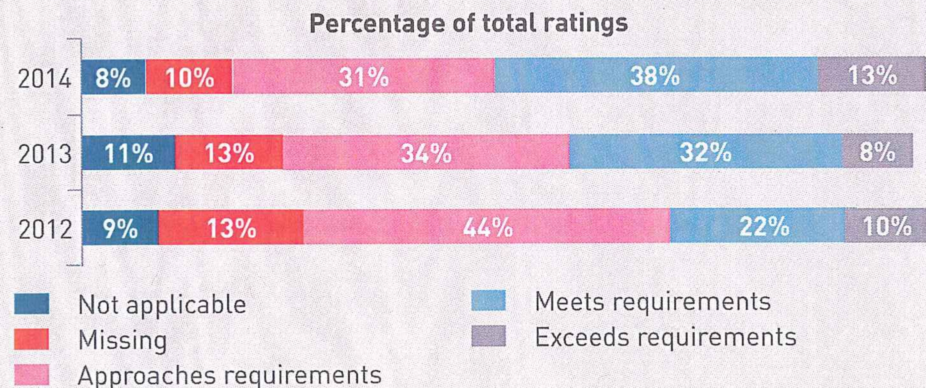
The UN system to date has reported against the UN-SWAP for calendar years 2012 – 2014 allowing for an assessment of baseline and areas of improvement.

In 2014, 90 per cent of the United Nations system agencies, a total of 62 organisations, reported an 8 per cent increase since 2012, and the same number as 2013, demonstrating continued system-wide commitment to the UN-SWAP. Figure 4 below illustrates that the UN system met or exceeded requirements for 31 per cent of ratings in 2012, 42 per cent in 2013, and 51 per cent in 2014. If this degree of progress is maintained, the UN system could realistically meet the UN-SWAP targets for most performance indicators by the end of 2017.

Disaggregated analysis by performance indicator for 2013 and 2014 is set out in Figure 5 on page 24 by level of performance. The third year of implementation of the UN-SWAP saw progress in 14 of the 15 performance indicators, including advances of more than 31 percentage points in the cases of gender policy, strategic planning, knowledge generation, and gender responsive audit, which registered the highest increase of 64 percentage points. Of particular significance is the increase in the policy performance indicator. Having a gender policy has been correlated with improved UN-SWAP performance, with entities with policies meeting requirements, on average, for double the amount of indicators as entities without policies.

With intensified efforts and senior management leadership, adequate resources and capacity, the UN system has the potential to achieve most UN-SWAP targets by the 2017 deadline set by the executive board.

### Figure 4: Breakdown of aggregate UN-SWAP ratings for 2012, 2013 and 2014 (% of total ratings)



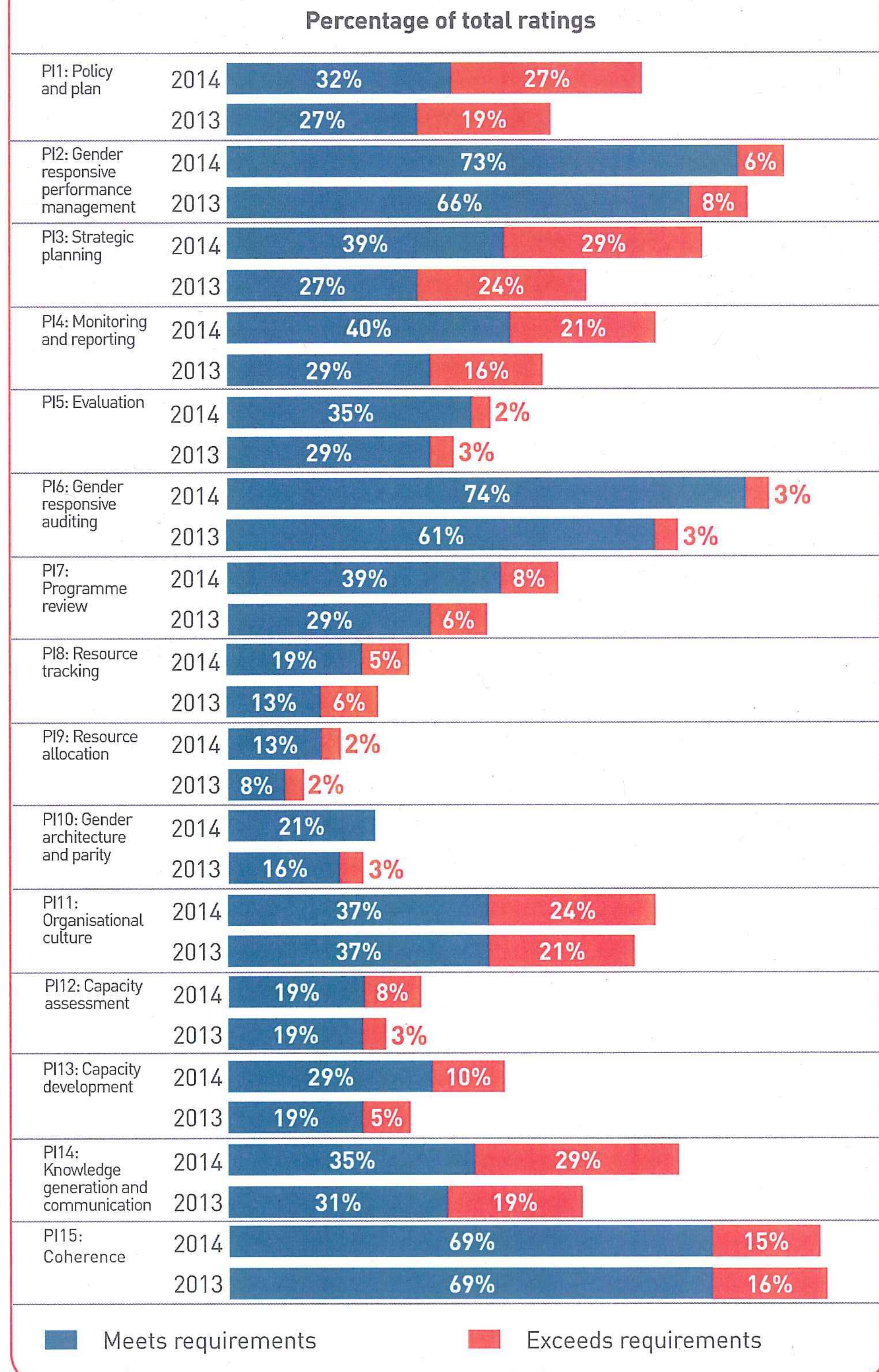


Figure 5: Disaggregated performance by UN-SWAP performance indicator, 2013 and 2014 (% of ratings meeting and exceeding requirements)
Percentage of total ratings
PI1: Policy and plan
2014
32%
27%
2013
27%
19%
PI2: Gender responsive performance management
2014
73%
6%
2013
66%
8%
PI3: Strategic planning
2014
39%
29%
2013
27%
24%
PI4: Monitoring and reporting
2014
40%
21%
2013
29%
16%
PI5: Evaluation
2014
35%
2%
2013
29%
3%
PI6: Gender responsive auditing
2014
74%
3%
2013
61%
3%
PI7: Programme review
2014
39%
8%
2013
29%
6%
PI8: Resource tracking
2014
19%
5%
2013
13%
6%
PI9: Resource allocation
2014
13%
2%
2013
8%
2%
PI10: Gender architecture and parity
2014
21%
2013
16%
3%
PI11: Organisational culture
2014
37%
24%
2013
37%
21%
PI12: Capacity assessment
2014
19%
8%
2013
19%
3%
PI13: Capacity development
2014
29%
10%
2013
19%
5%
PI14: Knowledge generation and communication
2014
35%
29%
2013
31%
19%
PI15: Coherence
2014
69%
15%
2013
69%
16%
Meets requirements
Exceeds requirements

# RESULTS OF INTERVIEWS WITH SENIOR NHS STAKEHOLDERS

The following account reflects the opinions of senior leaders in adopting aspects of the UN approach. Quotes are given in italics and are non-attributable.

## Key challenges in the NHS and the contribution of women

The senior leaders interviewed recognised that the NHS has to become increasingly productive, deliver higher quality standards and simultaneously transform.

Key priorities include promoting leadership styles required by system leaders, unblocking the talent pipeline, improving recruitment and retention, and enhancing staff engagement.

It was well understood that workforce is a critical issue, and as women are the majority, their participation and leadership affected how much progress can be made.

The NHS was seen as an attractive employer for women by those interviewed although there was much room for improvement. Policies are in place on equality, it is possible to work flexibly, including shift work, and to progress if women are ambitious. Benefits such as maternity leave were better than other sectors. Some trusts had facilities such as nurseries and crèches available on site. However, policies were not always implemented and the ability to work flexibly is variable depending on managers' discretion. The main area where improvements are required is medicine.

Women make up 77 per cent of the NHS workforce. Those interviewed described how optimising the contribution of this majority of staff through creating a better balance at the top of organisations and adapting working conditions more to meet their needs as carers, could help the NHS through enhanced performance, leadership and productivity.

- A greater balance of skills and experience at board level with more women leaders would improve decision-making, innovation and creativity and reduce group think.
- It was thought that women in general do not relate to a macho, crisis leadership style and behaviours perceived to be valued by the system. Women may offer a more collaborative and distributed style needed for system leadership.
- More women at board level would increase leadership capacity through fishing from a larger talent pool of skilled leaders.
- There is evidence that gender diversity increases organisational and financial performance and patient outcomes.
- Increasing participation rates, for example, through flexible working, and ensuring women were not lost from the NHS such as through returner schemes, would optimise resources and return on investment.

The consensus was that if appropriate workforce measures were not applied, this would exacerbate the problems currently experienced. Boards would have fewer 'checks and balances', the pool of talent available would be more limited, and women may increasingly leave, for example, due to growing caring responsibilities of elderly relatives. The NHS would fail to make the best use of its investment. Men were also losing out from unconscious bias, for example, in access to part-time work, from the long-hours culture and from employment at graduate level.

## Creating a focus on women

The following section describes the rationale for and against a focus on gender equality in the NHS. Appendix 1 outlines current legislation around positive action (also known as affirmative action) or special measures targeting various disenfranchised groups created to counteract systemic bias.

The argument for a focus on women was strong and most interviewed reported that the following are priorities.

- A focus on gender would raise awareness through debate and increase knowledge, and hence make change more likely to happen; could address the leadership imbalance short term; is needed as women experience specific problems in their careers, given their mostly primary role as carers; could address lifetime pay discrepancies; and may overcome many women's reticence to step into leadership roles.
- Positive action is required to achieve benefits in the system, overcome subconscious bias and the historic disadvantage inherent in society and is supported by legislation and the Public Sector Equality Duty.
- Women are the majority of NHS staff, and many also have other protected characteristics such as a disability or are from BME backgrounds.
- A goal for greater representation provides a common framework which has been successful in improving the number of women at board level in other sectors, for example, the private sector (Davies report), in academia (the Athena SWAN awards), and in other countries, particularly Scandinavia.

The perceived disadvantages of positive action were that women may be perceived not to be selected on merit; it could create a backlash and resentment among men and hence lose necessary support; there was potential for marginalisation of the problem; other protected characteristics could be overlooked (double jeopardy); and many women may not see the need for 'remedial' action, or want to be seen as different, which they may perceive could undermine their achievements. It was considered by some that the issue had already been addressed and was no longer a priority, for example, due to increasing numbers of female managers. For these reasons, women and men may be reluctant to champion the issue.

## Action required

### Quotes from senior leaders on gender equality in the NHS

*"We need to make best use of our resources, including workforce resources."*

*"There is a contradiction in that the NHS values the caring characteristics of women in the front line (gender stereotype) but there is a gap within the boardroom."*

*"The corner stone of gender equality of participation is to achieve diversity of thought, skills, expertise and background. We don't seem to be harnessing potential at all levels. This contributes to some of the challenges."*

*"The main reason why we need more women in senior roles is balanced perspective – what we need is complementariness not sameness."*

## Quotes from senior leaders on gender equality in the NHS continued

*"The most compelling thing is that women bring something else to the table that's missing from some boards... I don't want 50 per cent of women if they are going to behave like men."*

*"There is historic disadvantage as we live in a patriarchal society – the way leadership is seen is masculine."*

*"How you construct what a good leader looks like is based on male attributes such as charisma, presence, assertiveness, but these are not necessarily associated with women so when a woman wants to be leader, she may not fit this construct."*

*"The NHS is seen as a good employer of women. It is seen less as a place for ambitious women as there is little role modelling."*

*"There is a skewed demographic, which needs to be addressed at all levels. We need more men in frontline services. The advantage is that young male patients and boys will see better role models, and in leadership we need more women as role models."*

*"Within the 77 per cent (of the workforce who are women), there are women leading. What responsibility are they taking to enable other women to lead? How consciously are they thinking about talent in the team, and does it make it easier for women to appoint other women, in other words, everyone can be brilliant?"*

*"I've heard a lot of women say men have a major role in addressing the issue and describing how male mentors have been helpful. If that's true and they have a valuable role, we need to handle men better than they have been handled to date."*

*"With an aging workforce, we need to move towards a more agile workforce, including the way they juggle childcare and caring responsibilities and a work-life balance."*

A bundle of actions for the NHS were recommended by interviewees, targeted at system, organisational and individual levels. No single solution could address the challenge, a focus on women alone would be insufficient, and actions were the responsibility of a range of organisations and disciplines. Key recommended actions included the following.

### Measurement

The number of women progressing through the system should be measured and reported on a regular basis to identify gaps, good practice and changes in the system.

### National goal

A clear goal needs to be agreed for the NHS and for organisations to aspire to, for example, 50:50 male and female representation at board level. Most interviewed agreed 50:50 representation was reasonable overall, although this did not reflect the higher proportion of women in the NHS (77 per cent) and differences between professions, for example, nursing and medicine, and within professions, such as psychiatry and surgery. Opinion was mixed on the use of quotas, with the majority recommending aspirational targets while a few recognised that only quotas may be sufficient to overcome long-standing and unconscious practice.

## NHS system

The NHS needs to set out a clear, evidence-based vision and strategy for how it manages its talent, including women. A senior leader should champion gender equality as a priority, and other leaders support them, the majority of whom would be men. Action could be instigated following publication of an authoritative report, by a task force representing different parts of the system and the NHS mandate via the Department of Health. A guiding coalition, report and media triggered action to improve BME leadership representation and creation of the Athena SWAN awards and this approach was needed to improve gender equality overall. However, there is not yet an equivalent sense of urgency or critical voice in place promoting action on gender across the NHS which now needs to be created.

## Assurance framework

Those interviewed differed in their views on the best approach to start addressing the under-representation of women in the NHS, for example, through a compelling narrative and business case outlining the positive contribution of women similar to the Davies report and/or the creation of an accountability framework.

The NHS would need to hold organisations to account through a few sentinel metrics, for example, HR statistics such as promotions, maternity leave and returners, and organisations develop and own their own solutions. Too many standards would reduce effectiveness, or lead to tick-box mentality. A reward and sanction system was needed to create incentives for compliance.

Accountability could be assessed through the following:

1. **Standard process** – the NHS could assess action to achieve gender equality at board level through usual routes of performance management, for example, the Care Quality Commission.
2. **NHS equality systems and frameworks** – there is potential for workforce gender equality to be highlighted by NHS England as a topic that requires concerted national effort for improved equality performance. The new Workforce Race Equality Standard could be followed by a standard on gender in 2015/16 or thereafter. The scope for doing this is outlined in the 2013 publication, *A refreshed equality delivery system for the NHS*. The advantage of this route is that a process of stakeholder engagement, piloting and development is already in place and a standard will in time be integrated into routine NHS performance management and assurance.
3. **Creating a bespoke NHS gender equality report** – UN-SWAP has aspects from which the NHS could learn but the NHS needs to develop its own framework to create ownership. The Workforce Race Equality Standard provides a useful starting point.

## Leadership development

The NHS should reframe what is meant by leadership, and value skills that create teams and sustainable partnership for change. As well as being more effective, this style may be more attractive for women. Boards were seen as playing a critical role in promoting gender equality, through modelling equal representation among members and putting policies in place.

Leadership development should be available in women-only as well as joint programmes, the former providing a safer space to explore and learn from other

women. Development should include mentoring and coaching and be available throughout careers so as not to discriminate against women at a point when they are carers and hence unable to attend.

### HR practices and other enablers

The following actions were recommended as enablers.

1 **Talent pipeline** – a process should be developed to provide opportunities that encourage talented and ambitious women to step up, ahead of when they are ready, as well as at board level. Women, as well as men, could do more to support female colleagues' progression through sponsorship and mentoring, actively identifying people for development programmes.

2 **Policies** – such as for flexible working and bullying and harassment, should be more consistent and build on best practice for both men and women such as NHS England's approach to agile working.

3 **Recruitment and retention practices** – these should be more creative especially where women are the majority, such as in general practice as salaried GPs. Recruitment should address potential bias through balanced panels, no all-male shortlists, anonymised applications, and fair targeting for example, through search companies. Staff should be encouraged to remain in the NHS following a gap through returner schemes that allow for caring responsibilities for both men and women.

4 **Training and education** – bias awareness training should be made available at board level and below for all staff.

5 **Structural support** – such as making crèches and nurseries available for childcare, and not holding evening meetings when women are unable to attend.

6 **Communications** – good practice and role models should be showcased to challenge mindsets and misconceptions, and share solutions.

7 **Investment** – as well as prioritisation, investment over time is required to increase the number of women on boards across the NHS.

Please see Figure 1 on page 11.

### Actions recommended by NHS senior leaders

*"We need one big strategic vision from a top leader, like the Davies report. It needs someone saying 'this is not acceptable', it is written down and people are held to account. We need system-wide agreement of what good looks like, and then a plan for how to enact the vision. The action we need to take will be at system, organisational and individual level. This would include a national goal played out locally for everyone to aim for... The vision is national but it will be enacted bottom up."*

*"We need to have a deliberate strategy for how we are managing talent, including women. What the strategy needs to take into consideration for women is different – the business case is there. We will have higher performing services if we address the balance."*

*"There is no evidence that leadership development will affect under-representation or is sustainable. Days out are no help as then people go back to their organisation. Most sustainable efforts come from within."*

## Actions recommended by NHS senior leaders continued

*"A focus of attention can lead to ghettoization of the problems in that it's treated as a distinct and separate problem – and some female colleagues don't want to be seen as different, a special case deserving remedial help. However, the reality is that there are real challenges and these attitudes are there even in women. We need to educate women and men about what can be different and help women with opportunities that can be made available for them."*

*"In the past, interventions have not delivered system-wide changes as was planned, because they have to some extent ghettoised these issues."*

*"There are real issues around doctors and that is probably the one area where we don't do well enough, but the majority of staff, including frontline nursing, have the opportunity and access to flexible working, and there is some really good practice."*

*"Need to have infrastructure support of childcare in a wider package – practical help makes a difference".*

*"The advantage of women-only development was that it was the first time since university where I sat down with a group of women and had a structured conversation about sexism, networking and their impact. These things I have only talked about with my best friends or husband – then I could see it everywhere."*

*"I am a fan of quotas because they work. We have seen them work in the Labour Party, women-only shortlists, Denmark and Sweden, with quotas on boards and it has impacted on numbers. I would also advocate more networks, mentoring, coaching and shadowing."*

*"How much skin in the game does everyone have in this? Right now there is very little incentive to do this as the risk is to men, and they are running this. Even women are ambivalent."*

# DISCUSSION AND CONCLUSION

NHS England, under the new leadership of Simon Stevens, recognises in the Five Year Forward View that 'diversity in leadership is associated with more patient-centered care, greater innovation, higher staff morale, and access to a wider talent pool'. The NHS Five Year Forward View seeks to develop a modern workforce, the majority of whom are women.

The need to increase the representation of women in senior leadership positions is seen as increasingly important globally. It is recognised in law and in government requirements, by organisations given their need for talent and recognition of the business case, and through a growing social movement demanding change. It is now enshrined in the United Nations new sustainable development goals (SDGs) and commitment from all member states.

This report explored the application of the UN approach, and specifically the UN-SWAP, to the NHS to improve gender equality in leadership. In doing so, it identified that first, gender equality needs to be made a priority at the highest level – women are the majority of NHS staff – to meet the productivity gains required and to make best use of scarce talent. Greater board diversity is a priority as a moral imperative and business case, impacting on the care for patients. The NHS should keep pace with other sectors.

Once this has been done, interviews gave a clear sense of what action is now needed. This includes the creation of a guiding coalition, identifying a national champion, accurately measuring board membership by gender, setting aspirational targets, creating a framework for action including leadership development, improved flexible working, returner schemes and other enablers, and measuring progress. Much can be learnt from the UN system approach to gender equality, from policies – for example, gender mainstreaming – and from campaigns such as HEforShe which also identify benefits for men.

However, although senior leaders agreed something must be done, some voiced concerns about positive action and opinions differed on the degree of urgency. Views differed on the best approach, through a business case similar to the Davies report and/or around equality standards and accountability. Those interviewed were not aware of the whole range of potential actions as suggested by UN Women (see pages 20–21) indicating the need to learn from other sectors. There was a fear of backlash and tokenism, and a perception that the problem had already been addressed, unsubstantiated by data. To address these divergent views requires high-level leadership and open debate.

The UN-SWAP provides many benefits to the NHS as a common language, framework, and way to measure progress shown to increase representation of women in leadership. However, given the lack of clear direction and complexity, the interviews indicate that the timing is not yet right for it to be adopted or piloted across the NHS.

The first step is for senior leaders representing the NHS as a whole, to agree the under-representation of women in NHS leadership and talent pipeline are a priority and start a process for agreeing action before legislative changes make this a requirement. This report provides information on what could be done at a system, organisational and individual level including full consideration of UN-SWAP when work commences.

# RECOMMENDATIONS

The following recommendations are based on the range of actions identified from the literature, interviews and experience of UN Women (see pages 20–21).

A successful strategy involves a multi-pronged approach including, but not limited to, the following:

1. **Focus**: the NHS must adopt a focus on the equal representation of women and their advancement at all levels including at board level, or equivalent, to meet the workforce challenges it faces.
2. **Champion**: a high-level champion should be appointed, much as Lord Davies for industry, with a compelling narrative outlining the positive contribution of women and the business case for action.
3. **Task force**: a system-wide task force should be created to inform and support the high-level champion (inter alia) and to strengthen implementation.
4. **Mandate**: the Department of Health should include gender equality and all its appropriate manifestations within the Mandate of NHS England.
5. **Monitoring and accountability**: as a priority, data should be recorded and published to benchmark and track improvement. In addition, a broader system of monitoring and accountability should be developed. Such a framework may be built on the Workforce Race Equality Standards and the UN-SWAP, and should be piloted in selected NHS organisations.
6. **Organisational culture**: shifts in organisational culture constitute the bedrock of sustainability and progress. Issues of organisational culture should be systematically identified and effective plans and practices developed to address them such as organisational and exit surveys, unconscious bias training and promotion of flexible working. Higher decision-making levels such as boards and executive teams deserve special focus.

# APPENDIX 1: TERMS AND CONCEPTS ADOPTED BY THE UN

## UN Women

In July 2010, the United Nations General Assembly created UN Women as part of the UN reform agenda to address gender inequalities. Gender inequalities remain deeply entrenched in every society and impact on access to decent work, basic education and healthcare, equal wage, and representation including in political and economic decision-making. Women in all parts of the world suffer violence and discrimination. Gender equality is not only a basic human right, but its achievement has enormous socio-economic ramifications, fuelling thriving economies and spurring productivity and growth.

To address these challenges, the main role of UN Women is to:

- support inter-governmental bodies in their formulation of policies, global standards and norms
- help member states to implement these standards, standing ready to provide suitable technical and financial support to those countries that request it, and to forge effective partnerships with civil society
- hold the UN system accountable for its own commitments on gender equality, including regular monitoring of system-wide progress.

UN Women, among other issues, works for the:

- elimination of discrimination against women and girls
- empowerment of women
- achievement of equality between women and men as partners and beneficiaries of development, human rights, humanitarian action and peace and security.

**Source: www.unwomen.org/en/about-us/about-un-women**

## Gender

Gender refers to the social attributes and opportunities associated with being male and female, and the associated relationships between women, men, girls and boys. The attributes, opportunities and relationships assigned to women and men, girls and boys, are socially constructed and are learned; they are context and time-specific, and thus subject to change. In most societies, there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources and decision-making opportunities.
**Source: www.un.org/womenwatch/osagi/conceptsandefinitions.htm**

## Gender mainstreaming

Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality.
**Source: ECOSOC agreed conclusions 1997/2**

## Equal representation of women

The goal of gender balance / gender parity / the equal representation of women and men applies throughout the UN system, and in every department, office or regional commission, overall and at each level. Gender parity applies to all posts, without regard to the type or duration of the appointment, the series of staff rules under which the appointment is made, or the source of funding.

## Gender equality – equality between women and men

Gender equality refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men are the same but that women's and men's rights, responsibilities and opportunities do not depend on whether they are born male or female. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration, recognising the diversity of different groups of women and men. Gender equality is not a women's issue but concerns all men, women, girls and boys. Equality between women and men is both a human rights issue and a precondition for, and indicator of, sustainable people-centered development.

**Source: www.un.org/womenwatch/osagi/conceptsandefinitions.htm**

## Special measures known as positive action (UK) and affirmative action (USA)

Special measures targeting various disenfranchised groups were created to counteract systemic discrimination. They are being used increasingly, for example, through legally enforced and/or aspirational quotas in parliamentary elections and the selection of boards in the private sector which has resulted in the rapid rectification of gender imbalances around the world.

Article 4 of The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted in 1979 by the UN General Assembly and the UK is signatory.

- Paragraph 1 specifically refers to **temporary** special measures that aim to rectify gender imbalances resulting from structural, societal and cultural discrimination. Theoretically, once substantive equality has been reached, these measures are no longer needed.
- Paragraph 2 refers to special measures that recognise the **biological difference** between men and women means they necessitate differential treatment. The most notable example of this is maternity leave. These measures will be of a permanent nature.
- Recommendation No. 25 describes the various forms special measures can take: "Measures encompasses a wide variety of legislative, executive, administrative and other regulatory instruments, policies and practices, such as outreach or support programmes; allocation and/or reallocation of resources: preferential treatment: targeted recruitment, hiring and promotion: numerical goals connected with time frames: and quota systems. The choice of a particular 'measure' will depend on the context in which article 4 paragraph 1 is applied and on the specific goal it aims to achieve."

# APPENDIX 2: SEMI-STRUCTURED INTERVIEWS

## Use of UN-SWAP accountability framework in the NHS

Thank you for taking the time for an interview on ways to optimise the contribution of women in the NHS and reduce gender inequality through the use of an accountability framework. Your time and thoughts are appreciated in this complex and controversial area to help the NHS and UN Women consider the best approach. The paper sent prior to this interview outlines the issues.

### Questions focus on the following areas and will take 45 to 60 minutes to complete

- Challenges for the NHS and the role of women.
- Representation of women in leadership.
- The talent pipeline.
- Action needed including an accountability framework.

### Questions

1. What are the key challenges for the NHS right now?
2. Given 77 per cent of staff are women, how does this contribute to and/or meet these challenges?
3. What do you think the NHS does well in terms of employing and promoting women?
4. What are the pros and cons of a focus on solely women (versus all staff or other protected characteristics)?
5. What actions would improve representation of women in leadership and the talent pipeline?
6. What are the pros and cons of programmes targeted at women's development alone (such as Breaking Through, King's Fund Athena Leadership programme) versus an organisational approach such Athena SWAN and EDS2 targeted at women?
7. How could an accountability framework be developed to improve gender equality in the NHS? What steps would be needed, which organisations/ individuals involved, what should be the focus or pilots?
8. How do you think UN-SWAP could be adapted and used in the NHS (NHS-SWAP)?
9. Do you have any other comments?

## Interviewees

- **Maureen Baker**, Chair, Royal College of General Practitioners
- **Karen Castille**, Independent Consultant
- **Paul Deemer**, Head of Equality, Diversity and Human Rights, NHS Employers
- **Peter Lees**, Chief Executive and Medical Director, Faculty of Medical Leadership and Management
- **Gary Loke**, Head of Policy, Equality Challenge Unit
- **Clare Marx**, President, Royal College of Surgeons
- **Kathy McLean**, Medical Director, NHS Trust Development Authority
- **Habib Naqvi**, Equality Lead, Commissioning Strategy Directorate, NHS England

- **Vijaya Nath**, Director, Leadership Development, King's Fund
- **Danny Mortimer**, Chief Executive, NHS Employers
- **Andrew Pike**, Director of Commissioning Operations, East of England, NHS England
- **Ros Roughton**, National Director for Commissioning Development, NHS England

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## NHS Employers

The NHS Employers organisation is the voice of employers in the NHS, supporting them to put patients first. Our vision is to be the authoritative voice of workforce leaders, experts in HR, negotiating fairly to get the best deal for patients.

We help employers make sense of current and emerging healthcare issues to ensure that their voice is front and centre of health policy and practice. We keep them up to date with the latest workforce thinking and expert opinion, providing practical advice and information, and generating opportunities to network and share knowledge and best practice.

We work with employers in the NHS to reflect their views and act on their behalf in four priority areas:

- pay and negotiations
- recruitment and planning the workforce
- healthy and productive workplaces
- employment policy and practice.

The NHS Employers organisation is part of the NHS Confederation.

## UN Women

UN Women is the UN organization dedicated to gender equality and the empowerment of women. A global champion for women and girls, UN Women was established to accelerate progress on meeting their needs worldwide.

UN Women supports UN Member States as they set global standards for achieving gender equality, and works with governments and civil society to design laws, policies, programmes and services needed to implement these standards. It stands behind women's equal participation in all aspects of life, focusing on five priority areas: increasing women's leadership and participation; ending violence against women; engaging women in all aspects of peace and security processes; enhancing women's economic empowerment; and making gender equality central to national development planning and budgeting.

UN Women also coordinates and promotes the UN system's work in advancing gender equality.

## Health Service Journal (HSJ)

HSJ Women Leaders is a useful leadership community for women leaders and emerging leaders in health and social care. We aim to get fair representation of women on boards of health and social care organisations.

HSJ is an intelligence service for healthcare leaders, from clinical and non-clinical backgrounds and from public and private sectors. Our purpose is to help create better patient outcomes through better healthcare leadership.

We focus on providing analysis and best practice on the key challenges and opportunities facing the Boards of NHS organisations.

HSJ is a multi-award winning brand that serves its audiences digitally, in print and face-to-face, winning Business Intelligence Product of the Year, and Magazine of the Year at the 2014 PPA Awards.

We have been the independent Pan-NHS voice, and prior to that healthcare champion, since 1892.

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