

RELEASING POTENTIAL:

Women doctors and clinical leadership

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She was funded by the National Leadership Council to research the career trajectory and leadership roles of senior women doctors and has lobbied nationally for greater recognition of the contribution of sessional GPs. Penny works two days a week in a busy urban practice and has three small children.

If you would be interested in the creation of an interactive career and development network for women doctors (see page 26), or for any other correspondence, please email Penny Newman on penny.newman1@nhs.net



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FOREWORDS



I am pleased to endorse this important report, which was completed by Dr Newman, with the support of an NLC Emerging Leaders bursary.

The successful delivery of the NHS reforms is predicated, substantially, on the strength of our clinical leadership community.

This report highlights the challenges faced, specifically by women doctors, in achieving leadership positions. It makes pragmatic recommendations on how we can overcome these challenges - something we must do to ensure the NHS has clinical leaders with the necessary skills, in sufficient numbers, for successful implementation of the reforms.

Jan Sobieraj
Managing Director, Health and Social Care
Workforce, Department of Health



A critical role for SHA clusters during transition and later for the NHS Commissioning Board, will be to build leadership capacity and capability for the implementation of clinical commissioning groups and to ensure a pipeline of talented, enthusiastic emerging clinical leaders.

Women doctors make up approximately 60% of medical school entrants, 43% of GP partners and 70% of the sessional GP workforce, yet few women doctors are coming forward to take up leadership positions in the emerging Clinical Commissioning Groups. This is a workforce issue we ignore at our peril.

This important report was authored by Dr Penny Newman as part of her participation in the Senior Clinical Leaders Programme, one of the flagship programmes of the East of England approach to leadership development and talent management.

I am delighted to be able to endorse this report and its practical recommendations for supporting women doctors and developing the leadership skills and confidence of the medical workforce.

Sir Neil McKay CB
Chief Executive, NHS Midlands and East

EXECUTIVE SUMMARY

KEY MESSAGES

Numerous reports have identified the under representation of women doctors at board level, now mirrored on emerging Clinical Commissioning Groups (CCGs). Significant efforts to increase female representation on corporate boards in the UK and across Europe include the use of quotas.

This study provides qualitative data from in-depth interviews with senior female medics to highlight the contribution of women doctors at board level including on CCGs.

Increasing female representation will ensure use of talent and increase capacity, enable inclusive, non hierarchical behaviours, create powerful role models, reflect the needs of female patients and help ensure compliance with the Equality Act. Gender diverse boards have improved financial and organisational performance.

Action is needed to improve the talent pipeline and overcome complex barriers that impede female medical career progression.

The current focus is on clinical leadership; need for new leadership styles; organisational performance; and creation of effective CCGs following authorisation. These all create a unique opportunity and urgent need to address this long standing issue.

“Strong and visible clinical and professional leadership at all levels, focused on increasing trust and encouraging positive behaviour, will be key to bring about better outcomes for patients.”

NHS Future Forum June 2011

The current reforms present significant change in a severe financial climate. At the heart of these reforms clinicians are being asked to hold budgets and make the necessary savings while improving quality and maintaining patient safety, often through their day to day interactions with patients.

Clinical Commissioning Groups (CCGs) will take over responsibility for commissioning the majority of NHS services in England, with Primary Care Trusts (PCTs) due to be abolished by April 2013. All GPs in England will be required to join one of the CCGs, which will begin to assume their new statutory responsibilities following authorisation from 2013/14. A wider range of professionals will now be involved through clinical senates and networks, and with specialists and nurses formally part of CCG boards.

This change provides an enormous challenge to clinical decision making, but also an unprecedented opportunity for clinical leadership.

Will clinicians take up this leadership challenge and responsibility? Will they have the skills? Will they have sustainable capacity?

Women doctors have made up the majority of entrants to medical school since the early 1990s, yet relatively recent reports from the Royal College of Physicians and Department of Health (Deech Report) illustrate that only a small minority achieve senior leadership positions at board level or equivalent. Despite the talent pipeline having been primed for over two decades, women doctors remain under represented in academia, BMA, Royal Colleges and as clinical and medical directors.

Emerging CCGs are already dominated by male GP leaders, mirroring this trend. As GP partnerships become less available there has been a nearly tenfold increase in the number of salaried posts held mostly by women, with few opportunities for leadership.

The Future Forum acknowledged this under representation and the need for appropriate development opportunities to support a leadership role.

This report provides further additional qualitative evidence to strengthen the case for improving the talent pipeline of female medical leadership. To identify their career trajectories and views on the contribution of women doctors at board level and to the current reforms, between December 2010 and June 2011 twenty six in-depth, semi-structured interviews were held using the technique of ‘appreciative enquiry’ with female GPs and consultants who hold significant leadership roles across the country. The interviews were recorded and analysed to identify key themes which were then tested at a National Leadership Council workshop with a further 43 female medical leaders and other experts. Together with a literature review, validated by the International Centre for Women Leaders, Cranfield School of Management, this report draws together the findings.

Demonstrated through biographies of the women interviewed (listed in appendix 1), the report is written to celebrate the talent, dedication and experience of these doctors, and illustrate the untapped or “hidden” resource and alternative leadership approach they represent. It aims to inspire organisations to support women doctors in achieving leadership and management roles to the benefit of patients, the NHS and women themselves.

Why is the under representation of women in leadership positions important? This study illustrates that women doctors have the necessary skills, behaviours and flexible capacity to support delivery of the current reforms and contribute to improved outcomes for patients at a senior level.

The benefits of increasing the numbers of women doctors in senior clinical leadership roles include:

1. **A broader talent pool and increased capacity of capable clinical leaders.** Leadership is dependent on individual skills and expertise - everyone should be given an opportunity for leadership as far as their competence and aspiration allows. However, women doctors make up approximately 60% of medical school entrants, 43% of GP partners, 70% of sessional GPs and 28% of consultants - a sizeable chunk of the workforce and talent pool. Many work part-time and may have flexible capacity. As the biographies of interviewees illustrate, these women often bring additional qualifications and skills from portfolio careers. To ignore women would significantly reduce the talent pool.
2. **Improved financial performance.** Research from the private sector indicates improved financial and organisational performance with gender diverse boards. The business case for greater gender diversity is clear.
3. **Improved quality, safety and shared decision making.** Women doctors make safer decisions as illustrated through reduced referral to the National Clinical Assessment Service. Research shows they have longer appointments, better communication skills, include more prevention and are more patient-centred in their consultation with patients. They are therefore likely to value and promote shared decision making and self care - a central policy agenda.
4. **Representation of patients’ needs and inequalities.** Fifty per cent of our patients are women, as are the majority of staff in the NHS. Women doctors respect and understand the things that women need e.g. as patients, carers, mothers and employees, and can ensure these needs are reflected in services. Research indicates they are more likely to work with marginalised and vulnerable communities.
5. **New leadership styles and behaviours** are needed to engage colleagues and manage in complex systems. Women doctors interviewed uniformly articulated a people-centred leadership style and focus on patients, teams, relationships, engagement and inclusion. This is similar to the “shared, distributed and adaptive” or non hierarchical approach required to lead the new CCGs working across organisations and with constituent practices.
6. **The creation of role models** will inspire the next generation and future workforce, which will be composed mainly of women. As powerful role models women doctors can help define future policy and direction of medicine, train more junior colleagues and sponsor and promote other women doctors.
7. **An engaged and motivated workforce.** Increasing access to senior roles will enable women to realise their potential and increase personal satisfaction in a leadership role through career progression.
8. **Compliance with the millennium goal and in line with the private sector.** At the Millennium Summit in September 2000 world leaders adopted the UN Millennium Declaration, committing their nations to a series of time-bound targets, with a deadline of 2015 that have become known as the Millennium Development Goals. One of the goals is to “promote gender equality and empower women”. Significant efforts are now being made to empower women across the globe and increase female representation at board level in the private sector.
9. **Compliance with the 2010 UK Equality Act** which requires equal treatment for access to employment regardless of gender.

However, to reap these benefits, women doctors need to be enabled to contribute at top levels of management - a complex task. While some women did not perceive any barriers to progress, similar to research findings, many described:

- Role conflict and “structural” barriers including the triple burden of domestic, clinical and leadership responsibilities, part-time work, the sessional GP contract, lack of role models and little dedicated time for management roles - the latter is also experienced by male colleagues.
- Individual and organisational “mindsets” such as low personal aspiration, the perception of a traditional male cultural environment, a “boys club” and a lack of networking opportunities.

The affect of this “cumulative disadvantage” mean many women do not want, or are unable to achieve, senior leadership roles. Male and female perceptions of the size and nature of these barriers differ.

Solutions include flexible “ramp on and off” posts, networks, coaching and leadership development, role models, sponsorship, transparent and robust appointments processes and co-opted posts for sessional GPs.

However, piecemeal interventions have little lasting effect leading to calls for systemic organisational change. Change requires not only “fixing” the women but organisational support from the top to change mindsets and create the space for women once developed to move into senior roles. To address this need for organisational solutions, many countries have adopted quotas in the private sector, including the UK. Although a quota may not be acceptable for CCGs and other NHS boards, there is much to be learnt from the plethora of initiatives in the private sector to address this issue.

Gender is only one aspect of diversity, which includes consideration of age, sexual orientation, disability, race, religion and belief. While there is some commonality in the experience of women doctors and minority groups, women doctors are the majority of the medical workforce and so the under-utilisation of their talents requires specific attention. Many women doctors are also from black and minority ethnic groups.

This report highlights the very significant contribution women doctors are making in the NHS - but there is more on offer. If even more women doctors are supported to achieve senior roles it will be “all hands on deck” rather than a few, organisational performance will increase, the potential exists for cultural and behavioural change in our interaction with patients and between organisations, and a legacy will be left that ensures more motivated and inspired clinical leaders in the next generation.

If women doctors fail to be represented on CCGs and other NHS boards, the lack of diversity presents a risk to developing the collaborative and inclusive leadership behaviour needed for organisations to succeed in a complex system. The NHS will fail to obtain the improved financial and organisational performance and return on investment that comes with board diversity. GP leadership in CCGs may not be sustainable.

A window of opportunity now exists to address this long standing issue given the focus on clinical leadership and the ability of emerging CCGs, networks, senates and new Foundation Trusts to develop new leadership roles and gender diverse boards e.g. prior to authorisation. Coupled with the creation of the National Leadership Academy and significant momentum developing in the private sector, now is the time to take action when other initiatives have failed. There is now an unprecedented opportunity for clinicians to come forward in a new era for clinical leadership in the NHS; this opportunity is for all clinical leaders and must include women.

RECOMMENDATIONS

1 National level and SHA Clusters

1. Coaching and mentoring for women doctors in isolated senior leadership roles should be routinely offered where women doctors are a significant minority.
2. Role models should be identified and developed to encourage women doctors to aspire to leadership roles. Women doctors in senior leadership positions should be offered training to coach female colleagues and awards for their achievement and sponsorship of others will recognise and appreciate their value.
3. Work should be undertaken in collaboration with the National Leadership Council's Top Leaders programme to identify the pipeline of talented women doctors ready to apply for board level positions and challenge male only boards.
4. A women doctors' web-based interactive leadership social network should be created with support from NHS Networks to promote peer support, online co-coaching, career development and involvement in commissioning.
5. All appointment processes should be scrutinised to ensure they are transparent and robust.
6. The numbers of women doctors should be tracked to identify those achieving leadership roles by specialty and at board level, similar to the Female FTSE 100 board report.
7. All national primary care organisations should take joint responsibility to encourage and enable the development and contribution of sessional GPs at practice and CCG level and ensure their involvement in the future leadership of primary care.
8. Flexible training, part-time positions and posts where there is the ability to "ramp on and off" should be made more available across the NHS for all doctors, male and female.
9. A booklet or web page for junior women doctors should be developed to provide career advice on what to expect, highlight role models, and provide useful sources for support.
10. A steering group should be established to oversee implementation of these recommendations and consider the need for further research.

2 Organisational level

1. All emerging CCGs should be aware of the number of sessional GPs in their area, ensure they receive all communications, and have voting rights and access to development and leadership opportunities.
2. CCGs should consider the benefits of diversity and representation of the performers list at board level and the need to co-opt members who are under represented prior to authorisation e.g. female and sessional GPs.
3. All NHS organisations should develop sponsorship programmes to encourage women doctors in leadership, make roles available by having fixed board level appointments, monitor uptake of development programmes by gender and actively promote women doctors for local or national awards.

3 Individual women doctors

1. All women doctors should consider leadership opportunities, put themselves forward, join a network and offer to mentor or sponsor other women doctors.

1.0 INTRODUCTION

The Health and Social Care Bill sets out significant reform for the NHS focused on patient outcomes.¹ The intention is to transform the NHS into a devolved model in which local commissioners and providers of health services are freed from such central control, with an increased say for patients and the public, and wider use of data.

Central to these reforms is greater clinical leadership coupled with increased financial accountability. The aim is to replace top down targets with clinical decision making to improve quality at the same time as achieving £20 billion productivity gains by 2014/15. It is no longer enough to just lead a small clinical team; clinicians are now taking responsibility for whole patient pathways and the budgets that follow them.

CCGs will take over responsibility for commissioning the majority of NHS services in England, with PCTs due to be abolished by April 2013. All GPs in England will be required to join one of the CCGs, which will begin to assume their new statutory responsibilities following authorisation from 2013/14. A wider range of professionals will now be involved through clinical senates and networks, and with specialists and nurses formally part of CCG boards.

Will clinicians rise to this leadership challenge and responsibility? Will they have the skills? Will they have sustainable capacity?

Women doctors have made up the majority of entrants to medical school since the early 1990s, yet only a small minority achieve senior leadership positions on NHS boards or equivalent. This report strengthens the case for improving the talent pipeline of female medical leadership by using qualitative interviews to build on a robust body of research and numerous national reports that date back to the 1990s.²

Using biographies of those women interviewed as illustration (appendix 1), the report is written to celebrate the talent, dedication and experience of women doctors, illustrate the untapped or hidden resource and different leadership approach available, and inspire organisations to support women doctors in achieving leadership and management roles to the benefit of patients, the NHS and the doctors themselves.

2.0 AIMS, OBJECTIVES AND METHODOLOGY

The National Leadership Council's (NLC) role is to support and develop world class leadership which puts the quality of patient care at the heart of everything the NHS does. This project, funded by an NLC Emerging Leaders Bursary, arose from the author's participation in an NHS East of England Senior Clinical Leaders development programme. The National Leadership Council has more recently formed the National Leadership Academy.

The report is the result of twenty-six semi-structured, qualitative telephone interviews with 17 GPs, 6 clinicians from secondary care (consultants and Chief Executive) and three heads of policy conducted over a six month period December 2010 to June 2011. An 'appreciative enquiry' approach was used, with 15 key questions. Interviews were conducted and recorded on the telephone, lasted between 90 and 120 minutes, and were then transcribed. Analysis was undertaken using a content analysis approach in which scripts were read and re-read to identify key recurrent themes on 100% of the scripts. Another woman doctor colleague was asked to read and identify key themes which were then compared resulting in a high degree of inter-rater reliability (although not formally assessed). Verbatim quotations from the scripts were identified to be illustrative of these key themes.

The common themes, supplemented by a literature review, were tested amongst a wider group of 43 women GPs and consultants at an interactive workshop in London on 18th May 2011, with contributions from colleagues in the private sector (Price Waterhouse Coopers) and Cranfield International Centre for Women Leaders, who also validated this report for accuracy.

The objectives of the work were:

1. To understand the career trajectory of women doctors as leaders, their contribution at board level and implications for emerging Clinical Commissioning Groups
2. To identify how the talent pipeline of women doctors as leaders can be improved
3. To make recommendations to the National Leadership Academy, other NHS organisations and women doctors in order to improve their uptake of leadership roles.

The report is written in the following key sections that combine themes arising from the interviews and workshop with research findings. Recommendations are included in the Executive Summary.

1. Initiatives in the private sector (pages 11)
2. The facts (page 14)
3. Current experience of emerging Clinical Commissioning Groups (page 15)
4. The contribution of women doctors (pages 17)
5. Barriers to progress (pages 21)
6. Solutions to improve the talent pipeline (pages 26)
7. Conclusion (page 30)

Appendix 1 includes short biographies of many of the women interviewed. At the time this project started, it was hard to identify female GPs in senior leadership roles although more have come forward since. Those interviewed were therefore identified opportunistically through national networks, leadership programmes and on recommendation. Consultants were selected randomly from the last four cohorts attending the NHS East of England Senior Clinical Leaders Programme. Others were selected due to a specific role e.g. as chief executive.

Those women interviewed therefore represent a wide range of experience and careers that span different specialties, roles and responsibilities e.g. consultant, clinical director, GP partner, salaried GP, chair of emerging CCG, GP with a special interest, member of national committee and chief executive. Those interviewed worked in the East of England and nationally. Each biography is uniquely inspiring and each provides a word of wisdom for colleagues seeking a leadership position.

To protect anonymity, quotes have not been attributed to any one of the women interviewed apart from those attached to the biographies. The findings from both the GPs and consultants are combined - the issues they raised were similar and numbers too small to identify significant difference.

Throughout the work women doctors stressed the need to work together with their male colleagues. Women doctors believe that leadership is dependent on individual skills, values and behaviours, and that both female and male doctors play a critical leadership role in the new NHS. Everyone should be given an opportunity for leadership as far as their competence and aspiration allows.

Box 1. Terminology - Clinical Commissioning Groups

Clinical Commissioning Groups are emerging and not yet statutory organisations, to be approved through authorisation. In this report “emerging Clinical Commissioning Groups” are called “Clinical Commissioning Groups” or “CCGs” for brevity. Their boards likewise are currently sub-groups of Primary Care Trust boards. Again for brevity, the term “CCG board” is used to refer to these subgroups acknowledging that CCGs are evolving and are likely to create organisational forms as statutory organisations that are different to those currently adopted. It is hoped this report will help inform their ultimate leadership roles.

3.0 THE GLOBAL CONTEXT AND PRIVATE SECTOR INITIATIVES

“When women are so under-represented on corporate boards, companies are missing out, as they are unable to draw from the widest possible range of talent. Evidence suggests that companies with a strong female representation at board and top management level perform better than those without and that gender-diverse boards have a positive impact on performance. It is clear that boards make better decisions where a range of voices, drawing on different life experiences, can be heard. That mix of voices must include women.”

Lord Davies, Women on Boards, February 2011

“The gap matters not only because the familiar glass ceiling is unfair, but also because the world has an increasingly urgent need for more leaders. All men and women with brains, the desire and perseverance to lead should be encouraged to fulfil their potential.”

McKinsey 2011 Centred Leadership: How Talented Women Thrive.

“The strength, industry and wisdom of women remain humanity’s greatest untapped resource. We simply cannot afford to wait another 100 years to unlock this potential.”³

Michelle Bachelet, UN Women Executive Director, March 2011

Significant momentum is now developing in the private sector and globally to enable women to achieve their potential. Through raised labour participation, improved organisational performance and a different leadership style, McKinsey claim women can make a significant contribution to economic growth.⁴ Companies with gender diversity have improved organisational and financial performance, reflect consumer needs, and ensure use of talent, broadening the mix of knowledge and skills. Research has shown that having at least three women on the Board increases profitability threefold.⁵ The recent Davies Report outlines a clear business case for greater gender diversity.⁶

The proportion and characteristics of women at board level in the private sector is recorded and analysed annually in the UK through the Female FTSE 100 report.⁷ Similar to medicine, few women reach the top on corporate boards: Just 13.9% of FTSE 100 board positions are held by women - or 152 out of 1,086 seats.⁸ Female board representation in the FTSE 250 is lower at 8.7%, with the majority of those companies having all male boards, despite women being 57% of first degree graduates.

There are significant differences between countries as to the percentages of women who make up top corporate boards. The percentages vary from 3.5% in Portugal to 31.9% in Norway. Most countries show progress in women taking up boardroom appointments, except the USA, Canada and the UK.

Recent research from The Institute of Leadership and Management (ILM) found that three quarters of women (73%) believe there are barriers preventing them from progressing to top levels of management, compared to 38% of male colleagues.⁹ Obstacles to women achieving senior leadership roles include lack of flexibility around work life balance, a lack of female role models, the perception of a traditional male environment, “the old boy’s network”, “unconscious bias” in appointment processes and the lack of networking opportunities.⁵

Approaches to improve the talent pipeline can be characterised as “fix the women”, “fix the organisation” and “fix society”. Solutions focus on role models and mentors, creating networks, coaching, talent management, flexible posts, and rethinking recruitment and selection. Improved child care policies and paternity leave can facilitate greater mutual satisfaction and shared parenting, changing the role of men only as the sole bread winner.¹⁰ Examples of innovative private sector initiatives are illustrated in Boxes 2 and 3.

The third millennium goal is to promote gender equality and empower women globally and is backed by the first director of UN Women. The UN Women’s empowerment principles are a set of seven steps companies can take to empower women in the workplace, marketplace and community as part of its broader campaign for empowerment and equality. The steps include treating all women and men fairly at work; promoting education, training and professional development for women; and measuring and publicly reporting on progress to achieve gender equality.¹¹ However, piecemeal interventions have little lasting effect leading to calls for systemic organisational change. In 2003 Norway introduced a controversial quota system that stimulated public debate and requires all public sector boards to consist of 40% women by law.¹² Following its successful implementation since 2008, quotas and targets have been introduced in a number of European countries. EU Commissioner Viviane Reding is keen to impose an EU-wide quota of 40% women on boards if countries do not voluntarily increase their representation.¹³ In February 2011, the UK’s Davies Report recommended voluntary targets of at least 25% for the top 350 FTSE-listed companies.



“Evidence suggests that companies with a strong female representation at board and top management level perform better than those without and that gender-diverse boards have a positive impact on performance.”

Box 2. The 30% Club aims to bring about real transformation by:

- Motivating and supporting chairmen to appoint women to their boards.
- Providing information and support for businesses trying to improve their diversity and for women seeking board appointments.
- Women working with related groups such as cross-company coaching programme and executive search firms.
- Raising the profile of the issue by stimulating debate and influencing the political agenda. This involves media coverage, running events and collating research.
- Tracking progress towards the 30% target.

The 30% Club is a group of chairmen and organisations committed to bringing more women on to UK corporate boards. Its members have declared their voluntary support for the 30% goal and are taking action to achieve it - this is not a call for a quota. Instead, they want to achieve a better gender balance at all management levels in a way that encourages real, sustainable and faster change.

Box 3. Price Waterhouse Coopers - PWC Women

Price Waterhouse Coopers invests significant resources in programmes that benefit female talent. These include mentoring schemes, networking programmes, flexible working models and innovative development programmes such as reverse mentoring, bias awareness training and coaching schemes. Examples of initiatives in the UK include:

Bias awareness training is targeted at partners, directors and those in coaching and people development roles, helps participants to understand the nature and occurrences of bias, and shows techniques on how to challenge bias in the workplace. It recognises that our actions are rooted in internal values, beliefs and our background, and, accordingly, we all have biases. Diversity and inclusion relates to everyone, not just minorities; it is about thinking, feelings and beliefs.

Coaching squared brings together female managers from different organisations, who are paired up and meet regularly for nine months to offer each other confidential coaching support. Participants are given the opportunity to share experiences about work and any career or home pressures with another professional woman from a different organisation.



4.0 WOMEN DOCTORS - THE FACTS

Women make up the majority intake of students to medical school. Reports to address the future implications of this demographic change were most recently published by the Department of Health (Chief Medical Officer and Deech Reports)^{14,15} and Royal College of Physicians (RCP).¹⁶ These reports build on a body of work dating back to the early 1990s that seeks to close the gender gap. The under representation of women doctors in senior leadership roles was more recently highlighted by the NHS Future Forum.¹⁷ This report will therefore not cover the same analysis but key facts are given below (Box 4).

Compared to other professions, with the exception of the Civil Service, medicine offers women a reasonable chance of reaching the equivalent of consultant level or, until recently, becoming a principal in general practice and working part-time. However, there remains significant under representation of women doctors in senior leadership or board equivalent roles;¹⁸ a pay gap between female and male doctors;¹⁹ vertical segregation where men and women are initially recruited at a similar occupational level but where, as men proceed upward, women do not; and horizontal segmentation because women predominate in certain specialties.²⁰

Box 4. Summary of the Royal College of Physicians and Deech reports

Women have been the majority intake since 1991

- Female entrants 24% in 1960/61 to 56% in 2008/9, white males 27%
- Parity when become specialist registrars

Relatively few achieve senior leadership positions

- Women = 44-59% at lower grades, 28% consultants, 43% GP partners
- Variation between specialties e.g. <10% surgery and cardiology, 40% paediatrics, pathology and psychiatry, 50% in public health
- Under represented in academia, BMA, Royal Colleges, medical and clinical directors, Clinical Commissioning Groups
- Over represented as staff grades and as sessional GPs. Salaried and locum GPs account for 30-60% of GPs, 70% of whom are women. The numbers of salaried GPs increased tenfold and partnerships by 3% between 1999 and 2009.
- The pipeline has been primed for well over two decades, but the disproportionately low numbers of women in leadership positions remain.

Increasingly work part-time

- 34% of female consultants (cf 15% male) and 50% of female GPs (12% male) which increased by 200% between 1996 and 2007

Recommendations include:

- Improve access to mentoring and career advice
- Encourage women in leadership
- Improve access to part-time working and flexible training
- Ensure that arrangements for revalidation are clear and explicit
- Women should be encouraged to apply for Clinical Excellence Awards
- Ensure the NHS planning apparatus takes account of the increasing number of women in the medical profession
- Improve access to child care
- Improve support for carers
- Ensure these recommendations are enacted through the identification of champions

5.0 THE EARLY EXPERIENCE OF CLINICAL COMMISSIONING GROUPS

Little progress has been made in medicine since the RCP and Deech reports were published in 2009. Early experience of emerging CCGs mirrors their findings of under representation of female medical leadership at board level.

Currently CCGs are male dominated with a few exceptions, for example, in Cambridge. Those interviewed described how many women doctors are not sure they want to be involved at this stage. They find behaviours are inhibiting, they do not have the time, and there is pressure to be available for patients.

A number of those interviewed who had put themselves forward had experienced difficulties contributing despite significant experience and track record. "Clubs, gangs and mafia" were described implying exclusion, inequity and disengagement of the rest of the profession. This was more significant for salaried or younger GPs. The doctors recounted how voting processes did not always provide the opportunity to use all local talent, or even be considered, although a few had talent spotted and asked women doctors to apply or contribute in other ways.

All were insistent that women doctors should put themselves forward for CCGs. Chapters 8 and 9 describe the particular benefits and style they perceived that women doctors offer. Without women there would be "more of the same", CCGs would fail to use or engage two thirds of their talent.

Interviews were held at an early stage in the development of CCGs and many have since developed greater inclusiveness. For others there is still time to ensure greater diversity at Board level e.g. through rigorous appointment processes prior to authorisation. Whilst everything is changing there is an unprecedented opportunity to rethink the leadership role of women doctors in line with global and private sector initiatives.

"Predominantly the boys will take over the first few years (CCGs). It's very difficult - evening meetings, long hours. Women can contribute, a lot of brains, do things because they have to be done. It's not a place I'd like to be at the moment - because I am not sure its where GPs' skills are at the moment. Our time is precious."

"We agreed not to have more than one person from each practice on the board. I would like to get together with them more but I am not a board member. It seems very selection biased and not getting the best talent on board."

"Because of the behaviours of emerging leaders people feel they don't want to put their hands up... Without women it could be top down management style that isn't attractive to most GPs... It's a huge problem; all we have at board level are so pompous. I am in your gang, and you are not in my gang. The guys who are on the ground are thinking, why do I want to engage?"

"Tends to be men who are running lucrative profit-driven practices with profit interest - other doctors and patients will have less trust in them - are you feathering your nest? There will be a real temptation to feather your nest - quite a male way of operating, women are more straightforward."

"It's a real issue as in the current cohort (of GPs) 70% are women - the majority of workforce are female but minority of men are in the driving seat - this will lead to tensions in future."

"They are doing their best, I have just done the (CCGs) Chair's appraisal and they haven't got any time to do it - only a man is going to do that. Most women have kids and household work so stop these jobs being all consuming."

"Need to find younger women who are going to be the future, they are not coming forward or being allowed into partnerships and if not in a partnership they don't have a voice. Women are more inclusive and include salaried GPs."

"Women tend not to be too afraid about picking up the phone, so building relationships - community leadership - that's the sort of thing that would tick a lot of people's boxes... The key thing is involving patients that older tranche of paternalistic GPs wouldn't include... It seems that it is mainly the men that are taking the lead. There needs to be more joint commissioning and bringing more organisations together which woman are good at as they naturally make things happen as they come together."



"In the current cohort (of GPs) 70% are women - the majority of workforce are female but minority of men are in the driving seat."

6.0 NHS TRUSTS AND OTHER BOARDS

Although the proportion of consultants is smaller, women doctors are also under represented on hospital management boards with similar implications. NHS Trusts, Royal Colleges, and the BMA have had longer to address this issue than emerging CCGs and some progress has been made. For example, the BMA developed an action plan to increase the representation of women doctors, the RCGP has a female Chair and the Department of Health appointed a female Chief Medical Officer.

"We were slow to get female consultants, now there are many consultants but not many clinical directors - 4 or 5. Each specialty has a clinical director. In a room of 20-25 clinical directors there are 4 women and 2 speak."

"Senior women view things differently. You can't have an organisation that deals with equal numbers of men and women as patients when you don't have women at senior level offering a different perspective. Women understand the tensions for other women, are prepared to express weaknesses, they see what happens in relationships."

7.0 THE CASE FOR WOMEN DOCTORS

Women doctors can bring a number of substantial benefits to CCGs, senates, networks, trust management boards and other NHS organisations:

1. **Skills, expertise and flexible leadership capacity.** Women doctors make up 60% of medical school entrants, 43% of GP partners, 70% of sessional GPs and 28% of consultants - a sizeable chunk of the workforce and talent pool. Many work part-time and may have flexible capacity. As the biographies illustrate, these women often bring additional qualifications and skills from portfolio careers. To ignore women would significantly reduce the talent pool.
2. **Financial savings.** Research from the private sector indicates improved financial and organisational performance with gender diverse boards.²¹
3. **Improved quality, safety and shared decision making.** Women doctors make safer decisions as illustrated through reduced referral to the National Clinical Assessment Service.²² Research shows they have longer appointments, better communication skills, are more patient centered and include more prevention.^{23, 24, 25} They are therefore likely to value and promote shared decision making and self care - a key policy agenda. Self care is one of ten top priorities for commissioners leading to improved outcomes and financial savings.²⁶
4. **Ability to represent female patients and inequalities.** Fifty percent of our patients are women, as are the majority of staff in the NHS. Women doctors respect and understand the things that women need e.g. as patients, carers, mothers and employees and can ensure their needs are reflected in services. They are more likely to work with vulnerable communities.²⁷
5. **New leadership styles and behaviours** (section 8.0).
6. **Creation of role models.** As powerful role models women doctors can help define future policy and direction of medicine, train more junior colleagues, and sponsor and promote other women doctors. The future workforce in general practice will be composed mainly of women.^{15, 28}
7. **An engaged and motivated workforce.** Increasing access to senior roles will enable women to realise their potential and increase personal satisfaction in a leadership role through career progression.
8. **Compliance with the 2010 Equality Act** which requires equal treatment in access to employment regardless of gender.
9. **Meet the Millennium Goal and act consistently with private sector** (section 3.0).

8.0 LEADERSHIP STRENGTHS

Investment in leadership and new leadership behaviours are critical to the success of CCGs. ^{29, 30}

The women doctors interviewed unanimously describe a style of leadership based on people skills or emotional intelligence. They articulate a pragmatic approach and their liking for people - firstly patients, and secondly, teams - developing relationships and bringing people with them. The following is a summary of perceived attributes when the interviewees were asked about their strengths as female leaders.

1. **Commitment to patients.** Women doctors describe themselves as being empathetic, highly committed to their job, patients and medicine, and valuing that in others.
2. **Ability to connect and include.** In teams - real or virtual - they are inclusive. They are team players, build on ideas, are approachable, able to read people and enjoy supporting and developing others.
3. **Communicative.** Women doctors describe a strong focus on communication - an open approach and ability to have a frank conversation with no hidden agendas. They are able to listen, ask questions, admit vulnerability and give feedback.
4. **Non hierarchical and challenging.** They describe being informal and participative - "rolling their sleeves up". They are "intentionally provocative", cut through bureaucracy and are not unduly concerned with hierarchy.
5. **Positive outlook and values driven.** They are positive, enthusiastic and energetic. They stick to their values - make a difference, build trust, be loyal, honest, fair - and many said they put doing things for the greater good and quality above financial considerations.
6. **Strategic.** They can develop a vision and be intuitive and opportunistic to deliver it.
7. **Resilient and conscientious.** They are hardworking, determined, decisive, pragmatic and resourceful. They describe being organised, disciplined, tenacious, and having common sense to get the job done. They have extremely high standards ("perfectionists") and want to stretch or challenge themselves.

These traits are recognised in all good leaders irrespective of gender. While not all women doctors have these traits, it was perceived that women are more likely to demonstrate a preference for them. These strengths may also be a reflection of training. However, other authors have also noted the positive attributes of communication, collaboration, and emotional intelligence, and suggested that women should be considered for the qualities they bring to leadership, rather than needing to adjust to the male models.³¹

"I'd like to believe women are good in teams, but know men who are good - helpful, collaborative willing to listen. It's about individual capabilities."

"I like people - so it's all based on relationships, which is easy for me."

"I hope they would say ability to communicate, listen, approachable, engage them and move them forward, bringing people along."

"Integrity and trust, doing what I say I am going to do, holding people to account, building trust within my peer group and representing the group rather than self interest."

"I actually like patients and am interested in their lives; I am interested in what people have to tell me."

"Blessed with an ability to communicate and pick up nuances, talk to people on any level and be engaged and interested in people...I don't care about the pecking order just what's right."

"Women tend to be promoted late. So if in a top position she is really good...worthy and doing job well rather than chasing egos, status, hierarchy and winning arguments."

"Drive for the common good - not for status or profit or feathering your nest - this is essential for commissioning."



"I actually like patients and am interested in their lives; I am interested in what people have to tell me."

Box 5. McKinsey centred leadership - five domains

Meaning, or finding your strengths and putting them to work in the service of an inspiring purpose

Managing energy, or knowing where your energy comes from, where it goes, and what you can do to manage it

Positive framing, or adopting a more constructive way to view your world, expand your horizons, and gain the resilience to move ahead even when bad things happen

Connecting, or identifying who can help you grow, building stronger relationships, and increasing your sense of belonging

Engaging, or finding your voice, becoming self-reliant and confident by accepting opportunities and the inherent risks they bring, and collaborating with others

The style that women doctors describe fits well into the Medical Competency Framework³² which describes the leadership competencies doctors need in order to become more actively involved in the planning, delivery and transformation of health services. The seven domains are: demonstrating personal qualities; creating the vision; working with others; setting direction; managing services; improving services; delivering the strategy.

A very different model for leadership comprising five broad and interrelated dimensions has been developed by McKinsey following interviews with 85 senior women executives.³³ This model is about having a well of physical, intellectual, emotional and spiritual strength that drives personal achievement and inspires others to follow. It centres around five key domains; meaning, managing energy, positive framing, connecting and engaging (Box 5).

The women doctors interviewed described their passion and love of patients (meaning), managing energy through having hobbies, seeing friends and being with their families, “positive framing” or remaining positive to deal with the ups and downs they experience at work, developing relationships (connecting) and taking opportunities to improve their career and impact at work (engaging).

The difference between these models may perhaps illustrate that the innate style the women doctors describe is not one that has traditionally been recognised.

The Kings Fund report on the future of leadership and management in the NHS, however, stresses that the old style of “hero” leadership needs to change.²⁹

As organisational hierarchies are flattening, what is needed is a style that is “shared, distributed and adaptive”.

This requires a focus on:

- 1) developing the organisation and its teams, not just individuals
- 2) leadership across systems of care rather than institutions
- 3) ‘followership’ as well as leadership.

Different forms of leadership and ‘followership’ are required depending on the problem. Wicked problems - similar to those experienced by clinical commissioning groups - require a lot of collaborative work on the part of the followers to take some responsibility for addressing a collective problem.³⁴ Many of these followers will be women doctors.

The role of teams in flattened hierarchies is also now well recognised as an important contributor to patient safety.³⁵ Effective teams act as a check on “heroic leaders” and reduce the likelihood of individual errors. While the relationship between gender and team effectiveness is beyond the scope of this report, women doctors typically described a preference for good team working and constructive challenge.

The “people centred” leadership style that women doctors bring through their focus on patients, teams, relationships, challenge and inclusion is therefore consistent with this “unheroic” approach as both followers and leaders. It is well suited to addressing wicked problems and improving safe decision making, working across organisational boundaries and with peers in non-hierarchical relationships i.e. in constituent practices and clinical directorates.

9.0 BARRIERS TO CAREER PROGRESSION

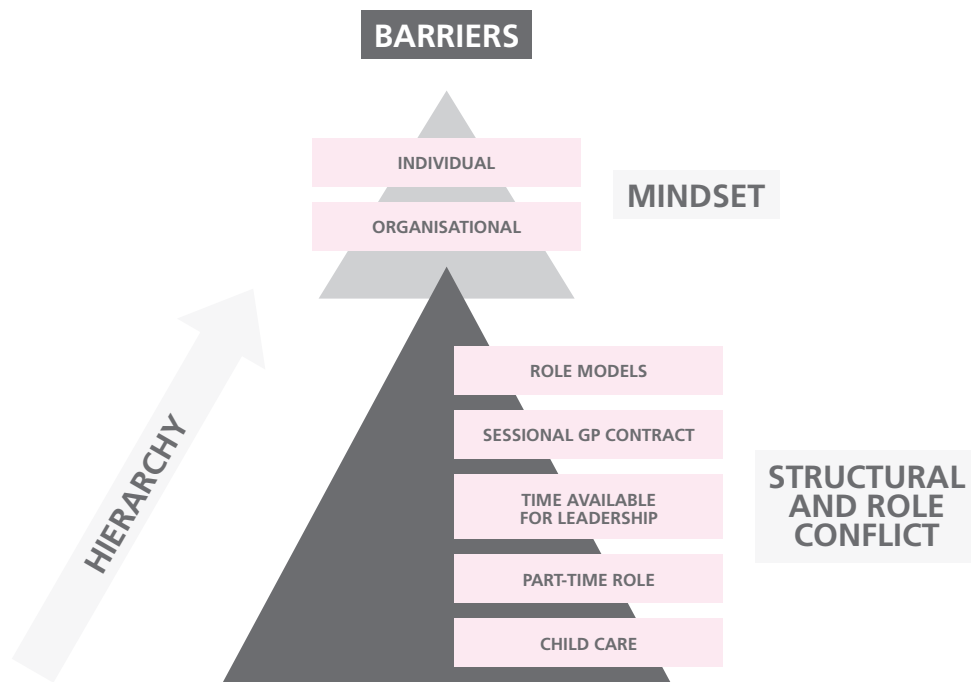


Diagram 1: Barriers to career progression

If the benefits on offer are so substantial, the talent pool so large, and the leadership style of value, why are there relatively few women doctors at board level? This chapter outlines some of the obstacles identified in achieving a leadership role. Several women said they had not experienced barriers or “if they were there, I ignored them”. The obstacles to women doctors achieving senior leadership positions have been well documented.^{36,37} These include role conflict and structural barriers, and individual and organisational mindset as described below.

9.1 Role conflict/structural barriers (Diagram 1).

Women doctors have the triple burden of domestic, clinical and leadership roles and so experience role conflict. Role conflict includes career breaks, child-care and difficulty combining professional and family demands.³⁸

As a result more female than male doctors remain childless, have fewer children and have them later.^{39, 40} Often the first time women doctors encounter obstacles is during pregnancy.

Studies indicate that having children and working part time impacts on women doctors’ careers.⁴¹ Career breaks can be damaging due to loss of skills and knowledge and few return to work schemes.

Many women enter general practice because of opportunities to have reduced hours and greater flexibility, and are more likely to have children than hospital doctors.⁴² Given that women choose general practice precisely because of these characteristics, they may be disinclined to take on a further role in leadership.

Women interviewed described similar barriers to those found in other studies. They stressed that the period of time when children are small is relatively short, however, compared to the length of a working life - 40 years. “Ramp on and off schemes” such as the GP returners scheme, or employment that is flexible enough to retain or rehire talented women while, or after, they look after small children, or act as carers, would ensure women can contribute flexibly throughout the course of their career.

Structural barriers to taking on a leadership role were also identified and include relatively few encouraging senior role models and mentors, but also evening meetings and time available for management tasks which are not formally recognised, especially in general practice, for both male and female GPs. The sessional GP contract is discussed on page 24.

9.2 Mindsets

A mindset is a set of assumptions, methods or notations held by one or more people or groups of people which is so established that it creates a powerful incentive within these people or groups to continue to adopt, or accept, prior behaviors and choices. The following mindset barriers were thought to impede career progression:

9.2.1

Individual mindsets such as lack of self belief, confidence in their ability to do the job and relatively low aspiration were perceived to be often held by women. Similar to findings with female managers,⁴³ the women interviewed thought that women doctors have in general lower ambitions, confidence and expectations leading to a more cautious approach to applying for promotions or leadership roles. They observed that women doctors wait to be asked, feel disempowered, underestimate their impact and are less likely to promote themselves. They may be happy to achieve less than they aspire to in order to achieve a work life balance and continue to have fulfilling contact with patients.¹⁵

9.2.2

Organisational mindsets or culture including career structures, male prejudice, opportunities available and working practices have been described as barriers in other studies.³⁶ The majority of the women doctors described an “unconscious bias”, especially negative attitudes to part-time work, the perception of a “boys club”, exclusion from networks, passive lack of support and not being visible or heard. Some of these behaviours have already been attributed to CCGs (section 5.0).

These mindset barriers were less of an issue in general practice amongst female partners, as they tend to be exacerbated by male-dominated demographic environments. However, as the leadership “pool” becomes smaller towards the top of the organisational hierarchy (Diagram 1), e.g. at trust board, CCG or on Councils of Royal Colleges, mindsets may present a greater obstacle to negotiate and require particular “political” skills that are not innate (section 8.0).

Male and female perception of barriers differ in nature and size; male doctors perceive gender discrimination does not exist, or is in decline, though acknowledging barriers related to family responsibility, while three quarters of female doctors identify barriers related to organisational culture or exclusion from networks.³⁶ This is similar to the findings in the private sector where 38% of male managers believe there are barriers preventing female colleagues from progressing to top levels of management, compared to three quarters of women (73%).⁹

“The barriers were that I wanted a family and children, and that is what stopped me.”

“The key is not just about women, but to provide more opportunities for men and women to have a part-time career and help them when they get back. Give them opportunities, either man or woman.”

“I think women are more likely not to take on senior positions, because they don’t want responsibility or have the confidence. Maybe as they are not seeing other women at a senior level, they are not having the encouragement.”

“There aren’t enough hours in the day, juggling it all, not having enough time to do everything. The biggest barrier is me - I felt I couldn’t let go, felt responsible, I couldn’t indulge myself. It got easier with time, as the children got older.”

“So many women with so much potential who don’t even believe, or think, they can do this stuff.”

“Female GPs say there is a laddish culture. For a young female coming into that environment it’s difficult to put yourself out there.”

"I do think there is a culture in medicine about men's and women's roles - implicit not explicit. Quite often I go to a national meeting and am the only woman and then I meet them again and they don't remember me. It's hard to be visible. I feel I am not heard."

"In the end it is down to each of us, but there does seem to be lack of aspiration... We are all different and not every female wants to become part of the management system."

"No one valuing me. Passive disinterest, passive lack of support, "the wibbly, wobbly girly". I was told you would never get a job in a teaching hospital, because I did flexible training - kiss of death. The irony I did have an MD - written up, so I have qualifications, very few people had that. Need so many tickets to get to where you need to go. So much prejudice. I can't be bothered."

"If you want to join a club you've got to be like them to be in it."

"Just the general prejudice of women with kids, and whether they are able to do the job."



10.0 SESSIONAL GPs AND COMMISSIONING

Women doctors are over represented as sessional GPs - a role with lower status - yet under represented at emerging clinical commissioning group board level.

Sessional GPs have the same training as contractor GPs and include salaried, locum and “retainer” GPs who hold a specific educational contract. Between 5% - 25% of GPs in the UK are locums, and approximately 23% are salaried, with higher numbers in England and London^{44,45} where up to two thirds of all GPs are now sessional.^{46,47} Retainers account for approximately 2.5% of the GP workforce.

GPs take a sessional contract as a positive personal choice, to have a portfolio career or to compliment childcare, but also because partnerships are less available. Between 1999 and 2009 there was nearly a tenfold increase in the number of salaried GPs, while the number of contractor GPs increased by only 3.3%.

While there are many advantages, such as the ability to work part-time and freedom from administrative responsibility, there are many down sides, including isolation and a lack of ability to develop additional roles.^{48,49}

In a recent BMA survey, 70% of sessional GPs were women, compared to 43% of contractor GPs. Female respondents were most likely to be aged between 36 and 40 i.e. early on in their careers, compared to male respondents who were most likely to be over 61 i.e. nearing retirement. Three quarters of respondents worked part-time and male GPs were more likely to be full-time. Only half the salaried GPs had a nationally agreed contract; one in 20 did not have a contract.⁵⁰ The recommended salary ranges for salaried GPs between £52,500 and £79,000 are at the lower end of the salary spectrum.

The GPC “strongly encourage sessional GPs to consider putting themselves forward for a leadership role”,⁵¹ and recommend inclusive appointment or election processes to emerging CCG boards.⁵² In some areas they are co-opted or elected onto CCG boards to represent their colleagues e.g. Camden, Smethwick, Cambridge, and Plymouth.

However, in other areas, sessional GPs have been excluded from voting on CCGs, as they are deemed to be unable to make decisions which may affect practice income.⁵³ This presents a significant barrier to clinical engagement and may impact on quality of care and ability to succeed if for example, referral or prescribing patterns are not adhered to.

There is a much bigger issue about the future of primary care leadership in general⁵⁴, and motivation and commitment of this disenfranchised group. When partners retire, these GPs will have had little of the experience required to run a practice. All those interviewed expressed concerns at developing a two tiered profession.

The issues affecting sessional GPs in providing and commissioning relate to both male and female GPs and it is difficult to isolate the impact of gender, part-time working and contractual issues. It is likely that a combination of all three contribute to their isolation and exclusion from leadership roles and opportunities.

“The way we are paid encourages GPs to take on salaried doctors. I don’t believe in the exploitation of young women doctors, it’s a dead end job. They should take on leadership roles as their kids get older. We have a two tier system. It’s an appalling situation. A lot of practices are giving short term contracts.”

“You can’t expect people who you treat as employees to care about the system in the same way as those who have bought into the system - it makes people less interested in providing health care. Salaried GPs feel they are left out of the management of the practice. And if they feel left out and disconnected they will not put themselves forward. If they never learn how to do management or take responsibility, when partners retire they will be unable to take this on. Many want to be partners and get stuck in. They are not paid well, feel left out, and GPs don’t like the BMA model contract as it is favourable to salaried GPs.”

"I can see the attraction - many days I wish I was salaried as you can stroll in and out but rubbish pay, undermined, undervalued, not influential, no power. Can't influence policy in your own practice so cannot practice negotiating or influencing skills. Excluded from any board room from start to finish, not taken seriously as a doctor. They see themselves as not having a voice, not important, so they don't put themselves forward."

"Being a sessional GP is acceptable if this is the only way to be part-time. Experiences vary depending on the practice and how it supports salaried GPs - some see it as the same as three years working towards parity while others see salaried GPs as doing the work and "more money for me". Some practices run through lots of salaried GPs, while there are others where salaried GPs never leave and become the partner, or stay because it suits them."

"There has been an assumption that how you form a consortium is a natural progression of practice based commissioning. Salaried GPs have never been invited to the table. Practice based commissioning groups are rolling into consortia, which will disenfranchise 42% of workforce. Partnership will be predominantly male and women end up in salaried positions...we need equity in funding opportunities and support irrespective of contractual status."



11.0 SOLUTIONS TO IMPROVE THE TALENT PIPELINE

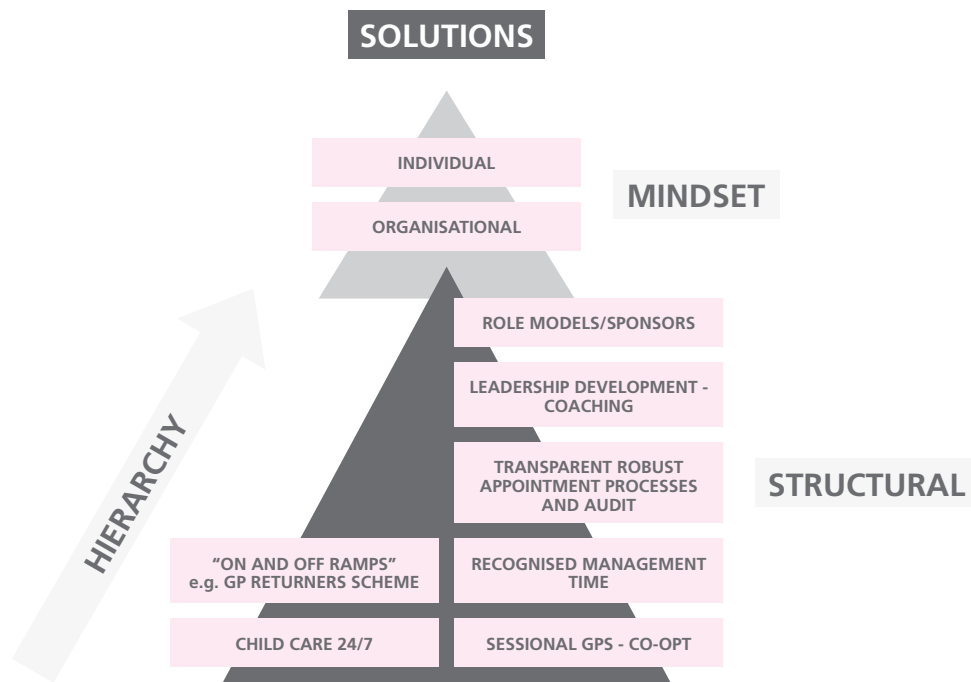


Diagram 2: Support to improve female talent pipeline

This chapter describes the solutions the women doctors perceived would help address the gender gap, often extrapolated from their own personal experience.

As well as support given to individual women, change is also required at an organisational and societal level (section 5.0). Development is needed for current leaders to raise awareness of mindsets and system bias, enable them to see the potential and to create the space and roles for women doctors to grow into.

11.1 Childcare and family support

Women doctors describe being inspired to work by their mothers, and supported by their husbands family, nannies, friends, job shares and a few colleagues. Robust child care and back up 24/7 was seen as essential. They considered the money they spent on childcare was an investment in their career.

11.2 “Ramp off and on” schemes

Many of the women had taken career breaks or worked part-time whilst raising a young family. “Ramp on and off schemes”, for example, GP returner and retainer schemes, are flexible posts that allow both temporary exit and re-entry to the workplace in order to retain talent. For most women, the period of time that they want to “ramp off” is a small proportion of their working lives and should not prevent them getting back onto a career path in leadership. Many said these posts should be available for both men and women.

11.3 Networks

Having good networks and social capital was seen as a prerequisite for success. Networking opportunities can dramatically change employment patterns e.g. the Women’s Network at Sheffield University, the Women’s Forum at Queens University Belfast, the Office for Women’s Affairs at Harvard Brigham and the Women’s Hospital Boston¹⁵.

A network was seen as an attractive solution to:

- Provide peer support - online or in person - and ways to informally share experiences.
- Facilitate access to coaching, job shares and career support.
- Arrange local groups and yearly meetings.
- Enable distance learning e.g. Myers Briggs, assertiveness, influencing skills, negotiation, pay and conditions.
- Provide information on childcare and career breaks.
- Identify role models. Senior women could run Q&A sessions and mentor others.
- Signpost women to other sites e.g. the Commissioning Zone.
- Be interactive, participative and non hierarchical.

The Medical Women's Federation already provides some of these functions.

11.4 Role models

Role models included women doing the same job e.g. other female surgeons, and women and men in leadership positions e.g. at the Deanery. Role models were particularly inspirational during training, but overall few were visible later in careers. Lack of role models can affect career choices e.g. in surgery⁵⁵ and cardiology.⁵⁶

Those interviewed described how role models and mentors modelled behaviours and demonstrated integrity, trust and respect. Small acts of encouragement had lasting impact on career choices. Credibility and a genuine interest in patient care inspired the women doctors to become similar leaders.

Visible and powerful role models would help women aspire to leadership roles. Senior women could share their experience through a body of written testimonials, video clips, "tips for the top", or a "Wall of Fame".

11.5 Sponsorship

A sponsor is a senior individual who is willing to spend his or her political capital on a protege's behalf and link his or her reputation to theirs. According to research in the private sector, women have three times as many mentors as men. But men have more sponsors. Additionally, men are more likely to also have informal sponsor-like relationships.⁵⁷

Those interviewed describe how sponsors actively supported them in promotions and helped them achieve leadership positions. Many felt talent should be spotted and nurtured, including juniors, given that women are less likely to put themselves forward.

11.6 Leadership development, mentoring and coaching

Several women had attended leadership development programmes which were cited as useful e.g. the NHS East of England Senior Clinical Leaders Programme, the RCGP leadership programme and Kings Fund programmes. Management training, action learning sets, coaching and mentoring, psychological profiling were also perceived to be extremely helpful when developing a leadership role.

Leadership development should be started at the beginning of training e.g. fellowship posts, making it clear at the beginning that being a leader is a career option for a clinician. All medical schools should have career sessions, sabbaticals and electives in management and leadership. Management training is now included in undergraduate and postgraduate curricula.

11.7 Sessional GPs

The role of sessional GPs in both primary care and commissioning requires urgent review to enable them to develop their skills and take on leadership responsibility.

11.8 Appointment processes

Robust and transparent appointment processes against clear job descriptions and competencies are required prior to authorisation. These need adequate scrutiny e.g. from the NHS Commissioning Board, given the abolition of the NHS Appointments Commission.

11.9 Time available

Adequate allocated time is needed for both male and female doctors in leadership roles, separate from clinical commitments.

"I have always believed I could do it all, have it all. I really valued my Mum for that."

"My husband - at times when there was tension between work and home - if he had said give it up, I would have."

"Doctors need childcare from 7 in the morning and goes on all night!"

"Personal coaching was helpful during a demanding period in my career... I had to do something very difficult - set up a system so patients came in the same day for day surgery. It was very unpopular and difficult to persuade everyone and depressing as I thought maybe I'd made the wrong decision. Coaching gave me an opportunity to run through the difficulties, talk through issues, encouraged me. Now it is all working and we have built a million pound unit".

"He did small things that recognised people's needs. He taught me it's not wrong to show emotion and humanity, all his staff loved him and were loyal as he supported and cared for them".

"Need to allow the right women to get to board level, we need to encourage them not to leave as having kids, not second class as having kids, but not to be ageist when women come back into work at a lower level and allow them to progress and be positively encouraged".

"Role models are different people at different stages who you value. People who are fantastic leaders who seem to exemplify the talents you want to develop - strategic, inclusive, listen particularly well, calm in face of adversity, never jump the gun, reflective, focused".

"I don't think I have ever been encouraged by doctors".

"My role models were smart and had vision - they knew what needed to be done, believed in themselves and other people around them, gave others opportunities. Part of their role was to nurture others".

"Role model, when other women see you they think they can too. Being listened to and being heard is positive for other women and men".



“My role models were smart and had vision - they knew what needed to be done, believed in themselves and other people around them, gave others opportunities. Part of their role was to nurture others.”

12.0 CONCLUSION

Women doctors already play a very significant role in looking after their patients, and developing and commissioning services. The biographies of those interviewed illustrate the wealth of expertise and talent on offer.

Improving the talent pipeline will tap into more talent and flexible capacity, positive and inclusive behaviours, patient centred care and safe decision making; create powerful role models; and reflect the needs of female patients. Evidence from the private sector is that gender diverse boards have improved financial performance. All NHS boards will need to comply with the Equality Act.

However, the new male dominated CCGs indicate women doctors are not coming forward or being enabled to participate. This pattern is also likely to be seen elsewhere e.g. on senates, networks and trust management boards. (The word senate is derived from Latin senex which means "old man" and refers to patriarchal decision making).

While the inclusion of nurses, lay members and practice managers at board level on emerging CCGs is a positive step, this may further mask the lack of female medical leadership.

It is also recognised that many of the issues described in this report affect other groups, for example, non white men.⁵⁸ However, while there is some commonality, women are the majority, not minority, intake to medical school and so the under-utilisation of their talents requires specific attention. Many women doctors are also from black and minority ethnic groups.

The issue is complex and there are no easy solutions to addressing the "cumulative disadvantage"⁵⁹ experienced by women doctors. Effective action focuses on women, organisations and society through, for example, changing paternity leave and childcare policies. The Deech report made a series of recommendations that covered leadership, flexible working, revalidation, and workforce planning and these should be revisited.

Solutions include flexible "ramp on and off" posts; networks; coaching and leadership development; role models; sponsorship; transparent and robust appointment processes; and co-opted posts for sessional GPs. These are reflected in the recommendations of this report. These recommendations need top level commitment to implement.

This report highlights the very significant contribution women doctors are making in the NHS - but there is more on offer. If even more women doctors are supported to achieve senior roles it will be "all hands on deck" rather than a few, clinical leadership in CCGs is more likely to be sustainable, the potential exists for cultural and behavioural change in our interaction with patients and between organisations, and a legacy will be left that ensures more motivated and inspired clinical leaders in the next generation.

If women doctors fail to be represented on the new CCGs and other NHS boards, the lack of diversity presents a risk to developing the collaborative and inclusive leadership behaviour needed for organisations to succeed in a complex system. The NHS will fail to obtain the improved financial and organisational performance and return on investment that comes with board diversity.

While other reports have failed to address this longstanding issue, there is now a real window of opportunity plus new drivers for change, including the Equality Act. Clinical leadership is a central policy agenda; there is an unprecedented opportunity to build the leadership role of women doctors into new appointments on CCGs, senates, networks and foundation trusts; the business case for gender diversity at board level is clear; global and private sector initiatives have government, public and media attention.

There is now an unprecedented opportunity for clinicians to come forward in a new era for clinical leadership in the NHS. Implementing the recommendations of this report to enable women doctors to fully contribute must now be a top priority - the NHS cannot afford not to do so.

APPENDIX 1: BIOGRAPHIES OF INTERVIEWEES

The following biographies are organised by roles in policy, general practice (national roles, clinical commissioning, education, special interest), and secondary care (as Trust Chief Executive and Clinical Director/Consultant).

POLICY

Director of the Nuffield Trust - Dr Jennifer Dixon

Dr Jennifer Dixon qualified from the University of Bristol in 1984, and trained in medicine, paediatrics and public health prior to embarking upon a career in health policy. She has a Masters in Public Health and a PhD in health services research from the London School of Hygiene and Tropical Medicine. In 1990, she was a Harkness Fellow in New York, and she joined the King's Fund in 1995. From 1998 until 2000, she was policy advisor to the Chief Executive of the NHS, and then became Director of Policy at the King's Fund in 2001. In 2008 she became the Director of the Nuffield Trust. Dr Dixon is also a board member of the Audit Commission, NAT CEN and visiting professor at the London School of Economics, Imperial College and the London School of Hygiene and Tropical Medicine. She was elected as Fellow of the Royal College of Physicians in 2009 and Fellow of the Faculty of Public Health in 2006.

"Develop insight into yourself as a person and as a professional. Make sure you are in the right environment for who you are."

Harkness Fellow - Dr Emma Stanton

Dr Emma Stanton, a 2010-11 Commonwealth Fund Harkness Fellow in Health Care Policy and Practice, is a Psychiatrist and former clinical advisor to the Chief Medical Officer, Department of Health. She is a core member of the NHS Leadership Council, recipient of the NHS London "Prepare to Lead" mentoring scheme and co-editor of Clinical Leadership: Bridging the Divide, as well as co-author of M.B.A. for Medics. Co-founder of Diagnosis, a clinical leadership social enterprise consultancy, Emma holds an Executive M.B.A. from Imperial College, London, a MRCPsych from the Royal College of Psychiatrists, and a bachelor of medicine from Southampton University.

"Be brave and do what feels right. This may not necessarily be what all your peers are doing or what those senior to you advise."

GENERAL PRACTITIONER NATIONAL ROLE

Chair RCGP - Dr Clare Gerada

Dr Clare Gerada is a GP working in London, and Chair of the Royal College of General Practitioners. She graduated from the University of London in 1983 and trained in general medicine and psychiatry prior to embarking on a career in General Practice in 1991. Throughout her career, she has successfully combined clinical practice with senior leadership positions, including Director of Primary Care for the National Clinical Governance Team and Senior Medical Advisor to the Department of Health. She is the Medical Director of the Practitioner Health Programme and has published a number of academic papers, articles, books and chapters. Dr Gerada has a long involvement with the RCGP; she was previously Vice Chair of College Council and immediate past Chair of the Ethics Committee. She established the RCGP's Substance Misuse Unit and also led on the delivery of the RCGP Annual National Conference. She was awarded an MBE in 2000 for services to medicine and substance misuse.

"Invest heavily in support at home if you have children. You can't have a successful career if you are worrying about them."

"Successful women need three pillars in place; a secure home, love and work. If these are missing, you won't be able to drive yourself."

"As a woman, don't expect to be treated any differently. You will have to work hard, but do it your way."

National Clinical Engagement Director - Dr Jane Povey

Dr Jane Povey is a Medical Director at NHS West Midlands, and Clinical Engagement Director at the Department of Health. She graduated in 1991 from the University of London and subsequently trained as a GP. She worked as a GP Principal immediately after completing her training, but the conflicting demands of her young children and busy on-call responsibilities led her to change career direction, becoming a GP Retainer and Clinical Assistant. Her drive to lead change in the health service inspired her to join the PCT's Professional Executive Committee and to become involved with service redesign. Pursuing her passion for clinical leadership, she was appointed to the post of PEC Chair and Medical Director at Shropshire PCT in 2004, and subsequently appointed to the post of Primary Care Medical Director at NHS West Midlands. She is currently seconded to the Department of Health, where she has taken on the role of national Clinical Engagement Director for Commissioning Development, working for Dame Barbara Hakin on the design and implementation of the proposed healthcare reforms.

"The best choices are the most painful ones. You won't often wake up the next morning and feel better for taking a difficult decision; it takes time to realise this."

President Medical Women's Federation - Dr Clarissa Fabre

Dr Clarissa Fabre is a GP Principal in Buxted, East Sussex, and President of the Medical Women's Federation. She graduated from Sydney University, worked for a year in Canada and then moved to London. After completing her MRCP, she trained in Paediatrics before taking a seven year career break to raise her three children. On returning to medicine, she trained in General Practice and subsequently became a partner in a single-handed practice which has since expanded to become an 8000 patient training practice. As a GP Principal, Dr Fabre developed an interest in medical politics and has been actively involved with the Local Medical Committee, the Primary Care Trust and the BMA General Practitioners' Committee. She became a member of the Medical Women's Federation in 1978 when she faced obstacles in her career, and later became the Secretary and then Vice-President. She has served as the organisation's President since May 2010.

"Have a satisfying career and personal life. It's very important for women not to expect special favours such as school holidays off work. Men are our colleagues and not the enemy."

President Elect Medical Women's Federation - Dr Fiona Cornish

Dr Fiona Cornish is a GP Principal and President Elect of the Medical Women's Federation. She studied medicine at the University of Cambridge and then St Thomas's before returning to Cambridge in 1985 to train as a GP. She became a GP Principal at a University practice in 1990, and has successfully combined clinical practice with active roles as an appraiser, GP trainer, undergraduate teacher and member of the University Health Services Committee. She is also the school doctor for King's College School in Cambridge, and a Trustee of Medical Support in Romania and the Paragon Trust. Dr Cornish has been a senior member of the Medical Women's Federation for many years and served as Local Secretary and President of the Cambridge branch, as well as Honorary Treasurer of the organisation. She is currently President Elect and will take office in May 2012.

"Women should feel they can go for anything and not be held back or forced take the easy option such as the part-time job. We need to give realistic but encouraging advice to junior doctors so they can achieve their potential."

Salaried GP and member of BMA General Practitioners Committee - Dr Vicky Weeks

Dr Vicky Weeks is a salaried GP in Hounslow, West London, and Chair of the BMA GPC Sessional GPs Subcommittee. She graduated from the University of London in 1980 and trained in acute medicine for the elderly prior to embarking on a career in General Practice. She has been a GP for the past 25 years and in her current practice for 12 years. During her career as a GP she has worked in a variety of roles as a GP locum, retainer and flexible career scheme GP, a principal and salaried assistant. During her years as a partner, she developed an interest in healthcare management and was the lead GP for fund-holding. As a sessional GP, she has continued to develop her interest in healthcare management and medical politics, representation, revalidation and support for continuing professional development. She is a GP tutor, on her LMC and active member of the BMA. She is a member of GPC, the current chair of BMA/GPC Sessional GP Subcommittee and a member of the Education, Training and Workforce Subcommittee. Dr Weeks has recently been described as one of the 'top 50 most influential GPs of 2011' in Pulse magazine.

"Good leaders do not work alone, they are supported by a team"

GP registrar, Chair of “The Network” - Dr Nikki Kanani

Dr Nikki Kanani is a GP Registrar and Chair of The Network. Having qualified from the Guy's, King's and St Thomas' School of Medicine in 2004, she is currently coming to the end of her General Practice training programme, and is starting a Masters in Healthcare Commissioning. As a junior doctor, Dr Kanani developed an interest in service development and she successfully implemented changes to the management of emergency admissions and in-patient discharge pathways in an acute hospital trust. Following on from this success, she led projects for her PCT in screening and intermediate care planning. Dr Kanani is also the Chair of 'The Network' which is an online resource for newly qualified GPs and consultants, and currently has 1500 members. She is also an RCGP clinical commissioning champion, and a member of the Council of the National Association of Primary Care.

“You need to be brave; have the courage to take a chance and opportunity, and not worry how it turns out.”

GENERAL PRACTITIONER CLINICAL COMMISSIONING

GP Principal and developed social enterprise - Dr Veronica Devereux

Dr Veronica Devereux is a GP Principal in Archway, London, and was the lead GP for commissioning in her locality from 2008 to 2010. She graduated from the National University of Ireland in 1997 and completed her GP training in Ireland. Since 2001 she has worked as a GP in London, and has been a partner in a training practice for the past 8 years. She developed an interest in commissioning whilst working as the executive partner for the practice, and subsequently became the PBC lead. Building on her interest in commissioning, she increased the engagement of local GPs with PBC through establishing a steering group, and represented a group of 11 practices in negotiations with the local PCT. She was the Chair of the Clinical Executive of the 'Independent Commissioners for Islington Society', a social enterprise. In 2011 the three Islington localities merged to become a unified commissioning consortium. Dr Devereux has also recently qualified as a GP trainer, and plans to focus on this aspect of her career in the future.

“If you don't join in, you can't shape the conditions you will work within.”

“My motivator is to provide better care for our patients - most of us go that extra little bit to sort out a problem which means doing things outside of the consultation.”

GP Principal and Chair of Commissioning Group - Dr Sarah Morris

Dr Sarah Morris is a GP Principal and Chair of a GP Commissioning Consortium in Bedfordshire. She qualified from the University of Leeds in 1982, and has been a General Practitioner since 1989. She is a partner at a GP surgery in Flitwick, Bedfordshire, which serves 16,000 patients. She has a longstanding interest in clinician-led commissioning, and was the fund-holding lead for her locality in 1994. Since then, she has been actively involved with commissioning services for patients through Primary Care Groups, Primary Care Trusts and Practice Based Commissioning (PBC). In her current role as PBC locality Chair, Dr Morris is supporting proposals to form a federation of 450,000 patients in Bedfordshire.

“Believe in what you are doing; you can make a difference. Accept that change is difficult, but press on despite hurdles and barriers.”

GP principal, lead GP Commissioner and special interest in gynaecology - Dr Pauline Brimblecombe

Dr Pauline Brimblecombe is a GP Principal in Cambridge, a GPwSI in gynaecology, and former Chair of a PBC consortium. She graduated from the University of Cambridge in 1978 and has been a GP Principal at a Cambridge Practice for 26 years. Having developed an interest in women's health at an early stage in her career, Dr Brimblecombe became a Clinical Assistant in colposcopy at Addenbrooke's Hospital, and later completed a Masters degree in Community Gynaecology. For over 10 years now, she has provided a community service in Gynaecology. She was the Chair of 'CATCH', a commissioning consortium for 250,000 patients in Cambridgeshire, from 2005 until 2010, and is currently on the senate of the PCT. She is also a GP trainer, former President of the Medical Women's Federation and a past member of the GPC and BMA Council.

“Women should be advised to do whatever they want to do; there is no barrier if they truly believe in themselves.”

GP Principal, developed social enterprise and GP Commissioner - Dr Niti Pall

Dr Niti Pall is a GP Principal at an inner-city practice in Smethwick, and Chair of Healthworks GP Commissioning Consortium. She has worked as a GP at Smethwick Medical Centre in the West Midlands since 1991, where she successfully combines clinical leadership roles with a passion for delivering high-quality clinical care to disadvantaged communities. She is a GPWSI in diabetes, and an ex-board member of Diabetes UK and the International Diabetes Federation. Dr Pall is also the Interim Chair of the LMC, and former PEC Chair. She is also a member of the National Clinician Commissioning Network and her interest in health service management crosses international boundaries as she is currently working with 20 health centres in India to develop their services. She is the Clinical Lead and Chair of a successful commissioning consortium in the West Midlands, and operates 'Pathfinder Healthcare Developments', a social enterprise with a £1.7m annual turnover.

"Women have strength in numbers in General Practice, but we haven't really built up our networks. We need to work on making ourselves more visible."

Associate GP Director and Board Member of Islington Clinical Commissioning Groups - Dr Rebecca Viney

Dr Rebecca Viney is an Associate GP Director and the Coaching and Mentoring Lead for the London Deanery Coaching and Mentoring Service. Launched in May 2008, the service offers accredited mentors to work with London's NHS doctors and dentists while in training or at other challenging times in their careers. The Service has received over 1,000 applications for mentoring and won a national award for best learning and development strategy. Prior to her role in coaching and mentoring Rebecca ran the flexible career scheme for GPs in London and she now supports the GP Retainer Scheme and the creation of a careers website for GPs. Rebecca has published and presented widely on GP careers, sessional GP CPD and Coaching and Mentoring. Rebecca has acted as member and Chair of the BMAs General Practitioner Committee sessional GP subcommittee, a Board member of Islington PCG and PCT PEC as educational lead, and was formerly Associate Director leading on sessional GP education. She is currently a practicing GP, an appraiser and board member of Haringey clinical commissioning group.

GENERAL PRACTITIONER GP EDUCATION

GP Director of GP Post Graduate Education - Dr Claire Loughrey

Dr Claire Loughrey is a GP and Deanery lead for GP specialty training, appraisal and CPD. After completing her GP training, Dr Loughrey worked as a GP Principal for 18 years, during which time she became responsible for GP appraisals in her locality. She was subsequently appointed to a Deanery post to develop GP training and education, and she represents the interests of GPs to the Royal College of General Practitioners. She is also an executive officer on the Deanery board where she provides the lead for personal and public involvement in healthcare. Dr Loughrey successfully combines these educational and corporate responsibilities with sessional work in General Practice.

Deputy Director Postgraduate GP Education - Dr Grainne Bonnar

Dr Grainne Bonnar is a GP Principal in Belfast and Deputy Director of Postgraduate General Practice Education for Northern Ireland. She graduated from Queen's University, Belfast, in 1987 and completed her GP training in the north east of England. Having worked as a locum GP for three years, she became a GP Principal in Belfast, and developed an interest in teaching and training alongside her clinical practice and membership of the Belfast Commissioning Group. She established a successful Nurse Practitioner course in her locality and subsequently became a GP Programme Director. In her current role as Deputy Director of Postgraduate General Practice Education, she has responsibility for CPD, GP appraisals and the GP specialty training programmes in Northern Ireland. Dr Bonnar has successfully completed the RCGP Leadership Programme, and believes this has greatly enhanced her career.

"I would advise other women to have a go if there are opportunities, don't let your first response be 'I can't'. Believe in yourself and take opportunities as they come."

Salaried GP and Associate Dean - Dr Kate Wishart

Dr Kate Wishart is a GP, Associate Postgraduate Dean at the Eastern Deanery, and Chair of the East Anglia RCGP Faculty. Having started her career as a professional musician, Dr Wishart embarked on her medical training at St. Mary's Hospital at the age of 28 and qualified from the University of London in 1985. She trained as a GP on the Huntingdon vocational training scheme (VTS), and worked as a GP Principal for six years. Alongside her clinical commitments, Dr Wishart developed an interest in medical education and became a GP VTS course organiser. She was subsequently appointed as Programme Director for HPE in Cambridgeshire, and then Associate Postgraduate Dean with a responsibility for Bedfordshire and Suffolk. She is the Eastern Deanery's workplace based assessment lead, and deputy recruitment lead. She continues clinical work one day a week, as a locum working in Cambridgeshire. Dr Wishart also does occasional assessments for NCAS, and is a GP appraiser.

"Many women tend to think they are not as good as the men, yet they're more likely to recognise their own and others' feelings. If professional women want to be considered as equal to men, they have to work as hard, which is difficult with a family. Women must be very good at time management or be prepared to make some sacrifices."

GP Principal and Director of VTS scheme - Dr Sally Whale

Dr Sally Whale is a GP Principal in Ipswich and Programme Director for the Ipswich GP Vocational Training Scheme. She qualified from the University of Birmingham in 1985 and subsequently completed her GP training in Walsall. Whilst working as a GP in Wolverhampton, she developed an interest in medical education and became a GP Trainer. In 2002 she moved to Ipswich, where she became a GP Principal, and she continued to work as a GP Trainer and supervisor of junior doctors. Building on her educational interests, she also became a Programme Director for the Bury St Edmunds VTS Scheme, before moving to the Ipswich Scheme in 2008. Dr Whale has previously been a GP Appraiser and PEC member, and she currently supports GP Trainers in her region through a trainers' group and pastoral work.

"Don't put up with things if you are not happy. Look for the right job and negotiate what you want, and make sure you stand your ground."

Sessional GP, Clinical Leadership Fellow and contributor to report - Dr Emma McGrath

Dr Emma McGrath is a sessional GP in Cambridge, and a Clinical Leadership Fellow at NHS East of England. Emma graduated from the University of Cambridge in 2004 and completed a paediatrics training rotation prior to embarking on GP training in 2007. She was appointed as a Clinical Leadership Fellow at NHS East of England in 2010, an opportunity which enabled her to participate in a leadership development programme facilitated by the Kings Fund alongside clinical and project work. In addition to her interests in Paediatrics and General Practice, Emma has also developed an interest in medical education and has recently completed a Post-Graduate Certificate in Medical Education and Leadership. Emma is currently working at the University of Cambridge Clinical School on the development of the management and leadership curriculum for medical undergraduates.

"Grasp every opportunity, work hard, be ambitious and take inspiration from all the talented women around you."

LEAD CLINICIAN - SPECIAL INTEREST

GP principal with an interest in Mental Health - Dr Mary Embleton

Dr Mary Embleton is a GP Principal and Mental Health lead for a GP consortium in Plymouth. She qualified from the University of Birmingham in 1991 before training as a GP in Birmingham, developing an interest in drug and alcohol addiction. On returning to the UK, after working in central America and Australia, Dr Embleton undertook a degree in Chinese Medicine, and became a GP Principal in Plymouth. She has developed outreach medical services for homeless patients in her locality, and has been appointed as lead clinician for Mental Health. She is a GPwSI in Addiction and Mental Health. Dr Embleton is an advocate of the RCGP Leadership Programme, which she completed 18 months ago.

"I would advise all women to find role models and mentors. Find people who will invest and believe in you; people you can look up to."

GP Principal with an interest in substance misuse - Dr Sandy Taylor

Dr Sandy Taylor currently works as a GP Partner at a practice in Nottingham. She graduated from Bristol University in 1989, and trained as a GP before pursuing her interest in international medicine. She volunteered as a District Medical Officer in Zambia and subsequently worked as a salaried GP in Lusaka prior to returning to the UK where she took up a GP partnership. Alongside her GP role, Dr Taylor has developed clinical expertise in the fields of palliative care and substance misuse, and an interest in medical education. She previously held the post of MacMillan GP Facilitator (2002-2006) and is an accredited GPwSI in substance misuse. She has also completed a Post-graduate Certificate in Medical Education, the RCGP Leadership Course and is a GP tutor.

"Talk yourself up. Be yourself, be your best self and don't let people ridicule you."

"Having a sponsor is important. There are now a few senior women who are sponsors - we need to seek those women out and ask for their advice and expertise. We try to do everything on our own."

ACUTE TRUST

NHS Trust Chief Executive - Dr Lucy Moore

Dr Lucy Moore has been Chief executive at Whipps Cross University Hospital for the last five years. She has developed a strategy in partnership with commissioners and other local acute providers to enable Whipps Cross to achieve Foundation Status, an integrated approach with primary care, and supported clinicians to develop clinical pathways. Underpinning this Lucy has developed clinical leadership within the hospital to achieve significant clinical redesign, financial turnaround, improved patient safety and reduced mortality rates. Lucy trained in medicine and practiced in paediatrics and public health before taking on a number of roles within education, research, commissioning and policy within the NHS. She became Director in Public Health after one year as a Consultant, then Deputy Chief Executive in a Health Authority. She took a Director of Operations role to gain hospital management experience, then became Chief Executive of a Workforce Confederation and Health Authority Director of Strategy for four years before moving to Whipps Cross in 2004.

"Do what you want to do. Draw clear boundaries around home and work and be clear about how much you want to work and how much of your life you want work to take up - which will be different for everybody. Have fun. Go with your instinct. Get on with difficult people. Don't take no for answer. Don't worry if you get things wrong."

CONSULTANT

Council of Royal College, Ex Clinical Director - Miss Clare Marx

Miss Clare Marx is a Consultant Orthopaedic Surgeon at Ipswich Hospital, and former President of the British Orthopaedic Association. Miss Marx graduated from the University of London in 1977 and undertook her orthopaedic training in London before taking up her first consultant post at St Mary's Hospital. She became the first female consultant surgeon to be appointed in East Anglia when she moved to Ipswich Hospital in 1993, and subsequently became the Clinical Director of Trauma and Orthopaedics (1994-1998). She has held a number of national leadership roles including the Chair of the Specialist Advisory Committee in Orthopaedics, President of the British Orthopaedic Association (2008-2009), and she is currently a Council member and Trustee of the Royal College of Surgeons. She has also published articles on arthroplasty surgery and was a co-author of the Trauma and Orthopaedic Curriculum. Miss Marx was awarded the CBE for services to medicine in 2007.

"Never close avenues because you think you won't make it; give it a go. It's better to have tried and not achieved than not to have tried."

Clinical Director - Dr Anna Lipp

Dr Anna Lipp is a Consultant Anaesthetist at the Norfolk and Norwich University Hospital (NNUH), and Chair of the Editorial Board of the British Association of Day Surgery. She graduated from the University of London in 1984, and trained in various locations in the UK and overseas before being appointed to a Consultant post at NNUH in 2000. She is the lead clinician for the Day Surgery and Pre-operative Assessment Units, and manages to successfully combine her clinical and managerial roles with teaching medical students and junior doctors. She is an Honorary Lecturer and student examiner at the University of East Anglia and is a council member of the British Association of Day Surgery (BADS). Dr Lipp currently chairs the Editorial Board of BADS, and is a member of the Royal College of Anaesthetists and Association of Anaesthetists. She has two children, and enjoys keeping chickens, gardening and playing the 'cello.

"My advice to women is to consider every opportunity, actively network, and do things when you can rather than waiting for the ideal time."

Clinical Director Women and Children's Health - Miss Michelle Judd

Miss Michelle Judd is a Consultant Obstetrician and Gynaecologist and Clinical Director of the Women and Children's Health Unit at the West Suffolk Hospital. She graduated from the University of London in 1984 and then embarked on a post-graduate training programme in obstetrics and gynaecology in Wessex. She has completed an MD at University College Hospital, London, and was first appointed to a consultant post at the West Suffolk Hospital in 1999. In 2002, she became the Clinical Director of the Women and Children's Health Unit, and she was appointed to the East of England Maternity and Newborn Programme Board in 2007.

"Take the opportunities when people offer them and run with them."

"Flexible training should be for everyone, including the chaps."

Consultant geriatrician and Clinical Director - Dr Helen May

Dr Helen May is a Consultant Geriatrician at Norfolk and Norwich University Hospital (NNUH) and Comprehensive Local Research Network (CLRN) lead for Norfolk and Suffolk. She graduated from Nottingham University in 1986 having done an overseas elective in Hong Kong, and then trained in geriatrics and clinical research in Nottingham, Kettering, Harrogate, Norwich and Cambridge. She became a Consultant Geriatrician in 1997, and was subsequently appointed to the post of Clinical Director for Medicine for the Elderly and Stroke Medicine. Dr May is lead clinician for dementia at NNUH and a fellow of the Royal College of Physicians. She is CLRN lead for Age and Ageing Norfolk and Suffolk, involved with recruitment into portfolio research studies and has published many academic papers in research journals.

"I'm a born optimist; my glass is always half full, and I try and try to find the positives in every situation. As a leader, you have to maintain the smile!"

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