An Exploration of Women's Representation in Senior Leadership Positions in the English National Health Service

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Dedication

For Jennie, Shirley & Caroline

Abstract

Overview

The inception of this research into a glass ceiling (GC) in the English National Health Service (NHS), is derived from my own observations as a former NHS employee. Initially, most attendees at the meetings I went to were female managers. This contrasted with my first board meeting at which only one female Executive Director was present. This led me to question why, when women comprise 77% of the NHS workforce, do they constitute only 44% of leadership roles (NHS, 2016)?

The title of this research project is *An Exploration of Women's Representation in Senior Leadership Positions in the English National Health Service*. This title is aligned to the following research question, 'Does a Glass Ceiling Exist in the English National Health Service and, if so, what are the factors acting as barriers to women accessing senior leadership positions?'

A GC is 'the unseen, yet unbreachable barrier that keeps minorities and women from rising to the upper rungs of the corporate ladder, regardless of their qualifications or achievements' (FGCC, 1995, pp. 4). The literature suggests many explanations for GCs; however, the main justifications put forward in the literature are not entirely pertinent to the NHS, given most of the NHS workforce and consumers are female, and the NHS is a comparatively flexible employer, which supports female staff and their development.

Objectives

The objectives of the research were to:

1. Explore whether data on female representation on NHS boards indicate a GC.
2. Understand, if a GC is proven, why it exists.
3. Suggest recommendations to address any gender imbalance.

Methods

Mixed Methods were employed. Quantitative analysis reviewed data on gender composition across the NHS, including an analysis of Trusts' boards and uptake of development programmes. The qualitative analysis consisted of twenty-six interviews

with NHS managers. The main challenge was accessing interviewees, for example, one gatekeeper to a subset of interviewees delayed access for almost a year.

To analyse the interview data, narrative analysis was applied to each of the individual transcripts. This was achieved using a Labov proforma template. Once the narrative analysis had been completed, it was then possible to analyse the interview data across the different groups of interviewees using thematic analysis.

Grounded theory was found to be valuable. Although insights from the literature were used to inform the initial development of the interview schedule, the emphasis was on open discussion to allow examination of the reasons for the possible existence of a glass ceiling in the NHS and to enable theories to be based on the emerging data.

Findings and Conclusions

Much has been done across the NHS to promote female progression to the boardroom; however, the glass ceiling remains intact. The quantitative research evidenced that trust boards still have a deficit in female members, especially in key leadership positions such as the CEO, Director of Finance and Medical Director. An analysis of recruitment data evidenced that women are less likely to apply for board level positions than men, but when they do apply, they are equally likely to be appointed.

The qualitative research demonstrated that more must be done to address the main barriers to gender equality, which are the responsibility for childcare and overcoming the 'old boys' network.' To ease the burden of childcare, organisations could implement job sharing and flexible working. The NHS advocates these measures for lower positions, but not at board level, due to the accountability and visibility required for executive positions. The main opportunity to breach the 'old boys' network', is for women to create their own networks, and by supporting each other through mentoring and signposting of employment opportunities.

My research suggested the creation of the Healthcare Leadership Equality Model. This framework recognises that the means of breaking the glass ceiling are within the reach of female employees (such as seeking out training courses, networks, and role models). However, there is also the need to incorporate wider macro factors, including the role of

government in driving forward initiatives, such as national frameworks for flexible working.

As this research project was conducted prior and during the 2020 Coronavirus pandemic, I was able to look beyond the primary research aims. It was possible, in real time, to evaluate how the unique demands of the pandemic impacted female career advancement. The pandemic presented situations in which women could build and display the skills which were viewed as necessary for board level leaders. Therefore, the acceleration caused by the pandemic enabled some women to rapidly build their careers, in line with the Healthcare Leadership Equality Model.

Stakeholder Impact

The purpose of my research was to identify the barriers to women reaching senior NHS positions and make recommendations on how to address these. Throughout, I engaged with NHS organisations, such as the NHS Leadership Academy, who have expressed an interest in the outputs of my research.

Acknowledgements

There are many people without whom this work would not have been possible. I am extremely grateful to my supervisors Prof. Betsy Thom, Dr. Rachel Herring, and Dr. Gordon Weller. Firstly, Betsy was able to see my initial ideas warranted developing into a research project. Then together with Gordon and Rachel, Betsy patiently guided me through the necessary theories and methods required to give my writing the necessary academic rigour. I whole heartedly thank all three of them for their intellect, patience, insightfulness, and instruction.

There are several people in my personal life who have given me the support and desire to complete this project. Undoubtedly my sister, Jennie, would have been the first in our family to undertake scholarly endeavours – in her place, I thought I best pick up the baton. Secondly, the desire to repay my mother, Shirley, for her unfaltering pride and faith in everything I have done, is hopefully slightly repaid. Finally, my wife, Caroline, who's unwavering support, words of encouragement and tireless proof reading made all this possible – thank you!

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"*Remember, Ginger Rogers did everything Fred Astaire did, but she did it backwards and in high heels*."

— Bob Thaves (1982)

1.0 Background

The title of this research project is *An Exploration of Women's Representation in Senior Leadership Positions in the English National Health Service.* To explore this in-depth the following research question was formed, *Does a Glass Ceiling Exist in the English National Health Service and, if so, what are the factors acting as barriers to women accessing senior leadership positions?*

This chapter explores the origins of glass ceilings (GC), from a historical and etymological point of view, to examine how the world of work evolved to a point where GCs came to be recognised and to explore the creation of the specific term '*glass ceiling*.' Once this has been set out, I then go on to outline why this area of study has been chosen, the impact it has on the National Health Service (NHS) and why it is important that GCs are dismantled – not only for the women they affect but for the wider population. There are many factors which influence the origins of GCs, both cultural and biological. Activism, from Suffragettes to modern feminism, played a vital role in the quest for gender equality. This gave rise to a host of measures which have been implemented to counter GCs, such as legislation on equal pay and discrimination, by way of designated programmes of development, through to transparent recruitment processes.

Given that the concept of Glass Ceilings has been discussed, dissected, and argued about since the 1970s, why should it be revisited now? When this research project was first contemplated in 2018, it was at a time when women across the world were desperately questioning if true gender equality would ever transpire. The culmination of the #metoo campaign, highlighting the astonishing number of inappropriate sexual advances by men on women (Jagsi, 2018); the fact that in the US, President Trump – with '*his well-documented history of sexual harassment*' (Setzler and Yanus, 2018, pp. 524) – occupied the White House; and that gender discrimination was rampant in a

central pillar of British culture, the BBC (Ruddick, 2017 and Grierson, 2017); all demonstrated that inequality was still very much present in society.

I had long since thought that issues like racism and gender discrimination had been consigned to the pages of history. It was not until I joined the workforce as a graduate management trainee in the NHS that the possible existence of a GC in healthcare management came to my attention. During my first year of employment in the NHS I attended many meetings at which none of the other delegates were male. At the time this did not seem unusual, as I knew that much of the NHS workforce was female. It did, however, provide a stark contrast to my first board meeting, in which the only female board member was the Director of Nursing. This experience contrasted sharply again with the time I spent in the Middle East, as the health economy had a high number of very senior female representatives. This included three of the most senior healthcare leadership positions in the country being held by female incumbents, including the Minister of Public Health, the Managing Director of the country's state primary healthcare provider and the Chief Operating Officer of the country's women's and children's tertiary hospital. Why was it that the – perceived – more paternalistic Middle East healthcare system (Jamal and Tessler, 2008) had greater gender equality in its senior appointments than the UK's NHS?

From my work-life, I recall one professional incident that I think displays why I felt this research was necessary. It was an occasion when I was interviewing candidates for a junior management position. The role was working in a small hospital trust in the Midlands. Whilst it was only a junior management role it would have meant a significant increase in salary and due to the size of the trust, roles like this came up very infrequently. When I contacted the standout candidate to offer the job, she thanked me but said she could not accept it as she was pregnant and did not feel it was *'fair'* to the other applicants. I replied that she was not only the best candidate, but none of the others were appointable, so there was no one she was taking the opportunity from. Secondly, I told her the law was on her side and there was no way we could revoke the offer. Next, I discussed how we could make the role work practically in terms of maternity leave and cover. Finally, I spoke to her in terms of her career and pointed out that a chance like this might not come along again soon. Despite all the reasons to accept the role, she eventually declined.

The term glass ceiling refers to an invisible barrier which stops women or people from minority groups entering executive positions in the business world (Princess et al, 2015). A fuller definition of a glass ceiling can be derived from the US Federal Glass Ceiling Commission (1995, pp. 4): '*the unseen, yet unbreachable barrier that keeps minorities and women from rising to the upper rungs of the corporate ladder, regardless of their qualifications or achievements*.' At the time when this definition was drafted, according to the US Department of Labor report (1995, pp. iii) into GCs, '*of Fortune 1000 Industrial and Fortune 500* [CEOs]…*95 to 97 percent are male.*' Fernandez and Campero (2017) perhaps defined a GC most succinctly as '*internal promotion biases'*; they added further detail by stating '*the glass ceiling describes a vertical form of job sex segregation*' (2017, pp. 73).

The important distinction of what constitutes a GC, however, is when positions are not awarded on merit; when this happens, it is because discrimination is at play. This makes Friedman and Laurison's (2020) the most comprehensive definition, stating a GC is,

> *'the invisible yet durable barrier that* [minority] *groups face in achieving the same rewards as white men in the same positions…from direct discrimination…the subtler more insidious effects of stereotyping, microaggression, tokenism and homophily.'*
> Friedman and Laurison (2020, pp. 17)

This highlights an important factor, because as Gates (2019) recognised, a GC is,

> *'not saying that women should be given positions…that they haven't earned.* [it's] *saying women have earned them and should be hired for them.'*
> Gates (2019, pp. 228)

The need to level the playing field is paramount because certain groups in society have an advantage, which was best described by Friedman and Laurison (2020) as *'a following wind*' (2020, pp. 4).

When the term was first introduced it referred exclusively to the discrimination of women in corporate America. The term was initially used by the Wall Street Journal in the 1970s (Akpinar-Sposito 2013; and Sharif 2015) before being popularised in 1978 by Marilyn Loden in her book *Feminine Leadership, or how to succeed in Business without being one of the Boys* (Loden, 1978). Speaking in an interview in 2017, Loden reflected that she first coined the term glass ceiling to highlight that, at the time, women often held themselves to blame for their lack of career progression. She had listened to women describing '*deficiencies in women's socialisation, the self-deprecating ways in which women behaved, and the poor self-image that many women allegedly carried'*; but Loden believed that '*the barriers to advancement were cultural not personal'* (BBC, 2017a).

In the forty plus years since the term glass ceiling was first used, there have been inroads into directly addressing it, for example, the introduction of compulsory appointments of female directors on boards in Scandinavia (Wang and Kelan, 2013). However,

> *'across the European Union, women accounted for only 11 percent of the membership of governing bodies such as boards of directors and supervisory boards.'*
> Desvaux et al (2008, pp. 1)

This problem persists even within organisations which may be regarded as some of the most progressive in the world. The technology giant Google was embroiled in controversy in 2017 when one of its employees distributed a memo claiming women should be omitted from the highest positions in software engineering because women are not '*biologically*' adapted to them (BBC, 2017b). The prejudice against women in other areas of new – progressive – industries has also been shown to exist. A 2017 study evidenced the reduced likelihood of female fronted start-ups being backed by venture capital organisations. The staggering difference in funding over the period highlighted the split was *'$58.2 billion in male-led start-ups, while women-led companies received a paltry $1.46 billion in comparison*' (Huang, 2017).

The question of whether it is appropriate for men and women to be represented in varying numbers due to the field or industry, is one that is fraught with difficulty to investigate. It has been shown that the issue of the GC can be difficult to evidence, and thus explore;

this is due in part to the sensitive nature pertaining to potential discrimination. For example, former President of Harvard University, Larry Summers, courted contention when he attempted to explain, rather than justify, the presence of a GC in fields such as science (Bombardieri, 2005). Summers received criticism for his comments, not necessarily for the reasons he gave, but because he *attempted* to provide a rationale for such an evocative subject (Barres, 2006). However, there is evidence amongst school children that at a young age boys and girls, in general, have different strengths and weaknesses. For example, a 2018 report by the World Economic Forum mapped out how performance in certain subjects at school indicated university course choices, which would then lead to a career in this industry (World Economic Forum, 2018).

1.1 History, Cultural Implications and Feminism

To reflect on the historical and societal explanations for the absence of gender equality, there exists a controversial school of thought which levels the blame at biology. One such commentator is Matt Ridley, the zoologist and evolutionary historian. He wrote in his 1994 work, *The Red Queen,* at length about how modern-day political correctness means that it has become taboo to discuss gender differences. Despite this, he asserts there are general fundamental biological differences between men and women. He provocatively writes,

> *'men and women have different minds. The differences are the direct result of evolution. Women's minds evolved to suit the demands of bearing and rearing children and of gathering plant food. Men's minds evolved to suit the demands of rising in a male hierarchy, fighting over women and of providing meat for a family.'*
> Ridley (1994, pp. 240)

In Harari's seminal 2011 work, *Sapiens,* he covered some of the evolutionary and historical factors that have dictated women's position in the modern world; '*in many societies' women were simply the property of men, most often their father, husbands, or brothers*' (Harari, 2011, pp. 162). In a similar vein to Ridley, above, Harari questions some of the social myths and truths around gender,

> *'Women are often stereotyped as better manipulators and appeasers than men and are famed for their superior ability to see things from the perspective of*

> *others. If there is any truth in these stereotypes, then women should have made excellent politicians and empire builders, leaving the dirty work on the battlefields to the testosterone-charged but simple-minded machos. Popular myths notwithstanding this rarely happened in the real world. It is not at all clear why.'*
> Harari (2011, pp. 176)

To jump forward to modern times, the cultural traits of prehistoric man have finally started to be questioned in earnest over the past hundred and fifty years or so. Figure 1 below, depicts the slow grind towards gender equality which started in earnest in the late 19th century as the Women's Suffrage movement began to take shape. Then throughout the 20th century, a host of female achievements in science, the arts and the workplace enabled the partial introduction of female voting in 1918 (Sebag-Montefiore, 2019). Another landmark for gender equality arrived with the outbreak of war, when women were able to demonstrate their ability to fulfil roles vacated by men, who had been called into the armed services. The war years were vital in the road towards workplace equality; '*the period of both world wars fundamentally changed the nature of labour'* for women, as for example, women '*began to do the war work of heavy industry…the number of women employed by Woolwich Arsenal rose from 125 to 28,000'*, in addition, there were '*female bus- and tube-drivers with a steady admission of women into clerical and commercial work*' (Ackroyd, 2001, pp. 636). Despite this, when reviewing the suffrage movement, Andrew Marr (2009) counters conventional thinking that the First World War was the sole explanation for the female voting franchise,

> *'the attempted strangling of Britain* [in WW1] *had made one thing plain: women could not be excluded from the modern economy or state. But that at this time the suffragettes were still in full revolt, more than a thousand had been imprisoned as leaders…there is a common belief that votes for women were finally won because of the Land Army girls…the suffrage case had been winning ground in 1913-14. Labour was likely to insist on all its candidates supporting woman's suffrage at the next election.'*
> Marr (2009, pp. 178)

The next period of note was the Swinging Sixties, triggering a raft of legislation across the developed world during the 1970s, which culminated in the appointment of the first

British female Prime Minister by the end of that decade. The new millennium brought further landmarks with mandatory board quotas for female posts and Saudi Arabia finally allowing women to drive. But this is not to say that the journey towards gender equality is anywhere near complete. Recent history is filled with workplace scenarios indicating discrimination; to take an example almost at random, in 2017 a report on the BBC's top earning presenters laid bare the marked difference in remuneration between their male and female stars (Grierson, 2017).

Hakim (2007) summarised what they saw as the major inflection points in society and the labour market. The contraception revolution, which began in around 1965, allowed women to take direct control of their own fertility. This was closely followed by the equality opportunities revolution which brought forth a raft of legislation (covered below in Section 1.2), which in effect made illegal many forms of discrimination. The movement from blue collar to white colour labour removed the need for physical strength, accelerating the perception that women were able to undertake a greater role in the workforce. The fourth factor was the rise of secondary jobs, the ability, for example, for women to take up part-time employment to complement their roles of mothers and housewives. The final piece of the jigsaw is the affluence of modern-day society, meaning that some individuals can choose to reduce their involvement in the labour market so that they have more leisure time – this increases the opportunities of women to participate in paid employment.

In the US, the situation was just as slow to evolve; Chomsky (2016) made the point that,

> '*the fifth amendment of the American Constitution guarantees rights of persons…But the concept of a person was sharply circumscribed. It plainly didn't include…women…women were basically the property of their farther, handed over to their husbands.*'
> Chomsky (2016, pp. 46)

Chomsky goes on to note that it was not '*until 1975 that the Supreme court recognized women to be 'peers' with guaranteed rights to serve on federal juries'* (2016, pp. 47). When reflecting on how much had changed in the 150 years between the first female candidate to stand for American president and Hilary Clinton in 2016, Fitzpatrick (2016, pp. 227), declared that for the '*highest glass ceiling'*, '*everything and nothing'* had

changed. Fitzpatrick stated that women face problems with financing and are considered a '*poor bet'* by donors. Throughout her 2016 book Fitzpatrick lists many examples from political speeches and press articles citing the perceived mental and physical weakness of female candidates as being the most frequently given explanation of women's reduced presence in the world of politics.

It is important to remember with such a vast subject matter as gender equality and the glass ceiling, that there is a need to recognise the constraints in which the discussion will take place. My research concerns the glass ceiling in the English NHS; therefore, the literature reviewed, research conducted, and the conclusions drawn are all done so with reference to democratic western society, specifically Western Europe. Cultural, economic, and social differences in other regions of the world are such that the status of women in society is very different. This said, it can be hoped that gender equality in one region of the world can help provide guidance to others.

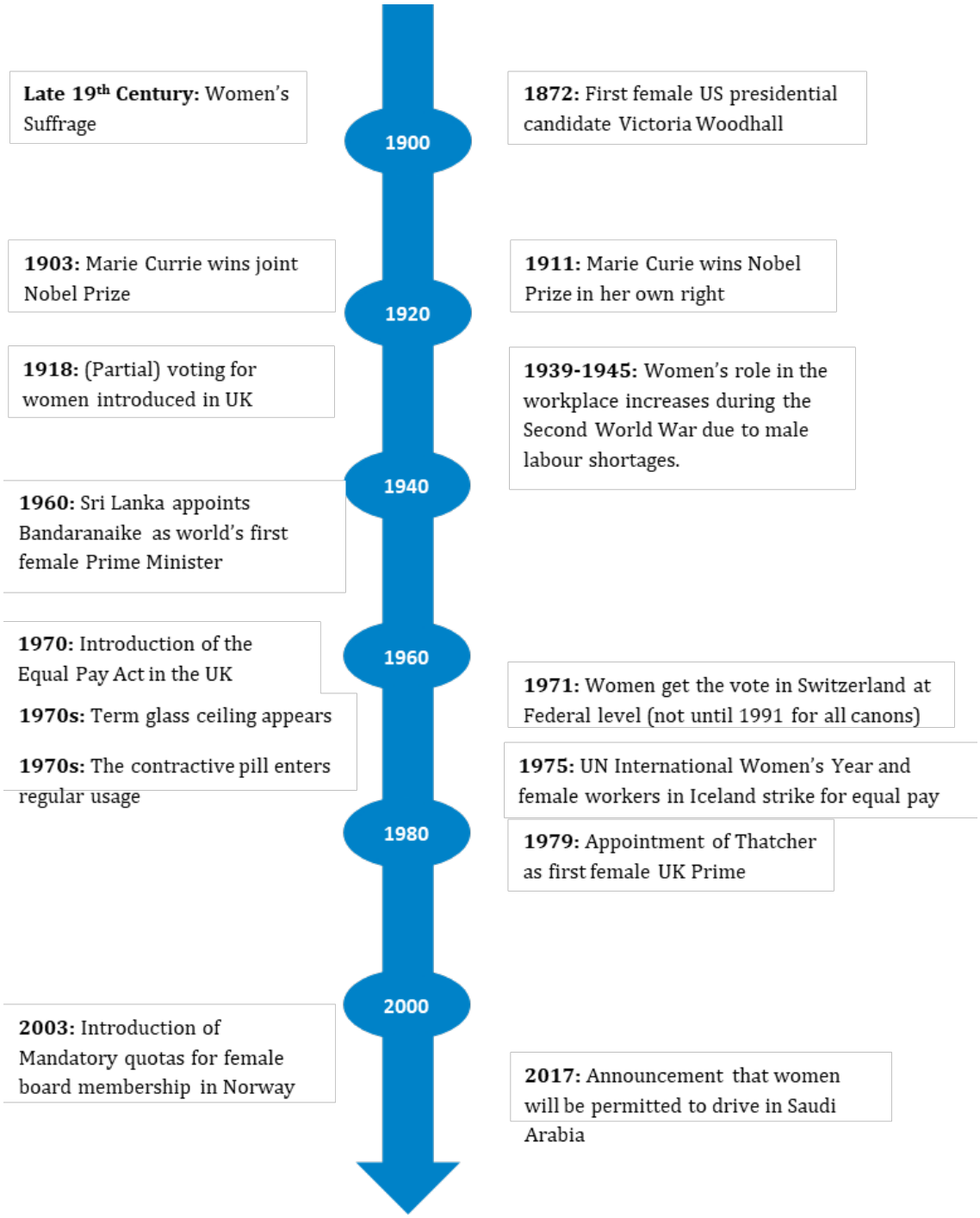

Figure 1: Time of Progression Towards Gender Equality

A discussion concerning gender inequality would be incomplete without reviewing the concept of feminism, as feminist perspectives are those which '*focus on the lived experiences of women and other marginalized groups*' (Hesse-Biber et al, 2015, pp. 4). In recent years, the concept of what constitutes feminism has evolved, Gates (2019) felt that,

> *'being a feminist means believing that every woman should be able to use her voice and pursue her potential, and that women and men should all work together to take down the barriers and end the biases that still hold women back.'*
> Gates (2019, pp. 7)

Margaret Atwood, writing in the introduction to her book *The Handmaidens Tale* proffers her own definition of feminism, which is that '*women are human beings – with all variety of character and behaviour this implies – and are also interesting and important'* (Atwood, 2017, pp. XII). This modern-day definition of feminism is insightful – it does not push for equality or lay out the issues of childcare but goes straight to the root of the issue, by simply stating '*women are human beings'*; does more need to be said?

Feminism itself '*has its foundations in equal human rights and as such, garners support from across the social spectrum*' (Sanderson and Whitehead, 2015, pp. 329). Steven Pinker (2011, pp. 404) commented that '*we are all feminists now'* when compared to even the recent history of the mid-twentieth century. He notes that both men and women are now much greater proponents of female equality than they were even fifty years ago – however society started from a low baseline. In terms of the lack of a meaningful role for women in society, Milkie et al (2009) shone the spotlight on the seminal role of the 1963 work of Betty Friedan, *The Feminine Mystique*, which,

> *'detailed a problem for educated, middle-class mothers of* [the] *era - an unfulfilled life centred around chores and children, where all the rushing about felt like it amounted to little: the work was not viewed as important, and it had to be repeated the very next day*.'
> Milkie et al (2009, pp. 487)

Friedan's book struck a nerve with the culture of the day and helped fuel the second-wave feminist movement, '*as mothers entered the paid labour force in unprecedented numbers'* (Milkie et al, 2009, pp. 487). *The Feminine Mystique* was followed in the feminist literary cannon by Arlie Hochschild's *The Second Shift* in 1989, which outlined the next issue women faced. Having made the leap from housewives to valued members of the workforce, the second shift referred to the fact that many mothers, straight from completing their *first shift* of paid employment, followed it up at home with a *second shift* as housewife. As Milkie et al (2009) highlighted,

> '*gender inequities have taken on an important modern-day form: employed mothers do most of the unpaid labour, are burdened with a double day of paid plus unpaid labour*.'
> Milkie et al (2009, pp. 487)

This second wave of feminism, or post-feminist movement, is distinct from the first wave because,

> *'The first wave of feminism focused primarily on women's rights to equal opportunities, such as access to education and healthcare, and the right to work, possess money, and own property. The second wave of feminism focused on expanding these opportunities by problematizing gender, race, class, and sexual orientation. Both first and second waves of feminism valued the notion of women as a "collective".*
> Soklaridis et al (2017, pp. 253)

It is possible to draw a line from the suffragette movement to Loden and Friedan, to Sandberg, who again brought gender equality in the workplace back into focus for popular culture with the publication of her own seminal book *Lean In*. Sandberg (2014) talked of the surprise when graduating from university and joining the workforce to find lingering gender inequality. This was despite the broad shoulders she was able to stand on, of the women who had gone before her and laid the path for equal rights for women. Sandberg describes a plateau over the past two decades where, despite the increase in educational attainment of women, and the time lag that this would take - in terms of graduating and working up the employment career ladder - women have still not reached

the boardroom in the numbers hoped for by Loden back in the 1970s. This demonstrates there are still factors maintaining the glass ceiling. The tension between women's own ability to promote gender equality and the need to be able to do so, was summarised by Sandberg,

> *'This is the ultimate chicken-and-egg situation. The chicken: women will tear down the external barriers once we achieve leadership roles. We will march into our bosses' office and demand what we need…or better yet, we'll become the bosses and make sure women have all they need. The egg: we need to eliminate the external barriers to get women into these roles in the first place. Both sides are right. So rather than engage in philosophical arguments over which comes first let's wage battle on both fronts.'*
> Sandberg (2014, pp. 10)

Much of the discussion above is predicated on a binary understanding of gender, this is a concept which is increasingly becoming to be understood as much more fluid. Societies understanding and expectations concerning gender have become much broader. There is greater recognition that 'characteristics can be much more complex than two distinct gender categories' (Gosling, 2018, pp. 76). An increasing number of terms and definitions attached to gender have helped expand people's understanding of what 'gender' means, outside the previous male / female dichotomy. In particular, gender fluidity,

> *'has come to convey a wider and more flexible range of gender expression that is not necessarily aligned with the anatomy of the genitalia. Such persons may have nongender-typical interests and behaviors that may even change from day to day.'*
> Gosling (2018, pp. 76)

As such, while much of the discussion in this research relates to a binary understanding of gender, there must be recognition that this is rapidly becoming an outdated understanding. However, this is an area in which the management literature is sparse and a theme I was unable to address in detail in the scope of my research.

Feminism creates one more topic which should be addressed; as a male researcher how can I claim to understand the complex socio-economic issues faced by women? In a 2015 TED talk, Steven Kimmel spoke about the pitfalls men should be aware of when they attempt to address feminism proactively. He refers to the danger of '*mansplaining*', to avoid giving the impression of '*it's OK, we got this now'* (Kimmel, 2015). What Kimmel was referring to is the bias that men can hold by thinking that, now they acknowledge that gender inequality is real and are prepared to act, it does not mean that it will simply disappear. However, as Gates (2019, pp. 150) notes, '*change comes when men see the benefits of women's power*.'

The involvement of men in representing feminism should not be dismissed out of hand. As the King's Fund advised the NHS in 2015, it can add significant weight to the fight against discrimination when maligned groups are '*aligned*' with representatives from the majority (King's Fund, 2015, pp. 12). The reasoning for this was two-fold. Firstly, it showed the cause is not purely self-serving, for example, having men speaking out for women's rights shows that addressing them is for the good of all of society, not only women. Secondly, it adds fresh perspective and insight to the cause, making the argument resonate with a wider audience. Sometimes being male provides the opportunity to speak openly about gender issues without being seen to score points or be discriminatory about gender. The feminist researcher '*aims to promote social change and social justice for women and other underprivileged groups*' (Hesse-Biber et al, 2015, pp 73). If taken at face value this would imply that it would be possible for feminism to be wider than just sexual equality; by definition, this could include issues concerning men if they were also from an '*underprivileged group*' (Hesse-Biber et al, 2015, pp 73).

1.2 UK Equality Legislation

The United Nations' International Labour Organisation (2015) employment discrimination definition is strikingly like that of the US Federal Glass Ceiling Commission on GCs (above). It states employment discrimination as,

> *'any distinction, exclusion or preference made based on race, colour, sex, religion, political opinion, national extraction or social origin, which has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation.'*
>
> International Labour Organisation (2017)

This proximity between GCs and employment discrimination brings to light the legal framework which covers them. Others took the view that a glass ceiling exclusively related to a '*situation where gender pay gaps are typically wider at the top of a wage distribution'* (Akpinar-Sposito, 2013). This later definition appears to be at odds with other interpretations of a glass ceiling as, whilst higher promotions do typically mean higher pay, this is the product of a GC rather than a cause or explanation. As such, this definition has not been adopted for the purpose of this research, as the focus is not on pay inequality. This study is specifically examining equity in terms of appointments to board level positions; one of the central reasons is that British law prohibits disparity of pay between similar roles for men and women, which was first enshrined in the Equal Pay Act. The Equal Pay Act was first ratified in 1970, coming into effect in 1975. The Act has since been superseded by EU Law and in the UK the 2010 Equality Act (Conley, 2014, pp. 313). The 1970 Act came about '*in the aftermath of strike action by women workers protesting about unequal terms and conditions'* (Deakin et al, 2015, pp. 383), most famously those at Ford's Dagenham factory. The Act aimed to deliver equal pay for equal work; in practice this meant a '*comparator had to be employed on a similar job ('like work') or on work which had been determined to be of equivalent value*' (Deakin et al, 2015, pp. 383).

The 2010 Equality Act built on the foundations of the Equal Pay Act, the Sexual Discrimination Act 1975, the Race Relations Act 1976, and the Disability Discrimination Act 1995. It was devised to cover and protect a wide range of people, not only in the workplace but in wider society as well, by providing,

> *'the basic framework of protection against direct and indirect discrimination, harassment and victimisation in services and public functions, premi, work, education, associations and transport.'*
> GOV.UK (2015)

These pieces of legislation have been used in the NHS. In the case of Enderby v. Frenchay Health Authority, Enderby used the Equal Pay Act to evidence in court that she was receiving lower pay than her male clinical colleagues (Conley, 2014, pp. 314). More noticeable was the case of Wilson v. North Cumbria NHS Trust (2005), which

resulted in an out of court settlement of £300 million for 1,600 female employees from two hospitals, when it was proven their terms and conditions were not on a par with male colleagues undertaking similar work (Labour & European Law Review, 2008). Whilst acknowledging that it is still possible that women are, in practice, paid less for similar work than their male counterparts - indeed, the data suggests this remains the case despite legislation (Bagilhole, 2010, pp. 265; and Van Zyl and Roodt, 2003, pp. 14) – the existence of a legal framework does ensure this practice, when proven, is illegal as well as unethical. The difficulty can be proving that the comparison of two roles is fair and evidencing what constitutes similar roles. This is where the Agenda for Change (AfC) job evaluation process (outlined below in Section 1.3), proves its effectiveness, as the salary for roles is determined even before advertising the position. The NHS did indeed successfully defend its AfC policy, under the antidiscrimination law during the case of Hartley v. Northumbria NHS Trust (2009). The courts rejected the case which claimed that AfC did not allow for parity of payment on grounds of gender (NHS Employers, 2017). This ruling was vital for the NHS because AfC covers a vast proportion of its employees. Had the case been successful it would have required a change of terms and conditions for hundreds of thousands of NHS employees.

Given the raft of legislation which surrounds gender equality and the protection of rights for maternity leave, does it mean women are adequately protected? A 2018 publication by the Institute of Fiscal Studies (IFS) suggests not. It found that whilst the gender pay gap has decreased it still stands at 20% in favour of men. This was attributed to maternity leave, resulting in women being absent from the workplace for protracted periods as being the main driver (IFS, 2018). Further evidence that the legislation is not being enacted effectively is provided by the existence of pressure and support groups trying to bring big business to task. Several support groups have sprung up in defence of those individuals who feel that the law has not protected them. The pressure group *Pregnant then Screwed* '*protects, supports and promotes the rights of mothers who suffer the effects of systemic, cultural, and institutional pregnancy and maternity discrimination'* (Pregnant Then Screwed, 2018). The group offer legal advice and mentorship for mothers who feel they have been unjustly treated during or after taking time away from the workplace for maternity related matters.

At the close of the last century in 1999, Tony Blair declared, '*the class war is over but the struggle for true equality has only just begun'* (BBC, 1999). Whilst he might have been shown to be premature in respect to the class war, his insight on true equality still rings true twenty years later. Traditionally,

> *'top jobs…were the reserve of not just the privileged but a particular white, heterosexual, able-bodied, privileged man, often embodied in the figure of the gentleman.'*
> Friedman and Laurison (2020, pp. 39)

As early as 1991, the Civil Rights Act in the US had widened the term glass ceiling to include gender and racial forms of discrimination, which prevent minorities from entering and gaining senior promotions in an organisation (Akpinar-Sposito, 2013). For the purposes of this research study, the term glass ceiling will pertain to Loden's original meaning, that is, solely to the factors inhibiting female progression into executive positions. This decision was taken because, whilst gender discrimination and racial discrimination are both vitally important topics, they deserve to be subject to their own exclusive means of investigation.

The Venn diagram in Figure 2, below, shows the interaction of gender, ethnicity and age - three commonly cited causes of discrimination and ones which can often impact a person's career trajectory. Of course, there are many more, such as sexual orientation and religion. The Venn diagram demonstrates that there are overlaps in terms of some causes and effects for the various types of discrimination, which can mean that some of the solutions will also have similarities. However, they will not always be a perfect match. There is a danger in suggesting that a person from a different ethnic background should be treated the same way as, for example, someone who is older or suffers from a form of disability. For this reason, I chose specifically to look at the causes of gender discrimination in this research project. It was obvious from conception that other forms of discrimination would be shown as interdependent and would create some similar barriers (and solutions) as gender, but the aim was always to focus on the gender interpretation of a GC.

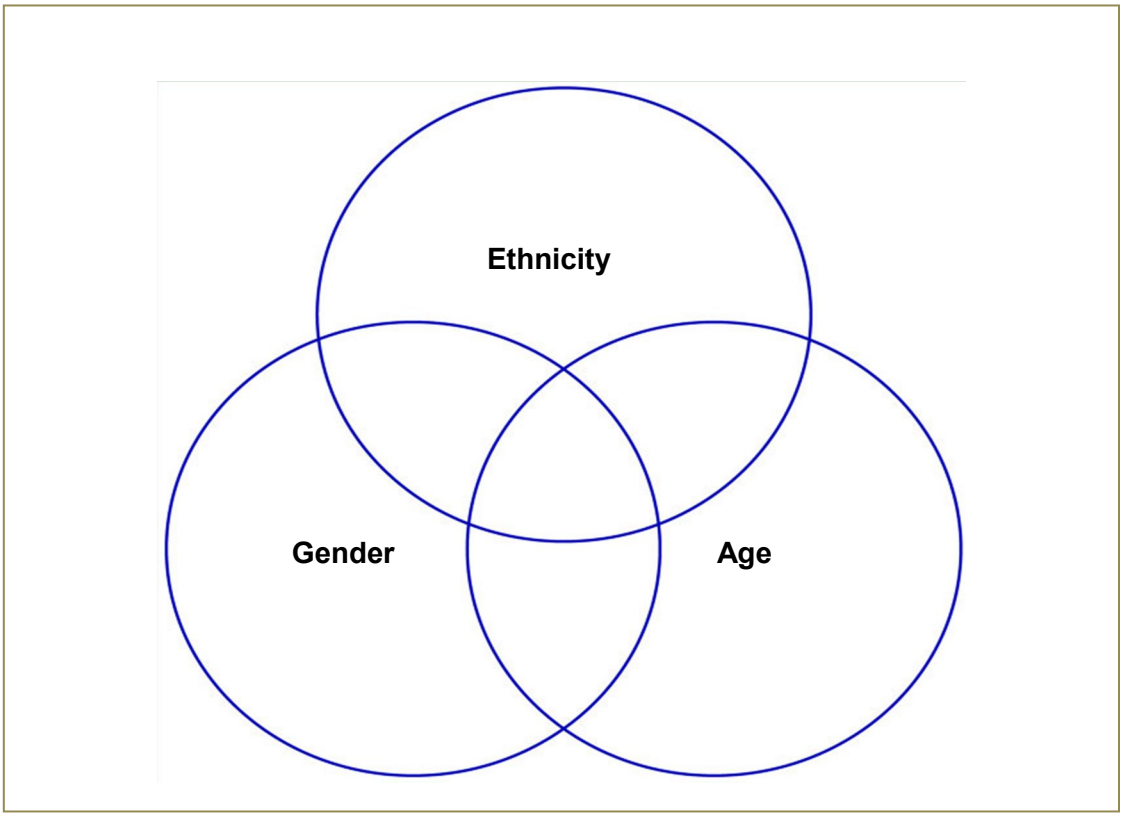

Figure 2: Venn Diagram Showing the Interaction of Ethnicity, Gender and Age

Source: Author Generated

Not only is there an overlap between the different minority groups, but there is evidence to suggest that fitting into one or more of these groups has an exponential effect on the individual. Piketty (2014) wrote at length about the reduced likelihood of someone with a disability, or from an ethnic minority group getting top jobs. Friedman and Laurison's (2020) work, was able to take this a step further by evidencing that someone from say, an ethic minority background who is also female, faces a double burden of discrimination. But it does not end there, because the burden is not double, it is in fact more. The reduction in wage they are likely to receive is not the same reduction as one minority minus the reduction of the other minority, Friedman & Laurison found the difference is even *greater.*

1.3 NHS Policies and Reports

Before considering female involvement on NHS boards, it is perhaps worth considering what the role of a board is. The NHS National Leadership Council (2010) provides two

key functions of strategy and accountability. In relation to strategy, the role of female executives is perhaps most important due to the need to understand the requirements of the local patient base; this is predominantly female, as women are the more frequent users of healthcare services. The NHS Leadership Council note that all NHS organisations receive guidance from the Department of Health regarding the need to comply to the legal obligations concerning equality and human rights. Therefore, boards need diversity in terms of gender, disability, and ethnicity, not only to comply with this legislation, but also because '*engaging effectively with local communities…may be aided through ensuring suitably diverse representatives on Boards'* (The NHS Leadership Council, 2010, pp. 25). The NHS Leadership Academy (2012) set out guidance for NHS boards on the recruitment of board members, stating representative boards are,

> *'responsible for ensuring the delivery of better outcomes for patients from all sections of society…this includes promoting integrated care for patients, promoting equality and diversity, and reducing inequalities.'*
> NHS Leadership Academy (2012, pp. 5)

The NHS Leadership Guidance continues by stating the need to reinforce diversity at all levels in the NHS, to understand the varied needs of the communities they serve. The case for board diversity is that it ensures '*boards are able to forge constructive relationships in the local health and social care economy*' (NHS Leadership Academy, 2012, pp. 5).

Published in 2016, a report by NHS Employers *NHS Women on Boards: 50:50 by 2020* explored the shortfall in NHS board membership in terms of achieving gender equality. The *50:50* report indicated that there was a need for an additional 500 female directors across the entire NHS, in both provider and commissioning organisations (NHS Employers, 2016). To facilitate a greater number of female executives they made several recommendations including, the publishing of data on board gender composition, national guidance on development, a national target of 50:50 gender split and increased research into '*blockages*' (NHS Employers, 2016). Stating the necessity of having a diverse board is one thing, facilitating it is another, especially when it has been shown that chair-people (statistically more likely to be male) '*favour those with similar characteristics to themselves'* (Chambers et al, 2013, pp.46), i.e., other men. It is

important to note that the chairperson has the ultimate responsibility for the recruitment and dismissal of the CEO. As such, it is necessary to think of a range of interventions that can help combat this inequity in the selection process for executives. Chambers et al (2013), provided such a list including,

> *'proactively putting diversity on the agenda in the recruitment process, challenging recalcitrant board members, focusing more on underlying competencies rather than previous experience, creatively expanding the talent pool, ensuring that women are on both the longlist and the shortlist of potential candidates and supporting them through the appointment process.'*
> Chambers et al (2013, pp. 46)

The NHS Employers 2016 report was followed up in 2020 by a report from the NHS Confederation (2020), *NHS Women on Boards 50:50 by 2020 Action for equality – the time is now*. The same lead author was employed (Professor Ruth Sealy) from the 2016 document, the aim was to assess the progress that had been made against the aspirational goal of the 2016 report, to achieve a 50:50 gender split on NHS boards by 2020 (NHS Confederation, 2020). To achieve the ambition of board level equality, as noted above, the NHS required 500 additional female executives; the report indicated that there remains a shortfall of around 150 women, with the largest deficits being in Chief Financial Officers and Medical Directors (NHS Confederation, 2020, pp. 4). The report did indicate some key advances over the four years between the reports, such as the fact that 115 out of 213 NHS boards now have at least 40% female representation. However, the report acknowledges regression in other areas, for example, the number of female Medical Directors had decreased by 1% (NHS Confederation, 2020, pp. 5).

The *NHS Women on Boards 50:50 by 2020 Action for equality* report centred on data on board representation and numerous interviews with board members. A key difference between the document and my own research, was that my work looked exclusively at the role of NHS executive directors, whilst the NHS Confederation included non-executive directors. My rationale for excluding non-executive directors was that they tend to come from a non-NHS background, therefore there is little of the NHS internal promotion biases that would impact on their level of representation. Where the NHS Confederation report was lacking, was its width of appreciation of the factors inhibiting

female career progression and its lack of breadth in considering possible solutions to the problem. I have explored a range of issues and possible solutions, whereas the report focused on data analysis as a central tenant of addressing the problem. On balance, the report does include a conversation on talent management, with solid tangible programmes of work (such as enabling flexibility and job sharing), but these are secondary to the more ethereal recommendations on *'boardroom dynamics'* and *'lift as you climb*' (NHS Confederation, 2020, pp. 7).

Speaking in a radio interview concerning the report, lead authors Prof. Sealy and Sam Allen reported a 5% increase in the number of women on NHS boards, which Prof. Sealy felt was '*pretty good'* (Women's Hour, 2020). The problem, Prof. Sealy noted, was the range across the trust boards; some had as low as 15% female representation. Sam Allen stated that '*tracking down the data'* on gender and other markers of diversity was key, as without tracking there can be no accountability. Ms. Allen did not believe the problem to be on the supply side (i.e., she felt the pipeline of women leaders was sufficiently stocked); it was therefore '*a demand issue'* (Women's Hour, 2020). The interview was in keeping with the contents of the report in that it sought to pin the hopes of gender equality on better data and better reporting. However, when asked about her own career, Allen attributed her success to luck, determination, and mentorship. She advocated that it was not necessary to follow '*a linear fast track role'* (Women's Hour, 2020), before praising the value of peer support networks, which was a key item that was omitted from the report.

The need for greater female representation does have another practical implication beyond that of equality. As financial pressures on the NHS increase, there is a growing strain on top level NHS management, causing the number of vacancies at board level to continue to increase (Janjua, 2014). Of note is a report by the King's Fund, a think tank for health and social care, based on Freedom of Information requests from 227 NHS provider organisations and expanded using 18 semi-structured interviews with senior NHS leaders. Given the profile of the King's Fund and the robust methodology of the report, its findings are highly valuable. One of the explanations the report provided for the high number of executive vacancies was because the NHS is not sufficiently tapping into the predominant gender of its workforce. Research into the NHS provided explanations as to what prevents women from becoming executives, and the reasons

they step down from board positions, such as the '*culture of old boys'* networks, nepotism and prejudice, and a '*macho*', pace-setting environment, compounded by unhelpful attitudes towards female leaders (Janjua, 2014, pp. 15).

Another study, specifically investigating the impact of female representation on NHS boards and the organisations' financial performance, discerned no correlation between the gender diversity of the board and the trusts' performance (Ellwood and Garcia-Lacalle, 2015). However, the authors did find some improvement when women occupied the Chair or CEO roles; this could indicate there is an advantage of having female board members, but they are crowded out unless women have the most influential roles. It should be noted that this was a very limited study and the methodology on differentiating between high and low board representation, as the researchers acknowledged, was flawed. What it does indicate is that boards are certainly no worse off for greater gender diversity.

From a wider government perspective, Lord Davies was commissioned to undertake a review of female representation on UK boards which was published in 2011 (GOV.UK, 2011). The report reviewed practices at FTSE 350 companies and opened with the assertion: *'At the current rate of change it will take over 70 years to achieve gender-balance in boardrooms in the UK'* (GOV.UK, 2011, pp. 2). This is followed by a statement from Lord Davies, which concisely articulates the paradigm of the GC,

> *'Board appointments must always be made on merit, with the best qualified person getting the job. But, given the long record of women achieving the highest qualifications and leadership positions in many walks of life, the poor representation of women on boards, relative to their male counterparts, has raised questions about whether board recruitment is in practice based on skills, experience and performance.*'
> GOV.UK (2011, pp. 2)

The above quote demonstrates the fine balance between eliminating bias and positive discrimination. The question is not one of giving female candidates preferable treatment, it is an issue of providing an equitable environment for all, in which women claim

positions for which they are rightly qualified and capable of doing. Lord Davies' next quote is just as important,

> *'Some people told us that the only way we could make real change in increasing the number of women on boards was by introducing quotas. They said that other routes have already been tried, but women still remain a small minority on UK boards. Many other people told us that quotas would not be their preferred option as they did not want to see tokenism prevail. On balance the decision has been made not to recommend quotas. Government must reserve the right to introduce more prescriptive alternatives if the recommended business-led approach does not achieve significant change.'*
> GOV.UK (2011, pp. 2)

This last section of his introduction was interestingly reserved for one specific topic, this being quotas, which as seen above have been viewed as the panacea for resolving the issue of the GC in other countries. The fact that Lord Davies opted to mention quotas, in what was a brief three paragraph forward to the report, shows that, firstly, this is obviously an issue that Lord Davies felt strongly about and was topical at the time of his writing the review. Secondly, as with his first quote above, Lord Davies wished to reinforce his belief that women do not need to be mandated roles – they should be there on their own merits.

The Lord Davies' review highlights several causes for the paucity of female board appointments. The number one contributor, it claims, is that of the pipeline, i.e., there are not enough women waiting in the wings, ready to take up the next available vacancies. This is contrary to the views of the NHS Confederation, above, but could denote changes made in the five years between the reports. The report did, however, make concrete recommendations on how the issue of the GC should be addressed. This included measures, such as setting targets for female board composition (which does sound strikingly like setting quotas), disclosing the number of female appointments each year, and applying guidance on diversity.

Such was the impact of Lord Davies' work that the report has been updated regularly since the initial publication in 2011. Each update tracks success against the

benchmarked figures from the first report and the impact of the recommendations it outlined. When the review was published, only 12.5% of FSTE 100 board members were female, by 2016 this had shot up to 26.1% (Diversity UK, 2016). This increase shows incredible progress. It must be noted though that the cause was thought to be the pipeline issue. If that is the case how was such progress made in such a short space of time? It seems that purely by shining a light on the matter, Lord Davies was able to resolve some of the potentially discriminatory practices – i.e., the female candidates were ready and waiting and it was the appointment process that was the issue. It must be acknowledged however this increase (from 12.5% to 26.1%) – whilst double – is still well below the 50% benchmark of true equality, and perhaps this is where the pipeline issue will really come into play.

A 2017 government sponsored review into the low number of female appointments to FSTE 350 boards, provided a telling insight into the thought process of the leadership teams in the largest companies in the UK. The following is a list of the actual justifications provided for not appointing more female board members by the respondents; again, it is important to reiterate this was in 2017 (FSTE Women Leaders, 2017):

Table 1: Comments from FTSE Executives on Female Board Representation

- "I don't think women fit comfortably into the board environment"
- "There aren't that many women with the right credentials and depth of experience to sit on the board - the issues covered are extremely complex"
- "Most women don't want the hassle or pressure of sitting on a board"
- "Shareholders just aren't interested in the make-up of the board, so why should we be?"
- "My other board colleagues wouldn't want to appoint a woman on our board"
- "All the 'good' women have already been snapped up"
- "We have one woman already on the board, so we are done - it is someone else's turn"
- "There aren't any vacancies at the moment - if there were, I would think about appointing a woman"
- "We need to build the pipeline from the bottom - there just aren't enough senior women in this sector"
- "I can't just appoint a woman because I want to"

Source: FSTE Women Leaders (2017)

Whilst the above is anecdotal and possibly the views of a small number of executives, it does give a window into the types of opinions held by people who have considerable authority in the business world. There seems to be two trends to the comments, one treats women as a finite resource, if boards '*have one'* then they have done their job and besides all the good ones have been '*snapped up'*, or they level accusations that women do not have the skills or capacity to do the job because of the '*pressure*', '*hassle*' and because the environment is '*extremely complex*.'

In 2017 the UK government introduced a programme of '*returnships*' (GOV.UK, 2017). This was a five-million-pound funded programme to help individuals back into the corporate world after career breaks, from such things as childrearing or other carer responsibilities. The scheme was open to both men and women but certainly appeared to be slanted towards women, with the information on the GOV.UK website flagging only figures pertinent to the female participants, such as the fact that it could help increase

the income of women by '*an average of £4,000'* (GOV.UK, 2017). The programme essentially consisted of work placements and designated training to help those returning to work to update their skill set.

1.4 NHS Guidance and Investigations

The *Making the Difference, Diversity and Inclusion in the NHS* (King's Fund, 2015) report was based on the NHS annual staff survey results from 2014. This provided a huge pool of data from 255,150 NHS employees working across all aspects of the organisation. Whilst the survey covered many additional areas other than discrimination, it was solely this area that the King's Fund focused their analysis on. The *Making the Difference, Diversity and Inclusion in the NHS* report included two interesting facts relating to discrimination. Firstly, discrimination varies significantly from NHS trust to NHS trust, meaning that location and geography could have a bearing, but the report found no overwhelming correlations between different regions. Secondly, and perhaps most interestingly, is that men are more likely to report discrimination than women. It would be expected, all things being equal, that there would be a higher number of discriminatory claims from women as they consist of 77% of the workforce.

In terms of combating discrimination, the *Making the Difference* report made several recommendations. This included actions, such as, people suffering from discrimination being '*allied*' (King's Fund, 2015, pp. 12) with people who did not take part in discrimination, to join forces against the individuals or groups doing the discriminating. They also made further recommendations concerning better diversity training and communication. The report challenged organisations to tackle discrimination through clear '*promotion and retention policies'*, '*coaching and mentoring'*, and more controversially through the '*use of quotas'* (King's Fund, 2015, pp.13-14). However, the report did note that '*policies alone are not enough'* (King's Fund, 2015, pp. 14), citing the culture within organisations as being the most important factor. This could be adjusted by changing the organisation's vision and mission, better use of objectives and performance feedback, and positive people management and engagement.

The most relevant study, in relation to this research project, is that of Kline (2014) and what he described as the '*Snowy White Peaks'* of the NHS. Kline's work mainly focused on the BAME (Black, Asian, and Minority Ethnic) composition of NHS boards; however, he did also conduct some analysis on female board representation. His work noted an

increase over time in female board members, which at the time of his study, was around 40%. However, when it is considered that the vast proportion of the NHS workforce is female, one might expect the figure to be well above 50%, if there was genuine equity in appointments. Kline discovered that women were particularly underrepresented at CEO and Chair level, reinforcing the Department of Health data in Chapter One, that female representation declines the higher up the organisational hierarchy you go. In his 2014 paper he reported that for trusts in London, 14 of the 40 chairs were female and only 9 out of 39 CEOs. There was greater balance in terms of Executive Directors of which the composition was 117 males, to 99 female members. Table 2, below, shows representation of women on NHS Boards between 2006-2013. Whilst some years are better in terms of female appointments, there is no real trend of improvement over the period, apart from 2013.

Table 2: NHS Trust Board Appointments (England) by Gender 2006-13

Year	Male	Female	Total	Female %
2006	126	70	196	35.7
2007	134	46	180	25.6
2008	119	50	169	29.6
2009	127	71	198	35.9
2010	127	71	198	35.9
2011	164	81	245	33.1
2012	166	59	225	26.2
2013	161	116	277	41.9

Source: Adapted from Kline (2014) based on figures from the NHS Trust Development Authority

Kline's 2021 work in conjunction with NHS East of England, reflected on the more recent data concerning the recruitment and promotions of female, disabled and BAME NHS employees. Kline asserted that not only has the situation not improved since his 2014 report, but there was also evidence to suggest that it is now measurably less likely that women and people from BAME backgrounds would be appointed to senior NHS positions. For example, the report noted that in 2016 it was 1.57 times more likely that a white person would be appointed to an NHS role; by 2020 this had increased to 1.61 (NHS East of England, 2021). In particular, the report acknowledged that '*Chief Finance Officer and Medical Director roles have poor female representation despite having majority female workforces'* (NHS East of England, 2021, pp. 20). The report highlighted

research on some of the reasons for the reduced likelihood of women applying for more senior roles, including the fact that '*women were much less likely than men to apply for jobs if they couldn't meet all the essential criteria'* (NHS East of England, 2021, pp. 40). More interestingly the report noted that the language of job adverts can disparage women for applying for roles when certain words are used, for example, '*competitive*' or '*ambitious*' (NHS East of England, 2021, pp. 40).

Another highly relevant study to my own work is that of Seraj (2015), who explored the role of mentoring and social capital to improve diversity in NHS Scotland. The work of Seraj differs from my own in several respects, Seraj looked specifically at Scotland, had a narrow focus on the role of mentoring and social capital, and considered all forms of diversity (such as gender, disability, ethnicity, and age). Despite these divergences there is much that can be gleaned from Seraj. With respect to social capital, Seraj advocated the Nahapiet and Ghoshal definition of,

> *'the sum of the actual and potential resources embedded within, available through, and derived from the network of relationships possessed by an individual or social unit.'*
> Nahapiet and Ghoshal (1998, pp. 243)

Seraj evidenced that women suffered from having reduced social capital, compared to their male counterparts, and she wished to seek out how this impacted their promotion perspectives. Seraj concluded that social capital is important to female leaders as,

> *'it helps individuals to find jobs…facilitates the formation of new organisations and reduces employee turnover and organizational dissolution rates; and it promotes inter-organisational learning, supplier relations and networks in regional production.'*
> Seraj (2015, pp. 92)

Given the work of Kline (2014) and Seraj (2015) evidenced underrepresentation of women on boards, it is important to understand which measures the NHS could address. The NHS published a document on work life balance in 2018, titled *Top Tips for a Work Life Balance in Leadership* (NHS, 2018). It consisted of numerous pointers from several

very senior managers within the NHS. Whilst this document was not intended to act as a policy document, it was endorsed by the NHS and included a foreword co-written by Dame Ruth Carnell and Samantha Jones (both former NHS CEOs, who have held a wide range of very senior positions in healthcare). Given the number of NHS luminaries it contains, it is supposed to be of benefit to NHS employees in leadership positions. The *Top Tips* document contains suggestions from 21 NHS senior leaders on how to deal with the '*challenges we all face'* (NHS, 2018, pp. 3). It is a valuable insight into the measures the NHS condones; however, it recognises that it contains '*musings'* (NHS, 2018, pp. 3) rather than hard line NHS policy.

Highlights from the *Top Tips* document include those from Hatty Cadman, who talks about the need to be ones '*own role model'* (NHS, 2018, pp. 7), due to the leadership vacuum in the NHS. What is pertinent about the *Top Tips* document is that it offers advice in line with the literature in terms of addressing the contributing factors of glass ceilings; for example, there is the advice to '*never, ever appoint in your own image'* (NHS, 2018, pp. 7). This was expanded on by Rebecca George OBE who discussed the need to '*promote, encourage, hire and give extra roles to minorities in your organisation'* and to '[pay] *special attention to people who are most different from you'* (NHS, 2018, pp. 13). George instructed women to negotiate more around salary increases and new roles, as she felt that '*women don't tend to be brilliant at doing this'* (NHS, 2018, pp. 13). There are undoubtedly a lot of pointers in the *Top Tips* document that can support women returning from maternity leave. Dame Ruth Carnell provides the example of when she herself returned from her second period of maternity leave and wanted to work part-time, so the organisation she worked in created a job share arrangement. This meant she was able to still work a high-profile role in the reduced amount of time she had, rather than taking a more junior position.

What is most telling about the *Top Tips* document is that it clearly identifies many of the barriers cited elsewhere in the glass ceiling literature about the barriers faced by women in leadership positions. Rather than cement the guidance in policy documents, the NHS has opted to provide some helpful suggestions from people who have been there and done it. Whilst this could be a refreshing approach, it is certainly a softer measure and women could well argue if the causes and the effects are so well known, why isn't more done to support them? Kate Jarman perhaps best sums this up when she vents that,

'*The NHS is 80% women – a phenomenal statistic that should mean the NHS is the most family friendly, flexible, feminist network of organisations in the world'*, before concluding bluntly, '*it has a way to go'* (NHS, 2018, pp. 17).

In terms of strategy documents, The NHS Long Term Plan published in 2019, whilst not making explicit references to the gender balance of NHS leadership, did highlight that '*three quarter of* [its employees] *are women'* (NHS, 2019). The report's intentions could easily be inferred as having the aim of addressing inequality in board positions, such as the commitment to,

> '*strengthen and support good, compassionate and diverse leadership at all levels – managerial and clinical – to meet the complex practical, financial and cultural challenges a successful workforce plan and Long-Term Plan will demand.'*
> NHS (2019)

This comment neatly encapsulates the issue, the needs, and the benefits. It recognises that NHS leadership is not sufficiently diverse, whilst illustrating that diverse leadership is necessary in '*challenging times'* (NHS, 2019).

In this section it has been shown that, relative to other employers, the NHS is a female friendly employer. Much of the workforce is female and compared to other industries, the NHS has numerous flexible working arrangements to assist working mothers. However, the data shows that the NHS still does not deliver equity in terms of board level appointments. Despite rafts of policy, the NHS still experiences variations from trust-to-trust on how measures such as flexible working are adopted. The NHS and the UK in general has neglected to adopt quotas, instead opting for less effective targets for female board membership. As seen with the *Top Tips* document, the NHS knows the problems and the solutions, yet still resists devising hard policy measures to enforce them.

1.5 Agenda for Change and The NHS Context

Agenda for Change (AfC) was introduced into the NHS in 2004; the aim was to regulate the pay of all employees across the country, except for some medical staffing groups. The aim of AfC was to '*ensure equity of rewards for all NHS staff for work of equal value, irrespective of professional background'* (Williamson and Williams, 2011). The

predecessor to AfC was the Whitley Council pay system used across the public sector, which found its origins in World War I and was, therefore, unsurprisingly, deemed no longer fit for purpose by the 1990s (Gill-McLure, 2018). The introduction of AfC was believed necessary due to the massive increase in the size of the NHS as an organisation, which at its peak employed more than 1.3 million people, making it the fifth largest employer in the world (Manoj and Renju, 2011). AfC was brought in to ensure that people doing the same work in any part of the organisation in any location in the UK, received the same amount of pay. NHS employees working in inner and outer London received an additional allowance in recognition of the higher cost of living in the capital, although it was noted that this did not go far enough (Hutt and Buchan, 2005).

The aims of AfC are listed in the text box below, the top two lay claim that AfC will improve service delivery, with the remaining four aims concerned with direct human resource issues. For the purposes of this study, it is the last two points which resonate; they clearly state that AfC was intended to '*improve all aspects of equal opportunity and diversity' and 'meet equal pay for equal work.'* This rhetoric is very much the language of those seeking to address the glass ceiling.

- Ensure that the new pay system leads to more patients being treated, more quickly and being given higher quality care.
- Assist new ways of working which best deliver the range and quality of services required, in as efficient and effective a way as possible, and organized to best meet the needs of patients.
- Assist the goal of achieving a quality workforce with the right numbers of staff, with the right skills and diversity, and organized in the right way.
- Improve the recruitment, retention and morale of the NHS Workforce.
- Improve all aspects of equal opportunity and diversity, especially in the areas of career and training opportunities and working patterns that are flexible and responsive to family commitments.
- Meet equal pay for work of equal value criteria, recognizing that pay constitutes any benefits in cash or conditions implement the new pay system within the management, financial and service constraints likely to be in place.

Figure 3: Aims of Agenda for Change

Source: Department of Health, 2004

AfC is structured under bandings which run from one, being the most junior, to nine being the most senior; in addition, there are four separate bandings in band 8; 8A, 8B, 8C and 8D. Above band nine there is the Very Senior Manager (VSM) scale which is reserved for individuals working at an executive board member level. Within each banding there are spine points which every individual works through on an annual basis – should performance warrant it – until they reach the top of the banding. Medical consultants operate under a different scale.

Table 3: Agenda for Change Pay Scales 2020/21

Experience	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6
< 1 Year	£ 18,005	£ 18,005	£ 19,737	£ 21,892	£ 24,907	£ 31,365
1 - 2 Years	£ 18,005	£ 18,005	£ 19,737	£ 21,892	£ 24,907	£ 31,365
2 - 3 Years		£ 19,337	£ 21,142	£ 21,892	£ 26,970	£ 33,176
3 - 4 Years		£ 19,337	£ 21,142	£ 24,157	£ 26,970	£ 33,176
4 - 5 Years		£ 19,337	£ 21,142	£ 24,157	£ 27,416	£ 33,176
5 - 6 Years		£ 19,337	£ 21,142	£ 24,157	£ 27,416	£ 33,779
6 - 7 Years		£ 19,337	£ 21,142	£ 24,157	£ 30,615	£ 33,779
7 - 8 Years		£ 19,337	£ 21,142	£ 24,157	£ 30,615	£ 37,890
8+ Years		£ 19,337	£ 21,142	£ 24,157		£ 37,890

Experience	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9
< 1 Year	£ 38,890	£ 45,753	£ 53,168	£ 63,751	£ 75,914	£ 91,004
1 - 2 Years	£ 38,890	£ 45,753	£ 53,168	£ 63,751	£ 75,914	£ 91,004
2 - 3 Years	£ 40,894	£ 45,753	£ 53,168	£ 63,751	£ 75,914	£ 91,004
3 - 4 Years	£ 40,894	£ 45,753	£ 53,168	£ 63,751	£ 75,914	£ 91,004
4 - 5 Years	£ 40,894	£ 45,753	£ 53,168	£ 63,751	£ 75,914	£ 91,004
5 - 6 Years	£ 41,723	£ 51,668	£ 62,001	£ 73,664	£ 87,754	£ 104,927
6 - 7 Years	£ 41,723					
7 - 8 Years	£ 44,503					
8+ Years	£ 44,503					

Source: NHS Employers (2020)

The position of a role on the AfC pay scale is dependent on a complex job evaluation process involving the Knowledge & Skills Framework; this considers such things as seniority of the role, the scope of management responsibilities, the amount of experience required, and the necessary qualifications required for the position. However, this is not an exact science resulting in some disparity for the same role across different organisations, a claim that has been made since the inception of AfC (Benton, 2003). Further criticisms of AfC have stemmed from its inflexibility and a lack of ability to adapt roles to local factors. For example, there may be a shortage of a particular staffing group and, because NHS organisations cannot exceed the pay scales, there have been examples where staff groups have left the NHS to operate as private contractors. These

individuals then provide their services back to the NHS, charging well above the amounts for substantive post holders (Donnelly, 2016). NHS organisations in some areas, such as areas of deprivation or very rural locations, are unable to use market forces to attract employees, such as offering higher salaries for work in understaffed areas of the NHS (Beech et al, 2019). A further criticism is derived from the fact spine progression points are awarded irrespective of performance (Beech et al, 2019). The existence of the spine points was supposed to reward achievement, with an employee only progressing to the next increment through a successful report at their annual performance appraisal and achievement of their Personal Development Record. However, in practice spine points were awarded routinely.

The need to explore the AfC process in respect to this body of research, is to argue that the issues the NHS is facing do not relate to inequality of pay. For all its short comings AfC offers a robust safeguard in this respect, not least because the pay scale for a position is set prior to the advertisement of the role, i.e., the salary is approved before it is known whether the successful applicant is male or female. That said, there is sometimes the opportunity to negotiate within the limits of the banding. However, within a small number of years the post holder would have worked their way to the top of the banding irrespective of gender, especially as (noted above) there is very little chance of an employee not being awarded their spine progression at each appraisal.

Medical Consultants in the NHS are not covered by AfC. A BBC investigation in 2018 reported that of the 100 top paid NHS consultants only five were female (BBC, 2018). The investigation, based on data gathered from NHS Digital, found that '*full-time women consultants earned nearly £14,000 a year less than men - a pay gap of 12%.*' Dr. Anthea Mowat, of the British Medical Association, was reported as saying that to address this gap, '*women needed more support, including leadership training, mentoring and more flexible working opportunities'* (BBC, 2018). What Dr. Mowat does not pick up on is that the gap between male and female consultants could be attributed to the fact that they are not covered by AfC, which would help prevent this kind of disparity.

As AfC ensures a large degree of parity in pay scales it becomes invaluable in proving the existence of a GC in the NHS, as it removes the significant variable of comparable salaries between men and women. Therefore, if men and women *are* paid the same no

matter the role, then the evidence required to prove a GC becomes more straightforward to present. This is because it makes the data more discrete, as there is less ambiguity of what consists as being a board level position, given it is part of the job evaluation process for AfC.

To be able to understand the reasons for a glass ceiling existing in the NHS, it is first necessary to understand whether a GC does exist. Fortunately, a wealth of data is recorded and published by the Department of Health (DH) relating to workforce statistics which can inform this discussion. The last time the DH published the workforce data was 2016. Using the NHS workforce statistics for September 2016 as a starting point, it is possible to see that the total head count for the NHS was 1,186,056 and of this figure 77.1% of the workforce were female (NHS, 2016).

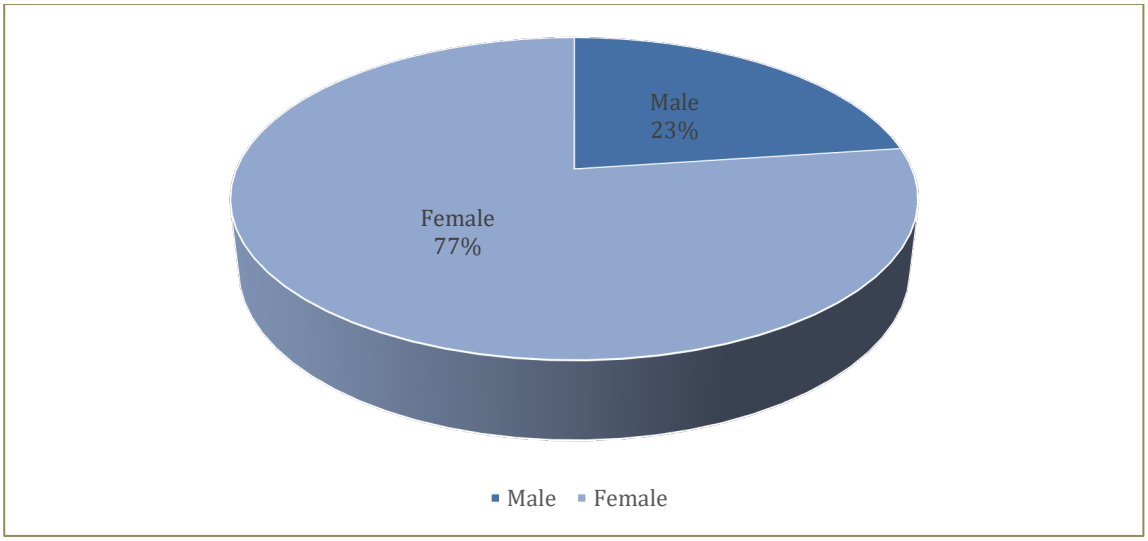

Figure 4: Proportion of the NHS Workforce by Gender

Source: National Health Service (2016)

A closer look at a subset of these figures demonstrates that women dominate all roles across the NHS (except for ambulance crews and their support staff). In terms of management positions, the number of female senior managers is higher than that of their male counterparts – 17,083 compared to 11,276 for male senior managers (NHS, 2016). The following graph explores the distribution of gender across senior management positions; it illustrates that female employees outnumber males across all Agenda for Change (AfC) bandings, except when they reach the Very Senior Manager (VSM) level,

which is the banding for many board-level positions. This graph helps pose the question of why, given the dominance of women employees across the NHS, do so few make the transition into the boardroom?

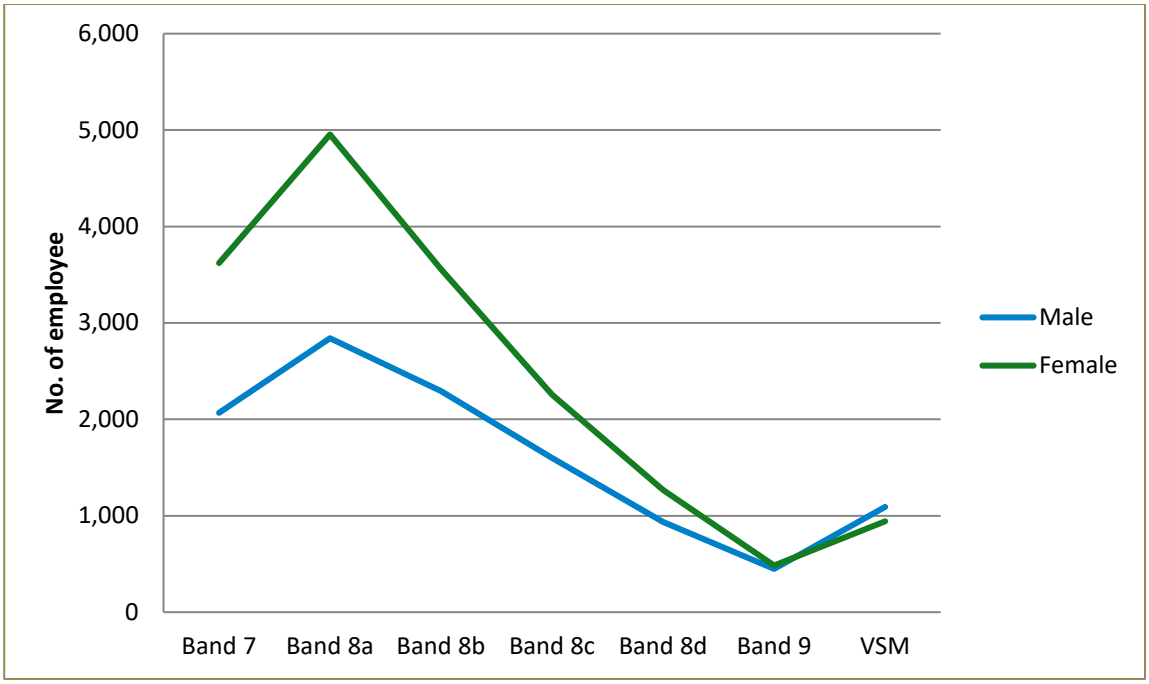

Figure 5: Number of Senior NHS Managers by Gender

Source: National Health Service (2016)

NHS Digital is an organisation within the NHS who are described as,

> *'the national information and technology partner to the health and social care system…using digital technology to transform the NHS and social care.'*
> NHS Digital (2019)

The employment data that NHS Digital provides is especially interesting to review, as unlike other parts of the NHS – such as nursing – it operates in IT which is a field traditionally dominated by men. Reviewing the graph below it is possible to see that it varies from other areas of the NHS, in the fact that there is a much closer split in terms of male and female employees (1,639 and 1,294 respectively); the average salaries are also very similar. However, the biggest difference between the genders is again most

apparent in the more senior job roles; whilst 44% of the workforce is female only 23% of Band 9 employees are female.

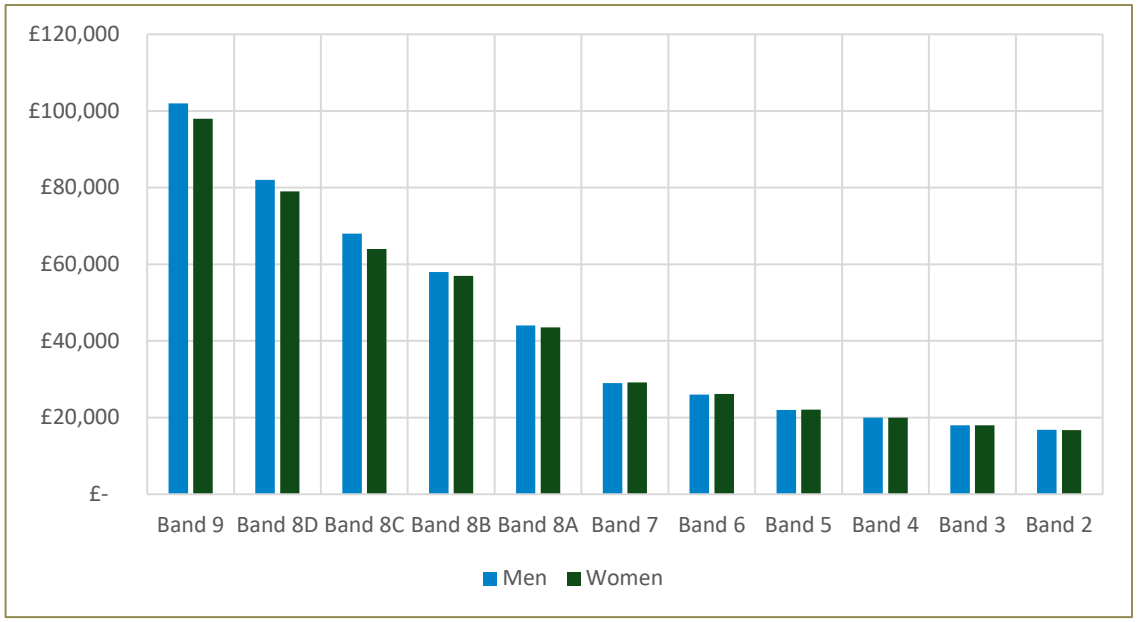

Figure 6: Total Average Whole Time Equivalent Salary by Pay Band and Gender

Source: NHS Digital (2018)

Published in 2019 to celebrate its 70th birthday, the NHS set out its priorities in a *New Long-Term Plan*; it devoted an entire chapter to workforce planning in which it recognised the challenges now facing its employees,

> *'The NHS is the biggest employer in Europe, and the world's largest employer of highly skilled professionals. But our staff are feeling the strain. That's partly because over the past decade workforce growth has not kept up with the increasing demands on the NHS. And it's partly because the NHS hasn't been a sufficiently flexible and responsive employer, especially in the light of changing staff expectations for their working lives and careers.'*
> NHS (2019)

The inability to maintain workforce growth at the same rate as demand is due to many factors, but a sizable one is the role of gender. For example, the inability to attract men into nursing positions, but also the failure to bring women into management roles in more

sizable numbers. Britnell (2019) was able to argue that this isn't just an issue for individual women. Because of global workforce challenges, he stated that the necessity to '*attract, engage, and retain female staff will become increasingly important to both employers and governments'* (Britnell, 2019, pp. 94). This is best evidenced by the fact that gender equality is one of the United Nations' 17 Sustainability and Development goals. But getting more women into executive positions will not be easy due to systemic factors in the NHS as an organisation and the wider world. Britnell was able to relate the problems facing females working in healthcare,

> *'despite strong female representation in the health workforce there are wide inequalities between men and women within it. Men still earn more and dominate leadership positions. Women are more likely to experience discrimination and harassment at work and are more likely to tame ambitions, cut hours, or drop out of the labour force after having children.'*
> Britnell (2019, pp. 94)

Figure 8, below, represents the associated pathways for clinical and non-clinical careers in the NHS. Figure 8 starts with Band 5 which is typically the lowest salary banding which can be classified as a 'managerial' role (as per Figure 6 above, taken from the data supplied by the NHS, 2016). Taking Band 5 as a starting point also works well, as it is the level at which newly qualified trainee nurses commence. There is a slight discrepancy with the medical salary gradings as they do not fall under the AfC bandings. The non-clinical job titles will vary from trust to trust but conform to the general terminology used when grading posts to the AfC job evaluation process. Similarly, whilst the clinical job titles may vary slightly from trust to trust, these will be titles that are familiar to many people working in a hospital setting. It is important to note that for all non-clinical roles it is, in theory if rare in practice, possible to transfer from a role in another sector or industry directly into an NHS management role; also, clinicians have been known to move from clinical roles to non-clinical managerial roles (although normally nursing rather than medical). The opposite is not true, non-clinicians are unable to transfer into clinical roles at the upper levels. Should managers wish to transition into a clinical role, it would mean moving to the bottom of the training and career rung of the ladder.

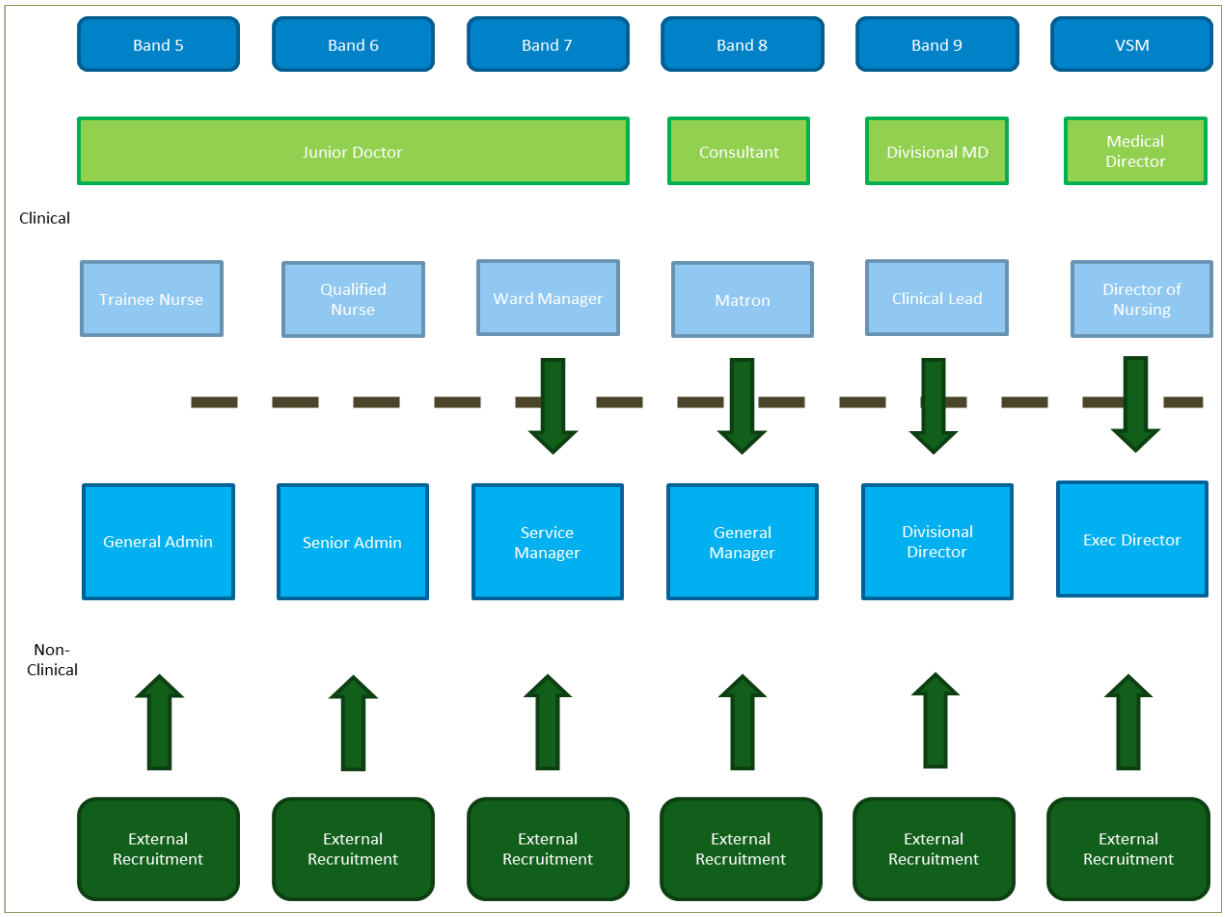

Figure 7: NHS Career Pathways for Clinical and Non-Clinical Positions

Source: Author Generated

In terms of the non-clinical roles, this side of the diagram is a blanket reference to a host of management roles in not only operational management but also HR, Finance, Estates, Procurement and IT. Moving between these disciplines is possible, if not always frequent, and there can be a need to obtain additional qualification or registration with the relative chartered body (the most common example would be becoming a charted accountant to work in finance). People making this switch can complete the additional qualifications in their own time and would not need to take time away from the workplace to completely retrain, which would not be possible with those wishing to move into clinical roles. Successfully working the way through the various levels ultimately results in reaching executive roles such as Medical Director, Director of Nursing, Chief Operating Officer or Director of Human Resources. It is worth noting that in the NHS it is common to jump bands, so that it is not necessary to come in at a Band 5 role and then take roles

at Band 6 all the way to Very Senior Manager (VSM) including the posts at 8a, 8b, 8c and 8d.

1.6 Summary

At this juncture it is appropriate to ask, why is this study needed? In his book highlighting the world shortage of healthcare practitioners, Mark Britnell noted that,

> '*much of the world of work is still modelled on an approach which may have suited men in the 1950s but is unfit for today's world.*'
> Britnell (2019, pp. 93)

The case for change he presented was based on the need to meet future shortages of global healthcare practitioners, as in particular, '*rates of female participation in the workforce…place an artificial constraint on the capacity of the health workforce to meet demand*' (Britnell, 2019, pp. 35). Without increasing the role of women across all workforce disciplines, including leadership positions there quite simply will not be a workforce of sufficient size to meet the global needs of the future. Of course, the GC in healthcare is not an issue that the NHS faces in isolation. Speaking at the Australian College of Healthcare Service Management, Women in Leadership, to celebrate International Women's Day in March 2019, Dr. Mellissa Naidoo, outlined the necessity for gender equality for Australia in an eloquent statement,

> *'In the business world it is pretty much accepted now that having diverse leadership is a strategic priority, providing competitive advantage to those businesses, and board diversity is increasingly a topic of conversation. It's recognised as essential to good governance and organisational performance. And increasing diversity is just as important in healthcare. In healthcare women are key stakeholders, they make up about 80% of the decisions for families, including important health care decisions, they are 78% of our workforce and they are 75% of the care givers in the home. But they are not key decision makers, women only make up 32% of doctors and surgeons, 18% of hospital CEOs and 4% of health company CEOs.'*
> Naidoo (2019)

The NHS context, discussed above, demonstrated the huge role that women play across the organisation. To re-cap, women make up around 77% of the workforce and are the dominant gender in most staffing disciplines. Despite this, women are still underrepresented in board level positions. Even in nursing, in which women compose 90% of the workforce globally, men still occupy many of the leadership roles (Britnell, 2019, pp. 98). It has been shown that there are career pathways for women to progress into management positions and, with AfC, there is a seemingly equitable way this career progression can be supported and rewarded. The following chapters will seek out answers to why, given the progress over the past 100 years and the legislative and organisational frameworks, the NHS still is unable to provide gender equality in its management positions.

The aims of this thesis are to examine whether a glass ceiling existed in the NHS and further the knowledge about any barriers and facilitators of women's advancement to board level. The specific research objectives are to:

1. Explore whether data on female representation on NHS boards indicate a GC.
2. Understand, if a GC is proven, why it exists.
3. Suggest recommendations to address any gender imbalance.

As discussed above, it is important to note the parameters of this research. Given I will be exploring the glass ceiling in the context of the English NHS, it is necessary to observe the narrow focus of the literature and research. Whilst the issue of gender equality is a pressing global issue, indeed it could be argued it is significantly more important in developing nations, the focus of this research shall therefore be on democratic Western European countries. Further to this, however, it is necessary to recognise and appreciate the diversity of the NHS patient base and the people who work within it.

This chapter introduced some of the anthropological and biological explanations for the origins of the glass ceiling, dating back to the age of hunter gatherers when men were the ones who went out to track animals, while women stayed back to rear children. This put in place a trend that stayed with us for thousands of years, which only started to gain real change when the suffragette movement pushed for enfranchisement for women voters. This move for gender equality gained a substantial boost with the subsequent

outbreaks of World War I and II, when women were able to undertake traditional male positions and prove their ability to be equal to the men they were replacing. Following the return from the battlefield men expected their roles back, and a grateful nation acquiesced – however women's role in the workplace was normalised, despite having to rescind from the more traditional heavy industries. Women's rights took a further boost in the late 1960s and 70s, when a raft of equal pay and anti-discrimination legislation was enacted. This coincided with a second push from the feminist movement, who gave vocal opposition to the '*old boys network'* and questioned why women could not hold the most senior roles in business and government.

The following chapter (Chapter Two) reviews the relevant literature on glass ceilings in general, the ways they came to exist and theories on smashing them, as well as focusing on glass ceilings in a healthcare practitioner context and the government policies concerning these issues. The third chapter reviews the methods and methodological approach to the research project, demonstrating why mixed methodologies were adopted to answer the research questions and objectives. Chapters Four and Five focus on findings, in terms of the quantitative data and qualitative interviews, respectively. I opted to provide a series of vignettes to present the contents of the interviews in a more accessible format in Chapter Six. Chapter Seven is devoted to the detailed discussion of the research results, dissecting the themes, and linking them back to the literature and then exploring the conceptual framework in Chapter Eight.

Whilst much of the data collection for this thesis was completed prior to the Coronavirus pandemic which started in 2020, I thought it important to include reflections of the pandemic in relation to my research. Whilst completing my final interviews it became apparent that the pandemic had accelerated some of the changes that I had observed in the early stages of my data collection. I therefore took the opportunity to include an additional chapter (Chapter Nine), on how this event had impacted female career opportunities, due to the rapid acceleration of some of the patterns and observations that had stemmed from the earlier chapters. It is of particular interest to explore how the impact of the pandemic corresponded to the conceptual framework which is introduced in Chapter Eight. Finally, in Chapter Ten conclusions are drawn, reflections on the process of conducting the project are examined and recommendations on the use of the research are discussed.

Chapter 2: Literature Review

"*I had to get a close-hand view of the misery and unhappiness of a man-made world, before I reached the point where I could successfully revolt against it*."

— Emmeline Pankhurst, My Own Story (1914, pp. 10)

2.0 Literature Review Introduction and Methodology

A literature review '*summarizes and evaluates a body of writing on a specific topic'* (Knopf, 2006, pp 127). The aim of this literature review was to seek a rounded view on the topic of glass ceilings (GC) and wider gender equality in management positions, and then to undertake a critical appraisal of the information which had been gathered. With such a large subject area as GCs it is necessary not only to gain a wide understanding on the many broad themes, but also to narrow the focus of relevant literature to my specific subject area of healthcare management. This creates a paradox for the researcher; there is the desire to read as widely as possible, to ensure no stone is left unturned in relation to GCs, but also, to read as narrowly as possible to generate an understanding of those factors which are unique to gender inequality in healthcare management. To facilitate this juxtaposition, I adopted an approach of effectively undertaking two separate literature reviews and then synthesizing the findings. This created issues due to the volume of documents it was necessary to review and the way I had to prioritise those selected for review. To this end, I was directed by Hart (2018, pp. 34), insomuch as I did not aim to '*include everything that has been found'*, but to present what is most '*relevant*.' This approach was vital to my research due to the sheer weight of literature that has already been published on the subject.

In essence, the two separate reviews consisted of a review of general literature pertaining to GCs, to ensure I was grounded in the developments in this theory since the phenomenon was first identified through to the current day. I then focused on specific healthcare literature to understand factors which were more pronounced in the healthcare industry. The detail of the strands of the literature review are listed here:

1. **Comprehensive Literature Review of all recent, relevant literature on glass ceilings**: Due to the paucity of literature directly relating to glass ceilings in healthcare, it was necessary to initially look at other industries. Using

literature predominantly from the preceding five years from when the review was completed (2013-2018), this review examined the learning from these industries and explored their applicability to the NHS. Only English language literature was reviewed, given this is the only language I am fluent in and translating articles would have created a resource burden. The trends from the literature (such as potential barriers and opportunities) were grouped into categories which were used to form interview domains for the qualitative elements of this research.

2. **Healthcare specific literature:** It was necessary to review healthcare specific literature on glass ceilings and gender discrimination, to identify relevant theories and any gaps which my research could hope to fill. Due to the smaller pool of literature, it was possible to look back over the same period of five years (2013-2018) and to review the reduced amount of literature in greater detail. Again, only English language literature was reviewed.

Whilst the aim was to only go back over five years, some journal articles outside this period kept being referenced in other literature. As such, I did go beyond the five-year period in instances where I felt the importance of the document warranted it.

The initial search terms and criteria were narrowed after a first round of searches produced too much material to practically review, especially when utilising the search engines Summon and Google Scholar. Once the search terms had been entered, the filters had been applied and the number of returns delivered, the returns were ranked by relevance. The articles were then reviewed via their title to predict their applicability, following this the abstracts were assessed in relation to relevance, quality of publication, and reliability of data and conclusions. Only those which were deemed appropriate across all these measures were included in my review. The tables below display the number of articles which were returned under each search term for the given database or search engine.

Table 4: Results of the Comprehensive Literature Search

Database / Search Engine	Gender Discrimination AND Career progression	Glass Ceiling AND workplace	Gender in leadership AND Career Progression	Gender in management AND Career Progression
Summon	2,042	20,936	2,750	6,145
Google Scholar	17,000	15,000	1	22,900
Business Source Complete	8	71	553	3
Emerald	361	170	712	1,004

Table 5: Results of the Healthcare Specific Literature Search

Database	Gender Discrimination AND Healthcare	Glass Ceiling AND Healthcare	Gender in leadership AND Healthcare	Gender in management AND Healthcare
Summon (Filtered for Public Health)	5,270	293	3,168	26,567
Google Scholar	23,100	10,600	29,500	18,600
PsycINFO	53	5	19	51
British nursing database	1,227	75	1,189	6,196
CINAHL	33	9	14	47
NICE Evidence	840	44	806	2,701

The databases which were selected were done so on the understanding that they have a wealth of articles that were relevant to my field of research, and, therefore, had the most up to date publications on the subject. The tables above demonstrate the vast amount of literature on this overall subject area; as such it was essential when reviewing the publications to be careful about which tangents to follow and which to disregard. This reduced the risk of the focus becoming too diluted and to adhere to the resource constraints of the project. Once the title of the article had been deemed relevant, the abstract was then reviewed to ensure the content would add to my knowledge on the subject. If it was evident that the document was applicable the article was saved for full review, with RefWorks used to ensure that all references were captured. Referencing was in line with the Harvard System, as per the University of Middlesex guidelines.

The total number of documents that were read and incorporated or informed the literature review was 108. The below table details the different articles which were used to inform the literature review. Unsurprisingly, given the search was solely for English language literature, the US generated much of the material. The table illustrates the paucity of literature pertaining to the glass ceiling in healthcare, with only 25 documents forming this section of the review. The lack of documents in this area highlighted the need for my body of research. Quantitative analysis appears to have been a popular method of inquiry, possibly because it allows analysis of large, country-wide data sets. Where qualitative methods were used, it tended to be for surveys with sample sizes of 200-500 people or semi-structured interviews with 10-20 individuals.

Table 6: Analysis of the Articles in the Literature Review

Area of Literature	No. of Articles	Quantitative Analysis	Qualitative analysis	Region
All literature of glass ceilings	83	26	20 Survey 15 Interviews 24 Other	32 US 14 UK 17 Europe (Non- UK) 21 Other
Healthcare specific literature	25	12	0 Survey 7 Interviews 6 Other	8 US 10 UK 6 Europe (Non- UK) 0 Other

The findings were organised by sorting the materials into themes which could then be coded. This enabled me to develop conceptual trends and begin to form a theoretical framework. The themes from the literature (such as potential barriers and opportunities) were grouped into categories which were used to inform interview domains for the qualitative element of this research. To build the argument from my literature I employed Toulmin's model, which Hart (2018, pp. 130) laid out in pictorial form, below. The diagram summarises that the literature research enables me to use data and form claims, which then can be explored and reinformed or backed up by data collection.

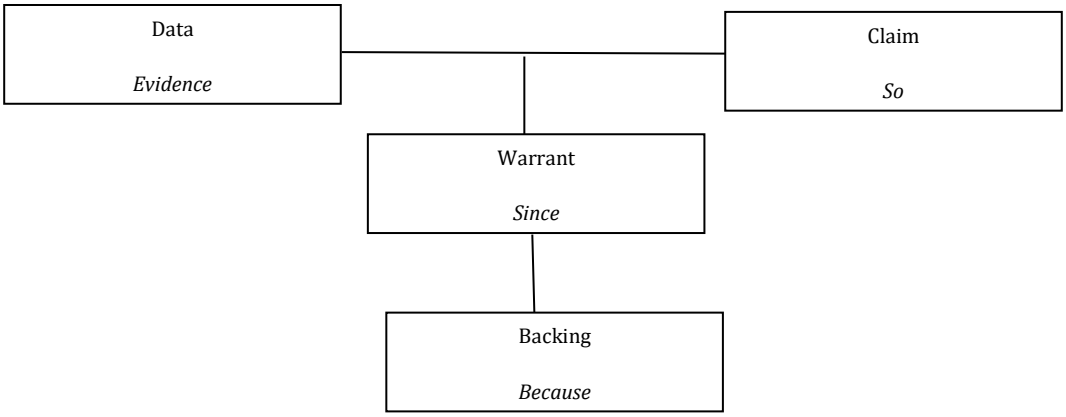

Figure 8: Toulmin's Model Structure of an Argument

Source: Adapted from Hart (2018, pp. 13)

2.1 Literature Review

The below summarises the various themes from the literature. It is important to note that whilst this was based on several different database searches and two separate strands (i.e., broad gender-based literature and healthcare specific literature), the separate strands have been interwoven as best as possible, to provide better continuity of the key themes. There are three central themes to the literature review; the evidence that the glass ceiling exists, the causes for glass ceilings existing, and the ways to smash the glass ceiling.

2.1.1 Evidence of the Existence of Glass Ceilings

Before explaining the reasons for the glass ceiling, it is necessary to explore if one exists. The NHS data explored in the introduction chapter, Section 1.3, suggests this is apparent; this was tested more robustly with quantitative research later in this study. However, the literature adds weight to this argument; there is a wealth of data which evidence that GCs exist across many industries and countries. One North American study found that only 36 percent of management positions have female incumbents (Ng and Sears, 2017). At a governmental level, it was shown that globally women made up 21.8% of parliamentarians and only 7.8% of heads of governments (Folke and Rickne, 2016, pp. 568). With reference to healthcare, in 2000 the UK Department of Health (DoH) reported that '*only 23% of Chief Executives in the NHS are women – and only 17% of Finance Directors*' (DoH, 2000). The DoH noted there are large regional variations with the comparable rate of female CEOs in the North-West Region of England, being only

17% compared to 35% in London. The problem of the glass ceiling extends beyond Western economies. In developing countries, such as Brazil, it has been shown that female entrepreneurs struggle to secure microfinance in contrast to their male counterparts (Agier and Szafarz, 2013). At the opposite end of the career scale, it has been recognised that women make up a mere '*2% of all presidential posts'* (Jalalzai, 2013, pp.12) with women '[seriously] *underrepresented as national leaders around the globe'* despite female levels of education surpassing male levels in some countries.

There have been improvements in the representation of women on boards in the UK. Sealy et al (2016) demonstrated a positive trend in relation to meeting the targets, laid out by Lord Davies in 2011, to have 25% female representation of FTSE 100 boards. Whilst optimistic about the increase in the proportion of female directors, Sealy et al (2016, pp. 2) did lay out the conditions that were required to continue this positive trend. This included the need for boards to turnover directorships (as there is no scope for women to join boards without vacancies); to ensure the pipeline of women in senior and middle management positions was maintained; and maintain transparency and targets for recruiting female directors.

A two-step process has been devised to validate whether a glass ceiling is present; first it must be proven there are '*discriminatory barriers to women's career advancement'* (Folke and Rickne, 2016, pp. 568). Specifically, it must be evident that women were disadvantage due to their gender and no other factor. To account for this, it is essential to consider all factors such as '*work experience, formal merits, and personal preferences'* (Folke and Rickne, 2016, pp. 568). The second stage is that the '*barriers increase for positions higher up the organisational hierarchy*' (Folke and Rickne, 2016, pp. 569). If this two-step process is applied, it is necessary to recognise that all glass ceilings are due to gender discrimination. Gender discrimination in the labour market, is a '*situation in which equally productive men and women are rewarded differently'* (Azmat and Petrongolo, 2014, pp. 33). This is aligned to Folke and Rickne's test, meaning that to prove the existence of a glass ceiling both conditions must be met – that is, it must be proven that output (of the individuals) is equal and that the rewards (i.e., remuneration and promotions) are different. Proving output is difficult, however, as it could be argued that equal output relates to the ability to execute one's job role. Because GCs fundamentally exist due to discrimination, it is important to understand that '*race and*

gender bias in society is invisible, deep, [and] *pervasive*' (Sheaffer, Levy and Navot, 2018, pp. 3). This means that it is difficult to prove that discrimination is taking place. Also, this creates a difficult issue when dealing with GCs, as the fundamental beliefs which created them are so embedded in people's psyche that they may not be aware they harbour them, in what is known as the '*gender bias perspective'* (Soklaridis et al, 2017, pp. 253).

Benefits of Smashing the Glass Ceiling

Before contemplating how to eliminate glass ceilings, it is necessary to consider the benefits this would bring, not only for the individual female employees' perspective but also from a business and societal angle. Looking at global political leaders in 188 countries it was found that '*female leaders were significantly more likely than male leaders to have fast-growing economies'* (Perkins and Phillips, 2019). Barak Obama was a notable advocate of female political leaders and the '*need to pay close attention to experiences of women and people of colour…the more perspectives around the table, the better the organization performed'* (Obama, 2020, pp. 535). Dutu (2014) claimed that gender equality is good for '*economic performance'*, as it '*increases long-term growth potential and contributes to a better allocation of human capital across occupations'* (Dutu, 2014, pp. 6). Furthermore, it has been evidenced that companies with higher-than-average female representation in senior management positions outperform the industry average by 15% (Perkins and Phillips, 2011).

Dutu (2014) pointed out the seemingly obvious but often overlooked point that, by better utilisation of the female workforce there is a greater '*return on educational investment'* (Dutu, 2014, pp. 6). There are further benefits of removing glass ceilings, as when promoting from predominately male employees, organisations '*limit the pool of talent'* (Powell and Butterfield, 2015, pp. 307), and it is '*illogical to only recruit from half the possible candidates'* (Amrein et al, 2017, pp. 288). On a wider macroeconomic perspective, in relation to the aging workforce, '*by 2040, Europe will have a shortfall of 24 million workers aged 15 to 65; raising the proportion of women in the workplace to that of men would cut the gap to 3 million'* (Desvaux et al, 2008, pp. 1). Within this shortfall, sectors that are more male orientated, such as engineering and IT, will be particularly affected unless they can find ways to attract, retain, and promote female employees. Similarly, the female workforce could hold the answer to the '*global talent scarcity'* (Bohmer and Schinnenburg, 2015, pp. 74).

Bohmer and Schinnenburg (2015, pp. 74) addressed a less obvious matter; they noted GCs create a '*justice*' issue, whereby if prejudice is observed because of the existence of a glass ceiling in an organisation, it creates the question of what other injustices might be present in the same organisation. This extends to a third issue of impression management; the existence of glass ceilings creates a question of fairness. Gender equality is a key driver of well-being and happiness; it has been recognised there is a '*strong correlation'* between gender quality and happiness; this does not mean '*income equality'* (Veenhoven, 2015, pp. 385). This is particularly pertinent to the glass ceiling because whilst related, income does not necessarily indicate a position in an organisation's hierarchy. One of the benefits that could result from trying to eliminate glass ceilings is the positive image it provides an organisation, due to the '*moral imperative'* (Ng and Sears, 2017, pp. 135). This is controversial, as what Ng and Sears are effectively saying is that companies should recruit women to their boards not because it benefits the performance of an organisation, but because it improves its reputation and '*gains legitimacy with customers and investors'* (Ng and Sears, 2017, pp. 135). However, they went on to say this was limited to '*the extent that they are valued in the marketplace'* (2017, pp. 135), meaning that this was not a universal principle and depended on the remit of an organisation. Although later in their research Ng and Sears (2017) did note the ways that female representation can affect performance. They saw that an organisation with above average female leadership can attract more female customers. A further, less obvious, factor they discussed was a case study of US defence contractors who, to obtain more government contracts, started to have stricter adherence to affirmative action laws (such as gender inequality).

Focusing on healthcare, Kline (2014) highlighted that the benefits to healthcare providers of having a diverse workforce can be *'linked to good patient care'* (Kline, 2014, pp. 3). In a health context it is easy to see why this is the case; your patient base will be as diverse as the population you serve. Having staff that can either interact with them directly, will ensure the most relevant care is provided. Sobieraj (2012, pp. 2) extended this thinking, noting that in healthcare '*diverse teams make better and safer decisions*.' To this end, Kline (2014) noted that having representative boards – in relation to the local community they serve – had started to become NHS policy. Following on from Kline's acknowledgement that healthcare leaders need to be diverse to best meet the needs of

their communities, Silvera and Clark (2019), take this argument a step further by evidencing that an increase in female CEOs leads to improved performance of healthcare provider organisations. They provide two propositions as to why women make better hospital CEOs:

> *'(a) female CEOs are more likely to address and improve the interpersonal care experience of patients because relational orientation is critical to improving patient experience and female leaders tend to have greater relational orientation than their male counterparts, and (b) the relationship between CEO gender and interpersonal care experience is strongest in the most complex environments because CEOs are most likely to draw on their personal experiences and orientations (e.g., relational orientation) when the demands of the job and strategic ambiguity are high.*'
>
> Silvera and Clark (2019, pp. 2-3)

Sharif (2015) believed that the existence of the glass ceiling was so extreme that it was pushing high performing female employees out of the corporate world, as they would rather go into business themselves than face the frustration of repeatedly being overlooked for promotion. This, however, is unfortunately a self-fulfilling prophecy as it leads to high numbers of female employees – who have sufficient experience to reach board level positions – leaving organisations. This reduces the potential supply of female executives, who then in turn are unable to act as role models and mentors to the next generation of female leaders. This phenomenon is regarded as *the new brain drain*, as women opt to withdraw from high profile careers by taking *off-ramps*, to become parents or part-time employees in lower paid sectors. The *new brain drain* has been seen to be present for over 15 years now, it has been suggested that as little as 38% of women graduating from Harvard Business School end up in full-time careers, wider analysis shows that 43% of highly qualified women leave full-time employment to have children, and 24% due to dependent parents (Hewlett and Buck-Luce, 2005, pp. 44). In addition to these statistics Hewlett and Buck-Luce provided explanations of '*pull factors'* driving women towards off-ramps, with 17% leaving because they did not find their roles satisfying and 32% of women stating their spouse's income was sufficient for them to stop working. Once women have headed for the off-ramp, the vast majority (93%) seriously intend to return to their chosen career; however, this does not necessarily prove

straightforward. The difficulties of returning to the workplace include '*penalties of time out'*, even though many women take only relatively short breaks (the average is 2.2 years) they '*lose an average of 18% of their earning power'*, with the impact being greater the longer they are outside of the workplace (Hewlett and Buck-Luce, 2005, pp. 45).

2.1.2 Causes of the Glass Ceiling

Historically it was thought that GCs happened because,

> *'traditionally, men were expected to fulfil the role of sole earner in the household. Women were then expected to assume economic dependency and the role of motherhood, with no aspiration for career acknowledgement.'*
> Motaung et al (2017, pp. 2)

The US Federal Glass Ceiling Commission (1995) was one of the first government organisations to explore the reasons for glass ceilings existing. They came up with three barriers; societal (the availability and qualifications of female employees); internal structural (the lack of organisations to reach out to female employees); and Government barriers (the monitoring and enforcement of law). Reflecting on the changes that have been made since the publication of the US Glass Ceiling Commission Report in 1995, Merida (2013) looked at progress against the three barriers outlined in the original report; they noted whilst there had been advancement in the education levels of female employees and significant increases in their salaries, female earnings were still not on parity with male ones. He reasoned that all three barriers remained firmly in place, making them the leading obstacles in '*women's upward mobility into senior management ranks*' (Merida, 2013, pp. 5).

Similarly, The Economist (2015) published a Glass Ceiling Index, charting reasons for a lack of progress against the glass ceiling; it cited factors such as '*higher education, labour-force participation, pay, childcare costs, maternity rights, business score applications and representation in senior jobs'* (The Economist, 2015) as all being important metrics. Between 1995 and 2017, Ng and Sears (2017) summarised that, women have made '*considerable inroads in the workplace'* due to equality programmes, rising education, and progressive work-life policies, but despite these inroads they '*continue to experience the glass ceiling'* (Ng and Sears, 2017, pp. 133). One of the

greatest barriers that women now face is the progression from low-level to medium-level roles, which is an obvious steppingstone on the route to upper-level management.

The most striking development in the research about the glass ceiling is not the progress made to abolish it but the multiple explanations for it (Powell and Butterfield, 2015). This raises the debate of whether commentators are trying to fan the flames on the subject and raise the profile of the matter through increasingly convoluted reasoning, or whether there should be a focus back on to the core original barriers to women being less present in the boardroom. *'Much has been written on the progress of women in the workplace'* although there is still little understanding of *'macro-strategies'* (Ng and Sears, 2017, pp. 134) for resolving the continued existence of glass ceilings. Similarly, Fernandez and Campero (2017, pp. 73) noted the '*research aimed at understanding the organisational roots and stratification has burgeoned'*, but this burgeoning of research has brought with it little increase in knowledge, with few meaningful interventions being implemented.

Fisk (2016, pp. 181) speculated that '*women take fewer risks than men'*; this extends to financial risks which is why men might be more desirable in boom times, when the risks are safer than in times of constriction when risk taking can be devastating. Additionally, when organisations expand overseas, they are reticent to recruit female employees due to bias against female leaders in foreign marketplaces (Ng and Sears, 2017), a worrying fact when considering increased globalisation. A study in the US regarding Fortune 500 companies presented ample evidence that over the 15-year period examined in the report, '*the promotion probabilities and leadership tenure of women and racial / ethnic minority CEOs…*[were] *consistent with the theory of the glass cliff*' (Cook and Class, 2014, pp.1080). This glass cliff phenomena, means that in times of difficulty women are more likely to be promoted than men. Some reason this is because failure is more likely during these times so boards are less concerned with appointing women. The glass cliff was supported by Bruckmuller et al (2014), who claimed that '*when companies were performing poorly, women were more likely to obtain leadership positions'* (Bruckmuller et al, 2014, pp. 204). Bruckmuller et al was able to evidence that women are more likely to be appointed to failing organisations rather than high performing ones. This leads to the question, why are boards reluctant to appoint women when things are going well but then turn to them in times of hardship? This has been further compounded by studies which show that the existence of a glass ceiling could be counter intuitive for business,

as increasing the number of female executives can increase the profitability of organisations (Adler, 2001; and Mercer, 2011).

A further metaphor from the literature, which is insightful when considering the issues prevalent in the NHS, is that of the glass escalator, whereby men in female dominated industries are promoted ahead of female managers (Price-Glynn and Rakovski, 2012). The data in Chapter One recognised that women outnumber men in all levels within the NHS, until it comes to board level positions, a handy illustration that the glass escalator could well be a factor affecting selection for executive roles. The glass escalator has been found to exist in relation to the care industry; it was speculated that the '*pink collar*' jobs are becoming more appealing to men due to the decline of more traditional male dominated heavy industries (Dill, Price-Glynn and Rakovski 2016, pp. 336). The explanation presented for men being more easily able to navigate their way to more senior positions, was a propensity to gravitate towards more specialist roles, which require higher levels of qualifications and thus higher renumeration. In the NHS, those board level positions requiring the highest level of expertise in terms of qualifications and experience are the Medical Director and Director of Finance. A review of the gender split of each executive role is undertaken in Chapter Five to analyse if this could explain the prominence of men in these types of roles in the NHS.

To counter these trends, it is necessary to reach a point where a concrete floor is achieved, whereby once a certain level of female representation has been reached, it rarely then falls back below. Once board level equality is achieved it is unlikely to be rescinded (Annesley et al, 2019). The phenomenon found its roots in governments across the world; when a new prime minister or president comes to power, they increase the number of women in their cabinet; the next person in power – seeking to better their predecessor – looks to increase, or at least maintain this level of gender balance and so on. The net result of this means that, even if for political, rather than for practical reasons, once gender equality improves it rarely regresses (Annesley et al, 2019).

An aspect of the work of Addison et al (2014) was to link higher promotions to higher remuneration. Whilst this might seem like common sense, it is important to consider the wider significance – for there to be pay equality there needs to be promotion equality. Addison et al (2014) confirmed that, whilst it is possible there might be '*discrimination*

against a group of workers when hiring them', employers are then less discriminatory when '*hiring from within'* (Addison et al, 2014, pp. 281). Essentially what this means in the context of gender, is that women may face prejudice when getting their foot in the door, but once in, the playing field is more level. The key then, according to Addison et al, is getting into the organisation in the first place.

Ng and Sears (2017) conducted research to explore if a fundamental reason for glass ceilings being in place could be related to the most senior leaders (i.e., CEOs). This may be an area to explore in the NHS, given the proportionally low number of female CEOs. It was speculated that the role of the CEO is of great importance due to the Upper Echelon theory, whereby organisations are '*fashioned after the people in power'* and the CEO has '*free will'* in shaping the firm (Ng and Sears, 2017, pp. 134). The CEO will shape the recruitment to their organisation to gain competitive edge – as such, would the female dynamic in the boardroom enable a fresh perspective, or in the case of the NHS would it provide a better insight into much of its (predominately female) consumer base?

The type of industry does affect the prevalence of GCs, with higher levels of female leadership being evident in non-manufacturing organisations (Ng and Sears, 2017). This is perhaps unsurprising, as these types of companies have higher levels of female employees. More interestingly, however, is the correlation between management turnover and female representation – higher turnover leads to more women in senior roles. The issue of the glass door, where women tend to be employed in companies which pay below the industry average, can mean that they are by default lower paid (Javdani, 2015). In Javdani's own words a glass door effect '*arises if women are disproportionately sorted into lower paying firms than their male counterparts'* (2015, pp. 531). What Javdani found was that glass doors *and* ceilings exist, creating a double whammy of inequality. Most interestingly, this work found that glass doors effectively exist through all subsets investigated – it did not matter if the female employees had children, did not have children, were educated to graduate level or not – across all segments women were at a disadvantage to their male counterparts.

Ezzedeen et al (2015) conducted a study following 69 female Canadian graduates into the workplace. The aim of the study was to question the validity of the 'pipeline

perspective' – the theory that women will achieve parity with men in due course, once all the female employees work their way up the career ladder. This theory could be used to explain why so much has been done to address GCs, but parity is not yet evident. That is because the pipeline involved a time lag, with a waiting game until all the measures currently in place take effect. Speaking in relation to the pipeline problem, Folke and Rickne (2016) stated that glass ceilings exist due to underrepresentation of female employees in the lower rungs of the corporate ladder, which stems from other drivers of vertical inequality. They meant that if there were more women entering the lower levels of organisations, then the higher levels would balance out over time. The pipeline perspective is inextricably linked to glass ceilings, as without female junior and middle managers there cannot be more female senior managers. An interesting perspective of the pipeline stems from a problem in relation to Swedish boards; it was noted that '*70% of female board appointments in 2013 were foreigners*' (Dutu, 2014, pp. 39). It was necessary to recruit internationally as there were so few women executives in the Swedish '*pipeline*' (Dutu, 2014, pp. 39).

Gender Personality Traits and The Female Identity of Leaders

The fear of failure theories suggests that women (and other minority groups) often do not push themselves for promotion due to the fear they may not be successful (Sheaffer et al, 2018). Sheaffer et al did go to pains to explain this is not an issue brought on women by themselves; this is caused, or at least exacerbated, by discriminatory behaviours pre-existing in the workplace. The key issues with the fear of failure phenomenon are that it becomes a self-fulfilling prophecy; if you believe you will not succeed in the workplace you do not put yourself forward for promotions. This means you will not be promoted, thus reinforcing the negative message. Conversely, Pinker (2011, pp. 525) noted '*men are overconfident in their prospects of success.'* Does this make them more confident and thus more likely to succeed?

Other research has explored the preference theory, which dictates that '*gender differences in preferences should also result in a difference in the extent to which men and women want to be promoted'* (Deschacht, 2017, pp. 582). The theory suggests men and women have different preferences for types of industries and types of roles in these industries. Deschacht (2017) therefore deduced that if preference theory exists, it must have some impact on the desires of the two gender groups in terms of seeking promotions. Using questionnaires (on 622 people) they sought to test out this theory.

They found that young female participants were less likely to apply for promotions, which creates a slow career at the start resulting in a slower lifetime career trajectory. Whilst this study could not provide an explanation as to why the preference theory exists, it must be considered in a broader context, which suggests that one solution to the glass ceiling is to increase the likelihood of women seeking promotions earlier in their career.

Selva (2018) compared the career trajectory of men and women and found that men's careers tend to be more linear whilst women's paths are more zig-zagged in nature. They also found that when companies expanded, it often led to '*an accelerated progression in* [women's] *careers*' (Selva, 2018). This is interesting because, as observed below, women are less likely than men to move organisation, often due to geographical ties of raising children. Differences in the attitudes towards career progress in men and women could explain variances in their career trajectories. It also means that women are more reliant on a position becoming available, rather than moving elsewhere for a more senior role.

When considering the gender of leaders, it is worth considering that preference theory extends to the gender of one's manager. It has been shown that men prefer having a female manager, whilst women on the other hand prefer male managers (Elsesser and Lever, 2011). This fits interestingly with the literature on queen bees (covered below). Do women prefer male managers as they find female managers less helpful in terms of realising their career goals? If this is the case, how do we explain the preference of men for female managers? Also, if men prefer female managers why is there evidence of gender bias in terms of recruiting women to board level positions? Do men prefer women as managers but not executives? The work of Elsesser and Lever (2011), whilst asking more questions than it answers, does help provide the answer to one possible conundrum. If women do prefer male managers and the NHS is a female dominated organisation, then can the disproportionate number of male executives be explained by the apparent preference of women to be managed by a male boss: is the presence of male managers due to the bias of women?

Friedman and Laurison (2020) found that the key characteristic sought when promoting an employee was confidence, which is '*of course deployed in different ways, and with varying degrees of approval or disapproval'* (2020, pp. 23). Often this confidence can be

attributed to people who '*take risks'* in their career or by '*actively seeking promotions or negotiating pay rises'* (Friedman and Laurison, 2020, pp. 23). It is possible to see that confidence is regarded as desirable and can set an individual out from the pack – in a seemingly non-discriminatory fashion – but on closer examination the two examples provided by Friedman and Laurison are disproportionately more likely to be found in men. Men and women have markedly different self-reporting levels of ambition, one study showed that around 50% of men claim to be extremely or very ambitious, whereas only around 33% of women do (Hewlett and Buck-Luce, 2005, pp. 48). This could be because,

> *'it's not surprising that men, the more dominance-obsessed gender, have stronger tribalism feelings than women, including racism, militarism, and comfort with inequality.'*
> Pinker (2011, pp. 570)

This is reflected in the often-told apocryphal tale, purported to be from an internal study conducted by McKinsey for Hewlett-Packard. It laid claimed to the fact that,

> '*women apply for jobs only if they think they meet 100 percent of the criteria listed, whereas men respond to the posting if they feel they meet 60 percent of the requirements.'*
> Desvaux et al (2008, pp. 4)

Differences in the attitudes towards career progression in men and women can explain variances in their career trajectories. Jung and Takeuchi (2016) found that people who tend to have more detailed career plans prosper better in the workplace, and this is a trait more commonly found in male employees. Jung and Takeuchi (2016) explored numerous ways women's careers could be accelerated, such as actively engaging women in goal setting and building relationships with supervisors. There is also gender variance in what constitutes career success in the workplace, as it is '*a dynamic social construction rather than an objective reality'* (Afiouni and Karam, 2013, pp. 549). This is important as the traditional '*social construct'* sees women as primarily '*expected to constrain employment opportunities in favour of familial and community obligations as with traditional gender role preference*' (Afiouni and Karam, 2013, pp. 550). The

implication is clear in relation to the GC, women are expected by society to be the ones who should sacrifice their career for their families, or risk characterisation as bad mothers. This undoubtedly has an impact on women's identity in the workplace, either consciously or subconsciously, which could diminish their views of themselves as professionals. To address this social construct, Ansari (2016) wrote about the need for '*respectable femininity'*, which is '*a gendered ideological construct* [and] *prescribes the rules of conduct for women in a particular socio-cultural setting'* (2016, pp. 529). Ansari (2016) noted several negative properties of this phenomena such as '*limiting* [women's] *ability to network and engage and influence behaviours'* (2016, pp. 530).

Education is like healthcare in that it has a predominantly female professional workforce. In Spanish schools women account for 70% of teachers, but the senior leaders are mainly male. It is suggested that the reasons for this imbalance could be attributed to a '*patriarchal worldview'* still dominant in our society and social expectations around work-life balance and the '*bad mother syndrome'* (Diez-Gutierrez, 2016, pp. 344). Gutierrez was also keen to extend this by identifying '*fear of failing'* as a key driver, whereby women employees resist career advancement to prevent breaking the traditional female role of caregiver. Leadership roles were '*an additional problem'* that would be taken on by forfeiting or neglecting other responsibilities. Diez-Gutierrez's work provided an additional insight, as it asked men directly about their views on the barriers that they saw as limiting women's progression into leadership roles. A large proportion (91.6%) of men felt family responsibilities were the biggest issue. This is somewhat at odds to the female leaders who took part in the research (i.e., those who had broken the glass ceiling), of whom only 60% saw this as the main barrier. Could this be because the type of women who make it into leadership roles have a different mindset to others?

Discrimination, Stereotyping and Homophily

The relationship between the job demands (i.e., the input in terms of difficulty and amount of time required), and job resources (such as renumeration) are important to consider as,

> *'Gender discrimination is related to the job demands and job resources, such that women who perceive to be discriminated against, perceive higher job demands and lower job resources than men and women who do not perceive discrimination.'*
> Dubbelt et al (2016, pp. 232)

The above may seem obvious; the more women must put up with, the harder they find their work environment, and the harder a job is, the more you would expect to be paid. What is interesting about the work of Dubbelt et al (2016) is the way they suggested this issue should be addressed; they believe that increasing the number of women in the workplace would directly reduce the amount of discrimination. More specifically, they advocated quotas as a manner of doing this. What this argument misses though, is that there are a finite number of jobs and that quotas could potentially have the effect of discriminating against men who are equally qualified for the roles.

The low number of women entering CEO roles in hospital management was reviewed in one study which conducted numerous interviews with female CEOs. It concluded that most of the female CEOs interviewed did *not* feel they have ever been discriminated against due to gender (Soklaridis et al, 2017). This conflicts with the data (above in Section 2.1.1), which strongly suggests that there is discrimination at play. A number of the participants in the study even claimed '*gender does not play a role in achieving leadership positions'* (Soklaridis et al, 2017, pp. 262). The women interviewed felt that adequate arrangements were in place to support women, such as flexible working and development opportunities. However, what must be remembered is that these are CEOs partaking in the interviews; these are people who have made it to the top of their profession. Their way of doing things could be the exception, or maybe they made it to the top because they have been blind to or unaccepting of any discrimination they have encountered.

The implication of discrimination on grounds of ethnicity has relevance when it is combined with gender, in what is known as the '*double minority'* status. This creates what is, in effect, a double burden of discrimination (Atewologun and Singh, 2010, pp. 333). Whilst I reason elsewhere why my research does not focus on ethnicity, as the causes of ethnicity require different solutions to those of gender, it is important to consider that many women fit into this '*double minority*.' Indeed, Atewologun and Singh promote the need to deepen the understanding of the inter-relation between race and gender, as opposed to glibly lumping them together. The core purpose of Atewologun and Singh's (2010) work was to explore individuals' identity at work and how the backgrounds of people from minority groups shape their work identity. They felt that

gender and ethnicity issues made social groups immediately weaker in the workplace, as they provide '*visible markers of membership to less powerful groups* [in society]' (Atewologun and Singh, 2010, pp. 334). An example they provided was stereotyping of women who are seen as '*maternalistic and nurturing'* (Atewologun and Singh, 2010, pp. 334). Whilst these initially might not seem like negative characteristics, Atewologun and Singh (2010) rightly pointed out that these are characteristics often regarded as '*incompatible with the manager / leader role'* (2010, pp. 334). Ultimately, the impact of stereotyping women was for them to employ '*agency to reconstruct and sustain their identities as minority professionals'* (Atewologun and Singh, 2010, pp. 334). Essentially this could lead to maintenance of the belief that women are a subset of leaders in the workplace, never being regarded on equal terms and always as outsiders.

The issue of stereotyping in terms of gender specific roles has been well documented since the 1970s. The concept of '*think manager – think male'* (Schein et al, 1996 pp. 33) laid bare the claim that men have traditionally been those most likely to be managers, and this was a viewpoint held by both men and women. Schein et al extended this work over twenty years and found that, whilst there had been some progression in this respect, there was still a perception that women did not have the '*required*' characteristics to be '*successful'* managers (Schein et al, 1996, pp. 34). A pivotal finding of Schein et al is that, whilst people held the belief of '*think manager – think male'*, they did not feel this was a discriminatory view, rather an ingrained truth. Should women opt to act in a similar manner to men, there is then an identity conflict because women are seen to be acting in a masculine manner. This '*double bind'*, when women in leadership roles operate in a '*masculine style'*, leads to them being regarded as '*not likeable'*; but when they behave in a feminine manner they are not '*leader like'* (Arnold and Loughlin, 2013, pp. 69). To conflate this further, Kiser (2015) noted that female leadership styles tend to be of a '*more interpersonal and democratic leadership style'* (Kiser, 2015, pp. 599), and it is these qualities which are most highly regarded of leaders – so whilst feminine leadership qualities are sought in *all* leaders, people are still reluctant to appoint women who exhibit them (Arnold and Loughlin, 2013).

A macro analysis on papers concerning GCs, reviewing five separate databases over the period of 1986-2014, concluded that the main cause for glass ceilings was '*gender stereotyping*' as '*women are stereotyped for holding family responsibilities of*

childrearing, nursing, cooking and other household chores' (Sahoo and Lenka, 2018, pp. 314). More interestingly the study by Ezzedeen et al (2015) found that female employees felt that '*executive work* [was] *fundamentally at odds with their identities as women'* (Ezzedeen et al, 2015, pp. 42). The reason again being that they view leadership qualities as masculine both in physical and personality traits. This was supported by Faniko et al (2017) who stated, '*the demands of effective leadership behaviours are not naturally compatible with the expectations of the way women should behave'* (Faniko et al, 2017, pp. 640).

Social class is defined by those factors which pertain to,

> '*economic capital (i.e., wealth), social capital (i.e., networks and connections), and cultural capital (i.e., cultural tastes and practices developed through educational and personal experiences).*'
> Grey and Kish-Gephart (2013, pp. 671)

The premise of social class impacts the workplace, as individuals are products of their backgrounds and upbringing; they '*import their experiences as a member of a particular societal social class into the workplace'* (Grey and Kish-Gephart, 2013, pp. 671). Class background is important in the workplace as it creates '*differential power advantages'* (Grey and Kish-Gephart, 2013, pp. 672) for those of higher-class status, which are not necessarily dependant on ability. An employee of a higher-class group will be deferred to by a lower-class group; this could lead to unjustified escalated career progression. The parallels to the glass ceiling are obvious, promotions are again based on the old boys' network rather than merit. The difference is the visual markers which set apart gender discrimination are replaced with more subtle markers of accent, the way people dress, the type of words they use and their tastes. Furthermore, society has developed a construct whereby people from higher social classes are deemed to have higher status, which in turn reinforces the view that they should hold more senior positions. This process has clear implications for gender, as

> *'Like gender, then, class is likely to function as a status characteristic within organisations such that class differences carry with them performance expectations.'*
> Grey and Kish-Gephart (2013, pp. 673)

Women may be viewed as less competent than men purely because they are female. Similarly, a working-class employee may be deemed inferior to a higher-class individual for no other reason than their social status. Like gender discrimination, social discrimination can be brought about by visual markers, such as wearing the 'wrong' (i.e., too gaudy, or inappropriate) clothes. Unlike gender, the ability to fake it until you make it can be possible; people from lower-class groups can alter their accents, wear different clothes, express different tastes. However, to paper over class differences, as with gender, can disadvantage both the individual and the organisation. As discussed above, having a varied management team allows an organisation to better connect with and service its customer base. Women are higher users of NHS services, as are people from lower social groups, having representation from both these sections of society will undoubtedly lead to better health outcomes (Kline, 2014; and Sobieraj, 2012). Finally, as discussed above, the double burden of discrimination would make it reasonable to assume that women from working-class backgrounds would be exponentially disadvantaged by being from a lower social class *and* female.

Even in the female dominated sector of nursing and midwifery, men are still more likely to be promoted to management roles (Berkery et al, 2014). A report by the London South Bank University identified that whilst nursing is still a predominately female profession with 89% of all nurses being women, men compose 17% of nursing leadership positions (LSBU, 2019). Perhaps more importantly, the report found that this position has hardly improved over the past 30 years. This is attributable to gender stereotypes as, even though men and women working in nursing and midwifery positions share characteristics of '*nurturing, caring and gentleness'* (Berkery et al, 2014, pp. 708), the men were the ones who were seen to have the additional traits necessary for leadership roles.

Adams and Funk (2011) attempted to analyse the behaviours and characteristics of members in the boardroom, which might identify if gender specific traits explain the existence of a pay gap. Their work did succeed in highlighting differences in the

behaviours of male and female board members. Whilst their study could not be used to justify paying more (or less) for these differences in behaviour, it does ask the question as to whether some gender specific traits are perceived as more desirable than others. To take this a step further, are there qualities which board members seek when recruiting other board members and do these have less to do with performance and more to do with seeking board members in their likeness?

The issues of stereotyping and the old boy's network can be distilled down to the concept of homophily, which is '*the tendency to associate with similar others'* (Karimi et al, 2018, pp. 1) or the '*preference of agents to be connected with other agents that share common attributes'* (Kim and Altmann, 2017, pp. 483). The two main areas which are associated with homophily are race and gender, which is to say, for example, white males may wish to socialise and network with each other. Homophily is especially important when it comes to networks. If those in more powerful groups opt to maintain networks with those of similar backgrounds to themselves and exclude minorities or those from less powerful groups, it can put those groups at a '*disadvantage by restricting their ability to establish links with a majority group or to access novel information'* (Karimi et al, 2018, pp. 1). Here '*novel information'* might be taken to mean information that is not commonly available, and therefore privileged. This might only be attainable by being part of this restricted network. In relation to career advancement, this could include information of upcoming vacancies, or inside information of what a recruiting manager is seeking in a new appointment.

Women in Leadership Positions

Exploring the position of female leaders in other industries can add insights into the existence of the glass ceiling in healthcare. Education is a particularly useful industry to explore as teaching, like healthcare, is a female dominated industry; one study noted 67% of British undergraduate degrees in education were held by women (Sanderson and Whitehead, 2015). As with healthcare, women are not '*rising through the ranks'* (Sanderson and Whitehead, 2015, pp. 330). The '*lack of female role models and mentors'* was viewed as a factor for this imbalance (Sanderson and Whitehead, 2015, pp. 330). It was also felt that the current leadership style required in school management was more masculine. Finally, they noted that whilst teaching does provide a good degree of work-life balance, this disappears when teachers take on the administrative burden

required for senior management positions, making it less desirable to female candidates who have child raising responsibilities.

Some positive changes have been made in education, including '*learning technologies that both enable greater flexibility with regard to time and location of academic work that benefits women largely responsible for childcare*' (Blackmore, 2014, pp. 85). However, changes to the ways in which educational institutions are managed and assessed have increased the pressure on leaders as '*accountability and ranking escalate demands for continual improvement'* (Blackmore, 2014, pp. 85). These factors make leadership roles more stressful and less appealing, especially for those with familial responsibilities (typically women).

In line with the motivations of those seeking management positions in the NHS, it has been observed that the main reasons for women entering management positions in academia '*were rooted in notions of good citizenship, altruism and civic obligation*' (Acker, 2014, pp. 77). Focusing specifically on leadership roles in education Blackmore (2013) highlighted the diversity in student population, the hand of regulation and the focus on metrics to analyse performance, as factors which heavily impact educational institutions. These have striking similarities to the role of hospitals and the way they are assessed. Blackmore makes the case that '*inclusive schooling requires inclusive leadership in which diversity of leadership is based on democratic processes and practices is a central aspect*' (Blackmore, 2013, pp. 148). This push for representational (i.e., diverse) leadership in education can also be seen in respect to the leadership in healthcare.

In her 2014 work Blackmore teased out more parallels which can be observed in both education and healthcare, such as the push for universities to operate more like business, financially driven institutions, and less like public bodies. Blackmore discussed the increasing difficulty in filling senior leadership positions in education (again something the NHS is struggling with). Further similarities between the demand on leaders in healthcare and academia can be derived from the volume and seemingly unending deluge of work and responsibilities (Acker, 2014). In relation to gender, women working in university management positions have reported a litany of issues, from literally tidying up after colleagues and being spoken to like children (Acker, 2014). Whilst it can

be argued that gender discrimination in education has become less overt, hangovers can be seen in the way '*institutions reward a stereotypically masculinist or macho way of operating*' (Acker and Wagner, 2019, pp. 65). These gender issues, stress of the roles, and strain they put on family life, have caused some female managers in academia to relinquish their leadership roles (Acker, 2014).

Blackmore (2013) discussed the movement towards EI (Emotional Intelligence) in leadership. Goldman (1995) points out that whilst EI is not necessarily an ingrained quality of all women, groups of women are '*more empathetic and more adept interpersonally'* (Goldman, 1995, pp. 7). This is comparable to the feminist leadership style which has been described as '*nurturing and listening and coaxing and being respectful'* (Acker and Wagner, 2019, pp. 72). This could be surmised as saying that whilst not all women have high levels of EI, it is more frequently a trait found in female leaders. This is beneficial for female leaders due to the movement towards more emotional intelligent leadership (both in education and the wider world) as,

> *'now, emotions are central to leadership, empathy and interaction with others and increasingly significant in intercultural contexts where cultural displays, both gendered and racialized, have to be negotiated.'*
> Blackmore (2013, pp. 145)

This said, Blackmore (2013) recognised the feminist perspective which seeks to move away from the '*reductionist binaries embedded in twentieth century Western social theory between mind/body, rationality/emotionality…that reduce to essentialist understandings of man/woman*' (Blackmore, 2013 pp. 146).

Female leadership in nursing is highly relevant to this research. Despite the workforce being around 90% female (Prosen, 2022), it is still thought that gender discrimination exists for nurse leadership positions. A 2019 report found that nursing leadership *'marginalize and exclude especially female nurses from decision-making roles and career progression*' (Intrahealth, 2019, pp. 6). This was attributed to gender discrimination and stereotyping, which reduced the likelihood of women applying for leadership positions. The stereotypical view of nurses being nurturing and caring, was viewed as being at odds with the necessary traits of leaders. This creates a situation

whereby '*men are favoured more for promotion*' (Intrahealth, 2019, pp. 6), because they are thought to be more leaderlike than their female nursing colleagues.

Prosen explored the belief that women are better suited to nursing, stating that the '*myth surrounding female nurses and femininity and male nurses and masculinity is misleading'* (Prosen, 2022, pp. 2). The view of Prosen was based on two factors. Firstly, there is a lack of evidence to support these stereotypes. Secondly, he found these views discriminatory. The argument put forward is that to eliminate the view that leadership should be seen as a masculine trait, society must also remove other stereotypes, such as the nurturing aspect of nursing as a female reserve.

Other explanations for the career progression of nurse leaders have stemmed from the fact that '*women traditionally unlike men have not been socialized to pursue career interests as their primary objective'* (Tracey, 2007, pp. 677). Tracey argued that this is compounded by the fact that leadership roles in nursing are a relatively recent development. This contributes to the fact that female nurses are more inclined to take sideways moves into other specialities (thus starting in the new speciality at the bottom of the career ladder). This differs from the approach of male nurses who,

> *'conversely tend to take a more direct linear route up the nursing hierarchy and progress more rapidly through the nursing career hierarchy than women.'*
> Tracey (2007, pp. 678)

Role Models and Queen Bees

The lack of females in senior positions across society matters as,

> '*the dearth of women in* [senior] *positions means that women's voices are not being heard and policies, laws, and business decisions are more likely to advantage men.'*
> Fisk (2016, pp. 181)

To combat this, it is felt there is a greater need for role models, the lack of which is the *'most significant barrier to female career progression'* (Cross et al, 2017, pp. 86). Given people are often keen to seek role models in their own likeness, many women in senior positions can become role models without even realising it. However, what is unique

about Cross's research is that it explored the unintended consequences of having female role models. Should females in the workplace encounter negative role models, it can be a '*relatively deflating impact on women's self-perceptions and leadership aspirations'* (Cross et al, 2017, pp. 86). A further interesting aspect of Cross's work is that it is possible that some women were elected to leadership positions by behaving in ways more associated with masculine traits. If these women are behaving this way, it creates a pipeline of women who try and emulate them, meaning more feminine traits may never become the norm.

One review of 20 years' worth of studies assessing the progress against the glass ceiling is noteworthy, as it acknowledged how little advancement had been made but (as mentioned above) did note that the number of explanations for GCs have '*flourished'* (Powell and Butterfield, 2015, pp. 313). The authors explained that there has been a '*considerable growth in metaphors for the phenomenon'* (Powell and Butterfield, 2015, pp. 313). The review highlighted areas where women themselves have been deemed to be the root of the issue, through concepts such as '*the queen bee'* and '*the bully broad'*, when women prevent other women from entering leadership positions.

> *'Yes, women will gang up on other women. Yes, they will accuse other women to keep themselves off the hook: we see that very publicly in the age of social media, which enables group swarming. Yes, they will gladly take positions of power over other women, even - and, possibly, especially - in systems in which women as a whole have scant power: all power is relative, and in tough times any amount is seen as better than none.'*
> Atwood (2017, pp. XII)

The queen bee principle was investigated in depth by Faniko et al (2017), who offered the following succinct definition of queen bees as '*women who have been successful in male-dominated organisations* [who] *do not support the advancement of junior women'* (Faniko et al, 2017, pp. 638). Faniko et al noted previously that queen bee behaviour had been attributed to '*competitiveness*', but they felt the cause was due to successful women seeing themselves as '*different*' to other women. They even suggested that their interpretation of the literature on the issue supports the idea that women are in fact more competitive than men in the workplace. However, Faniko et al (2017) acknowledged that

the question needs to be asked whether the queen bee phenomenon should be applied to a small subset of female managers, rather than all female employees. As such, it should be seen as one of many issues supporting the glass ceiling theory and attention must not be taken away from other more dominant factors.

To succeed in the workplace '*women have to lift each other up – not replace men at the top of the hierarchy, but to become partners with men in the end of hierarchy'* (Gates, 2019, pp. 150). To '*lift each other up'*, O'Neil, Brooks and Hopkins (2018) speculated that women need to '*collaborate to improve social and organisational realities for women in general*', which extends to '*females in high status positions work*[ing] *to advance other women into their ranks'* (O'Neil, Brooks and Hopkins, 2018, pp. 320). In theory though they found that whilst the expectations of support were high, the needs of women, in terms of reliance on other women can often go unmet. Hurst, Leberman and Edwards (2016, pp. 61) wrote about the role of '*sisterhood*' whereby women support each other in the face of gender discrimination. This said, because of the queen bee phenomena, '[some] *women managers actively work against the interests of other women'* (Hurst, Leberman and Edwards, 2016, pp. 65). This could be labelled '*anti-feminist'* as '*feminists have long held the view that by collectively working together and showing solidarity, women can effect real organisational change'* (Hurst, Leberman and Edwards, 2016, pp. 65). Peer support is vital, as Sandberg (2014) writes that in an interview with Deborah Gruenfeld; Gruenfeld stated,

> '*we need to look out for one another, work together, and act more like a coalition. As individuals, we have relatively low levels of power. Working together…*[we] *have real power.'*
> Sandberg (2014, pp. 202)

Scholten and Witmer (2017) discussed the '*prevailing theory that women are not provided equal opportunities early in the leadership identification process'* (2017, pp. 48). Their work centred on the Nordic countries, where gender inequality was lowest in the public sector. When looking at case studies in Sweden, they found that '*women had to be tomboys, competitive, or take on male symbols of power to be considered for management positions'* (Scholten and Witmer, 2018, pp. 59). The characteristic traits argument is an important debate, as it assumes that all women have similar personalities

and behave the same way in all situations (Ezzedeen et al, 2015; and Faniko et al, 2017). The same assumptions are not made by labelling all male employees as having the same personality traits, so why is this the case with women? The second puzzling strand to this debate is, who finds the traits of men favourable to those of women? Literature elsewhere (Adams and Funk, 2011) suggests that male board members like people like them (such as physical appearance and educational background). But this train of thought does not pertain to personality traits; two men that went to the same school could have vastly different characteristics. Therefore, the literature fails to support why these alleged differences in personality traits between sexes prevent them attaining leadership roles. In terms of physical characteristics and other tangible factors, Silvera and Clark (2019) point to a gaping hole in the literature concerning leadership, given,

> '*research has typically centred on the role of executives' age, tenure, and education. Missing from this literature is a careful consideration of the role of CEO gender.'*
> *S*ilvera and Clark (2019, pp. 2)

This highlights that whilst there are tomes of work devoted to discovering what makes an ideal leader, very little of this has explored the gender of successful leaders.

Motherhood

A review of wage distributions across Europe in 2007 highlighted a definite widening of gender-based pay distribution towards higher salary ranges – i.e., it is common in other industries for the male / female disparity to be more obvious in very senior roles (Arulampalam et al, 2007). The evidence presented in the study suggested that childcare costs can affect the distribution of salaries in EU countries, as when childcare costs are high women stay at home to raise children, thus placing their careers on hold. Hurn (2013) listed several issues that he felt persist as barriers to women gaining full equality in the boardroom. At the top of their list was the lack of affordable childcare and the double burden of looking after a family and having a career. Furthermore, the impact of carer responsibilities cannot be underestimated, *'often women can be caught up in providing care for months or years'* (Hurn,2013, pp. 200). High intensity care (taken as at least 20 hours per week) can significantly affect *'people's ability to hold down a full-time job'* (Britnell, 2019, pp. 58). Attempts to monetise, that is to pay women for carer responsibilities, have been rejected in some countries, as it is deemed it would '*hold*

back ambitions to raise the female participation rate in the shrinking workforce' (Britnell, 2019, pp. 59).

Looking at healthcare roles, a study of thirty-two NHS clinical staff found that mothers were hampered in terms of career, and '*the younger the child, the greater the impact'* (Watt and McIntosh, 2012, pp. 62). The number of children each woman had also correlated to greater career setbacks. The impact of having children was doubly restrictive if the mother had to '*take a career break of more than two years'* as it saw *'their careers depressed and restricted'* (Watt and McIntosh, 2012, pp. 62). Referring to the healthcare sector, Amrein et al (2017) took the issue of motherhood a step further than most authors, when they noted it is not merely the fact that women are more severely impacted by children, but it is also an issue of timing. Women tend to have children at the point in life when they would be advancing their careers the most. This would also be a time when they would have served as role models for other women but miss this opportunity. For example, they miss out on being '*potential speakers at conferences'* (Amrein et al, 2017, pp. 288), where they would be a visible signal of female leadership to their peers.

The timing of having children has a great impact on the career progression of women but is an area which requires more research. Addison et al (2014) felt this was a huge gap in their own work, as exploration of '*the difference of timing of fertility*' is needed to understand whether having children has a greater impact at the beginning or later in a woman's career. Some studies have shown that if mothers follow the general trend of having children in the twenties or early thirties, it can result in them missing promotions early in their careers. Other research highlighted that, '*early-career obstacles are important because they may propagate into later career phases (eventually contributing to glass ceilings)*' (Deschacht et al, 2015, pp. 581). This is because small differences in seniority earlier in a person's career widen over time. To combat this, it can be argued it is necessary to first address the issue of sticky floors (i.e., promotions early in women's careers), as without female middle and senior managers there can be no female directors.

Summary of the Causes of the Glass Ceiling

In this section the literature has explored many of the reasons for the GC remaining intact well into the twenty first century. Societal hangovers explain that women are still not

widely viewed as leaders (a view held by both men and women). When women exert skills deemed necessary for leadership they are regarded as masculine and even unlikeable. To survive, a subset of women, 'queen bees', adopt masculine qualities and resist the advancement of other women. The homophily, of existing formal and informal networks, perpetuates the white male tone of the boardroom. On a fundamental practical level, women's continued requirement to be the lead carer for children seriously diminishes their ability to contend with their male peers, in terms of time in the workplace (and the associated experience) and their ability to work extra hours or attend networking events.

2.1.3 Ways of Smashing the Glass Ceiling

Networks and Mentoring

Networking has long been considered a '*male dominated game'* (Socratous, 2018, pp. 167), but it is a game that is fundamental to career progression. Networks are so important as they assist with *'information sharing, introduction to business partners, moral and professional support'* (Socratous, 2018, pp. 170). Socratous (2018) divided networks into two categories of formal, such as dinners organised by a company, and informal, such as socialising at a football match. We have seen elsewhere that the reliance on women as the main carer for children inhibits their ability to attend events outside work. Networking was regarded by Socratous (2018) as being a central pillar of the old boys' network, and thus difficult for women to penetrate. One solution is the development of women only networks. In 2015 the leading British publication for healthcare managers, the Health Service Journal, launched their Women Leaders Network. The purpose was to provide '*women in leadership roles, or those aspiring to be leaders, a safe space in which to examine difficulties, challenges and opportunities'* (Nath, 2015). The major flaw to female only networks is that, by their nature, they exclude exposure to a large proportion of the workforce (i.e., men).

The work of Amrein et al (2017) is highly relevant as it looked at the glass ceiling in relation to healthcare professionals (such as doctors and nurses). It demonstrates that as with healthcare management, there is a disparity between the gender composition of the workforce and that of its executive leadership. Amrein et al (2017) discussed a case study in Sweden, whereby it was found that female researchers required '*2.5 times as many publications as a male medical researcher to achieve the same score at the Swedish Medical Research Council'* (2017, pp. 287). However, their specific focus was

the smaller number of female attendees at medical conferences compared to their male counterparts, given there are more female medical students and junior medics. This is a highly interesting phenomenon as these types of conferences are '*extremely productive'* and the starting point for '*many successful projects'* (Amrein et al, 2017, pp. 287). They also are fundamentally networking events due to the dinners that take place. At the specific event analysed by Amrein et al only 20.9% of the speakers and moderators were female – this again ties in with examples of having gender role models. More tellingly, the event organisers reported that they had made a conscious effort to have more female speakers but *'not enough high-profile women could be found'* (Amrein et al, 2017, pp. 287). The researchers reviewed female participation at medical conferences and suggested female delegates should boycott events where there were all male panels. However, this approach has the potential to reinforce the 'old boys club' rather than counter it. Amrein et al (2017) reported on one medical conference where the organisers had resolutely aimed for a minimum of 40% attendance of female delegates; they noted that this was '*promising*' but could lead to '*younger than usual women to give talks*' (Amrein et al, 2017, pp. 287). The inference being that the '*younger*' female delegates would be less experienced than the male speakers and therefore potentially carry less gravitas, thus undermining their inclusion. Abelson et al (2016) cited several recent initiatives to increase the number of women entering surgical training. These included the use of social media to promote female role models in the surgical specialties, including Twitter and YouTube campaigns.

In respect to healthcare professionals, one study examined the progression of female surgeons in the US; they noted that,

> *'Since 2005, the number of women entering medical school has been nearly equal to that of men. Yet the number and percent of women in surgical training and academic leadership positions remains low.'*
> Abelson et al (2016, pp. 566)

Abelson et al were particularly concerned because they felt that over the past 30 years there had been '*multiple efforts'* (2016, pp. 566) to increase the number of women in the surgical profession. Whilst it was felt that some of the measures introduced gained early

traction, these had levelled off over the past decade. They examined several potential causes for this and concluded it was '*unclear*' what the main reasons for this was.

Mentoring '*is the process where a more experienced person supports the personal and professional growth of a less experienced person'* (Seraj, Tsouroufli and Branine, 2015, pp. 50). Female centred programmes of mentoring have been proven to successfully '*encourage* [women] *to seek out new positions more aggressively'* (Desvaux et al, 2008, pp. 4). Mentoring provides '*support to protégés, including career development support*…[it] *involves forming networks with resourceful people who could benefit one's career development'* (Broadbridge, 2010). Because of this many legal firms are trying to encourage female board membership by offering mentoring programmes (Hurn 2013). However, mentoring alone will not progress careers. The rising star hypothesis dictates that people are more likely to seek out informal mentoring opportunities when they are *'motivated, high performers who are career savvy and take a proactive approach to their career'* (Singh et al, 2009, pp. 11). If this hypothesis is correct, then mentoring will disproportionally reward subsets of employees – it will not create rising stars, but it will facilitate career orientated individuals towards their goals.

Whilst it is universally acknowledged that mentoring is beneficial, it does not necessarily confer its benefits equally; for example, Hurst, Leberman and Edwards (2016) acknowledged that '*women often have less access to influential mentors than men'* (2016, pp. 64). Sandberg (2014) agreed, adding that,

> *'men will often gravitate toward sponsoring men. Since there are so many more men at the top of every industry, the provincial boys network continues to flourish. And since there are already a reduced number of women in leadership roles, it is not possible for the junior women to get enough support unless senior men jump in too.'*
> Sandberg (2014, pp. 90)

This issue of supply, with too few female leaders in the system to have sufficient capacity for the next tranche of leaders coming through, needs addressing. One solution, based on academia, is for male supervisors to mentor female employees (Bednar and Gicheva, 2018, pp. 428). In some ways this is a logical argument to make; if the problem is

surviving in a male dominated world, why not ask a man for his perspective? This is an area where there is a dearth of literature, highlighting that more research is required to address the imbalance in the number of mentors for women.

Looking specifically at the NHS and reflecting on the role of social capital and mentoring when reviewing gender discrimination, it was found that

> *'although females recognise that mentoring is very useful to their career progression, sometimes they are unsure of how to use the mentoring received effectively'*, and that '*senior male mentors can provide female protégé's with sponsorship and legitimacy that are possessed by powerful, connected and visible mentors.'*
> Seraj, Tsouroufli and Branine (2015, pp. 61)

Turner (1960) introduced the power of sponsorship, the context he derived it from was the elite schooling systems of the UK and US. He noted that sponsorship, whereby a senior member of society takes under their wing and promotes a junior member, has exponential impact on the more junior's career trajectory. Whilst Turner introduced the idea as a negative, observing that roles were less likely to be awarded on merit and more dependent on who you know, sponsorship does not have to be a bad thing. If the idea of sponsorship can be successfully inverted, it can be used to promote a person who, on merit, deserves a more senior role, but for some reason (for example, originating from a minority group) requires additional assistance to reach their rightful place.

Career Advancement and Professional Development

Seraj (2015) discussed the role of the glass ceiling in the NHS, and she considered several Human Resource Development (HRD) models as a means of addressing all forms of diversity. HRD models seek to bring together '*research and writing from disciplines such as economics, psychology, industrial relations, management, education, and adult learning'* (Werner, 2014, pp. 127). HRD models are not just training models; they look to address all aspects of an individual's career advancement. To be considered a HRD model there needs to be three central components '*training and development, career development, and organization development'* (Werner, 2014, pp. 128). Seraj (2015) contended that these three strands working in unison can provide women and

those from minority groups the necessary skills and experience to reach their full potential.

Seraj thought HRD to be important in managing diversity because it is a method of developing systems, as well as people, which is to say they operate at both the organisational and individual level. HRD models '*provide competitive advantage'* and for the individual this takes the form of *'improved knowledge, skills and resources, which enhance their personal development'* (Seraj, 2015, pp. 96). This in turn increases their career development opportunities and the likelihood of being promoted to senior management roles. The organisation benefits from having a more competent workforce. Seraj (2015) highlighted several HRD models they thought could be adopted by the NHS, such as Mankin's strategic model (2009), which combines mentoring and developing employees' social capital. This model heavily focused on taught learning.

The second model Seraj discussed was the Kenexa Framework for female career progression (Figure 9), which built on earlier work of Pringle (2009). The Kenexa High Performance Institute (KHPI) is a global provider of human resource business solutions (Woods, 2011), who primarily use employee survey data to measure business performance (Kenexa, 2018). The sections of the KHPI framework were based on research the institute undertook, in the form of a global survey of female business leaders (Churchard, 2014). Whilst the model was based on research from private sector companies, the applicability of the model to the public sector (and healthcare) appears appropriate. The Kenexa Career Progression Framework is of note because it is a model developed specifically for female leaders, based on research into areas which can have the highest impact for their professional development. The Kenexa model also provides a wide range of tools as well as useful delineation between what is in the employee's gift to influence, and which factors employers need to facilitate.

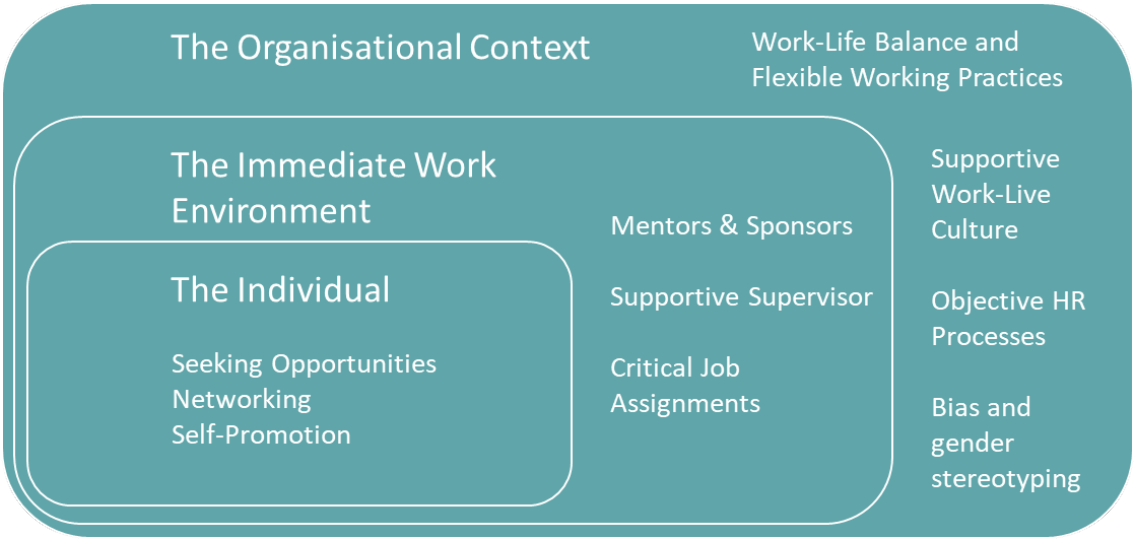

Figure 9: Kenexa's Career Progression Framework

Source: Wichert (2013)

Due to my use of an updated application of grounded theory (Flick, 2018b), whilst the field of HRD models was known to me, the Kenexa model was unknown to me until after the collection of my data. I am providing a background to the model in this section of the document, as this is the most appropriate section to include this discussion. Preliminary analysis of the themes emerging from my data, indicated the relevance of the Kenexa model but also provided insights into how my data was useful to propose amendments and elaboration of the model.

Education and Skill Set

A study of educational attainment across the OECD identified 2012 as a tipping point, as for the first time, women overtook men in terms of the average number of years of formal education they had received (Dutu, 2014). This gap had been closing for many years and it can be argued that, with a greater level of education, women could be better placed to take on director level positions. However, as seen with the pipeline perspective, above, it must be noted that there is a time lag between individuals leaving education and reaching the boardroom. It might be possible that this piece of evidence alone would signify a potential increase in competition from women in years to come. However, it must be acknowledged that this is only one piece of the puzzle, and that the whole premise of a glass ceiling is its discriminatory nature. Being equally or even better qualified than a male candidate alone will not be sufficient *if* a glass ceiling is in place. Despite the increase in the educational attainment by women entering the workplace,

Addison et al (2014) conducted a comprehensive study on the role of education and career advancement. They found, whilst education is an important factor in terms of determining wages and promotions, it did not confer the benefits equally between men and women. As such, men with the same qualifications as a female colleague would progress more quickly. The study reasoned that the lack of promotion was attributable to motherhood, resulting in less time in the workplace.

Another study used the reference point of a Masters in Business Administration (MBA) as a measure for an analysis on the causes for glass ceilings (Merluzzi and Dobrev, 2015). The presence of an MBA is a mark of a desirable skill set and competency, and therefore following holders of MBAs of both genders into the workplace enables a comparison of success or barriers to success. The drawback of the research is that using MBAs as a proxy measure is not wholly reliable. Just because someone holds a qualification does not mean that they are guaranteed a successful career. The individuals could be lacking in other necessary skills, such as leadership ability; this is a factor Merluzzi and Dobrev (2015) skirt in their write up. However, the sample size of their study was considerable with over 600 respondents, 22% of whom were female. They were able, through their analysis, to show strong evidence to suggest that when all other conditions were held constant, women did receive lower pay. This study suggests that the glass ceiling holds true, even for women with MBAs from well-regarded business schools, suggesting again that education alone is insufficient in breaking the glass ceiling.

Akpinar-Sposito (2013) explored skills sets, or rather the assumed skill sets of female employees. They noted that the typical female skill set ensured that they dominated certain functional areas of organisations which attract fewer opportunities for promotion, such as human resources, communications, and governance. When looking at skill sets required for board level positions, could it be that one of those most favoured is financial acumen, such as those found in accountancy? Using accountancy as an example, despite huge efforts among the Big Four accountancy firms, they have so far failed to achieve equitable numbers of female executives (Hurn, 2013).

Fitzenberger and Muehler (2015) suspected that women accessed less training at the start of their careers compared to their male counterparts. This is exacerbated when

women take time off to raise children. To explore what could be done to develop the skills of women when absent from the workplace due to childrearing, Kibelloh and Bao (2013) explored the potential of online training courses such as MBAs, as a flexible means which could be incorporated into mothers' other day-to-day responsibilities. Although their work centred on the Chinese workforce, it is worth reviewing, as an MBA is a desirable qualification for executives globally. Whilst the work of Kibelloh and Bao (2013) found women favourable to the idea of MBAs, it does little to acknowledge that it would still be a challenge for mothers to undertake the course with young children. Further still, they do not propose that an MBA can replace the real-world experience which women are missing when out of the workplace for extended periods. The study did however highlight some flaws with the online MBA programme, such as the lack of face-to-face learning and networking, as well as the fact that online courses are often seen as less credible (Kibelloh and Bao, 2013, pp. 225).

Recruitment, Policy and Quotas

The importance of '*getting a foot in the door'* was discussed by Fernandez and Campero (2017, pp. 74), who felt that organisations and observers spent too much time looking at internal factors to identify causes for glass ceilings, when in fact they should have been focusing on '*external market competition'* (2017, pp. 74). To address these external factors, they directed their research at recruitment practices. More specifically they theorised that by using external, rather than internal recruitment, for senior roles it would be possible to overcome internal biases. This resonates with the NHS as many people are tied to their local hospital and rarely move. Women are '*less available for geographic mobility'*, due to child commitments and '*household*' responsibilities (Akpinar-Sposito, 2013, pp. 493). On a policy level, an implication could be to mandate the opening of all promotions to external candidates, especially for senior roles. A footnote to Fernandez and Camper's (2017) study recognises that external hires tend to be more expensive than internal ones. If women are recruited internally (which could well be the case in the NHS), they are less likely to be remunerated at the highest level. However, the main issue with the work of Fernandez and Campero (2017) is that women also face discrimination in the recruitment process, therefore it is potentially fruitless to advise external recruitment as a means of overcoming internal biases, just to be met with another form of discrimination. This does contrast with the work of Powell and Butterfield (2015). They evidenced that recruitment to management roles was actually more

favourable to female employees, although they did point out this did not *'refute the existence of glass ceilings'* (Powell and Butterfield, 2015, pp. 312).

Breaking the GC does not mean all the burden should be shouldered by women; organisations and governments have their own significant roles to play. These bodies need to take an '*agentic role in creating a better organisational culture for women'* (Holton and Dent, 2016, pp. 557). Due to the discriminatory nature, the very presence of a glass ceiling '*opens the door for government intervention'* (Hejase and Dah, 2014, pp. 956). One government initiative has been shown to be highly successful; in Norway the number of female directors in public companies has been mandated since 2005. Bertrand et al (2016) demonstrated that this has been shown to have two main effects; the average level of qualifications for board members has increased, whilst the pay gap between male and female board members has decreased. However, this policy has yet to lead to a trickledown effect to the rest of the workforce (i.e., middle and junior management roles).

Despite the introduction of quotas and being perhaps world leaders in gender equality, Hardoy et al (2017) found that in Norway *'women are still grossly underrepresented in management positions'* (2017, pp. 124). This, they proposed, was attributable to the fact that changes in the home had not kept pace with changes in the workplace. Women face the double burden of a professional career alongside the historic role of childrearing. Perversely they found other government initiatives were the cause of women splitting themselves between work and family life, as whilst on one hand government was mandating female board quotas, on the other it was promoting longer maternity leave and better conditions for part-time working. This, instead of making it easier for women to return to the workplace, had the unintended consequence of removing women from the workforce for a length of time, after which it is difficult to return. The example from Norway is significant for the NHS, as the NHS already has parity in the rest of the workforce, with the only discrepancy in the very senior roles. As such, it could be argued that such legislation would be effective in the NHS.

A further characteristic of the Scandinavian labour market again stems from its welfare system. Denmark had a welfare-through-work model, which is a variant on the UK welfare-to-work programme. The UK model, which included programmes such as the

New Deal, offered experience in work placements to the long-term unemployed whilst they continued to receive their unemployment benefit. The Denmark welfare-through-work model differed, as it offered a more robust package of training, development, counselling, childcare schemes, and job rotation (Etherington and Jones, 2004). Of particular interest here are the job rotation and the childcare schemes. The job rotation programme allowed the unemployed and those on maternity cover (by utilising the childcare programme) to take an active part in the workforce. It worked by providing cover for roles when the incumbent was, for example, completing additional educational qualifications. It would be problematic to import this system wholesale into the NHS; however, the ingenuity of the scheme does indicate some of the options available. One example could be, when a female leader takes educational or maternity leave, she is replaced by another female leader to gain experience in a senior position for a fixed period.

In the UK, Hurn (2013) felt that positive inroads are being made in this area and that this was backed up by an increase in the number of female executives. He cited Lord Davies's Women on Boards Review 2012 as an example of this, noting *'women account for 15.6 percent of FTSE 100 Directorships'* (Hurn, 2013, pp. 195). By 2020 progress against the Lord Davies targets had been made. For example, for FTSE 350 companies in 2011 female representation on boards stood at 10%, by 2020 this had increased to 33% (Boardex, 2020). The most recent data suggested that women now make up around 40% of FSTE 100 board members, taking the UK to second place in the global listings for board gender equality (GOV.UK, 2022).

Elsewhere, there have been numerous policies by governments to increase the number of female board appointments in Europe and Asia, including the use of mandatory quotas for determining the number of female board members. In France since 2011 legislation mandates that companies must reserve 20 percent of board seats '*for each sex'* (Hurn, 2013, pp. 196). Belgium and Italy have gone even further by implementing a 30% quota. These quotas have been made mandatory elsewhere in Europe but not in the UK and, as such, not in the NHS.

Quotas are not always seen as positive; they are *'typically…met with considerable opposition, not only from men but…also from women'* (Faniko et al*,* 2017, pp. 638). The

reasons for the unpopularity of quotas were stereotypically, people being offered jobs for which they are '*not sufficiently qualified'* or '*could not succeed on their own'* (Faniko et al*,* 2017, pp. 638). This seems paradoxical as quotas are used because there is inequity of senior appointments, i.e., there is injustice in the system; but by implementing quotas people reason weaker candidates are appointed to senior roles. The reason for implementing quotas is because biases were stopping the best person being appointed in the first place, due to discrimination.

Research looking specifically at the effect of quotas for female leaders in relation to 'queen bees' has been completed. Faniko et al (2017) believed that women were opposed to the idea of quotas when it referred to their specific area of an organisation but not quotas in general. However, they did conclude this was more evident when the quotas pertained to more junior female staff members, as they were deemed not to have gone through the similar sacrifices that the queen bees did on their ascent to the top. The queen bees *were* however in support of quotas that positively impacted themselves directly. This said, Faniko et al (2017) were keen to point out that a limitation to their study was it only looked at the view of queen bees in relation to junior staff, a different subset might have yielded a different interpretation.

Childcare and Flexible Working

A range of societal changes are helping to address the GC, as women are becoming more '*self-sufficient…remaining single or co-habiting and marry later in life'* (Hurn 2013, pp. 199). These changes mean women are no longer relied upon as much in the home and have more time to devote to work. These types of social trends remove some of the reasons previously given for gender inequality in the workplace. However, as discussed above, motherhood is still a fundamental barrier to female career advancement. Especially because when women return to the workplace after having children, they are much more likely to work part-time (Rose et al, 2013), thus garnering less time and experience in the workplace.

Flexible working practices are commonly believed to be a good measure of increasing diversity. In practice, however, they are difficult to implement and, as such, they are '*insufficiently utilised'* (Michielsens, Bingham and Clarke, 2014, pp. 52). They also have disadvantages for the employee in terms of career progression, as it is harder for their work to be seen by their supervisors due to lack of visibility. For flexible working to be

successful it needs to be regarded not to tackle diversity, but as a '*tangible tool'* (Michielsens, Bingham and Clarke, 2014, pp. 63) for improving the operations of an organisation. Michielsens, Bingham and Clarke (2014) find many issues with the current policies and practices of flexible working but are short on solutions. This demonstrates that, whilst flexible working is a useful system (especially for those with responsibilities as a mother), in practice it will be detrimental to employees' career progression.

There is a premise that public sector organisations, such as the NHS, can be *'the vanguard of programmes involving equal or even preferential treatment for women* [by] *affording them greater flexibility'* (Addison et al, 2014, pp. 282). Mark Britnell, in his quest to resolve the global shortage of healthcare practitioners, was effusive with respect to flexible working and pointed to the role of self-rostering and e-Rostering, as,

> *'self-rostering has been around a long time, although the newest software allows employees to select, and swap shifts via a phone app at a time that suits them. But for employers it offers much more. As well as cutting administration and reliance on agency staff, it can help map demand across the hospital in real time and allow better deployment of available staff.'*
> Britnell (2019, pp. 93)

In a 2016 report into female board representation among FTSE100 companies, the authors cited numerous changes which they felt would help promote equality. These included the need for diversity to be a strategic priority, that women's leadership programmes must be part of overarching organisational change programmes and that men must be fully engaged in the process (Sealy et el., 2016, pp. 11). Similarly, strategies for breaking the glass ceiling suggested by Sahoo and Lenka (2016) included mentoring, work-life balance, gender policies, career planning and diversity programmes. Family life has been frequently cited in the literature as being a cause of the glass ceiling. Akpinar-Sposito (2013) specifically discussed the responsibilities of childcare, and that for women to progress in the workplace, it was increasingly necessary for employers to offer improved childcare and maternity arrangements. Amrein et al (2017) stated they are unable to '*offer quick solutions'* given the many facets of the glass ceiling, but the primary aim of policy should be to *'raise the awareness for this systemic problem'* (Amrein et al*,* 2017, pp. 288). They also put the challenge at the feet of women

by asking them to '*lean in'* to the issue and '*actively seek out and accept challenges'* (Amrein et al*,* 2017, pp. 288), to push themselves and raise their profiles.

A practical example of how women can adapt to meet the needs of childcare whilst working was presented by Sandberg (2014),

> *'One of the immediate questions new parents face is who will provide the primary care for a child. The historical choice has been the mother. Breast-feeding alone has made this both the logical and the biological choice, but the advent of the modern-day breast pump has changed the equation.'*
> Sandberg (2014, pp. 124)

Gender inequality in the workplace is echoed by that in the home. How can women be expected to devote the necessary attention to their careers, when so much time and energy is devoted to running a household?

> *'On average women around the world spend more than twice as many hours on unpaid work, but the range of disparity is wide. In India, women spend 6 hours a day doing unpaid work, while men spend less than 1. In the US, women average more than 4 hours of unpaid work every day; men average just 2.5.'*
> Gates (2019, pp. 117)

Men can help make a significant difference by taking *'the second shift'* (Milkie et al, 2009); this is to recognise that many women who work still have the larger burden of the housework and childcare responsibilities, which men can assist with by taking on their fair share of the housework. Trends have changed over the last fifty years demonstrating that men are doing more around the home. Additionally, '*studies in several nations find that men's greater hours of paid work counterbalance women's greater hours of housework and childcare'* (Milkie et al, 2009, pp. 489). However, the important factor is that men are doing more paid work and at the same time being recognised by their employers for working longer hours.

2.2 Summary

The literature has presented numerous facilitators which can assist in dismantling the GC. Some of these measures directly counteract the barriers laid bare in section 2.1.2.

For example, overcoming the dominance of the old boy's network by starting other female friendly networks. Secondly, by fostering a host of role models and mentors to show how career advancement is possible and sourcing the support network to make this happen. Some of the measures however, go beyond the role of the individual, such as organisational policy, concerning things such as recruitment and promotions, alongside the introduction of quotas, which have been successful elsewhere. With relation to motherhood, whilst the career impact of bringing up a family can never be totally offset, there are measures which organisations can take to assist parents, including the introduction of flexible working and job sharing. On a personal level, women can leverage their support networks to help their professional careers. Stewart (2011) promoted the comments of Harvard Business School Professor Rosabeth Kanter, who when asked how men can best support their partners' careers, answered, '*the laundry*.'

Perhaps the broadest appeal from the literature review is garnered from the content on the benefits of smashing the GC. This paints the most compelling picture of why breaking down these barriers is of vital importance to everyone, not just to the women peering up at the glass ceiling. The justifications for the existence of GCs are far ranging stereotypes, from biological (women have always had to raise children), social (men have always been in charge), psychological (women are not ruthless enough) to structural (this instance requires the knowledge of men who have worked at the coal face). Most of these reasons sound dated, and indeed few additions have been added to this list in the past half-decade. The prevailing schools of business management philosophy have shown so called '*masculine*' leadership traits are dated and the - more feminine – style of collaboration and engagement are better suited to the twenty first century business world.

Glass doors, glass cliffs, sticky floors, and concrete floors – as Powell and Butterfield (2015) demonstrated, the developments in relation to GCs have mainly been an increase in the number of explanations, rather than a significant increase in strategies to smash them. The above literature review has sought to cover a wide spectrum of causes and explanations for GCs. Before considering the broad themes of the review, I have mapped out some of the gaps in the literature and weaknesses in the arguments put forward, starting with two of the most controversially reported factors, quotas for female managers and the queen bee phenomena. Authors such as Faniko et al (2017) and Hurn (2013)

note that women in leadership positions are opposed to quotas and can be resistant to other women entering management positions. However, what these articles fail to identify is whether this view is shared by all women in the workplace or purely a subset of those who have already ascended to the top. The queen bee theory suggests that women at the top are often protective of their ascension. However, can this belief work in parallel with these self-same people being role models for the female leaders of the future? It could be argued that women either fit in one or other of these two camps, either queen bee or role model, and exist side by side in the corporate world. However, the whole issue of the glass ceiling concerns a paucity of women in leadership positions, so there needs to be a fuller debate as to the size of the queen bee problem and whether this group of people can become the much-needed role models.

When the theories behind smashing the GC are considered, there are two schools of thought. One is that it is the responsibility of government or business to fix, or secondly, that women need to empower or upskill themselves to carve their own path. If left to government policy (for example via quotas) or businesses (for example through positive discrimination), there is a high risk of implementing changes that are unpopular with both men and women. Men feel maligned by such measures and women feel they are reluctantly being handed roles which are rightly theirs. Therefore, if it is possible to discount measures of positive discrimination, the focus must shift to personal and career development opportunities for prospective female leaders. But how can it be possible to create development activities and programmes for women without the same claim being levelled that these measures disadvantage their male counterparts? The answer is both subtle and simple – women are not asking for an unfair advantage, only a level playing field, therefore these opportunities must be made available to both men and women. Given the contradictions in the literature, it is necessary to consider the validity of evidence presented above as a complete body of evidence. The fact that there are apparent weaknesses and inconsistencies indicate there is still work to be done in this area, and that perhaps some of the underlying factors remain unexplored. This example of the two conflicting schools of thought on positive discrimination is a premise which shall be explored in my research.

The literature has provided areas to focus upon when attempting to identify reasons for the existence of a glass ceiling in the NHS. For example, comments in the literature have

shown that in other industries women are underrepresented, as they are believed to lack the skills prevalent in that type of industry (e.g., software engineering). The NHS is different in this respect, as female employees are the core of the NHS and are highly qualified in the key staffing groups, which constitute the largest percentages of the workforce (and patient contacts). Most of the previous research explores the glass ceiling in industries other than healthcare. In cases where it has been examined in relation to women in healthcare, this has been almost completely limited to their advancement in clinical careers, whereas this research project will focus on progression of female employees in management positions, advancing towards the boardroom. Whilst one study (Kline's *Snowy White Peaks*) reviewed discrimination inhibiting advancement into the boardroom, it covered gender *and* ethnicity, making the scope much wider and as such the conclusions that could be drawn much broader. From the literature there appears to be an assumption that all the factors that relate to gender discrimination also relate to race, but there is a lack of evidence to justify this position. A further distinction between this proposed research and the work of Kline is that this study will look at the actual technical requirements of board level positions for female managers.

In summary, the literature review was useful in several respects, it was primarily used to discover explanations for glass ceilings in other relevant organisations, which could then be considered to see whether they were relevant to the NHS. Next, the literature was utilised to structure qualitative elements of my research, such as the interview domains to test the patterns in the literature against the experiences of the interviewees. Thirdly, the literature was used to identify how barriers caused by GCs have been overcome, so the viability of this being useful in the NHS could also be tested out through the interviews. The Trust level research was especially helpful in terms of providing the context from which an initial sampling frame for interviewees was chosen, as it identified boards with varying levels of female representation. It explored the structural and societal constraints which have allowed GCs to be created and sustained into the twenty first century. Finally, throughout my research it was always important that I was mindful that for a GC to exist it must be proven that discrimination exists, and this discrimination prevents women gaining access to higher positions in the organisation, that is to say proving discrimination alone is not sufficient (Folke and Rickne, 2016).

Given the duration taken to complete my research project, and the fact that new literature on my chosen area of study is published on such a frequent basis, it was necessary to constantly review new literature because as,

> *'in the social sciences, even the most basic knowledge goes off very quickly. As with milk and vegetables, you aim to keep getting it fresh. Because everything changes.'*
> Rosling (2018, pp. 180)

As such, the literature review was returned to throughout the development of this body of work, when more specific areas had been identified, and updated throughout the course of the research. This was particularly important should new work be published which was relevant to my research. Whilst undertaking the literature review, I was conscious to look for gaps in the existing body of work on this subject, which I could add to, to help develop the body of literature.

Chapter 3: Research Methodology and Methods

"*Real integrity is doing the right thing, knowing that nobody's going to know whether you did it or not*."

— Oprah Winfrey (The Independent, 2020)

3.0 Introduction

This chapter outlines the methodology and methods that were employed throughout my research project. The study utilised several research methods to explore each of the research aims, employing mixed quantitative and qualitative methods. This chapter will review why and how mixed methods were used; it will outline why grounded theory was felt to be valuable in informing the examination of theories and explanations identified in the literature; and will detail the merits of using narrative analysis as a means of interpreting interview data. It will then explain how thematic analysis was used to identify key themes emerging from the interviews and, finally, why vignettes were used as a device to illustrate the interview findings in an accessible and engaging manner. Figure 10, below, shows how the various methods, theories and frameworks informed each other throughout the research project.

My use of quantitative data analysis sought to indicate the existence of a glass ceiling in the NHS by reviewing NHS wide and individual trust data. It was also used to examine the number of female applicants for a development programme, and the number of female applicants seeking board level positions. This provided a broad understanding of the nature of the glass ceiling in the English NHS, suggested areas for enquiry, and helped to contextualise the qualitative part of the research.

The main research approach used qualitative techniques, in the form of in-depth interviews. The information obtained from the literature review was used to inform the choice of interview domains and questions. However, due to the vast number of theories revealed by the literature, a grounded theory approach was adopted. This influenced the choice of an open-ended discussion format for the interviews, which enabled exploration of a wide range of facilitators and barriers to female career progression, examination of existing explanations for the glass ceiling, and allowed for the potential emergence of new perspectives and new theories. As explained in more detail below, my initial

observations (outlined in Chapter One) were located within grounded theory as originally envisaged by Glaser and Strauss (1965) and then drew on an adaptation of grounded theory as described by Moerman (2016) and Flick (2018b). This approach allows for the incorporation of different data collection methods as part of an iterative process between data collection and analysis. A grounded theory framework was also conducive to adopting a narrative enquiry approach to data collection (Riessman, 2008), providing interviewees with an opportunity to 'tell the story' about their career pathways. These conceptual frameworks are explained in more detail in the following sections.

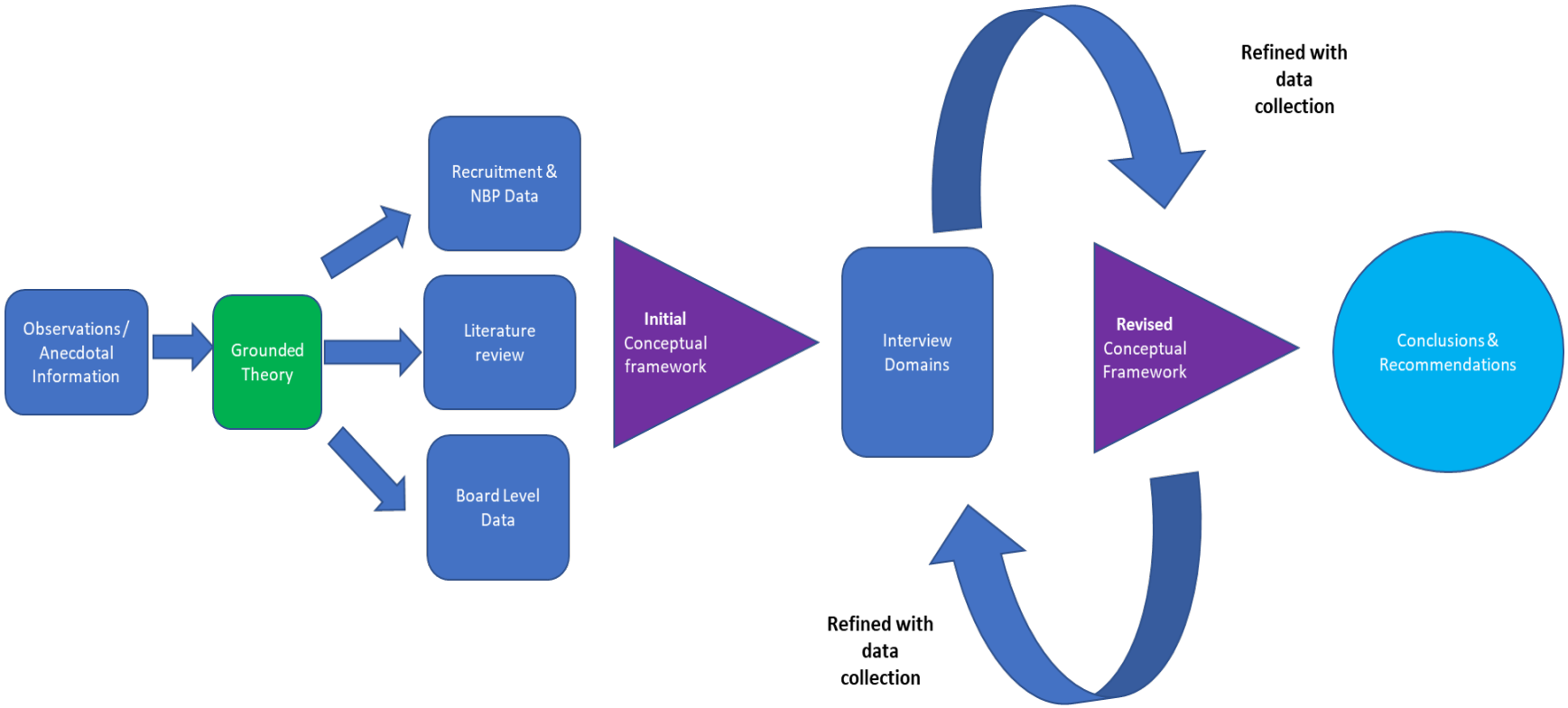

Figure 3: Diagram Detailing the Methodology Process

Source: Author Generated

Mixed Methods

Mixed methods are '*an umbrella term to cover the multifaceted procedures of combining, integrating, linking, and employing multi-methods'* (Creswell et al, 2003, pp. 165). Mixed methods have been cited as being particularly effective when researching matters pertaining to gender equality. This was demonstrated by Roth (2011) when exploring the glass ceiling (GC) on Wall Street in her study *Selling Women Short: Gender and Money on Wall Street.* In line with my own work, Roth employed open ended interview questions in her qualitative research. It was noted that Roth's quantitative element allowed her to,

> *'take into account all those factors which might legitimately explain gender differences in wages…*[but] *it was only when the qualitative data was brought…she was able to gain a fuller and more complex understanding of the specific process in the workplace.'*
> Hesse-Biber et al (2015, pp. 15)

Creswell et al (2003) discussed the use of mixed methods and highlighted several of the benefits of adopting this approach,

> '*the use of multiple methods can neutralize or cancel out some of the disadvantages of certain methods…Thus, there is wide consensus that mixing different types of methods can strengthen a study…Also, because social phenomena are so complex, different kinds of methods are needed to best understand these complexities.'*
> Creswell et al (2003, pp. 164)

When planning my research design and data collection, I was mindful of guidance from Creswell et al (2003), who instructed that it was necessary to have clear rationale for using each element of the quantitative and qualitive methods, but also to be absolutely clear about the interrelationship of the two methods and the data they produce. To this end, my decision to employ mixed methods was based on my desire to use the data from the quantitative analysis to be able to contextualise the findings of the qualitative research. Which is to say, I wanted the numerical data analysis to help shape the interview process, by signposting areas for useful inquiry. An example of this can be

derived from the fact that the numerical data evidenced that women were less likely than men to apply for director roles. This allowed me to shape my interview schedule to explore why this might be happening. This approach of using quantitative methods followed by qualitative was identified by Creswell et al (2003, pp. 179) as '*sequential explanatory'* design from one of the seven types of mixed method designs that they presented. In this design they recognised that neither the quantitative nor qualitative elements need to be regarded as more important than the other. This meets with my research design as whilst more time and resource were devoted to the qualitative elements, I did not weight these findings as being more or less important than the quantitative data. This sequential explanatory design was also in line with my application of grounded theory and the desire to build theory as more data were collect, because sequential explanatory design is used '*when testing elements of an emergent theory resulting from the qualitative phase and that it can also be used to generalize qualitative findings'* (Creswell et al, 2003, pp. 182).

A further rationale for opting for the use of mixed methods is that I wish to pull together several methods to create a mosaic of the factors influencing gender equality in the NHS. Because it is such a broad subject matter, I felt that it was necessary to have a range of sources indicating the existence of a glass ceiling and possible routes to overcome it. This mosaic approach has a body of supporting literature. Most notably Kincheloe (2001) discussed the concept of bricolage. The word bricolage is derived from a word meaning '*a handyman or handywoman who makes use of the tools available to complete a task'*, which can be adopted by researchers through '*using multiple methods and perspectives in research…to synthesize contemporary developments in social theory'* (Kincheloe, 2001, pp. 680). Kincheloe notes that bricolage draws criticism for being 'superficial' (Kincheloe, 2001, pp. 681) because rather than use one method thoroughly it adopts several without applying each to the same depth. However, the strength of bricolage is to recognise that using only one method limits the research and their outputs. Furthermore,

> '*Researchers employing multiple research methods are often not chained to the same assumptions as individuals operating within a particular discipline.*' Kincheloe (2001, pp. 686)

Grounded Theory

A modified version of grounded theory was used, which, despite being called a theory, is more a qualitative approach. This used the data to generate numerous concepts which were continually tested and refined, as more data were collected. Grounded theory is '*the relationship between theory and data in qualitative research'* (Bryman, 1996, pp. 83), it stems from the work of Glaser and Strauss and their 1965 work *Awareness of Dying.* As the title suggests their study examined aspects of patients dying in medical establishments. Glaser and Strauss, using observations and interviews, described the flexibility of their methodology as '*moving rather freely'* (Glaser and Strauss, 1965, pp. viii). This gave them the ability to hone in upon the areas they felt more important to their study rather than following a purely systematic approach. Expanded in the 1967 work *The Discovery of Grounded Theory,* they explained that grounded theory is *'the discovery of theory from data'* (Glaser and Strauss, 1965, pp. 1). They claimed this theory contrasted *'logical deduction from priori assumptions'* (Glaser and Strauss, 1965, pp. 3). In summary, this can be interpreted as grounded theory using the data to generate concepts and hypotheses rather than test the data against a predetermined theory.

Grounded theory seeks to link data analysis with theory rather than the deductive approaches which proceeded it. With a deductive approach research tends to verify or contradict the theories that existed at the outset of a research project, which can lead to researchers being blindsided to alternative hypotheses. Conversely, grounded theory builds theory as the research and analysis progresses. Walker and Myrick (2006) provided an updated summary of grounded theory, which recognised that it is especially useful when using qualitative methods of research such as interviews, as it enables '*coding of the responses'* (Walker and Myrick, 2006, pp. 548). These codes are collected into concepts that enable them to be grouped into categories to generate a theory, as represented in Figure 11, below. This constant comparison compares data-to-data point or, as with my research, interview content with interview content, with the aim of achieving a higher abstract concept, which will create categories to derive a conceptual framework. These conceptual frameworks then go on to be tested against each other as more data points are collected (i.e., more interview responses). Then the concepts can be compared to one another. For these reasons grounded theory assumes all concepts to be temporary. As such, the focus is for grounded theory to view research as a

processional approach. There is a search for deviant cases (or data points), whereby similar cases might consolidate the theory, deviant cases help expand thinking. The aim, therefore, is to achieve a sufficient level of sampling whereby theoretical saturation is reached, i.e., each additional data point does not lead to a refinement of the theoretical model or concept. This led Glaser to comment '*all is data'* (Glaser, 2001, pp. 145).

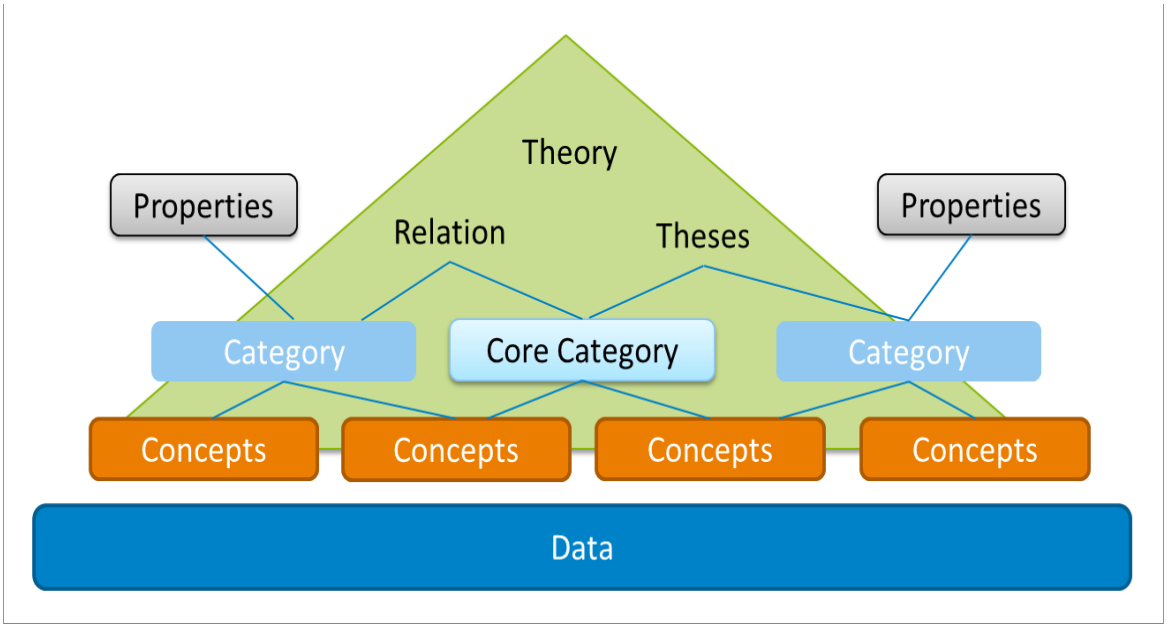

Figure 4: Grounded Theory Steps

Source: Moerman (2016)

Kelle (2015) understood that Glaser and Strauss developed grounded theory to provide a,

> '*strategy of empirical research whereby data are not used to test a readymade hypothesis…instead categories and statements are considered empirically grounded if they emerge from the data.'*
> Kelle (2015, pp. 598)

This was done to prevent prior theories being '*forced*' onto the data. Kelle (2015) also believed that whilst grounded theory was useful, it also needs to be remembered our previous opinions can always '*tint*' our views on a theory, making it very difficult to disassociate our original theories. Kelle though, believes that Glaser and Strauss did realise this, labelling the phenomenon '*theoretical sensitivity'* (Kelle, 2015, pp. 598).

It has been described that there are four key features of grounded theory, which are,

> *'minimal preconception about the issue under study, simultaneous data collection and analysis, using various interpretations for data, and aiming at constructing middle range theories as the outcomes of the research.'*
> Flick (2018b, pp. 3)

As Flick noted, grounded theory is most relevant to qualitative research by providing '*the specific conceptualisation of coding data and materials'* and what he deemed as '*a spiral of cycles of data collection, coding, analysis, writing, design, theoretical categorisation, and data collection'* (2018b, pp. 18). Throughout this research project, the aim was to stay aligned to Flicks' contemporary doctrine on grounded theory by taking '*the theoretical knowledge from the literature…from which hypothesis are derived which are then…tested against empirical conditions'* (Flick, 2018b, pp. 20). The whole structure of the interviews and questionnaire process was to tease out each explanatory model from the literature and attempt to analyse the response, to inform or debunk, whether these models were prevalent in the NHS. The interview questions could then evolve as the number of interviews increased, to test emerging themes and omitting areas which had no relevance to the NHS.

Grounded theory in its purest sense means arriving at the research stage of a project without preconceptions of an overarching theory. This is difficult to achieve with a study area such as mine, given the wide range of related theories. In relation to my own work, my initial observations (outlined in Chapter One) were driven by grounded theory as originally envisaged by Glaser and Strauss (1965) – I realised there was an absence of women in NHS board rooms and set out to discover why this was the case, without a '*priori assumption'* (Glaser and Strauss, 1965, pp. 3) in mind. The data presented in Chapter One firstly, evidenced the issue and, secondly, was useful to see if there were potentially other avenues for exploration. By the time I had reached the literature review stage, it is not possible to state that I was using grounded research in its original format, as the literature provided such a comprehensive array of (sometimes conflicting) theories and explanations for the presence of a glass ceiling. However, it could be argued that

grounded theory in a more modern adaptation was used based on the model above (Figure 11) of Moerman (2016) and the work of Flick (2018b). This is because there was no preconception from myself at the outset of the research, as to which theories would be shown to affect the NHS.

Grounded theory, therefore, informed the method of data collection; the interview schedule sought to address key theories from the literature in an unbiased manner, to explore if they resonated with the interviewees. I was then able to devote more questions and time to relevant themes in future interviews and drop questions (or devote less time) to areas which seemed to have little relevance to the NHS. This follows the '*spiral of data collection cycles'* which Flick (2018b, pp. 18) incorporated into his updated application of grounded theory. This process is not perfect and is open to bias. For example, just because the first six interviewees did not deem a theme relevant, does not mean the seventh interviewee would not. However, the general consistency amongst the interview responses did provide validation that this approach was effective.

3.1 Methods

3.1.1Quantitative Data Analysis

If methods are '*tools; a researcher's methodology determines the way in which each tool is utilized'* (Hesse-Biber et al, 2015, pp. 6). The first method or '*tool*' employed was the data analysis component of the figures reviewed in Chapter One, which indicated the existence of a glass ceiling. However, further macro data analysis on NHS workforce figures was required to increase confidence in the existence of a glass ceiling in the NHS and explore trends over time. This took the form of reviewing data from sources such as the Department of Health, for the entire NHS. In addition to this, a more detailed picture of what was happening at an individual trust level was developed by reviewing the gender composition of executive directors (i.e., those directors with board membership) at provider trusts, through publicly available information (e.g., NHS trust websites). If any trusts did not display the necessary information on their website, it was originally planned to issue Freedom of Information Requests to these trusts; however, the publicly available information was enough to undertake the analysis. This data analysis was performed by entering the composition of boards for all provider trusts in the Midlands and London (in relation to the male / female breakdown and their relative roles) into a statistical

programme (in this case Microsoft Excel). This enabled me to look for patterns, such as whether geographical location made a difference to the gender composition of the board. This had the dual purpose of confirming or rejecting the existence of a glass ceiling, whilst starting to outline possible areas for exploration by looking at any trends in the data.

To analyse the gender split in terms of the number of male and female directors on NHS trust boards in London and the Midlands, a list of all NHS provider trusts was taken from the publicly available NHS England Data Catalogue website (NHS England, 2016). From there, it was possible to download a CSV file which was converted to an Excel file; this file contained all NHS provider organisations in England. The trusts were then sorted into broad geographical regions, using the filters already contained in the Excel file. It was necessary at this stage to format the spreadsheet line by line to ensure that only trusts from London and the Midlands had been included. This was done on a geographical basis (using county boundaries) rather than looking at NHS sector groupings (such as Local Area Teams), as these can be fluid and changeable with each NHS reorganisation. Grouping the trusts using geographical boundaries allows for a constant categorisation over time. All the provider trusts for the two regions were included; this included secondary care organisations, community services, mental health trusts and ambulance trusts. No commissioning organisations, such as Clinical Commissioning Groups, were included as the data was not available in a comparable format. Foundation Trusts (FTs) and non-FTs were both included, as one of the abilities that comes with the additional autonomy of FTs is to have a larger board of voting directors (Monitor, 2014). This said, it has been found that whilst FTs can form larger boards, they still tend to have similar sized boards to non-FTs (Mannion et al, 2015).

Obtaining the gender composition of each trust board involved searching through the individual trust websites. In almost all cases these sites listed the names of directors, normally with accompanying profile pictures and a brief biography. There were some issues, such as various almost interchangeable job titles being used for similar roles. For example, in some instances the title Chief is used rather than Director; in these instances, they have been treated as equal titles (e.g., Chief Financial Officer was classified the same as Director of Finance). The gender was not always obvious,

especially where there was no picture of the individual; however, it was often possible to assume based on name – this should however be noted as a possible source of error or bias. In two instances it was necessary to read the biography and look for pronouns to indicate gender, for example a director named Chris had a gender-neutral biography until the last paragraph where it stated *'she'* had been a nurse for several years. Not all trust websites had lists of Directors; in two instances not a single director was listed and in a third instance only the CEO's name appeared. Furthermore, the data on websites could have been out of date; for this reason, the date of access for each website was included in the tables in the appendix. A final point relates to the likelihood of data entry mistakes due to the manual entry of 368 data points taken from 66 different websites.

Not all Director posts were listed on the trust websites, possibly due to vacant roles, given the high number of vacancies for senior roles in the NHS at the period the data were captured (The King's Fund, 2018). Alternatively, this could be due to some roles being merged under a single post holder. Where this was evident on the website information, the most senior post was recorded (e.g., if a person was CEO and Director of Finance, then CEO was recorded). The data only relates to Executive Directors, Non-Executive Directors were not included as in many cases they would have no former NHS career, and as such had not faced the issues concerned with internal NHS promotions. Some trusts had directors for positions that did not exist in other trusts. Where unusual director roles appeared on the trust websites they were not included in the analysis; however, the full data set has been included in the appendix. The inclusion of Deputy CEO role was made on the basis that some trusts have a designated Deputy but, in many cases, the Deputy also had another board role (for example, the Deputy CEO could also be the Director of Nursing). For the purposes of this review the gender of the Deputy CEO was not listed if they had another executive title.

The roles of executive directors did vary slightly from trust to trust; as such, given the low number of boards reflecting some positions (such as Directors of Redevelopment, Estates and Transformation) the roles were omitted from the final analysis. Similarly, Associate Directors were not included as they were not viewed as executive roles. The net effect of these assumptions was to include a list of executive roles which were the most highly regarded in the organisation. Whilst it is likely that the final list included some

roles for some trusts which do not hold voting rights (a requirement for the post to be regarded as '*executive*'), it is considered that the selection of roles enabled a close as possible uniform comparison across the organisations.

It is perhaps important to reiterate at this point that, whilst undoubtedly a factor that could impact career progression, an exploration of ethnicity, is not a central aim of this research. As highlighted in Chapter One, ethnicity may well impact career progression (as could age, religion and many other factors) but the causes, effects and solutions are not necessarily the same as those for gender. Furthermore, this section of the research includes evaluating a person's gender from a website entry which was not always conclusive; undertaking the same exercise for ethnicity would have been extremely subjective given their ethnicity was not listed and it would require assumptions based on the individual's name and appearance. That said, ethnicity is a factor considered in the qualitative section of the research to explore the potential '*double burden'* of gender and ethnicity.

A second form of data analysis was used to look at the recruitment practices in a single trust, comparing the number of applications for VSM (Very Senior Manager) and board positions in terms of male and female split in relation to the number of appointments made. The aim was to identify if the recruitment process had some effect on appointments. For example, if only a small proportion of female candidates applied for roles, was the barrier related to the lack of encouragement for female applications? Conversely, if a large proportion of female applicants were applying and not being appointed, the reasons for this would need to be explored in detail. To conduct this review of applications, it was necessary to find a hospital trust willing to provide this information, given there would be a risk of the equity of their recruitment processes being questioned. This concern was overcome by anonymising the trust involved. When conducting the analysis, it was necessary to identify the number of applicants split by gender compared to the number of appointments, also the type of role was required (e.g., Chief Executive Officer, Director of Finance, etc.). To provide a more detailed picture, ideally a summary of the skills and experience of the applicants and the successful candidates would have been made available. However, the trust could not easily access this information as they had used a third-party recruitment consultancy for

the shortlisting process. Several requests were made to HR directors from those trusts which took part in the interviews for this application data; however, only one responded. This created issues from a methodology perspective as it only looks a one trust; however, the aim of the exercise was to start to explore whether the recruitment pipeline could be a reasonable area to explore, rather than having it as a central component of the research.

3.2 Sampling Strategy and Interview Methods

The literature review highlighted the areas to explore in terms of barriers and opportunities faced by female employees; it was then possible to categorise them to measure how prevalent they might be in the NHS. This literature was then used to formulate the interview domains which informed the questions for the interviews. The interviews were conducted on a semi-structured basis and used the understanding of the barriers and opportunities drawn from the literature to devise open questions for the respondents to discuss their perceptions and experiences. It was particularly useful to explore what the individuals regarded as the success factors necessary to make it to the boardroom, to see if this matched the areas highlighted by the literature as being important factors in other industries. Where necessary, for example when limited responses were offered on a subject, pre-determined prompts were used to steer interviewees towards more expansive answers. The Interview questions were developed based on the following domains (the full interview schedules are included in Appendix A.7 and A.8):

1. Details of NHS employment career to date and current role.
2. Experience and perceptions of barriers faced when seeking promotion.
3. Explanations for barriers – particularly in relation to gender.
4. Experience and perceptions of opportunities which had aided career development.
5. Discussion of specific gender related issues affecting career progression (including childcare, other family commitments, ability to move roles and relationships with peers).
6. Views on what assistance could be put in place to help female career advancement.

7. Details of any specific skills and experiences sought out to enhance career development.

The trusts – and therefore the individuals – who took part in the interviews were identified through the macro analysis of the composition of female boards from the data analysis section, with purposive sampling being applied to choose the sample. The purposive sampling considered whether the trust was an outlier in terms of female board progression (either above or below average) as determined from the trust level data. Purposive sampling was useful as it is aimed at situations where '*a certain cultural domain with knowledgeable experts'* needs to be targeted (Tongco, 2007, pp. 147) – the '*cultural*' aspect being potential gender discrimination, and the interviewees being the '*experts'* in their relevant fields. Furthermore, purposive sampling is '*a deliberate choice of informant due to the qualities the informant possesses'* (Tongco, 2007, pp. 147); as such purposive sampling for this study was deemed appropriate. It was beneficial to the research to identify and target organisations and individuals who fit the relevant criteria compared to random sampling, as a deliberate choice of interviewees provided the most insightful responses. It also allows for an iterative approach whereby themes emerging from interviews can be explored in later interviews and theoretical perspectives built up as the interviews progress. Flick (2018b, pp. 82) noted that along with theoretical sampling, purposive sampling can be employed to '*focus the diversity in the field'* (Flick, 2018b, pp. 82). He advised that this can be performed based on selecting '*experts in the field'* or '*sensitive cases'* to make the '*evaluation most effective.*' Thus, the interviewees were selected based on their experience, skills, and positions within organisations.

With reference to selecting the right number of interviewees, I was mindful of Jackson's criterion of data collection adequacy, which essentially reflects that,

> *'The total amount of information that is collected* [is sufficient] *regardless of the number of sources. Hence, qualitative inquiry can gain depth of understanding from comparatively few sources.'*
> Jackson et al (2015, pp. 1402)

I felt that the number of interviews, initially being twenty-five with twenty different interviewees (as those on the Nye Bevan Programme were interviewed twice) met the test of adequacy given the subject matter knowledge of the interviewees. The interviewees were drawn from four groups, with five people in each of the four groups making a total of twenty interviewees (the five from the NBP were interviewed a second time approximately 18-months later). An hour was allowed for each interview, with an additional contingency of 15 minutes being allotted, in case it was deemed that insufficient data was obtained. However, in all instances this contingency was not required due to the richness of the interviewee's responses. The four groups of interviewees were as follows:

1. Those on the Nye Bevan Programme, these individuals were interviewed at the beginning of the programme and then followed up longitudinally (approximately 18-months later), aiming to explore their career advancement and experiences over time. The rationale for the second interview was to allow for a comparison of their views before and after participation on a professional development course, to see if the programme had any impact on them.
2. Women currently operating at board level – to explore how they got there and what they saw as barriers and opportunities in the NHS in reaching board level.
3. Women just below board level – to examine what they believe the barriers and opportunities to be. Just below board level was identified using the Agenda for Change pay scales, looking at those individuals at bands 8D and 9, at which the next pay increment would have likely been a board level appointment.
4. Men operating at or around board level (again using Agenda for Change pay scales to inform this selection), to explore their views on the necessary requirements for board level positions and the potential barriers that might prevent gender equality.

For all those, apart from the Nye Bevan group (which had a national pool of candidates), the focus was on two geographical areas (London and the Midlands) to compare practices in a region of high board level diversity to one of less diversity. It was hoped that this would provide a degree of insight as to whether local policy or socio-economic factors influence board appointments. Additionally, it allowed exploration on whether

there were differences between Foundation Trusts and Non-Foundation Trusts (both regions had a mixture of FTs and Non-FTs) – given the different composition of their boards and the greater financial freedoms of Foundation Trusts – was thought to be beneficial. To clarify, as noted elsewhere, only provider trusts were approached. A provider trust is one that provides clinical services (such as a hospital) as opposed to an NHS organisation which commissions or regulates provider trusts (such as a Clinical Commissioning Group). Solely provider trusts were chosen due to the board structure of the organisation and the career trajectory to board level, which is much more uniform and transparent in provider organisations.

To identify interviewees on the Nye Bevan Programme, it was necessary to select those from the most recent intake on the programme – which at the time was the January 2019 cohort. Those on the programme had been split into Learning Sets, each of these Sets had a facilitator. To get a spread of interviewees who would not be aware of the other interviewees' involvement, each facilitator put forward one female member of their set for interview. This selection was informed by the criteria the facilitators were provided with, which was a female manager from a provider trust. Should no one in their set fit these criteria, the facilitators were able to nominate a female manager from a non-provider trust. Ultimately the five names put forward were all from provider trusts.

All research instruments were piloted before use with a small number of three candidates, so that the questions could be refined to ensure they elicited a depth of relevant responses. Following this there was a need to consider the demographic information that needed to be collected, which included age, gender, ethnicity, family and carer responsibilities, education, and relevant experience. Given that my research focus was not specifically exploring ethnicity, the sampling noted ethnicity, though this was not a key variable in my sampling strategy. Because of the amount of demographic information and time it would have taken to record in the interview, it was decided to collect this information prior to the interview through a brief questionnaire, which was circulated at the same time as the consent form and participant information sheet.

After conducting the first seven interviews there was a natural pause until the next group of interviews took place. I took this opportunity to perform a brief analysis of the data I

had collated up until this point, and to reflect on my performance as an interviewer. In relation to the information I had gathered, patterns were starting to emerge from the responses, which enabled me to refine my interview schedule – in line with Flick's (2018b) revised approach to grounded theory. One example of this was the apparent belief of the interviewees that they needed to move roles frequently to facilitate their career advancement – I opted to develop an additional prompt to check if this belief was held by future interviewees. I also noticed that the power of networks kept coming up as an important factor, in terms of support, personal development, and career advancement. Because of this I probed more on networks; whilst this was a possible methodological issue – given that the later interviews were conducted slightly differently from the first seven – I felt this was worth it, to dig down into a potentially fruitful area.

A further reflection, after the first seven interviews, caused me to change the order of the questions. I moved to asking the questions concerning opportunities before those relating to barriers, as I found if I went straight into barriers the interviewee closed up more, as the interview felt more negative. One question that I found elicited useful and insightful responses from the first batch of interviews, was the final question which was essentially an invitation to add anything else the interviewee wished, either new information or additional detail to a previous question. This question flagged several new areas to probe in future interviews. In conversation with my supervisors, it was suggested that a similar question was added concerning what other information the interviewee might give to a person going into the same career as them. This allowed them to reframe their experiences and add information from a new lens. The analysis that I conducted at this stage also helped shape how I compiled my responses for more detailed analysis in the future, it was at this point I began to consider the use of vignettes and narrative presentation of my findings.

I was conscious of my own interview style after reviewing my first cache of interviews. I was mindful that my role would affect the data I received. As Roulston et al (2003) noted, issues can often stem from *'poor phrasing and delivery of questions and not listening closely*' (2003, pp. 631). At this juncture, one strong realisation was that I was abandoning the style that I employed in my working life. There was a difference in my style when I interviewed potential candidates for my 'day job' and that of myself as a

‘researcher.’ When interviewing people for job roles in the organisation where I work, I was much more prone to dig and challenge the candidate. Whereas, as a researcher I recorded without probing. For instance, in the second interview I undertook the interviewee discussed their time working in Zambia, they said this could be viewed as a negative by some interview panels when applying for roles. In this instance I inferred my own interpretation of this and did not press the interviewee on why this was risky – this realisation encouraged me to probe and challenge more in future interviews.

A further refinement was to the interview schedule, whereby interviewees were asked to start by reflecting on their career progression, with specific attention to transition points – i.e., moving from one role to another – what inspired the change, what were the enablers? I also refined the wording of several of the questions to be more open. A more introspective analysis of my feelings at the time, perhaps driven by the thought that I was imposing and taking up time of busy people, was the fact that I seemed to be rushing the interviews rather than trying to maximise the quality and value I could derive from them. A prime example being when an interviewee emailed just prior to the Skype call, to inform me they would only have thirty minutes for the interview. In the end the questions were rushed, and opportunities were missed to explore some interesting details in more depth. Following a review of the call, I decided that should this happen again I would ask to cover the second half of the conversation later.

The main external difficulty I encountered through the interview process was accessing interviewees. One gatekeeper to a subset of interviewees delayed access for almost a year by not responding to emails, delegating the task to other staff, and putting in place unnecessary governance steps, which had already been covered. Access to interviewees was further hampered due to the 2020 Corona Virus pandemic, because many of the interviewee’s roles and workload changed, making time for them to take part in the follow-up interviews difficult.

One of the rarer aspects of my methodology was the extensive use of Skype for the interviews. Skype is a VoIP (Voice over Internet Protocol) which enables voice and video calling. My use of Skype was due to the geographical spread of the interviewees, the availability of the interviewees (many of whom held senior operational roles) and my

personal work commitments. Despite Skype being a readily available research tool for approaching two decades, there remains a *'dearth of research'* into its use (Deakin and Wakefield, 2013, pp. 604). This is because, as Lo Lanco et al (2016) point out, '*VoIP as a qualitative research data collection technique is often grouped together with other methods, such as email and online messenger services'* (2016, pp. 2). Deakin and Wakefield wrote extensively about their experiences of using Skype whilst conducting their own PhD research. Their use of Skype came about as they felt '*face-to-face interviews can be problematic, due to time and financial constraints, as well as other logistical considerations'* (2013, pp. 604).

Skype itself is free, although a more robust paid for business product is available. It can be used on mobile platforms, meaning it can be used anywhere, although mobile usage tends to weaken the signal and the small screen removes some of the intimacy of the conversation. Lo Lanco et al rightly highlight the key benefits, *'time can be used in a more flexible way, around the needs of participants'* (Lo Lanco et al, 2016, pp. 5). Also, the less considered but important practical advantage is the '*associated health and safety risks of traditional interviewing at night, for example, were also reduced when using Skype'* (Deakin and Wakefield, 2013, pp. 608). This health and safety aspect was brought to the fore during the 2020 Coronavirus pandemic, when not only was it prudent not to conduct face-to-face interviews, but because of some of the lockdown constraints it would have made it illegal to move to different locations to conduct them.

It is important to note that Skype does create a different interview environment and might yield slightly different results,

> *'Online interviewing technologies can change the sense of the interview, particularly if the participants have specific requirements, which make face-to-face interviews difficult or require a novel approach.'*
> Deakin and Wakefield (2013, pp.607)

Even prior to the Coronavirus pandemic, the prevalence of Skype and its high usage, people were starting to accept its role in communication; '*many participants take the opportunity of the option of an online interview over the face-to-face, in effect normalizing*

the Skype interview' (Deakin and Wakefield, 2013, pp. 607). This was even more evident following the 2020 pandemic, which extended the use of other tools such as Microsoft Teams and Zoom.

Skype was ultimately used in nearly all interviews (23 out of 26). It is a half-way house between a telephone interview and a face-to-face interview. Being able to view the person allows for greater reading of body language and other non-verbal communication. However, this often falls short of the value of in person interviews, as interviewees can be prone to adopting the persona of a formal telephone conversation – especially if they are unfamiliar with using this type of video conferencing tool. This has the effect of reducing the bond between interviewer and interviewee, which can result in the interviewee withholding some more personal or controversial points of view. This is particularly problematic in a research project which deals with sensitive subject matter. Deakin and Wakefield did note that other researchers had highlighted the issue of '*building rapport online* [being] *different from building a relationship face-to-face.* [It] *can be problematic during online interviews due to a lack of visual cues'* (2013, pp. 610). However, in their experience '*this was not deemed to affect the quality of the conversations'* (2013, pp. 610). Lo Ianco et al (2016) did feel that with sensitive subjects it could be more difficult to gather in-depth responses, in their view this was mainly due to the fact the interview was being recorded rather than the lack of rapport.

One big drawback with using VoIP (Voice over Internet Protocols) can be the lack of IT literacy of the interviewees (Lo Lanco et al, 2016). However, given the seniority of those who took part in my research and the fact that computer literacy is a key requirement of their roles, it was anticipated that this would not be an issue, especially given the ease of use for Skype. One key issue with Skype is connectivity; the quality of the Skype signal varies greatly, usually depending on the hardware and the internet signal. A telephone signal, particularly when using a landline connection can be relatively stable, whereas a Skype call can frequently degrade. This is problematic for several reasons, not least as it means sections of the conversation have to be repeated, it can cause some of the conversation to be omitted and can be a source of frustration for the interviewees. One of the methods of improving the quality of the Skype call is to move from a video call to voice only, as this reduces the bandwidth requirements. But with this option the visual

element, which is so valuable in relating to the interviewee and building a level of trust, is lost.

There are ethical considerations with Skype purely for voice calls as,

> '[with] *online interviews that do not use video, the lack of visual clues such as age, gender and ethnicity are suggested to be a benefit as this can decrease interviewer effect during interviews.'*
> Deakin and Wakefield (2013, pp. 605)

However, there are draw backs in relation to ethics, '*data security and consent online are just two examples that cross over with more traditionally considered ethics'* (Deakin and Wakefield, 2013, pp. 609) – this is significant. Whereas previously the interviewer may have just made notes or record it with a Dictaphone, now the individual's identity is clearly visible, and if the materials are not securely maintained they are easily sharable over the internet. This has the potential to cause distress to the interviewees if comments they thought were anonymous are spread over the web. To deal with these ethical considerations and explain the confidentiality process, information was sent to all interviewees prior to the Skype call in order that it could be read before the call. This information was the Participant Information Sheet and the consent form, both of which had been approved by the University of Middlesex Ethics Committee. Scanned copies of the consent form were returned prior to the interview, to ensure that receipt of consent was not an issue afterwards. In addition to these two documents (as mentioned above), the demographic questionnaire, discussed above [in appendix A.5], was sent to the interviewee to request basic demographic and career information. This facilitated the questions in the interview becoming more targeted and less time was lost on basic background information.

In this study, there were several practical considerations with using Skype regarding quality and access. On three occasions, while the interview commenced with video, it was necessary to move to voice only. On a further occasion, the interviewee was expecting a voice only call and as such requested that the conversation be conducted solely as a voice rather than video call. This could have been for numerous reasons,

such as the interviewee did not feel presentable, or they were in a venue that they did not want the interviewer to see (such as their home residence). Three of the first seven interviewees did not have Skype accounts or could not remember their usernames or passwords. In the case of those who did not have accounts this created time issues for the interviewees, in relation to setting up accounts. With interviewees who did not have their log in details this delayed the start of the interview, which meant the time available for the interview was curtailed.

An hour was set aside for each interview, three latest this duration and four lasted between 30-45 minutes, the remainder took between 45-60 minutes. As a matter of good research governance, the transcriptions were sent to the interviewees for review. However, to remove the obligation of the interviewee to wade through large amounts of text, the transcript was sent to them for information only; they were asked to review it if they wished, and a time limit of two weeks was given to provide feedback. None of the interviewees provided any comments.

3.3 Analysis: Approaches and Methods

When it was time to organise and analyse the wealth of data from all the interviews I had undertaken, it was necessary to decide on the most appropriate method. The analysis of interview data is notoriously difficult, Mishler underscored the issues which researchers are faced with, as,

> *'they must convert voluminous, multidimensional, and variable language samples into the types of objects that allow them to apply standard procedures – sampling, measuring, counting, and hypothesis testing.'*
> Mishler (1990, pp. 424)

The first factor to consider is the way the interviews were conducted, such as the nature and structure of the questions used and the output in terms of the format of the data produced. It was important when evaluating the data from the interviews, to incorporate a method which identified that the content of the language was more formal than the interviewees would typically use in their everyday speech. Reflecting on these factors and because I wished to explore how a glass ceiling may be prevalent in the NHS, I

initially considered undertaking a discourse analysis due to its ability to '*analyse and understand real language data'* (McCarthy et al, 2013, pp. 17). However, I rejected discourse analysis as I was also interested in female leaders' identity development within the NHS, interpretive phenomenological analysis was instead appealing because the interviews provide an '*examination of personal lived experience'* of the interviewees, as women working in the NHS and related aspects of their personal lives (Eatough and Smith, 2008, pp. 193). Ultimately, a pluralistic technique was engaged to approach the same set of interviews with two separate analytical methods, by combining narrative analysis of the individual interviews with interpretive phenomenological and thematic analysis for comparison across the various sets of interviews.

3.3.1 Narrative Analysis

The term narrative is loosely defined as the telling of a *'story*.' That said, a more detailed definition is difficult to conclusively provide. Indeed, Riessman (2008) went as far to declare, in her book solely dedicated to narrative methods, that she would not attempt a single definition that could cover *'all applications'* (2008, pp. 3). Adopting an open discussion format for conducting the interviews and providing interviewees with an opportunity to *'tell the story'* allowed for a narrative inquiry approach to data collection. Narrative analysis, was, therefore, used as the first method for interpreting the data. Broadly speaking, narrative analysis is the '*family of methods for interpreting texts that have a common storied theme'* (Riessman, 2008, pp. 11). Narrative inquiry allows people to give you their story, '*as humans we tell our stories, we attempt to make our narrative meaningful for the listener, to help them see connections'* (Luhman and Boje, 2001, pp. 166). Narrative inquiry '*takes as its object of investigation the story itself*' (Riessman, 1993, pp. 1), it does this by '*examining the stories people tell about their experience'* (Gilbert et al, 2014, pp. 1445). As interviewees tend to '*organise replies into long stories'* the traditional qualitative approach tends to '*fracture these texts in the service of interpretation and generalization'* (Riessman, 1993, pp. 3). Furthermore, Kim (2016) felt that narrative analysis '*utilises interdisciplinary interpretative lenses with theoretical, philosophical diverse approaches and methods'* (2016, pp. 2).

Narrative inquiry can be considered as a '*non-pedantic nature that values stories of lay people'* (Kim, 2016, pp. 4), because, whilst the interviewees in this study were not lay

people in their area of expertise, they were in the world of research and lacked knowledge of the various causes of glass ceilings. Therefore, they had knowledge and experience of the structures of the NHS but may not have been aware of how or why these support a glass ceiling. Using a narrative inquiry approach in conducting the interviews elicited their knowledge and grounded the relationship between their expert knowledge and the research topic. Indeed, during my research many of the interviewees seemed surprised at some of the questions, as they could not associate the question (the origins of which were rooted in the literature) with the relevance of a glass ceiling. Gentle probing during the interview process, enabled exploration of the intersection of the interviewee's personal life and career, which '*prompts the reader to think beyond the surface of the text…toward a broader commentary'* (Riessman, 2008, pp. 13).

Using narrative methods is practical when interviewees,

> *'represent the individual as an intentional agent whose subjectivity, experience, and actions are shaped by the constraints and opportunities of the social world.'* Goodbody and Burns (2011, pp. 177)

Lifting this to a meso-level, by adding the contextual piece of the NHS structure and current events, meant it was possible to mesh the narrative with the external factors, by showing the impact of meso-level factors on people's everyday working lives. As, '*metaphorically speaking, each narrative inquiry is a quilt made out of pieces of personal and social stories* (Kim, 2016, pp. 4). Further rationale for employing narrative inquiry for data collection and narrative analysis as an appropriate means of interpreting the accounts stemmed from Goodbody and Burns (2011). Given that the interviews were designed to have a low number of questions they, '*act*[ed] *as an invitation to speak and to elicit narratives with minimal intervention by the neutral researcher'* (Goodbody and Burns et al, 2011, pp. 175).

Bruce et al (2016) argued that whilst qualitative investigation is often thought to be lacking in scientific rigor, the use of narrative analysis helps to provide a balance, to objectively dissect a person's story and explore their rationale for imparting information which might not be completely in line with the reality of the situation. Furthermore, there

is an argument that the story is the reality of the narrator even though another individual might interpret the same scenario differently. This idea was reinforced by Luhman and Boje as the use of narrative '*embraces the presupposition that knowledge is a social, historical and linguistic process…an intersubjective and emerging reality'* (Luhman and Boje, 2001, pp. 159). More simply put, Moen (2006, pp.63) felt '*fiction then is truth'*. Luhman and Boje (2001) were also keen to explain that stories change, '*our narratives are on-going linguistic formulations, composed in the moment and responsive to circumstances of a particular time and space'* (2001, pp. 166). Whilst the story might change depending on the audience and when or where it is shared, this does not make the story more or less true at a given time or place, because there is '*no single, dominant or static reality'* (Moen, 2006, pp. 60). Furthermore, when we explore complex systems or large organisations, such as the NHS (which, it could be argued, is both a system *and* an organisation), we are entering a domain with a huge number of individual discourses, which *'collectively construct* [a] *system of organisational reality'* (Luhman and Boje, 2001, pp. 163).

Goodbody and Burns explained the urgency of narrative by researchers can be attributed as *'slippery, unruly, rich, and sometimes indigestible, characterised by diversity, differing levels of analysis, and contrasting philosophical assumption'* (2011, pp. 177). Narrative inquiry has a place in qualitative methodologies as there are still '*flaws and limitations of applying a solely scientific knowledge to understanding human phenomena'* (Goodbody and Burns, 2011, pp. 177).

People are not always completely rational beings and do not always say exactly what they think. A drawback of narrative inquiry is that it presents the view of the individual, and whilst they might believe what they are saying to be correct, it is based on their worldly experience which is not necessarily reflective of other people's experiences. Being based on personal interpretation rather than facts and evidence is one of the reasons that narrative inquiry is often criticised for its '*lack of academic rigor'* (Kim, 2016, pp. 4).

There is no definitive '*how to'* guide for narrative research; it remains elusive as there are many ways of undertaking narrative analysis due to the ontological standpoint of the

researcher. Kim (2016) explained that ontology is one of the three pillars of narrative analysis, the three being ontology (questions about reality), epistemology (questions about knowledge), and methodology (questions about methods of obtaining knowledge). The ontological standpoint being that '*of a person, community, or turn…a way of understanding the nature of reality…* [it can] *literally, be thought of as how the world is'* (Heikkurinen et al., 2016, pp. 706). Given the variable nature, '*no two narrative studies will look alike'* (Bloomberg and Volpe, 2018, pp. 50). This knowledge provides freedom to the researcher to be creative in their design, pulling together desirable threads from multiple other studies to form a hybrid model of their own. The difficulty derives from working through the '*complexity of the multiple layers of stories'* (Bloomberg and Volpe, 2018, pp. 50), that interview subjects provide when retelling their own experiences. In my chosen field of study there exists the interplay between a person's identity of self, of profession, and their social views about discrimination. It was also vital to remain mindful of what Bloomberg and Volpe deemed the interplay formed when '*the narrative views from the participants'* life with those of the researcher's life, culminate '*in a collaborative narrative'* (2018, pp. 51). Their point being, that my own views will have subconsciously impacted the results of my data collection from the interviews. For narrative analysis it is necessary to closely review the transcript whilst:

> *'Bearing in mind the 'context' of the interview, and the role of the researchers in shaping and constructing the narrative performance and subsequent interpretation.* [And] *considering issues such as the gender of the interviewer and researchers, the interview setting, our subjective interpretations of his account, the topic of discussion as well as the circumstances surrounding the interview.'*
> Gilbert et al (2014, pp. 1447)

There are two separate strands to a narrative, that of '*the realm of experience, where speakers lay out how they…are put to use in order to make sense'* (Bamberg, 2012, pp. 3). Bruce et al (2016) described their problem in deciding '*what constitutes a story and narrative'*, because alongside '*coherent narrative transcripts'* are the '*incoherent, multi-layered, and fragmented'* (2016, pp. 3) elements to a person's story. During narrative analysis it is important '*to remember the link between the individual and her or his context'* (Moen, 2006, pp. 60). Moen (2006) provided a simplistic example of how

narrative style changes; the example he provided was of a teacher in a classroom talking differently to how they would in the staff room, i.e., the teacher has multiple voices for different audiences. This has led to narrative researchers not thinking in terms of a person's voice but of their voices (Moen 2006; Wertsche 1991; and Gudmundsdottir 2001).

When it comes to undertaking narrative analysis, there are a variety of approaches described in the literature. Denzin (1989) broke it into the three stages of a story, a beginning (this can be setting the scene, introducing the characters), a middle (the main event of the story occurs) and an ending (the impact of the story or lessons learnt or how the narrator felt or was impacted by the events in the narrative). Narratives are temporal in the sense that they have a casual sequence to them. Denzin believed that during a person's narrative they are telling you things because they matter to them, even when they might seem inconsequential. The role of the narrative researcher, therefore, is to understand why the interviewee has opted to disclose this information. Bruce et al (2016) laid out their four concepts of narrative analysis,

> *'meaning making (the belief that stories hold meaning); close study of the particular within individual stories, to illuminate universal human experience; social constructionism (meaning is co-created and co-constructed); and the role of metaphoric language and metonymies in stories.'*
> Bruce et al (2016, pp. 2)

Lieblich et al (1998) used a four-part system for narrative analysis as set out in Table 7, below. The holistic content concerned things such as the person's background, relationships, and vocation. For my research, the fact that the interviews largely explored people's work lives was particularly significant in the narratives, as people can attach a large amount of their personal identity to their vocation. The holistic form concerns itself with the plot or style of the story, which might be, in simple terms, a satire or a tragedy. The categorical content is the analysis of the categories, be it the number of categories or comparison to other persons' narratives. The categorical form pertains to the linguistic elements which identify the inner meaning of the story, through use of similes or choice of verbs, when and where the story was placed or even the use of tense.

Table 1: Lieblich et al Matrix of Reading Narrative

	Content	Form
Holistic	1	2
Categorical	3	4

Source: Adapted from Lieblich et al (1998, pp. 13)

Later, Riessman (2008) introduced the tripartite approach to narrative analysis, that of the thematic structure (i.e., the subject or topic), the structural and the dialogue / performative approach. She was primarily interested in how the story is organised, how it then develops and how the narrative begins and ends. This is an advancement on Murray (2000), who proposed that the first step in narrative analysis is to organise the questions into one of four categories: personal, interpersonal, positional, and ideological levels. Goodbody and Burns (2011, pp. 180) provided examples of what level of analysis was undertaken under each of these four areas:

- Personal: 'narrative individually, idiosyncratically, and holistically as an aspect of a life story.'
- Interpersonal: 'narratives were communications occurring within the local social grammar of the research context.'
- Positional: an example of this is 'the ways in which self ("I") was positioned by the narrator in relation to others ("They") and researcher ("Thou") were seen as providing information about agency and the construction of personal identities.'
- Ideological: 'illuminate the workings of power in participants' narratives and subjectivities.'

  Source: Goodbody and Burns (2011, pp. 180)

Taking the application of the narrative analysis a step further, Boje (2001), proposed the antenarrative as he claimed, narrative inquiry is '*a simple telling of chronology'*, which is at odds with the '*self-deconstructing, flowing, emerging, and networking'* (Boje, 2001, pp. 1) reality of stories within an organisation. He describes antenarrative as being *before* the narrative; it is the story that sits before the conclusion, or the '*flow of lived experience'* (Boje, 2001, pp. 1). Antenarrative was useful in looking at the output of the interviews in

my study, especially because many of the questions were indirect routes to identifying bias the interviewees had experience or observed. There were no overt questions on this, rather they started conversations which led to the subject of bias. In this sense interviewees told their story and the antenarrative reflected their meaning. The antenarrative analysis draws together seemingly unrelated or unconnected experiences to provide a coherent trend. Again, this was useful, as even though all interviewees were working in the same industry, they all had varied backgrounds, with varied career routes and a wide range of examples of the discrimination they had observed. It was, therefore, the role of antenarrative to find the similarities in this range of experiences. Boje (2001, pp. 6) laid down the eight steps of antenarrative analysis:

1. Deconstruction: unravelling the various strands to provide a coherent story.
2. Grand narrative: breaking down the overall story into one of 'many voices.'
3. Microstoria: looking for the little story to illustrate the overall narrative.
4. Story network: linking the individual stories into 'nodes' of a larger piece.
5. Intertextuality: the piecing together of the smaller stories.
6. Causality: showing the relationship between the stories in the network.
7. Plot: used in this instance to suggest a plot where one might not be readily obvious.
8. Theme: engaging of the fragments from the smaller stories.

   Source: Boje (2001, pp. 6)

One of the pre-eminent names in narrative analysis is William Labov. He wrote extensively on structural analysis and, as early as 1972, was implementing analytical systems to explore the link between oral narrative and individuals' experience. This approach explores narrative through examination of core elements, the visual and textual modes of construction (Labov, 1972). The Labov approach takes each individual event or element of a story and uses them to construct an overall cohesive picture. Later Labov expanded his work on oral narrative analysis to cover the abstract, orientation, complication, resolution, and coda elements of a person's story (Labov and Waletzky, 1997). Cortazzi (1993) augmented the original 1972 model adding in an evaluation stage prior to the resolution. Strong advocates of Labov's work were Porto and Belmonte

(2014), they felt Labov placed the greatest emphasis on the evaluation category of analysis,

> *'as it reveals the real purpose of telling the story to a given audience…evaluation is not confined to a specific part of the narration, but can be present all through it, at every level of language structure.'*
> Porto and Belmonte (2014, pp. 16)

Table 2: Labovian Narrative Structure

		Narrative Category	Narrative Question	Narrative Function
Category	**Function**	Abstract	What was this about?	Signals that the story is about to begin and draws the listener.
Evaluation	Provides comments and reveals the attitude of the narrator towards the events	Orientation	Who or what are involved in the story and when and where did it take place?	Sets the scene and thus helps the listener to identify the time, place, people, activity, and situation of the story.
		Complication Action	Then what happened?	Describe the actions or events that occurred
		Resolution	What finally happened?	Explains the outcome of the story.
		Coda	How does it end?	Brings the listener to the present time.

Source: Porto and Belmonte (2014, pp. 16)

In a practical context Table 8, above, relates the categories of the Labov scheme, to which Porto and Belmonte (2014) provided concise definitions and examples of what each section refers to. The abstract can be regarded as the summary of the story, it is a compact statement of the story teller's background and overview of the narrative. The orientation and complication stages are when '*the narrators locate the story in a specific time and place and tell their personal stories'* (Porto and Belmonte, 2014, pp. 18). The orientation is literally where the story takes place, both in terms of the geographical location but also the context of the location, for example the workplace. The complicating action is the actual events that occur in the narrative. The resolution is the outcome, the message or result of the narrative. The coda is the '*so what'* or the '*moral of the story*', a

reflection of the impact of the events of the narrative or what has been the result of the process or story that was recollected by the narrative.

Ultimately, I adopted a slightly modified version of Labov's narrative structure. Labov's work appealed to me as being most useful in the context of my research, as it looked at people's experiences in the same organisation, under similar constraints, and enabled the differentiation between the same experience but from separate viewpoints of different people. For example, did senior male managers have different views of NHS personal development than female managers? The proforma template I used for analysing each interview, which incorporates Labov's format for narrative analysis, is provided in Appendix A.9.

Practically speaking then, how does one apply the theory of narrative analysis on the transcription of interviews? Alongside the application of the Labov approach, it was important to be cognisant of the approaches of the more general aspects of narrative analysis mapped out above. To this end, I was mindful to look at the types of words people used. Secondly, to note how they place themselves within the narrative. Thirdly, omissions from a narrative can be just as important as what is included. Interviewees often are intentional in their omissions; therefore, it is important to note the omissions and consider the rationale for them. Additionally, for small sections of the text which I found to be most pertinent to the key research objectives, I undertook a close examination of the text; underlining elements related to the facts of the event and then reviewed those words not underlined – this gave a sense of how the individual felt about the story morally and how central their actions were to the events.

To have data that can have narrative analysis applied to it, it is important to start with the interview schedule. The interview schedule was structured in a way to help people tell their story or experiences in a narrative manner, for example, by keeping the questions very open and using phrases such as, '*can you tell me about an experience concerning X*.' Furthermore, I refined the schedule as the interviews progressed to enhance the narrative flow. Using the criteria of Bruce et al (2016, pp. 2), above, it could be argued that the refinements to the interview schedule as the interviews progressed was compliant with the concept of emergent design (as well as aligning to Flick's (2018b)

updated use of grounded theory). This is because, whilst data was being collected, there was ongoing analysis of the questions, which were '*adjusted in an iterative fashion in response to what is being learned'* (Bruce et al, 2016, pp. 2). Next, the researcher must understand that when opting to undertake narrative analysis, during the interviews they act as *'a collaborator rather than an informant guide'* (Moen, 2006, pp. 61). Mishler (1986) was aware that the role of the interviewer plays an important part in the narrative, not only in terms of eliciting the story but they also interpret and become involved in it; to this end they influence the flow of the story. Whilst Mishler (1986) was not opposed to techniques such as coding of responses, he was concerned that becoming over reliant on them can lead to a separation of discourse and meaning.

The transcription process is a vital first step in research analysis as, when conducting interviews, it is important

> '*not as a means of ensuring students are capturing the "truth"… rather to ensure that the transcript provides a thorough account of the oral record in keeping with the theoretical assumptions underpinning the study.'*
> Roulston et al (2003, pp. 657)

I recorded and transcribed all the interviews myself. When undertaking the transcription, I was mindful of Bamberg of '*picking out and communicating what is considered relevant about reality…to the imperative task at hand'* (2012, pp. 19). Bamberg described the task as a balancing act of what was described and what happened. Whilst the initial transcriptions were accurate depictions of what the interviewee *said,* the use of the narrative analysis pro forma enabled this to be dissected into a more realistic and coherent overarching whole. Once the interviews had been fully transcribed, the salient themes and key points were then transposed into the Labov template shown in Table 8 above (with a worked example contained in Appendix A.9), so that the individual interviews could be dissected and analysed. This proforma helped with the organisation of the data, by revealing the commonalities, which paved the way for a thematic analysis to compare the narratives side by side.

3.3.2 Thematic Analysis

As discussed above, due to the number of interviews, I decided to apply a slightly modified version of Labov's narrative structure as the approach to conducting a narrative analysis on each individual interview. Flick suggests that an in-depth analysis of each single interview helps to preserve the meaning and paves the way to *'develop a system of categories for analysis'* (2018a, pp. 478), i.e., analysis is done on individual interviews prior to trying to find commonalities across the range of a group of interviews. Flick states that once analysis has been completed for all interviews separately, then they can be compared to each other in terms of thematic structure. I found this approach appealing and most appropriate, as all interviewees were reporting on the same subject matter with their experiences varying greatly. Therefore, it was necessary to look at each interview in explicit detail prior to looking for overarching trends or '*themes'* and conducting thematic analysis.

The main challenge when using qualitative methods, according to Vaughn and Turner, is '*they tend to present challenges for analysis'* (2016, pp. 42) and, according to Sankaran (2018), '*narratives are also not easy to generalise'* (Sankaran, 2018, pp. 55). Braun and Clarke (2006, pp. 87) proposed thematic analysis as a method. They described the six stages of thematic analysis as:

1. Familiarising yourself with the data – undertaking the transcription process and coming close to its content.
2. Generating initial codes – the sematic and latent codes (i.e., the words used and the underlaying meaning or messages).
3. Searching for themes – sorting of the themes.
4. Reviewing themes – categorisation of the themes from step three.
5. Defining and naming themes – providing a visual representation of the themes and subthemes.
6. Producing the report – presentation of results.

Following the procedure recommended by Braun and Clarke (2006), three layers of factors were identified: national level, organisational level, and employee level and within each layer several themes emerged, agenda for change and recruitment (national level), flexible working and childcare, gender stereotypes, and NHS culture and discrimination

(organisational level), career progression, professional development, and networking (employee level). These themes are discussed in Chapter Five.

3.3.3 The Use of Vignettes

Vignettes are sometimes used as a data collection tool, for example to present a scenario to gauge research subjects' responses. However, I have opted to use them as a way of presenting data from my narrative and thematic analysis. Vignettes are *'short stories, hypothetical scenarios, or descriptions of incidents'* (Jackson, 2015, pp. 1395). They can provide '*a short, carefully constructed description of a person, object, or situation, representing a systematic combination of characteristics'* (Aguinis and Bradley, 2014, pp. 353). The central issues with the use of vignettes are whether there is '*correspondence between the participants' responses…and what they would actually do in real life'* (Crafter et al, 2014, pp. 83). Proponents of the use of vignettes argue they display the analysis of data as '*a way of presenting truthful cultural portraits'* through the grouping of '*thematically connected categories'* (Bloomberg and Volpe, 2018, pp. 208). The thematic element being of note here, given the decision to utilise thematic analysis. Crafter et al (2014) described vignette methodology as being useful as it '*allows researchers to systematically explore issues that could, potentially, be sensitive to research participants*' (2014, pp. 83). The relevance here is the '*personal information*', given that the content of the interviews was often highly sensitive to the interviewee. This sentiment was echoed by Jackson (2015, pp. 1395), *'vignettes have been used by social and health researchers to explore issues that might be sensitive, painful, or controversial*.'

Narrative and thematic analysis proved valuable tools for providing robust and detailed exploration of the interview text. An in-depth review of the interview data enabled me to see the value in presenting the voices of the interviewees, rather than solely the more data driven reflection. The personal accounts of the interviewees added a richness and detailed records of experiences. In certain instances, these experiences merited being presented '*as is'*, using vignettes, as it allows segments of text to be retold in full. Humphreys (2005) spoke of the ability of vignettes to bring '*vivid*[ness]…*and contextual richness…to construct a window through which the reader can view'* (2005, pp. 842). I personally felt that vignettes, when discussing a sensitive subject matter, remove any

filter that the researcher might inadvertently apply when compiling their findings. Finally, I understood that vignettes provide a level of authenticity to the text, precisely because they are unfiltered; the reader can feel the emotions of the interviewee. As such, once I had completed all interviews, I took the opportunity to construct a vignette for each of the four interviewee groups, which provided an easy to comprehend story for the common threads of the narrative of the members in each group. Whilst lacking in certain scientific rigour and excluding some individuals' details to promote the themes of the cohort, this can be excused as the detail is picked up in the thorough narrative analysis in Chapter Six – it is the aim of the vignettes in Chapter Seven to give a flavour of the responses in a concise and accessible telling.

3.4 Conclusion, Ethics and Wider Applications of this Research Project

This chapter has mapped out the methods and methodology for my research project. I have explained that mixed methods provide quantitative data on the prevalence of a glass ceiling within the NHS, and the reasons for the existence of a glass ceiling are derived through qualitative analysis over twenty-five interviews. The quantitative data presents the size of the problem by demonstrating the gender board composition and the level of female representation in NHS trusts; through the qualitative analysis we hear the voices of NHS managers explaining why this is the case. To ensure the qualitative data is reflected in a balanced and meaningful manner, an overview is provided in the form of four vignettes (one for each of the interview groups) to offer a sample of each group's common background and opinions, which is provided in a more rigorous level of interpretation through narrative and then thematic analysis. Finally, it was explained how the outputs of the data analysis were continually tested to identify and then confirm the relationship between the findings and theory, using Flick's (2018b) updated understanding of grounded theory.

An obvious source of bias which could be levelled at this research project is the gender of the author and the subconscious views which I may hold (Holdcroft, 2007). However, the fact that I have chosen this subject matter should evidence that I wish to look at it objectively. The scepticism of those partaking in the research must be allowed for; as an example, female participants might have been wary that the author is looking to justify the glass ceiling, rather than address it. Throughout the project it was essential to reflect

regularly, repeatedly asking myself questions. Did my being male shape the responses of the interviewees? Did my subconscious bias reflect the way I presented the data? These factors are more relevant when we consider the underlying feminist element of the research project, as '*for the feminist researcher, there is no knowledge without bias'* (Hesse-Biber et al, 2015, pp. 4). It is important to be mindful that most early feminist research involved only interviewing male research participants, reaching conclusions on matters pertaining to women without even involving women in the research. While this trap is avoided here, due to the inclusion of mainly female participants, it is pertinent to be conscious of the legacy this created. It has been noted that previous feminist empiricists have developed certain rules to reduce bias in their research, which included '*not treating Western sex roles as universal, not transforming statistical differences into innate differences, not translating differences as inferiority'* (Hesse-Biber, 2015, pp 73). This formed a useful checklist to continually refer to when deriving conclusions from the data.

Beyond gender there were other factors that could have affected the project. The NHS management world is notoriously small; additionally important when it is factored in that the interviewees were operating in regions in which I have formally worked. Therefore, did knowledge of me (either from networks or because of my credentials – someone could have checked on LinkedIn for example) make a difference? During the interviews, the interviewees made many comments such as '*you know how it is'*, causing me to reflect whether this amounted to collusion. Did it encourage interviewees to use specific '*codes*', which, as a former NHS employee, I would have picked up? Furthermore, did they use concepts or terminology which I was familiar with but neglected to explain or expand upon in the analysis? Again, the best defence against these traps is to be mindful and seek to explain, discuss, and represent as openly as possible; however, it is disingenuous to suggest these forms of bias can be eliminated.

This research project avoided deception by being open and transparent about the intentions of the research. All participants received a summary of the aims along with materials requesting their involvement. Ultimately, the purpose of the research project was to benefit those people who may have been consciously or unconsciously victims

of discrimination as, by definition, they may not have been admitted to roles they are rightly qualified for.

This research ensured ethics were adhered to by following the University of Middlesex policies and by applying for ethics approval through the Middlesex MORE portal (the approval is included in Appendix A.1). All participants received written instructions on the nature of the research and its potential uses in the form of a Participant Information Sheet, then completed a consent form prior to taking part in the research (copies of both are included in the Appendix, A.3 and A.4 respectively). As a further measure, all interviewees were sent copies of the interview transcript; this way they maintained agency through the ability to change any of the content that was not in line with what they had intended to disclose. This also gave them the ability to retract any statements which they later wished to withhold (none of the interviewees asked for any amendments).

The use of Skype and the ethics considerations were covered at length above. In summary the use of Skype created several areas for ethical consideration. Firstly, there is the validity of findings when the voice only mode is used (i.e., without video), as visual prompts may have been missed which could change the meaning and interpretation of the data. Secondly, because the research was conducted and recorded electronically, the content would be easily sharable over the internet. Due to the sensitive nature of the content, it was necessary to ensure that data security was upmost, with only University of Middlesex approved methods of storage used. This included such measures as off-line memory sticks temporary stored in locked containers and transferred online via the University's secure One Drive account. Additionally, all ethics concerns regarding the use of Skype were cleared with the University's Ethics Committee.

The names of those who took part in the interviews were anonymised to protect the individuals from any potential harm it could cause them. The identities of the organisation were also anonymised; however, there was a recognition that it may be possible to link the data back to an organisation. For example, by noting the number of female board members it might be possible for someone reading the research to tie it back to the

organisation, as much of this information is already in the public domain (e.g., from published board papers and NHS websites).

As this project is related to the NHS, it was essential to understand whether it would be necessary to obtain approval via IRAS (The Integrated Research Application System), which is the '*single system for applying for the permissions and approvals for health and social care / community care research in the UK'* (IRAS, 2018). The IRAS approval can have a long lead time, so it was necessary to seek approval as early as possible. On completing the electronic pro forma on the IRAS website, it was determined that IRAS approval would not be required because this project did not deal directly with patients or medical research; therefore, the study was deemed to be a service evaluation. This IRAS response can be found in the Appendix A.2.

The primary difficulty for this research project was the size and geographical spread of the NHS. The NHS is the fifth largest employer in the world and has hundreds of trusts spread throughout the UK (Forbes, 2015). To minimise this, only executive directors from trusts providing secondary care services in the NHS in England were targeted for the quantitative analysis. However, some of the data available was only available in aggregated data sets, which could not be split out solely for England or secondary provider trusts. The size of the NHS created resource pressures when compiling the quantitative data analysis in terms of time, due to the large number of data points that required analysis. To allow for this, it was necessary to have very specific research aims and a focused approach to minimise reviewing unnecessary data. Where practical, electronic data collection was used as well as drawing upon the data sets published by the Department of Health.

A research project of this nature was subject to common methodology limitations and risks encountered in other studies when using interviews for data collection. There was a danger that the interviewees selected did not reflect general views of similar people in similar positions, that not enough people in each of the chosen groups were interviewed, or those interviewed lack significant experience. The use of purposive sampling, as explained above, attempted to address these risks. Even with purposive sampling, identifying and then accessing the right people to take part in the interviews was

problematic in an organisation the size of the NHS. This was coupled with the potential reticence of some individuals to be involved in a study of a sensitive nature. However, using my strong personal and professional networks, I was able to locate people who fitted the predetermined criteria, albeit in a longer than anticipated timeframe. The most useful of my networks were my contacts from the NHS National Graduate Management Scheme, due to its national reach.

A final note on methodology should be reserved for the dissemination of the outputs of my research project. One of the deliverables from my work is a list of recommendations for NHS which will be channelled through the NHS Leadership Academy. To ensure that I did not arrive at a list of unworkable and unpractical solutions, the continual engagement of the Leadership Academy allowed for sense checking of the recommendations to ensure they were fit for purpose and actionable. This consisted of a series of four meetings with four senior managers at the Leadership Academy. The first meeting was at the outset of my research (within the first year), the second prior to the first interviews with those on the Nye Bevan Programme (around 18-months in), the third prior to the second interviews with the Nye Bevan (around 36-months into my research), with a final meeting just prior to the submission of my completed research. The recommendations document (discussed in Chapter Eleven) was also submitted to the Leadership Academy for comments following the fourth meeting, to allow time to incorporate their feedback.

Chapter 4: Project Quantitative Findings

"*I have always believed that women are not victims. We are agents of change, we are drivers of progress, we are makers of peace–all we need is a fighting chance*."

— Hillary Clinton (Women in the World Summit, 2015)

4.0 Introduction

The first chapter of this thesis includes data taken from the Department of Health website in relation to the gender split across each of the Agenda for Change (AfC) salary bandings. From the analysis that was conducted on this data, it was evident that female employees out number male employees in all salary bandings bar the top two tiers. This finding was a key catalyst for this research project. However, it was clear that more in-depth primary research and analysis was required to establish, with greater certainty, that a glass ceiling was in place in the NHS.

This chapter explores:

- The gender composition of NHS provider boards and compares different roles across organisations, to see if there are patterns in gender imbalance.
- Figures from a leadership development programme (the Nye Bevan Programme), to consider the prevalence of women applying and being accepted onto this course.
- The number of applicants for director positions, to assess the likelihood of women applying, being shortlisted, and being successfully appointed to board level roles.

Taken together these separate levels of analysis help to build a picture of female career trajectories.

As stated, the initial aim of this research project was to determine whether a glass ceiling existed. The findings from the quantitative analysis, below, start to provide answers to questions which might explain how the glass ceiling remains in place, in terms of geographical location of the trust (e.g., is London more diverse than the Midlands?), in terms of the type of board positions that tend to be male or female dominated (e.g., are most Directors of Finance male?) and in terms of the size of the board (e.g., do larger

Foundation Trust boards offer greater diversity?). The results of these analyses were used to direct the qualitative elements of the research project. For example, they provided indicators of how to group the NHS organisations, from which to select interviewees (as the data identified boards with high, average, and low female board representation). As discussed in the methods section in Chapter Three, from these three groups of trusts, individual organisations were randomly selected to provide a blend of trusts.

4.1 Analysis of Gender Composition of Boards

The overall findings from the table below demonstrate a slightly higher number of male directors than female, with 54.3% of all 368 post holders being male. Whilst this number does not represent a significant dominance of men in the boardroom, it is still important to remember that at every more junior level in the NHS, women are far greater in number. As such, for parity to exist it could be argued that there should indeed be a higher number of female board members than male.

The full method for obtaining the below data, in Table 9, is presented in Chapter 4.1.1. It should be noted that the data is from 2016, as this was the last time that the NHS published the data in the required level of detail to enable this analysis. It was originally decided to compare the Midlands with London as previous work (Kline, 2014) had reviewed solely London board membership and found a significantly higher proportion of male board members. Kline speculated that in the wider NHS, outside of London, there might be an even higher level of discrimination, as it was suggested that London is a more diverse area to work in. However, the table below does not represent a statistically significant difference in the number of female board members between the Midlands and London. In fact, there is a slightly higher percentage of female post holders in the Midlands (44.4% and 46.3% respectively).

Table 3: Gender Composition of Boards – London Compared to Midlands

		CEO	Dpt. CEO	Chief Operating Officer	Dir. of Finance / CFO	Director of Nursing	Dir. Of HR	Med. Dir.	Dir. Strategy	Total Posts
London	**Total Men**	13	4	10	14	1	6	16	5	69
	Total Female	9	0	6	5	19	8	5	3	55
	Total	22	4	16	19	20	14	21	8	124
	Total % male	59.1%	100.0%	62.5%	73.7%	5.0%	42.9%	76.2%	62.5%	55.6%
	Total % female	40.9%	0.0%	37.5%	26.3%	95.0%	57.1%	23.8%	37.5%	44.4%
Midlands	**Total Men**	29	1	18	28	3	11	29	12	131
	Total Female	13	3	17	12	35	17	11	5	113
	Total	42	4	35	40	38	28	40	17	244
	Total % male	69.0%	25.0%	51.4%	70.0%	7.9%	39.3%	72.5%	70.6%	53.7%
	Total % female	31.0%	75.0%	48.6%	30.0%	92.1%	60.7%	27.5%	29.4%	46.3%
Total	**Total Men**	42	5	28	42	4	17	45	17	200
	Total Female	22	3	23	17	54	25	16	8	168
	Total	64	8	51	59	58	42	61	25	368
	Total % male	65.6%	62.5%	54.9%	71.2%	6.9%	40.5%	73.8%	68.0%	54.3%
	Total % female	34.4%	37.5%	45.1%	28.8%	93.1%	59.5%	26.2%	32.0%	45.7%

Source: Author Generated in 2018 using NHS (2016) list of Trusts by Region

What the data does illustrate quite dramatically is the variation in gender mix between different types of position; nearly all Directors of Nursing were female (93.1%), whilst only just over a quarter of Medical Directors were women. If Directors of Nursing were omitted from the table, then the percentage of female post holders would reduce dramatically to 36.8%. The high percentage of female Directors of Nursing is perhaps less surprising given the prevalence of women in the nursing profession – 89% female to 11% male (LSBU, 2019). However, the low number of female incumbent Medical Directors is questionable given the gender split in the medical profession, with 64% of consultants being male compared to 36% women (NHS Employers, 2018). The three most influential board members are commonly thought to be the CEO, Chief Operating Officer (COO) and the Director of Finance; the data demonstrates male dominance in all three areas (65.6%, 54.9% and 71.2% respectively). These are standout figures which deserve attention. Most notable is that two-thirds of the most senior roles (CEO) are held by men. The most equitable role was the COO, which could be explained by the fact the COO's often have a clinical background (i.e., nursing), so there is a more straightforward

route for women to transition into this position. However, the startling fact that over 70% of Directors of Finance / Chief Financial Officers are male does indicate an issue. As noted previously in this research, financial acumen is a key requirement for the most senior roles.

Prior to collating the data, it was decided to compare the board composition of Foundation Trusts and Non-Foundation Trusts. This was due to the ability of Foundation Trusts to have greater autonomy in the make-up of their boards and their power to increase the number of directors. The table below shows that Foundation Trusts do indeed have a slightly higher number of female executive board members than non-Foundation Trusts (46.3% and 44.8% respectively). The larger board size is perhaps a reflection of the higher number of Deputy CEOs, which - whilst small - is a greater proportion of women than non-FTs. The other notable area is the Medical Director posts, where, in non-FTs, only 15.4% of post holders are female; in FTs this jumps considerably to 34.3%; however, this is notably still well below the 50% bar of equality.

Table 4: Gender Composition of Boards – Foundation Trusts Compared

		Chief Exec Officer	Dpt. CEO	Chief Operating Officer	Dir. of Fin / CFO	Dir of Nurs-ing	Dir of HR / Work force	Medical Director	Director of Strategy	Total Posts
FT	Total Men	24	3	17	22	3	12	23	11	115
	Total Female	13	2	13	11	30	13	12	5	99
	Total	37	5	30	33	33	25	35	16	214
	Total % male	64.9%	60.0%	56.7%	66.7%	9.1%	48.0%	65.7%	68.8%	53.7%
	Total % female	35.1%	40.0%	43.3%	33.3%	90.9%	52.0%	34.3%	31.3%	46.3%
Non-FT	Total Men	18	2	11	20	1	5	22	6	85
	Total Female	9	1	10	6	24	12	4	3	69
	Total	27	3	21	26	25	17	26	9	154
	Total % male	66.7%	66.7%	52.4%	76.9%	4.0%	29.4%	84.6%	66.7%	55.2%
	Total % female	33.3%	33.3%	47.6%	23.1%	96.0%	70.6%	15.4%	33.3%	44.8%
Total	Total Men	42	5	28	42	4	17	45	17	200
	Total Female	22	3	23	17	54	25	16	8	168
	Total	64	8	51	59	58	42	61	25	368
	Total % male	65.6%	62.5%	54.9%	71.2%	6.9%	40.5%	73.8%	68.0%	54.3%
	Total % female	34.4%	37.5%	45.1%	28.8%	93.1%	59.5%	26.2%	32.0%	45.7%

Source: Author Generated in 2018 using NHS (2016) list of Trusts by Region

As discussed above, the primary purpose of this analysis was to add confidence to the existence of a GC in the NHS, which it did provide. The secondary use was to inform the qualitative analysis by identifying roles, organisations, and regions to form part of the sampling and inform the type of interview questions to be used. To see if the practices and experiences of women employed in trusts varied between boards with differing levels of female board representation, the trusts were split into three bands - high, medium, and low representation. The board with the highest female representation had a gender split of 16.7% male to 83.3% female board gender split, whilst the lowest (where more than one board member was listed on the Trust website) had a split of 83.3% male to 16.7% female, the exact inverse. By ranking all trusts from high-to-low female representation and then collating into three equal groups (with 22 trusts in each), it was possible to create the following groups:

- The high female representation group ranged from 50.0% to 83.3%
- The mid-level female group ranged from 33.4% to 49.9%
- The low female representation group ranged from 0.0% to 33.3%

Once the trusts had been assigned into one of the three groups, a random number generator was used to select one trust from the high representation group, one from the low and three from the middle. These five trusts were approached to request interviewees for the next stage of data collection.

The data helped refine the interview questions; the trends showing the existence of several gender dominated roles and the slight distinction between FT and Non-FT, resulted in the creation of role and trust status questions in the interview process. The data concerning the Director of Nursing and the Medical Director was particularly interesting, as these are much more likely to be female and male roles respectively, and both are roles which require a clinical background. Similarly, the prominence of male Directors of Finance and the likelihood of being Deputy CEOs indicates a career progression factor. These trends ensured that it was necessary to probe, with respect to career path, in the interview process. What was not possible to ascertain from this piece of research was whether the post holder was full-time or part-time, which was a factor that was indicated in the literature as having a bearing on the potential for working mothers to apply for the role. As such, this was an area which needed addressing through the qualitative interview process.

4.2 The Nye Bevan Programme Intake Data

Nye Bevan is the individual commonly regarded as the driving force behind the creation of the NHS in 1948 (Britannica, 2019). The development course named in his honour is for senior NHS managers and clinicians looking to work towards director positions. The two-year course managed by the NHS Leadership Academy, contains various written and group assignments, as well as numerous activities aimed at making leaders more introspective regarding how they interact with and manage people. To date the course has produced over 1,000 alumni, with the aspirational aim to

> *'accelerate individuals into executive roles, helping them perform better at board level, and help boards better meet operational challenges today and enable change for tomorrow.'*
> NHS Leadership Academy (2019)

As already witnessed above there are fewer women, proportionally, in the most senior NHS management roles. One explanation of this from the literature was due to an insufficient number of women in the pipeline for senior manager positions, either by choice or due to other structural factors based on skills, experience, or some form of systemic discrimination. Data obtained from the NHS Leadership Academy on the gender split for the Nye Bevan Programme offered a valuable insight into the pipeline of female leaders coming through the NHS ranks. These data enabled an exploration into how many women were applying for the programme – compared to men – which provides an indication as to the willingness and ability of female managers to work towards director level posts. Secondly, it was possible to analyse whether female managers were accepted onto the programme, which would demonstrate their suitability to be on a programme that produces directors of the future.

Table 5: Gender Split of Applications and Participants of the Nye Bevan Programme 2013-2019

		2013/14	2014/15	2015/16	2016/17	2016/17	2017/18	2018/19	
		Intake 1	Intake 2	Intake 3	Intake 4	Intake 5	Intake 6	Intake 7	Total
Applicants	Female	N/A	135	256	59	116	99	175	840
	Male	N/A	100	161	39	58	77	101	536
	Total	**N/A**	**235**	**417**	**98**	**174**	**176**	**276**	**1376**
Participants	Female	244	134	115	56	94	85	79	807
	Male	129	100	74	33	49	59	48	492
	Total	**373**	**234**	**189**	**89**	**143**	**144**	**127**	**1299**

Source: Based on data from the NHS Leadership Academy (2019)

The below graph shows (based on the above table) the gender composition, in terms of the percentage split of applications and percentage split of those who were accepted on to the programme between 2013 and 2019. It should be noted that there was some fluctuation in the number of places on the programme – due to funding constraints – from a maximum of 373 for intake 1 to a low of 89 in the fourth intake; additionally, there were two intakes in 2016/17. The number of applicants was on average 186 per intake, and whilst there are changes in the number of applications, the overall gender split is consistent. It is also clear from the data that most people who apply for the programme are accepted onto it (except for 2015/16). This could be for several reasons, such as the

barriers to being accepted onto the programme are low, or that only those people who meet the criteria of the programme apply or are asked to apply. Again, there seems to be no significant variance in the gender split between being accepted into the programme or not.

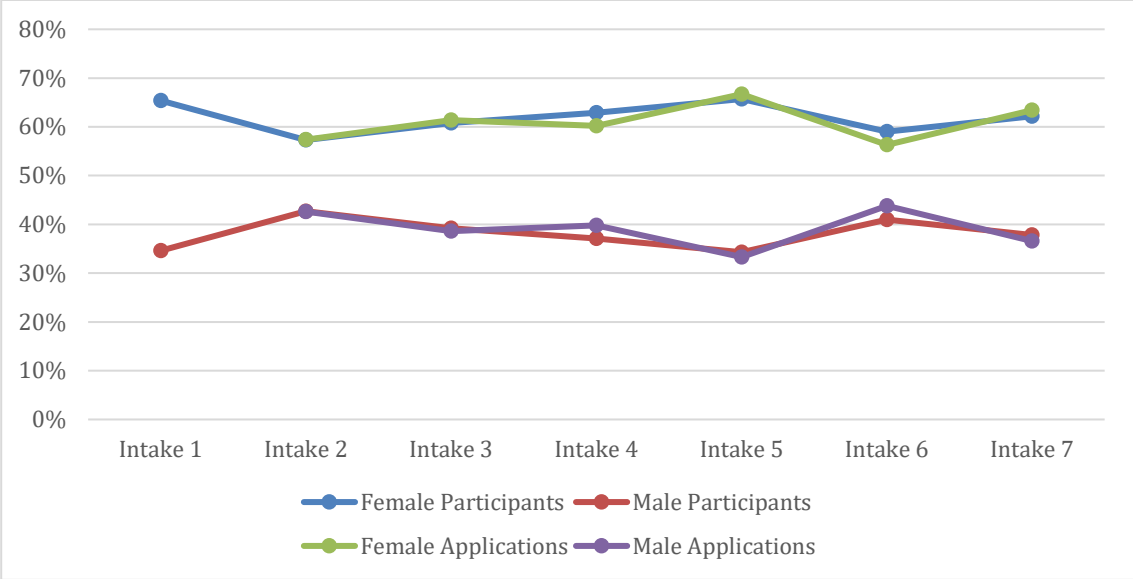

Figure 5: Gender Split Between Applicants to the Nye Bevan Programme

Source: Based on data from the NHS Leadership Academy (2019)

It is clear from the above graph that female applicants and participants outnumber men every single year. On average women make up 62% of all cohorts. As the programme is aimed at around 8D AfC level, this is roughly in line with the composition of the workforce, as women make up 59% of 8D managers (NHS, 2016). The question is then, do these data contribute towards the pipeline argument? Taking the numbers at face value it is possible to conclude that there are women in sufficient numbers, who are willing and able to be in the pipeline for future director roles. However, a counter argument could be that the male applicants feel they do not *need* programmes like the Nye Bevan, as they are able to secure director roles without demonstrating further development.

To add weight to the data from the Leadership Academy it would have been useful to have figures on what happened to the participants after the programme; do they reach the positions they seek? If so, how long did this take? Were the skills and experience

gained on the programme useful in progressing the applicant's careers? Unfortunately, at the time of writing, the Leadership Academy did not collect this data. As this long-term information was not available, I augmented my interview methodology and conducted two interviews with those five individuals who had been on the Nye Bevan Programme, one at the beginning of the programme and another 12-18 months later. This longitudinal approach enabled me to observe the impact of the programme on its alumni, by contrasting their views and experiences at the beginning of the programme with those afterwards.

4.3 Applications for Director Roles in an Acute Trust

One key determinate of the future gender split in the board room is the pipeline of employees ready to take on executive roles when they become available. If there is a line of experienced and qualified women ready to apply for board roles when they become vacant, then it stands to reason there will be a higher likelihood of them securing a role, than if no experienced and qualified women are waiting in the wings. The next factor to consider is whether this group of women applies for executive board positions. Once this is known it can be established whether this is a potential structural barrier which needs addressing. Given the size of the female NHS workforce and their prominence at all levels below board membership, it is possible to assume that there exists a sufficient number of women with the required experience. Therefore, by looking at the number of women who apply for board positions compared to male applicants, it is possible to be better informed as to whether it is necessary to encourage female managers to apply. To take this a step further, if a high number of qualified women are applying, but not securing roles, it would be an indicator that the barrier is the recruitment process, not the lack of applicants.

As such, I decided to secure data on the number of female applications for executive roles at a large teaching hospital; the data is mapped out in the table below. It is important to remember that this data only covers one trust. This small sample size – whilst informative – must not be regarded as conclusive. It does also cover non-executive roles, which are outside the scope of the main research question. That said, it does provide an insight into the numerous appointments over a three-year window.

Table 6: The Gender Split of Applications for Board Vacancies at a Teaching Hospital 2016-19

Role	Number of female applicants	Number of male applicants	Female candidates interviewed	Male candidates interviewed	Gender of successful applicant
Chief Exec 2017	3	6	2	1	Female
Executive Director 2017	0	9	0	3	Male
Executive Director 2017	18	17	2	1	Female
Executive Director 2018	9	3	3	0	Female
Executive Director 2019			2	1	Female
Executive Director 2019	10	9	3	1	Female
Executive Director 2019	2	7	0	1	Male
Chair 2016				3	Male
Non-Executive Director 2017	3	6	3	6	Male
Total	**45**	**57**	**15**	**17**	
				Female	5
				Male	4

A condensed summary of the data in Table 12, above, has been provided below in Table 13. The first observation that it is important to make from the below table, is that there is a near 50:50 split across the recruitment pathway from women applying, to being shortlisted, interviewed, and then finally being selected for the roles. The second observation is that women appear to fare better the further along the pathway they get. Proportionally women are slightly less likely to apply, but when they do are more likely to be appointed. Whilst the number of actual female appointments is positive, the lower level of applications (given that we know that two thirds of the workforce is female) is a concern. To gain an understanding of what is preventing women from applying for these roles, targeted questions were added to the interview schedule for the qualitative research aspect of this study.

Table 7: The Summary of Gender Split of Applications for Board Vacancies at a Teaching Hospital 2016-19

Female Applicants	44%
Female Shortlisted	47%
Female Appointments	56%

There are, of course, other factors we need to consider when interpreting the data above. As already seen in this chapter the likely gender of a director is highly dependent on the type of role; for example, Directors of Nursing tend to be female. Therefore, if one of the roles being appointed to was for the Director of Nursing, the appointment of a female Director would not buck the trend of gender inequality. Expanding this piece of work to include more organisations, more posts and having knowledge of the exact roles would be a useful piece of further investigation.

4.4 Pre-Interview Questionnaire Data

As detailed in Chapter 4.2, prior to undertaking the interviews, which formed the qualitative element of my mixed methods, all interviewees were sent a short questionnaire to complete. The full data set from the demographic questionnaires is included in Appendix A.6. The aim of the questionnaire was twofold, firstly it enabled me to elicit demographic information which would have been time consuming and sensitive to extract in the interview. Secondly, it provided a discrete data set which could then be analysed in conjunction with the interview data to explore the contrasts between the four interview groups. The appendix contains a copy of the questionnaire (Appendix A.5) in addition to the complete tabulated responses from the questionnaires (Appendix A.6), with the methods chapter describing how this information was obtain and analysed. To offer an initial picture of the interviewees I have provided an abridge version of the pre-interview questionnaire results below.

Table 8: Abridged Summary of the Pre-interview Questionnaire Results

Interviewee Group	Alias Name	Age bracket	Gender	Marital Status	Children / Carer (age)
1	Allie	50 - 59	Female	Married	Stepparent
1	Anita	30-39	Female	Single	None
1	Zara	50 - 59	Female	Married	1 child (19)
1	Ellie	30 -39	Female	Married	2 child (8 and 6)
1	Fiona	30 - 39	Female	Married	2 Child (10 and 7)
2	Lucy	30 - 39	Female	Divorced	None
2	Sandra	40 - 49	Female	Married	2 Child (11 and 9)
2	Barbara	50 - 59	Female	Married	2 Child (5 and 7)
2	Sue	50 - 59	Female	Separate	2 Children (25 and 21)
2	Helen	50 - 59	Female	Married	2 Children (25 and 38)
3	Deborah	30 - 39	Female	Married	2 Child (5 and 1)
3	Sam	30 - 39	Female	Married	2 Child (1 and 5)
3	Lyndsey	40 - 39	Female	Single	None
3	Isabelle	30 - 39	Female	Married	None
3	Sally	30 - 39	Female	Separate	2 Children (3 and 5)
4	Terry	30 - 39	Male	Married	None
4	Mark	30 - 39	Male	Prefer not to disclose	1 Child (3)
4	Jed	30 - 39	Male	Married	2 Child (1 and 3)
4	Tony	30 - 39	Male	Married	None
4	Ted	40 - 49	Male	Married	2 Child (17 and 22)

In terms of the overall demographic data, there are several similarities across all four groups (the four groups being, those on the Nye Bevan Programme, women at board level, women just below board level, and men at or around board level). For example, most of the respondents were married, most were qualified to post-graduate level, and the majority fell into the 30–39 years old age bracket. All but one of the respondents was white; there was one person who indicated they were ‘white – Irish’ and one respondent who reported being from an ‘Asian’ ethnic background. Across the four groups, people predominately had one or two young children and the children were typically under five. Notably the oldest average age of children was in the female board level executives (group two interviewees).

In terms of the experience of the four groups, most people surveyed were operating at director level. It is important to remember that to be at board level you are required to be in an *executive* director position. The group with the greatest level of experience was the women already operating at board level. This of course makes sense, as they were specifically targeted for that reason. The level of aggregate experience between groups one and two was near identical; again, there is a degree of logic to this; both are groups of women who are looking for executive positions as their next step on the career ladder. The level of experience was higher in group four (male interviewees) than groups one and three. This can again be explained by the methodology which sought a range of male interviewees both at and below executive director level.

4.5 Summary

This chapter reviewed the quantitative data concerning the gender split at various points through the NHS. The first step was to look at NHS boards for provider trusts in the Midlands and London; this data demonstrated that men are represented in greater numbers than women, as 8.6% more of the board level positions are occupied by men. This figure alone masks more troubling facts. If Directors of Nursing (who are predominately female) are removed from the statistics, the percentage of women plummets to 36.8%. Men are also much more likely (31.2% greater) to be Chief Executive Officers than women.

The next area reviewed was the applications for a development programme, to see if women were seeking to enhance their career skills at the same rate as men. The data from the Nye Bevan Programme was proof women are proponents of this form of personal development, given that on average the programme consisted of 62% women. The next piece of the jigsaw was to look at applications for board positions within one provider trust. These data displayed that 44% of applications were from women; this converted to 56% of appointments. Given the sample size of this data, it is not possible to make definitive conclusions, but within this one trust we can say that women were less likely to put themselves forward for board level positions, but when they did apply, they were more likely to be appointed.

Taking the first three pieces of analyses together helps build a picture; we can surmise that women make up 77% of NHS positions and women seek out development programmes (such as the Nye Bevan Programme) more than men, to develop board level skills. Despite this, women are still underrepresented on NHS boards. Feeding in the recruitment data, we can see that when women apply for roles, they were *more likely* than men to be appointed. From this, it is possible to make a jump to suggest that the issue is getting women to apply for roles, for which there are several solutions proposed in later chapters.

Chapter 5: Interview Findings

"*Men make the moral code and they expect women to accept it. They have decided that it is entirely right and proper for men to fight for their liberties and their rights, but that it is not right and proper for women to fight for theirs*."

— Emmeline Pankhurst, My Own Story (1914, pp. 268)

5.0 Introduction

The aim of this chapter is to provide a comprehensive summary of the themes from the twenty-five interviews which were conducted for this research project. It is the intention of this chapter to lay out the findings of the interviews, to dissect their narratives and use thematic analysis to compare the various responses to each of the themes, before linking these findings back to a theoretical framework in Chapter Eight. At this junction it is appropriate to signpost the reader to the fact that I have employed the use of vignettes as a way of summarising the interview data for each of the four interview groups. These vignettes are contained in Chapter Six, and the reader may wish to review them prior to reviewing the interview findings, as they provide a useful overview.

As explained in Chapter Three, narrative analysis was used primarily to provide a system of managing the vast quantities of data from the interviews, by fitting the key points and textual findings from each interview into the template based on the Labovian model of narrative analysis (Porto and Belmonte, 2014). Two worked examples of these are included in Appendix A.9. A thematic review of each of the templates (based on the Labovian summary of the interview transcripts) was then undertaken to identify a series of major narrative themes, each of which has been synthesized into subheadings below. Whilst it is not possible to detail how every single element from the narrative analysis was employed in the construction and presentation of the interview findings, it is appropriate here, however, to recall that narrative analysis helps to work through the layers of a story (Bloomberg & Volpe, 2018), to draw out the textual findings. Narrative analysis also helps to consider how the individual portrays themselves within their own stories (Gilbert et al, 2014), as well as the type of language or their '*voice*' (Moen, 2006, pp. 60) and how they construct their stories (Denzin, 1989).

It is important to acknowledge the necessity to ensure that the interview data included in the text is balanced and representative, and that it is not dominated by a small number of interviewees. This is another way that the narrative analysis proformas were useful, as they enabled a review process, whereby looking over the abridged interview contents provided a useful cross reference, so that I was able to check that everyone's narrative had been included. However, to provide the reader with assurance that the data I have opted to present is measured, I have taken the additional step of highlighting several key quotes from each of the interviewees and including them in an additional table in the Appendix A.11. It is my intention that the reader will be able to review this table and acknowledge that the salient points from each of these interviewees has been absorbed into the data and vignettes.

The three major narrative themes are listed below, each had several sub-themes, which provides the structure for the main body of this chapter:

- The Influence of National Level Factors:
    - Agenda for Change
    - Recruitment
- Organisational Level Factors:
    - Flexible working and Childcare
    - Gender Stereotypes
    - NHS Culture and Discrimination
- Employee Level Factors:
    - Career Progression
    - Professional Development
    - Networking

It is useful at this point to reiterate the distinctions between the four interviewee groups and explain how they are identified in the text below. Three of the groups consisted solely of female interviewees, each group consists of five participants:

1. Women on the Nye Bevan Programme (all at senior manager level) – e.g., Allie, NBP
2. Women at Executive Director level – e.g., Lucy, Executive Director
3. Women at Senior Manager level (also includes directors who do not sit on Trust boards) – e.g., Isabella, Senior Manager
4. Men at senior manager and executive director level – e.g., Terry, Male Manager

5.1 The Influence of National Level Factors: Agenda for Change and Recruitment

5.1.1 Agenda for Change

One of the subjects that was discussed by all interviewees, without exception, was the Agenda for Change (AfC) pay scales. As examined at length in Chapter One, AfC was introduced by the NHS to provide equality in renumeration for roles across the UK and remove discrimination, by using a grading criterion to set salaries. The interviewees focused their attention on AfC under three distinct themes, the rigidity of AfC, the equitability it provides, and the ability to circumvent it.

Looking first at the rigidity, this was viewed as both a positive and a negative. People felt that the rigidity was misaligned with retention and the ability to reward performance, especially in terms of talent management. The positive aspect was that AfC should, and to a large extent does, provide equity over the hundreds of thousands of employees it covers. However, it does mean that employees wanting to increase their earnings must continually look for new roles, as they cannot be further financially compensated in their existing posts. This was commented on by two individuals (Deborah, Senior Manager and Ellie, NBP), who moved roles only to find their old positions had to be re-banded – that is to have the salary or AfC banding changed – to find a person as competent as them to fill the position, which had evolved and expanded under their watch. In terms of talent management, it means that individuals cannot be rewarded for their future potential (or the degree that they have developed since starting in the role). These highfliers (e.g., Isabelle, Senior Manager) then will move roles sooner – potentially too soon, both in terms of their personal development but also in terms of their ability to fulfil the merits of their role adequately – resulting in both losses for the employee and the organisation.

The equality of AfC was recognised by most of the interviewees as being a fundamental factor. It ensured that there was a rigorous process behind the grading of every single role. But this did carry with it some detrimental labelling of employees; often it was remarked that an individual was '*just a band 7' or 'just a band 5*' (Helen, Executive Director). The implication being that the person in question could not possibly have the competence or experience to conduct a given task. This labelling becomes dangerous; the participant narratives demonstrated that when people are branded as being at a certain level, it can suggest that the person does not have the potential to progress their career to the next level. One interviewee gave the example that being told that you are '*just a band 5'*, can affect confidence, prevent employees from gaining experience in more complex activities and drive home a system of regimented top-down autocracy.

The most controversial element concerning AfC, and probably the most controversial thread that ran through all the interviews in general, was the ability of management to circumvent the system. Interviewees talked of gaming the system, mainly by using their network to obtain job roles which had not been advertised, for which they were the preferred candidate. Gaming the system here refers to people working just within or sometimes just outside the constraints of the AfC system. For example, the advertising of all NHS roles, the strict grading criteria, and the insistence on a transparent recruitment process, are central tenants to ensuring the success of AfC. However, time and time again interviewees talked about how the process had been manipulated for them or by them, to ensure that they - or the person they wanted - got the job at the salary that *they* deemed appropriate by '*getting around the system'* (Isabella, Senior Manager).

One method of gaming would be to advertise the role, but in a manner where only limited people would see it or advertise it only for a limited time. Another instance of gaming would be to write the person specification, so it met the exact experience of the person you wished to appoint. This approach by managers at worst derails the entire purpose of AfC. The interviewees knew that to be the case and progressed anyway – this was not done with the rationale that AfC is ineffective, more that it is not perfect. Managers, rightly or wrongly, believed that the AfC system was correct most of the time, but in exceptional circumstances, i.e., in circumstances with talented individuals, it was OK to

find a back door to the system. Finally, one interviewee thought that AfC is not applied uniformly from one trust to the next, so a job banded at one trust was not equivalent to the same job '*at a trust just down the road*' (Mark, Male Manager).

The range of different roles in the NHS was noted by one interviewee, '*if you asked people to name ten jobs in the NHS, they'd probably struggle: yet there's about 120-130 different careers'* (Ted, Male Manager). Despite this huge range of opportunities, a key barrier preventing more external leaders joining the NHS is that most roles stipulate the need for NHS experience. This is a factor often added into job descriptions to enable them to conform to the AfC grading process. One interviewee had moved from working in the Local Authority sector to the NHS late in her career. When she was finally able to secure a role in healthcare she noted,

> '*it's not an easy thing…to join health at a senior point in one's life. I was 52, 53 when I came into this post in health; it was a vertical learning curve.*'
> Allie (NBP)

Because of this, the NHS acts as a *'closed shop'* (Ellie, NBP) when it should be more concerned about the '*ability* [of prospective employees] *to form relationships and interpersonal skills*' (Mark, Male Manager). This unduly impacts women as, when the preference is for experience over ability or skill (as we shall see below), it can be more difficult for women to obtain this depth of experience, if they have spent less time in the workplace.

It is appropriate here to reflect on the importance of AfC in relation to gender equality. As established in the introductory chapter, the framework provided by AfC was devised to provide parity – equal work in equal roles should be remunerated consistently across all NHS organisations. AfC should be a structure which prevents gender-based pay discrimination. So, if the system can be gamed, does this mean that it is not the failsafe against pay based discrimination? Overall, the sentiment of the interviewees was that AfC does help to safeguard against pay discrimination, whilst gaming exists it does so evenly for men and women.

5.1.2 Recruitment

It must be recognised that there are several stages to the recruitment process prior to interviewing for a role. I have already explored the role that AfC has in assigning the salary for a role by grading the job description (JD) and person specification. Once a JD has been assigned a salary, the job is advertised along with a person specification. The candidate will assess the role based on these documents and consider whether they a) would want the job and b) would be successfully appointed. If women do not think they will be successful in being appointed to a role, this will limit the likelihood of them applying and therefore limit the possibility of being promoted, a necessary step on route to breaking the glass ceiling.

Five interviewees referred to the study by McKinsey for Hewlett-Packard, which claimed that men will apply for a job when they meet only 60% of the job description, whereas women will tend to apply only if they meet 90% of the job description (Desvaux et al, 2008, pp. 4). Whilst each of the five people were vague about the exact details of the study, the notable factor is that they were aware of the central argument of the research. They agreed with it as being personally true for them, whether they were male (and stated they would apply for a job without meeting all the requirements) or female (and stated they would need to meet most, if not all, of the requirements).

One interviewee (Isabella, Senior Manager) who agreed with the study, said she would need to meet all the requirements of a role but had witnessed her husband speculatively apply for many jobs for which he was not fully qualified (in relation to the JD) and had often been successfully appointed. Another female interviewee (Zara, NPB) stated that men will apply for roles, knowing that they are not fully suited, but will be so convincing or charismatic at interview that they will secure the role. One person described this situation, '*men will tick six out of ten* [on the JD] *and go ahead to interview, sparkle, and get the job*', to address this '*women need to work on their imposter syndrome*' (Sandra, Executive Director). This highlights the importance of encouraging women to apply for positions, even if they are concerned about meeting all the requirements of the role. Similarly, as an HR director, Sue (Executive Director), had noticed that men are better at negotiating pay, she also felt that women are more likely to accept if a man is appointed in front of them. Despite this, one female manager (Sam, Senior Manager)

had tried to negotiate a salary increase after being offered a job, only for the offer to be revoked purely because she had attempted to negotiate. This raises the question of whether the issue is women being afraid to negotiate or if employers are resistant to the idea of women negotiating?

There were two themes concerning discrimination, firstly the role of discrimination during recruitment and secondly the treatment of those from minority backgrounds throughout the NHS. Discrimination is governed by legislation set by the European Union. Due to the legal framework surrounding discrimination, on grounds of gender, race or age, there was a feeling that discrimination is rarely overt. This could be because the recruiting managers are concerned about the legal ramifications or are not conscious of the views they hold,

> *'I've not seen an interview where I've thought a better candidate didn't get appointed, and was actively discriminated against, but subconsciously it's happening, it's absolutely happening otherwise there would be at least more representation.'*
> Terry (Male Manager)

One interviewee felt she has seen people passed over for promotions because their '*face didn't fit*' (Sandra, Executive Director). Others felt that NHS managers need training for recruitment to help them become aware of their ingrained biases, and that NHS policies are in place but do not stop subconscious biases, so the effect is minimized.

> *'Despite whatever the actual legislation and whatever the actual policies say, you can't help it it's human nature - you form a view in the first few seconds of meeting them.'*
> Tony (Male Manager)

Two female interviewees (Sue, Executive Director and Allie, NBP) recognised the gender imbalance at senior management level and insisted that more women are needed on boards for the organisation to be able to relate to its customer base. Like many of those interviewed, Terry (Male Manager) was aware that approximately three quarters of the

workforce is female but noted that this is misleading due to the high proportion of female nurses. With reference to board level positions, he thought '*we are battling with history*', because men had always tended to '*recruit in their own image*' (Terry, Male Manager). This is important when the causes of the glass ceiling are considered; it is relevant to the origins of the old boys' network. They are perpetuated because of the homophily effect of likeminded people from the same background supporting each other on a mutual basis. All the male managers referred to the fact that being a white male gave them the advantage when it came to gaining promotions. A common reflection was that '*the system is set up for me to succeed*' (Jed, Male Manager). The female interviewees agreed that it was easier for white males to work through the management hierarchy, given that it is dominated by other white males, meaning their appointment is '*less challenging to the status quo*' (Allie, NBP).

One interviewee was keen to note that whilst NHS recruitment is not perfect, it compared favourably with their experience working for a Local Authority,

> *'So often it's about reputation and particularly at the more senior end – it quickly becomes less about the nuts and bolts about what you've done and what experience you have. Its whether or not you will be considered favourably by those appointing.'*
> Allie (NBP)

In summary, this section has pinpointed the most significant national level factors which influence gender parity. AfC, which should be a key tool in delivering gender equality is not a panacea, but since its implementation it has had a reportedly positive impact. When AfC is '*gamed*' or circumvented, it is only for a small number of posts and does not necessarily mean that the entire AfC programme is ineffective. AfC still helps with gender equality by setting the salary prior to advertisement to help provide pay parity. It also provides a candidate evaluation system that assesses the applicant without their gender being known to the recruiting manager. The interviews showed, however, the problem comes with encouraging women to apply for roles. The awareness of the AfC evaluation process means that the interviewees knew they must meet the requirements of the Job Description to apply for a position. Despite this, men apply for roles when they do not

meet all the requirements (and are sometimes successful), whereas women are much more reticent. This represents a problem with the AfC process, whilst not overt, it unfairly rewards more typically male behaviour.

5.2 Organisational Level Factors

5.2.1 Flexible Working and Childcare

Showing some similarities to the subject of AfC, a common thread through nearly all interviews (seventeen out of twenty) was the practical implications of flexible working policies at an organisational level. The themes which emerged clearly from the data included the consensus that flexibility existed to varying degrees, but that flexibility was not possible at board level. As stated by Helen (Executive Director), '*I do think it is difficult to do as a job share at a very senior level* [due to] *the accountability*.' The importance of flexible working must be regarded as a paramount feature in enabling women to reach board level positions. Some of the reasons for that are not immediately apparent but can be clearly construed. Women, in general, are still the primary care givers both for children but also dependant adults (such as elderly parents). Maintaining a career and being a carer is a difficult balancing act logistically, as well as being draining mentally and physically. However, it becomes near impossible if women are not able to access suitable flexible working patterns.

There was wide recognition that the NHS has a prolific amount of organisational level policies to assist working mothers and those with carer responsibilities. Regardless of these policies, one woman felt, the '*expectation of coming early and staying late was huge, regardless to the fact that it was known I had a small child*' (Zara, NBP). This opens another aspect. Almost diametrically opposed to the concept of flexible working is the concept of presenteeism. Within the NHS there appears to be a focus on being in the workplace for as many hours as possible. This is opposed to flexible working, because with flexible working, employees are attempting to use their contracted hours as wisely as possible. Presenteeism sees employees working informally above their contracted hours, for no additional pay. A male manager even went as far as to say, '*there's a sense that unless you are in the hospital for twelve or fourteen hours a day, you're not really pulling your weight*' (Jed, Male Manager). One interviewee was about to move into a Chief Operating Officer role and said whilst she had been '*happy*' to work 13-hour days,

she cannot do so anymore as a single mother (Sally, Senior Manager). If presenteeism is valued more highly than other methods of assessing a manager's performance, then there is little chance that someone working 37.5 hours (or less) will be regarded as highly as an employee putting in 50- or 60-hour weeks. Because of this, one male manager (Terry) felt that the NHS still had much more to do on flexibility and needed to focus much less on presenteeism as a measure of being good at your job.

Two of the narratives provided by female leaders (Deborah and Sam, Senior Managers) who had young children, noted that their priorities had changed after giving birth. They wanted to spend more time with their families, and because of this accepted there were roles they could not apply for due to the time commitments. This resulted in these two interviewees (Deborah and Sam, Senior Managers) not seeking board level positions.

> *'I'm not as ambitious as I was, and I think a lot of that has come down to the fact that your priorities do change when you have kids.'*
> Deborah (Senior Manager)

In operational management, there is a need to have a lot of urgent care experience, which, due to the long hours, '*is not conducive to family life*' (Sam, Senior Manager). Another female senior manager had moved to interim roles (short-term contractual positions) since having children, which offered greater flexibility and higher remuneration. But she did note that interim roles made it harder to gain promotions. The male managers acknowledged the challenge for working mothers, as '*basically working 24/7 really, that is a challenge for anyone*' (Mark, Male Manager). Having worked for both acute providers and in commissioning organisations, one female executive found a work life balance much harder to achieve when she moved to an acute provider role. She was still happier to work harder in a hospital because she preferred the work. She admitted that while it '*sounds awful to commissioning people, those working in hospitals work longer hours*' (Barbara, Executive Director).

Two interviewees readily acknowledged that the reason they had initially chosen the NHS was because at the time, as young mothers, the NHS offered paid employment, the chance of development, but most importantly the flexibility needed to raise children.

However, once they started to move into more senior roles, the flexibility was insufficient to balance both work and family. For example, one interviewee (Helen, Senior Manager) found it necessary to go part-time after the birth of her second child, due to the impossibility of continuing to do her role full-time. Whilst working part-time she took on additional responsibilities, such as being a school governor and doing some consultancy work, to make sure her professional development would not stagnate. Similarly, Fiona (NBP) was emphatic that the only reason she joined the NHS was because of the flexibility it afforded her with a young family. She had heard that the NHS was very accommodating and had quit her role in the finance sector before having children. What Fiona (NBP) found especially beneficial was that as her children got older, she was gradually able to increase her hours to match. This ability to amend working patterns to fit around family life was a big pull for several interviewees, who noted that whilst public sector employment, such as the NHS, was not the most well remunerated, there are other factors that make up for this. Here Fiona's views were representative of many of the interviewees:

> *'I think staff that have only ever worked for the NHS take a lot of stuff for granted – it really is a caring supportive employer…the way it treats its staff, the way it comes out with terms and conditions and agenda for change, it is an extremely generous employer – your salary might not be huge but the benefits in kind are massive.'*
> Fiona (NBP)

With direct reference to gender discrimination, a representative comment was put forward around the importance of flexibility, '*I don't think we have created cultures where women with children can continue their careers at the rate that men can*' (Helen, Senior Manager). Others felt the premise of flexible working reinforced outdated norms that the burden of childcare should always fall on one parent (nominally the woman), and that there was a need to have policies that allowed both parents to have a joint plan for childcare arrangements. One female interviewee reasoned childcare policies are not fit for purpose as they do not consider the needs of the individual; policies are too general to be of practical use. Furthermore, working practices make it hard for those with

children; as one observer noted, a lot of people put meetings in the diary for 08:00, which does not work for people who must do the school run.

Flexibility was not always completely valued by all the interviewees. Six interviewees noted that when staff members make requests for flexible working there is a need to be realistic about how it can be delivered, with a perception amongst some that working at home is less productive. This was a view held even by the most senior leaders. One person described how her CEO had instructed her, when referring to a woman returning from maternity leave, to not '*make any stupid flexible working arrangements with them*' (Sandra, Executive Manager). It was felt that good employees would not '*take the micky*' (Sandra, Executive Manager) if they work flexibly, indicating that flexible working does have a place, but there needs to be trust between the employee and manager.

An often-discussed point was that flexible working does not provide parity. Those on shift work could be disadvantaged by a colleague already taking the more favourable shifts because they had additional carer responsibilities; or a manager might block flexible working in their area because they did not think it was aligned to the business needs of the department. More touching examples were provided, whereby employees had banded together to provide cover for a member of the team with complex home life arrangements. This was cited as a prime example of the NHS culture, which exposed the caring and altruistic nature of people who opt to work in healthcare. A further benefit of flexible working was that it enabled staff to be mentally present in the workplace and not concerned about external factors. One manager surmised, '*I don't want people who are here when their mind is on something else*' (Allie, NBP).

Some felt that it was not always possible to offer complete flexibility for staff because the NHS is '*very rule, process and policy bound*' (Sue, Executive Director). This means that it is often impossible to meet the needs of the individual, because policies must be applied consistently. For example, if one person is granted flexible working and another – with similar circumstances – is not, the trade unions will pick up on this discrepancy, so it can be easier to block both requests. The feeling that the NHS approach to flexible working policies is outdated, led one interviewee to refer to the NHS as '*a dinosaur*' (Fiona, NBP). As the NHS increasingly becomes more concerned with 24/7 services, it

needs to be explored if the NHS is creating policies which benefit people who want to work more flexibly. Nurses have long been able to work flexibly and in the last ten years have benefited from the introduction of e-Rostering (an electronic, online shift scheduling tool), to accommodate the needs of their personal circumstances. However, interviewees noted that e-Rostering has made it harder for some people with carer responsibilities. For example, some people are '*gaming the system*' (Sue, Executive Director) by remaining on flexible shifts from several years ago, even when their children have grown up, which disadvantages others.

In terms of the interviewees' own ability to work flexibly (as opposed to the teams they manage), one Female Director felt they could occasionally make this work for one off events, such as their children's school Christmas plays. However, more substantial use of flexible working was uncommon, resulting in one male manager (Jed) giving up his director role in a large teaching hospital to make a sideways move into a role that allowed him to work from home several days a week. Women returning from maternity leave had been successful in applying for flexible working but ended up being paid for reduced hours, in practice doing the same work for less money. This practice of working reduced hours but doing the same amount had led to '*resentment…* [when people] *do a full-time job in four days only get 80% of the salary*' (Deborah, Senior Manager).

Eleven of the interviewees, whilst promoting the necessity and ability of the NHS to provide flexible working for the rest of the organisation, stated emphatically that it was not possible for them personally to utilise it. There were several reasons for this, such as the need to '*lead by example*' (Sally, Senior Manager). The most frequently cited explanation was the need for operational managers to be onsite and in charge throughout the workweek (and often beyond). One interviewee went as far as to suggest that flexible working does not apply to senior managers, and if a person wants to have flexible working, they should not even apply for the job in the first place, '*there are unwritten things…If you want flexible working well then don't put yourself forward for a senior role*' (Barbara, Executive Director).

On a more procedural level, three interviewees stated that flexible working and job sharing is not possible at a director level due to the legal accountability that comes with

the position. The regulatory responsibilities of directors mean that they have a duty of care, which they would not be able to honour if the manager is regularly off-site. Interestingly, one female manager (Fiona, NBP) felt that senior leaders can pay for more childcare, which should allow them to focus on their careers. Mark (Male Manager) was against job sharing for operational roles on grounds of pure practicality, given the difficulty in splitting operational activities between multiple people. Other interviewees also did not think that job sharing works for executive roles, but part-time could. For example, some noted that the Medical Director is a part-time role, and wondered why couldn't the Directors of Nursing or Strategy be?

An interesting juxtaposition in the way that male and female leaders approach gender related issues was provided by the narratives of two of the interviewees. Whilst their circumstances were almost identical, both Deborah (Senior Manager) and Mark (Male Manager) had very divergent paradigms that they had constructed to justify their separate approaches concerning childcare and flexible working. Deborah (Senior Manager) described that after the birth of her children her career took a back seat, despite being the higher wage earner in her relationship. Her husband was a trainee surgeon, and their shared view was that, whilst he earned less then, he would be the higher wage earner in the future. Ultimately it was Deborah's career that was sacrificed in the short-term, '*I have made concessions…for our children now*' (Deborah, Senior Manager). This was compounded by the fact that her husband, as a surgeon, could not work flexibly, because his clinical sessions were set for him. However, Deborah's husband's main consideration was that he would be looked down upon by his peers if he – as a male surgeon – left early to collect the kids. Mark's story offers a counterpoint, as his wife was acknowledged as the main carer, even though she held down a role as a successful consultant in the same hospital where he worked. His argument was that, as a doctor, she had more control over her clinical sessions than he did, as Chief Operating Officer, over his meeting schedules and demands of the hospital.

From the male interviewees' perspective, they noted their wives understanding of their long working hours. Three of the male interviewees acknowledge that their careers had progressed due to their wives' commitment to childcare, and that they would not have been able to devote as much time and mental energy to their jobs otherwise. For

example, Terry's first child had just arrived, coinciding with his first director role. Whilst he was looking for flexible working to spend more time at home, his wife – who had a leadership role in education – was covering the brunt of the carer commitments for the foreseeable future.

Such were the demands on senior NHS managers, one interviewee noted her biggest challenge was having a successful career whilst being present as a mother. Despite the options for flexibility in the NHS, often women with young families could only fulfil their work obligations if they had a strong support network. This occasionally was provided by the husband, who had the flexibility to work from home or because he had a more junior or less demanding role. One female manager felt *'really lucky*' that her husband could do the school run, because he was '*not in a senior position*' (Ellie, NBP). Another female manager acknowledged the importance of her husband's ability to work from home in addition to having '*a tube stop with a nursery close by, with wrap around care*' (Sandra, Executive Director).

The issue of childcare was often accompanied by the comment that many hospitals lack creche facilities. One interviewee recalled an instance where they were recruiting to an Accident & Emergency consultant post, a role in the NHS which is notoriously difficult to recruit to. The deciding factor for the candidate to join their trust was that they had an onsite creche. Another interviewee referred to the fact that previous NHS national guidance had instructed all hospitals to have onsite creches, but this had seemed to mysteriously disappear over the past few years. Other factors which support working mothers include having a supportive line manager. Deborah (Senior Manager) added that having a manager who has family commitments is especially helpful as they understand the challenges which parents face.

Summary of Flexible working and Childcare

It has been evidenced, above, that NHS employees place a high value on presenteeism for two reasons. Firstly, as an operational manager it is important to be onsite to ensure the smooth running of a complex hospital system. Secondly, being present is seen as a badge of honour amongst NHS managers, and there is still a feeling that those who work the longest hours are the most dedicated. Next, due to accountability, it would be difficult

to split a director position into a part-time role. Presenteeism and accountability taken together would imply that it does not matter how positive the rhetoric is around remote working or how robust an organisation's flexible working policy is, those with carer responsibilities (which are mainly women) are going to be at a disadvantage.

With respect to flexible working, it has been shown that flexible working policies do exist, but there is a perception that they are based on outdated norms and not fit for the modern world. They are often predicated on the assumption that women will be the lead carer and are not adaptable, so parents are unable to split childcare responsibilities. Flexible working is viewed as being possible for lower-level employees, but there is scepticism as to whether working from home can be as productive as being onsite. As noted, the culture of presenteeism in the NHS is diametrically opposed to the premise of flexible working. Additionally, senior managers felt the accountability their roles demanded meant they were unable to be away from the hospital building during the working day.

5.2.2 Gender Stereotypes

In this section stereotypical gender behavioural traits and inter-gender relationships are reflected upon. It explores the ramifications of gender stereotyping and the damage this can do to the credentials of people of either gender, should they not align with the expected behaviours of a leader. The difference between the behaviours of men and women in the workplace polarised the interviewees. Approximately two-thirds (twelve out of twenty) of the interviewees felt there was no difference between how men interact with each other compared to how women interact and support each other. Some of the two-thirds category seemed surprised at the question and gave it very little thought before affirming there were no differences. The remaining one-third came up with a litany of stereotypical language and behaviours that they had observed, such as that women are '*warmer*' to each other in the workplace, whilst men tend to engage in physical '*back slapping*' (Allie, NBP). Even when working in female dominated areas, men's ability to be more stereotypically male, played to their advantage. For example, it was felt that male nurses were able to progress more quickly in their careers because '*they were charming and were funny*' (Zara, NPB). One female leader felt the NHS had become a '*parody*' of itself, with men sitting as the decision makers, whilst the women were very

much the '*doers*', and that female presence in the leadership team was merely '*tokenistic*' (Fiona, NBP).

With respect to female management styles, five female interviewees presented cases when other women had been unduly overbearing or unhelpful. One example concerned several of the female Chief Operating Officers (COO) that a Senior Manager had worked with, '*I think that women COOs tend to be very bitchy and make bitchy comments in open meetings to other women more than men do*' (Isabelle, Senior Manager). There was a counter argument to this; it was viewed that women working in operational management must have a harder side to them, as they are making important decisions and these decisions need to be executed with precision, which has led to a more direct leadership approach. But this can lead to other undesirable traits where female leaders adopt '*a heroic style of management: here comes X to save the day*' (Lucy, Executive Director), which made female leaders seem more masculine in style. Alternatively, it can manifest as a '*foot stomping style*' (Lucy, Executive Director), which again seems to be stereotypically male. Two other female interviewees echoed this thinking. In the past, successful women are more likely to have had male traits, which were effective due to the previously autocratic nature of the NHS. Five of the women interviewed noted difficulty working with other female leaders, as '*women do not always champion each other's journeys'*, but this was in part attributable to these women being '*products of their experiences*' (Sam, Executive Director). Which is to say, some women have risen through the ranks by mimicking stereotypically male behaviour and by being domineering, but this was necessary for their own survival.

Not all female leaders were judged as having these negative traits. Many women commented on the positive female leaders and role models they had come across. It was felt that male leaders could be overbearing and too direct, with women better suited to collaborative leadership,

> *'because there is less ego involved with women and we are more used to talking. Because all system leadership is about making relationships and talking, and women inherently have those skills.'*
> Fiona (NBP)

The good female leaders tended to be, '*people who were accessible, open and supportive of the development of others*' (Allie, NBP). More positively, it was observed that as the culture of the NHS changes, the required type of leadership is moving to one more suited to female leaders,

> *'When I started* [in the NHS] *14 years ago, in my eyes the manager was someone that had to be horrible, did not show any emotion, didn't smile…not a nice person. I think over the years, those types of people still exist, but in senior management people are starting to become more authentic so you can see more of their personality.'*
> Barbara (Executive Director)

From the men's perspective, one male manager believed that often there is more friction when women work with other women, than if two men were to work together. One man's view of female senior managers was that, sometimes women '*try and emulate stereotypically masculine ways*' (Terry, Male Manager). This extended to other areas, concerning recruitment; it was felt that women sometimes take part in '*not very pleasant competition*' (Terry, Male Manager) against each other when applying for promotions. Again, reflecting views on female managers, the male interviewees felt future leaders need emotional intelligence, which women are more likely to have. Furthermore, it was stated that requirements for future board members will be about '*how you build partnerships with people from other organisations, how you build better self-awareness…more empathetic*' (Terry, Male Manager), all of which were felt to be more suited to the female style of management.

In general, there was a prevailing view in the interviews that historically the predominant style has been masculine, finance focused and lacking in compassion, a reflective comment was,

> *'with females…the patient often comes more into the heart of what we are talking about. …in the generation I've grown up in, it's very macho and we will talk about*

the money, and we never talked about patients, we never talked about staff – it was all about activity and money.'
Helen (Executive Director)

Secondly, because of this historic hangover, many women have assimilated to this masculine style of leadership to survive. However, the consensus is that the NHS needs to change and is doing so. There is recognition that the NHS of the future needs to be more focused on '*compassionate, inclusive, system leadership*' (Sue, Executive Director) and these changes will signal a brighter future for female leadership.

5.2.3 NHS Culture and Discrimination

Above, discrimination was considered in relation to the recruitment process and national level factors and policy to combat it. Next, the culture within the NHS is explored in terms of how discrimination has affected other areas of the organisation, such as leadership. Following this, I explore more indirect aspects of gender discrimination, such as being a single mother, and the interplay of being young and female. In addition, I also highlight discrimination faced by some of the male interviewee participants.

One female senior manager (Isabelle) spoke about discrimination she had witnessed. When she had been part of an interview panel, one panel member did not want to appoint a female candidate, as the candidate might want to have children soon. In a similar situation, another female senior manager recalled comments from a female Chief Operating Officer in relation to her family, '*you need to get a nanny so you can focus on your job*' (Deborah, Senior Manager). The individual did not infer this as a negative comment, it was meant as genuine career advice – this does not stop it revealing the belief that women with young families are not able to hold senior roles unless they can source outside support.

One female executive, Helen, had faced discrimination whilst working in the NHS. She commented, '*I have experienced loads of sexism throughout my career. It is hidden, it is not transparent'* (Helen, Executive Director). Helen went on to explain in detail the various levels of sexism she had faced. Whilst an inpatient during the birth of her daughter, the nurses on the ward treated her badly because she was a single mother.

Secondly, when Helen was a nurse on the wards it was very hierarchical, with the level above bullying the level below. Helen then suffered discrimination whilst working as a health visitor for being younger than her peers, in what she described as '*a real load of bitchiness*' (Helen, Executive Director). Later again in her career, her boss bullied her for several years.

> *'My first experience of truly being bullied, really manipulative, powerful guy – if I wasn't at my desk at 7:00 in the morning was phoning me and saying, where are you?'*
> Helen (Executive Director)

Other female interviewees had similar experiences to those of Helen. One female manager had faced direct sexist comments made by a very senior board member, who, for example, asked her to make him tea in the middle of board meetings, even though there were people in the room whose role it was to make the tea. An Executive Director (Lucy) described how she had been a victim of sexist comments from both men and women. In one instance a female director asked her '*are you on your period*', because she did not think Lucy was in a good mood. On another occasion a male CEO made a remark about all female networking groups, '*the CEO jokes about it, but I think he means it. He is not a big fan of women only events...maybe he doesn't understand the unconscious bias that women face*' (Lucy, Executive Director).

Lucy (Executive Director) was an interesting case in other respects; she had previously completed the Nye Bevan Programme but was not in the Nye Bevan cohort of interviewees. The main issue she highlighted throughout her interview was the discrimination she had faced due to her age. For example, on the Nye Bevan Programme Lucy was fifteen years younger than the second youngest person. Perhaps because of this, the rest of the group had decided she did not have enough real-world experience to progress her career. Two other female interviewees stated that whilst they had not faced gendered discrimination, they had received an array of negative comments concerning their age. One highlighted that these age-related comments tended to come from women,

'*I think when you are young and a high-flyer…people think that you should have earned your stripes…I get a lot of that from females rather than males.*'
Sally (Senior Manager)

When the interviewees were pressed as to whether they would have felt if they would have received the same level of criticism concerning their age if they had been young and male, they all reported that they did not. Conversely, a male manager felt that being younger had worked to his advantage. He had previously been offered a promotion because his line managers had viewed him as '*coachable*' (Jed, Male Manager). A male manager offered another layer of discrimination he had faced; he was from a northern working-class background and had been discriminated against when going for a role, for being too working class, or '*too local*' (Ted, Male Manager). This male interviewee noted that as he was an older white male working in the NHS, he had started to feel like a '*pariah*' (Ted, Male Manager). He observed that due to the increasingly diverse culture in the NHS, he perceived that there was almost a movement against white males.

I have noted in previous chapters that it is not within the scope of this research to incorporate the impact of racial discrimination. However, feedback from the interviews means that it is important to discuss racial discrimination for two distinct reasons. Firstly, there was feedback from the only BAME representative, that women from BAME backgrounds suffer the double burden of discrimination, which stems from being female and being from an ethnic minority. Secondly, the existence of prejudice against people from ethnic minorities indicates the possibility of other forms of discrimination occurring. The consensus amongst the interviewees was that discrimination existed but the main examples given were those of racial discrimination.

Regarding wider NHS discrimination, it was felt that low BAME representation is of much greater concern than other forms of discrimination. The consensus was that racial discrimination was not deliberate, but that '*the numbers speak for themselves*' (Terry, Male Manager), meaning it happens, whether consciously or not. The single manager from a BAME background stated that she had never faced overt discrimination because of her race. However, she reported it being something which gave her an extra reason to prove herself. In her own words,

'I've been quite lucky because my insecurities have been ruled by myself; the things I've really struggled with are speaking up and doubting whether my ideas or viewpoint is credible – I only want to speak if I've got something valid to say.'
Barbara (Executive Director)

Barbara (Executive Director) did report that her family background and their cultural expectations made the fact she was a working mother more pronounced. This was because of the pressure she received from her husband and mother-in-law to live up to the image of an attentive Muslim housewife. To note, information relating to religion was not collected through the pre-interview questionnaire and none of the other participants mentioned religion, meaning there was less opportunity to compare feedback from other interviewees on religion.

The role of Barbara's (Executive Director) husband was particularly insightful - her husband worked from home several days a week and her mother-in-law helped with the children. However, being from an ethnic background where it is common for women to contribute the most around the house, her absence from wider family events, her career and her long working hours had become a point of contention for her husband and the family.

'Being BAME, being a woman, those two things mean that you should be available for your family. You are the homemaker. During the time that I have been in this job my husband is now a lot more domesticated than he used to be. In our community these are not the expectations of the man.'
Barbara (Executive Director)

However, Barbara was keen to point out that after a period of adaptation her husband, despite still feeling '*hard done to*', had taken on a lot of the household responsibilities, albeit with assistance from his mother.

The managers highlighted the sensitivity and difficulty in helping address discrimination from their own experiences. One Male Manager (Ted) had recently discovered that the

Aspiring Chief Nurse Programme wanted people from underrepresented backgrounds and approached his Director of Nursing (DoN). The DoN would not apply because she stated, '*if I'm going to get a chief nurse post, I'm going to do it without anyone else's help*' (taken from the interview with Ted, Male Manager). Ted thought that people from underrepresented backgrounds need to realise that sometimes it is OK to accept help.

The importance of having a leadership team within the NHS, which is diverse and representative of its patient population, was acknowledge by the interviewees, and that this went beyond just gender or race. Allie (NBP) raised the significant point as to why gender is so important for the NHS, due to the increasing need to recognise and accommodate individuals beyond the strict male-female divide. An increasing number of patients, as well as employees, identify themselves as transgender (Meerwije & Sevelius, 2017). Because of this, the NHS needs to be prepared to provide for them as patients as well as an employer. It was highlighted that there are many other issues which people do not discuss because they are still seen as taboo, but are still vital issues in combating inequality, such as the need to '*help women manage the menopause at work*' (Sandra, Executive Director).

Finally, whilst there was recognition of the need for greater equality, there was scepticism about past and current initiatives. So ingrained in the culture of the NHS and society in general, the interviewees were dubious about the impact of current anti-discrimination programmes,

> '*I think the agenda around gender equality and transparency – there is a huge amount of work going on in this area, but I think there is a danger that it just becomes tokenistic.'*
> Jed (Male Manager)

One highly relevant issue in terms of equality has been the deference to the medical profession since the start of the NHS. Doctors are trained to be the decision makers and have overarching responsibility for patient care. This can often lead to them being forceful in the approach of their leadership style, to the point they are beyond reproach. Nurses are often reluctant to question the decisions of their medical colleagues. It is

common to refer to doctors as having a god complex, because they save people's lives daily, but also because they have a reputation for having egos to match their skill set.

> *'We have a load of work to do in the NHS, particularly in my organisation, getting everyone thinking that they are equal. It doesn't matter what your role or position in the hierarchy is your opinion matters... And if we don't have an organisation where people feel like they can talk freely and give their view, as a nurse or as a female, something is wrong. I think that is years of just how the NHS has evolved. I think it goes back to how doctors are trained. For years – and this sounds awful – but their egos are massaged – they are the oracle, but actually, get yourself down to a busy ward, it is the nurses that run the show.'*
> Anita (NBP)

When the role of the medical profession is considered in a wider context, it is possible to understand how this links to gender equality. Considering the quote above from Anita, it highlights that the power and decision-making lies, typically, with the doctors. As shown in the data from Chapter Five, most medical leaders are male. Doctors are a group which the nursing staff (who are the largest staffing group and predominately female) have been culturally trained not to challenge. It was suggested that the new generation of NHS managers come with fewer ingrained biases than their older colleagues, which could be promising for the future of the NHS, '*I think the younger generation probably doesn't come with the same gender and society biases*' (Fiona, NBP).

Through this section the various organisational level factors which can influence female career progression have been examined. The interviewees were all aware that the burden of childcare responsibilities generally falls unfairly on women. The male leaders excused this because they felt that they earnt more or that their schedules were less flexible. The female leaders were, overall, accepting of this and were happy to be the main carer, even if it impacted their careers. Both men and women did agree that to improve gender balance in board level positions, greater flexible working was required. The problem with flexible working, if it can be achieved, is that women are still disadvantaged due to the ingrained culture in the NHS of presenteeism and the need for operational experience. This is because women are unable to gain the same experience

or gain the same recognition for their work, if they are not in the hospital for the same amount of time as their male counterparts.

The next trend evident in this section concerned gender stereotypes; typically, more masculine styles of leadership have been successful in the NHS, and some women adopted this style to succeed. However, there was consensus that the NHS is moving towards a more compassionate and engaging approach to leadership, and this will benefit future female leaders. With respect to the general theme of discrimination, the interviewees acknowledge the need and benefits from having more balanced representation. There was also acceptance that the NHS does not have equality, not only in terms of gender, but also race, age and class. There was evidence of programmes to combat these inequalities, but they were felt to lack impact.

5.3 Employee Level Factors: Career Progression, Professional Development and Networking

5.3.1 Career Progression

For women to progress to the boardroom they must first work their way up through the management hierarchy. To understand how this can be achieved, I will now explore career progression and barriers facing women; then I will consider some of the opportunities to overcome these barriers. The main barriers seen from the interview data are the vast jump from manager to director level, the need for geographical mobility to seek promotions (which works against women with carer responsibilities) and how being young *and* female can alter people's perception about a person's readiness to progress.

In terms of opportunities, the distinction between career progression and professional development must be understood. Career progression is the physical process of securing senior appointments. Whereas professional development is learning and enhancing new and existing skills – this is not always done specifically to chase promotions, but it is a significant requirement for those seeking to advance their career. The literature has provided arguments that having a robust career plan assists with career progression. Similarly, it can be a potential barrier if many women do not join the NHS looking for a career in leadership, as they will not look to progress their careers at the same pace.

A representative view from four female interviewees, was that they joined the NHS because it was a '*very flexible and supportive employer*' (Fiona, NBP), which was important to those with young families. Those joining the NHS for this reason therefore did so with '*no career aspirations*' (Fiona, NBP). As such, the typical theme of career progression of many of the women interviewed was that movement through the NHS was steady, one promotion at a time. Often the female interviewees had to be pushed and supported by their immediate line manager to go for the next role.

The next issue is the limited opportunities for promotion within the same organisation. It was mentioned by three female interviewees that they had been advised to move roles frequently to further their careers. One female Manager (Isabelle) was representative of other women who had achieved rapid promotions, in the sense that she had moved roles regularly to progress her career. She reported that she tended to move role approximately every two years, because '*it's a piece of advice I was given – take one year to learn it and one to do it well*' (Isabelle, Senior Manager). This advice originates from the observation that NHS managers tend to stay in post for a long time, meaning that, unless an individual is prepared to move organisation, promotions only occur when stepping into '*dead man's shoes*' (Lucy, Executive Director). Which is to say, opportunities often only arise when someone retires or is given a promotion. The need to move organisation to gain a promotion, can involve a longer commute or even relocating. This is pertinent to those with carer responsibilities; for example, if they have children to drop at school each day then it is not possible to commute far. An example from the interview data was a mother who was only able to relocate once her children went to university. Such is the limit on opportunities for those not able to relocate that there were two examples of women rushing back from maternity leave to take up promotions, which they feared they would otherwise miss. Sally (Senior Manager) gave a first-hand example of a similar situation; she returned from maternity leave early. This was a decision she soon came to regret; in retrospect she wishes she had taken more time to be with her child.

A major barrier to career progression identified by interviewees was the gap between roles. For example, it was felt that it is a huge jump from deputy to director level and it is difficult for people to gain the right experience to bridge this gap. This issue with the

leadership pipeline has been exacerbated by the move in the NHS to remove tiers of middle management, creating '*an increasing gap between functioning at the exec level*' (Allie, NBP). Additionally, the consensus amongst the female interviewees was that they did not believe in promoting women without due process (in relation to AfC); it needs to be on merit. Women need to feel that they have earned their roles to ensure there is no recourse from others who have missed out on the same promotion. Therefore, there needs to be a way for women to gain sufficient experience to warrant promotions. One solution suggested was to work in a small trust at director level first before moving to a larger organisation; but again, this is not possible for those who do not have the same geographical mobility. Sue's (Executive Director) experience of the private sector was that it is better at moving people and giving them different experiences. In the NHS (under AfC) everything is advertised, so it is not possible to just move people.

To address the issue of the pipeline of future directors, one HR Director (Sue, Executive Director) was engaged in a project to identify upcoming leaders through a regional talent board. It works by reviewing all senior managers in the region and dividing them into three pools; the split consists of a third who are ready for director roles now; one third who will be ready soon (12-18 months); and the remaining third who are further away and need more development. This talent pool does not guarantee a role in the future but allows for the individuals to be automatically shortlisted.

Many of the interviewees had been with the NHS for over 10 years (18 out of 20). During this time, the interviewees had noticed the encroaching hand of regulation, which concerns even the most junior staff, who are worried about budget cuts and Care Quality Commission [the healthcare regulatory body] inspections. This had in turn led to too much bureaucracy. One common observation was that due to pressure from regulators, the autonomy of organisations has seeped away. This has led to people not wanting to take director roles, because '*they just don't want the stress*' (Ted, Male Manager). This barrier was observed by one interviewee (Sue, Executive Director), who recognised that within the current pipeline of future executive directors, deputies – particularly those with young families – did not want to take the next step to director because of the pressure and accountability. Instead, their preference was to dedicate their time to their families.

These interviewees did not say that it was not possible for managers to have both a career and a family, more that it was necessary to prioritise one over the other.

One female Senior Manager (Lyndsey) worked in the digital data field, which was particularly interesting as it is one of very few areas of the NHS dominated by men. She reported that, because she is not constantly looking for her next promotion, she felt a sense of '*guilt*.' This is because she is a leader in a male dominated field and not constantly spearheading female progression. Her preference is to create '*interesting*' roles for herself and feels that she is *'classically female*' (Lyndsey, Senior Manager) in that she must be pushed to apply for new roles. Lyndsey realises there are too many white middle-aged men in her field, but the culture is shifting; she is seeing more women enter the area. In the past she witnessed male peers being promoted rather than her and it was not until it was raised with her line managers' superior that things changed. On a day-to-day basis she notices men taking credit for her work. Previously, she had observed that her male line manager tended to listen more closely to male colleagues in meetings. When she raised this with her other colleagues, the excuse given was he was '*awkward*' (Lyndsey, Senior Manager) around women.

5.3.2 Professional Development

I explore in this section the professional development available in the NHS and look to tie it back to the areas identified, above, as being significant for career progression. I examine if these opportunities exist in the NHS or whether the NHS needs to expand its offerings on professional development, to drive up the number of female board appointments. The second factor is the role of the individual and what they can take responsibility for, to enhance their leadership capabilities. Professional development available in the NHS is wide ranging with designated programmes from graduate to CEO level. There are a range of in-house courses available on things like leadership, in addition to the mandatory units on HR and recruitment for managers. Mentors were also commonly available to senior leaders, even if this was not widely advertised. The NHS also holds a prodigious number of conferences, which offer the opportunity to hear inspirational speakers, share best practice and network with peers.

The link between professional development and career progression was observed in one interview with Isabelle (Senior Manager). She noted how, initially, she had rapidly worked her way up the NHS management hierarchy, but this had recently plateaued. This lull in career advancement had coincided with her taking part less in development activities, such as mentoring and networking. It was possible to observe the correlation between devoting oneself to professional development and seeing the resulting benefits in terms of career progression.

A proportion (seven out of twenty) of the interviewees were alumni of the NHS Graduate Management Scheme. The Graduate Scheme was highly valued by all who had undertaken it; a typical view was that it was '*an excellent platform'* (Terry, Male Manager); others found that it, '*open*[ed] *doors'* (Mark, Male Manager) for them because completion of the scheme was regarded throughout the NHS as a '*kite mark'* (Jed, Male Manager) of quality. Sally (Senior Manager) found the most impactful elements were, time spent with the King's Fund, Action Learning Sets, having a mentor appointed and having a large proportion of her Masters degree funded. A common thread from the interviews was that those who had taken part in the graduate scheme came across as confident, well connected and appeared to be progressing their careers at a considerable rate.

As an HR expert, one of the female executives thought that the various Aspiring Director programmes and the role of the Leadership Academy were big positives for the NHS, especially for promoting female leadership. However, she believed that staff were not getting enough time for training and development because of the current financial NHS constraints – finding this time for staff is critical for them '*feeling valued*' (Sue, Executive Director). Others, for example Allie (NBP), were able to compare the NHS to previous roles. For Allie her time in Local Authority led her to feel that the NHS was much better in comparison to councils' employee development programmes. Speaking about development, she emphasised that,

> *'the NHS have a fabulous framework for learning and development, and it goes right the way through apprenticeships to preparing to be a CEO.'*
> Allie (NBP)

Others concurred; they shared very positive thoughts about development, '*there's a wonderful selection of opportunity for people who want to progress in the NHS'* (Ellie, NBP).

In terms of internal training, one Executive Director (Lucy) listed NHS opportunities that she had been able to access and noted that this had helped her reach Chief Operating Officer at a young age. For example, she had been involved in visiting a hospital in the US, which was working with her trust. She had also previously taken part in the Nye Bevan Programme. However, Lucy (Executive Director) was not solely reliant on the development opportunities available through the NHS; she had taken on other leadership opportunities, such as being a school governor, sitting on the board of a charity, and being part of a netball team. All of which had helped with her development and been things to add to her CV. People working in the NHS often feel the need to help each other to develop; one interviewee thought a reason for her successful career was the helpful input of others. There is '*a real passion to see people do well and to give something back to the NHS*' (Fiona, NBP). A prime example of someone who fits this description was Sally (Senior Manager), as she gives coaching to other staff specifically to '*give back'* (Sally, Senior Manager).

Several people who had only worked in the NHS, felt that the NHS was poor on talent management and development. One interviewee was much less positive about the NHS professional development offer, '*I would say the NHS has done the square root of zero until probably the last five years'* (Helen, Executive Director). An alumnus of the NHS Graduate Scheme (Sam, Senior Manager) acknowledged that the NHS made huge investments in terms of her development whilst on the programme but thought there was a lack of onward talent management post-scheme. With reference to in-house NHS training, it was reported that training courses tended to be of a low quality, as the person conducting the training was often poor, '*because that is all the NHS trusts can afford'* (Barbara, Executive Director). In a similar vein, it was felt that the NHS female only courses were not ideal, but for different reasons:

> '*I'm not particularly fond of dedicated female leadership courses, because in my head that seems to be coming from a premise that women need them to get on.'*
> Sue (Executive Director)

Falling back on her experience in the private sector, one manager highlighted that developing talent is '*not as easy as in the private sector because of the whole Agenda for Change thing*' (Anita, NBP), because targeting specific individuals for development can contravene AfC guidelines on fairness.

It has been shown, above, that a major barrier for those with family commitments is to gain sufficient operational experience; professional development can help combat this. One suggestion was that the NHS look at short-term placements for up-and-coming talent to get the experience they need. When talking about what other activities individuals could undertake to further their own careers, job shadowing and the ability to '*act up'* (normally when there is a gap due to maternity leave, sickness or when waiting for a new substantive postholder to commence) were suggested, primarily because these activities provide hands on experience of doing the role. The interviewees agreed that job shadowing can help gain experience, but that there is no substitute for '*getting your hands dirty*' (Mark, Male Manager). Similarly, with reference to gaining operational on-call experience, it was mentioned that

> '*unless you've done it yourself it's not the same – when you're called at 2am about a massive crisis, you're on your own…nothing beats doing it.'*
> Mark (Male Manager)

Additionally, it was suggested by Isabelle (Senior Manager) that an internal NHS consultancy could help women progress and help with flexible working, for example short-term assignments could be based around school term time.

Mentors and coaching were key development tools mentioned frequently in the interviews. They were discussed by all respondents as there was a designated question relating to them. Mentoring and coaching are two elements which are not uniformly offered to employees. Those on specific development programmes (such as the Nye

Bevan and the NHS Graduate Scheme) were tasked with finding mentors themselves. That said, mentors are often willing to offer their time for free, so there is little preventing higher numbers of senior managers finding one. Coaches were less accessible due to the cost involved. This would require the individual to pay themselves or have a line manager agree to fund them. Some felt that mentors were best used when people are new to a role or being prepared for their next role. A common view was that mentors are useful for senior people, as it is possible to be more '*isolated from your peers'* (Fiona, NBP) the higher you go. To get the most out of a mentoring relationship '*it's about having that rapport*' (Sally, Senior Manager) with the mentor.

Mentoring was not favoured by all interviewees; some used dismissive language to describe it as unstructured, with no fixed ways of getting results. Similarly, others felt internal NHS coaches did not always work:

> '*some of the coaches that I've been to just go on about themselves, and it becomes more about "look at my portfolio", rather than trying to support you.'*
> Barbara (Executive Director)

This could stem from the fact that NHS coaches are paid, compared to unpaid mentors. Thus, coaches may be more prone to self-promotion, to ensure repeat business.

Some were able to provide concrete examples of how having a mentor had benefitted them. Sam (Senior Manager) had used mentors throughout her career and was able to provide a very specific example of when a mentor had been of huge benefit to her. During her involvement in a whistle blowing situation, her mentor helped guide her through a very sensitive process. She was able to '*go and talk to* [mentors] *for advice in certain areas*' (Sam, Senior Manager), they also provided moral and mental support. When Isabelle (Senior Manager) was starting to think about having children, she went as far as to specifically seek out mentors who had families, to gain insights into how they balanced a career and a family. One person's mentor pushed him to apply for more senior roles than he was planning to and helped him to secure a role when he relocated from Wales to London. Another male interviewee noted that he always found having a mentor beneficial, but during the discussion he realised his relationships with his various

mentors differed depending on their gender. He tended to meet with male mentors in the pub, but with female mentors, meetings would be in the workplace.

The Nye Bevan Programme

As five of the interviewees were currently undergoing the Nye Bevan Programme, which is a professional development programme, it deserves special attention here. The course content of the Nye Bevan Programme asked delegates to consider a wide-ranging number of subjects, including how to better serve local populations, consensus building, self-reflection, and the issue of racial discrimination, but surprisingly '*gender has not been a consideration'* (Zara, NBP). The purpose of the Nye Bevan Programme is to help individuals develop a board level skill set; therefore, it is unsurprising that obtaining an executive position was the interviewees' key motivation for signing up to the programme,

> *'I think I recognised in myself there was a bit of development that I needed to do, because in a director role I recognised that it wasn't just about my professional expertise as a communications expert, but as the director of a hospital you have to be able to contribute across the board really, on a breadth of different issues and aspects of the business.'*
> Anita (NBP)

Further appeal of the NBP was about the individual exploring themselves '*in the context of the workplace'* (Allie, NBP), and that the content reflected their value system. Not all interviewees on the Nye Bevan Programme had such explicit motivations though. One purely felt she had a '*gap*' (Zara, NBP) on her CV, which applying to the programme could fill. In another case, when the individual joined her current employer, her talent was recognised by the executive team and they pushed her to take part in the Nye Bevan Programme, with an eye on her becoming a leader of the future.

As outlined in the methodology in Chapter Four, the purpose of including interviewees on the NBP was to measure the impact of a development programme on women's ability to build board level skills and experience. The Nye Bevan is particularly useful in this respect as its purpose is specifically to build board level competencies. The intention behind my interviews was to see if the female participants on the programme feel that

they had acquired skills they were lacking; to see if they had gained the confidence needed to apply for board positions; and then, on a more obvious level, whether they had obtained or applied for more senior roles. To assess the impact of the NBP, the interviewees were spoken to when they had first been accepted on the programme and then interviewed again approximately 18-months later. It is important to note that, in the gap between the first round of interviewees in June and July 2019, the COVID-19 pandemic had radically affected the NHS and the lives of the interviewees; undoubtedly this impacted their responses to some degree. More about the impact of the pandemic is included in Chapter Nine.

The five women who had completed the programme were equally effusive of its benefits. First and foremost was the exposure to national networks of likeminded people, who were facing similar work challenges and operating on a similar level within the NHS hierarchy. All five interviewees stated that they maintained these networks and found them a continued source of advice and strength.

The NBP '*helped me with confidence…much of Bevan for me was about believing … that I was a competent and credible leader*' (Ellie, NBP). Similarly, self-reflection was a significant element of the course content; '*what Bevan actually teaches you is that you become very aware of yourself*' (Fiona, NBP). This involved how people respond and react under pressure. In terms of integrating this into their day-to-day working practices, Ellie provided the example of how she now asks for regular feedback after meetings on how she comes across. Other management practices discussed were system leadership, concerning how to involve a range of stakeholders, both NHS and non-NHS organisations, to come together to reach consensus on the healthcare and wellbeing of people across extended geographical areas.

Much of the course content was devoted to the issue of race and ethnicity. It appeared that the NHS recognised the challenge it has in terms of getting more leaders from BAME backgrounds and the course content was designed to equip the delegates with the skills to help rectify this. It is extremely positive that the NHS was committed to increase BAME representation; however, this glosses over the fact that the NHS has yet to reach equality on grounds of gender. This said, much of the content regarding race and ethnicity is

transferable to the realms of gender equality; '*the programme was very much about inclusivity and being aware of your biases'* (Fiona, NBP). For example, participants were trained on recognising unconscious biases or how to understand their '*white privilege'* (Zara, NBP) with respect to the recruitment process. Whilst Anita (NBP) noted it helped her gain an understanding of the challenges faced by people from minority groups and therefore change the way she planned services for these groups. This is a skill which will help combat not only racial discrimination but also those of gender, age, and disability.

The evaluation of the actions taken after the NBP was divergent. Two people had reported that the programme gave them the confidence to apply for new roles. Ellie had progressed to a position of equitable rank to executive director largely because of the confidence the NBP helped her build. In contrast Zara said that she felt ready for a board level position but after being unsuccessful in one application she had opted to wait until after the COVID-19 pandemic before trying again. Zara gave the impression that whilst the NBP had similarly helped build her confidence, one knock back had quickly eliminated this temporary boost. Ultimately, however it was the feedback from Allie, which was the most damming, not of the NBP itself but on life post-Bevan. She noted that it was her executive team that had persuaded her to apply for the programme; however, on graduation she discovered that her post had been eliminated and replaced with an executive role which she was not deemed sufficiently experienced for. Allie questioned what the point of the programme was if there was no onward progression.

5.3.3 Networking

Here I lay out the views of NHS managers in relation to networks, explore what exists and how networks can be important for many aspects of a manager's life. It is shown that, historically, networking was seen as a barrier for female advancement. However, creating new networks can be a major opportunity for women to take control of their own development and progression. There seemed to be a lack of consensus amongst the interviewees as to what constituted a network. Most thought this to be a very formal web of likeminded contacts who met regularly at external events. To ensure that all the information possible could be reaped on networks, it was necessary to reinforce (with the interview questions and prompts) that interviewees should also consider informal networks.

One response was typical of many of the interviewees; they acknowledged that they had social networks but did not consider them as networks. They thought of social networks as just that, 'social' – they did not deem the support they got from them as professional, mainly because it came through things like WhatsApp and Facebook. Another trend was that the '*NHS management world is pretty small'* (Sam, Senior Manager), which is to say they found the NHS management world one big network and it was unnecessary to cultivate networks within it.

Four of the interviewees, even those who did not consider themselves to be '*networkers*', mentioned how they had used networks to further their careers or as a way of developing professional knowledge and contacts. For instance, the standard answer from many of the respondents was that they did not consider themselves networkers but had used informal networks to get new roles. One person stated that networks are important in building careers as,

> *'a network undoubtedly creates opportunities down the line…when jobs are becoming available then people potentially have you in mind.'*
> Terry (Male Manager)

Further benefits of networks were 'learning best practice' and '*sharing things that haven't gone well*' (Sally, Senior Manager). In addition, the whole process of networking is '*cathartic*' (Barbara, Executive Director), as it provides an opportunity to '*offload*' (Ellie, NBP) because people talk about problems with peers. When thinking about reinvigorating their personal development activities, one female leader recognised the importance of reenergising her networks as the first step. She had established a women's network, featuring '*mentoring, looking at speaker events, bringing inspirational women to come in and talk about their careers'* (Sandra, Executive Director).

Whilst nearly all (seventeen out of twenty interviewees) saw the benefit of networks, not everyone enjoyed the process; some found networking '*pretentious and false'* (Mark, Male Manager). Tony's (Male Manager) motivation for minimising his use of networks was down to the fact that he did not consider himself sociable. Because of this Tony

tended to keep strong links with a small group of individuals that he had known a long time, to the extent that he would even follow these individuals when they move to new organisations if they secured him a job.

There had been a recent push in the NHS to work more in networks across regions. Fiona (NBP) felt this creates a conflict in the NHS between working collaboratively and the internal market. For example, giving activity to another local hospital might be in the best interests of the patient but it can deprive an organisation of income. In general, it was thought the NHS could be better at promoting networks, for example, '*if I went into the private sector, I think I'd probably have a networking opportunity much greater than the NHS currently does*' (Sally, Senior Manager). When considering when and where networking takes place, NHS managers reported attending a range of different formal conferences. Regarding informal events outside of the workplace it was noted that many networking and social activities are not inclusive (e.g., drinks down the pub). This was attributed to a *'laziness of thought'* (Lyndsey, Senior Manager). The time and place of networking events is important. If an individual has carer responsibilities, then events outside the normal working day could dissuade them from attending.

As seen above, two key development programmes in the NHS, the Nye Bevan Programme and the Graduate Management Scheme, contained elements of networking. Allie (NBP) highlighted that her favourite aspect of the Nye Bevan Programme was the ability to network, especially in terms of broadening the geographical spread of her network, due to the programme being national rather than regional. For others, networks took on a slightly different meaning – having worked for twenty years in one area and having a '*name built on reputation'* (Fiona, NBP), Fiona moved to a new region where she was unknown, had no reputation and no support network. Because of this she spent 18-months aggressively building a web of contacts by joining numerous different networks, building her social media presence, and attending many external work events.

The Graduate Scheme again featured heavily when the conversation turned to networks. One person went as far as to say that the reason that the graduate scheme had been the '*single biggest driver of my career'* (Jed, Male Manager), was mainly due to the networks it provided. The networks that the Graduate Scheme offers access to, present

opportunities which others would not be exposed to, and '*people who network well* [make the most of] *those opportunities*' (Sally, Senior Manager). Another male manager found that networks have been very useful in promoting himself – as chair of a national meeting it provided exposure to the NHS top leadership.

Summary of the Employee Level Factors

The barriers to career progression and the need for professional development in the section above are subtle but important in terms of gender equality. It has been evidenced that development opportunities offer a fundamental solution to women aiming for career progression; by focusing on professional development; by having a coach or a mentor; by applying to a programme such as the Aspiring Director or Nye Bevan Programme; by being part of a network which can signpost opportunities and help build a reputation. In this way both men and women can proactively manage their career advancement.

Whilst opportunities exist, they are not equitable. Again, women battle against the impact of being the lead carer and its tendency to reduce exposure to opportunities, such as courses or networking events held outside the working day. Targeted development courses for minority groups are unpopular with women and people from BAME backgrounds, as people want to be awarded positions and opportunities based on ability.

5.4 Summary

This chapter has highlighted several key points emerging from the interview data. Gender discrimination was seen to operate at three levels, national, organisational, and individual. Throughout the interviews there was broad consensus on the importance of these themes in relation to the subject of the glass ceiling. There was recognition that the three levels all play a vital part in the existence and overcoming of workplace gender discrimination. The individual narratives on the specific factors indicated there is a role for the government to set national policy and guidelines; there is a requirement for NHS organisations to enforce this policy and create a climate of equality. This must be backed up by individual employees who develop themselves and gain the experience needed, to ensure they are the best qualified employee for board level roles when they become available.

The key driver to the national policy level discussion was the role of AfC. Whilst the general feeling amongst the interviewees was that there are concerns about the policy, there was also a grudging acceptance that it was effective in its objectives of gender pay parity. As noted, the need to move organisation unfairly discriminates against women with carer responsibilities. The adherence to the AfC process, for example, the need to meet all the requirements of the Job Description, is likely to disadvantage women who believe they need to meet all the job requirements to apply. There was evidence that women were less likely to be appointed at interview when there was a possibility that they may wish to start a family soon, and therefore need maternity leave. In addition, while women were reluctant to apply for roles for which they were not fully qualified, men applied and '*aced the interview'* or '*charmed*' (Zara, NPB) their way through.

The organisational level conversations were undoubtably influenced by the response to national policy. What is noticeable is that despite all being NHS organisations operating under a common framework, there is widespread difference in the way organisations shape and execute policy. This topic of conversation drilled down into flexible working, which showed a contrast in organisations' willingness to provide it. There was a degree of scepticism pertaining to employees working from home, as to whether they were as productive. Mainly because it was adjudged that they did not work as many hours as when they are in the office.

In relation to board level positions, the most significant finding was that many believed flexible working was inappropriate for senior leaders, who need to be present, on-site, and accountable. The gender issues pertaining to these factors stem from the fact that women were more likely to utilise flexible working. Therefore, if employees working flexibly are less valued than those working normal patterns, it is disproportionately going to discriminate against women. A lot of the content from the interviews recognised that women are more likely to utilise flexible working because women remain the primary care givers for children. This led to a focus from the interviewees on the practical elements of life, predominantly things such as childcare, as these are very real everyday issues which concerned the interviewees.

The tone and language used by the interviewees was one of concern and understanding; they were adamant that they do not personally discriminate on grounds of gender, race or otherwise. But they were also adamant it was happening all around them, thus enabling them to appear the moral heroes of their stories, whilst casting doubt on the behaviours of their colleagues. The female interviewees were united in their views that sexism existed. There was evidence of the old boys' club, with its protection of board level positions for their other white male colleagues. In contrast, the language used by women to describe their treatment by other women was telling, reporting the use of terms such as '*bitchiness*' (Helen, Executive Director), or others thinking they were too young to be a female senior manager. For many women it had been a lifelong experience of sexism. As such, these women were probably '*products of their experience'* (Sam, Executive Director). Conversely, some women did say they found women warmer than men and credited other women for supporting their career and pushing them to apply for promotions.

From the perspective of the level of the individual healthcare leaders, the findings set out the increasing pressures on them brought about by national controls on NHS finances and the encroaching hand of regulation, which has now permeated through all levels of NHS employees. Resilience to these stresses is thought to be a core requirement of NHS leaders. The relevance to the glass ceiling, is that the female interviewees spoke of their preference, because of the immense pressure on executive directors, to shift their focus onto their family lives.

Several people felt that the NHS was poor on talent management and development for senior managers; therefore, it was a necessity to take ownership of ones' development. This said, those who had been part of the NHS Graduate Management Scheme or those who had experience outside of the NHS, spoke highly of certain elements of the NHS development programmes. The consensus was that professional development (including networking and mentoring) is a central tenant to career progression.

Networking was a controversial topic; whilst many recognised it as a necessary evil, around half of the interviewees spoke of their distaste for it, as being false or uncomfortable. Those who had invested in networking were effusive of the benefits it

instilled, due to the exposure to national level leaders or the ability to vent or problem solve with peers. To reiterate, networking is highly divisive in terms of gender equality. Historically networks were, by their nature, the reserve of wealthy white males. Whilst positive change has been made in this respect, many networking events are still suited to men. For example, many events are outside working hours (again disadvantaging working mothers) or in more masculine environments (such as sporting events or pubs). These factors are critical because of the far-reaching consequences networking can have on an individual's career.

Chapter 6: Interview Vignettes

"*I am no bird; and no net ensnares me: I am a free human being with an independent will*."

— Charlotte Brontë, Jane Eyre (2000, pp. 216)

6.0 Introduction

This chapter provides a concise overview of the interview data in the form of a series of vignettes, one for each of the four groups of interviewees. This chapter seeks to present the reader with the voice of each of the interviewee groups, it offers an insight into the narratives, so that the background and professional and personal life can be better contextualised.

6.1 Interview Vignettes

The method and rationale for compiling vignettes is explored in depth in Chapter Four. In summary, to enable the twenty-five interviews to be digestible to the reader I opted to provide a vignette for each of the four interview groups. These vignettes offer a unified narrative based on a synthesis for each of the five participants within each group. The vignettes are typologies, which are useful here to isolate career pathways and understand the nature of peoples' work-life balance. As explained in Chapter Four, these vignettes are less scientific in their approach but provide an understanding of the interview contents, having been dissected through the narrative and thematic analysis in Chapter Six. The aim of the vignettes is to humanise the data from the pre-interview questionnaire and the high-level trends from each of the four interviewee groups, by producing a brief story reflective of the people in each of the groups.

Given that each vignette is a culmination of the interviews from the five people in each interview group, it was decided to use a new alias for each group rather than re-use an alias of one of the interviewees from that group. For example, Jane was a new alias given to those interviewees from interviewee group one (those on the Nye Bevan Programme).

Group One: Female Managers on the Nye Bevan Programme

Jane joined the Nye Bevan Programme in 2018 when she thought it was time to take her career to the next level. Being in her mid-thirties, Jane thought that her career was stagnating. After rapid progression early in her career there was now no sign of a promotion on the horizon, despite feeling that she was excelling in her current role. Early on in her career Jane had progressed from administration manager to assistant general manager to general manager. Her roles had ranged from managing waiting lists, overseeing patient flow and various project management roles. Having only lived and worked in the same city all her career, she knew everyone at her hospital well and every department inside out.

The Nye Bevan Programme appealed to Jane because it was a national programme and was well regarded by people that matter, i.e., those on interview panels. Applying for the programme was a relatively straightforward case of putting in a written application, then doing a presentation, followed by a panel interview. Her line manager approved her application and was supportive of the idea and the time she would need away from the office. She found the mix of people on the course diverse; whilst a healthy proportion of the other delegates were female, many of them had different backgrounds from her, outside of hospital management. There were medics and nurse managers – who were fed up with having no authority – to GPs and practice managers, who were looking to move into senior Clinical Commissioning Group roles. The content of the programme was of great interest to Jane. She had never come across exercises like the Myers-Briggs evaluation, and Learning Sets were a real revelation, as she learnt to look at work issues in a different light. However, Jane's favourite aspect was networking with colleagues from all over the country and finding out why they did things differently in their respective trusts.

Reflecting on the Nye Bevan Programme 18-months later, Jane felt that, whilst she hadn't learnt any '*hard skills'*, she had learnt a lot about self-reflection and the course had really helped her to build her confidence. Whilst she has not yet made it to a director post, the programme gave her the confidence to apply for other roles, as she felt that she could evidence real personal growth on her CV. Jane still stays in touch with the

people she met on the programme, mainly through social media, especially the WhatsApp group they set up.

Group Two: Female Board Members

Sarah has worked her entire career in the NHS, although this was never her intention when she started in her early twenties, straight from university. However, after a few years when she started thinking about having children in her early thirties, she realised that she could not maintain her current workload and raise a family. Her husband is a lawyer and works long hours, but his salary is much larger so there was never really any doubt that her career would take a back seat while the children were young.

When her eldest son started at university and when their second son started secondary school, Sarah, then in her mid-fifties, no longer had to do the school run every day, which meant that for the first time in years she was able to commit more to her career. It is not that she was not committed throughout, it is just once the children were older, she felt like she was able to spend the hours in the office that a director level role required. Getting her first director role was not easy; she eventually left the trust she had worked at for many years when it was apparent she would never be considered for the next promotion she wanted. Even in this new organisation she had to wait four years for her predecessor to move on, which happened when the Trusts' A&E performance declined, and someone had to bear the responsibility.

Early in her career Sarah felt that people did not take her seriously being young *and* female – she realises in retrospect these people were always other women. To get things done Sarah knows she can be very direct. People have complained in the past, but they do not realise the pressure she is under and the need to be forceful when things get hectic. Sarah also feels that having a '*hard edge'* is needed and even expected in operational roles. In the past she has seen men apply for roles they were not qualified for and get them; she has also looked on, with jealousy, when they have asked for pay rises and got them – something she had not been brave enough to do in her junior roles. She feels that women in general are much more accepting when a man is appointed above them. Sarah has recognised that the male consultants have different conversations with her than with her male managerial colleagues; but this is mainly about

informal stuff, such as tax advice when talking to men and relationship advice when talking with her.

Sarah's views on flexible working are complex, she recognises the need for greater flexibility in the NHS, but she managed to get where she is without too much help; in fact, some of her requests for flexible working were rejected with little consideration. She also thinks that people are a lot less productive when working from home, so works hard with staff to get the balance right – for example, maybe half a day a week working from home when a full day was requested. The NHS has many policies concerning things like childcare, but alone these policies are not good enough; there needs to be more tangible support. A prime example Sarah provided is the lack of crèche facilities at many hospitals.

The NHS is a tough place to work now; staff are not getting enough time for training and development. Making that jump from deputy to director level is also difficult because of the huge change in accountability and responsibility – many deputies just simply do not want the roles now. In terms of appointing more women to director level, women should be appointed on merit. Sarah was successful in making it, so feels that it is possible for other women. By using hard measures, such as quotas, it detracts from women who made it there on their own. Sarah's success has been driven by her reputation, which meant that she has often been asked to apply for jobs, rather than applying cold.

After returning from maternity leave for the second time, Sarah became a lot more focused on her own productivity, to fit as much work in as short a time as possible, to get home in time for her children. This involved cutting down on things like catching up over a coffee and answering emails after the kids had gone to bed. Throughout Sarah's career she has always recognised the need for personal development, undertaking a range of courses run by the Leadership Academy, and she has had a range of mentors, with networks for women being especially important. Sarah is involved in a regional talent management network to identify a pool of future leaders.

Group Three: Female Managers below Board Level

Liz's career started at a frantic pace. After university she was accepted onto the NHS graduate management programme, which she applied to because it had a great

reputation. Liz moved home several times to relocate for various promotions, which seemed to arrive one after the other. She knew that if she wanted to get ahead, she needed to do well in a role for a year or two, and then look for the next challenge.

Whilst she cannot remember the exact point when her career stopped being her focus, Liz knows that it was when she started thinking about having a family in her late twenties. Liz had been married for a couple of years and children seemed liked the logical next step – all her friends were having them. Liz's husband's career took precedence; it was more difficult for him to get the flexibility he would have needed from his employer, potentially because he was male. When she did return to the workplace her parents were instrumental in helping with childcare; fortunately, they are now retired and live close by. Even so, when Liz returned to work after her first lot of maternity leave, she remarked that even before getting to her desk in the morning it was like she had to get three people ready, herself, her husband, and her son.

Liz felt that she rushed back to work too soon after her first period of maternity leave. She tried working part-time for a while, but found she was still doing 100% of the work in 80% of the time, for 80% of the pay. Liz acknowledges the next step for her is the board room but that is impossible for her with her current family commitments. Although childcare is a barrier to her career, she *wants* to spend more time with her family. Liz has a lot of operational experience but thinks that for the next step, she needs more Urgent Care experience (e.g., working in the Accident & Emergency Department). This brings with it long hours and lots of stress, neither of which are desirable with a young family. Whilst flexible working is an option, she tried it previously and it did not work for her; plus, at a senior level she now feels that she must lead by example.

Liz thinks that the old school style of NHS management, especially for female leaders, is to be loud, direct, and sometimes even aggressive to get things done. Women in senior roles can be '*bitchy*' about other women. That is not how she sees herself and she will not compromise her morals just for a promotion. Liz feels she has been a victim of some discrimination; for example, she has been asked to make the tea during meetings, which she attributes to being the most junior woman in the room. When she was on an interview panel another member did not want to appoint a woman, who *might* want to have children

soon. One female executive told her that she needed to get a nanny so that she could focus on her career. Liz did not think this was meant to be offensive, just that the colleague felt it to be a fact.

Liz feels that whilst there is a glass ceiling in the NHS, this only applies to more senior roles and does not affect junior management appointments. Liz feels that men are much more likely to apply for promotions than women, even when they do not meet all the criteria of the job description. Sometimes she feels like men have taken credit for her work; also, men defer to other men in meetings rather than seeking out her opinion. Liz thinks the lack of women at board level can, in part, be attributed to the inability to have flexible working and job sharing for executive roles, which is driven by the constraints of NHS regulators. Liz also feels that whilst it can be challenging for women, it is probably much harder for people from BAME backgrounds.

Liz acknowledges that the NHS made a huge investment in her during her time on the NHS graduate scheme, but now feels there is no proactive talent management process she can link into. She thinks this is probably the same situation for a lot of other women in her position. Having female '*champions*', who can tell their story of how they made it, might help women who want to progress their careers. Another solution would be to start an internal NHS management consultancy, whereby female employees could work short-term assignments in areas where they need to gain exposure.

Liz knows that professional development is important but has focused on it less in recent years; for example, she has had mentors in the past but does not have one now. Liz is extremely proactive in terms of her networks and still stays in touch with her former colleagues and all the friends she met through the NHS graduate management programme. In the past she has enjoyed coaching and mentoring junior staff members, as she feels it helps her to give something back to the NHS. A course that Liz found hugely beneficial to her career was one around what to wear at work, and how people interpret your appearance. This helped her maintain a style of dress that she was happy with, but also one that would help her be taken seriously at work.

Group Four: Male Managers

Gavin has one young son; his wife works too but only part-time. Gavin is very appreciative that without his wife's support he would not have been able to get to where he is, which involved a lot of long days, weekends, and on-call commitments. His career started on the NHS graduate management programme; he feels like this has served him well, as the scheme acted as a '*kite mark'* of quality, facilitating rapid promotions. Earlier in his career Gavin moved roles frequently; he felt he did this to experience as many new challenges as possible and because he is curious. He acknowledges that the breadth of experience in a short space of time certainly helped his career. Whilst doing operational roles, Gavin understood how important presenteeism is for NHS roles and as a result ensured he was early into the office and late to leave – which was necessary given the high workload. He is now changing his work-life balance as he is very keen to see more of his family. He is managing the exceptions around high '*on-site'* commitments at work and is exploring a more flexible work pattern, including working from home one day a week.

Gavin knows he is lucky to have a wife who supports his career. He is also aware that he is fortunate to be a white male and thinks this has certainly helped his career, although he feels reaching a leadership role at a younger age than his peers meant that he was not always readily considered for senior roles. To counter this Gavin subconsciously acted very seriously at work, feedback he received with great surprise, when it was relayed to him as part of his personal development programme. Gavin hates to say this, as he thinks its prejudicial and not true of all women, but he does think that some of the worst behaviours he has witnessed in the NHS are when women try and adopt masculine stereotypes and male characteristics. He also thinks that female competitiveness against other women in the workplace can reach the point where they are unpleasant to each other.

Gavin is very conscious of the female / male composition of the workforce, is well versed on the statistics concerning the ethnic makeup of the population and that of NHS management. He is actively concerned about these imbalances due to the need for NHS bodies to reflect the populations they serve. He has been involved in several projects in the past to promote the pipeline of women and ethnic minority leaders. He thinks this

imbalance is probably due to men appointing other men in their likeness for board positions. However, Gavin appreciates changes are not going to happen overnight and need to happen at all levels of the organisation, not just targeting the level below directors. He thinks the NHS is poor at talent management and that programmes targeted at women and people from ethnic minorities work, but that they are not palatable to the workforce. Additionally, they are often viewed as tokenistic by minority groups.

Throughout Gavin's career he has been focused on personal development. He tries hard to find weaknesses and gaps in his knowledge and sets out to address them. He reads widely and has taken up a range of in-house development courses. He has had active networks and socialised widely with colleagues outside of work, either over curry or a pint. On reflection he acknowledges that only those (typically male) colleagues without childcare responsibilities could network regularly in this way. He feels he has benefited from many wise mentors during his career, with whom he still stays in touch, meeting his male mentors at the pub and female mentors for coffee in the workplace. Gavin's major network is the contacts he has made through the NHS graduate scheme. He thinks that his first director role was a direct result of having a graduate scheme alumnus as the recruiting manager. He feels these practices are possible because reputation trumps NHS policies and Agenda for Change. He also thinks that Agenda for Change is never going to be able to counterbalance recruiting managers' subconscious biases.

6.2 Summary

To reiterate the purpose of the above vignettes is to provide insight into the conversations held with the interviewees and give a direct sense of their own narratives. By understanding these vignettes it is hoped that the reader will gain greater appreciation of the findings, concepts, and recommendations in future chapters because the reader has heard more of the voices of the research participants.

Chapter 7: Discussion of Results – Key Findings

"*For the record, feminism, by definition, is the belief that men and women should have equal rights and opportunities. It is the theory of the political, economic, and social equality of the sexes*."

— Emma Watson (Speech at UN Women, 2014)

7.0 Introduction

This chapter outlines and groups the key findings from the qualitative and quantitative research. The use of mixed methods for this research project was successful as the two elements combined well to reinforce one another. The quantitative data analysis was able to identify and add credibility to those factors which were later explored in the qualitative interviews. The quantitative and qualitative worked in tandem to address different aspects of the research aims, highlight various avenues for exploration and deliver ideas for potential solutions, opportunities, and enablers to address the glass ceiling.

To recap, the quantitative research covered several areas. Initially, national data on gender composition over the various levels of management was used to demonstrate the potential existence of a glass ceiling; this confirmed that woman outnumber men in the NHS at every salary level, apart from the top two tiers. I was then able to evidence, by reviewing all NHS provider organisations in the Midlands and London, that men outnumber women in terms of board level positions. This was particularly evident in Chief Executive Officer (CEO), Director of Finance and Medical Director roles. Next, data was reviewed on development programmes and recruitment, to explore if these two areas could offer suggestions for the gender imbalance at board level. By reviewing the applications to, and uptake of, the Nye Bevan Programme (NBP) I saw that women applied to and were accepted in greater numbers than men. This displayed the willingness of female managers to take on board level development. The recruitment data for one acute provider trust, told the story that a slightly lower number of women were applying for board level positions but those who did apply were just as successful as men in terms of securing roles. These recruitment data asked if the solution to the glass ceiling was getting more women to apply for board level positions?

Moving onto the qualitative research, this consisted of twenty-five interviews. There was a total number of twenty interviewees. The five people from the Nye Bevan Programme were interviewed twice (once at the start of the programme and then once at the end) to consider the effects the development had on them. The interview domains were derived from the various theories put forward in the literature and matters arising from the quantitative data. The applicability of these theories was then explored and refined with each subsequent interview. This flexibility ensured that trends could be explored in more depth and any irrelevant areas could be dropped from the interview domains. For example, when it was evident that childcare arrangements and flexible working were salient factors (in relation to the glass ceiling), these areas were expanded upon. Whereas there was an absence of data relating to specific skills set requirements (such as financial knowledge), so less time was devoted to this section of the interview schedule.

In previous chapters the structure has been based on examining the data at national level, organisational level and then the role of the individual. For this chapter it is more pertinent to present the analysis in a more coherent flow, by splitting the discussion into barriers and opportunities. Starting with the barriers to female equality, I considered whether those barriers suggested by the literature are thought to exist within the NHS. Then I switched focus to the opportunities present in other industries and organisations, explored in the literature, to see if they could be exploited by the NHS, to meet the objective of having equitable board membership.

7.1.1 Barriers

This section introduces the key barriers including the impact of childcare responsibilities on career development. It identifies some of the stereotypes which were found in the data, then explores the recruitment to board level posts.

Childcare and The Second Shift

The literature demonstrated that having children can severely restrict a woman's career; this is heightened the younger the mother or if a career break extends beyond two years (Watt and McIntosh, 2012). The time when most women have children is a key factor,

given that most women tend to have children at the stage when people see the greatest acceleration in their careers; missing this opportunity can have a lifelong impact (Addison et al, 2014; Deschacht et al, 2015). The pre-interview survey demonstrated that female interviewees tended to have children in their early thirties, which is a time when the most rapid promotions take place. Three of the five male interviewees readily admitted that they would not have been able to focus on their careers if their partners had not taken such an active role in terms of childcare. One of the female interviewees was given a poignant piece of advice, to hire a good nanny if she wanted to progress her career. To reiterate, the interviewee inferred this as genuine advice from a successful female leader, but we must question if this would have ever been given to a male counterpart?

When women are away from the workplace for an extended period, they are missing opportunities to develop their skills and experiences. One solution is to undertake academic qualifications, but it has been noted that this cannot fully replace real world experience (Kibelloh and Bao, 2013). Next, when women do find a workable timetable to balance childcare provision, they are still required to undertake significantly more of the housework than men (Gates, 2019). A tangible way that men can assist their spouses' careers is by taking '*the second shift'* to help '*counterbalance women's greater hours of housework and childcare*' (Milkie et al, 2009, pp. 489). Achieving gender equality at home is indeed the first step to delivering gender equality in the boardroom.

There are significant financial considerations with respect to childcare. The high cost of childcare in Europe often means that it can be a considerable percentage of a person's salary, almost nullifying the benefit of going to work (Arulampalam et al, 2007). One way of offsetting this is childcare vouchers, which were mentioned in the interviews. They are a government initiative where it is possible for parents to have a proportion of their income (up to £55 a week) exempted from income tax and National Insurance, to offset against the costs of childcare. However, as of October 2018 the government started to wind down the scheme (GOV.UK, 2019). The childcare tax vouchers were highly valued by the working mothers who were interviewed. The fact that the government is eliminating them can only be bad news. Another interviewee said she was not aware of the voucher scheme until she moved employer, who informed her when she was enrolling her children in the creche based on the hospital site. This lack of awareness

concerning the scheme indicates it was not sufficiently promoted. Onsite creches are a boon for working mothers; the interviews demonstrated that having one can boost recruitment and one interviewee gave the example of how they had attracted a specialist consultant to a hospital. However, there is a paucity of onsite creches, despite previous government initiatives pledging to increase the number.

The next factor, regarding the cost of childcare in relation to gender, concerns the choice of which parent reduces their work hours to be the primary caregiver. Given the high costs of childcare, parents can be less flexible in terms of how this is achieved. Men in general earn more than women (The Economist, 2015). The interviewees stated this is the reason men's careers take precedence because it makes fiscal sense. However, the reason that men are thought to be paid more is because they spend more time in the workplace. By further reducing women's working hours in this manner, it creates a vicious cycle (Arulampalam et al, 2007).

A powerful example concerning the burden of childcare was highlighted by the interviews. The data presented the cases of two couples, one where the man was an NHS manager, and the woman was a doctor. In the other couple the man was a doctor, and the woman was an NHS manager. In both circumstances the couples had come to contradictory reasoning which resulted in the childcare falling to the women. That is to say, the couples constructed their own separate narratives to justify the men's careers being more important. Both men's schedules were less accommodating to making the school run, their early morning meetings were more important and their bosses less forgiving. Here the reality of the interviewees exploits a contradiction to the literature; it states women stay at home because they earn less (Motaung et al, 2017; and Hewlett and Buck-Luce, 2005), but even when women earn more, they still take the burden of childcare.

Obviously, it is unfair to say all men attempted to carry less of the burden of childcare responsibilities. In the interview responses two husbands did in fact take the lion's share of the childcare responsibilities. However, this was when the children were older (and more self-sufficient) and when the husbands were already working shorter hours and working mainly from home. When reflecting on their decision to focus on career in the

interviews, the women with children who had opted to focus on family life all claimed to have made the correct decision. Had they all made the right decision for them as an individual or was this hindsight bias? Had they constructed their own narrative to make them feel better about the path they had chosen?

One, often overlooked, aspect of being the parent responsible for childcare is that it can restrict, in geographical terms, the available pool of promotions (Selva, 2013; and Akpinar-Sposito, 2013). If a parent must drop-off and collect children at certain times, then their place of work must be a commutable distance from the school. In NHS terms, there may only be one hospital which meets these criteria. Therefore, the interview data threw up the issue of being geographically tied to the same location. This limits promotions as, within an organisation, people tend to stay in the same role for many years, creating the need to move location frequently for those seeking new roles and promotions.

The Identity of Female Leaders

It has been suggested, above, that women tend to prioritise family above career. It also has been recognised that women can have different priorities when gauging their success in the workplace, with increased focus on communal rather than individual success (Afiouni and Karam, 2013). The literature explained that the role of the female executive can be viewed as being '*at odds with their identities as women'* (Ezzedeen et al, 2015, pp. 42), predominantly due to the perceived need to adopt masculine styles of leadership (Faniko et al, 2017). Whilst twelve out of twenty interviewees claimed there was little difference between the behaviours of men and women in the workplace, the interview data did draw out different characteristics in male and female leaders. Back slapping bravado was viewed as the reserve of men, with warmth and empathy as the qualities of female leaders.

The issue of a leader's identity is significant when we consider the concept of *'think manager – think male'* (Schein et al, 1993, pp. 33), where female leaders are discriminated against in the workplace because – both men and women – primarily think of senior managers as being male. Not only do both men and women '*think manager – think male'*, but there is evidence that many women also prefer being managed by men

(Elsesser and Lever, 2011). It was viewed that previously women had adopted these masculine behaviours to be promoted. However, there was a recognition that this style of management is no longer fit for purpose. The future of the NHS will require more collaboration, more empathy, and greater ability to identify with the needs of the patients (Kiser, 2015) – all factors which the interviewees felt were more prevalent in female leaders. The fact that the NHS appears to be actively moving towards a leadership culture which is more in line with the characteristics of female leaders (NHS, 2019), is positive in terms of helping to dismantle the glass ceiling.

It has been argued that '*women take fewer risks than men'* (Fisk, 2016, pp. 181), particularly when it comes to financial matters. The interviewees reflected that there is a tendency in the NHS to focus on finance above patient care; the female interviewees felt that men risk patient care in favour of financial stability. In relation to women's leadership identity, the caring traits of women ensure that the wellbeing of patients is paramount, even when offset against the financial implications. This makes sense when you consider the role of a hospital is to treat patients, not make a profit. The interviews represent past leaders in the NHS as being bullish, finance focused and autocratic – qualities that were adjudged to be more masculine in nature.

Several (four out of twenty) of the female interviewees reported issues relating to being bullied or having their work ignored or misappropriated (by male colleagues). Bullying has been reported in the NHS, in part due to the hierarchical nature of the organisation. This has most notably been observed in the field of nursing. Nurses report not only bullying and intimidatory behaviour from patients and doctors, but the main cause is their senior colleagues (Attenborough, 2021). Some of those interviewed felt they were discriminated against due to their age, being perceived to have less experience. This demonstrated that some women face a double burden of discrimination. The double-burden phenomenon has its origins in discrimination in terms of gender and race (Atewologun and Singh, 2010), but there is evidence from the interviews that it could extend to being female and young. What makes this more interesting is that the comments regarding age were received from female colleagues.

The first ever female Secretary of State for the USA, Professor Madeleine Albright, once remarked, '*I think there is a special place in hell for women who don't help other women'* (Voepel, 2006). We saw in the literature that '*queen bees'* are women '*who have been successful in male-dominated organisations* [who] *do not support the advancement of junior women'* (Faniko et al, 2017, pp. 638) or when women *'actively work against the interests of other women'* (Hurst, Leberman and Edwards, 2016, pp. 65). Faniko stated that the two characteristics of the queen bee are competitiveness and thinking of themselves as being different to other women. There was evidence from the interviews to support these types of behaviours as being present in the NHS; those women who feel like they have '*made it'* in the face of adversity are less welcoming to female colleagues coming through the ranks who have not '*earned their stripes'*. However, using this limited data to state that this is the fundamental barrier to female career progression must be cautioned against. At best queen bees are a small proportion of women (Faniko et al, 2017) and this is not thought to extend to all female leaders. That said, it is important to recognise what the interviews tell us in relation to queen bees; this is because, due to the lower number of female leaders (proportional to men), even a small number of queen bees could be problematic.

It was remarked upon by a male interviewee that when women do compete against each other it is '*not very pleasant'* and that friction between two women is much more prevalent than between two men. A female interviewee concurred, acknowledging '*women haven't necessarily championed the journeys of* [other] *women…*[but] *these women…are probably products of their experiences*'. However, these issues can be seen to be related to the fact that, historically, women have needed to adopt more competitive traits and more masculine management styles to survive in the wider NHS hierarchy. So, whilst queen bees can be said to exist this is potentially a product of a patriarchal system, an approach they have adopted to survive.

Recruitment

In both the qualitative and quantitative research, recruitment practices were explored to analyse if processes unfairly inhibit women seeking promotions. The two elements to explore were, the recruitment pipeline, and secondly, the physical application and appointment process. A robust pipeline ensures that women managers are being

progressed at all levels of the hierarchy, to ensure women can gain adequate experience prior to applying for board level positions (Ezzedeen et al, 2015). The data reviewed in Chapter Five does indicate that women are present at all levels within the NHS in sufficient numbers, which suggests that the pipeline is adequately stocked with potential female applicants. The analysis of the uptake of the Nye Bevan Programme in Chapter Five demonstrated that women are actively seeking board level development programmes in equal proportions to men.

The data did identify a gap when the number of applicants for board level positions was reviewed, showing that women were not applying in the same proportion as men. The interview responses provide an explanation for this imbalance, which was due to the job description. It appeared that men were successfully recruited for roles for which they did not meet all the requirements of the job description (in terms of experience or qualifications). This indicated that the process of evaluating applicants against the job description was not robust. If requirements for a role are set at a certain level which inhibits women from applying (because they do not meet the requirements), but men see the role, realise they do not meet the requirements but still apply and are successful, then the recruitment process is broken.

The literature (Desvaux et al, 2008) supported the interview data, i.e., that men will happily apply for roles in which they do not meet all the requirements of the job description. This could be attributed to men being inherently '*overconfident in their prospects of success'* (Pinker, 2011, pp. 525), and confidence has been argued to be a characteristic which is a desirable trait in potential employees (Friedman and Laurison, 2020). Alternatively, this could indicate a systematic error, that either the supporting documentation for job descriptions in the NHS needs amending, to state that there is flexibility in the requirements, or that the requirements of the job role should be reduced, or that better training on recruitment and identifying potential biases is provided.

Gender preference theory (Deschacht et al, 2015) argues women are less likely to apply for promotions, especially in the early stages of their careers. It was also possible to see preference theory come into play in relation to the heightened regulation and accountability that the NHS has been facing in recent years. This means that both men

and women are feeling increasingly pressurised in the NHS. However, if women are more likely to have other – potentially conflicting priorities – such as childcare responsibilities, it is possible they will opt to devote more time and mental energy on their other priorities, resulting in them being less likely to apply for more senior promotions.

The impact of gender preference theory extends beyond the female leaders themselves and can become a factor for recruiting managers. There was evidence from the interviews that men on recruitment panels show gender preference; they will potentially discriminate against women who are of an age where they might be thinking of having children. This type of discrimination is particularly problematic for two reasons. Firstly, the recruiting manager may not even be aware of this internal bias. Secondly, just because the applicant is of an age when women might typically have children, it does not mean that she will, and even if she does have children, it does not mean she will necessarily be the primary care giver. It must also be remembered that discrimination of this manner is not just unethical, it is covered by legislation. Therefore, the recruiting organisation risks not only disqualifying the best candidate for the role but also breaking the law; thus, making it twice as important to have robust anti-discriminatory recruitment policies.

The subject of AfC was influential in the literature and the interview data. The aim of AfC in relation to gender equality is to '*improve all aspects of equal opportunity and diversity'* and to ensure '*equal pay for work of equal value'* (Department of Health, 2004). The interview data demonstrated that the AfC system can be circumvented, albeit in a small number of instances, which means it does not offer complete protection from discrimination in turns of recruitment and remuneration for female leaders. The rigidity of AfC meant that interviewees were forced to move roles frequently to seek promotions and higher wages. As seen above, mothers with childcare responsibilities are disadvantaged in terms of moving job role, as they are tied to organisations closer to their homes. Whilst AfC does fix the salary for positions, there is some ability to negotiate within the salary band, but women are less likely to do this (Friedman and Laurison, 2020). So, whilst AfC offers near parity, men can still be slightly advantaged by their propensity to push the salary boundaries.

People were apprehensive when discussing how AfC was used to benefit them; they deflected how it affected them, often removing themselves from the narrative and discussing other individuals. There was an element of conspiracy when it was discussed; it was spoken in almost hushed tones. Also, there were omissions from the interviewees of how the gaming took place, presumably because this contravenes the national policy. The interviewees were reluctant to provide details of how this occurred, and I did not feel it appropriate to investigate further. At this point I felt like a co-conspirator in the story as I understood some of what was not said; I understood the desire to sometimes work around the system and how this could be achieved.

7.1.2 Opportunities

This section uses the quantitative data and interview findings to start to explore opportunities for combating the glass ceiling. Initially I explore some of the higher-level strategic possibilities before looking at the options available to individual female leaders.

Strategic Approaches for Addressing the Glass Ceiling

Breaking the glass ceiling benefits organisations both on grounds of reputation – by being seen to be an equitable company (Böhmer and Schinnenburg, 2015; and Ng and Sears, 2017) and because a representative board can better serve the needs of its customer base (Kline, 2014) whilst improving patient safety (Sobieraj, 2012). As seen above, female leaders are viewed to be more focused on patient care, as women were thought to be more caring and less focused on financial performance. This more compassionate style was deemed by the interviewees to be the direction the NHS is moving towards. To achieve more equitable, reflective, and compassionate boards, the literature indicated some areas to explore, such as centrally driven quotas, flexible working policies, and a range of measures for female leaders to develop themselves to reach their full potential. These are discussed in turn below.

The issue of quotas is divisive, but I am quick to remember the words of Hejase and Dah (2014) who recognised that the very presence of a glass ceiling '*opens the door for government intervention'* (2014, pp. 956). It must be recollected that glass ceilings exist due to discrimination; if discrimination is illegal then there is a role for government in taking proactive measures. The introduction of quotas for Norwegian boards in 2005 had

the desired outcome, as the number of female executives increased whilst decreasing the gender pay gap and increasing the average level of qualifications of board members (Bertrand et al, 2016). As discussed in Chapters Two and Three, mandating quotas in the UK has been rejected, as fixing the pipeline was deemed a more pressing remedy (GOV.UK, 2011). However, the King's Fund did promote the use of quotas in the NHS (King's Fund, 2015). The literature indicated quotas are unpopular with both men and women, as it was felt it led to people being appointed to roles that they were not qualified for (Faniko et al, 2017). The interview data reinforced the literature, as it demonstrated that the NHS leaders were in general opposed to quotas, as people want to feel that they have earned their position on merit. This thought process even extended to other forms of positive discrimination. There was evidence of people from minority backgrounds turning down development opportunities, as they felt they did not need special assistance to progress.

Flexible working was reported in the literature as a means of increasing diversity, but it remains '*insufficiently utilised'* by organisations (Michielsens, Bingham and Clarke, 2014, pp. 52). Flexible working does have problems, for example it can be difficult for an employee to prove their worth as their work is less visible to their supervisor, so it can end up being detrimental to career progression (Michielsens, Bingham and Clarke, 2014). However, flexible working can be much more important to female leaders as they tend to have greater childcare responsibilities. These assertions were borne out by the interview findings. Firstly, flexible working is at odds with one of the fundamental values of NHS managers, which is presenteeism, often viewed as a proxy measure for job performance. This contrasted to interview data showing that women joined the NHS because of the flexibility it offered, but by the time they reach board level, there was a need to be visible as a leader, as well as the need for accountability as a director in a public body. Due to the sheer breath of the role, flexible working was not viable.

Gaining Tacit Knowledge

The tacit knowledge of organisations stems from the knowledge and experiences of internal employees as opposed to written down, explicit, codified, or external knowledge (Irick, 2007). Tacit knowledge is particularly relevant to the culture of NHS organisations. My data analysis on the interviewees showed often incumbents would have been in the

organisation for over ten years, meaning they will have a working knowledge of all aspects of their hospital and staff. This is vital as hospitals are not uniform environments; for example, different names are used for similar departments, different specialties might exist in different directorates. The hospital buildings themselves are unwieldly places, which can take years to effectively navigate. Also, the power structure in hospitals can be dissipated in a manner whereby a certain individual, for example a receptionist, can be central to the smooth operation of a whole department.

At an executive level, this tacit knowledge can be best evidenced in relation to the on-call commitments. Typically, an executive would be on-call for 3-7 days at a time and be expected to take phone calls or be present in the hospital for essentially 24-hours a day. As highlighted in the interview data, a phone call at 3:00 am would not be uncommon, to inform the on-call executive that the organisation was breeching the government Accident and Emergency target for a patient waiting in the department. In these instances, the executive's knowledge of the hospitals' systems, personnel and layout are vital. The options available to the on-call director require an understanding of where the patient can go (in terms of which wards), the on-call consultant team and whether they could be called to admit the patient (thus meeting the waiting time target), and an understanding of the patient's clinical condition to ensure they receive safe and appropriate care. The interview data identified the significant factor here in terms of gender equality; women are often unable to gain the type of experience required to enhance their tacit knowledge, due to maternity leave or inability to commit to the on-call rota because of childcare commitments. Despite on-call commitments potentially breaching the conditions of an employee's contractual obligation to their employer, the psychological contract (Argyris, 1960) between the NHS and its senior managers, dictates that these on-call commitments are expected to be fulfilled.

To continue with the importance of tacit knowledge, the interview data displayed tacit knowledge is instrumental in bridging the gap between deputy director roles and director roles. As seen elsewhere, there is difficulty in women who are utilising flexible working patterns to gain sufficient operational experience. This creates a further '*double-bind'* (Arnold and Loughlin, 2013, pp. 69), not only is it difficult to get experience below director level, but there is also a huge gap between what experience is needed at this level and

the next. The interviewees had considered this in depth and did offer solutions for addressing this, such as working in a smaller trust, increased job shadowing and the need for more designated leadership development programmes.

Professional Development and Networking

There was a group of interviewees who felt the NHS was poor on talent management when compared to the private sector. However, there were NHS initiatives which aimed to support professional development and, despite issues of time away from the office and funding, several of the interviewees reported that they had benefitted from programmes such as leadership courses. In terms of what development was impactful, the data on the applications to the Nye Bevan Programme displayed men and woman are equally likely to seek out development programmes. The NHS Graduate Management Scheme, which eight of the interviewees were alumni of, was cited as an example of what the NHS can deliver in terms of development programmes. This was due to the content (such as a MSc in Leadership and courses with the King's Fund), but also the intangibles, such as the alumni network it provides access to. Similarly, those currently on the Nye Bevan Programme extolled the virtues of the networks it provided for them.

While networks are recognised as an important aspect of career progression (Socratous, 2018; Broadbridge and Simpson, 2011), there was inconsistency in how interviewees defined networks, with some differentiating between formal (work related) networks and '*social'* networks. This inconsistency in the definition of networks, led to respondents claiming they were not part of a network, as they only counted formal networks in their definition. On closer examination, it was evident that all had their own networks in some form. The wide range of benefits can be difficult to realise for women because childcare arrangements inhibit participation in many networking events. A further concern raised by the interviewees was the falseness of networks and that they felt themselves *'poor'* at networking. These concerns must be overcome when the benefits are compelling. Five interviewees unequivocally stated their networks had secured them promotions, whilst another evidenced how his network had helped facilitate his role as the chair of a national committee.

One way that women can help with the development of future female leaders is through being role models and mentors; unfortunately, there remains a shortfall in both areas (Sanderson and Whitehead, 2015). The importance of female role models, whilst being listed in the opportunities section of this chapter, is also currently a barrier within the NHS. The quantitative data illustrates that women are insufficiently represented on NHS boards. In parallel the interview data showed that women often do not provide the support they could to other female leaders. A lack of female role models has been described as the '*most significant barrier'* to female career progression (Cross et al, 2015, pp. 86). Furthermore, the Upper Echelon theory has shown when women reach CEO level, they are best placed to address board level gender imbalances by quickly recruiting a more balanced board (Ng and Sears, 2017). If queen bees do inhibit other females from progressing, then the antiphrasis to this, of female support and collusion must be beneficial factors.

Mentors are important in career progression as they encourage mentees '*to seek out new positions more aggressively'* (Desvaux et al, 2008, pp. 4). Given that men '*gravitate*' towards sponsoring other men (Sandberg, 2014, pp. 90), this alone can be a key factor for perpetuating the '*old boys'* network. When men do sponsor or mentor women it can provide them with '*legitimacy*' in the eyes of others (Seraj, Tsouroufli and Branine, 2015, pp. 61). The interviewees were split on the role of mentors, some viewed mentors as a tool for addressing personal weakness and preparing for the next rung on the career ladder. Others were concerned that mentoring only works if the right mentor can be found.

Overall, the presence of a mentor appeared to be linked to those interviewees who were actively involved in career development and there was evidence to suggest the mentors can be impactful, such as helping to secure job opportunities. Sponsorship was an idea promoted twice during the interviews; it varies slightly from the role of a mentor. Sponsorship is much more about promoting the individual to others in the organisation and providing them with more visible opportunities, in effect the sponsor takes the employee under their wing whilst advocating their skills to others (Turner, 1960).

7.2 Summary of Barriers and Opportunities

This chapter has sought to bring together the initial theories first identified in the literature and explore their validity in the NHS by comparing them to data from the quantitative and qualitative research. It was demonstrated that the central barrier to female progression to the board room remains the fact that women still tend to be the main carer for their children. The next issue was that, historically, women have adopted male traits to facilitate their careers, which is at odds to the identity of female leaders. This has led to a dearth of feminine leadership skills on display at executive level. This is changing however, as the importance of a diverse leadership team is becoming better understood. The other fundamental barrier is ensuring female leaders have the belief and willingness to apply for executive roles. Women are less likely to apply for director roles, as they think they are less likely to be successful when compared to male applicants. Women are also less willing to apply as they do not want the increasingly thankless task of being an NHS board member.

The interviews generated a wealth of data falling across several key areas. Agenda for Change (AfC), the system introduced to safeguard against pay based discrimination could, in certain circumstances, be circumvented with the potential to unfairly discriminate against women and people from BAME backgrounds. It was evident that some form of discrimination was taking place across the NHS. This came in a variety of guises, including gender and ethnicity but also extended to age and class.

From the interviews it was shown that flexible working practices, which are a primary device for enabling mothers to take an active role in the workplace, were present but the policies were variable in quality. Additionally, flexible working for board level positions is very difficult to achieve because of the cultural bias towards presenteeism and the need for accountability. If flexible working is utilised, it can still inhibit the ability of those individuals to achieve the necessary experience and exposure required for rapid escalation to board level employment. A further barrier suggested from the interviews, was the lack of peer support by women for women, which could be fundamental in combatting the presence of homophily.

There are opportunities available to women seeking to progress their careers, successful female leaders have robust and detailed career plans, they seek out mentors and development programmes and most importantly they are plugged into the right networks to enable them to garner support in their roles, build their reputations and locate career progression opportunities. The NHS provides a range of professional development tools for all NHS employees. However, there was a view that the NHS does not manage the most talented employees well, and when there is professional development, there is not necessarily a possibility of a promotion at the end of it. The biggest facilitator from the interview data was the use of networks and mentors as a mean of promoting one's skills and seeking new employment opportunities.

In summary, the barriers and opportunities offer no conclusive single answer; it is a confluence of many separate factors. It came as little surprise to see that childcare responsibilities still represented the greatest barrier for women. Less obvious was the findings that both men and women still find masculine qualities representative of a leader, although there is evidence in this research that this perception is changing. Recruitment practices may still unfairly work against women, as women are (consciously or unconsciously) discriminated against because of the possibility that they will need to take maternity leave. Also, it was noted that women need to put themselves forward for roles with the same confidence as men, as they are as likely to succeed when they do.

Chapter 8: Discussion II – Development of Concepts

"*I do not wish* [women] *to have power over men; but over themselves.*"
— Mary Wollstonecraft (1792, pp. 130)

8.0 Introduction

In this chapter I take the findings from the quantitative and qualitative research and relate them to explanatory models, to provide an underlying conceptual framework which unifies my research. I then present my observations on the two types of career progression I found were utilised by the female leaders whom I had interviewed. Finally, I consider a new approach which aspiring female leaders could take, to help support and develop each other, to achieve board level roles.

8.1 Explanatory Models and the Conceptual Framework

As noted in previous chapters, I adopted Flick's (2018b) updated use of grounded theory. This meant that the research project was developed without '*priori'* assumptions as to what the underlying theories would be, in relation to the causes and the solutions to the glass ceiling. As such, several explanatory factors were identified as the research progressed and the data was accumulated. The explanatory factors were then tested further as additional points were collected prior to being refined or rejected. This process was helpful in developing the ultimate conceptual framework, which brought together the central pillars of my findings. To demonstrate how this process was conducted it is useful to review several practical examples.

The first explanatory factor which I thought would be helpful to describe the phenomena of the GC was flexible working. The volume of literature devoted to flexible working provided compelling arguments as to why it was the primary means of facilitating gender equality, making it the first model I focused on. However, the data collection started to show that this was not the panacea, because it fell victim to uneven policy implementation, and ultimately flexible working cannot fully replicate the need for operational experience and visible leadership.

The next explanatory factor I found useful was the paucity of female role models. Again, the literature was helpful in presenting the concept of the '*queen bees'* and their

destructive influence on other female leaders. This I tested in the interviews, and while the influence of '*queen bees'* was apparent, the inverse of this also became obvious. Which is to say the female interviewees spoke at much greater length about the positive influence on their career of other (non-queen bee) female leaders. I then ran into a further factor in terms of promoting female role models as the primary means of driving gender equality. There are quite simply not enough female role models for this to be the sole catalyst to enable parity on NHS boards. Whilst a prominent factor, this solution could not operate in isolation.

Following the importance of role models, I explored whether female empowerment could influence a greater number of other female leaders. The process of iteration led me to focus on networks. Networks offered many of the similar benefits as having female role models, but also provided an extended range of advantages in the form of sign-posting job opportunities and as a support network. I explore in Section 8.2.2 networks in future detail. However, even networks alone could not be used as a single model to deconstruct the GC. This was because networks are limited in scope, often informal, and not necessarily all female leaders can or want to engage in networking.

This need for a range of resources to address the root causes of the GC, drew me back to the literature. It is necessary to have a replete range of measures which incorporate mentoring, work-life balance, gender policies, career planning, and diversity programmes (Sahoo and Lenka, 2016; and Wichert and Steele, 2013). From the quantitative and qualitive research I was able to expand the list of opportunities to include dedicated more formal networking and greater promotion of female role models. However, to overcome what is still a male dominated arena the controversial notion of quotas must be contemplated, thus indicating a place for government policy intervention. One conceptual framework which included the factors emerging from my research is the Kenexa High Performance Institute (KHPI) Career Progression Framework (discussed in detail in Chapter Three). This model was unknown to me until after I had completed my research. It does however fit with my revised interpretation of grounded theory, whereby the culmination of the observations from my research refined my reasoning to help identify an overarching conceptual framework.

The Kenexa Career Progression Framework provides a condensed overview of the key barriers and opportunities which I recognised from my research as relevant for those looking to develop their careers. The Framework is a helpful tool to share with female employees and human resource managers, for them to formulate road maps for career advancement. The Kenexa Career Progression Framework consists of three levels, the individual, the immediate work environment, and the organisational context. The aims of the individual level factors are '*visibility* [to] *become better known in senior management circles and build a strong reputation'* (Wichert and Steele, 2013, pp. 127). The second section on work environment enables the individual to draw on external resources, connecting, gathering feedback, and learning from influential people (such as mentors and supervisors), and building their intrinsic ability to do their job role well (critical job assignments). The third section concerns the organisation, it outlines factors which are outside the individuals' sphere of influence but are ones which impact their ability to progress their careers.

The Healthcare Leadership Equality Framework

Whilst much of my research findings fit concisely within the Kenexa Career Progression Framework, there are some additional factors which I found important in terms of dismantling the glass ceiling, which are not encapsulated in the framework. The Kenexa Career Progression Framework, due to the nature of its intended implementation (which is based at the employee and employer level) omits macroeconomic factors and government policy relevant to the public sector. My research has shown that these macroeconomic factors when implemented alongside organisational level improvements and personal development programmes, work in tandem to facilitate gender equality.

I propose an expansion of the Kenexa framework in terms of extending the model to include a level above the organisational context section as relevant to the UK public sector. This macro level includes factors such as government policy on the NHS, the presence of quotas and equal pay and employment legislation. The addition of these factors generates a new model, which I have termed the Healthcare Leadership Equality Model (Figure 13, below), as through the application of the model it will assist in providing gender equality across the NHS. I am mindful to limit its applicability, at this stage, to gender equality in NHS leadership positions, as this was strictly the area I researched

and therefore the only sector I have observed for which it would be fully relevant. Further work would be required to see if the model would, for example, help with racial equality in NHS leadership or gender equality in other industries.

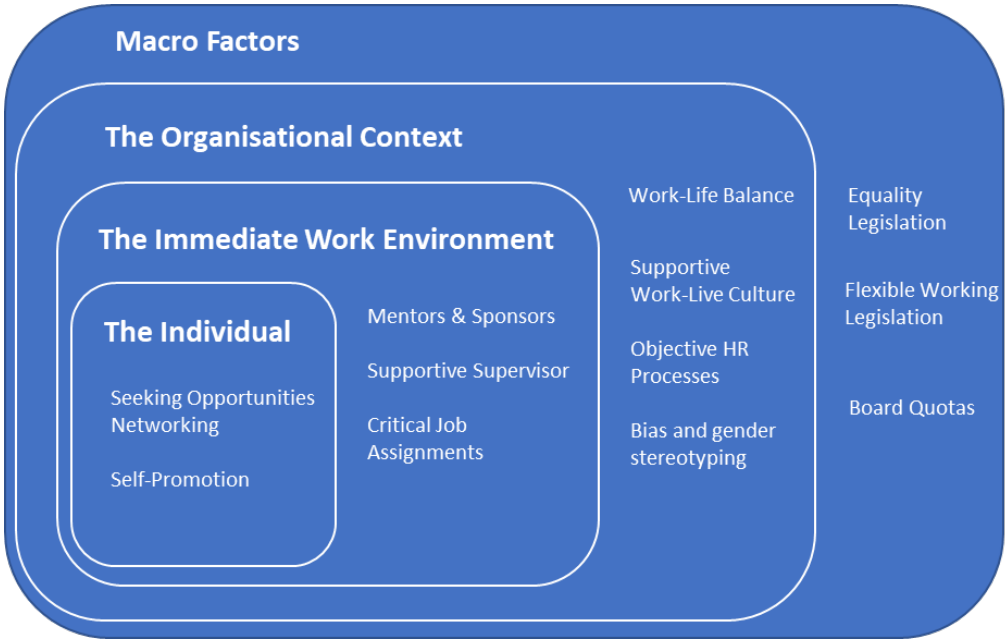

Figure 6: The Healthcare Leadership Equality Framework

Source: Author Generated

Chapter Nine takes the Healthcare Leadership Equality Framework and explores its implications in a real-world setting. It was possible to relate how the Coronavirus pandemic presented barriers and opportunities to female leaders and how the elements from the Healthcare Leadership Equality Framework can explain the reactions and effects of the pandemic on the careers of the leaders interviewed.

8.2.1 Reclassification of Interviewees: Go Getters Vs. Meanderers

In the following two sections, I first explore the key difference between the types of female interviewee and their approach to career development, I provide real life examples of how the factors discussed above impacted their careers. Secondly, I suggest a solution of how women can address the embedded structural pillars of the '*old boys' network'*, which holds the glass ceiling in place – to beat the old boys' network there is the need for a '*new girls' club'.*

In grouping the twenty interviewees into four distinct segments (women on the NBP, women below board level, women at board level and a group of men) for the purpose of data collection, I inadvertently created a way to group the data for analysis. On reflection this masked some of the texture from the responses. On further consideration it was apparent that while the segmentation provided a useful insight into where the individuals were in terms of their current career path, it did not provide a comparative measure of individuals overall career trajectory. For example, a person currently occupying an executive position might have secured their role after thirty years, whereas an individual with five years' experience might be only one rung below.

Reading the vignettes from the four interview groups, I was struck that by rearranging the order, a chronology can be formed. Women arrive in the workforce eager and can progress quickly through the junior positions (interview group three). Then there is a fork in the path, women wanting to progress their career look for future personal development opportunities, such as the Nye Bevan Programme (interview group one). Whereas those who start families look to delay their career trajectory, waiting for a time when their children have flown the nest (interview group two). Backing this chronology up with data from the pre-interview questionnaire, does indeed support this conjecture. Interview group three is the youngest demographic and have fewer or younger children. Those in interview group two are typically older, with older children. The higher level of attainment of those in group two could be explained as being a product of more time in the workplace equating to more skills and experience resulting in career opportunities. However, this dismisses a level of detail that the interviews provided; it was a conscious decision to delay their careers; as mothers they knew the difficulty in balancing their home life with that of a career. These women also held the view that their partners' careers were more important, even if their partners were not the higher wage earner. Contrast this now with the vignettes for the male interviewees - nothing had interrupted the march of their careers. They are young, they have families, but they still have on average a higher level of career attainment than the females in group three.

With the above observations concerning the vignettes in mind, I re-examined the interview data and discovered there were in fact two distinct groups of female

interviewees, which I dubbed the '*go getters'* and the '*meanderers*.' The '*go getters'* were typified by rapid career progression, they sought out all opportunities for career development, moved roles rapidly and systematically, created and maintained strong networks and mentoring relationships; they had a plan which they stuck to and achieved their goals. If the go getters had young families, then they leveraged a support network to help them focus on work. In this respect the go getters are like '*rising stars'* (Sigh et al, 2009), as they have mentors, a detailed career plan and seek out professional development; all those factors acting together combine to amplify one another.

The meanderers' careers were less planned, and things seemed to happen to them rather than them making things happen. The meanderers were still successful in their chosen careers; they are valued by their peers and are highly competent. The key variance is that they achieved their position in a less deliberate manner; it was less of a conscious process. They were no less or more competent than their '*go getting'* comparators, but they were less focused on status and attainment. An example might be that a meanderer was encouraged by a superior to apply for a new position, whilst a '*go getter'* had proactively sought out a new opportunity.

It must be recognised that grouping individuals in this manner does, of course, open the door to biases as another person might well categorise the same individuals into alternate brackets. To fall back on a theory-based system for the utilisation of these two distinct labels, it is possible to reflect on Weber's value-freedom, which removed the necessity of '*social phenomena* [to] *be scientifically validated'* (Ciaffa, 1998, pp. 13). This approach often faces the criticism of being '*arbitrary and dangerously restrictive'* (Ciaffa, 1998, pp. 13) due to its apparent discounting of empirical research and scientific rigour. However, Weber argued that empirical evidence must remain '*value free'* (Ciaffa 1998, pp. 16). A central purpose of value freedom is to '*deepen the analysis and theorise better…with new facts'* (Betta and Swedberg, 2017, pp. 446). The aspiration, therefore, is to reach beyond existing theories and explanations to identify new ground. However, the other theme central to Weber's position was that it was not for the researcher to advocate their own values or what they deem to be the '*preferred version'* (Betta and Swedberg, 2017, pp. 448). This creates a contradiction, as it requires the researcher to promote something which they have observed but do not necessarily believe to be just.

I can relate to this last element, as whilst I feel there are two distinct methods of career progression (i.e., go getter or meanderer), I am not advocating one over the other.

Fiona, who I classified as a meanderer, had this to say about how she perceived the split in the two types of individuals that she saw,

> '[There are] *two different types of people in the NHS, there are those that are really passionate about it, they want to be hands on and be very patient facing…then I think there is very much the career NHS person, as I like to call them, who will be fast tracked through everything; their only aim is to be on a board and they miss quite a bit of that understanding on their way there.'*
> Fiona (Nye Bevan Programme)

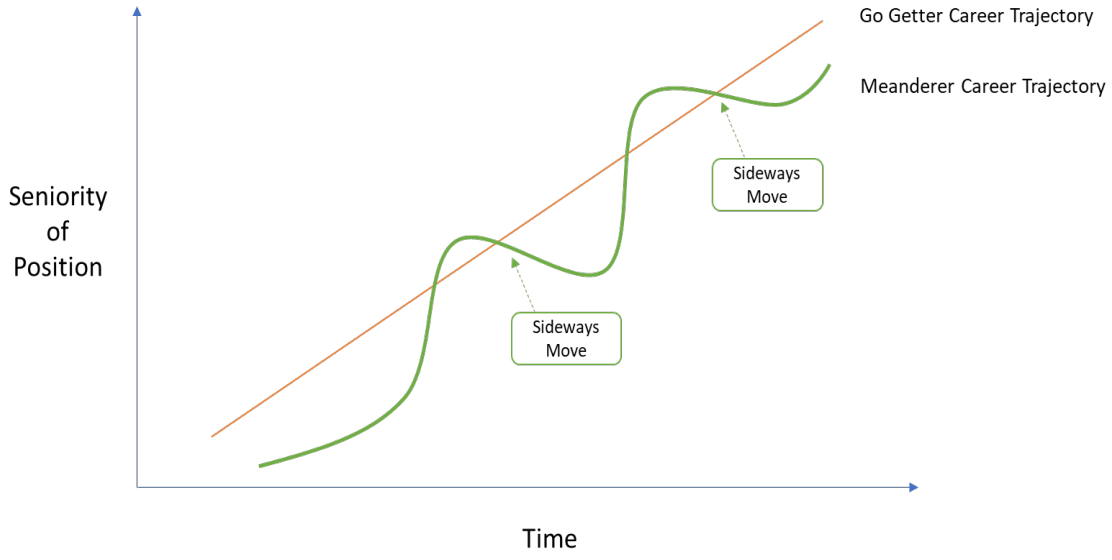

Figure 7: The Career Trajectory of Go-Getters Vs. Meanderers

Source: Author Generated

The meanderers trajectory displayed in Figure 14, above, is reminiscent of the zig-zagged path more commonly associated with women (Selva, 2013). Could this then suggest that meandering is a more typically female approach to career progression, whilst the go-getters are following a course previously the reserve of men? To take this

a step further, by being more aggressive in their career plans, are they able to make greater inroads into senior level appointments? This more masculine approach to career progression may have its routes in the historic difference in each gender's level of ambition (Hewlett and Buck-Luce, 2005), otherwise construed as the male need for '*social dominance'* (Pinker, 2011, pp. 570). Additionally, I have noted above that those with a more detailed career plan progress more quickly and, again historically, this was something men were more prone to do (Jung and Takeuchi, 2016). Finally, this '*go getter'* approach has been advocated by those working to eradicate the glass ceiling at a national level. The promotion of '*a linear fast track role'* (Prof Sealy, Women's Hour, 2020) as the key manner of accelerating women's careers, was highlighted by Prof Sealy, lead author on *The Female Board Report 2016,* a document aimed at increasing female board membership in the NHS.

The classification of people into these two groups is not meant to say one is more desirable than the other; often it is a question of choice rather than ability. This aligns to preference theory (Deschacht et al, 2015), as explained in the literature review; this dictates that some women will opt to choose a slower career trajectory – they prefer to prioritise other aspects of their life, such as raising a family (Deschacht et al, 2015). However, it could be argued that by preferring the go getter approach, it is possible to reach executive roles sooner. The difference therefore between a go getter and a meanderer helps answer the research aim of this topic, how do you break the glass ceiling? You make it your aim to smash it. This by no means attempts to hide the existence of the glass ceiling or suggest that its existence is merely a question of paradigm. What it does indicate is that to overcome discrimination, the eradication of the glass ceiling must be added to the career to-do list.

8.2.2 The New Girls' Club

When Loden popularised the term Glass Ceiling, she did so in her book *Feminine Leadership, or how to succeed in Business without being one of the Boys* (Loden, 1978). In the book title Loden made it evident as to what she thought was a major cause of the glass ceiling: it was a result of not being '*one of the boys'* or in other words, not being part of the '*old boys' club'*. The old boys' club creates images of old school ties, back slapping, and bonding on sports fields. This has come to traditionally mean white middle-

upper to upper class men, who offer promotions and business opportunities to people from their own exclusive – higher status – network of friends and associates (McDonald, 2011). The old boys' club sometimes utilises visual markers; think about civil servants in Whitehall, their network stems from the dark blue and light blue ties of Oxford and Cambridge, demonstrating their alliance to elitist universities (Friedman and Laurison, 2020).

In practical terms, why is the old boys' network a concern to women; how does it exclude them from power? The old boys' network traditionally ensured ownership of ideas; think of conversations taking place in locations that could exclude the presence of women, such as private members clubs with exclusive membership, only open to men by invitation. A prime example of this old boys' network is the number of Old Etonians who are Conservative MPs in the British Parliament, which was around one in ten following the 2017 general election (Pasha-Robison, 2017). An even weightier example comes from Oxford University's Bullingdon Club, which in recent history spawned three of the most senior Conservative MPs in the country, who were all club members together at the same time (Ronay, 2008).

Forty years on from Loden then, how might we overcome the dominance of the old boys' club? The need for a new girls' club was first raised in the literature when it was noted that women have '*visible markers of membership to less powerful groups in the workplace'* (Atewologun and Singh, 2010, pp. 334). Thus, there is the need to invert this image by creating stronger mental associations. The old boys' network creates a mental image of private members clubs, Eton school ties and firm handshakes, what then might a new girls' club look like?

The new girls' club is a way of working within the system to succeed without breaking the rules. It consists of discussions over coffee, WhatsApp and Facebook groups, offers of formal mentoring and coaching, as well as all important information about the job market and promotions. Social media has already been shown to be successful in establishing female networks in healthcare, especially the use of Tweets and YouTube videos (Abelson et al, 2016). Inclusion in this group appears difficult to specify; to the outsider it can look like two extremes. At one extreme, it entails your face having to '*fit*'

to be part of the group - you must be successful, driven and bring something to the table. At the other extreme it is just a group of friends chatting over their lunch break. What makes the new girls' club so special is that its members are not even necessarily aware of its existence; it has sprung up because of the need for an antidote to the old boys' network, but it was not intentional or even conscious. With the new girls' club, it is a question of when to act and how to use the network, e.g., for new employment opportunities. It is a female tendency to not *'showcase'* (Hurn, 2013, pp. 200) their skills in the same way men would. However, women may be less resistant in showcasing the skills and ability of a female colleague. Therefore, one role of the new girls' club could be in promoting fellow members to those both in *and* outside the network, to enhance their reputation and therefore the likelihood of their appointment to more senior roles.

The new girls club is a disruption to the current status quo, but without realising it. As evidenced in the interview data, most interviewees stated they did not think of their networks as networks because of their informal nature. The term new girls' club is already alive on social media networks, although a Google Search (as of January 2022) whilst returning close to a billion hits, had few of any great relevance. '*Lean In circles'* offer a valuable insight into the type of activities that a new girls' club might offer to its members. Lean In circles are a product of Sheryl Sandberg's book *Lean In* (2014), in which Sandberg challenged her female readers to lean in, which is to say, seek out challenges and push themselves. Speaking at TEDWomen in 2013, Sandburg stated there were already over 12,000 Lean In circles across the globe. The dedicated Lean In website describes their purpose,

> *'Our Lean In Circle community is a vibrant network of women in almost every country. Since 2013, we've been connecting over shared experiences, building each other up, and cheering each other on.'*
> LeanIn.org (2019)

Lean In circles are meetings either in person or virtually to '*connect with other women, build new skills, and support* [their] *career*' (LeanIn.org, 2019). The idea behind Lean In circles is that women can generate support and encouragement for each other which is lacking in the workplace or wider world. This peer support and advice covers issues such

as challenging gender bias, developing leadership skills, learning negotiation skills, and dealing with work-life balance (LeanIn.org, 2019). All these are elements that were continually highlighted in the literature, interviews, and quantitative research as being vital in moving towards gender equality.

Why is a new girls' network the answer compared to other interventions? The statistics and literature repeatedly demonstrate that whilst vast inroads have been made into the glass ceiling, it still exists. This is despite a host of measures from quotas to employment law, to dedicated development programmes for minority groups. So, considering the evidence of discrimination and the inadequacy of the measures brought in to eliminate it, how are women managing to break through the glass ceiling in some industries and organisations? The evidence gathered in the literature review appears to demonstrate that the most effective tool available to women, beyond unpopular quotas and positive discrimination, is the power of networks. The ability of women to come together to mentor, support, discuss up-coming challenges and job opportunities, and to offer advice of balancing family life and a successful career. These informal support groups have created the new girls' club.

It is clear to see the applicability of the new girls' club in relation to the overarching conceptual framework of the Healthcare Leadership Equality Framework, Section 8.1. Networking is a central element of the framework pertaining to the role of the individual and aligns to the two other elements of seeking promotions and self-promotion. Looking at wider theory, it could be suggested that the model of the new girls' club fits well with the female preference for transactional-transformational leadership (Wolfram and Gratton, 2014). The relevance is the fact that transactional leadership is '*exchange relationship between leader and follower'* (Bass, 1999, pp. 10), which can be linked to the importance of the interactions of members in a network, as both senior and junior members benefit from the relationship. On the transformational side of the equation, these traits speak to the qualities which have been observed as predominately female. These transformational qualities include '*a more socially oriented or relational approach to leadership, which is less hierarchical and focuses on collaborative learning'* (Wolfram and Gratton, 2014, pp. 340). Using the qualities of the transformational leader it is

possible to see again why the new girls' club would be so potent, as it is by its nature a social construct based on relationships not seniority.

From an additional theoretical standpoint, the establishment of a new girls' club would align with the conception of phronesis, which provides '*distributed wisdom'* (Nonaka and Ryoko, 2007, pp. 371) through a network. Further exploration of phronesis in professional practice, is its use to seek '*moral significance'* (Kinsella and Pitman, 2012, pp. 1) of what it means to be a professional. Aristotle first discussed the idea of phronesis, which he conveyed to mean a form of prudence, wisdom, or '*an intellectual virtue that implies ethics'* (Kinsella and Pitman, 2012, pp. 2). Whilst Aristotelian in origin, its roots lie with Socrates' reflection on dialogue, which fits the nature of an informal network.

Given phronesis is '*closely related to wisdom'* (Kinsella and Pitman, 2012, pp. 7), it can be taken to mean that group wisdom can be derived from the interactions of likeminded individuals. Similarly, Jones et al (1996) described knowledge elicitation as '*the subset of knowledge acquisition which relies upon a human expert as the primary source of information'* (1996, pp. 3). It is interesting to explore the link between the phronesis which generates knowledge in a female workplace network (such as the new girls' club), with phronesis information which would be shared for the '*common good'* (Nonaka and Ryoko, 2007, pp. 378). This common good would take the form of job advice or information about new opportunities. Such a knowledge basis and pedagogy would be passed on through these formal and informal networks, enabling the members to learn from the senior contributors (or leaders) on, for example, techniques on excelling in a male dominated hierarchy.

8.3 Summary

This chapter has sought to bring together the initial theories first identified in the literature and explore their validity in the NHS by comparing them to data from the quantitative and qualitative research. It was demonstrated that the central barrier to female progression to the boardroom remains the fact that women still tend to be the main carer for their children. The next issue was that, historically women have adopted male traits to facilitate their careers, which is at odds with the identity of female leaders. This has led to a dearth of feminine leadership skills on display at executive level. This is changing

however, as the importance of a diverse leadership team is becoming better understood. The other fundamental barrier is ensuring female leaders have the belief and willingness to apply for executive roles. Women are less likely to apply for director roles, as on the one hand they are less likely than male applicants to think they will be successful. Contrast to this, women are also less willing to apply as they do not want the increasingly thankless task of being an NHS board member.

To address the glass ceiling my research suggested three emerging strands which should be considered. Firstly, the Healthcare Leadership Equality Framework should be regarded as a useful tool which can be used to structure a process of professional development and career advancement. Secondly, patterns were established through the interview data, that those most proactive in terms of their career development, the go getters (by applying the elements of the Healthcare Leadership Equality Framework), were able to accelerate their careers much more quickly when compared to the non-linear career paths of the meanderers. Thirdly, the new girls club provides a means for female leaders to network, exchange knowledge and subvert the old boys club.

In the following two chapters, there is first the opportunity to test out some of the ideas discussed in Chapters Seven and Eight, in a real-world situation, given that the COVID-19 pandemic occurred prior to the second set of interviews with those on the Nye Bevan Programme. Thus, I was able to take some of the initial theories discussed above and consider whether the pandemic had provided any evidence to support or amend existing explanations for the glass ceiling. In Chapter Ten, I provide several recommendations directed towards various stakeholders based on the entirety of my research, prior to reflecting on the overall research process.

Chapter 9: The Impact of COVID-19 on Female Leadership Progression

"*Men are taught to apologise for their weaknesses, women for their strengths*."
— Lois Wyse (Time, 2008)

9.0 Introduction

During the third year of my research, in 2020, the COVID-19 pandemic spread across the world. Initially I felt that this would have little impact on my project, having already conducted much of the data collection, with only five interviews remaining. As the pandemic set in, I started to discuss the impact it was having on healthcare managers and realised that the effects of COVID-19 permeated all aspects of their work-life. I observed that many of the trends, traits, and patterns that I had identified in my primary research were being accelerated because of the response to the virus. For example, research published in 2021 noted that working parents stated that the pandemic had positively impacted their workplace culture (Working Families, 2021), due in part to the increased use of flexible and remote working. This led me to expand my research to see how the pandemic affected barriers and opportunities identified in the previous chapters. Section 9.3 demonstrates how much of conditions which the pandemic created fit within the conceptual framework from Chapter Eight. These were enablers which were identified earlier in my data collection as being important to female career development (for example, remote working) and were normalised or accelerated due to the pandemic.

Secondly, due to the wide-ranging impacts of the pandemic, it was possible to ask if the NHS would fundamentally ever be the same again? The delay to elective surgery had caused waiting times to balloon (British Medical Journal, 2020) and the already precarious financial position of the NHS had weakened (The King's Fund, 2020). However, public opinion regarding the NHS rocketed, with the majority of the public feeling NHS staff deserved to be paid more (UNISON, 2020). The pandemic required new ways of working, brought new practices to the fore and tested system wide integration and leadership. If the NHS is changed forever, will the new structure accelerate the smashing of the glass ceiling?

One of the most obvious examples of this was the need to normalise flexible and remote working – two factors which had been shown in my earlier research as being especially

beneficial to young mothers. Similarly, at a time of crisis, I was keen to explore if the pandemic focused people on their careers or did it make them feel their families were more important to them, leading them to question the value of their career goals? Or did it increase the belief in the work they did and encourage them to push their careers to the next level?

Third, the Coronavirus brought to the attention of the world the ability of female political leaders, who quickly understood the magnitude of the outbreak and took swift decisive action to minimise the effect on population health and the financial impact. Those lauded through 2020 were Jacinda Ardern, Prime Minister of New Zealand, and Angela Merkel, the German Chancellor – they were not alone. An article in Forbes as early as April 2020 also credited the rapid intervention of the leaders of Taiwan, Iceland, Finland, Norway, and Denmark – all women (Wittenberg-Cox, 2020). This led to the question, is there something about the female leadership style which is better suited to a crisis than the traditionally masculine approach?

9.1 Research Process

The Coronavirus reached the UK after I had already conducted the first twenty interviews. However, I still had the second interviews with those on the Nye Bevan Programme (NBP) to complete. This meant that the second interviews with those on the NBP provided a unique insight into how a major event had affected their views on their professional standing, their industry, and their wider lives. As such, whilst the Coronavirus did not affect my ability to complete the research in the given timelines, it did add a richness of responses which was explored in the final group of interviews. To gather additional further information and context from the other fifteen interviewees (i.e., those not on the NBP) about the impact of COVID-19, an email was sent to them asking for their comments based around a set of prompts or if they preferred, they were given the opportunity to take part in a shortened 30 to 45-minute interview. Five people responded to my email providing written comments and one person agreed to a follow up interview. In terms of analysing the interviews, the same approach and methods were adopted as for the previous interview data, which is mapped out in detail in Chapter Three.

In total there were contributions from eleven individuals. Those who provided responses in writing were two male managers (Jed and Tony), two female directors (Sandra and Lucy) and one female senior manager (Isabelle). The non-NBP person who agreed to a follow-up interview was Barbara (female senior manager), in addition to those five people on the NBP who provided relevant content during their second interviews.

The domains which were provided for written responses and used for the interviews (for both those on the NBP and the other person who volunteered for a dedicated interview on COVID) were:

- Has COVID-19 changed the skill set, approach or leadership style required by NHS managers?
- Have your opinions on flexible working been altered by how you have needed to operate during the pandemic?
- Have your views on career progression been altered over the last 18-months?
- Have your feelings towards how you approach your work-life balance changed?
- Have your views on your role as a healthcare professional changed?
- Do you have any other thoughts which you would like to add?

9.2 Written and Interview Content

The pandemic had such a profound impact on healthcare professionals, not only because they were on the frontline, delivering services, working additional hours, and having their roles changed, but also because with such big teams to manage they directly experience the human toll of the virus.

> *'A number of staff have lost members of their family; we have one member of staff who lost five members of their family…We lost a member of staff as well unfortunately, she had a sudden and unexpected cancer diagnosis went into hospital, contracted COVID and went. That was shocking. And I had at least 5 members of staff at one point hospitalized with COVID. The fears for staff, the anxieties for staff are absolutely tangible, perfectly legitimate.'*
> Allie (NBP)

The respondents felt like the NHS had been able to react rapidly to the pandemic; it '*broke a lot of preconceived ideas about what can and can't be done'* (Tony, Male

Manager) by creating a '*burning platform and that sense of urgency'* (Fiona, NBP). NHS staff did feel underprepared for the '*tsunami*' (Fiona, NBP) that hit them, but it was viewed that managers were able to act more cohesively and flexibly to facilitate new ways of working. This was combined with a need for a new range of technical and tactical changes. It also meant that the NHS could implement changes which it had contemplated for years, in terms of improving services and saving money, which have been vital during the pandemic.

> *'The changes that we have seen through COVID have just been astronomical in terms of the impact on the NHS, but also the stuff that we have just been able to do, that we have been talking about in the NHS for years, like virtual appointments. It has just cut through a lot of unnecessary red tape and faffing that we like to do sometimes in the NHS. It has been a catalyst for loads of positive changes.'*
> Anita (NBP)

At the start of the pandemic the prevalent management style was described as '*command and control*' (Sandra, Executive Director). As seen in the previous interview data, this style of leadership was deemed as outdated and at odds with the more feminine style of management. Some felt that this happened because '*people gravitate towards what they know*' (Fiona, NBP) in a time of crisis. That said, there was a '*grudging acceptance*' (Barbara, Senior Manager) that in times of crisis, command and control can be the most appropriate management system, but only for a short period. Around four weeks into the crisis, once the scale of the challenge was known, there was the need for a more collaborative (more feminine) management style, due to the need to engage with all parts of the healthcare system, so they could work in unison to bring '*structure and clarity'* (Barbara, Senior Manager).

When considering their identities as healthcare managers, there was talk of the pandemic providing a '*guiding principle'* (Jed, Male Manager). I inferred this to mean it enabled managers to see what was important in their careers and day-to-day practice; it removed conflicting priorities of access targets and finance, which enabled them to focus on delivering safe patient care. There was a recognition that the normal routine of the

day job, with its focus on cost improvement, performance targets and risk management, was somewhat divorced from the role the leaders found themselves needing to take during COVID-19. In a way it recontextualised their roles, which had been overburdened with administrative tasks, into more important first line decision makers, proactively responding to an evolving situation. This was a premise which all the respondents appeared to relish, as it was this aspect of the role which drew them to the profession, and it increased their sense of self-worth as a healthcare manager. As one respondent noted, it helped them answer the question of '*am I good enough'* to do my job, with a resounding '*yes*' (Barbara, Senior Manager).

An often-cited requirement for working through Coronavirus was resilience, because as Zara (NBP) put it, the pandemic added more work to an already stressful job and COVID '*has been an enormous test of resilience*.' Other qualities required, after the initial shock of the pandemic, was the need to be '*compassionate and to be open and transparent*' (Sandra, Executive Director), again traits, from the first raft of interviews, thought to be more prevalent in female leaders.

Strong communication processes were important, even when the message to staff was to admit that leaders did not have all the answers but were prepared to listen to the concerns of staff. Lucy (Executive Director) described the need to communicate and listen to staff members as being akin to '*holding*' the staff member, in what can be best regarded as a verbal hug. This move to compassionate leadership created a sense that, not only had women leaders shown their value as equals during the pandemic, but that in many ways they had outshone their male colleagues.

> *'The* [value] *of female leaders* [during the pandemic was demonstrated]*, because females do tend to be a lot more compassionate. I don't really care who says anything to come back at that. And I think that leadership has been really telling globally, female leaders are better at responding to crisis than our male counterparts, both in the political realm and the healthcare realm as well.'*
> Barbara (Senior Manager)

Even when working remotely, there was evidence to suggest that men can still try to dominate and misappropriate work from female colleagues, an obstacle to gender equality gleaned from the literature in Chapter Two. Barbara felt undermined by a male colleague who wanted to detract from her achievements. As recounted by Barbara, this male counterpart was focused on minor administrative tasks during the peak of the pandemic, whilst Barbara was at the heart of the action, making key operational decisions from the middle of the COVID wards. It could be argued that the choice of her male colleague not to work on the hospital site during a pandemic was due to concerns over his own health. However, the fact that he was trying to undermine her, by going behind her back to try and implement conflicting plans with the Chief Operating Officer, betrays a fear that he did not want to be undermined by the achievements of Barbara.

In practical terms, the most obvious disruption the pandemic caused related to the place of work and the duration of the working day, with many managers working from home and some changing their work patterns to cover weekends and evenings. There was a trade-off, as operational managers were keen to be onsite and in command, which conflicted with the need to work remotely where possible, to minimise the spread of the virus and promote social distancing. With many hospital services suspended, the role of managers changed and, due to operational needs, most managers frequently worked long days (mainly at home but two managers on-site also reported working longer days). Finally, there was an increase in remote working and virtual meetings. The confluence of these factors affected all the respondents differently. For example, Jed (Male Manager) moved from working Monday-Friday 09:00-17:00 to working every other day (including weekends) for twelve hours at a time. Those who remained onsite during the pandemic spoke of the need for '*visibility*' as a leader (Sandra, Executive Director). Barbara (Senior Manager) moved her physical workspace to being adjacent to the wards where COVID patients were being treated, to be '*side-by-side'* with her clinical colleagues. Meanwhile, her line manager opted to work remotely for the entire period.

When managers did work from home, either out of choice or due to the need to self-isolate (because they were exhibiting COVID like symptoms), they spoke of being successfully able to utilise a range of IT solutions, such as WebEx, and Microsoft Teams. They were also able to connect to their work files and maintain communication with their

colleagues. Despite the success of the IT connectivity, two of the respondents (Sandra, Executive Director and Barbara, Senior Manager) were keen to highlight that their personal preference was to meet people in person and that remote meetings are not as valuable as face-to-face ones. Virtual meetings were thought to feel more formal; attendees waited for their time to talk and were less concerned about the content the other delegates provided; there was less cutting across and less challenge to the speaker. This lack of cross fertilisation and lack of '*soft intel'* (Barbara, Senior Manager) meant meetings were more often a tick box exercise than a tool for creative thinking and problem solving - although there was a feeling that Microsoft Teams meetings would now become part of the working norm.

Despite not being as effective as meeting in person, there was a view that some meetings, i.e., those that do not require a great deal of interaction between attendees (such as waiting list performance meetings), could remain on Microsoft Teams, especially as this would eliminate travel for hospitals based on multiple sites. Additionally, one manager (Zara NBP) noted that even though she had only been in the office once a week, because of the push to virtual meetings she had received feedback that she was more visible to her team (who were spread over a large geographical area). This paradox of being more visible during the pandemic was echoed by Alli (NBP); the feedback from her staff was such that the management team received its best staff satisfaction survey results ever.

Not all respondents had benefited from flexible working arrangements, but there was consensus that there was bound to be a movement towards greater flexible working in the NHS, as it followed other industries. Jed (Male Manager) described his team as '*place neutral*.' However, Jed's team were in the minority. When other leaders were asked to speculate on whether they could retain more flexible, remote working after the pandemic, the common view (five out of six respondents) was that it was still not possible for operational managers to work off-site, '*given the need for managers to be visible. I think that COVID only emphasised that need even more'* (Anita, NBP). However, when I posed a follow up question, one Senior Manager (Barbara) thought it might be possible for senior managers to work at least one or two days per week at home. To reiterate, flexible working is a key tool in enabling increased participation of leaders with childcare

responsibilities. Therefore, the increasing flexibility of the NHS is a positive change; however, even with the stimulus that COVID gave the NHS, there are still attitudinal barriers which mean that NHS managers will never enjoy complete flexibility.

The pandemic did create challenges in terms of line management. Zara (NBP) saw a lot of her staff redeployed to other teams. Ellie (NBP) spoke of the difficulties in measuring the mental health impact of the virus on staff and finding ways to support them. Apart from this there were practical issues to contend with. Ellie (NBP) had a new staff member start with her team, but the individual was struggling as she did not have people around her to show her the ropes. With other team members, Ellie discussed how it had been hard to motivate people; there were staff members who were not working to capacity, and '*some people sacked it off and were not fully utilised'* (Ellie, NBP).

The interview data in Chapter Five identified that operational managers required experience in on-call and urgent care to build their careers. This is because of the enhancement it provided in terms of tacit knowledge and the confidence acquired from exposure to critical decision making. The information gleaned from the COVID responses indicated that leaders were able to gain a huge amount of this type of experience during the pandemic. A reflective comment was that the pandemic '[had] *been a huge learning curve but really valuable'* (Anita, NBP). This was particularly beneficial to female leaders, whose work-life balance had previously precluded them from being able to be on-call or taking on more hands-on operational roles. One example was Ellie (NBP), whose remit was changed at the start of COVID to look at regional planning; this meant taking part in the incident manager rota and working some weekends. This allowed Ellie to demonstrate her skills and enhance her reputation with her line manager. COVID took Ellie outside her comfort zone which she valued; however, she would have liked to work on some of the larger, '*sexier*' (Ellie, NBP) projects such as the Nightingale Wards.

Barbara (Senior Manager) felt that the pandemic had provided her with both a platform to showcase her talent as well as a valuable learning experience, which enabled her to hone her skills. Whilst her line manager opted to work from home, Barbara spent the period of the pandemic on-site and, by working closely with her clinical colleagues, was

able to enhance her reputation, particularly with her CEO. On the back of this, Barbara achieved a promotion to director during the pandemic. She felt that the operational experience she gained gave her the knowledge and confidence to perform her new role better. This example illustrates that the pandemic did enable female leaders to showcase their talent and be recognised for it. Another respondent (Zara NBP) discussed the effect of the pandemic on her search for career advancement; she had suspended her job search because of the uncertainty of COVID, stating she would look to '*regroup'* and look for more opportunities in six months. Allie (NBP) also reported putting her career on hold; she had been informed that her post was being removed as part of a re-organisation. She found this deeply disheartening on the back of what had been a very involved period.

I was keen to gauge whether the NHS leaders' views on career progression had changed because of COVID. The reason for this was to see if they had become more career focussed because they saw greater value in their work, or conversely, they decided that time with their families was more important. This was important as seen in Chapter Five; presenteeism was highly valued in the NHS in terms of career progression, so if the pandemic resulted in managers opting to spend less time in the office, it could negatively affect their promotion opportunities. The managers surveyed were asked, on reflection, if the pandemic had made them question whether dedicating so much time and energy on their careers was justifiable in relation to their work-life balance. The responses from the NHS leaders were uniform in that it had not changed their views, although one person (Sandra, Executive Director) did feel that it could facilitate a better work-life balance for working mothers, as the pandemic had shown that flexible working was possible.

One observation was that the pandemic had resulted in all respondents working substantially more hours. As seen in the initial interviews in Chapter Five, the interviewees were accustomed to working well above their contracted hours (for no additional remuneration) – COVID exacerbated this pattern. One person described this need to work longer hours as, '*a duty and responsibility….and I'm happy to do it'* (Tony, Male Manager). Being '*happy*' to do it demonstrated not only the willingness to work significant unpaid hours, but also the pride the managers were able to derive from their work during the pandemic. One person quipped that they did not mind working the additional hours because their '*social life* [had] *been quiet'* (Sandra, Executive Director).

However, three people were unified in their view that it has shown what is most important in life, best surmised as '*there is more to life than work'* (Lucy, Executive Director).

Continuing from the theme of pride detected in Tony's comment above, the respondents were then asked if their views on their role as a healthcare manager had changed. This question elicited the most positive comments, in terms of identifying a '*can do'* attitude or because of the satisfaction and self-respect the managers obtained from their jobs. Tony (Male Manager) discussed '*an obligation to deliver'*, meaning that he saw how important his role was to patients, in terms of them receiving the care they deserve. However, it was probably Sandra (Executive Director) who best captured the sense of self-fulfilment, '*I still love my job and I feel proud to be part of the NHS response to COVID*.' Part of the reason for pride was probably due to the public support of the NHS during the pandemic. The Clap for Carers campaign became a regular Thursday night fixture, as thousands of people showed their appreciation for key workers each week by clapping (Nursing Times, 2020). Public support did not end there; the respondents spoke of regular gifts to the organisations they worked for, in the form of donations of food, drink, clothes, toiletries, and money.

When given the opportunity to add any additional comments relating to the pandemic two people chose to highlight the positives that had come from the outbreak. Lucy (Executive Director) felt that three months' work had strengthened relationships which might have otherwise taken three years to develop. The pandemic had cut through red tape and accelerated budget decisions at a rate not previously seen. Fiona enthused about the opportunities that the pandemic had created, not only on a personal level where it had enabled her to build her networks and promote her skills, but also, she felt that she had been able to undertake a reconfiguration of the services that she managed which '*would have probably taken about 5-10 years to do ordinarily'* (Fiona, NBP). Isabella (Senior Manager) concurred that '*decisions have been made much more quickly*'. However, Isabella did also see some negatives, as some senior managers had tried to use the crisis for personal gain. In this respect she has seen some managers (of both genders) rush to be seen to be the ones driving forward the pandemic response, trampling colleagues in the process. Drawing this back to gender equality, this is

important because as seen in the literature and the interview data, this type of behaviour is more obvious in male leaders and more likely to disadvantage women.

Sandra (Executive Director) discussed the light the pandemic shone on the inequalities in society. At the time when Sandra submitted her comments to me it was publicly known that people from BAME backgrounds had been disproportionally affected by Coronavirus, as they were increasingly more at risk of contracting the virus (Pan et al, 2020). Here is another example of how the pandemic did not necessarily change society but magnified underlying conditions.

9.3 Links to the Healthcare Leadership Equality Framework

The Healthcare Leadership Equality Framework, presented in Chapter Eight, mapped out several enablers to female career advancement. These were evident at the meso, macro and micro level for the framework. It is possible to argue that the pandemic provided several opportunities for female leaders to leverage elements from this framework and use them to gain valuable experience. The most obvious where this was possible were work-life balance, self-promotion, networking, and critical job assignments.

The area of the framework concerning micro or individual level factors related to self-promotion. Whilst this might sound like self-aggrandizement, what this really means in terms of career advancement is gaining recognition for one's work. In earlier chapters it was evidenced that one of the best forms of self-promotion was presenteeism – being at work more was seen a measure of ability. Presenteeism often unfairly disadvantaged women, who had the burden of childcare commitments and were unable to be as present as a colleague without the same family undertakings. The pandemic enabled women to showcase their talent in rapidly evolving operational situations, often in a manner which could be shaped around their home arrangements, potentially by using remote working.

In a similar fashion to self-promotion and flexible working, the pandemic also enabled females to network more easily. This was partly because the normal working day was disrupted and partly because networking was much more virtual. Networking was pivotal during the pandemic; there was the need to quickly share information on best practice on how to manage the rapidly changing situation. Furthermore, the pandemic required

all players in the healthcare system to work together in a manner rarely done in the past. Again, female leaders had the opportunity to gain a large amount of networking experience and exposure in a short space of time, build a web of new contacts and display their talents to a range of new people. It was noted that this networking was not purely about self-promotion or sharing of best practice, but also to give and take emotional support by simply asking each other '*how are you doing?*' (Fiona, NBP).

The pandemic was instrumental in providing critical job assignments, by providing female leaders with greater opportunities to obtain operational experience. As expressed above, female leaders felt the exposure they received, in a relatively short timeframe, helped them build confidence and demonstrate their worth to their line managers. The pandemic, in the words of one interviewee, created opportunities which enabled them to '*raise my own profile, because I have been very proactive, and problem and solution focused rather than the normal culture*' (Fiona, NBP).

At a meso level, government interventions through the enforcement of social distancing and school changes, had a direct impact on the necessity of homeworking. Exploring firstly the work-life balance element of the Healthcare Leadership Equality Framework, the data from the interviews and written responses covered many of the issues set out in the earlier chapters as effecting gender equality. During the pandemic, managers had much greater ability to work flexibly. In previous chapters it was seen that greater flexible working can help dismantle the glass ceiling, as it allows working mothers to take a more active role in the workplace. However, the responses indicated that such a level of remote working seen during the pandemic cannot be sustained permanently and, whilst it reaffirmed the view that some administrative tasks can be delivered off-site, leadership cannot be done remotely. One of the much-touted tools for enabling flexible and remote working is the increased use of IT solutions, which after many years of low usage were finally jumped on by the NHS. Microsoft Teams and cloud storage of files (for remote access) were all valuable tools but could not completely replicate or replace face-to-face interactions.

9.4 Summary

Undoubtedly the number of NHS leaders who provided data for this chapter is low, and one must ask how firm the findings are. Secondly, it is also impossible to state that the

changes observed will lead to permanent structural alterations. However, such distinctions miss the point of this chapter; what was being explored were the findings from the previous chapters and testing them against an accelerated change process – albeit potentially temporary – to see if those factors deemed as important to promote gender equality, when played out in the real world, sufficiently benefit female leaders.

The purpose of this chapter was not to explore if COVID-19 had had some profound implications which would change the nature of work, although this could well be the case – indeed one interviewee noted '*I mean it's a completely different world'* (Fiona, NBP). More, the purpose was to explore whether COVID-19 had sped up some of the underlying opportunities which had already been seen to be at play in promoting gender equality in the workplace. Whilst there was some evidence to show that this was indeed the case, with one female leader stating that she had '*a lot to thank COVID for'* (Fiona, NBP), there was also evidence to suggest the pandemic amplified some of the barriers to workplace equality. Also, in relation to their identities as leaders, it helped remind managers (male and female) why they wanted to be healthcare leaders, due to the sizable contribution they were able to make to their communities and patient care.

It is necessary to highlight some of the limitations with this chapter, which are primarily a consequence of having such a small number of responses and a limited pool of interviewees. The most obvious limitation is the absence of women with backgrounds that might have reaped different responses. For example, I did not interview any single parents for this chapter or any women who were home schooling their children. Had I done so, I may have received very different responses; they might have reported that the pandemic affected them much more in respects to their ability to function in their job roles.

Chapter 10: Conclusions and Recommendations

"*We but mirror the world. All the tendencies present in the outer world are to be found in the world of our body. If we could change ourselves, the tendencies in the world would also change.*"

— Mahatma Gandhi (1913, pp. 241)

10.0 Introduction

This chapter provides a summary of the content of the earlier chapters. It then reviews the objectives of this project to assess whether these objectives were met, before providing an answer to the overarching research question. I then proceed to present several recommendations for the NHS. The aim of these recommendations is to improve gender equality within the NHS management hierarchy. Next, I seek to consider the contribution this study has made to the field of the glass ceiling in healthcare management, explore the limitations of this project and highlight areas for potential future research.

Chapter One provided definitions of the Glass Ceiling and reviewed the legislation which has been introduced to combat discrimination, including the Agenda for Change (AfC) pay scales in the NHS. The first chapter presented initial data to make the case as to why this study was necessary, as 77% of the NHS workforce is female but this translates to only 44% of leadership roles (NHS, 2016). In this primary chapter I also explained why gender equality is needed, which is to better serve the patient populations through a more diverse and more highly skilled leadership team.

Chapter Two reviewed the relevant literature, from three separate strands. I started by looking at all literature on glass ceilings from across the globe and from a range of other industries. I found that the causes of the glass ceiling such as discrimination, the lack of female role models and the necessity of women to provide childcare, still permeated the NHS. The solutions offered by the literature were to increase the use of quotas, better flexible working policies, development programmes and more female friendly networking opportunities. The possible barriers and opportunities identified in the literature helped to formulate my research tools. I was able to see which areas of data collection would be most useful, for example the quantitative analysis focused on the gender composition

of NHS boards, the recruitment pipeline and uptake of development programmes. The qualitative approach was designed to test out each of the barriers with current NHS leaders, to establish the relevance to the NHS and identified opportunities for overcoming them.

The method and methodology were explained in Chapter Three. I discussed how I targeted the various trusts and individuals to take part in the quantitative analysis and interview process. This was done primarily by focusing on two geographical areas (London and the Midlands), to see if gender equality varied across these regions. I then described how by ranking the diversity of NHS boards, I was able to sample a range of NHS provider trusts by selecting organisations with high, medium, and low gender equality to establish if any reasons for these variances could be garnered. In Chapter Three I outlined in detail why I had adopted narrative analysis to digest the interview data, including how I came to opt for the Labovian approach to narrative analysis. This was due to the uniform template it provided, to look at all aspects of a person's narrative, in a manner which provided a straightforward output from the individual interviews. These templates could then be concisely compared across the interviewee groups through thematic analysis.

The quantitative and qualitive data were presented in Chapters Four and Five respectively. The numerical data demonstrated that whilst overall, there is only 54.3% male to 45.7% female imbalance, in terms of the total number of female executives, this masks some important factors. For example, if the figures discount the Directors of Nursing (which are predominately female), the proportion of female executives drops dramatically to 36.8%. Just as troubling was the dearth of female incumbents in the Chief Executive Officer and the Director of Finance roles, which had a proportion of male managers of 65.6% and 71.2% respectively. When I looked at the figures on the uptake of a development programme for those seeking roles as executive directors (the Nye Bevan Programme), it was possible to see that the gender split was proportional to the number of male and female employees at the level at which the programme was aimed. The next section of data analysis reviewed recruitment for executive positions at one NHS hospital and showed that, whilst women were less likely to apply, they were as likely to be appointed as men. Taken as a whole, the varying levels of quantitative

analyses provide a useful narrative: whilst there is gender imbalance at executive level, women are seeking out board level development programmes and when they apply for executive roles, they have a strong likelihood of being appointed. The difficulty it would seem, was increasing the number of female applicants for board level roles and understanding why this number was suboptimal.

The interview schedule for the qualitative analysis was shaped to help understand the trends from the quantitative data. Chapter Five was able to expound that many of the explanatory models from the literature were relevant to the NHS. There still existed in the NHS, an ingrained culture of discrimination. For example, this meant that women were less likely to be appointed if the interview panel members thought that the person might soon need maternity leave. It was shown that there was still a lack of female role models in the NHS, with a proportion of current female leaders (queen bees) less willing to support the advancement of new female leaders. It was childcare responsibilities which had the greatest impact on women's careers, since they still faced the higher burden of care (compared to men). The flexible working policies, designed to help working mothers, were ineffectual for senior female leaders. Chapter Six took the interview data and presented it in vignettes, so that the reader was able to gain insights into the lives of each of the interview groups.

Chapter Seven pulled together the various strands from the literature, quantitative and qualitative research. Chapter Eight acknowledged the findings above, then sought to provide a unifying conceptual framework which incorporated the causes of the glass ceiling, whilst categorising them in a manner which enabled opportunities to overcome these barriers. This was encompassed in the Healthcare Leadership Equality Framework, a Human Resource Development model which provides a concise overview of the four levels of factors which emanate from the data, the macro level, those at an organisational level, the immediate work environment and those which the individual can affect. In addition to the Healthcare Leadership Equality Framework, Chapter Eight investigated areas from the framework in more detail to offer more prescient insights on the key trends from the data. Firstly, there was the observation that there appeared to be two distinct approaches towards career advancement noted from the interviewees. The go-getters were much more career orientated, taking a linear and targeted approach

to gaining promotions, whilst the meanderers took a more circuitous route. This observation of a difference in mindset did not seek to use it as a justification of the glass ceiling or state that one approach was more desirable than the other. It did, however, suggest that by having a more pro-active and targeted approach to career advancement, it might be possible to overcome the discrimination present in society and the NHS more quickly. I then went on to note that the powers of informal and formal networks (a new girls' club) were such that, by adopting networking more readily, it would be a signifcant boost to an individual's career. This is due to the support they provide, in addition to accessing best practice and knowledge of job opportunities.

Due to the unique time in which I undertook my research project, it was possible to expand my data collection to observe the impact of COVID-19. This forms the basis of Chapter Nine, in which I was able to use interviews and a brief questionnaire to garner the impact of the pandemic. Therefore, I was able to further test my assertions from Chapter Eight and see how the Healthcare Leadership Equality Framework could explain what the data was relaying. For example, because of the pandemic it was possible to see that some female leaders had been able to gain significant operational experience, which they had previously missed due to being the lead carer for their families. This had the benefit of them achieving promotions to executive positions. Secondly, the enhanced use of networks throughout the pandemic, for support and instruction on how to deal with it, was noted as a huge benefit by the female leaders.

Overall, it is firstly important to acknowledge that the NHS is doing well compared to other industries and has committed resources to the issue of combating gender inequality. It is doubly important that the NHS achieves gender equality to act as a beacon to other sectors. It could be argued that, as a public body and one of the largest organisations in the world (Forbes, 2015), dismantling the glass ceiling in the NHS could have wide reaching consequences nationally, if not internationally. The data presented in earlier chapters noted NHS female boardroom representation of 42% (Kline, 2014), which far exceeded the average of FSTE 100 companies of 16% (Hurn, 2013). However, my research has shown that progress in the NHS appears to be slowing, whilst other industries continue to advance. As seen in the literature, the NHS does not have some of the challenges that other industries claim inhibits gender equality. The NHS workforce

is almost three-quarters female (NHS, 2016); it has a well-stocked pipeline of future female leaders and has well-defined career pathways for female managers to become executives. Despite this, my research shows there is still severe underrepresentation of female leaders in some key executive positions, most notably at Chief Executive Officer, Medical Director and Director of Finance level.

The NHS may be reaching a plateau in its quest for gender equality; my research showed little progress from that of Kline (2014) in terms of the number of female board members. Explanations for this stagnation, stemming from my interview data, were shrinking budgets, increasing demands and excessive pressure – even before factoring in the COVID-19 pandemic. All these elements combine to make board level positions in the NHS much less desirable. A departing CEO's open letter to staff as she left her post in 2019 illustrates this perfectly. Siobhan McArdle wrote about the '*very challenging financial and regulatory environment'* she was forced to work in, which was '*underfunded and unsustainable'*, before she signed off with a warning to future CEOs that '*life is too short'* (HSJ, 2019).

The acknowledgement that the NHS still has some way to go to achieve true gender equality came as a surprise to several of the interviewees in my data collection. They questioned why I would even bother to explore the topic; but the data is solid - there is still an imbalance at the senior leadership level, albeit that it is not the case for junior management positions. It is prudent to ask if, with time alone, would the NHS self-correct in terms of gender parity? I think it is possible, but how long would it take for the glass ceiling to naturally erode? Also, time is something the NHS does not have, with diminishing budgets and spiralling demand, the NHS needs to act now to ensure its future viability.

10.1 Research Question

To recap, the title of this research project is *An Exploration of Women's Representation in Senior Leadership Positions in the English National Health Service*. To investigate the issues associated with this, the following research question was developed, Does a Glass Ceiling (GC) Exist in the English National Health Service and, if so, what are the factors acting as barriers to women accessing senior leadership positions?

In answering this research question, the following research objectives were developed:

1. Explore whether data on female representation on NHS boards indicate a GC.
2. Understand if a GC is proven, why it exists.
3. Suggest recommendations to address any gender imbalance.

Each of these research objectives are reviewed below to examine in turn if they have been achieved.

10.1.1 Does Data on Female Representation on NHS Boards Indicate a Glass Ceiling?

The first factor to be established was whether a glass ceiling does exist in the NHS. Folke & Rickne (2016) provided two separate criteria which must be met to evidence if a glass ceiling is present. Firstly, there must be discriminatory barriers in place, which is to say there is no other reason which can explain the gender imbalance other than discrimination. Secondly, the imbalance is more pronounced the higher up in the organisation you go.

When considering discrimination, one must be mindful that it can be '*invisible*' (Sheaffer & Levy, 2017, pp. 3). Indeed, amongst some of the interviewees there was a perceptible degree of surprise, bordering on scepticism in relation to the need for this research project. This is not surprising considering that a study by Soklaridis et al (2017) of hospital CEOs found that the female CEOs also felt that gender discrimination was not a factor in healthcare leadership. One supposition which I was unable to validate, is whether when people see a board where around 40% are women, they subconsciously feel this is equitable, as they are unused to seeing many women in these positions – their bias leads them to see that any female representation is equitable. This is a phenomenon regarded as the '*gender bias perspective'* (Soklaridis et al, 2017, pp. 253). The evidence for discrimination being present (beyond the statistical data) came from those interviewees who were adamant that discrimination must be happening, or boards would be more representative on grounds of both gender and ethnicity. They were also able to provide examples of discrimination that they had witnessed first-hand, such as women not being appointed due to concerns that they may wish to take maternity leave. Furthermore, the interviewees highlighted that whilst some of the discrimination is overt some is hidden, possibly in the form of subconscious bias that men and women hold in terms of their views on female leaders.

The next factor to consider, according to Folke & Rickne (2016), is whether there is a graduated effect, whether the effect of discrimination becomes more pronounced the further up the management hierarchy. As evidenced by the workforce statistics in Chapters One and Five, the number of women does indeed decline in a linear manner in the NHS. Whereas, as I have previously postulated, with the workforce composition of the NHS, it could be viewed that NHS boards would need more than 50% female membership to make them reflective of their workforce and patient population. In summary both the requirements of Folke & Rickne (2016) are met, thus indicating the presence of a glass ceiling in the NHS.

10.1.2 Why does a Glass Ceiling exist?

Having evidenced that a glass ceiling was in place, it is now necessary to ask why? This research has highlighted reasons why a glass ceiling still exists in the NHS despite the numerous measures that have been implemented, both internally within the organisation and externally either through legislation or wider political changes. The methodology of my approach was detailed in Chapter Three. It explained how initially grounded theory was employed to use a blank canvas approach, to explore the initial data on workforce gender composition without prior expectations of what the causes of the glass ceiling could be. This presented several avenues for exploration which were then extended through the literature review. In turn the literature displayed a series of possible factors. The combination of the themes from the literature review and the preliminary data analysis, were used to shape the quantitative and qualitative research, to explore if these factors were present in the NHS. This multistage approach enabled me to take the vast quantities of previous research on gender equality and process it in a concise, methodical, and logical manner.

My research demonstrated that the main factors inhibiting female progression to the boardroom can be grouped into each of the areas from the Healthcare Leadership Equality Framework, as presented in Chapter Eight. The Healthcare Leadership Equality Framework consists of four distinct sections: the individual, the immediate workforce environment, the organisational context, and the macro-environmental factors. The

following section summarises these factors which have their origins in the literature and have been reinforced continually through my quantitative and qualitative research.

The Macro-Environmental Factors

These factors pertain to wider governmental policies and legislation. My research evidenced that one of the most effective tools in combating boardroom gender inequality has been the implementation of quotas, which have been highly impactful in Scandinavian countries. However, reports and policy in the UK have rejected the implementation of quotas. Most notably the Lord Davies review (2011) detailed at length that it would not seek to promote quotas, despite later work by the think-tank the King's Fund (2015) indicating them as something that would be beneficial to the NHS. Findings from my research lend support to Lord Davies decision in that leaders of both genders do not desire the introduction of quotas. Thus, the lack of a quota system may be a factor in the continuing existence of the glass ceiling although there is no direct evidence to support this contention.

The Organisational Context

Unquestionably the most prominent factor that came out of my research is the fact that women remain the primary carers for children. This had several impacts on female leaders. Firstly, to meet the demands of being a mother and fulfil their job obligations it was necessary to draw down on flexible working policies. I saw that the NHS did support flexible working, however the policies were not routinely available to all mothers. Even when women were able to leverage flexible working, being a mother still had implications on their careers, as it remained difficult to be in the workplace as much as others and therefore be as visible as those without childcare obligations. This was significant in the NHS as presenteeism was highly valued culturally. Women looking to job share struggled because of the need for accountability in executive positions, which is difficult to attribute when two people share a corporate function. In summary, flexible working practices are adequate for junior managers but do not meet the needs of senior executives.

The next issue in an organisational context is the gender bias concerning the style and abilities of female leaders and resulting stereotyping. Historically, society has not equated women with managerial roles; this hangover, whilst outdated and unproven,

remains. This lingering bias means that institutional hierarchies are structured in ways that are weighted heavily in favour of men. Consciously or subconsciously men occupying senior roles prefer to promote those in their likeness, which is to say other (normally white) men. When women start to exhibit male traits, they are deemed as un-leader like, and whilst they might succeed this works against promoting a feminine style of leadership. A further point of the historical context is the social norm of the expectations of the female role as mother and homemaker. This is a perspective which feminism continues to battle well into the twenty-first century. This is an illustration of the way in which macro factors, such as wider cultural norms and beliefs continue to impact on and sustain '*traditional'* attitudes and behaviours.

The Immediate Work Environment

The interview data demonstrated that those individuals who were actively looking to further their careers had detailed professional development plans. A central tenet to those development plans was the presence of a mentor, who often took a sponsorship role in promoting their mentee to their wider network, which provided a marketing tool for their skills. The interviewees, when asked to discuss their role models, frequently mentioned a previous line manager (which would fall under the '*supportive supervisor'* label in the Healthcare Leadership Equality Framework), who had inspired them to push their career goals along either through the embodiment of desirable leadership traits or their ability to motivate those around them to be the best manager possible.

Critical job assignments are vital for leaders of both genders; however, they were particularly difficult for working mothers to obtain. As such, gaining operational experience can be difficult when raising a family. This also limits women's ability to showcase their skills. Critical job assignments were one element that was heavily represented as being a positive outcome for female leaders from the Coronavirus pandemic. Three interviewees were able to provide concrete examples of opportunities where they had to step up into a leadership void (as a result, for example, of colleagues opting to work remotely). These opportunities enhanced their reputations and in two instances had directly led to promotions. Interestingly, in these instances, the female leaders had been on-site in the hospital working significantly longer hours than peers

who had opted to work remotely. This relates to the issue of presenteeism, explored above, as a cultural phenomenon that the NHS valued highly.

At this point it is worth reflecting on how there are a range of cultural norms specific to the NHS which influence gender parity. In addition to the presenteeism element, it was evident from my research that, despite policy measures to the contrary, it is possible to circumvent them. For example, there were several cases of managers gaming the recruitment process to offer jobs to their preferred candidate, instead of following the robust Agenda for Change and recruitment processes. This builds on the importance of internal culture. Despite the presence of substantial policy frameworks and the bureaucratic nature of the NHS, there remains much latitude for NHS managers to work in (or just outside) these structures. Beyond the cultural elements of presenteeism and gaming of the Agenda for Change framework, I was able to show the importance of tacit knowledge in managing large unwieldy hospital organisations. This leads to the informal power structures of the NHS and how the balance of power is defused, from the power of doctors to the ability of receptionists to hold together whole departments.

The Individual

The role of the individual is perhaps the most important for female leaders, as it is the area they can most directly influence. Furthermore, on an individual level a person's career is time sensitive; if they wait for national level policy to take effect, they risk missing valuable experience and promotions. The role of the individual is also the least controversial to implement, as it has been noted several times that wider policy measures, such as quotas, can be generally unpopular. The role of the individual has two aspects, firstly they must proactively seek out opportunities for development and experience. Secondly, once they have honed their skills, they must make their peers and senior leaders aware through networking and self-promotion. This second aspect can be problematic for female managers as they can be averse to – often male friendly – networking situations which tend to happen informally outside of their working day and the workplace (often in the pub or at a sporting event). Additionally, the literature suggested, and the interview data confirmed, that women are more reluctant self-publicists than men and less confident about their abilities.

10.2 Recommendations to Address the Glass Ceiling

From the outset of this research project, I was resolute that I wanted to be able to provide a workable set of recommendations which could be shared with and implemented by NHS organisations. The way the recommendations will be shared is covered below in the community contribution section. The recommendations themselves have been discussed with NHS leaders and with representatives of the Leadership Academy to '*sense check'* them and ensure they are practical and implementable. The recommendations concern various stakeholder groups; beyond the Leadership Academy, there are individual NHS organisation, NHS senior managers and aspiring female leaders.

When I started this project, I expected to find one reason above all others for there being a glass ceiling in the NHS. Furthermore, I assumed there would be one silver bullet solution which would solve it. This now appears somewhat naive. The host of reasons indicated in the literature for the existence of a glass ceiling, appear to be present to varying extents. As to the silver bullet, it is possible on an individual level that there may be one action above all others which could make sufficient difference to propel one's career to an executive level. However, NHS wide I do not think there is a single solution, but I do think there is a complementary range of ideas that if implemented in conjunction with each other can go a long way to balancing the scales of equality.

This body of research has identified several measures which could be powerful in helping to eliminate glass ceilings and encourage female leadership. As discussed above, any recommendations that unfairly advantage women are likely to be rejected by both men and women, as positive discrimination has been shown in the literature and the interviews to be unpopular with both genders. In the NHS it is possible to negate this by offering opportunities to both men and women jointly, and, because of the composition of the NHS workforce (being 77% female (NHS, 2016)), women by the very nature of the gender split of the organisation should be the greatest beneficiaries. Furthermore, it must be remembered that whilst women do not want an unfair advantage, they do not need one – all that is required is a level playing field. Glass ceilings exist *because* of discrimination, by levelling the playing field you in fact introduce measures that reduce discrimination albeit in a, sometimes, indirect manner. Should the issue of gender

discrimination reduce in its prevalence, it might be prudent to review this limited definition of a glass ceiling and move from the premise of equity rather than equality. Creating an equitable work environment could well be the definition of a neo-glass ceiling. Therefore, there needs to be a recognition of when the NHS should treat all people the same and when there is a need to treat people differently. In the case of aspiring female leaders, there is the argument to favour equity over equality, due to the need to level an uneven playing field. The glass ceiling exists due to discrimination and ingrained social factors which women face, treating men and women the same does not acknowledge the disadvantages that women tend to experience.

In Table 15, below, I have provided a summary of the recommendations that my research has shown may be the most effective for the NHS which if implemented, will facilitate gender equality. Each of these recommendations, sit within one of the four sections of the Healthcare Leadership Equality Framework. Whilst Table 15 provides a compact summary of the recommendations, they are explained in more detail below. As already mentioned, the recommendations table was designed to be shared with NHS organisations, most notably the NHS Leadership Academy.

Table 9: Recommendations for Addressing the Glass Ceiling in the NHS

Recommendation Number	Stakeholder Group(s)	Purpose	Detail
1. Flexible Working	NHS England (create national policy) NHS provider organisations (create local policy an oversee implementation)	Provide a meaningful way for working parents to contribute to the workplace and progress their career, whilst also being the lead carer for their children.	• Enable remote working. • Revise job sharing to make it possible for board level positions (address the split of accountability for job shares). • On-site creche facilities or assistance with childcare costs for non-workplace-based provision.
2. Talent Management	NHS Leadership Academy	At present, beyond the NHS graduate programme there is little onward development of talented individuals.	• Devise national programme, with regional hubs. • Identify future leaders. • Provide signposting to development opportunities. • Create pools of candidates for upcoming promotions and guarantee interviews for suitable roles.
3. Short-term Job Assignments	NHS Leadership Academy NHS provider organisations	Operational experience in certain departments (e.g., Accident and Emergency) is integral for career development but does not fit well with carer responsibilities.	• Provide access to short-term roles for positions in specific departments. • This could be over school term time or to cover maternity leave, to meet the needs of the individual and the organisation.
4. Female Friendly Networks	Individual Employees	Networking has been shown to be incredibly important for supporting leaders and providing access to job opportunities. Many of the networks do not fit with carer responsibilities. Networking activities often take place in environments which are not female friendly.	• Establishment of virtual and in person networks. • In person events would be at times and locations that would facilitate female participation. • Networks could be formal and informal. • They would offer advice, consist of activities (such as inviting external speakers) and support the identification of job opportunities.
5. Role Models	NHS Leadership Academy	The presence of female role models demonstrates the probability of becoming a female executive. These role models can share advice based on their own success.	• Create a pool of female role models. • Promote this group of individuals to networking groups, conferences, and development activities / away days.
6. Mentors / Coaches	NHS Leadership Academy NHS Organisations Individuals	Mentors and coaches have been shown to be valuable in terms of providing support, identifying necessary career development, and providing job opportunities.	• A pool of mentors and coaches should be collated and funded nationally. • Encourage leaders to access this pool. • Individuals should be committed to finding a mentor / coach who is a good fit for them, and then commit to regular meetings and engage with the advice they receive.
7. Community of Practice	Networking groups NHS Leadership Academy	Peer support, particularly during COVID-19, has shown to be a powerful tool for female leaders.	• A community of practice meets on a regular basis. • It is a method of learning about a new area. • The aim is to discuss a different subject at each meeting in a high level of detail. • Examples can be reviewing journal articles or inviting expert speakers.
8. Career Planning	Individuals	My research has shown that those with a detailed career plan are more like to progress their careers at an accelerated rate.	• Career plans should be detailed but can be changed as necessary. • They need to have specific, timed goals, with a detailed means of achieving each objective. • These would incorporate and be supported by mentors / coaches.
9. Encouraging Female Job Applicants	Mentors NHS recruiters / HR teams	I discovered that women are less likely to apply for promotions. However, when they do, they are more likely than men to be appointed.	• Leaders and recruiters should encourage capable female leaders of applying for roles which they may think are beyond them. • HR teams should structure the advertising, application, and recruitment process, to encourage female applicants.

Flexible Working and Work-Life Balance

To enable a manageable work-life balance for women in executive positions, it is vital that flexible and remote working is normalised throughout the NHS. Seen repeatedly in the interviews, whilst flexible working was possible for lower management positions, executive positions were thought to be the exception because they required onsite visibility to ensure accountability. From an organisational perspective, the NHS needs to consider the governance aspects of flexible working patterns, such as job sharing with reference to how accountability is split. This should be possible, because as evidenced with medical directors (who have two distinct roles within hospitals) it exists for some positions already. An example of how accountability could be split by two people sharing the same role, could be easily achieved by going through the job description for the roles and assigning one person lead responsibility for each element.

One of the few positives to come from the COVID-19 pandemic, was the realisation that no one is too important to be needed on-site for more than 8-hours a day. The pandemic helped to normalise the use of Microsoft Teams for meetings, the use of Whatsapp for real time messaging, and the use of flexible shift patterns to provide responsive operational management cover throughout the week (not just Monday-Friday 9:00-5:00).

A more intricate national flexible working policy is needed for the whole of the NHS. The current arrangements are piece meal and largely left to individual hospital trusts to design and implement. This is problematic and it creates disparity from one trust to another. Secondly, the current arrangements for levelling-up are such that women can be afraid of the perceptions of others if they request it, especially in the NHS culture of presenteeism. As noted above, the COVID-19 pandemic showed remote working is possible and affective. Therefore, one approach could be for the NHS to dictate that all administrative staff are able to apply for a minimum of half a day per week remote working. This would need strict guidance with a review period.

For women with children, it was observed from the interview data that several successful female leaders were able to leverage family networks to assist with childcare. Aspiring leaders should be prepared to have robust conversations with the people they share their lives with, to ensure that childcare responsibilities are split in an appropriate

manner. This extends beyond childcare but also things such as housework and caring for elderly relatives.

The data highlighted the importance of providing onsite childcare facilities. Where funding is an issue, the NHS could generate revenue by renting creche space to the private sector who would in turn provide spaces for employees' children. This is an area where the trust could further aid staff, by deducting the cost of the creche places from the employee's pay cheque pre-tax to, in effect, reduce the cost of the childcare. Of course, onsite creches will not be favoured by all, so assistance with wider childcare commitments should also be explored.

Professional Development and Talent Management

Given the unpopularity of government-imposed policies and quotas it is necessary to reflect on what other measures can be enacted to promote female development. The next section will be concerned with what women can do to take responsibility for their own careers. However, I shall first detail what the NHS can put in place to support them. Using the Healthcare Leadership Equality Framework as a guide, it is possible to look at the recommended areas of activity which the NHS can support. Given the range of measures it would be helpful to have a body overseeing and coordinating these activities.

The role of the NHS Leadership Academy needs to be augmented, the organisation has a strong reputation and provides many resources which are beneficial in addressing the causes of glass ceilings. Both main development programmes featured during the interviews, the Nye Bevan Programme, and the Graduate Management Scheme, are hosted by the Leadership Academy. Both development programmes have stellar reputations throughout the NHS, and many of the directors I interviewed, not only have partaken in one or both programmes, but also credited them with having a major input into their careers.

The question then is, what specifically can the Leadership Academy do to help address the NHS GC? Firstly, to address the section on the Healthcare Leadership Equality Framework of '*seeking opportunities'*, the Leadership Academy can further the idea of regional recruitment hubs which are already being trialled in the Midlands. These hubs

look to identify future directors, then guarantee all those individuals an interview for director level positions in the region. This automatically removes one milestone thought to impair the progress of women, which is having the self-belief to apply for roles in the first place, due to the fear of not being shortlisted.

Secondly, when appointing individuals to their development programmes the Academy should review the recruitment policies to explore the number of female applications and appointments to their schemes. The data I analysed for the Nye Bevan Programme showed an appropriate gender split for the proportion of men and women working at the salary bandings the programme is aimed at (i.e., 8C-8D on the AfC pay scale). Therefore, the way this recruitment process is balanced should be a model for other development programmes.

Almost half of the interviewees stated something in line with the statement the NHS '*does not do talent management well.'* It was recognised that there are pockets of excellence in the NHS, such as the NHS Graduate Management Scheme and the Nye Bevan Programme. However, much of the criticism from the interviews was reserved for the onward management of alumni of these programmes, leaders are given skills but then left without a forward plan. This talent management process would be best placed with the NHS Leadership Academy, given the strong reputation it has, and the skill set of its employees. The Leadership Academy could partner with or establish regional hubs which would manage elements of the programme. For example, job shadowing was suggested as something that could be particularly useful. This builds on the models which are already prevalent in some Scandinavian countries, pertaining to job rotation and job sharing (Etherington and Jones, 2004). The Danish model of job rotation can be augmented to provide healthcare leaders experience in more challenging positions within the NHS. Rather than, for example, asking young mothers to commit to a two-year posting managing an Accident & Emergency department, they could be rotated through the department for a fixed period, as with the training of junior doctors.

The issue of funding is an important one. However, most of the proposed activities could be provided at low or no cost, with the practical teaching elements delivered through online materials and seminars. Additionally, with respect to funding there are a multitude

of programmes already operating in this space, so it might be more of a process of repurposing, reallocating or even rebadging current resources so that they fit together under the rebranded talent management programme. Furthermore, if the process was to be successful it could have a net effect of saving money in the long term, by assisting with recruitment and retention. More importantly, by having a ready-made talent pool it would mean the leaders of the future are not only aligned to the strategy, aims and values of the NHS, but they also would be the best in operating under NHS policy. This in turn makes most effective fiscal sense – as the best NHS managers use their resources most wisely. This better use of resources is an important factor given the future shortage of healthcare managers (Britnell, 2019) and the increasing financial constraints to the NHS.

Talent management would address several sections from the Healthcare Leadership Equality Framework, relating to the individual, helping in seek opportunities, build networks and self-promotion. In relation to the work environment section, it would cover mentors and sponsorship, and critical job assignments. More specifically, the talent management process can be directed at the areas where it is known the issues are more relevant to female employees than male employees. These have been shown through the literature and research to be elements such as securing effective mentoring, building successful networks, improving confidence in applying for roles, alongside dedicated work shadowing.

Networks have already been thoroughly explored above. In summary, networks offer day-to-day peer support and advice, they provide exposure to a wide range of individuals from wide geographical areas and, perhaps most relevant here, they provide insight into promotion opportunities and recommendations. To focus solely on female networks by excluding men, is to narrow the reach and opportunities these networks provide. A suitable model for networks therefore could be to follow the '*Lean In'* model, promoted by Sandburg (2014) – which by their nature are female friendly, suiting the needs of female participants but emphatically not excluding men or any other group.

Providing aspiring female managers with role models provides visible beacons of success. They can see that other women have been able to navigate the same environment and become influential leaders (Sharif, 2015; Hurn, 2013; Cross et al,

2015). The Leadership Academy could not only provide access to role models but take this a step further by selecting role models who the aspiring managers could relate to, for example, those with young families or from similar ethnic backgrounds. As with mentoring, sponsorship has been shown to be a valuable tool in the development of female leaders (Turner, 1960; Seraj, Tsouroufli and Branine, 2015). Sponsorship differs from mentoring, as sponsorship not only provides elements of the mentoring relationship but also promotes the skills of the individual being sponsored. For example, they might recommend the person being sponsored for a job opportunity or a chance to display their credentials, such as being a speaker at a conference. Coaching again would work on similar lines to mentorship and sponsorship. It offers a much more structured and formal programme of development to individuals. However, coaching comes at a substantial cost, which may be inhibitive for cash strapped NHS organisations. One option could be to explore splitting the costs between the individual and the employer.

As I have already mentioned, the approach I describe is not revolutionary in the sense that it provides a clear solution to a hidden problem; the problem is known and, as with most solutions in the NHS, the solution exists in a patchwork manner with pockets of excellence already operational. From the interview data it was noted that two individuals are involved with a similar programme in the Midlands region, where talented managers are identified at early stages in their career and supported to apply for senior roles at the appropriate time. An interesting continuation of this logic and indeed this talent management programme, is whether it would also support - albeit with tweaks where appropriate - the needs of the other minority workforce groups.

The Role of the Individual

At the individual level, there are many processes that women can leverage to assist their own careers – again it is important to reiterate that these do not only apply to women but do cover some areas in which women are more unfairly burdened, judging by the research which has been conducted.

- If you are the main carer for children, then you need to leverage your support network. The interviewees gave examples of how they had obtained support by asking grandparents to help where possible, sharing the school run with friends, coming up with a rota for housework.

- Women could formulate a robust career plan, which is achievable, measurable, and adaptable to the constant change we see within the NHS.
- Leaders need mentors, someone they can relate to and learn from. This might be someone from a similar background or who has achievements which they want to emulate. This relationship does not need to be overly formal, and it is also important to remember that it is possible to change mentors at different points in one's career.
- Networks are valuable for all the reasons discussed above. Not everyone likes networking therefore it is important to find a network which women are comfortable with but also one which is beneficial.
- Apply for roles which they are suited for and do not be overly dejected by rejection. If women are unsuccessful in their applications, they need to discover what their application was missing and acquire this knowledge or skill.

Do Nothing

There is an argument to suggest that no interventions are required. The literature has shown that women are now, on average, leaving university better qualified than men. In the workplace the leadership pipeline is well stocked with female leaders. In the NHS there is a move towards a more compassionate or feminine style of leadership, which signals that the demand for female leaders is going to increase. As the workforce continues to age and more of the current executive managers retire (who are predominantly male), this will create the opportunity for women to enter the boardroom in greater numbers. The only issue with this is the potential time it will take to deliver gender equality – as noted in an early chapter, Keynes recognised that '*in the long run we are all dead*' (Keynes, 1924).

10.3 Further Aspects of This Research Project

The following sections cover some of the wider aspects of the project, some factors which influenced my research, areas which for various reasons were omitted and descriptions of how my findings will be applied in the real world.

Limitations and Research Issues

This research project faced several of the typical issues for a study of this type. For example, whilst the overall field of literature on glass ceilings is extremely broad, providing reams of material to review, the specific literature relating to a glass ceiling in healthcare management is very small. Similarly, the population size for the data collection is vast, which was challenging when undertaking data analysis on all NHS Provider Trusts. Conversely, when interviewing only a small number of people the sample size is tiny in comparison, creating separate issues of generalisability when extrapolating upwards to make solid conclusions (Aguinis et al, 2014). Finally, whilst the NHS is a huge institute and my research centred on the English NHS, it is hoped that the conclusions reached will have validity for the wider UK NHS.

Even though my research contained only 26 interviews and the NHS is the largest employer in Europe, with over one million staff (NHS, 2019), I do believe the methodology and interview design were sufficiently robust that the conclusions I have presented are valid. A point of proof to this fact is the commonalities in the interviews and the absence of contradictory views in what is a potentially contentious and controversial subject. I felt that the views of the interviewees were representative and the number sufficient to draw solid conclusions. This confidence is in part derived from the saturation point that was arrived at in the interviews. Towards the end of the interviews, rather than new data being provided, the interviewees were reinforcing the content already provided in previous Interviews. This said, it was notable that some key demographics were underrepresented. A prime example for this was when seeking responses on the impacts of the Coronavirus pandemic; I did not interview any single mothers. Single mothers may well have been much less positive about the potential of the pandemic to further their careers, if they had been home schooling several children at the same time as trying to do their day job. Another obvious shortfall was that fact that only one interviewee was from a BAME background – whilst this individual was able to

provide valuable cultural insights into being female and from an ethnic minority, it would be disingenuous to state this was reflective of all female BAME professionals.

There were several challenges it was necessary to contend with over the course of my research. In terms of the data collection, the main challenge was accessing interviewees. For example, one gatekeeper to a subset of interviewees delayed access for almost a year by not responding to emails and creating additional governance steps. Secondly, whilst the COVID pandemic did allow for a useful adjunct to my research, it did hamper the data collection. It was necessary to reschedule several interviews multiple times because those interviewees were working at capacity due to the demands of the pandemic. In relation to the data used for my quantitative analysis, the Department of Health stopped publishing the detailed data sets in 2016, meaning that there was a lack of the most up to date information concerning staffing numbers.

Stakeholder and Community Contribution

The premise of the glass ceiling has spawned vast quantities of research, countless theories, and huge amounts of journal articles. However, much of the existing literature concerns industries outside healthcare management or looks at gender inequality in addition to other forms of discrimination, such as ethnicity. As such, the primary contribution my work will make is to highlight which factors from the existing body of knowledge are relevant to the NHS, and the factors which are unique to healthcare.

My background is not as a theorist, and it was not my intention to make significant progression in the already saturated field of the glass ceiling. The number of theories for the glass ceiling grows rapidly, whilst progress in dismantling the glass ceiling is slow. Widening the theory on glass ceilings then, would have at best limited impact. My intention therefore was to validate (or reject) those theories already in existence and look for ones that best unite the elements prevalent in the NHS. The Healthcare Leadership Equality Framework, appeared to best provide a unifying conceptual framework, a theory that tied together the various strands emerging from my research.

One area where my research does seek to break new ground is the insights it provides on the response to the COVID-19 pandemic, as it will be one of the first PhD projects to explore the nascent effects of COVID-19 on NHS management. Whilst the specifics of

COVID-19 are undoubtedly new and of interest to those who have lived through it, it also adds to the conversation concerning glass ceilings. I was able to observe, almost in real time, how factors derived from my earlier research and the elements in the literature about overcoming the glass ceiling could be put into practice. The most obvious example was the observation from my research that young mothers often miss out on important operational experience. The literature suggested that critical job assignments can replicate this experience. The pandemic provided such critical assignments which I was able to explore through the second tranche of interviews (mainly in the form of the follow up interviews with those on the NBP). These confirmed that critical job assignments had provided invaluable experience and had furthered the interviewees' careers.

To find a channel to submit my recommendations to the NHS, I have engaged with the Leadership Academy, to share the scope of my research and discuss my outline recommendations. At the time of writing, I have already met with them multiple times, and will engage with them again once my research has been submitted. Additionally, during my data collection I have also linked in with two HR directors, who have expressed an interest in my findings and willingness to help locate suitable avenues in implementing recommendations.

Ultimately, the most important contribution my research could make, is assisting female leaders achieve the roles which they are suitably qualified for. It is my aspiration that elements from my research are helpful for those seeking an understanding of how and why the glass ceiling exists and what they can do to eliminate it.

Other Lines of Inquiry

An adaptation of grounded theory was used at the outset of my research, meaning that without priori assumptions on what the underlying causes of the glass ceiling was, I was guided by the results of the literature and quantitative analysis. Then through the interview process I honed questions to explore trends emanating from the data. An example of this was the decision to focus increasingly on the importance of networks, which was made about a third of the way through conducting the interviews. This decision was taken when it became apparent that those who had accelerated their careers quickly had drawn down heavily on networks for finding new roles. However, there is the need to be emphatic that networks are by no means the panacea.

Throughout my study I have identified many other useful areas of exploration that would have been fruitful to delve further into. As such, it would have been useful to study other factors, such as the role of sponsorship in more detail. In this respect I was constrained by the interviewees as none of them had been products of sponsorship there was only a limited degree to which they could comment on it.

The key area which I believe would have been most insightful to explore would have been the recruitment pipeline, including the interview and contract negotiation process. Through the quantitative analysis I was able to gain an understanding about the number of applications for director level positions in terms of the male / female split. From that, it was possible to work through the gender split of those selected for interview and the gender of the candidate who was ultimately selected for the role. As this data pertained only to one hospital trust it was very limited. This said the data displayed trends that were valuable to my research, that being that women did not apply for roles in the same numbers as men, but when they did, they were equally likely to be appointed. If I had the opportunity to expand this element of the research to increase the confidence that these factors were prevalent across the NHS, then it would be possible to make a more concrete policy recommendation (concerning increasing the number of female applicants for executive roles). Expanding this data for a wider number of hospital trusts would have developed a much richer picture in terms of, firstly, the number of women applying for roles to start with; secondly, if access were provided with regards to the granularity of the shortlisting process, it would have been possible to explore if and why women were not being shortlisted for roles and the reasons for this. For example, was it because their applications did not contain sufficient breath or depth, or did they lack experience in a specific area? It would then be possible to move through to the interview and conduct another level of detailed analysis on the relevant successful and unsuccessful interviews. What were the commonalities of those applicants who were appointed versus those who were rejected at this stage? What got successful women appointed? Finally, following this through to the contract negotiation stage, how did women conduct this compare to their male counterparts; did they negotiate on salary; did they make requests for flexible working?

As I discussed on several occasions throughout this document, my objective was not to blur the lines between gender discrimination and other forms of discrimination (such as racial). This decision was taken under the belief that all forms of discrimination are important, and all need their own separate lines of investigation and solutions. However, there are undoubtedly some reforms which can be beneficial across the board in addressing discrimination. It was possible to see with the Nye Bevan Programme, that those people who received training to recognise their biases along racial lines, were able to take this learning and apply it to wider forms of discrimination. Additionally, it must be recognised that more research into other forms of discrimination would be impactful for women who face double or even triple-burdens of discrimination, for example, those who are from BAME backgrounds and disabled. In this sense my research was limited, as only one of the interviewees was from a BAME background, and whilst other interviewees did report being victims of other forms of discrimination (e.g., age and class), these did not form a significant proportion of this project.

With a subject matter as vast as the glass ceiling it was tempting to explore more of the underlying theories in greater detail. However, to do so would have spread the focus, findings, and recommendations too thinly. For example, an interesting adjunct to this research would have been to explore the phenomenon of queen bees in detail, given the apparent evidence of such individuals existing in the NHS. I would have been keen to ask interviewees about their thoughts about those regarded as queen bees by others, to explore whether they felt they conformed to the required characteristics and what their motivation for adopting this approach was. However, to focus on queen bees would have been to abandon my research methodology, as this was not in the direction which my amended grounded theory approach took me.

Wider Implications

At this point it is worth reiterating the wider implications of why this research project was worth undertaking. There are two central reasons; firstly, should a GC exist due to some form of ingrained institutional discrimination, there needs to be a programme of policy reform and education to eradicate it. Secondly, if such a ceiling exists due to an absence of, say, certain skill sets in aspiring female executives – which prohibits their recruitment to board level positions – then it is necessary for this to be highlighted to those with board level career trajectories, so they can gain the requisite skills and experience to realise

their full potential. This research project will also have wider implications, such as whether similar observations could be made on the grounds of race, age, or disability. This is particularly pertinent in the National Health Service as it has above average representation from those from BAME backgrounds in many staffing areas, but BAME representation again falls short in the boardroom (Kline, 2014).

Gratitude

The process of gratitude stems from being listened to and having the complete attention of the other person. It was what *Humans of New York* creator Brandon Stanton dubbed '*the appreciation of being heard'* (The Tim Ferris Show, 2018), based on his experience of photographing and interviewing over 10,000 people in New York City. Through my research I was able to observe the '*gratitude when researchers are within their own workplace'* (Gibbs, 2009, pp. 55). Whilst I was not an NHS employee at the time of undertaking the research, I was still working in healthcare management. Having five years' experience in the NHS, I was very familiar with the organisation as a workplace, and I had even worked in some of the same hospitals as the interviewees (albeit not at the same time) and very much see myself returning to the NHS one day. As such, I think the interviewees very much regarded me as '*one of their own'*, despite being completely aware of my background. This is a fact reflected in the interviewees' use of detailed healthcare terminology and phrases such as '*you know what it's like'* when responding to me.

This theme of gratitude struck a chord as I was looking at an issue that directly related to my own industry. I deeply agreed with Gibbs (2009) that working on a subject matter that was close to me, provided,

> *'morally compelling obligations on the researcher that are more pressing than those of an outside researcher because of the closed dynamics of the workplace.'* Gibbs (2009, pp. 55)

In essence, I was morally obliged to ensure the research was robust as I owed that to my colleagues. The main reason, however, for sighting Gibbs' work was to examine what this meant for the participants of my research. Many of the interviewees confessed at the end of the interview how useful they had found it to voice their opinions on how the

issue of gender equality could be resolved. Some of the interviewees revealed information that to them was deeply private and had previously not been shared, as the correct time or place had never presented itself. I was able to derive some benefit knowing that in return for the interviewees gifting me their time, they were also able to reap some gain from the experience. The most notable measure of the gratitude in research was when the interviewees talked about the cathartic effect of sharing their story; they held out hope that the information and ideas that they shared would make a positive change.

Gibbs (2009) acknowledged that a researcher who knows the industry has additional inside information and insight and, as a part of this industry, has the duty to use this knowledge to create meaningful conclusions. This '*obligation*' is therefore picked up by the participants of the research, which heightens the forthrightness of the information they disclose. They are more grateful to take part in the research because they place more value on the ability of the researcher to do *something* with what they discover. This is a reciprocal arrangement, with the disclosures of the participants being a '*gift*' (Gibbs, 2009, pp. 56) to the researcher, which they must in turn be grateful for.

Many of the interviewees seemed appreciative of the opportunity to discuss the topics covered in the interview. It is possible that they had never had the opportunity to discuss this type of information in such a candid manner. Overall, the expressions of gratitude from the interviewees came at the end of the discussion. They were done in a manner which is difficult to garner from the transcripts alone, as it was the *tone* in which the interviewees expressed their thanks. The tone was one of relief – from having disclosed thoughts held privately for a long time – almost as though the individuals had been involved in some form of counselling, reaching some form of internal epiphany. The reason for this gratitude is related to the subject matter; the interviewees were discussing something they observe every day but have little recourse to talk about. There are still taboos about recognising and flagging up discrimination in the workplace, possibly because it is largely thought to have been eradicated. Secondly, because it is covered by a legal framework, accusing someone of discrimination is tantamount to accusing them of a crime. Therefore, the interviewees were appreciative for being able to disclose their personal beliefs in a safe space, in the knowledge they were being listen to and that

these thoughts would inform a piece of work, which would hopefully influence decision makers. Indeed, several interviewees proactively asked how the findings might be incorporated or used by the NHS.

There were several direct examples of expressions of gratitude from the interview data; one interviewee talked at length about why she was pleased to have taken part in the interview.

> '*If I am honest with you, I have found it quite reflective, to actually sit and think about specific areas because you don't always get the time to in the day to do it, so I suppose that I should be thanking you as well actually.'*
> Fiona (NBP)

In the case of the only BAME interviewee, she also appeared particularly grateful for the opportunity, due to the confluence of the issues of race, religion, and gender – it is possible that she has never had this type of conversation with a fellow healthcare manager before. Undoubtedly, she will have discussed these issues with her family and friends but, given the manner she addressed certain elements in the interview (such as the initial resistance of her husband to take on household responsibilities), it is possible that she has never shared these thoughts with her workplace peer group.

Perhaps the most interesting aspect of Gibbs' (2009) work was the observations he made about how the relationship between the participants and the researcher can affect the analysis of the data.

> *'The role of researcher shifts from using methodology to hold apart the subject and object of the research programme to merging the processes of understanding in the political and social context of the workplace.'*
> Gibbs (2009, pp. 59)

Essentially, I take this to mean that having a researcher who knows the workplace enables them to gain a deeper undertaking of the layers of socio-political construct, to understand the nuances and the soft power structures of the organisation. They know

what it is like in practice rather than just on paper. This is useful and it will make the conclusions more applicable. The downside is that an outside observer may feel like the researcher is jumping to conclusions without having the evidence from the research materials. In such situations it was important when conducting the interviews that when an issue, policy or working practice was discussed, which I was familiar with (and that the interviewee took as implied knowledge because of my background), that I ask them to explain so it was evidenced in the transcription.

10.4 Personal and Learning Reflections

On completion of my research, it was useful to reflect on the reasons for choosing this area of study and the impact it has had on me in terms of the learning and experience that I had gained. It was also possible to consider how I would use the skills I had acquired moving forward with my professional career. Obviously, I had asked myself several of these questions at the outset and held them as given. However, as my studies progressed, I did notice a shift in my views and realised that there were several other motivating factors beyond those which I had assumed at the start.

Primarily, having worked in the NHS and having, for a long time, felt that the organisation is one of the greatest ever British achievements, I have, like many other people who have worked for the NHS, been driven by a need to '*give something back.'* This sense of obligation was echoed by others throughout my data collection. For those who have worked or still work in the NHS, the organisation provides not just compassionate care, a safety net which we can all rely on, but also a career.

I believe sometimes when you make a life decision you are not always cognisant of your reasons for doing so, but over time the rationale becomes clear. Whilst this could be attributed to confirmation bias, in the instance of my research project as my work progressed, I developed a stronger sense of why I had opted to explore the subject of gender equality. The more I read and the more people I talked to, the more I started to think about my own upbringing. Coming from a working-class single parent family, I was able to see the world from the perspective of my mother. My mother was an intelligent woman, who worked a succession of menial jobs having missed much of her working career to raise a family. As my mother often used to say, *'it's a man's world.'* On the occasions she did unsuccessfully apply for more senior roles, it would knock her

confidence to the degree that she would not apply for another job for years. Despite coming from a female led household, I did find it challenging to read some of the literature on gender, quite often and unapologetically an author would make a comment that was derogative towards men, with the sweeping generalisations such as that men did not care about women's rights, men do not help with housework as much as they should, or that men find strong women challenging.

Beyond the scope of gender equality, I did gain a sense of another of my passions coming to the fore as the project took shape. The more I worked on the project the more I was reminded of my deep interest in personal development; this had been sparked by my time on the NHS graduate programme. We were given a detailed personal development programme and access to numerous resources, including mentors, job shadowing, and courses with the King's Fund. I felt that this programme of development vastly accelerated my career. From this point on personal development was something I always valued, not only for myself but I promoted to others. For example, after I had completed the NHS graduate programme, I continued to work with the programme on developing a buddying scheme between junior medics and incoming management trainees. The aim of this was to create a network between the two – often siloed – groups, as a means of understanding each other's point of view, which is heavily influenced by their professional training. Later in my management career whilst working as a director in a management consultancy, I had a team of over 50 expatriate consultants who felt their development needs were not being met whilst working in the Middle East. As such, I introduced a programme of activities to best meet the varied needs of the team. This included quarterly away days with external speakers, initiating a community of practice, developing a mentoring programme, and starting an individual learning fund for all employees.

In terms of completing this research project, one of my biggest learning points was the transition from writing in the style of a management report, with focused objectives and recommendations, to an academic format, creating a piece of research that builds on existing literature to develop a conceptual framework and elevating my work to a higher theoretical plain. Initially I was too focused on solving the problem I saw, rather than fully comprehending the complexity of the causes. With my background in management

consultancy, I started to see a contrast between the way consultancy and academia operate. The first event was the redrafting of my research proposal, I was keen to get this signed off as soon as possible, so I could get on with what I had decided was the '*proper'* work.

To me the research proposal was akin, in project management terminology, to the Project Initiation Document. The differences I found with my research proposal, was that it was much more critically analysed, so that it was necessary to repurpose and redraft it several times. At the time I was surprised by the scrutiny it went through, given that so much would change during the project. However, as my research progressed, I realise the research proposal was an assignment in its own right. It demonstrated to the University that one could undertake the necessary rigour that a PhD would require; it sets you up for the journey that is the PhD.

The second point of learning from the research proposal is the way feedback is received from one's supervisors. In the consultancy industry the process is much more linear, a document would be submitted, feedback receive and incorporated, and it would be signed off. In the academic world, a document is submitted, and comments come back in varying levels. The first draft might illicit comments regarding the central arguments, the second on the structure, the third on the referencing, the fourth on the spelling and grammar and so on. This world of multiple drafts was new to me, and initially was a huge dint to my confidence: was the quality of my work insufficient, was my thought process lacking? Once I had been through the registration process, the merits of the feedback method became clearer to me, and I appreciate that there were different approaches of achieving the same output. For example, if I had received all levels of feedback at once, I would never have completed a second draft. The iterative process of feedback allowed for gradual improvements over time and, more importantly, maturing of ideas.

One of the issues I struggled with, especially through the development of my research proposal and registration process was the necessity of repeating my reasoning for electing to approach the project in certain ways or excluding various elements. For example, I was questioned several times as to why I intended to only study gender and not gender and race. Initially I questioned why I needed to keep re-defending my

selection criteria, however I soon realised that due to the volume of work required it would be impossible for anyone – including myself – to remember the rationale behind every decision. The need to repeat my reasons had a huge benefit as well, it enabled me to rehearse my arguments and make them much more concise. This was useful because, as with the example of excluding race from my research, this was an issue brought up repeatedly by other parties, such as the NHS Leadership Academy and interviewees, not to mention other people with whom I discussed my research within a social setting.

There were many different skills and experiences I either learnt from scratch or sharpened through the process of completing my research. Those skills which were newly acquired concerned learning theory behind the methodologies which I used; the best example was coming to terms with narrative analysis. I found that in the world of academia, there is a degree of assumed knowledge. When looking into narrative analysis, I found there was very little in terms of '*how to'* guides. This meant I reviewed large volumes of texts before my supervisors provided me with some very useful references, which eventually cleared the fog. I particularly found it useful to start writing about narrative analysis, even though initially it did not make sense to me; the process of trying to explain it on the page helped formulate my comprehension.

An area which I sharpened was my interview skills. Prior to beginning the project, I thought this would be a strength, as I often interview people for my day job. However, after I had completed my first batch of interviews, I realised that I was not eliciting from the interviewees as much detail as I required, and they were taking less time than I had envisaged. After acknowledging this I reviewed my interview schedule and refined my questions, included more prompts, and made sure that the interviewees had answered the question presented to them rather than solely providing – potentially irrelevant – information. The most important change, however, was the difference in the *way* I interviewed. In a work / job interview I am often looking for a specific response; for example, I want them to tell me about their programme management skills or risk mitigation. With my research interviews, because I was unable to second guess what the interviewee might say, I needed to listen more closely and let the interviewee talk with fewer interruptions and less guidance on what I was hoping they might say. In a work

interview you want the candidate to give you the answer you require so you can offer them a role; with research interviews you are hoping for richness and variety, looking for factors which you might not have thought about previously.

I was familiar with dealing with large amounts of numerical data, mainly through my employment career but also through other research projects I had undertaken as part of my post and undergraduate studies. What I had not experienced previously, was synthesising the huge amounts of written data which was produced from the interviews. As such, I found this a very time-consuming part of the project and I also found it mentally taxing; when dealing with so much information it is difficult to identify trends and attribute responses or patterns to certain interview groups.

The largest benefit by far, in terms of my personal development, was the progress of my written prose; it helped me more concisely convey my thought process into text. I quite often found I knew what I wanted to say but found it difficult to articulate onto the page. Whilst I am still cognisant that I have far from perfected the skill, I have noticed that other written information that I produce for example work reports, emails and – in my private life – blogs, have improved in clarity and quality. The volume of written text it was necessary to produce was also a challenge for me; to stay motivated for four years to produce the requisite quantity of written work, I adopted the approach of little and often. Going as far as affixing a post-it note above my computer, which read *200 crappy words a day*. Producing the quantity of work made it much less daunting to go back later and improve the quality.

I thought when I discussed my research topic with people, particularly men, they would ask why, as a male, was I opting to investigate gender equality? I was wrong; most people seemed engaged and interested in what I had discovered or what my hypothesis was. I did quickly learn however, to avoid bringing the topic up in mixed groups, as there was always at least one person whose views were less than progressive, and I would then spend the next hour waiting for the arguing to subside. These '*disagreements*' did demonstrate a couple of factors; firstly, people still have prejudicial views, albeit on a contracting spectrum. Secondly, I realised that perhaps people were interested in gender equality. I wrote in the introduction to this document about how many people believe the

gender equality box has been ticked and humanity can move onto battling other forms of discrimination. However, as recent media events and global politics have shown, this battle is far from over.

In addition to the community contribution mentioned above there is another route in which I hope to employ the findings of my research. Due to my interest in personal and professional development, I would like to use my PhD to provide coaching to junior female managers, who hope to be leaders of the future. I have formulated a series of workshops which I would look to roll out to individuals or small groups, which cover each of the key barriers and facilitators to female career progression. My aspiration is that these workshops would help women to recognise some of the obstacles they may face and equip them with the tools to deal with them, as and when they encounter them.

10.5 Final Comments

I started (in Chapter One) by making the case why it is still necessary in the 21st century to improve the understanding of the glass ceiling. I reviewed how history, biology and society created a system of gender inequality, and the benefits to organisations of smashing the glass ceiling and creating equitable boardrooms. Chapter Two attempted to distil the most relevant literature on gender discrimination. This provided a platform to structure my own research, so that fresh perspectives could be offered on legacy issues.

The methodology was explained in Chapter Three, showing how an adapted version of grounded theory provided an opportunity to approach my research unburdened by the priori assumptions of researchers who had gone before. Chapters Four and Five laid out the quantitative and qualitative findings, before bringing them together for analysis in Chapters Six and Seven. I was then able to opportunistically explore whether the strands presented in Chapter Eight could be seen to be played out in a real-life setting. The COVID-19 pandemic allowed me to see if the areas suggested by my conceptual framework (the Healthcare Leadership Equality Framework), could be seen to be a way of explaining how and why women were able to use the pandemic to gain experience and evidence their leadership skills to benefit their careers. Finally, in this chapter I have presented my recommendations and explained how they can be adopted in the NHS, for the benefit of future female leaders.

For female leaders, my work would suggest a staged approach. Firstly, they would need to consider where in their career they are and what their current career aspirations are, where they fall on the meander / go-getter split. Again, as preference theory (Deschacht et al, 2015) dictates being a meanderer is not necessarily a question of ability but one of choice. It is important to recognise that neither is preferable to the other, and under both approaches it is still possible to reach the top. However, my research has shown that committing to the more targeted approach of the go-getter may facilitate this trajectory. Once the individual has determined where they sit in this split and is comfortable with this, it is then necessary to adopt the required approach. I have shown that the go-getter was more proactive in respect to career development and had a specific plan to achieve their career goals. The next step is to review the segments of the Healthcare Leadership Equality Framework and ensure that they are addressing each of these areas. Are they seeking additional job assignments? Do they have a suitable work-life balance and a means of supporting this?

It is important to reiterate why this body of research is vital, not just for aspiring female leaders but for the wider population. Having equitable boards means they are more representative, have better decision-making ability and better serve their consumers. Given the NHS is a tax funded, public organisation, better boards mean better healthcare services for all, and better use of the public purse. I also have evidenced that there exists a shortfall in terms of able executives in the NHS. This problem is being amplified due to the financial constraints the NHS finds itself in and due to the pressure of accountability the board members are under. To meet this shortfall the NHS must recruit from all suitable candidates, not just the male ones. If the NHS fails to develop female leaders, it excludes 77% of its workforce (NHS, 2016).

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13. Glossary and Appendix

Glossary of Terms

Action Learning Sets – A development activity in which a group of individuals work through a set of career barriers.

AfC – Agenda for Change.

DH – The Department of Health, the government body which oversees the NHS Foundation Trust (FT) – a hospital body which has reached additional autonomy, allowing greater independence in terms of governance, guidance and board membership.

Glass Door – a barrier making it difficult for women and minority groups entering an organisation.

Glass Ceiling – an invisible barrier which prevents women and people from minority groups reaching executive positions.

Myers-Briggs Evaluation – A psychometric test to evaluate an individual's personality type.

NBP – Nye Bevan Program.

NHS – National Health Service.

Provider – an organisation which offers clinical services.

Queen Bee – a female leader who does not support the advancement of other female leaders.

Sticky Floor – a process which makes it difficult for women and minority groups to obtain junior promotions.

Trust – a health care body, such as a hospital.

VSM – Very Senior Manager, the grade for managers above band 9 on the Agenda for Change pay scales.

A.1 University of Middlesex Ethics Approval

Middlesex University London

Health and Social Care Sub-Committee

The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 0208 411 5000

07/06/2018

APPLICATION NUMBER: 3553

Dear Andrew Atherton

Re your application title: NHS Glass Ceiling

Supervisor: Betsy Thom, Rachel Herring, GordonWeller

Co-investigators/collaborators:

Thank you for submitting your application. I can confirm that your application has been given approval from the date of this letter by the Health and Social Care Ethics Sub-Committee.

Although your application has been approved, the reviewers of your application may have made some useful comments on your application. Please look at your online application again to check whether the reviewers have added any comments for you to look at.

Also, please note the following:

1. Please ensure that you contact your supervisor/research ethics committee (REC) if any changes are made to the research project which could affect your ethics approval. There is an Amendment sub-form on MORE that can be completed and submitted to your REC for further review.

2. You must notify your supervisor/REC if there is a breach in data protection management or any issues that arise that may lead to a health and safety concern or conflict of interests.

3. If you require more time to complete your research, i.e., beyond the date specified in your application, please complete the Extension sub-form on MORE and submit it your REC for review.

4. Please quote the application number in any correspondence.

5. It is important that you retain this document as evidence of research ethics approval, as it may be required for submission to external bodies (e.g., NHS, grant awarding bodies) or as part of your research report, dissemination (e.g., journal articles) and data management plan.

6. Also, please forward any other information that would be helpful in enhancing our application form and procedures - please contact MOREsupport@mdx.ac.uk to provide feedback.

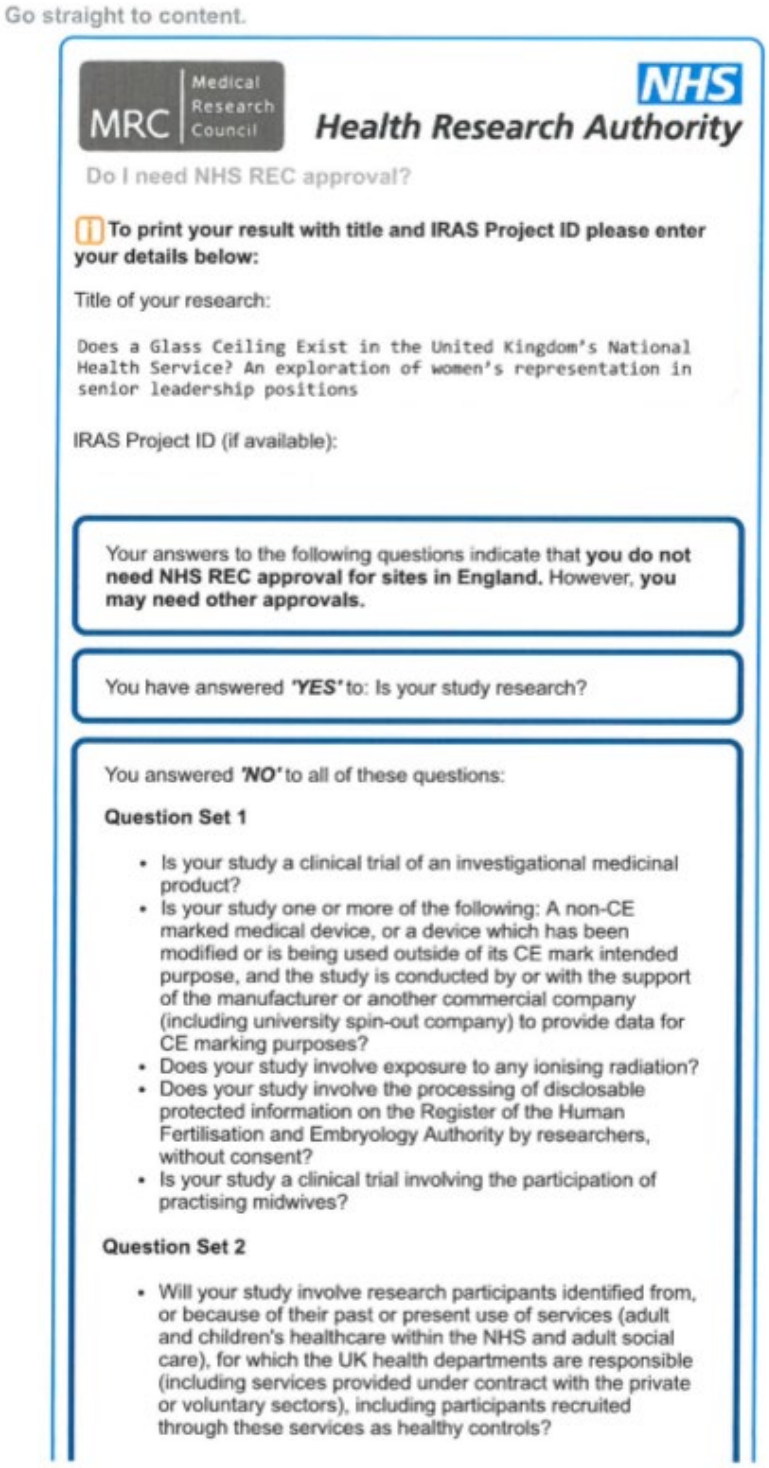
Good luck with your research.

Yours sincerely

Kay

Professor Kay Caldwell

A.2 NHS IRAS Form



Go straight to content.

MRC Medical Research Council

NHS Health Research Authority

Do I need NHS REC approval?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

Does a Glass Ceiling Exist in the United Kingdom's National Health Service? An exploration of women's representation in senior leadership positions

IRAS Project ID (if available):

Your answers to the following questions indicate that **you do not need NHS REC approval for sites in England.** However, **you may need other approvals.**

You have answered ***'YES'*** to: Is your study research?

You answered ***'NO'*** to all of these questions:

Question Set 1

- Is your study a clinical trial of an investigational medicinal product?
- Is your study one or more of the following: A non-CE marked medical device, or a device which has been modified or is being used outside of its CE mark intended purpose, and the study is conducted by or with the support of the manufacturer or another commercial company (including university spin-out company) to provide data for CE marking purposes?
- Does your study involve exposure to any ionising radiation?
- Does your study involve the processing of disclosable protected information on the Register of the Human Fertilisation and Embryology Authority by researchers, without consent?
- Is your study a clinical trial involving the participation of practising midwives?

Question Set 2

- Will your study involve research participants identified from, or because of their past or present use of services (adult and children's healthcare within the NHS and adult social care), for which the UK health departments are responsible (including services provided under contract with the private or voluntary sectors), including participants recruited through these services as healthy controls?

- Will your research involve collection of tissue or information from any users of these services (adult and children's healthcare within the NHS and adult social care)? This may include users who have died within the last 100 years.
- Will your research involve the use of previously collected tissue or information from which the research team could identify individual past or present users of these services (adult and children's healthcare within the NHS and adult social care), either directly from that tissue or information, or from its combination with other tissue or information likely to come into their possession?
- Will your research involve research participants identified because of their status as relatives or carers of past or present users of these services (adult and children's healthcare within the NHS and adult social care)?

Question Set 3

- Will your research involve the storage of relevant material from the living or deceased on premises in the UK, but not Scotland, without an appropriate licence from the Human Tissue Authority (HTA)? This includes storage of imported material.
- Will your research involve storage or use of relevant material from the living, collected on or after 1st September 2006, and the research is not within the terms of consent from the donors, and the research does not come under another NHS REC approval?
- Will your research involve the analysis of DNA from bodily material, collected on or after 1st September 2006, and this analysis is not within the terms of consent for research from the donor?

Question Set 4

- Will your research involve at any stage intrusive procedures with adults who lack capacity to consent for themselves, including participants retained in study following the loss of capacity?
- Is your research health-related and involving prisoners?
- Does your research involve xenotransplantation?
- Is your research a social care project funded by the Department of Health?

If your research extends beyond **England** find out if you need NHS REC approval by selecting the *'OTHER UK COUNTRIES'* button below.

OTHER UK COUNTRIES

If, after visiting all relevant UK countries, this decision tool suggests that you do not require NHS REC approval follow this link for final confirmation and further information.

Print This Page

NOTE: If using Internet Explorer please use browser print function.

About this tool **Feedback** **Contact** **Glossary**

A.3 Participant Information Sheet

Version Number and date 1.4 6/5/18

MIDDLESEX UNIVERSITY
SCHOOL OF HEALTH AND EDUCATION

Health and Social Care Ethics Sub-committee

PARTICIPANT INFORMATION SHEET

1. Study title

Does a Glass Ceiling Exist in the United Kingdom's National Health Service? An exploration of women's representation in senior leadership positions

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

3. What is the purpose of the study?

This study is exploring if there is a glass ceiling, which hinders progression of female employees reaching board level positions in the National Health Service.

Should the existence of a glass ceiling be proven, the study will then explore possible reasons for this and ways that these barriers can be mitigated.

4. Why have I been chosen?

You have been selected because you fit into one of the following categories:

- You are a female NHS employee on the Nye Bevan Program, whose career progression over next three years would be of value to study;
- You are a female NHS employee operating at board level and it would be of value to study how you were successful in making it to this point in your career. This would include what barriers you see to progressing to the board room and what opportunities there are for women on a board level trajectory;
- You are a female NHS employee who is currently on a board level trajectory, and it would be of value to study what barriers you see to progressing to the board room and what opportunities there are to assist you in this transition; or

- You are a male NHS employee who is currently working at or around board level, and it would be of value to study what barriers you see to progressing to the board room and what opportunities there are to assist people in this transition.

In total around 20 people will be interviewed for this research project.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form (not applicable for an anonymous survey questionnaire). If you decide to take part you are still free to withdraw at any time and without giving a reason.

You should think about the opportunity to withdraw; normally interview data will be anonymised and amalgamated into the analysis and so difficult to delete if requested.

Withdrawal will be possible up to one month after the interview, after which time, the data will be anonymised and amalgamated into the analysis'

6. What will happen to me if I take part?

You will need to take part in a one-to-one interview with a researcher. The interview can be at you place of work or at a venue of your choosing. Alternatively, it could take on the telephone, Zoom, FaceTime or over Skype. The timing of the interview would be at your convenience and would last for around 60 minutes.

It is possible that you may be contacted in the future to take place is a follow up interview, under the same conditions as above, should it be felt this would be of value to the research and should you be willing.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

7. What do I have to do?

You will be interviewed to gain understanding of your professional and personal circumstances, to explore details of your career path and aims for the future. The interview will last around one hour.

It is possible that you may be contacted in the future to take place is a follow up interview, under the same conditions as above, should it be felt this would be of value to the research and should you be willing.

8. What are the possible disadvantages and risks of taking part?

There is no known risk in participating in this project. There is a time commitment require from you and there is a possibility you would be contacted in the future for a follow up interview.

9. What are the possible benefits of taking part?

By taking part you will aid a study which is looking at ways to minimise gender discrimination in the NHS board level appointment process.

10. Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it.

The research team has put a number of procedures in place to protect the confidentiality of participants. You will be allocated a participant code that will always be used to identify any data you provide. Your name or other personal details will not be associated with your data, for example, the consent form that you sign will be kept separate from your data. All paper records will be stored in a locked filing cabinet, accessible only to the research team, and all electronic data will be stored on a password protected computer. All information you provide will be treated in accordance with the UK Data Protection Act.

For overseas registered nurses and midwives

However, if any information is disclosed that someone may be at risk, nurses and midwives are professionally required to report this to an appropriate authority.

For UK registered nurses and midwives

NMC code www.nmc-uk.org/Nurses-and-midwives/The-code/ states that as nurses and midwives 'you must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practicing'.

The University has a Safeguarding policy and the research team members are guided by professional codes of conduct which requires to us to report any information to the appropriate authority where a person may be at risk of serious harm. We will always endeavour to discuss this with you first.

11. What will happen to the results of the research study?

The results of the research study will be used as part of a Postgraduate dissertation. The results may also be presented at conferences or in journal articles. However, the data will only be used by members of the research team and at no point will your personal information or data be revealed.

12. Who has reviewed the study?

This study was reviewed by the Research Ethics Committee at Middlesex University, School of Health and Education, Health and Social Care Ethics Sub-committee

13. Contact for further information

You should give the participant a contact point for further information. This must be your name and Middlesex email address only and not your work title or details. You should also include your supervisor's name, work/university address, work/university telephone number and e-mail address. (Please do not disclose personal home and mobile telephone numbers on the PIS)

If you require further information, have any questions or would like to withdraw your data then please contact:

Researcher: Andrew Atherton AA4212@live.mdx.ac.uk

Supervisor: Prof. Betsy Thom B.Thom@mdx.ac.uk

Supervisor: Dr. Rachel Herring R.Herring@mdx.ac.uk

Middlesex University
Hendon campus
The Burroughs
London
NW4 4BT

Telephone: +44 (0)20 8411 5000.

Thank you for your time.

Thank you for taking part in this study. You should keep this participant information sheet as it contains your participant code, important information and the research teams contact details. You will also be given a signed consent form to keep.

A.4 Consent Form

Version Number 1.3

Participant Identification Number:

CONSENT FORM

Title of Project: Does a Glass Ceiling Exist in the United Kingdom's National Health Service? An exploration of women's representation in senior leadership positions

Name of Researcher: Andrew Atherton

Please initial box

1.	I confirm that I have read and understand the information sheet dated .....……..…for the above study and have had the opportunity to ask questions.	1
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	2
3.	I agree that this form that bears my name and signature may be seen by a designated auditor.	3
4.	I agree that my non-identifiable research data may be stored in National Archives and be used anonymously by others for future research. I am assured that the confidentiality of my data will be upheld through the removal of any personal identifiers.	4
5.	I understand that my interview may be taped and subsequently transcribed.	5
7.	I agree to take part in the above study.	6

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of person taking consent (if different from researcher)	Date	Signature
_____	_____	_____
Researcher	Date	Signature

1 copy for participant; 1 copy for researcher;

A.5 Pre-Interview Questionnaire

Version Number 0.2

Participant Identification Number:

Demographic Questionnaire

The information below is kindly requested in advance of your interview. Can you please answer the following questionnaire, it should take no longer than two minute and all responses will be treated in confidence, in line with the Middlesex University guidelines on data collection.

1. **Which category below includes your age (Please put a X in the appropriate box)?**

18-29		50-59	
30-39		60 or older	
40-49		Prefer not to disclose	

2. **Race (Please put a X in the appropriate box)**

White – British		Asian / Asian British – Any other		Black or Black British – African	
White – Irish		Mixed – White & Black Caribbean		Black or Black British – Any other	
White – Any other		Mixed – White & Black African		Other Ethic Group – Chinese	
Asian / Asian British – Indian		Mixed – White & Asian		Other Ethic Group – Any other	
Asian / Asian British – Pakistani		Mixed – Any other		I do not wish to disclose	

Asian / Asian British – Bangladeshi		Black or Black British – Caribbean		[redacted]

3. **Gender (Please put a X in the appropriate box)**

Female	
Male	
Other	

4. **Marital status (Please put a X in the appropriate box)**

Married		Separated	
Widowed		Single / Never married	
Divorced		Prefer not to disclose	

5. **Do you have children and / or carer responsibilities?**

No children or carer responsibilities	
Children (please include number and ages)	
Carer (please provide details)	

6. **What is the highest degree you have received (Please put a X in the appropriate box)?**

A-levels		Post-graduate	
Bachelor's degree		Prefer not to disclose	

7. **Please detail your most recent career history (for last 2-3 positions, include job title, responsibilities, number of staff managed, and dates)**

A.6 Pre-Interview Questionnaire Responses

Alias	Alias Name	Q1. Age bracket	2. Ethic Background	Q3. Gender	Q4. Marital Status	Q5. Children / Carer (ages)	Q6. Education	Q7. Career Summary
G1I1F	Allie	50 - 59	White - British	Female	Married	Step-Parent	Post Grad	Director / Head of / Head of
G1I2F	Anita	30-39	White - British	Female	Single	None	Post Grad	Head of / Manager / Officer
G1I3F	Zara	50 - 59	White - Irish	Female	Married	1 child (19)	Under Grad	Director / Head of / Dpt Director
G1I4F	Ellie	30 -39	White - British	Female	Married	2 children (8 and 6)	Under Grad	Director / Dir / Div Dir
G1I5F	Fiona	30 - 39	White - British	Female	Married	2 Child (10 and 7)	Post Grad	Head of / GM / GM
Group 1 Average		30 - 39	White - British	Female	Married		Post Grad	Dir / Head of / GM
G2I1F	Lucy	30 - 39	White - British	Female	Divorced	None	Post Grad	COO / DCOO / DCOO
G2I2F	Sandra	40 - 49	White - British	Female	Married	2 Children (11 and 9)	Post Grad	Dir / Dir / Dir
G2I3F	Barbara	50 - 59	Asian	Female	Married	2 Children (5 and 7)	Post Grad	Dir / As Dir / GM
G2I4F	Sue	50 - 59	White - British	Female	Separate	2 Children (25 and 21)	Under Grad	Dir / Dir / Senior Manager
G2I5F	Helen	50 - 59	White - British	Female	Married	2 Children (25 and 38)	Post Grad	CEO / CEO / Dir
Group 2 Average		50 - 59	White - British	Female	Married		Post Grad	COO / Dir / Dir
G3I1F	Deborah	30 - 39	White - British	Female	Married	2 Children (5 and 1)	Post Grad	Dpt Dir / Asso Dir / Head of
G3I2F	Sam	30 - 39	White - British	Female	Married	2 Children (1 and 5)	Post Grad	Consult / Asso Dir / Dpt Dir
G3I3F	Lyndsey	40 - 39	White - British	Female	Single	None	Post Grad	Head of / Head of / GM

G3I4F	Isabelle	30 - 39	White - British	Female	Married	None	Post Grad	As Dir / Consult / GM
G3I5F	Sally	30 - 39	White - British	Female	Separate	2 Children (3 and 5)	Post Grad	Head of / Dir / COO
Group 3 Average		30 - 39	White - British	Female	Married		Post Grad	Dir / Head of / GM
G4I1M	Terry	30 - 39	White - British	Male	Married	None	Post Grad	Dir / Div Man / GM
G4I2M	Mark	30 - 39	White - British	Male	Prefer not to disclose	1 Child (3)	Post Grad	COO / Div Dir
G4I3M	Jed	30 - 39	White - British	Male	Married	2 Children (1 and 3)	Post Grad	Head of / Dir / GM
G4I4M	Tony	30 - 39	White - British	Male	Married	None	Under Grad	Dir / Con / GM
G4I5M	Ted	40 - 49	White - British	Male	Married	2 Children (17 and 22)	Post Grad	Ex Dir / Dir / Ex Dir
Group 4 Average		30 - 39	White - British	Male	Married		Post Grad	Dir / Dir / GM

A.7 First Interview Schedule

Question No.	Interview Question
1.0	Details of NHS employment career to date and current role. • Can you please give me a brief description of your career pathway, with specific attention to the past 2 roles (NHS and non-NHS)? • Can you please tell me about your current role (job title, general responsibilities, number of reports, who you report to)? • Can you provide a brief overview of your personal life (material status, number of children, carer responsibilities)? • How would you describe your ethnicity?
1.1	What are the expectations over the Nye Bevan course of the program? [Nye Bevan Participates Only] • What were your reasons for joining? • What was the selection process?
2.0	Experience and perceptions of barriers faced when seeking promotion. • In your career have you ever faced difficulty when trying to gain promotion? • During your NHS career have you ever noticed anyone else being discriminated against or facing undue difficulty when trying to gain promotion? • What do you believe the main barriers are to career progression? These might include lack access to childcare or training courses, not having the correct skill set, difficulty in finding work life balance.
3.0	Experience and perceptions of opportunities and what has aided career development. • In your career what have been the most important factors and biggest opportunities for you in terms of career progression? • During your NHS career what do you think have been the most important factors that have helped other NHS employees progress in their careers? • What do you believe are the main opportunities for women in general, in relation to progressing their NHS careers?

4.0	Discussion of specific gender related issues as affecting career progression, e.g., childcare, other family commitments. • Have any external factors inhibited your career progression in the NHS (e.g., time off for maternity leave, reducing working hours due to carer responsibilities)? • How has your family supported your career? • Do you think that with fewer family / external commitments you would have been able to progress your career more quickly?
5.0	Views on what assistance could be put in place to help female career advancement. • What measures could be put in place by the NHS to ensure that female employees reach their maximum potential? • Does the NHS do enough to help female employees with family commitments? • Is there any specific training that could be put in place to help female employees progress in their NHS careers? • Do you feel that female NHS employees are given enough support when supporting and commencing new roles?
6.0	Details of any specific skills sought out to enhance career development. • Can you discuss what measures you have taken to develop your skills in order to further your career? • Have there been any specific courses or training you have sought out to further your career? • Are there any opportunities that you have not been able to follow up due to external factors (such as childcare commitments)?
7.0	Do you have any observations on how women and / or men support each other in the workplace and how? • Are these positive or negative actions? • What form has this taken? • What more could be done to support each other in the workplace?
8.0	Can you discuss any networks that you are aware of or part of and how they have impacted your career? • These can be formal or informal • How did you access these networks and when? • Can you describe how the network works and how it benefits you? • Do you think any all-female networks have been especially impactful?

9.0	Are you involved with mentoring? • Can be as a mentor and mentee • How does this work and what have been the benefits?
10.0	Is there anything else you would like to add, that you feel is relevant or that we haven't already cover?

A.8 Second Interview Schedule

Question No.	Interview Question
1.0	Can you give me a brief outline of how things have been over the past year, since we spoke last? • Have you changed roles since we last spoke? • Have you had any key achievements? • Have you had any setbacks?
2.0	When we last spoke you were just starting out on the Nye Bevan Program, what did you take away from the program? • What activities did you find the most beneficial? • Were there any aspects that you didn't enjoy / connect with? • What sort of person would you recommend the program to? • How has it made you feel about your future development needs?
3.0	Tell me about your networks. How has the Nye Bevan program improved your networks and helped you become a better networker? • Do you think that you have more diverse networks since we last spoke (either formal or informal)? • Can you recap how you have used these networks over the past year (advice, career progression, support)? • What do you other networks look like and how do you use them?
4.0	What career advice would you give to someone starting up in healthcare management? • This could be a type of role, which type of organization to work in. • Why is this piece of advice important to you? • Do you think it is a good industry to work in and why?
5.0	What has been the key moment in your career? • This could be a promotion, an important piece of work you were involved in, a person who impacted your career. • How did this make you feel? • What was the outcome?
6.0	Who do you look up to? • Either someone you have worked with, someone in your industry or outside healthcare.

	• What qualities do they have? • What about their achievements do you admire?
7.0	Last time we spoke about mentors, can you please review your thoughts on them? • Can you recap your position on mentors? • Do you currently have a mentor or are you looking for one? • What attributes do you seek in a mentor? • What do you think ensures a successful mentoring relationship?
8.0	What are your views on sponsorship? • Sponsorship is similar to mentoring but where a more senior leader takes a junior member of staff under their wing and guides them longer term, creating developmental and promotion opportunities. • Do you think this is a fair system or could be open to bias? • Is it a system (either formally or informally) that you have seen take place or been involved with?
9.0	Is there anything else you would like to add, that you feel is relevant or that we haven't already cover?

A.9 Narrative Analysis Pro Forma - Illustrative Example

Interviewee Ref:	G2I2F	Alias:	Sandra

Category & Questions	Interviewee Response
Abstract: What was the story about?	- Joined NHS as Graduate trainee - Took career break in Australia and two lots of maternity leave - Worked various jobs at one London trust - Last left role as wasn't getting executive roles
Orientation: Who or what are involved in the story and when and where did the story take place?	- Roles are more to do with fit than experiences - Have seen people get passed over for promotion as face doesn't fit - Roles have come about by being asked to apply for them / opportunistic - Have be paid for reduced hours before but end up doing same work in fewer days - Staff members have requested flexible working but need to be realistic about how this is delivered, recognition that working at home is less productive
Complicating Action: Then What Happened?	- Been head hunted for two COO roles, didn't get one due to experience, one due to needing to relocate family - Ops roles need time of site and A&E experience - CEO reluctant to allow flexible working - Not enough hospitals with nursery facilities
Resolution:	- Took local roles to get breath of experience

What finally happened?	- Husband works from home and can cover childcare responsibilities - Live 'close to tube with a nursery close by, with wrap around care and the drop off and pick times work from a work perspective' - For flexible working solution could be longer days when in work and a shorter day at home - When returning to work and wanting to get back home earlier to see children, more focused at work, less 'let's go a get a coffee' - Has 'just set up at North Mids., a women's network, focusing mentoring, looking at speaker events, bringing inspirational women to come in and talk about their career' - Used mentors at various times but not one at present
Coda: How does it all end up?	- Found work balance through husbands' ability to undertake childcare - Have found productive way of working to manage time and fit around family life - Uses networks to find about roles and provide support - Is in role which will provide the next step up

Additional Notes & Quotes on the Interview	- Current CEO said, when referring to a woman returning from maternity leave 'don't make any stupid flexible working arrangements with them' - Thoughts on when allowing flexible working 'there is something about if you really do value an employee and their contribution then you know that they are not going to take the micky' - On managing workload 'I've got to the point where people know that I can manage my diary, so when it's a Christmas

	play, I'll leave early but that doesn't mean I'm not getting my work done.' - On why men progress more quickly 'men will tick 6 out of 10 [on the JD] and go ahead to interview, sparkle and get the job. Women need to work on their imposter syndrome without being arrogant.' - On women in the workplace 'Some women who have senior positions have risen up the racks by mimicking what might be seen as stereotypical male behaviour and being quiet domineering – bordering on bullying – and there are another group who have risen up the ranks by being much more inclusive, supportive, engaging with the whole workforce' - Keen to see more around 'helping women manage the menopause at work, so these things are becoming much more common place and I assume that is about recognizing diversity' - Closing comments 'I've really started to see a shift in the types of people that are leaders of organizations. Especially in women, most of them are women. I'm wondering if there is something about what the NHS needs now from leaders are more skills that come more easily to women than men.'

A.10 Narrative Analysis Pro Forma - Illustrative Example II

Interviewee Ref:	G2I3F	Alias:	Barbara
Category & Questions	Interviewee Response		
Abstract: What was the story about?	This was Barbara's second interview in June 2020. It came about after she responded positively to an email asking her to share her thoughts on the effects of the Corona Virus pandemic. There were two central themes to the interview, the relationship with her former boss, which I have use a blue front for and her role in the pandemic, which I have used a purple font for. Barbara's narrative switch between these two themes but also revealed a change in how she spoke about herself, she had recently started a more senior role and spoke with much more confidence (she even stated feeling more confident), perhaps due to the new role, her involvement in COVID or a combination of the two. There was also notable pride which Barbara had taken from working for the NHS during the pandemic.		
Orientation: Who or what are involved in the story and when and where did the story take place?	Relationship with former boss: - When I first spoke to Barbara (July 2019) she was acting up into the role of Director of Ops, following the departure of her previous line manager to a new trust. - Her new boss had started in September 2019, which meant that Barbara had revert to her previous role as his deputy. - Barbara felt her values and style were oppose to her new manager. COVID Pandemic: - The COVID pandemic started while Barbara was working at her original organization.		

	- She was offered a role at her new organization to start immediately but stayed at her old trust to help with the pandemic. - Initially it was thought within her trust, by the management team, that the pandemic would be similar to SARS or Ebola and not affect the UK - As such there was little preparation and hospitals were expected to act as normal.
Complicating Action: Then What Happened?	Here the two narratives start to merge as the start of the pandemic exacerbated the relation between Barbara and her manager as their two styles and value systems started to conflict with each other. Relationship with manager: - Barbara's manager did not want to engage with the pandemic, he did not attend meetings where it was discussed and did not heed the warnings of his clinicians. - Because of this Barbara was left to drive the pandemic response, this led to her manager claiming she didn't involve him. - When the pandemic started to develop, her manager worked remotely and would email the team with requests to complete insignificant bureaucratic tasks when the focus should have been on the pandemic. - Even though the day she left the trust most people were working remotely at the time, they came into work to say goodbye – she took this as a sign that she was valued and appreciated. Pandemic response: - The clinicians wanted to stop routine work before there were any signs of the pandemic developing in the UK to be prepared.

	- Barbara took a huge risk in stopping some routine surgery to allow for training. - During COVID home working was not possible for her, but it was for support services and admin.
Resolution: What finally happened?	Relationship with manager: - Barbara was asked to stay on by the CEO to continue to oversee the COVID response. - Barbara's manager intervened, stating he didn't need Barbara, she believes this was because she was overshadowing him and because she was taking the side of the clinicals. Pandemic response: - Ultimately the government guidance to cancel elective surgery came soon after Barbara had made the decision local, she was vindicated, and the risk was worth taking. - Whilst many people worked remotely during the pandemic Barbara was at the heart of the action thought out.
Coda: How does it all end up?	Relationship with manager: - The CEO has told Barbara she would welcome back at any time. - The behaviour of her manager confirmed to Barbara that his type of management is no longer appropriate in the NHS and helped to validate her own value system and style of leadership. Pandemic response: - Barbara felt the pandemic had separated the good managers from the bad, it had shown who was just a waffler and who could actually take control and manage situations.

	- Barbara spoke with a sense of pride about what she had achieved during the pandemic, there was a sense that it helped cement her relationships. - Whilst the pandemic made Barbara want to spend more time with her family, she thought it was worth working long hours as the health system was for the benefit of her family and the wider population. The two narratives combined to create a picture of a more confident and knowledge leader with a greater understanding of her role and importance of healthcare leaders. There is the sense that leading on large operational project developed and reminded her skills. In these situations, Barbara felt that female compassion was vital and something lacking in male leaders. It is notable that due to the scale and volume of work and the number of hours each work day, Barbara was able to obtain a huge amount of experience in a short space of time, this reinforces the importance of busy operational and on-call work in obtain promotions. This is something parents with young families would had found difficult to commit too. Remote working featured heavily in the interview, it was thought to be good for when briefing was required but when a dialogue was needed the connectivity and the means of VOIP was stilted and more formal. Remote working misses the corridor conversations with the NHS thrives off.

Additional Notes & Quotes on the Interview	- About managers priorities during COVID: 'It was like he was on a different planet' - Behaviour of manager when Barbara took on COVID lead: 'he started feeling really insecure and tried to push me out' - Worried about waiting lists targets at the start of the pandemic: 'I would get a real bollocking for that' - Why remote working doesn't work in operational management: 'in ops you do have to be visible and a lot of it is around conversations around meeting'

	- On her role post-COVID: ‘honest I feel really lucky that I work in the NHS’. - On moving to her new role, because of the experience gained during COVID: ‘I feel stronger inside, I feel stronger coming into this role’. - On female leadership because of COVID: ‘females do tend to be a lot more compassionate. I don’t really care who says anything to come back at that. And I think that leadership has been really telling globally, female leaders are better at responding to crisis than our male counterparts, both in the political realm and the healthcare realm as well, I think.’

A.11 Direct Quotations from the interview Participants

Alias	Quotations taken from Narrative Analysis Pro Forma
G1I1F Allie	• On handling staff during pandemic 'but it is the strongest staff survey we've ever had' • 'A number of staff has lost members of their family, we have one member of staff lost five members of their family. That's the worst example that I am aware of. We lost a member of staff as well unfortunately, she had a sudden and unexpected cancer diagnosis went into hospital, contracted COVID and went. That was shocking. And I had at least 5 members of staff at one point hospitalized with COVID. The fears for staff, the anxieties for staff absolutely tangible, perfectly legitimate' • On pipeline and removal of middle management: 'What I am seeing is an increasing gap between functioning at the exec level' • On the NHS being a closed shop: 'Its not any easy thing, Andrew, to join health at a senior point in one's life. I was 52, 53 when I came into this post in health it was a vertical learning curve, for me, which I believe I addressed.'
G1I2F Anita	• On what is need to become a board member: 'I think I recognized in myself there was a bit of development that I need to do because in a director role, I recognized that it wasn't just about my professional expertise as a communications expert but as the director of a hospital you have to be able to contribute across the board really on a breath of difference issues and aspects of the business.' • On promoting talent: 'it's not as easy as in the private sector because of the whole agenda for change thing,'
G1I3F Zara	• On support from female CEO: 'I worked there with a girl who is now Chief Executive, and she was quite inspirational in how she approached things and I learnt a lot from her and in fact I've worked with her on two other occasions in my career and she's been quite instrumental in supporting me in my development really'. • On the Nye Bevan Program 'this particular leadership program is for aspiring directors and if I'm completely honest I'm not sure I completely appreciated that when I applied to do the course I just thought it looked really interesting and also focusing on leadership in the NHS, but at the first residential it became quite clear that the focus really was on succession planning and developing the next batch of executive directors'. • On challenging female colleague: 'no matter how senior you are suddenly your face doesn't fit that ways can be found to get rid of you'. • On applying for jobs 'when I was looking at the job description, that's where I would usually start, I would look at the job description, I think can I do this and if the majority of it is yes, I think I can do it, then I look at where the gaps are and consider how I might develop those'. • On progression 'even though we have a good number of senior male nurses but its' about people who put themselves forward for these positions when they became available'
G1I4F Ellie	• On NHS development: 'I think there's a wonderful selection of opportunity for people who want to progress in the NHS, you just have to be a little bit brave'. • On having a young family: 'my biggest challenge and that's been the thing that holds me back and limits my career'

	• On the NHS being a close shop: 'I think the NHS is pretty awful in wanting everyone to have NHS experience' • On NHS leadership: 'The leaders who I've admired have always been people who were accessible, and open and supportive of the development of others… I think there's a lot if autocratic leadership in the NHS, but I don't think its necessarily a good thing'.
G1I5F Fiona	• On joining the NHS: 'there were no career aspirations that got me to join the NHS, it was just that they are a very flexible and supportive employer' • On her career path: 'I was just fortunate to have a line manager that spotted my potential' • On reason for relocating: 'The [region I used to work in] is very much dead man's shoes, so the further up the career structure you get the opportunities are much more limited – for me to move in my career I would have probably had to wait for someone to retire' • On working in the NHS: 'I think staff that have only ever worked for the NHS take a lot of stuff for granted – it really is a careering supportive employer, you might work with people that you don't like, but actually the way it treats its staff the way it comes out with terms and conditions and agenda for change, it is an extremely generous employer – your salary might not be huge but the benefits in kind are massive.' • On the pace of change in the NHS: 'were like a dinosaur' • On trying to do a senior management role with a young family: 'you'd probably need a really good support network underneath you' • On different types of NHS managers: two different types of people in the NHS, there are those that are really passionate about it, they want to be hands on and be very patient facing and I think that is male and female that do that, then I think there is very much the career NHS person, as I like to call them, who will be fast tracked through everything, there only aim is to be on a board and they miss quite a bit of that understanding on their way there'
G2I1F Lucy	• 'a [female COO] when I was working at [organization X] asked me 'are you on your period' because she didn't think I was in a good mood.' • Male CEO on all female networks 'The CEO jokes about it – but I think he means it – that he is not a big a fan of women only events, as he thinks women should be there on their own rights. But maybe he doesn't understand the unconscious bias that women face.'
G2I2F Sandra	• Current CEO said, when referring to a woman returning from maternity leave 'don't make any stupid flexible working arrangements with them' • Thoughts on when allowing flexible working 'there is something about if you really do value an employee and their contribution then you know that they are not going to take the micky' • On why men progress more quickly 'men will tick 6 out of 10 [on the JD] and go ahead to interview, sparkle and get the job. Women need to work on their imposter syndrome without being arrogant.' • On women in the workplace 'Some women who have senior positions have risen up the racks by mimicking what might been seen as stereotypical male behaviour and being quiet domineering – bordering on bullying – and there are another group who have risen up the ranks by being much more inclusive, supportive, engaging with the whole workforce' • Keen to see more around 'helping women manage the menopause at work, so these things are becoming much more common place and I assume that is about recognizing diversity'

G2I3F Barbara	• Current CEO said, when referring to a woman returning from maternity leave 'don't make any stupid flexible working arrangements with them' • Thoughts on when allowing flexible working 'there is something about if you really do value an employee and their contribution then you know that they are not going to take the micky' • On managing workload 'I've got to the point where people know that I can manage my diary, so when it's a Christmas play, I'll leave early but that doesn't mean I'm not getting my work done.' • On why men progress more quickly 'men will tick 6 out of 10 [on the JD] and go ahead to interview, sparkle and get the job. Women need to work on their imposter syndrome without being arrogant.' • On women in the workplace 'Some women who have senior positions have risen up the racks by mimicking what might been seen as stereotypical male behaviour and being quiet domineering – bordering on bullying – and there are another group who have risen up the ranks by being much more inclusive, supportive, engaging with the whole workforce' • Keen to see more around 'helping women manage the menopause at work, so these things are becoming much more common place and I assume that is about recognizing diversity'
G2I4F Sue	• Current state of the NHS: '[it's] around recognizing that the NHS is a pretty challenging place to work at the best of times, and unless we are able to demonstrate that we care for people and treat them as individuals then they will struggle to give the best of themselves to patients.' • On how to develop people for director roles: 'Letting them go and be a director in a smaller organization and then let them step back and become a director in a bigger one a couple of years later. One of my observations around the private and public sector, is that the private sector, that's just how you did businesspeople did just get moved, for development reasons. And the role wouldn't necessarily be advertised'. • On female only courses: 'I'm not particularly fond of dedicate female leadership courses, because in my head that seems to be coming from a premise that women need them to get on'.
G2I5F Helen	• On having a career with a young family: 'Everything you did was in spite of the system' • On being younger than other Health Visitors: 'I suffered a real load of bitchiness' • On NHS development: 'I would say the NHS has done the square root of zero until probably the last 5 years. The majority of my career was about me being absolutely determined' • On NHS bullying: 'leaders around me would feel jealous of any skills that I was demonstrating' • On sexism: 'I have experienced load of sexism throughout my career. It is hidden, it is not transparent. Very often throughout my career I've been in a room when is it 10% women and 90% men.'
G3I1F Deborah	• On flexible working 'I think there is always a bit of resentment there of people doing full-time job in four days and getting 80% of the salary'. • On being a working mum 'You get to work, and you've had three people to sort out before you've even got to your desk' • On flexible working 'Flexibility is really important, and I was lucky that I was in a commissioning role really at the point because it tends to be a little more flexible than an operational management role.' • On her career vs. husbands 'I have made concessions; I've got a much more limited ability of the sort of things I can do to give me that flexibility to do what I need to do for our child now.' • Comments from a female COO 'you need to get a nanny so you can focus on your job'

G3I2F Sam	• On board level positions while working reduced hours 'I couldn't give it all that it needs, and I want to work four days a week. You can't do that at board level. It's also down to accountability, how can you be accountable to the board if you aren't in the building half the time?' • On development 'Broadly speaking, the NHS isn't great at development. There isn't a route for talent management.' • On the effects on children on promotion 'Before I had kids there was a point in time when I said I wanted to be at board level.'
G3I3F Lyndsey	• On career progression: 'My ambitions are much more about having a meaningful job, rather than raising through the ranks'. • On being a woman working in Data: 'I think also there are a lot of old, middle class, middle aged men in the system and I think sometimes that gets tiring to work for'. • On BME staff: 'It's never overt but I also think it is much harder for people from a BME background than it for women.' • On subconscious biases: 'I think a lot of it is about just helping people who their ingrained behaviours or actions might be causing a problem for others.'
G3I4F Isabella	• Gender in different types of roles: 'I can't imagine it is easy for men to go into nursing because of their family and friends do not have a positive view of men working in those types of things. I've worked a lot in orthopaedics, and it is definitely male dominated, but I think GPs tend to be women now because they can be self-employed, running their own businesses when they can work flexible. And of course, GPs can opt out of on-call commitments which hospital consultants can't.' • On moving role to progress career: 'I moved around a lot as an NHS manager there is a view that you need to spend about two years in role – it's a piece of advice I was given – take one year to learn it and to do it well.' • On female leaders: 'I think that women COOs can tend to be very bitchy and make bitchy comments in open meetings to other women more than men do.'
G3I5F Sally	• On networks: 'I think that people who network well get those opportunities.' • On private sector networks: 'I think if I went into the private sector, I think I'd probably have networking opportunity much greater than the NHS currently does.' • On use of networks: 'Advice, for example, if I am struggling with something has anyone done it well? Sharing good practice, sharing things that haven't gone well.' • On cutting maternity leave short: 'I only had 6 months maternity leave because my boss wanted to leave, and they wanted to give me that opportunity.' • On leaders working part-time: 'and I query how as a director you can do that if you're not working full time, which is really negative, but how can you?' • On age discrimination: 'I think when you are young and a highflier…people think that you should have earnt your stripes…I get a lot of that from females rather than males.' • On age: 'straight away before you even start there is a prospection because of your age in the NHS' • On mentors: 'it's about having that rapport and getting on'.
G4I1M Terry	• On being a white male: 'I guess as a white male, that I would be less likely to be facing barriers than many other people who might be applying for jobs.'

	• On BAME workforce: 'In my current trust the proportion of people from ethic minority backgrounds at particularly board level and directly below board level is very low and not representative of the rest of the workforce.' • On recruitment of BAME staff: 'I've not seen an interview where I've thought a better candidate didn't get appointed and was actively discriminated again, but subconsciously it's happening, it's absolutely happening otherwise they would be at least more representation.' • On male board appointments: 'we are battling with history which is traditionally had males up there who are more likely to recruit in their own image.'
G4I2M Mark	• On apply for a role 4 bands higher: 'I thought – well I think I'm good enough – and I went for it.' • On working long hours: 'you basically worked 24/7 really, that is a challenge for anyone' • On gaining operational (on-call) experience: 'The on-call element, unless you've done it yourself it's not the same – when you're called at 2am about a massive crisis, you're on your own…nothing beats doing it' • On gaining operational experience: 'The difficulty about this is that if you are serious about doing a senior operational job you are going to have to get your hands dirty and do the work, whether you are male, female or an alien from space, ultimately there is always the responsibility on you to just do it.' • On getting the right role: 'I think the organization that you chose to work in and the manager you choose to work for are critically important judgements' • On flexible working: 'I think that when you get to really senior posts that is difficult because they are full time jobs'
G4I3M Jed	• On not experiencing discrimination: 'I'm white, male and middleclass. So, in a sense the system is set up for me to succeed.' • On the need to work long hours in the acute sector: 'There's a sense that unless you are in the hospital for twelve or fourteen hours a day, you're not really pulling your weight.' • On taking a role outside of the acute sector: 'I've made a choice around being present for my family'. • On current anti-discrimination programs: 'I think the agenda, around gender equality and transparency – there is a huge amount of work going on in this area, but I think there is a danger that it just becomes tokenistic'.
G4I4M Tony	• On his use of networks: 'I break the norms on this because it's all about networking managing your network, keeping you know these contacts alive, and stuff, but I don't do that.' • AfC and equal opportunities: 'I know its Agenda for Change its equal opportunities and blah blah blah blah blah… once you work with people the NHS is a small place, which you get a good reputation and relationship that will carry you quite far.' • On NHS policies: 'despite whatever the actual legislation and whatever the actual policies say you can't help it it's human nature you form a view in the first few seconds of meeting them.' • On skills needed for NHS management: 'it's all about bringing people…you can't do anything on your own so it's what relationships you have, what relationships you are able to build. Judgement more than technical skills I would suggest.' • On childcare arrangements: 'this whole conversation is built on a sexist premise, in so much that I'm talking about childcare needs and whatever and the women that work in the NHS but obviously men are involved in raising children.'

G4I5M Ted	• On jobs in the NHS: The breath of opportunities within the NHS is frequently not known to people on the outside, if you asked people to name 10 jobs in the NHS they'd probably struggle, yet there's about 120-130 different careers.' • On people not wanting to take director toles: 'they just don't want the stress' • On regulators: 'NHS has become more under pressure the regulators have become more overbearing…the autonomy seems to have seeped anyway' • On all types of discrimination: 'Looking at our board, about a year ago we used to get a lot of stick for it being quite white and quite male, from a diversity perspective what that photo doesn't show is that one of those people was in a wheelchair, one of those people was gay, one of them might be white but he is a Muslim. Sometimes I think that inclusivity can be deemed as just skin deep at a times.' • On flexible working: I think the go to position for the average manager in the NHS is just to say no'

A.12 NHS Employers Website Data Monitoring Form