WHAT MAKES A TOP CHIEF EXECUTIVE?

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PART OF HUNTER HEALTHCARE’S INSIGHT FOR SENIOR NHS LEADERS SERIES 2015
This is the second report in our *Insight for Senior NHS Leaders* series and looks at what makes a top NHS chief executive. It focuses primarily on chief executives in an acute trust setting.

It is based on in-depth interviews with more than 30 chief executives and the results of a joint survey of 49 chief executives by Hunter Healthcare and the *Health Service Journal (HSJ)*. It is not intended as a formula for excellence, rather as an insight into what top chief executives in the NHS are doing to ensure the long-term survival of the organisations they lead. The report aims to explore some of the ways in which chief executives are meeting the challenges they face.

Having set out to find out what makes a top chief executive, we discovered common approaches but also found many chief executives feel they are not fulfilling their potential, or are concerned their tenure could be cut short. Chief executives tell us the fear of failure is greater than it has ever been.

Given the current leadership crisis in the NHS, it is all the more important that we understand the pressures they face and how they are overcoming them, because this will undoubtedly have an impact on how top chief executives are identified through the recruitment process.

This report was produced with the support of Hunter Healthcare, specialists in providing executive talent to the healthcare sector. You can find more out about the company at [hunter-healthcare.com](http://hunter-healthcare.com).
On paper the role of an acute trust chief executive is daunting. The NHS is facing its worst financial crisis for a generation and the environment in which chief executives operate is one of competing agendas, with increasing scrutiny and regulation against a backdrop of heightened media and public awareness, together with rising demand for healthcare services driven by an ageing population.

Chief executives face a different environment from the one in which their counterparts operated 30 years ago, as one who was a trainee manager in the 1960s points out. He says it is far less supportive now and there is little room for mistakes.

Good chief executives are able to take this in their stride and rely on their leadership qualities and behaviours to be able to steer the trust on an improvement journey. These attributes include resilience, emotional intelligence, good communication skills, integrity and compassion.

They will ensure there is a vision for the organisation, whether driven from the top or from the front line, and be able to engage staff by enabling a clear sense of purpose. This is often developed as a narrative that staff can relate to and believe in. Top chief executives will also work across organisational boundaries, be able to see the bigger picture and maintain an overall focus on the patient and improving care.

Comparison is often made between the role of chief executive and that of the manager of a top-level football team. Those drawing this comparison point to a focus on results and the fact that the tenure of football managers and coaches is often brutally cut short. In the NHS even the best chief executives are aware that they could be shown the door with little warning. Short tenures are seen as contributing to the NHS leadership crisis by making the next generation of leaders fearful of stepping forward.

Some of the chief executives we talked to said a lack of support led to loneliness in their roles. They felt that was one area where the NHS could do better, by providing greater support and mentorship from early on in their careers.

Initiatives such as the NHS Leadership Academy’s Healthcare Leadership Model and its Aspiring Chief Executive programme are welcome, but the feeling of isolation talked about by many chief executives will be hard to overcome. The challenge for the NHS is that ensuring greater support for the next generation of chief executives will mean working to understand and address the negative feelings of those who currently occupy the role.
Great ideas, it has been said, come into the world as gently as doves. Perhaps then, if we listen attentively, we shall hear amid the uproar of empires and nations, a faint flutter of wings, the gentle stirring of life and hope. Some say that this hope lies in a nation; others in a man. I believe rather that it is awakened, revived, nourished by millions of solitary individuals whose deeds and works every day negate frontiers and the crudest implications of history. As a result, there shines forth fleetingly the ever-threatened truth that each and every man, on the foundation of his own sufferings and joys, builds for all

Albert Camus
The role of chief executive

It has been described as one of the toughest jobs, more difficult than leading a FTSE 100 company, or being a secretary of state. Today’s NHS trust chief executives face a unique set of challenges. As well as being the organisational head, with financial and managerial responsibility, chief executives also have overall accountability for the quality of care provided by their trust.

Although the scope of chief executives’ activities may not have changed much over the past 30 years, the environment in which they operate has. The King’s Fund says: “Increasing complexity has shaped the development of the management task: the NHS system has grown exponentially, with complex structures developing to underpin it.” It points out there is now a complicated system of public and private providers, with a plethora of regulators. The advent of the internal market in particular, together with a growing recognition of national and international competition law, means the task is one of complex system management rather than simple administration. As well as coping with increasingly complex structures, NHS leaders are subject to greater public scrutiny, locally and nationally.

Former M&S chief Lord Rose says in his leadership review that the NHS is drowning in bureaucracy. “This is evident at all levels. There are two reasons for this: first, the NHS is too vertically structured and second, there are too many regulatory organisations making too many reporting requests.”

Sir Leonard Fenwick is chief executive of Newcastle upon Tyne Hospitals NHS Foundation Trust and the longest-serving chief executive in the NHS. When he first became chief executive expectations were very different. “I came through the ranks as a management trainee from the mid-1960s onwards,” he says. “The model of management was of leadership by example and we were let loose on a long lead. There was trust, confidence and support and NHS leaders tended to stay in the job for longer.”

Sir Leonard believes the environment has changed and that today’s expectations can be unreasonable. “There is more of a blame culture, with media reporting leading to unfair criticism which inevitably has an impact on staff morale. In recent times, the NHS has become more bureaucratic than ever before. We have ringside commentators, accreditation agencies, vested interests and, on top of that, the NHS is a political football.”

Chris Hopson, chief executive of NHS Providers, highlights the challenge of being in the media spotlight. “For a start, you’re running a safety-critical organisation – getting it wrong can mean the difference between life and death on a systematic basis and there aren’t many organisational leaders who directly bear that responsibility. Your role is usually subject to the full glare of local, and sometimes national, media attention. Service failures and service changes are all front-page headline news and there’s often a level of personal vilification involved in the coverage. Health issues understandably generate strong emotions in local communities and this is often reflected in the way the local debate about healthcare is conducted.”

The unrealistic expectations of the time it can take to reverse organisational decline is a theme picked up by the NHS Confederation. It says this is compounded by a perverse tendency to appoint new chief executives to carry out this task yet provide inadequate support. As a result, these organisations often have a high casualty rate at the top, which in turn deters applicants, particularly more experienced chief executives who are likely to be more aware of the hazards associated with the role.

The regulatory burden, bureaucracy and external environment were themes echoed in the results of the Hunter Healthcare/HSJ joint survey. It found that 60 per cent of chief executives thought the regulatory burden was too high. A similar percentage (58 per cent) said external pressures, such as political interference, got in the way of their job.

Professor of public leadership and management at Warwick Business School, Keith Grint, has described the NHS as a “wicked problem”. He says: “A wicked problem is more complex, rather than just complicated – that is, it cannot be removed from its environment, solved, and returned without affecting the environment. Moreover, there is no clear relationship between cause and effect. Such problems are often intractable.”

If the NHS is an intractable problem, what does this mean for the role of chief executive? The insight we gained suggests top chief executives are accustomed to balancing priorities while at the same time relying on their skills, behaviours and management approach to engage staff in a vision for the trust. They are working more closely with external organisations and have abandoned ‘heroic’ leadership in favour of shared cross-organisational leadership.
Richard Lewis, a partner at Ernst and Young, agrees being outward facing is a necessary approach. He says: “The next generation of leaders must look beyond the walls of any single institution and discover how to reshape whole health and care systems. They need to understand the interdependencies between hospitals, primary and social care, and how the demand for services may be shaped through new information shared with patients and citizens.”

Sir Robert Naylor, chief executive of University College London Hospitals NHS Foundation Trust, says top chief executives have to adopt a system-wide view. “We need a change in leadership style so chief executives have a much wider understanding of their role in the system. Ultimately, there are too many separate organisations in the NHS, so should we encourage mergers to ensure we have the best system leaders?”

The challenge of adopting a system-wide view is highlighted neatly by Dame Julie Moore, chief executive of University Hospitals Birmingham NHS Foundation Trust. Writing about her own experiences, she explains how Birmingham City Council convened a meeting about acute care in the city in response to issues being faced in A&E. “It started out with the three acute trusts and the ambulance service. But then the mental health trust said it had acute beds too and needed to be there. Then the community people said they needed to be there, and then the commissioners, and in the end there were 27 people in the room and it was such a big meeting that nothing was achieved. Nobody wanted to be there, but nobody wanted not to be there. It got so involved that nothing was achieved.”

Lengthy job descriptions give a flavour of the demands on NHS trust chief executives. They serve as a stark reminder of the extent of the role and the need for chief executives to be outward looking while at the same time focused on ensuring their trusts meet statutory and service obligations.

The descriptions also beg the question: who would want to do the job? The recruitment crisis in the NHS suggests the answer is fewer and fewer people. Latest figures compiled by the HSJ show that 14 per cent of chief executive roles in the NHS are not filled permanently and 12 per cent are only in post for a year.

NHS Confederation chief executive Rob Webster says many would conclude the role of trust chief executive is “undoable, impossible and unattractive — except to masochists, idealists and thrillseekers”. “This cannot go on. Aside from the pressures our senior leaders have to bear, a revolving door of leadership in any organisation is not good for patients or staff,” he says.

This view is echoed by Lord Rose, who says: “The level and pace of change in the NHS remains unsustainably high: this places significant, often competing demands on all levels of its leadership and management.”

One chief executive we spoke to says you can be an exceptional leader and a great chief executive, but still fail in this environment. As chair of the HSJ’s Future of NHS Leadership inquiry, Sir Robert Naylor is particularly concerned. “In an increasingly complex health system, there is a danger the situation could worsen unless NHS organisations and the system as a whole takes action,” he says.

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**CEO job satisfaction**

Hunter Healthcare/HSJ chief executive survey 2015

- **86%** of NHS chief executives found their work challenging and rewarding
- **58%** said external pressures (such as political interference) got in the way of their job
- **60%** said the regulatory burden was too high
- **60%** rated their job satisfaction as 8/10 or 9/10

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The role of chief executive / What makes a top chief executive?
Personal qualities that make a difference

Although the 1983 Griffiths Report effectively put an end to consensus management and called for clear leadership, the best chief executives are not autocratic in their management style. Our survey results and interviews support the view that good leaders in the NHS, as in many other sectors, are enablers. They are also adaptable and make sure they adjust their style of leadership according to the situation they find themselves in.

The best chief executives can get the most from their staff and do this in such a way that it meets their organisation’s objectives. The qualities they need are not in themselves unique, but their combination can often be persuasive. They include: integrity; honesty; humility; courage; commitment; passion; confidence; determination; compassion; and sensitivity.

The NHS Leadership Academy’s Healthcare Leadership Model aims to help those who work in health and care to become better leaders. In a section entitled ‘The nine leadership dimensions’, it says: “It is vital to recognise that personal qualities like self-awareness, self-confidence, self-control, self-knowledge, personal reflection, resilience and determination are the foundation of how we behave. Being aware of your strengths and limitations in these areas will have a direct effect on how you behave and interact with others, and they with you. Without this awareness, it will be much more difficult (if not impossible) to behave in the way research has shown that good leaders do.”

Our interviews with chief executives reflected these qualities, but also found that emotional intelligence was high on the list of attributes recognised as important.

Resilience

In order to withstand constant scrutiny, while pursuing a chosen strategic intent, focus and resilience are required. More than half of the chief executives who responded to the Hunter Healthcare/HSJ survey named strong personal resilience as one of their top three qualities.

Many chief executives will be familiar with a situation where the local media have taken issue with their leadership, prompted by a striking failure of compassionate care, a damaging Care Quality Commission report or poor performance figures. For chief executives, it is hard not to take such high-profile shaming personally. They will have invested time and energy, and often made personal sacrifices, so the ability to remain calm, collected and rational in the face of adversity requires personal belief and resilience. Resilience and the ability to lead turnaround in distressed organisations was a key recommendation of a 2015 review of centrally funded improvement and leadership development functions.

Jim Mackey, former chief executive of Northumbria Healthcare NHS Foundation Trust and now chief executive of NHS Improvement, emphasises the importance of remaining determined in challenging times and not worrying or negatively influencing staff. He says this approach was key to developing a positive culture within his trust.

Resilience is one of the most valuable leadership qualities in today’s NHS according to Suzanne Rankin, chief executive of Ashford and St Peter’s Hospitals NHS Foundation Trust. “We’re dealing with rising demand and coping with uncertainty. Resilience is important,” she says. But Cally Palmer, chief executive of The Royal Marsden NHS Foundation Trust, emphasises the point that to be resilient, chief executives require a strong, supportive team. She says: “It’s becoming a tougher and tougher market and as such it is becoming more and more important to have a strong team around you.”

Of course, the public sector and the NHS do not have a monopoly on challenging situations and in Tough at The Top, a Marketing Society/Accenture survey of 40 private sector chief executives and company chairmen, chief executives were asked about the qualities of top leaders. Carolyn McCall of easyJet responded: “A CEO needs fitness, resilience, and to have a lot of stamina. You need to continue and not be waylaid, you can’t be downhearted, and you need a vision and a purpose.”

So how do chief executives build the resilience they need? Harvard Business School senior fellow Bill George, who teaches leadership development, describes the ‘Atlas mentality’ where leaders in a crisis try to take the weight of the world on their shoulders. “To avoid the Atlas mentality, leaders must build resilience into their lives by keeping their body in shape, their mind sharp, their spirit high, and not taking themselves too seriously,” he says.

One chief executive we interviewed agrees, saying personal resilience needs to be worked at and that includes keeping...
healthy. “Chief executives have to make sure they get enough sleep, keep fit and maintain some work-life balance so life isn’t just work. With this job there will inevitably be days when everything will go wrong at the same time, and you have to remain measured. You have to watch the alcohol intake and you need close friends who are supportive, strong interests outside work and regular holidays – the belief that the organisation can’t function without you is very old fashioned.”

Writing in the HSJ, Sara Williams and Dr Jane Keep echo this view, pointing out that resilience is less about stoicism and more about being focused on developing a positive mindset and being happy. “Given the NHS is awash with resilience-building exercises and the promotion of this culture of stoicism, does mental toughness, or having a positive mindset actually work in these environments? Or is there another way?” They call for a more supportive culture of compassionate care based on the acceptance of “sensitivity”.

**Emotional intelligence**

This is the ability to identify and manage your own emotions and the emotions of others. There are three skills linked to emotional intelligence. First, the ability to identify your own emotions and those of others. Second, the ability to harness emotions and apply them to tasks like thinking and problem solving, and finally the ability to manage emotions, including being able to regulate your own emotions and the ability to cheer up or calm down other people. Sir Robert Naylor says emotional intelligence is the “most important” quality in a top chief executive. “Being able to relate to staff and see things from their point of view is critical,” he says.

The term ‘emotional intelligence’ was referred to by US psychologists John Mayer and Peter Salovey. They described it as an ability to perceive emotion in oneself and others, integrate emotion into thought, understand emotion in oneself and others, and manage or regulate emotion in oneself and others. Daniel Goleman continued the theme in his 1998 book *Working with Emotional Intelligence* and linked it to leadership performance.

The Consortium for Research on Emotional Intelligence in Organizations, based at Rutgers University in New Jersey, collaborates with a number of organisations to share research and ideas relating to emotional intelligence. In a leadership study with Johnson and Johnson it found that staff identified at mid-career as having high leadership potential were far stronger in emotional intelligence competencies than their less-promising peers.

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**Five tips for improving emotional intelligence**

1. **Improve your self-awareness**
   Find people who will tell you the truth about how you come across to others and how you might improve. This might mean a mentor who will give you honest feedback.

2. **Develop better listening skills**
   Listening is the counterbalance to good communication and understanding its importance is the first step to developing better listening skills. By connecting with others it is easier to pick up hidden messages behind the spoken word.

3. **Be genuinely interested**
   Learning the names of colleagues and their significant family members, and what they do when they are not at work, will help you find out what is important to the people you lead. This also helps staff feel valued as individuals.

4. **Learn how to manage your own emotions and those of others**
   Good leaders can read the emotional barometer and diffuse anger by listening and recognising the feelings of others. Acknowledge negative feelings; do not allow them to fester.

5. **Develop a strong sense of appreciation**
   Good leaders are always appreciative and recognise that they have others to thank for helping them get where they are. Self-aware leaders consider how they would like to be treated when dealing with those reporting to them.

*Harvey Deutchendorf, author of The Other Kind Of Smart: Simple Ways To Boost Your Emotional Intelligence for Greater Personal Effectiveness and Success*
Integrity
Chief executives who exhibit integrity insist on openness and communication, motivated by values of inclusiveness and getting on with the job. They act as a role model for public involvement and the dialogue that all staff, including those on the front line, need to have with colleagues and service users. Ultimately, they believe in a set of key values – born out of broad experience of, and commitment to, the service – which stands them in good stead, especially when they are under pressure.

Sir Robert Naylor agrees that integrity helps to build trust and says chief executives should “display honesty and integrity in everything they do”. Jo Cubbon, former chief executive of Taunton and Somerset NHS Foundation Trust, makes a practical point about personal integrity, saying it is a stepping-stone towards trust. “Spending time to develop relationships demonstrating personal integrity and humbleness with the patients and local population will ensure a CEO is trusted and believed by the patients,” she says.

Leadership gurus, such as the late Warren Bennis, have been quick to point out the importance of integrity. “One thing that has become clearer than ever to me is that integrity is the most important characteristic of a leader,” Bennis wrote in his book On Becoming a Leader.

David Weinberger, senior researcher at Harvard University’s Berkman Center for Internet & Society, concurs that integrity has become the central quality of modern leaders. “Modern leaders with any degree of self-awareness recognise that they don’t know – and can’t know – enough to be qualified to lead a large modern business,” he says.

In 2010, IBM carried out a survey of 1,500 chief executives from 60 countries and 33 industries worldwide, and found that integrity was second only to creativity among leadership qualities cited by respondents as essential: 60 per cent chose creativity as a top quality while 52 per cent chose integrity.

Compassion
This is a quality that has been talked about a great deal, following the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. The report talked of the need for improved support for compassionate caring, and committed care and stronger healthcare leadership.

Being genuine is the starting point for leading with compassion and care. “You have to be able to connect with people and genuinely care about them – you have to care for your team and respect them and listen to them,” says one chief executive we interviewed.

According to the NHS Leadership Academy, leading with care is a must. It says leaders should understand the underlying emotions that affect their team, and care for team members as individuals, helping them to manage unsettling feelings so they can focus their energy on delivering a great service that results in better care for patients and other service users. In the academy’s nine leadership dimensions, three questions are asked of leaders in the ‘Leading with care’ dimension:

• Do I notice negative or unsettling emotions in the team and act to put the situation right?
• Do my actions demonstrate that the health and wellbeing of my team are important to me?
• Do I carry out genuine acts of kindness for my team?

The challenge for chief executives is that compassion has the potential to transform patient care, yet according to NHS managers it still fights for space on crowded board agendas. “Although progress has been made, on some wards, the challenge for stretched teams is to move beyond transactional care, beyond risk mitigation and compliance to protocol,” NHS England says. As well as showing compassion themselves, chief executives have to ensure everyone in their organisation is able to do the same.
Head of thought leadership at The King’s Fund, Dr Michael West, believes that feeling positive emotion is a prerequisite to compassion. Writing in the HSJ, he said: “For staff to be attentive, feel empathy and take intelligent action for patients (the key elements of compassion), they need high levels of positive emotion at work. Optimism, cohesiveness, humour, support and a sense of efficacy all contribute to this. Balancing negativity with an atmosphere of positivity and support enables staff to be compassionate, make better diagnostic decisions, be attentive to patients and deliver high-quality care.”

Dr West argues that leaders must: reinforce an inspiring vision of the work; listen and respond to patient experience; promote positivity, staff health and wellbeing; empower staff to solve problems and innovate; and ensure staff feel safe, supported, respected and valued.

He thinks a collective and inclusive model of leadership will be most effective in this respect. “This means everyone taking responsibility for the inclusivity, civility, culture and success of the organisation as a whole – not just for their own jobs or work area,” he says. “This contrasts with traditional approaches to leadership, which have focused on developing individual capability while neglecting the need for developing collective capability or embedding the development of leaders. Collective and inclusive leadership offers huge opportunities for creating cultures of continually improving, high-quality, and compassionate care.”

**Compassion and mindfulness**

The neurological response to threat and the desire for self-protection — designed to attract attention, detect, process and respond — often limits our ability to be compassionate. Threat-based emotions such as anger, anxiety and disgust, and defensive behaviours, such as fight, flight, submission and freeze, can all inhibit readiness to connect with others.

Mindfulness is a way of paying attention to, and seeing clearly, whatever is happening in our lives and around it. It will not eliminate pressures that prevent us from behaving with compassion, but it can help us respond to them in a calmer manner that benefits our heart, head and body, and those around us. It helps us recognise and step away from habitual, often unconscious, emotional and physiological reactions to everyday events. It provides us with a scientifically researched approach to cultivating clarity, insight and understanding.

**NHS England, 2014: Building and strengthening leadership: leading with compassion**

**Communication**

Rewording a political mantra, Sir Robert Naylor says good leadership is about “communication, communication, communication”. He cites the example of his own trust, University College London Hospitals, where employees are given the opportunity to contribute to the trust’s annual objectives, and the results are cascaded throughout the organisation. Every employee then knows what the organisation is going to focus on.

Peter Homa, chief executive of Nottingham University Hospitals NHS Trust and one of the HSJ’s top 50 trust chief executives for 2015, underlines Sir Robert’s message, saying communication skills are vital. “You have to be straight talking but also have the ability to present a message in an empathetic way. It’s my role to ensure the challenges are presented to staff in a realistic but optimistic manner.”

Former chief executive of Cambridge University Hospitals Foundation Trust Dr Keith McNeil is also clear about the need to be a good communicator. “There has to be visible leadership, you have to get out and meet people and have an open-door culture; you have to give people the right support in whatever form to make things happen,” he says.

Communication is one of the eight essential leadership skills identified by the Marketing Society and Accenture in their Tough at the Top survey: “For chief executives nowadays, effective communication is no longer an add-on; it must be a core competence. Whoever the audience and whatever the message, rapid, relevant and accurate communication must be at the heart of everything the CEO does.”

So what does good communication look like? From an NHS perspective it means being able to reach and engage a wide range of people: staff, patients and external partners, including commissioners and community service providers. Some chief executives have spoken of being able to tell a convincing narrative about the organisation, the challenges it faces and the desire to put patients first. The importance of being able to articulate the vision to a wide range of stakeholders, adjusting it accordingly, was picked up by several of those we interviewed.
The most effective leaders are all alike in one crucial way: they all have a high degree of what has come to be known as emotional intelligence. It’s not that IQ and technical skills are irrelevant. My research, along with other recent studies, clearly shows that emotional intelligence is the sine qua non of leadership. Without it, a person can have the best training in the world, an incisive, analytical mind and an endless supply of smart ideas, but he still won’t make a great leader.

Although good communications skills are recognised as an important quality, the results of the 2014 NHS Staff Survey suggest much improvement is needed, given that only 31 per cent felt that their managers involved staff in important decisions.

Authenticity plays a significant part in connecting with staff and they will latch on quickly to communication that is false in any way. Sir David Dalton, chief executive of Salford Royal NHS Foundation Trust is a firm believer that authenticity goes hand in hand with success. “People have to really believe in what you are saying. They are, at all times, observing the signals that you generate. They will immediately spot if you are saying one thing but then doing another. Most people can see a leader who is not authentic and it is then very hard to regain credibility.”

Social media is one channel where this is particularly important. With more NHS chief executives using social media, an authentic voice is more important than ever. People have an acute sense for communication they believe is not genuine and this will make it harder to convince them of your message. As for using social media and email for engagement, openness is the best approach. Carolyn McCall of easyJet says: “It’s important as a CEO now that you understand the power of social media.”

What are the top three qualities of an NHS chief executive?

Hunter Healthcare/HSJ chief executive survey 2015

- 55% chose strong personal resilience as one of their top three
- 38% chose inspiring others
- 28% chose humility
- 23% chose good communications skills
- 23% chose being a good listener

Communication from a staff perspective

NHS Staff Survey 2014

- 37% said communication between senior managers and staff was effective (an increase from 36 per cent in 2013)
- 29% Less than a third of all NHS staff reported that senior managers acted on feedback from staff
- 81% said they could identify the senior managers in their organisation
- 31% felt that their managers involved staff in important decisions
Could the Ferguson formula work for chief executives in the NHS?

The role of NHS chief executive has been compared with that of the manager of a top-level football team. The pressure to improve performance, coupled with intense scrutiny and the likelihood that the tenure will be cut short, are all factors that support this comparison.

In a Harvard Business Review case study, Anita Elberse, professor of business administration at Harvard Business School, examined the qualities that made Sir Alex Ferguson the most successful football coach ever in England. Under his tenure, Manchester United won 13 English league titles and 25 other domestic and international trophies – double the haul of the next-most-successful club manager in England. So are there lessons for other leaders, specifically in the NHS? Elberse describes several elements of Sir Alex’s leadership approach and qualities that could be applicable more widely.

Building a strong foundation by nurturing talent was a particular focus, says Elberse. “The best-known of his early signings was David Beckham. The most important was probably Ryan Giggs, whom Ferguson noticed as a skinny 13-year-old in 1986 and who went on to become the most decorated British footballer of all time. International stars Paul Scholes and Gary Neville were also among Ferguson’s early youth program investments.” For NHS chief executives, building a strong foundation for future growth is fundamental and the best are always looking to develop talent. “When you give young people a chance, you not only create a longer life span for the team, you also create loyalty. They will always remember that you were the manager who gave them their first opportunity,” she says.

One aspect of Sir Alex’s career that has drawn criticism was his succession planning, as the man who replaced him at Manchester United, David Moyes, did not meet expectations. In subsequent interviews, Sir Alex has said that had Ryan Giggs retired from playing earlier he would have appointed him to the job. Similarly, in the NHS, every chief executive should be thinking about succession planning to ensure there is a talent pool of individuals ready to become the next generation of senior leaders.

Communicating well to match the message to the moment was something to which Sir Alex paid particular attention. Telling a player that they weren’t picked for a game required a private conversation and being honest by saying “I might be making a mistake, but I think it is best for the team today”. “Few people get better with criticism; most respond to encouragement instead. So I tried to give encouragement when I could. For a player – for any human being – there is nothing better than hearing ‘Well done’. Those are the two best words ever invented. You don’t need to use superlatives.”

Being able to communicate effectively is a key skill for any chief executive and although Sir Alex’s famous “hair dryer” reprimands would be out of place in the NHS, leaders should know how to instil a sense of togetherness and ownership of a shared vision. Diane Wake, chief executive of Barnsley Hospital NHS Foundation Trust, sees her role as not dissimilar to that of a football manager. “You are only as good as the team around you. If you treat people fairly and have objective appraisals from the start (firm and fair conversations), generally people will respond,” she says.
Vision, shared purpose and improvement

According to the Care Quality Commission in its 2015 State of Care report: “Well-led services have a positive organisational culture that is open and transparent, and a culture where the vision and values are embedded and really understood by staff across the service. In a service where there is pride and enthusiasm among staff, which is echoed by people using the service, this is often indicative of both good leadership and a safe culture.”

Setting a vision for the future can be difficult, given the day-to-day challenges faced by every NHS chief executive. The pressures on trust emergency departments are a good example of such a challenge. John Deffenbaugh, of consultancy Frontline, writing in the British Journal of Healthcare Management, says acute providers are at the front of the tsunami that has washed over their emergency departments. “A combination of elderly population with comorbidities, a lack of community infrastructure, and services that are not joined up means that emergency department targets are now breached on a regular basis. This is at the front door of hospitals – at the back door, patients ready for discharge are not able to leave because of lack of suitable places to go. Hospitals are in danger of becoming nursing homes.”

His remedy lies in taking a system approach that goes beyond the NHS operating in its comfort zone of the local health economy. This is, he argues, because the problem is not just about health; it’s about housing, community services and support, daytime activities, primary care services and local diagnostics. “The system here reaches well beyond the NHS to embrace local government, the police, community groups, citizens and their families,” he says.

Some chief executives we interviewed disagreed with the notion that vision setting always comes from the top. The Royal Marsden’s Cally Palmer says: “The direction of travel should be set from the bottom up and not imposed; this means having a deep buy-in from clinicians where priorities are raised from the frontline.” Barnsley Hospital’s Diane Wake agrees. “Our vision is created from the bottom up. We get genuine feedback from a whole variety of forums, one of our executive directors leads on external issues to ensure collaboration with key partners.”

Whether driven from the top down or from the front line, sharing the vision is equally important. The NHS Leadership Academy says this means communicating a compelling and credible vision of the future in a way that makes it feel achievable and exciting believes. One of the questions leaders should ask is: Do I clearly describe the purpose of the job, the team and the organisation and how they will be different in the future?

Sharing the vision is closely aligned to creating a shared purpose. Chief executives we spoke to talked of inspiring staff so they could believe in shared values. They recognised that their own behaviour was a catalyst in this respect. In other words, they had to “live the values”.

The ultimate aim is that every member of staff takes responsibility for the success of the organisation. The King’s Fund has described collective leadership as being in contrast with traditional approaches focused on developing individual capability. It believes that if leaders and managers create positive, supportive environments for staff, those staff then create caring, supportive environments for patients, delivering higher quality care. Where there is a culture of collective leadership, any member of staff is likely to intervene to solve problems, to ensure quality of care and to promote responsible, safe innovation.

The Care Quality Commission believes engaging with staff and people who use services is a central factor in being well-led. “Services that prioritise quality and safety have created an environment where staff are encouraged to be involved in recommending new ways of working and suggesting ways to put the organisation’s values into practice. In these organisations, an emphasis is put on learning and staff development.”

However, a further challenge for chief executives is that vision setting and engagement requires not just an ability to see the bigger picture, but also to work with others who may be less
willing to participate in that vision. Add in the complexity of internal structures, hierarchy and culture, and the challenge might seem unsurmountable.

There are inevitably instances when strategic objectives don’t align across the system. Katrina Percy, chief executive of Southern Health NHS Foundation Trust, says: “There are times when the long-term vision clashes with what needs to happen now. For instance, community nurses undertake a lot of work which could be considered as social care. I could say our imperative is to reduce costs and we shouldn’t do this, but that is the wrong thing to do in terms of fostering relationships with GPs and the integration of health and social care.

“Being able to keep a grip of delivery targets today and having the right framework in the organisation to deliver what you need to do is a challenge, but just as difficult is enabling the clinical team to move forward for the future — with external organisations as well as within the trust itself.”

Katrina Percy says her board constantly debates the future direction of the trust and how it will cede control of some services and at the same time retain control of others and move into completely new areas. “That is a difficult balance in a world where you are highly regulated,” she says.

Ashford & St Peter’s Suzanne Rankin agrees that delivering a strategic vision is challenging. Rankin has a military background and was deployed to the Middle East in the first Gulf War, serving on the RFA Argus ship. She sees similarities to the NHS. “It’s not dissimilar to running a military operation, where the operational environment is highly complex, there’s risk and you tend to be working in coalition with other organisations, such as NATO.”

Contrary to popular belief, she says, the military takes a devolved approach and her learning from the military was around clarity of vision. “It’s about being clear about a plan, but also how important it is to empower people who work with you to deliver that plan. My role is to enable people to deliver that plan without feeling constrained,” she says.

This approach is reflected by the NHS leadership Academy which says good leaders champion learning and capability development so others gain the skills, knowledge and experience they need to meet the future needs of the service, develop their own potential, and learn from both success and failure. Providing regular positive and developmental feedback for the team to help them focus on the right areas to develop professionally is one way of achieving this. As is creating the conditions in which others take responsibility for their development and learn from each other.

Ensuring staff are given autonomy is an approach used by Northumbria Healthcare’s former chief executive Jim Mackey. He says: “I would rather staff have a go and fail than not try at all. I don’t want them to be satisfied, I want them to go one better and build on their success. This helps to create a culture of improvement.” He acknowledges that such a culture is created by gaining trust and building something as a team that connects all members of staff. (See case study, page 19).

Chief executives we spoke to agreed that a culture of improvement is closely aligned to a values-based culture and this cannot be achieved by a command-and-control approach. Salford Royal’s Sir David Dalton says: “Creating this culture requires leadership attention, and a fundamentally different approach in many organisations, but the results can be significant. Leaders must make sure that they minimise the disconnection between themselves and staff, and that they achieve real alignment between the goals and values of an organisation and the individual contribution of each member of staff.”

Ros Tolcher, chief executive of Harrogate and District NHS Foundation Trust, talks of generating internal alignment between the wider strategy and internal objectives. “We develop an annual plan, from which we take strategic objectives and personal objectives,” she says. “We create the right conditions for success.”

Her trust is a member of the Harrogate Health Transformation Board, which has representation from commissioners, the local authority and providers. The board’s governance framework is designed to realise its ambitions over the next five years and these are linked closely with those of the trust, for example, driving forward improvements in the quality of services to improve patient safety, outcomes and experience for people who use its services. (See case study, page 19).

One of the NHS Leadership Academy’s nine leadership dimensions is ‘holding to account’ — agreeing clear performance goals and quality indicators, and supporting individuals and teams to take responsibility for results. It says leaders create clarity about their expectations and what success looks like in order to focus people’s energy, give them the freedom to self-manage within the demands of their job, and deliver improving standards of care and service delivery.
Transformational change requires strong and capable leadership. There are many successful NHS organisations and individual leaders with a track record of delivering consistently high-quality healthcare to patients, but many have not thought beyond their current organisational boundaries. Leaders of successful organisations should become ‘system architects’, encouraged to use their entrepreneurial spirit to develop innovative organisational models and to codify and spread their success to other localities.

The Dalton Review, 2014
What top three management approaches do you consider most important for the job you do?

Hunter Healthcare/HSJ survey 2015

- 61% of chief executives felt that not being afraid to have difficult conversations/honest dialogue was one of the top three approaches.
- 61% said spending time networking and influencing colleagues was one of the top three approaches.
- 40% said spending time networking and influencing external contacts to drive change was one of the top three approaches.

Creating a culture of improvement at Harrogate & District NHS Foundation Trust

The trust has a five-year strategic plan with outcomes against each strategic objective. These objectives are owned within job descriptions. Activity is split into Business as Usual, Clinical Transformation (overseen by a clinical transformation board) and Business Transformation (for which there is a programme management office and associated performance dashboards).

Chief executive Ros Tolcher says: “We have a culture of restlessness and aim constantly for the upper quartile. We challenge what is green on our dashboards and do not get sucked into believing everything is okay. We have a huge emphasis on quality and practise a forensic scrutiny of excellent care because we want to learn/understand why things went well.”

Each division has a governance forum and governors undertake patient safety visits. The trust also has an active patient voice group. “Forensic scrutiny” includes director team visits and patient safety walkabouts, as well as shadowing staff. The aim is to ensure staff have the skills and insights to make the change happen by creating the right conditions to allow them to flourish. “All these mechanisms and processes ensure that we meet regulator expectations, embrace the patient perspective, manage risk and do no harm,” Ros says.

Driving change by embracing the patient perspective at Northumbria Healthcare NHS Foundation Trust

Jim Mackey, former chief executive of Northumbria Healthcare NHS Foundation Trust, has helped to shape the trust’s culture around the patient experience. He finds it astonishing that the NHS still doesn’t fully see patients as the end users of a service. He says that in the private sector it is always about the customer, whereas it doesn’t feel that notion is as well embedded within the NHS. To help tackle this at Northumbria, a new position was created within the organisation – a director of patient experience, who has put a great emphasis on patients as customers. Each year, 30,000 patient surveys are completed, which provides good feedback on how they rate their experience, whether it is onsite or in the community. This has helped the trust manage performance for all staff, particularly on the wards, but it has also helped identify more efficient processes and systems to avoid duplication of work.
Creating a supportive environment for the next generation of chief executives

The average tenure of an NHS trust chief executive is around 24 months and only 8 per cent of respondents to the Hunter Healthcare/HSJ survey had been in post for more than 15 years. Research from NHS Providers shows that since October 2014, at least 17 trusts have lost their chief executive. More than one in six trusts has no substantive chief executive and it is widely accepted there is a crisis in leadership\textsuperscript{15}. So, how do we begin to reverse the trend?

Jim Mackey believes NHS trusts are too big for the majority of directors to make the step up to operate as a successful chief executive. There is, he says, a gulf between working as a director of finance, for example, and becoming chief executive. Mackey also highlights a lack of regional connectivity between organisations, which could allow staff to move around, develop their portfolios and further enhance their experience. This, he feels, would better position people to make the step up and allow for better succession planning. But he accepts that many directors across the system are content to continue to operate at their current level, with no wish to make the move. “Being a chief executive is a very lonely job at times and it simply won’t appeal to everybody,” he says.

In \textit{Changing of the Guard}\textsuperscript{16} Brian James, former chief executive of Rotherham NHS Foundation Trust, echoes this theme. He says: “What I wish I had known before I became a chief executive is how lonely it is. There is little support, and there is no real training for it. Indeed, you can’t really be prepared for it. It is very different to being a director. I was a director for nearly 20 years before I became a chief executive, and it is just completely different.”

In the Hunter Healthcare/HSJ survey, one in four (27.5 per cent) of respondents said they did not feel supported by senior colleagues, the wider system or the public. This lack of support is therefore an important factor for most chief executives, with politicians and the media playing a significant part in creating negative pressure. Rob Webster, chief executive of the NHS Confederation, has described a “toxic environment where the gravitational force of the media, the regulators and the politicians can make the burden become too heavy”.

Newcastle upon Tyne Hospitals’ Sir Leonard Fenwick feels a lack of external support has helped deter the next generation of chief executives. The environment, he believes, is far less supportive than when he started out. “I see more chief executives retiring early and we should be nurturing a more discretionary culture,” he says.

“More support is needed for leaders to develop large-scale change management; strategic and commercial skills and the ability to lead in a networked or group structure are becoming more important,” adds NHS leadership review author Lord Rose.

One remedy proposed by Nottingham University Hospitals’ Peter Homa is to provide newly appointed chief executives with a coach and mentor. “This should be a given and not up to the individual to decide whether they need it. They need a safe and secure sounding board, someone who they are comfortable to talk to and admit at times they don’t know what they are doing,” he says.

Mentorship is an area many chief executives agreed would be helpful. This means creating structures around chief executives to nurture success. Some went as far as to say they could not be expected to survive in a system where such support was lacking.

The value of creating a stable and supportive environment cannot be underestimated. Brian James cites the example of the unions’ and media reaction to proposed changes to staff terms and conditions to mitigate the potential loss of 750 jobs. “This issue was then hijacked by regional union officers and the next thing was headlines in the local press to the effect that 750 staff were to be made redundant imminently, with a call for strike action – even though we made it clear that forward planning would mean that the majority of losses would have been perfectly manageable through natural turnover,” he says.

As for supporting the next generation of leaders, it is likely that more clinicians will be sought to fill senior posts and ultimately become chief executives. But for this to happen clinicians will need training to emphasise the skills required, such as emotional intelligence and the ability to connect with a wide range of organisations across the public, private and third sectors.

Emerging leaders also need the opportunity to take responsibility early on in their careers and take on projects that will help them grasp what it will be like to step up to the next level.
Dr Lucy Moore, former chief executive of Whipps Cross University Hospital Trust, thinks clinicians are untapped talent. "Coming through the system – and it is a generational issue – there are some extremely able and willing medical leaders, which will make a massive difference to patient experience, quality and the efficiency of the way we do things. In the past it was tokenistic because many clinicians didn’t want to do it, and – particularly at the middle level – managers didn’t want them to either, perhaps because it was too intellectually challenging, and managers might have to do something differently,” she says.

Having spent time working for consulting firms, Dr Moore has seen how they invest in leadership development in a different way – operating their graduate entry as part of a much bigger leadership scheme. “The NHS Management Training Scheme is fantastic. But it is small scale, and there is nothing else really. We describe it as a National Health Service, but as far as that sort of leadership training and succession planning is concerned, it’s not at all. I’ve been very struck by that in my new life, where it is taken much more seriously,” she says.

Acceptance of failure, or allowing chief executives in waiting to learn from mistakes is another area of potential focus. Sir Robert Naylor puts his finger on this, pointing out that when he was coming up through the ranks he not only learned directly from his chief executive, but also learned from the mistakes he made.

Our key conclusion, and the one on which our recommendations are built, is: if leadership within the NHS and across health and social care is to be strengthened and successful, then the task must be made more manageable, more attractive and more sustainable.

*NHS Confederation

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*A supportive environment for the next generation* / *What makes a top chief executive?*
Conclusion

The role of chief executive is a complex one and taking into consideration factors that are often beyond control – the worst financial crisis for a generation, and a high-pressure environment with unprecedented media attention – you could be forgiven for thinking it is an impossible job.

There are several qualities and behaviours that top chief executives exhibit and these are used in different combinations to achieve success. They must be resilient, have emotional intelligence, and act with integrity and compassion, while being good communicators.

The Hunter Healthcare/HSJ survey and the in-depth interviews have given us further insight into what makes a chief executive beyond these qualities and behaviours. We have seen that vision setting is particularly important, as is being able to describe a narrative that staff and patients can buy into.

Top chief executives invest in creating a values-based culture to drive improvement and many of those we spoke to believe this culture has to be authentic and not necessarily driven from the top down. Being able to work across organisational boundaries is crucial to making change happen and the best chief executives are able to balance the day-to-day management of their own organisations with longer-term objectives of improving outcomes for patients in their area.

We also discovered that many chief executives feel lonely and unsupported and yet they keep doing the job. The majority (60 per cent) rate their job satisfaction at 8/10 or 9/10. We found that despite a willingness to get on with the task in hand, they are still concerned with failure. They feel they have to be brave in order to ensure a successful future for their organisation and yet at the same time they could be punished for stepping out of line in the view of regulators. The fear of failure is greater than it has ever been, according to some we spoke to.

This does not bode well for resolving the current leadership crisis. Our interviews suggest there are several areas the NHS could focus on to help make chief executives more successful in the future. This includes encouraging emerging leaders to take on greater responsibility earlier on in their career.

We also heard that many chief executives wanted to be mentored as soon as they took up their post; one chief executive we spoke to felt this should be obligatory. Mentorship would help chief executives feel less isolated and at the same time give them a personal sounding board.

Succession planning has to be high on the agenda in order to help the next generation of chief executives to come through unscathed and ready to hit the ground running. In practice, succession planning is inadequate in many trusts and this has to be addressed. All too often we see instances where chief executives are forced from their post with no one ready to step into their shoes. The NHS cannot continue to function effectively unless the next generation of chief executives is ready and waiting in line.

There are clearly some exceptional leaders in the NHS and although we need to support the next generation, we must provide support and freedom to our existing leaders so they can demonstrate exemplary leadership and inspire future leaders.
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