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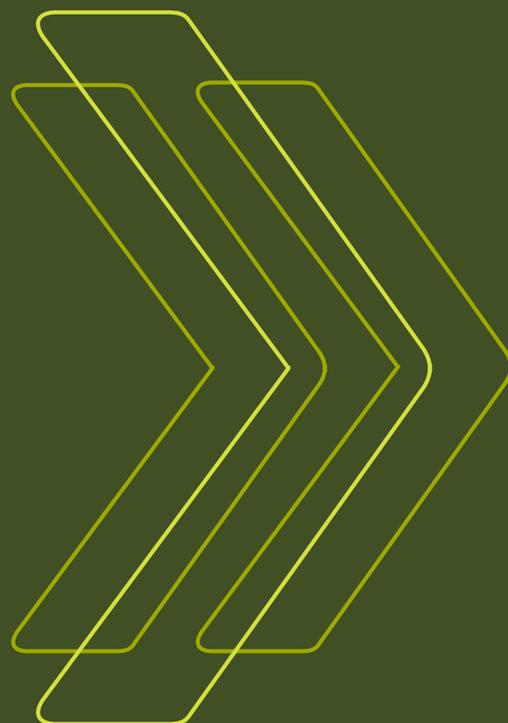
The chief executive's tale

Views from the front line of the NHS

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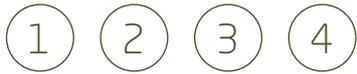
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Contents

	Foreword	3
1	Introduction	6
2	Overview	8
	Beware a 'better yesterday'...	9
	The NHS is not a single organisation...	10
	And, of course, it is the cash...	10
	But more importantly the system...	12
	And above all the regulation...	12
	Which has produced a loss of support...	16
	And an interesting reaction...	17
	And other unintended losses...	18
	To whom do chief executives feel accountable?	20
	And to whom do they look for support... and how do they cope?	20
	And are they confident that there is a strong pipeline of successors?	21
	So what's it like being a chief executive?	23
3	In their own words: the interviewees	25
	Angela Pedder	25



Ben Gowland	30
Catherine Beardshaw	33
Edward Colgan	37
John Pelly	41
Sir Jonathan Michael	45
Karen Dowman	50
Keith McNeil	54
Mark Newbold	60
Sir Robert Naylor	64
Steve Shrubbs	70
Tim Smart	74
4 A leadership and organisational development perspective	78
References	83
About the author	84



Foreword

It was the best of times, it was the worst of times.

Charles Dickens' memorable words from *A tale of two cities* echo down the years and offer an apposite, albeit incomplete, epitome of the story, or stories, that will unfold in the pages that follow. The King's Fund and NHS Providers are indebted to Nicholas Timmins for eagerly accepting our challenge of talking to a small number of chief executives to capture their reflections on life as a chief executive, most of them at or towards the end of their career in the NHS. We are equally indebted to the chief executives who responded positively to our invitation to take part and to share their experiences – as far as possible in their own words and on the record – with a wider audience.

The sense of possibility in being a chief executive within the NHS is palpable in the stories that Nick has recorded. The ability to make a difference to people and patients through the leadership of often large and complex organisations such as hospitals is a key driver of the experience of the chief executives who took part. From this perspective, being a chief executive can properly be described as 'the best of times', giving a feeling of achievement and fulfilment that would be difficult to realise in most other leadership roles, as those who had experience of these other roles readily testified.

The sense of pressure and constraint, in some cases bordering on bullying, is also palpable. Without exception, those who took part described an NHS in which autonomy was increasingly circumscribed, and regulation ever present. A number of the chief executives whom Nick interviewed left their post as a result of critical reports by the regulators, specifically the Care Quality Commission and Monitor. Some of those who left did so in circumstances in which they were put under so much pressure by the regulators that being a chief executive came to feel like 'the worst of times'.

The high personal cost for these individuals is hard to exaggerate. The cost to the NHS of the loss of experienced leaders is in some ways even higher at a time of growing concern about vacancies in top leadership positions. With the NHS in



England facing financial and performance challenges that are arguably greater than at any time in its history, there is an urgent need to find better ways of supporting leaders who get into difficulty rather than replacing them *pour encourager les autres*. Many of the support systems that used to exist are no longer available, and today's chief executives operate in a more isolated and sometimes hostile environment than in the past.

This matters for a number of reasons, most obviously in deterring the next generation of top leaders from putting themselves forward for chief executive roles. This is one of the reasons why both NHS Providers and The King's Fund are offering support to leaders. We are also working with NHS Improvement under its new leadership to bring about the changes needed to enable leaders to thrive in difficult times.

We strongly endorse the views of Ed Smith, chair of NHS Improvement, on the pernicious impact of 'firing squads' who sack chief executives and chairs when things go wrong (Ham 2016). Like Ed, we believe that 'regulated trust' is much less effective than 'real trust', which is based on a belief that leaders have a strong intrinsic motivation to perform to the best of their abilities. Real trust is not fostered through a reliance on rules but rather through positive organisational cultures that encourage calculated risk-taking and avoid blame.

These cultures support people to act in a way that is trustworthy and to do the right thing. They encourage behaviours and instincts that enable people to behave with integrity at all times. Positive cultures take time to develop and require sustained effort by leaders and followers at all levels. Rules and regulations designed to increase trust all too often have the opposite effect, resulting in over-reliance on compliance rather than the nurturing of commitment. Real trust cannot be mandated and emerges through the actions of leaders who create the conditions in which people are supported to be effective.

Dickens' passage in *A tale of two cities* continues with words that are less well remembered, namely: '...it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair.'

The NHS now needs to value wisdom, belief, light and hope to counter the forces of foolishness, incredulity, darkness and despair that are gathering at the gates.



We hope that those who read this report will see it as a wake-up call to change the culture in which talented people are ground down, however well intentioned the regulators and performance managers may be. Good leaders do not thrive when, as Don Berwick put it in his review of patient safety ([Department of Health 2013](#)), there is a culture of fear that creates risk aversion and inhibits creativity and innovation. The culture of fear needs to be replaced, and rapidly, if the NHS and its leaders are to rise to the challenges with which they are faced.

Chris Ham,
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1 Introduction

What follows is the product of two organisations having the same idea. In late 2015 it turned out that both The King's Fund and NHS Providers had decided to seek to interview a clutch of recently departed, or soon to be departed, NHS chief executives, plus a few who were simply changing jobs within health care.

The motivation was the continuing perception that there is 'a crisis of leadership' within the NHS.

Surveys over the past 18 months suggest that the mean tenure of an NHS provider chief executive is just three years, and possibly less ([NHS Providers 2016](#); Barnes 2015; [Health Service Journal 2015](#); [Janjua 2014](#)). Significant numbers of chief executive posts are vacant or are currently filled by interims. There is a view that it is becoming more difficult to recruit directors – whether clinical, financial or operational – and in turn that it is becoming more difficult to persuade people to step up from director posts to become chief executives. All that, plus the unquestionable fact that, in 2015, a number of the longest-serving chief executives – people who have held the job in one form or another for 20 years and more (Sir Robert Naylor, Karen Dowman, Angela Pedder, Steve Shrubbs and Sir Jonathan Michael to name but five) – were all shortly to retire from their current posts.

It seemed important to give such people a voice, and by interviewing a dozen of them to give them, so to speak, a form of collective voice – not that they all hold, by any means, the same views about everything.

Both The King's Fund and NHS Providers had started doing the interviews and, while we were asking slightly different questions, there was sufficient overlap for it to make sense to merge the two. So some of the interviews reported here were conducted by Sivakumar Anandaciva of NHS Providers, the majority by Nick Timmins.

Our essential recommendation would be to read the interviews. They are the key part of this report. They are full of wit and wisdom. They explain why people want to become chief executives – partly to be the boss, of course, but also to be able to influence health care for the good for large numbers of people, not just individual



patients, a point particularly made by those who started out as clinicians. They tell of the dark side and the bright side of being an NHS chief executive. They contain lessons learned and much else. And from these interviews readers will, inevitably, draw their own conclusions and quite possibly different ones from those outlined in the next section.

It should be understood that each interview is the product of at least an hour-long conversation. The transcripts typically ran to between 9,000 and 10,000 words. So they have been heavily edited to the point where only around 20 per cent of those words survive in the transcripts in order to produce a document of manageable length.

We have deliberately tried to keep the conversational tone – these are, after all, the chief executives' tales. And we have sought to edit them to bring out common themes while avoiding excessive repetition.

So, for example, it was notable how many of the interviewees, when asked to whom they felt accountable, instantly volunteered 'the patients' – way ahead of them then spelling out their formal accountability to their chair or their board or their commissioners or their regulator or the Public Accounts Committee. But to avoid repetition we haven't highlighted this in every interview.

Nor have we reflected every common theme in each of the transcripts. What we have tried to do is draw out the common themes in the overview section, which on occasions includes quotes that are not in the transcripts.



2 Overview

It is important to state that this report doesn't present the views of a scientifically selected sample of chief executives across the NHS. Rather, it presents the views of a dozen who were generous enough, or in some cases brave enough, to agree to interviews and then find the time for them. To all of them we are immensely grateful.

It is also not a piece of balanced reporting. Various organisations – the regulators, NHS England and some clinical commissioning groups – come under fire here. They will doubtless have their own views on the merit, or otherwise, of some of what is related. They have not, however, been approached to give their side of the story because that was not the object of the exercise.

The object was to give a voice to a dozen NHS chief executives about what the job is like now, how it compares to the past, how they cope and coped, to whom they feel or felt accountable, how far they feel there is a pipeline of successors to follow them, and so on. But it remains *a* voice, not *the* voice, and with the regulators' voice missing.

Those qualifications aside, this report does have the advantage that the dozen interviewees represent a fair spectrum of NHS care, from teaching hospitals to district general hospitals, from community to mental health services, from providers (including in one case a GP provider) to commissioners. They include clinicians who became chief executives and people who started out as general management trainees – plus some who did both – and some who came to the NHS from a non-health private sector background. And most were in a position to be free, or relatively free, about their views, because they did not have to worry about their next appointment.

Take, for example, Karen Dowman's story. A few months back she binned, as a waste of time, half a dozen emails from higher up the 'food chain', while conceding that five or ten years ago, when younger in the job, she might not have felt able to. Or Keith McNeil's assault over being at the wrong end of a Care Quality Commission (CQC) inspection, in an organisation whose own self-diagnosis was that it required improvement but which did not believe itself – and does not believe itself – to be



‘inadequate’. Or Catherine Beardshaw’s anger at being in a meeting with half a dozen people on her side of the table while there were 38 on the other side, hammering her about her hospital’s performance. And so on.

So what emerges?

Beware a ‘better yesterday’...

Well, first of all it is worth stating that both the interviewers and interviewees were keen to guard against ‘a better yesterday’ even if some readers may judge that we have fallen into that trap.

Guarding against ‘a better yesterday’ was deliberately raised in the course of many of the interviews and some of the interviewees have been around long enough to remember as far back as 1987. This was a time when the NHS was in so much debt to its suppliers that it was technically bankrupt, when it closed 4,000 beds almost overnight and when it cancelled countless operations, with fatal consequences in some instances. It was that crisis that led to the then Conservative government’s review of the NHS, which in turn led to the original purchaser/provider split.

In the early 1990s, the average tenure of an NHS chief executive was little more than two years. The interviewees talked about bullying – occasionally in those terms but more often by implication. Like the financial situation, this is an issue that has come and gone over the years. Back in 1992, Duncan Nichol, then Chief Executive of the NHS, felt the need to go public to demand an end to ‘macho management’ as people were being told to instantly ‘clear their desks’, either by the new breed of chairs of the early-wave NHS trusts or by the people who had been general managers but who had all suddenly restyled themselves as chief executives.

Many of the interviewees remembered the late 1990s when money was immensely tight, as it is now, although for a shorter period than now. This was a time when, on some pretty reliable estimates, some 500 patients a year were dying while on cardiac waiting lists. Times may be tough at present. Waiting time targets may be being missed left, right and centre. But nothing like that, as yet, is currently happening, although it may come to that.



Then again, in the mid-2000s, times were far from easy as the service had to bring its budget back into balance because it had – quite remarkably – managed to overspend despite record levels of real-terms growth.

Furthermore – and the inclusion of this is perhaps justifiable both to keep a sense of proportion and because this is partly a deliberate trip down memory lane – the author remembers going to the Freeman Hospital in Newcastle to talk to Leonard Fenwick and Chris Spry about good things that were happening there in the late 1980s. They told him all about them. But out to dinner afterwards, Chris Spry explained that money was so tight that he was on the brink of having to make decisions that he could not stomach. And that he might, therefore, leave the NHS. Times did indeed get better. On and off, and then on and off again. Chris stayed to become head of the South West Thames region and then Chief Executive of the Greater Glasgow Health Board, while mentoring a huge number of up-and-coming managers, including clinical managers. Sir Leonard is still there as Chief Executive of Newcastle upon Tyne Hospitals NHS Foundation Trust. So ‘beware a better yesterday’.

The NHS is not a single organisation...

It is also worth noting a well-known fact that is rarely acknowledged in the public discourse – that the NHS is not one organisation but many hundreds of organisations when all the commissioners and providers are counted in. Each has its own history, culture and local circumstances. So we asked the interviewees a number of questions about relations with local authorities, with the media and with Members of Parliament (MPs) and the answers were hugely varied – some grim relationships, some good or even excellent ones and sometimes variation within the same patch where a chief executive was dealing with more than one local authority or MP. Nothing much by way of common themes emerged. And even where, as set out below, common themes did emerge, there was rarely total unanimity. For example, when asked about support for chief executives, while one thought that it was better than in the past, most felt the opposite. And on most issues someone disagreed or had a slightly different take.

And, of course, it is the cash...

What did emerge from the interviews is that the job right now is clearly tough. At the root of that, as Bill Clinton might have put it, is ‘the money, stupid’.



The NHS is going through by far the longest period of restrained growth in its history. Since 2010, and allowing for population growth, spending per head has risen by 0.1 per cent per annum and is currently projected to remain at that level all the way to 2021 (Lafond et al 2016). Spending as a share of the nation's income will have fallen to 6.6 of gross domestic product (GDP) by 2021, from a high of 8.8 per cent in 2009 back almost to the 6.3 per cent being spent in 2000 (Appleby 2016).

The current lack of growth money, the provider deficits and the huge cuts to social care funding framed many of the conversations during the interviews, perhaps inevitably.

As Karen Dowman of Black Country Partnership NHS Foundation Trust put it:

Nationally I don't think there is any acceptance, by any politician, of just how bad things are. We will have gone from spending at roughly the European average in terms of GDP to what will soon be 6 per cent. And that has happened very rapidly... there has been the destruction of local government, particularly social care... we are left holding the baby in the NHS and there is no acceptance nationally of that at all. We are still expected to make more savings...

Yet while the money framed all these conversations, it was far from the prime cause of complaint. As Steve Shrubbs put it:

It clearly... impacts on care and is very challenging. [But] I've been a chief executive for nearly 20 years and this is the third recession I've lived through. So coping with lack of resources is not something that I would put at the top of the list of things I don't like about the job, because that comes with the territory and can often drive innovation.

Rather, it is the way the money interacts with much else. Sir Jonathan Michael of Oxford University Hospitals NHS Trust said:

Most of the levers that we used to use to balance the triumvirate of finances, quality and operational performance have gone. You could increase waits to help manage the finance, or slightly alter things on quality. But each of them has been nailed to the floor by regulation or legislation so the job is inherently more difficult. There are a number of chief execs who have left on grounds of ill health and stress and so on and so forth, which says quite a lot, and I think that's worrying.



But more importantly the system...

There was barely a good word said during the interviews about the 2013 reorganisation of health and social care, though there were some. Greater clinical involvement in commissioning won some praise. A few acknowledged the intent behind health and wellbeing boards and local government's greater involvement in public health. But more generally the adjectives used about the 2013 changes were 'disastrous' and 'catastrophic'. Tim Smart, former Chief Executive of King's College Hospital NHS Foundation Trust, declared: 'I think the system was broken by the 2012 [Health and Social Care] Act. And that's a real shame.'

With that went the grim acknowledgement by many interviewees that the present Conservative government was so burned in coalition by the experience of Andrew Lansley's 2012 Act that it is not going to legislate to change things; that somehow the NHS is going to have to work around what is there to make a reality of the *NHS five year forward view* (Forward View) (NHS England *et al* 2014) – a document that received a pretty near universal welcome, even as the chief executives who were interviewed said that making a reality of it would be a huge struggle and challenge.

And above all the regulation...

It is the enhanced role of regulation, and its concomitant information demands, that were the prime source of complaint among the interviewees. That manifests itself in many ways. Jonathan Michael again:

One of the frustrations particularly recently has been the lack of understanding that health care is an inherently risky business but there has been this drive from regulators and politicians to somehow present it as something that ideally ought to be risk free.

Being alive is risky... being treated is risky... but equally not being treated is inherently risky... the drive politically and publicly to say the ideal model is risk free is generating a degree of pressure on clinicians, on organisations, and therefore on the chief executive...



If you are going to be doing things in a different way, innovating, trying things out, you have to have some appetite for risk. If you have no appetite for risk, you are paralysed by fear of doing something different and, of course, the regulatory framework doesn't really encourage people to take risk. The regulatory framework does feel much more intrusive and oppressive than when I came in.

All of the interviewees recognised that inspection and regulation are these days inevitable in a tax-funded, publicly accountable, service. As Angela Pedder of the Royal Devon and Exeter NHS Foundation Trust put it, no one is saying 'go away and leave us alone'. It is the scale, intensity and overlap that drives people up the wall. There were few complaints from the interviewees about Monitor in its earlier days, despite some of these chief executives saying that during their foundation trust applications they initially lived in fear of Bill Moyes, Monitor's then chair and chief executive – while then conceding that in practice the process felt both rigorous and fair.

But there was an overwhelming sense from the foundation trust chief executives that their freedoms have been repeatedly chipped away as the money has got tighter. Sir Robert Naylor of University College London Hospitals NHS Foundation Trust said that those freedoms have 'pretty much entirely disappeared. I think there's still some benefit in being a foundation trust as compared to being a more directly managed unit. But it's been very, very severely eroded.' Comparing the days when Tony Blair and Alan Milburn were trying to put foundation trusts genuinely at arm's length, and the current obsession with almost daily inquiries about four-hour trolley waits and other political targets, he said that 'the micro-management has gone from one extreme to the other'.

John Pelly, who headed Moorfields Eye Hospital NHS Foundation Trust, said of foundation trusts: 'I could see that at some point in the future they will go the same way that the old-style NHS trusts went – everybody became an NHS trust in the end and most of the freedoms associated with them dissipated. I see that as unfortunate.'

But it is much more than just a question of foundation trust freedoms. It is a broader picture involving the CQC, the Trust Development Authority (now merged with Monitor into NHS Improvement), NHS England, the other commissioners and Health Education England, and their interactions.



The NHS in England now has 15 years' experience of inspection and its nature has changed over the years. It is perhaps worth observing that inspection is in fact a by-product and – in its scale and scope – perhaps an unintended by-product of purchaser/provider splits or their equivalent. This applies across much of the public sector, not just in the NHS – in schools, in social care, in criminal justice and elsewhere. When services were more directly managed, ministers and civil servants could believe – on occasions demonstrably erroneously – that they somehow 'knew' what was going on in the world for which they were responsible. Or at least that they ought to. The separation of provision from commissioning shredded that illusion and led to the rise of the inspectorates as a way of telling ministers and indeed the public what was happening. Thus, the original Ofsted for schools was followed by the Commission for Health Improvement (now the CQC), by national social care inspection, by enhanced prison and probation inspection, by the transformation of the Audit Commission into a local government inspectorate (now gone in the name of 'localism') and by a parallel rise for rather different reasons in the inspection of universities via the Quality Assurance Agency for Higher Education and other agencies.

The NHS, in particular, has seen the rise of the regulators in the wake of the Mid-Staffordshire and Francis inquiries, the enhanced role for Monitor and the creation of the Trust Development Authority (the two now merged) and of a statutorily independent NHS England. Well intentioned though all this is, it has clearly not been problem free, certainly for those who sit in the chief executive's chair. Take Keith McNeil's vehement view – having ended up on the wrong end of a CQC inspection at Cambridge University Hospitals NHS Foundation Trust – that the CQC has placed process above outcomes. Or Angela Pedder's take that we seem to have 'moved to a place where it feels like people think you can inspect quality and safety into a service and I don't fundamentally believe you can do that' – which is itself a partial reflection of Jonathan Michael's view quoted earlier.

Some interviewees specifically said that they had no complaint about their own CQC inspection. But others felt that the scale of it was out of control and indeed one or two with no complaints said they knew colleagues who had 'horrendous' experiences.



With the growth of regulation has come a renewed growth in information demands. This is, of course, a far from entirely new preoccupation. Take one relatively recent example: three years ago, as the 2013 reorganisation of health and social care was taking effect, the Nuffield Trust undertook a similar exercise to this, interviewing a dozen departing chief executives, or their equivalents. As Brian James, chief executive of Rotherham NHS Foundation Trust put it then:

The bureaucracy includes the targets and all the reporting up the line of endless key performance indicators. The micro-management from the centre. The huge number of regulators and the amount of information they demand, often the same information in different forms, and the massive amount of money being spent to feed that beast.

(Timmins 2013, pp 35-6)

But these days too, as Karen Dowman reflected:

When you have a number of different commissioners all wanting the same information in slightly different ways and then the various national tiers – CQC, Monitor, the TDA [Trust Development Authority], NHS England – the regulation and the information demands have got overbearing. A disgraceful waste of money. We are in constrained times financially, and I am sure we could lose 20 posts if it wasn't for this endless different tweaks of information for different things.

Angela Pedder said: 'Quite a lot of the job is holding up an umbrella to keep the stuff that's coming down from up high away from the people that need to do the really good work day to day with the patients.'

But it is not just about information. It is the failure to co-ordinate, despite the efforts of those in charge to change that, and the time that takes from the day job of endlessly seeking to improve services. Take the view of Mark Newbold of his time at the Heart of England NHS Foundation Trust when differing problems from the same root cause arose and the differing regulators and commissioners all demanded action. He said: 'It felt like you were tied to a tree, and each time they just went around with the rope another time, so you were getting more and more tied down. It was all terribly counterproductive and fruitless, not helping patients at all.'

Keith McNeil summarised these interactions in one word: 'Kafkaesque'



Which has produced a loss of support...

No one expects an inspector, or regulator or commissioner to be their closest friend. But the hostility experienced by some of the interviewees – and the scale of regulation – have taken some experienced chief executives aback. Catherine Beardshaw, of Aintree University Hospitals NHS Foundation Trust, described attending a ‘quality summit’ at which

I remember sitting on one side of a table with six or seven of my team to talk about improving A&E [accident and emergency] performance, strengthening our quality strategy and reducing our avoidable mortality and there were 38 people from other agencies sitting opposite demanding ‘where, why, how’, each of them marking our homework. Thirty-eight of them! From Monitor, from the commissioners, from the NHS England region, from CQC, Healthwatch and so on and I remember thinking: ‘What the “f” is this all about?’ It made me so angry. We managed it by being very open, saying: ‘Come and work with us.’ But I was spitting feathers. The support and the experience was not out there.

The ‘experience’ in that quote, as came out in some of the other interviews, includes an understanding by the supervisory machinery of actually running services and thus of some of the inevitable trade-offs in large, complex organisations such as a decent-sized NHS trust.

So, take Mark Newbold’s thoughts on a ‘risk summit’ called by NHS England

about all the same issues already being handled by CQC and Monitor, with everyone there – NHS England, Monitor, CQC, Health Education England. It was the worst moment, I think, in my professional career. It was like a ritual humiliation and bullying session. And the tone of it was as if they thought that we were somehow not sufficiently concerned about the problems, not trying hard enough to sort them, when here was a highly experienced and deeply committed executive team and board that was living and breathing these issues. We all came out deflated and offended by the attitude taken towards us.



They [the regulatory bodies and NHS England] were all duplicating each other. And they were all nervous, I think, that this was a very big trust, one of the busiest in the country, and it is as if they didn't want to be the one that missed a new problem. So they're all over you. There was a real sense of being constrained the whole time – not able to get on with the job really.

Or as Karen Dowman put it: 'On the one hand they want us to be independent and free and innovative and the next moment they want to control our every waking moment. They can't have it both ways.'

And an interesting reaction...

Nigel Edwards, now chief executive of the Nuffield Trust, used to joke that the only two things guaranteed to survive nuclear war were cockroaches and regional health authorities. But they, or more precisely their equivalent – strategic health authorities – did in fact disappear as part of the 2013 health and social care changes.

Strategic health authorities were not, of course, universally loved. Even their strongest advocates would concede that they varied in quality and effectiveness. And some at least do not regret their passing. John Pelly, for example, said that he wanted to head a foundation trust 'to get away from the absurdities of some of the decision-making at the SHA [strategic health authority]'. Others recalled behaviour by strategic health authorities of which they disapproved – back to the bullying culture.

But the sense that something serious has gone missing with the loss of an intermediate tier is strong. Tim Smart, despite having a private sector background that you might think would make him keenest about running an entirely independent show, was specific: 'The really, really bad thing it [the 2013 reorganisation] did in my estimation is that it dissolved the strategic health authorities.'

Edward Colgan of Somerset Partnership NHS Foundation Trust said that the strategic health authority 'has been replaced with a whole myriad of organisations and committees and groups, which are very difficult at times to navigate your way around.'



Catherine Beardshaw reflected:

I think we've lost something, certainly in geographic areas where there is a lot of competition. Liverpool is a classic. Nine trusts in a small city. It is madness. And the competition between the different elements, not only for business, but kudos and status, is huge. It is very divisive. There is no one with the experience to hold the ring around a reorganisation in the way the SHA could. Not all the SHAs were great. But the good ones could do that.

Angela Pedder said:

It is clear the national leaders of the NHS system are committed to limit the impact of the multiple silos of regulation we have. People are trying very hard to work, in the absence of a controlling mind, to create coherence. But we are not there yet. And the path to get there is not clear. At the moment it is a bit like one of those Escher pictures where everybody seems to be marching in one direction but actually they are going nowhere fast. My hope is the establishment of NHS Improvement and its ability to work effectively alongside NHS England will help.

Or Karen Dowman again:

SHAs, for all their faults, still looked at things in the round, they still looked at the service delivery, they still looked at the population needs of a patch. But with NHS England and all the regulators, they all have their own roles, and there are all these conflicting messages, and there has been no one in charge for years now.

Which, at least in the view of these interviewees, makes implementing the Forward View harder, for all its welcome messages about local initiative and differing solutions in different places. As one interviewee agreed when it was put to them: 'You can't, these days, draw an organogram of the NHS, or at least not one that tells you how it actually works.'

And other unintended losses...

Strictly speaking, one might not need an intermediate tier to do this. But it was notable how many of the longer-lived chief executives we interviewed came up through various forms of the graduate training scheme and a regional or area



structure. Not all, but many of them, remember that shaping their career, having it overseen and facilitated, with the result that many of them by quite a young age had worked, often for short spells, in many parts of the NHS – from hotel services, to mental health, to community services, at an area or region or in the Department [of Health], or in commissioning, as well as in the acute sector.

Angela Pedder said that this made them

rounded... which meant when you were working with other organisations and across sectors you had a better, more direct understanding of the issues. I was never as expert as they were in their particular sector, but it meant that when you were talking about how a service should change you could go beyond the concept to thinking with others about some of the linked actions that need to be taken, and what needed to be aligned to deliver the system change required.

We have lost the sense of need for our managers and future leaders to have a broad knowledge base. Even within the hospital sector we do not enable people to have a breadth of experience in the same way now. We appoint people into managerial roles, or clinicians in managerial roles, in defined areas, and very few will move from that into hotel services or planning and strategy. Even fewer people will move between sectors so the potential to develop whole-system knowledge and skills is very limited. So you have people coming through into very senior roles that may have only worked in one sector, and siloed within that.

Sir Robert Naylor, who like several other interviewees listed ‘a particular interest in leadership development’ as a key part of his role, asked:

Is there less support for people on the way up than when I started? Yes, undoubtedly. I was a graduate trainee and my first mentor was a guy called Ken Lewis. He was very inspirational and a hard task master but he took a real interest in my development. And there was a guy called Ray Lawrence, the regional staffing officer, whose job was to spot talent and steer the most promising through their career.



So I'd get a call from Ray to say: 'There's a piece of work that needs doing over there for six months and I suggest you go and do it'. So I spent some time in a mental health trust and in community services and in the Department of Health so that by my mid-twenties or so I'd got experience of pretty much every aspect of the NHS.

Little of that exists today. It is much more serendipitous. If you are fortunate enough you might get a good mentor and the right sort of support, but lots of talented people lose their way and get frustrated.

To whom do chief executives feel accountable?

Aside, as already noted, from the number who first volunteered 'patients' as those they feel accountable to, it is clear that the relationship with the board chair is crucial. As Sir Robert Naylor neatly put it: 'The best chairman you have ever had is your current chairman! If you don't have a good relationship you have a real problem.' There was plenty in the interviews about the relationship with chairs – and how chief executives and chairs have to adapt to each other.

And to whom do they look for support... and how do they cope?

That varied appreciably, sometimes by sector. The teaching hospital chief executives all mentioned the Shelford Group. On the basis of these interviews, mental health chief executives appear to have a strong network. It is absolutely clear that having other chief executives to talk to when under pressure really matters – whether that is through a formal, informal or build-it-yourself network. 'Find the people who will tell you when you are being irrational,' as Angela Pedder put it.

Several interviewees when reflecting on bad times – a lousy rating from CQC or other assorted crises – stressed family and friends, even 'the cats, the dogs, the hens... they help you keep a sense of perspective'. Or as another put it: 'I just got up earlier in the morning and ran further... and I played the guitar more.'

One talked of the 'dark days' when their hospital was under scrutiny for its hospital standardised mortality ratios and for other parts of its performance:



And they said we were killing people, and this, that and the other – which was a load of nonsense but we had to go through all the mechanisms to prove that – I found all that really hard. And I nearly gave up. It was just knacker. I thought about retiring early. And I didn't. This may sound slightly noble, but I thought: 'I will not leave this trust at this moment.' There was something about not wanting to let people down. I wanted it all sorted. And there was something about leaving at the top...

Not everyone gets through, however. Several of the interviewees said that they knew of people who had suffered 'horrendous' experiences at the hands of regulators, or who had quit, or for whom the stress had led to early retirement. Two of those we approached to take part in this study declined because the experience of leaving when they didn't want to, or in effect of being sacked, was too raw.

Almost all said that not only has early career guidance either been diluted or gone missing but also that there should be more support not just for newly appointed chief executives but also for chief executives generally. As Steve Shrubbs put it: 'We need to apply the same supportive values to CEOs [chief executive officers] that we seek to apply to the rest of the staff.'

And are they confident that there is a strong pipeline of successors?

Not very, might be the best way to sum that up. It is not that they don't think the talent is out there but they worry for a range of reasons. One is the public portrayal of chief executives. They are too often seen as 'the cause of the problem rather than the solution,' as Sir Robert Naylor put it. Again, this not entirely new. Back in 2013 in the Nuffield Trust interviews, Robert Creighton, chief executive of the then Ealing Primary Care Trust, lamented that 'we have gone the way of estate agents and politicians themselves in terms of public esteem' (Timmins 2013, p 5) – the charge being, as Andrew Lansley was arguing for clinical commissioning, that managers and chief executives were merely 'pen pushers.'



Today, the charge is similar if somewhat different. And even since 2013 there has been the further rise of social media. Sir Robert Naylor said:

If I do something this afternoon that is significant, it will be on social media later this afternoon and that was never the case when I came into the health service.

So it's a much more exposed position to be in, and hence it's probably not surprising that it is a more vulnerable job. And that is why a lot of people nowadays are reluctant to move beyond the middle management tier into the chief executive level – hence why we've had so much difficulty recently in filling the chief executive posts.

Steve Shrubbs challenged the way politicians have taken to presenting chief executives

as being dishonest, or incompetent, or being only motivated by our own interests. We are increasingly portrayed as greedy fat cats who would do anything to save their butts. We are much more public property with the social media stuff. And I've had some experience of that where the press attacked me and the organisation, and because of social media that's actually affected my wife and children. I can understand why a number of younger executive directors wouldn't want to put themselves in that position.

There is a strong desire to see more clinical involvement in management at all levels, including as chief executives. Keith McNeil said:

There are good people around, for sure. But I think you'll find that the prospect of senior clinical people putting their hands up to do this will become vanishingly rare. When you have 90 per cent of hospitals in deficit it is difficult to get clinicians to volunteer for that. It is already hard to get people to step up as divisional directors and clinical directors, because it is a job that is really difficult in the current climate. If you are a clinician you can turn up, do your job, and get your pension. And in times like this you think: 'Cripes, that's not a bad option really.' But we need clinicians to step into leadership roles at a whole lot of levels in the system. They determine where all the money is spent, and if they disengage you can spiral out of control very quickly. However, once you unleash their ingenuity, they'll deliver for you time and time and time again, because they are the rocket scientists. They know how to build and run the rocket ship.



Tim Smart felt that the chief executive of an organisation like King's College Hospital NHS Foundation Trust ought to be a clinician. But a London strategic health authority programme for 'next-generation' chief executives, including clinicians, got scrapped as the money got tighter. 'It didn't cost much, and it has gone,' he said.

Angela Pedder said:

People do see some behaviours out there that don't encourage them to take the step up... I don't want to say bullying because bullying is a very strong word – but on occasion people experience some unacceptable behaviour and don't necessarily think that's something they want to devote their life to.

She stated that such behaviour has come and gone over the years, 'but it feels quite high at the moment'. There is 'a cautionary note' around all that, she said.

And there is the loss of the old guided career path outlined earlier. With less of that available, Sir Robert Naylor said, people get frustrated and

they either go off and do something else or get two-thirds of the way up the ladder and say: 'I'm being paid a decent salary; do I really want to spend 24/7, with all that exposure, being a chief executive?' Work-life balance is much more important now than it was in my day, and middle management jobs are relatively better paid.

Others made a very similar point.

So what's it like being a chief executive?

Several remarked upon the loneliness of the job, that suddenly the buck stops with you. 'I am not sure anything can really prepare you for what it's like to be a chief executive,' Ben Gowland said. 'It is so different from being a director.'

Being a chief executive was nonetheless a job Ben enjoyed when heading what was in effect a non-statutory commissioning and providing organisation in primary care. After something over two years spent as the chief executive of a clinical commissioning group, however, he left in frustration:



I used to spend all my time in meetings, literally, and that is the experience of many chief executives, and I just didn't feel that they were making things happen. And I felt the best place to do that was from outside the NHS rather than in one of the statutory roles.

So there is plenty of shade here. Being a chief executive is a job that:

- feels much more exposed than it used to be
- is hugely pressured at times – the more so currently because of financial constraints
- is a struggle, in the current regulatory and commissioning system, and in the current state of social care, to achieve the changes that everyone accepts are needed, and needed urgently
- can expose those in the role to what some describe as 'unacceptable behaviour', and others describe more bluntly as bullying.

But there is also plenty of light.

As all the interviewees stressed, it is a job that offers the opportunity to improve health care both for the individual patient but, more powerfully, for huge numbers of patients – a point particularly made by the clinicians who had moved from treating individual patients into a broader role.

Asked about the job overall as opposed to its problems, the adjectives most used were 'fantastic', 'a huge pleasure', 'the best job on the earth [on its good days]' and 'rewarding' – with, notably, those who came from the non-health private sector, also saying that it was the most rewarding thing they had done. John Pelly described it as 'a huge privilege for the most part, huge pleasure and reward', while Tim Smart said: 'I have never done anything more rewarding and enjoyable in my life... even compared to running a pretty big part of BT.'

'No regrets' was the repeated theme, even from those who found themselves leaving a post when they would rather have stayed. 'The best [job] I ever had,' as Keith McNeil put it.



3 In their own words: the interviewees

Angela Pedder



Angela Pedder is Chief Executive of the Royal Devon and Exeter NHS Foundation Trust. She started work in the NHS at the age of 18 as a management trainee in the North West Thames Regional Health Authority. She worked in acute hospitals, mental health, learning disabilities, community services, commissioning and human resources. She got her first chief executive equivalent post as unit general manager for community services in North Hertfordshire in 1987 at the age of 29. In 1991 she became Chief Executive of St Albans and Hemel Hempstead NHS Trust, leading a major programme of service rationalisation while eliminating a significant financial deficit. In 1996 she became Chief Executive of the Royal Devon and Exeter, which in 2004 became one of the first 10 foundation trusts. She is a member of the Secretary of State's National Stakeholders Forum and in 2007 was made an OBE in the New Year's Honours list.

What has changed about being a chief executive? Well, I think the honest response is that it is harder. It is hard at multiple levels. There's the biggest financial challenge that I've seen in 40 years. There have been short periods of time in the past when it's been really tough, but not for the sustained period that we are now experiencing. And we've always had silos. But not as many as we currently have and that makes things overly complicated.

I started on the training scheme in 1975 and of course we had a very different structure then [regions, areas and districts and no purchaser/provider split]. And, to take just the hospital sector, you spent part of your time almost learning how a hospital worked right from the bottom up. So you needed managing hotel services on your CV. And the training scheme, and the region I worked in after the scheme, moved you around to build a broad base of experience. As a consequence, the



system and individuals were more willing to place and support candidates with potential in challenging roles, and offer support when it got tough. So I worked in acute, in learning disabilities, community services, mental health services – not necessarily for a long time in each of them – and I was a director of HR [human resources] for a while for a large district health authority, which gave you contact with the regional structure. Now my career may have been broader than most. But quite a few people I know went through a similar experience. So we were encouraged to be more rounded as our careers progressed, which meant when you were working with other organisations and across sectors you had a better, more direct understanding of the issues. I was never as expert as they were in their particular sector. But it meant that when you were talking about how a service should change you could go beyond the concept to thinking with others about some of the linked actions that need[ed] to be taken, and what needed to be aligned to deliver the system change required.

We have lost the sense of need for our managers and future leaders to have a broad knowledge base. Even within the hospital sector we do not enable people to have a breadth of experience in the same way now. We appoint people into managerial roles, or clinicians in managerial roles, in defined areas, and very few will move from that into hotel services or planning and strategy. Even fewer people will move between sectors so the potential to develop whole-system knowledge and skills is very limited. So you have people coming through into very senior roles that may have only worked in one sector, and siloed within that.

But against that, the most positive change is our approach to safety, quality and performance. It is much stronger than it used to be. Certainly the questions that we ask as a norm now, as standard, about patient safety, clinical quality and patient experience, when I first came through they weren't questions you even thought you should ask. If you had asked them the clinical professions would have told you to keep your nose out, and challenging clinical performance was not encouraged within the leadership and managerial hierarchy. Now we have really effective teams. Their management attention is focused on safety, governance and learning alongside finance and performance. The triumvirate of nurse, doctor and manager – adopting a much more holistic approach to building services around the individual's needs and holding each other to account. So we are in a fundamentally different place to when I started, and that is all really positive stuff.



But I think we've culturally moved to a place where it feels like people think you can inspect quality and safety into a service and I don't fundamentally believe you can do that. To be systematic and comprehensive is important, but things can become overly complex and prescriptive as a consequence. If you can't draw a simple diagram of something to easily explain how things work together to deliver the outcomes you want then it's very unlikely to work effectively. Then overlay that approach with the people driving performance and inspection regimes who may not have first-hand experience of the trade-offs you sometimes need to make to keep the whole organisation safe. The consequence is the conversations become very transactional and potentially confrontational. That steals time from the process of developing, empowering and building the system-wide services and teams that you need to transform the offer we make to the populations we serve.

Accountability and performance management is essential, so I am not saying: 'Go away and leave us alone.' If you haven't got information you can't ask the right questions. But multiple spreadsheets that nicely balance in the right-hand corner, or a fully completed matrix confirming you have a process in place to maintain safety, or you have a sentence on every single national priority in your plan – that isn't the way to achieve the best outcomes. There is an awful lot of feeding the 'multiple beasts' when an awful lot of what we are being asked for could be asked for once from the local system. The response to the current financial situation has been additional regulation requirements and performance reporting. At one level this is understandable. But if you want creative solutions, if you want transformative solutions, a very different approach is required.

My organisation was one of the first 10 foundation trusts to be established. My chairman at the time said to me that we were moving from a position where for years it was convenient to operate in a way where we could say 'if only *they* would do something then we could...' to a future where it would be 'if *we* do this then we could...' The board was accountable. Permission didn't need to be sought from above. The environment is undoubtedly more difficult at the moment, and what we don't need in this current climate is for everybody to stop and look to see whether somebody else in the system is going to give them the answer or take responsibility. The more that you create frameworks, require closer performance management and additional returns, you're feeding a culture of dependency and the last thing we need, to get out of the challenges that we've got, is for leaders to forget that they're leaders and start becoming dependent on somebody telling them whether they can or can't do the right thing.



It is clear the national leaders of the NHS system are committed to limit the impact of the multiple silos of regulation we have. People are trying very hard to work, in the absence of a controlling mind, to create coherence. But we are not there yet. And the path to get there is not clear. At the moment it is a bit like one of those Escher pictures where everybody seems to be marching in one direction but actually they are going nowhere fast. My hope is the establishment of NHS Improvement and its ability to work effectively alongside NHS England will help.

Any system can paralyse you if you let it paralyse you. Leadership is needed most when times are tough, so you have to keep working with your board and with your team to find a way through. And like anything in life, you are negotiating the boundaries, and the job of a chief exec is to spot what needs to change for a given time. You have got to always bring yourself back from 'let's stop describing the problem or what somebody else should do to sort it' to 'what is within your gift to do?'. Stretch the boundaries and focus on that.

You asked about relationships with chairs and a support network. The relationship with your chair is really important and I've worked with some great chairs. You have to build that relationship and work out what it is to be, because they are not all the same. And you do need a sounding board. People who will tell you if they think you are going off on one, or there is another perspective you need to consider. Independent thought is critical to appropriate holding to account so it will not always be easy but should always be productive.

Are there people in the pipeline to become chief executives? I think there are some really good people out there. And in my trust over the last two years the board has been developing the leadership team, asking what skills do people need to develop, and helping with that. Not to shoehorn someone in as my potential successor but so they can be a credible candidate in a national pool. But talking to the leadership centre, I think we are quite unusual in having that overt conversation.

Roger Stokoe was my boss when I was appointed to my first chief exec role and the best advice he gave me was to just be prepared for it being the loneliest job you'll ever do. Find the people to put round you with whom you can safely touch base; the people who will tell you that you are being irrational, or whatever. This was great advice.



So there are half a dozen people that if I've got a problem I will pick up the phone and say: 'Can I just talk this through with you?' And part of how I work is really making sure that I offer to others the level of mentoring and support I received as my career developed. It doesn't have to be in a formal way, but knowing that you can pick up the phone when you have had a really bad day is important.

It's a tough environment in which to be a newly appointed chief executive. People do see some behaviours out there that don't encourage them to take the step up. There is a fine line between strong and appropriate performance management and being fairly and appropriately held to account and – I don't want to say bullying because bullying is a very strong word – but on occasion people experience some unacceptable behaviour and they don't necessarily think that's something they want to devote their life to. Perceptions about the level of poor standards of acceptable behaviour have varied over the years, but it feels quite high at the moment. You would expect it to be higher when things are most stressed, as they are currently. But we do need to be careful about behaviours – there is a cautionary note that needs to be heard if we are to encourage people into these key roles. But more importantly we should apply everything we know about the benefits of positive staff engagement and organisational culture at all levels of the service.

But at the end of the day it is a hugely rewarding and enjoyable job. And it is very, very rewarding. Forty years on I still enjoy the job. It has the potential to impact on so many people within the NHS but also in our wider society. Most of the time you work with great people who are committed to doing great things for the people most in need of support – that's why we need good people to take on these roles.

So I am positive – but positive in a sort of pragmatic way!



Ben Gowland



Ben Gowland is currently Director and Principal Consultant at Ockham Healthcare. He left his role as Chief Executive and Accountable Officer of NHS Nene Clinical Commissioning Group in 2015, after leading the organisation from its inception as a practice-based commissioning organisation through to becoming one of the largest clinical commissioning groups in England. He has also been director of an acute trust, and run national improvement programmes.

I guess the reality of becoming a chief executive was different to my expectation. When you are a junior manager you think the chief executive makes all the decisions and decides what happens.

When you are in the job you perhaps feel like there is less freedom than when you were a junior manager. And that is because of the way the NHS works. It has its priorities. And the things that it thinks are important may not be the same as those that the individual organisation thinks are its priorities. But the NHS has a way of persuading chief executives of what the priorities are. The NHS operates from the top down. But what makes sense in Whitehall rarely makes sense to the staff on the front line.

I came to be a chief executive by a slightly unusual route as I had held several hospital jobs and had worked on national improvement programmes before becoming chief executive of a practice-based commissioning organisation in Northamptonshire in 2007. Now that was a community interest company, a membership organisation for the GP practices who contributed money to do their practice-based commissioning. It was not a statutory body. It worked with the PCT [primary care trust], and when clinical commissioning groups [CCGs] came along it sort of became the CCG. And my reflection is that we were able to make more change in the community interest company than we were in the CCG as a statutory body.

We had the responsibility to make change happen and we were successful in doing that. We introduced a new end-of-life service, putting elderly care consultants working out in the community, and with more care outside hospital. When I went into the statutory body it felt hard to make those types of change happen.



The pressures on emergency care and on the finances meant that essentially is what the CCG had to focus on because they were the areas that people were struggling with in terms of national priorities. That meant that the capacity to drive other types of change that we'd had in the past wasn't there. In a sense, in the practice-based commissioning organisation we had had the protection of the PCT. We were doing commissioning for the PCT as the statutory body.

In the CCG we were exposed not just to NHS England but we had two hospitals, one regulated by the TDA and one by Monitor, both with their own individual issues. So we spent much more time managing those relationships. And they had different opinions about things.

And there was definitely a sense that the trust boards and the CCG boards were accountable for their own organisations, and that was made very clear to them by their regulators, who have their own accountabilities, and all that worked against whole-system working. Even when we tried to get into whole-system redesign with all the regulators at the table, we weren't able to negotiate a new style of contract because one of the regulators would not let it happen. So it didn't happen. Not because there was a lack of desire from local leaders to make it happen.

You ask to whom did I feel accountable? You would think the answer would be the board. But in the CCG it felt I was accountable to NHS England. Because if you ever felt your job was under threat, they would be the ones making the decision. Of course, if the board was not happy you would be in trouble. But you felt with the board you were part of a team trying to do things. You did not feel part of a team with the regulators.

Things had changed by 2015 in the sense that general practice was in a much better place in 2007 than in 2015. Recruitment issues simply didn't exist in Northamptonshire in 2007. And there was the money. It was made very clear to me that emergency care and the finances were the priorities. Health and wellbeing boards arrived and the Better Care Fund. And that did make relations with the local authority stronger. But when there is not enough money in the system you both end up arguing for your share of the money. So we spent a lot of time arguing about how the money would flow through the system. It wasn't personalities. They all worked fine. But some of the cuts the local authority was having to make year on year...



You asked about support. Well I was a management trainee between 1995 and 1997 but I guess the support I got after that was support I generated myself. There was the top leaders programme around 2004. But when I first took on a chief exec role the system didn't say: 'Right, here is a really experienced chief exec to help you,' even though John Parkes, my predecessor, was very helpful.

I am not sure anything can really prepare you for what it's like to be a chief executive. It so different from being a director. As a director you have the support of other directors and the chief executive, whereas as the chief exec you are part of that team but you can't really use that team for support. You are the team leader. And with your board you are trying to get the support of the board, not from the board. So there is no natural place to get support from inside your own organisation. So when you are then faced with making often difficult decisions about your organisation, maybe about individual directors or whatever, you need a sounding board or place to go. It depends on what type of personality you are as well. I like to talk things through. I'm not the quiet, reflective type to sit in the office and work out what needs to be done. So having a network around you is important. And I did build that, but I think I did it too late. It would be better having it in place when I started. So there is an issue about how do you support people in the first year or so? And I get a sense from people who have been around longer that in the old days the strategic health authority would have done that.

Do I think there is a strong pipeline of chief executives coming through? Well, I don't know if everyone would say this, but I don't see the same hunger in junior and middle managers now. I talked to the middle managers in my organisation about their aspirations and there is a bigger focus on work-life balance. And I think they look at chief exec and director posts, and the pressure that is put on chief executives, and they don't think it looks as attractive maybe now as it looked in the past. When I was a trainee in Manchester my mentor said: 'If you really want to move through the NHS quickly you need to go to London.' So I uprooted myself and went, and I am sure people still do that, but I don't see it as visibly now.

And I left the job because I didn't feel in that role that I was making the level of difference that I wanted to make. I loved seeing things through that made a real difference to patients. I was halfway through a 40-year career and thought: 'Do I want to do another 20 years of what I am doing now and does it really make a difference?' I used to spend all my time in meetings, literally, and that is the



experience of many chief executives, and I just didn't feel that they were making things happen. And I felt the best place to do that was from outside the NHS rather than in one of the statutory roles. I want to deal with customers and patients where we can make a difference rather than having organisational interest as the main driver, because I think the current regulatory framework creates organisational interest as the main driver for what goes on.

Catherine Beardshaw



Catherine Beardshaw trained as a radiographer in Sheffield and worked as a clinician for 20 years across South Yorkshire and North Nottinghamshire. She moved into general management in 1995 and obtained a Master of Business Administration [MBA] from Durham University. She worked at Leeds Infirmary and then Leeds Teaching Hospitals for 14 years, learning her trade as a general manager in most clinical specialties before becoming Director of Operations in 2002. She became Chief Executive of Warrington and Halton Hospitals in 2006, taking it to foundation trust status in 2009. She then moved to Aintree University Hospitals NHS Foundation Trust in Liverpool as Chief Executive Officer in 2011 before retiring in 2015 after 42 years in the NHS.

What is it like to be a chief executive in the NHS? Well it goes from absolutely fantastic – the best job on the earth – to the depths: ‘Oh my god, so what are we going to do about this?’ It is that huge a spectrum. It is the most varied, interesting, inspiring job you can do and I don't regret any of it.

I was a chief exec for nine years and I'm a great believer that the NHS is a people business, and if you don't do people well – relationships, communication, all of that stuff – then to be honest I don't think you can do the job. I also think you need to be passionate about the NHS and health care and be able to keep that passion fresh because if you don't have that passion as CEO, how can you expect anyone else to?

There were some dark points during that time without a shadow of a doubt. Some of that was about system change and the fact that we're still different tribes within the NHS – doctors, nurses, managers, commissioners, providers and so on. And that's a great shame, and maybe we need to do more in the future to learn, train



and develop together because I just don't think we do enough of this to break the tribal barriers down.

So it was great, but with some really black points. I'm lucky because I managed to survive those – personal resilience, family and stuff like that – but I know some colleagues who've not done so well, and it's not been good for them.

When I went to Warrington it was very brave of them to appoint me as an untested chief executive. It was basically a good trust with a big financial problem but the main problem was it had had six chief executives over the previous seven/eight years. And when I got there the financial problem was much bigger than they had told me and the docs were all hacked off because there had been so many chief executives coming and going for various reasons. I remember at the 'trial by buffet', the consultants were all saying: 'So what commitment are you going to give us?' And I said five years and stayed four-and-a-half. I have to say the strategic health authority was super. They said it was not a bad trust but it needed someone to get a grip and bring the team together. So we got a turnaround team in to help with the financial problems, but more than anything else we engaged with the consultants and really got things moving and we did pretty well.

And then the Aintree job came up. I'm a great believer in leaders for the right time. And the leadership for sustaining an organisation is not necessarily the same as lifting it up, giving people the confidence and taking it forward. So I suppose I was a bit fearful that I wouldn't be able to do the sustaining bit, the gradual ongoing improvement, if I'd stayed at Warrington any longer.

I'd always wanted to go back to a university teaching hospital and I loved Aintree. The humour and commitment of the staff and the local community were incredible and when you work somewhere like Liverpool and see some of the deprivation that there is around, it is a case of: 'Why shouldn't they have the best services that you can possibly provide?'

Your relationship with the chair is absolutely crucial. It is a unique relationship and it has got to be based on trust and openness. As CEO you have to have someone outside the executive team that you can have honest discussions with to work some issues through that you can't really do with anyone else. You have to watch his or her back so they are never unprepared, or exposed, but they can bring great wisdom



and a different perspective that really helps. It is a relationship that has to work. And there were a couple of examples where I went for jobs that I didn't get and looking back I am glad because I am not sure I would have got on with the chairs.

I am more ambivalent about boards as a whole. I think the move to having high-powered financial and business people sitting on boards as we moved into the foundation trust era was a mistake. You obviously need some of that experience, but we lost some of the NHS family experience, so to speak – people who understood the complexity of delivering health care and the culture of how things work. Non-execs can learn about that if they walk round and talk to people and see what really goes on. Unless they understand and get a feel for that they can't really add value. I remember sitting in meetings where the board was discussing risk assessment and thinking: 'Doctors and nurses manage a huge amount of risk every day and you [non-executive directors] probably wouldn't sleep at night if you truly understood the level of risk in hospitals that clinical staff manage routinely.' Clearly, you need strong governance arrangements but these should support people to do the right thing and not just be for their own sake.

You ask how the environment has changed. I think it has been very difficult in recent years. Two or three years ago – when we in the furore of post-Francis, and the new commissioners were trying to get a grip of things and the revamped CQC was finding its feet, all in the wake of the 2012 [Health and Social Care] Act – the grip and the control that other organisations and regulators were trying to assert over trusts was massive. We had a quality summit because a few things weren't as good as they should be and required improvement. I remember sitting on one side of a table with six or seven of my team to talk about improving A&E performance, strengthening our quality strategy and reducing our avoidable mortality and there were 38 people from other agencies sitting opposite demanding 'where, why, how', each of them marking our homework! Thirty-eight of them. From Monitor, from the commissioners, from the NHS England region, from CQC, Healthwatch and so on and I remember thinking: 'What the "f" is this all about?' It made me so angry. We managed it by being very open, saying: 'Come and work with us.' But I was spitting feathers. The support and experience was not out there. If you go back to the old SHA days in my first job in Warrington, if there was a problem I could ring up Mike Farrar [Chief Executive of the North West SHA] and even though I didn't know him very well, I could say: 'I really need some advice here.' And that support, that level of wisdom, just dissolved.



I was on the Foundation Trust Network Board and some of the trustees would say: 'Well, you don't need it – you don't need that layer above you.' But I think we've lost something, certainly in geographic areas where there's a lot of competition. Liverpool is a classic – nine trusts in a small city. It is madness. And the competition between the different elements, not only for business, but kudos and status, is huge. It is very divisive. There is no one with the experience to hold the ring around a reorganisation in the way the SHA could. Not all the SHAs were great. But the good ones could do that.

Some of the clinical changes that are needed in Liverpool have taken forever, and to be quite honest it is quite unforgiveable. The centralisation of upper gastrointestinal cancer surgery has still not happened five years later because people are quasi-independent. There has been no one to pull all that together and just say: 'Right, we are going to do it.' I just hope the commissioners have managed to do this in the year since I retired.

What else has changed? Patients and families can be much more aggressive. I've sat in complaints meetings with families and been spoken to in a way I never expected. That wouldn't have happened 10 or 15 years ago but I suppose that's partly the nature of society today and, on the plus side, it does help you understand what staff have to put up with sometimes. Chief executives also have to take more account of the wellbeing of their staff because there has been an exponential growth in busyness and pressure in hospitals. I often looked at my clinical and managerial teams and thought: 'I don't know how you get through the day, day in, day out,' because they not only have to carry out their professional duties but the clinical teams also have to manage the emotional relationship with patients as well and that is very draining. The burden on you as a leader to maintain and support your staff is huge and probably greater than it ever has been.

Am I confident that there is a good pipeline of chief executives coming through? Well, there are a lot of vacancies at the moment and people I've talked to at director level have said: 'Well, why would you? It's a hard life. I'm getting well paid at the moment so why should I put my head above the parapet?'

I do believe you need to have a lot of experience before you become a CEO in the NHS. It is an apprenticeship. I was 50 when I first became a chief executive but some of the people who are needed to fill the vacancies are much younger. You can do all



the MBAs and management courses but you have to develop your own leadership style. There is so much to be said for learning on the job, working in different specialities and sectors, the sort of Cook's tour for general management trainees but over a longer time period. So do we have enough people coming through? No. I don't think we do. I'd like to see more doctors becoming CEOs. They have the leadership skills and they certainly have peer influence. People talk about who runs a hospital. Well, it's not the chief executive and the executive team alone and when you have the clinicians with you leading their colleagues, they are the best, most powerful, supportive force you can have.

At Aintree I had a hospital management board with a majority of doctors on it and it completely changed the content and the conversation. It was about reducing avoidable mortality and improving quality and safety. So I'd like to see more doctors doing the job, supported by managers. It's not a quick fix because they will need the apprenticeship experience and development as well. But I'd really like to see it happen.

Edward Colgan



Between 2002 and 2006, Edward Colgan was Chief Executive of Taunton Deane Primary Care Trust. From 2006 for nine years, he was Chief Executive of Somerset Partnership NHS Foundation Trust, which provides mental health, learning disability, community health and social care services. He took Somerset Partnership to foundation trust status in 2008 and in 2011 the trust acquired Somerset Community Health Services. Edward has played and plays a number of national roles including being a trustee of the NHS Confederation, a member of NHS Employers' policy board and chair of the NHS Benchmarking Network's Mental Health Reference Group. He was also Chair of the South West Leadership Academy.

I've been in the NHS for 36 years and I came in from university into the equivalent of the general management training scheme. I've worked across all elements of the NHS. Acute services, mental health and learning disabilities, and community health services. I've worked both as a commissioner of services, and was also seconded for nearly three years to the NHS management executive, leading on contracting policy, which gave me exposure at a national level to policy-making.



I became an executive director in 1995 and the big opportunity for me came in 2002 with the creation of primary care trusts when I became the chief executive of Taunton Deane and had the opportunity to set up a new organisation pretty much from scratch, starting with just me, a chairman and a PEC [professional executive Committee] chair designate and a secretary, and we essentially had to create an organisation from that.

My first impression, to be quite honest, when I became a CEO was how lonely the role was. Suddenly you were there on your own. Of course, you are part of a team. But there is the sudden realisation that essentially the buck stops with you. The person you probably work closest with is, in many ways, the chairman. You have, of course, got executive directors who are colleagues, and who will work with you and support you. But at the end of the day they are accountable to you, and you have to recognise that at times you may find yourself in difficult situations managing that working relationship. So at times it can feel a very lonely position.

The relationship with the chair is very important. It is a partnership at the very top of the organisation and you have to have a very open, trusting relationship, with no surprises on either side, and where you can have open discussions about worries on either side. It is almost a confessional relationship. Ultimately, of course, you are accountable to the chair and the board. But if it is going to work effectively it has got to be a partnership. I have worked with three chairs and each had a very different approach, very different style, very different views about how they wished to actually undertake their role. So getting to a good working understanding of that is very important.

Did I get a lot of support when I first came in as a chief executive? Well, no, not really. I did have a colleague who was a management consultant who I talked to, and that was very useful in the early days in working through issues. But when I became a chief executive in 2002 a lot of new NHS bodies were being created, with a lot of churn in the NHS architecture, and a lot of people were new to being a chief executive.

I think probably the process is better now in some ways. For example, in the South West we now have a mental health chief executives group. So my successor will actually be working with a group of people who include some already well-established chief executives. There is a great deal of emphasis on supporting CEOs at all stages of their career – some formal, some informal. When I took up the role it seemed very much as though it was swim or sink.



I think the job is pretty much the same across all sectors in the NHS – developing and communicating a vision, trying to inspire people and bring them along, and ensuring that you are offering safe, effective, high-quality services. I've not been in the acute sector for a number of years but I think they have faced particular challenges – the performance challenge around waiting times and targets – not that we don't in mental health have to set our own performance challenges.

In mental health and community services our biggest challenge has been around partnership working, and major service redesign. We've found ourselves working more closely with other organisations, whether local authorities, other NHS providers and with the voluntary and third sector in a way that up to now has not affected acute services to the same extent. And I think the power of the service user in community and mental health services has been greater. You have to be much more open to working with service users, their families and carers because you are dealing with people who are engaging with your organisation for a much longer period than you would typically find in an acute service setting – although there are obviously some specialities in the acute sector where that applies.

What keeps me awake at night? I think the answer to that depends very much on the personality of the individual. In my case, working in high-performing organisations, it was not the budget line, or the 18-week target or whatever. It was the smaller personnel issues. Did I say something that has upset someone or make a remark that could be interpreted in the wrong way? Could I have handled something better, or did my intervention make a difficult situation worse? That and the 'never events': a serious untoward incident, for example, where in mental health we're maybe more aware of that – the possibility of a patient suicide or homicide, for example – where you have the constant worry about whether your systems are robust enough to ensure that, wherever possible, these sorts of events do not occur. The things that come from left field, or off the field, that you haven't prepared for.

Where are we now? Well there was strong leadership in Somerset when we had the primary care trust, which was a respected commissioning body, and that has been lost. And while I was working in a foundation trust, which meant that the health authority had less relevance to us, the strategic health authority did 'hold the ring' and that has gone. It has been replaced with a whole myriad of organisations and committees and groups, which are very difficult at times to navigate your way around.



The commissioners have the opportunity to act as system leaders, but in many cases they seem to have abdicated that role to providers – leaving it to them to try to work together to drive forward major change. Couple that with the complexity of the architecture we now face, and that cuts across what we are all trying to do, namely recognising that the status quo is not an option and that we have to have redesigned services with partnership working. At the end of the day, however, the regulatory system requires us to ensure that we are each delivering our financial surplus, that we're meeting our performance targets, etcetera. The system seems to be looking to provider organisations to change the pattern of services, to shift more resources into the community, and to some extent we can do that. But with the current regulatory regime it is very hard for the provider organisations to manage all of that process themselves.

I think everyone in Somerset, the leadership community, is signed up to what needs to happen and recognises that our principal concern is the best possible services for patients, not organisational survival. It is how you make that a reality when the system to a certain extent works against that.

My advice to potential chief executives? Don't recruit people like yourself. It was one of the best bits of advice that I was given. It is important to be brave enough not to recruit in your own image and ensure that you have a balance in the team, and to be willing to recruit from other backgrounds than just the NHS, whether that's from a local authority or the independent sector or from a commercial background. And be mindful of talent management, seeking to develop people. So, one of the things I have done is appoint people to be associate directors to broaden their experience.

I do understand why some people at the moment are reluctant to put their head over the top and apply for chief executive jobs. And I think that is sad. Hardly a day goes past without the NHS and some of its chief executives and other leads being subject to criticism – for example the 'fat cat' articles. There is a lot more exposure than in the past. But if they don't apply they are missing a great opportunity. The job is challenging. It can be incredibly frustrating and occasionally a bit soul-destroying. But being a CEO puts you in a powerful position to bring about improvements in patient care, improvements for the staff who work in your organisation and improvements for your local community. I would encourage people to have the courage to seize those opportunities and to take them.



John Pelly



John Pelly qualified as an accountant in 1978 and spent the early part of his career in the commercial sector, notably some 11 years with Rank Xerox Ltd where he held a number of financial management and marketing positions. He joined the NHS in 1990 as Finance Director of West Lambeth Health Authority, becoming Finance Director of Guy's and St Thomas' NHS Foundation Trust when the two hospitals merged in 1993. He became Chief Operating Officer of the trust in 1998, where he remained until 2004 when he took up the position of Chief

Executive of Queen Elizabeth Hospital NHS Trust in south London. Four years later he was appointed Chief Executive of Moorfields Eye Hospital NHS Foundation Trust in early 2008, a position he held until his retirement from the NHS in November 2015.

I came into the NHS almost by accident, aged 36. So I am not an NHS boy. I'd been in the commercial world prior to that, a lot of my time with Xerox. I came in as finance director at West Lambeth Health Authority, which managed St Thomas' and all the community and mental health services in the parish. Then Tommy's [St Thomas'] and Guy's merged and I became the finance director of the combined organisation, which was then the biggest trust in the country. I did that for five years. And then my boss Tim Matthews asked me to be the chief operating officer, which wasn't a role that was widely in place in the NHS then.

I said: 'Well, I haven't the first idea how hospitals run, I am the finance director.' But Tim insisted, and I did that for six years before being asked to be the chief executive at Queen Elizabeth Hospital, Woolwich, which was a very, very troubled organisation. Mainly financially challenged but also clinically challenged and challenged in lots of other ways.

It was a first-wave PFI [private finance initiative] trust with the most appallingly badly negotiated PFI contract, and there was never any prospect of being able to overcome the financial consequences of that.

The strategic health authority thought they had a solution, which was the merger of all four of the south-east London hospitals, which was never going to work, particularly as one of the other four was also a first-wave PFI with the same sort of problems. At that point, it all started to get personally unpleasant as well as corporately unpleasant.



I thought, this is not the way to make a living frankly. And I wanted to get away from the absurdities of some of the decision-making at the SHA. I wanted a foundation trust and fortunately I got the job as chief executive at Moorfields.

I never imagined or planned that I would become a chief executive. For much of my time I had been, in effect, a deputy and I was perfectly happy being a number two. But I was constantly being told I ought to be a chief executive and eventually took notice. And I don't understand even in the very, very difficult climate that we are working in now, why anybody at that level would say they don't want a chief executive job. Because for all its sleepless nights and everything else that you have to live with, it is a fantastic job. It is a fantastic responsibility you are given. If you feel you've got the ability to do it, I would say you should do it.

Of course, you are accountable to the board, and you are accountable to all sorts of people. But ultimately you are running this thing. And Moorfields is rather unusual in being one of the most highly regarded organisations of its kind in the world. So it is a huge privilege for the most part, huge pleasure and reward. Not a huge financial reward but I can't think of a career route that I would rather have taken.

And working in an FT [foundation trust] has been fantastic. The real worry I've got now is, of course, the FT freedoms are eroding. It hasn't just started. I've been warning our board probably for two years, if not three years, that the FT model is progressively being chipped away at and undermined. I could see that at some point in the future they will go the same way that the old-style NHS trusts went – everybody became an NHS trust in the end and most of the freedoms associated with them dissipated. So I see that as unfortunate.

I can distinguish my time at Queen Elizabeth Hospital from Moorfields in this way. Queen Elizabeth was a really, really difficult environment, not just financially. We didn't have enough nurses on the wards and there were care quality and safety issues every day. And it was a real shock, when I had been there about a year, and we were really struggling with the A&E target in the winter, and there was this very nice Australian bloke who was running south-east London at the SHA, and he phoned me up – rather apologetically because clearly he had been told to phone me up – to say: 'John, performance has got to improve and if we don't see any improvement within two weeks then find yourself another job.' Those are the sorts of things that make life really very unpleasant as a chief exec. But of course, it is happening all the



time around the country now. Nothing much has changed and I think it's going to get worse.

At Moorfields I haven't had any of that because we have been financially and operationally very successful. Our clinical outcomes are very, very good, and by international standards for the most part. We do have issues. The treatment is brilliant but the whole patient experience is not always good. One of the things at Moorfields, and at some of the other specialist hospitals I suspect, is that you can get a bit of corporate arrogance. What does it matter if the patients have to wait a few hours to see one of the best doctors in the world? Well, we've changed that a lot but we still have not completely cracked it.

In terms of leadership style, well when I first became a chief operating officer I knew not one jot of my subject. So I had to rely on people I could trust to advise and guide me. And that applies in spades at chief executive level because there is so much you don't understand or don't have the detailed grip on. So what I have done as best I can is develop really, really good teams around me. I know that some people think I am authoritative and I don't listen, and I'm a bit of an autocrat. But we do tend to come to decisions collectively at Moorfields and then live with them.

How do I keep myself motivated and fresh? Well, they are two different questions. Motivated is easy at somewhere like Moorfields, because of the range of things we do and because it is just such a fantastic place. There are many places that are research intensive, but few as research intensive as Moorfields where we have a very close relationship with the Institute of Ophthalmology, and that gives you a buzz. And there's the international angle. We do philanthropic work. So we've just built an eye unit for the main teaching hospital in Accra in Ghana. There's the World Association of Eye Hospitals and we do our own fundraising. Not as successful as Great Ormond Street. But we are planning on moving the hospital a few miles away, which will be a £450 million capital project. So there is plenty to keep you motivated.

Fresh is a different question. And my answer is I failed to do that. That's a large part of why I am moving on. I was talking to Robert Naylor about this the other day. I have never been in the same job for as long as I've been at Moorfields. If you are me, you get to a point where you think you've done a lot in the early years, mostly for good but occasionally not, and then the things that you do are sort of incremental. So I think for me personally I need a fresh challenge, and I think the organisation



needs a fresh pair of eyes. People like Robert and Len Fenwick clearly can keep themselves fresh. But I've not been able to do that, and maybe that is a shortcoming.

In terms of mentors and role models, there aren't many that I've worked for about whom I would say: 'That's how I want to do the job.' When I was at West Lambeth the guy who ran Tommy's was Stephen Jenkins, an interventional cardiologist, who is now a very good friend of mine. He had great vision but he was a tad chaotic. Wasn't strong at translating his vision into implementable plans. He is a lovely guy who had a very, very loyal team around him. It was a lot of fun working with him. But in terms of management style he wasn't someone I was ever going to aspire to be. I have huge admiration for Alan Langlands, and for Robert Naylor who has been fantastically successful. A very troubled organisation financially when he took it over. And Simon Stevens, who was junior to me at St Thomas' when he came through as a general manager for surgery, and I always thought that 'this is a class act and he's going to go places'. I like Simon a lot, I hugely admire him. But these are not people I've worked for directly.

In terms of Moorfields, it attracts the very best in the ophthalmic professions who will gravitate towards Moorfields. But it can be hard beyond that. Why would you want to be an ophthalmic pharmacist or an ophthalmic anaesthetist or an ophthalmic nurse? Most people don't go into nursing to nurse people 98 per cent of whom go home the same day. And the same applies to the management cadre, where attracting really good people is hard. So we are constantly recruiting from outside and one of my disappointments is that I haven't really made much of an impact in changing that.

One of the good things we have done is develop a clinical management structure which gives clinicians significant delegated responsibility to run their bit of the organisation as well as a major voice in all significant corporate decision-making. Interestingly, we had to jump a generation of doctors in order to get to any who were interested and capable of doing that kind of a job. But we did. And some of them have turned out to be very good at it. Some less good.

My advice to new CEOs? Trust your instincts. There are times when the arithmetic and the analysis says if you do this you will get that, and your gut tells you it is wrong. And you have to have strong individuals around you who are prepared to argue with you, and argue their ground. Otherwise you get into group think, and that can be really damaging. And even if you think you are encouraging that kind



of behaviour, you need to be aware that people defer to the CEO and some people are not confident enough to tell you that you are talking bollocks. So suddenly you think you have a consensus when in fact you have no consensus at all.

Sir Jonathan Michael



After a distinguished clinical career as a consultant physician and nephrologist at Queen Elizabeth Hospital in Birmingham, Jonathan Michael became Medical Director and, in 1995, Chief Executive of the University Hospitals Birmingham NHS Trust. In 2000 he moved to London as Chief Executive of Guy's and St Thomas' Hospitals, which he led to become one of the first-wave NHS foundation trusts. He was knighted in 2005 for services to the NHS and in the same year was elected Fellow of King's College London in recognition of his role in improving collaboration between the NHS and universities.

In 2007 Jonathan moved to BT to join its health care team, developing a global health care strategy and delivering BT's contribution to the NHS information technology strategy, ultimately becoming Managing Director of BT Health. In 2010 he returned to the NHS as Chief Executive of Oxford University Hospitals NHS Trust, where he delivered operational and financial stability and a partnership with the University of Oxford to develop one of the UK's foremost academic health science centres.

In 2015 he retired from the NHS and is now working as an independent health care consultant and senior associate with KPMG.

The reality is that I have enormously enjoyed the 20-odd years that I have been a chief executive in the NHS, so although there is always a lot of negativity around, the overall message is very positive.

When I made the transition from being a renal clinician to a chief executive, people asked me why I was doing that. But I found, over my career, that when I made the move from being a clinician dealing with individual patients, to being responsible for a clinical programme, and then to being a medical director, I was able to influence the outcomes and the quality of care for many more patients than when I was just treating those for whom I was directly responsible as a clinician. There



was enormous satisfaction from helping the organisation that I was responsible for deliver good-quality care for patients.

There are enormous pressures. But are they greater than they were 20 years ago? I am not sure that is true. When I moved from having been a consultant for 15 years to my first chief executive job in Birmingham, I was moving from a guaranteed job until I retired, to becoming the fourth chief executive of the organisation in five years. Quite an interesting career move! Foolhardy, you could say. I did retain my consultant contract as a parachute in case it did not work out. But I remember talking to Alan Langlands, the NHS chief executive at the time, and asking why the turnover of chief executives was such that they only lasted in post about two years. And he talked about the expectations and the demands put on the person who leads the organisation. And there are an awful lot of things that happen within an organisation with thousands of staff and for which you are actually accountable as the accountable officer, but over which in fact you don't have any direct control.

That creates pressure, and I remember one of my medical directors at Birmingham saying that when he took on the job, the more he knew, the less he slept!

One of the frustrations particularly recently has been the lack of understanding that health care is an inherently risky business but there has been this drive from regulators and politicians to somehow present it as something that ideally ought to be risk free.

Being alive is risky, particularly when you're very young or very old, and being treated is inherently risky. But equally, not being treated is inherently risky. We need to understand risk and mitigate and minimise it. But the drive politically and publicly to say the ideal model is risk free is generating a degree of pressure on clinicians, on organisations, and therefore on the chief executive.

I am not sure the regulators fully understand relative risk. And if you are going to be doing things in a different way, innovating, trying things out, you have to have some appetite for risk. If you have no appetite for risk, you are paralysed by fear of doing something different and, of course, the regulatory framework doesn't really encourage people to take risk. The regulatory framework does feel much more intrusive and oppressive than when I came in.



Fairly early on when I was a chief executive the Blair government introduced clinical governance and that was a seminal piece of legislation. It was the first time that the organisation had accountability and responsibility for the quality of clinical care and there was the reciprocal accountability of the clinicians to the organisation. But regulation has become much more oppressive.

Take Tim Smart who I worked for when I was at BT, and I was a non-exec on his board at King's when I was still at BT. Tim is a very experienced private sector manager, very tough and resilient character, very committed to patient care; but beaten down by the oppressive regulatory framework to the point of illness so that he had to resign, particularly when things started to go wrong after the Bromley acquisition. Now you can argue that the Bromley takeover was a mistake. But rather than being supported he was pressurised and insulted to the point where it all became too much. That's not a healthy environment for people to be working in.

And most of the levers that we used to use to balance the triumvirate of finances, quality and operational performance have gone. You could increase waits to help manage the finance, or slightly alter things on quality. But each of them has been nailed to the floor by regulation or legislation so the job is inherently more difficult. There are a number of chief execs who have left on grounds of ill health and stress and so on and so forth, which says quite a lot and I think that's worrying.

When you are as long in the tooth as I am you can push back a bit more. So in Oxford I remember getting quite a lot of pressure from the strategic health authority after about nine or twelve months as to why I had not solved all the problems. And I was able to sit back with its chief executive and say: 'Look this job is not that easy and it's much more difficult if you're constantly doing it under friendly fire.' Basically: 'Get off my back. Let me get on with the job and I'll deliver. But I'm not going to deliver it in six months.'

Do I worry that people will not want the jobs? Yes, I do. I particularly worry about the clinical community. I think the move to hold people more directly and potentially legally accountable and the 'fit and proper person' regulations and so forth, allied to the behaviour of professional regulators, the Nursing and Midwifery Council and the General Medical Council, where, if someone is a chief executive, medical director or director of nursing, he or she is in danger, if there are clinical



quality problems, of losing their professional registration as well as their job – it is beginning to cause clinicians to have reservations about a move into managerial roles, saying ‘that’s too risky’.

On the one hand the system says: ‘We want to encourage clinicians to become involved in management’, and I absolutely endorse that. Having clinicians in senior management positions provides a much wider influence on the quality of patient care. But on the other hand the system sets things up in such a way that you discourage people.

To whom did I feel accountable? Well, the board first and foremost because they appointed me, and I suppose ultimately to the secretary of state, though I’ve never had one of those silly conversations with the secretary of state when they’ve rung you up and shouted at you, although I know people who have. But emotionally I was accountable to the patients.

People get quite excited by the language, but I like the language of thinking about us as a service provider. There for our patients, but as our customers rather than supplicants. The NHS has taken a long time to move from the welfare-based, paternalistic approach, where patients ought to be grateful for the treatment they are given, to one where they can have reasonable expectations about treatment of a certain quality, and within a timeframe, and so on. I’m not very good at queuing, when I go to the supermarket or whatever, and I know I can get pretty impatient. So I expect the NHS and health services to be able to behave in the same sort of way, although of course some of the flexibility that the private sector has in terms of managing demand – it can always get rid of the customers that it doesn’t want, for example – are not available within the public sector.

The role of commissioning has changed over the years, and I’m not sure that the Lansley move of putting it all into primary care has been particularly helpful. As a specialist clinician running a renal failure programme, a lot of what I was doing was always essentially centrally funded and commissioned. And the commissioners I dealt with in the West Midlands were very intelligent and informed. We had some pretty robust fights. But there was no lack of understanding. I find it less impressive these days, both in terms of what is done and the people doing it.



I'm a great believer that the best model going forward is vertical integration, which in some way incorporates primary care. That does of course raise all sorts of contractual questions that have not been addressed since 1948. I don't think it really matters whether that is built out of the hospital or built in from primary care, but what you have got to have is an integrated governance model. Before I left Oxford we were working on that.

And when I say that, I am left wondering whether I am arguing for the return of the health authority. I am not certain I am. But the better ones could and did co-ordinate things. They had a wider picture, and they were not conflicted. There is inherent conflict in the current structure.

You asked about a support network. Well, when I started I had Robert Naylor, David Loughton and David Fillingham, chief executives of three big trusts in the West Midlands and we used to get together and it was a sort of quasi-collaborative, quasi-competitive relationship – which was quite interesting. I had no management training. But I had a very experienced NHS manager as an executive coach for the first two or three years to whom I could take problems and discuss things as a sort of mentor. More recently there are the chief executives in University Hospitals UK [the Association of UK University Hospitals]. And if you've got a good chair, that can be very supportive, and I've been predominantly lucky in that. But I am not sure how much formal structure for support there has ever been. One of the things that would undoubtedly help would be to have something that is more obviously available.

I am not particularly optimistic about the future pipeline for chief executives. We've talked about the clinical side of that, and I don't know why we have not made more of the graduate training scheme. If you look at the people that have come through that, it has produced some really strong managers. And yes, we have the Leadership Academy, but more could be done.

It doesn't help when you have a secretary of state who spends a fair bit of time rubbishing the people who are trying to run the service. And in spite of their theoretical independence, the current regulators are all very much under the cosh, or under the eye, of the secretary of state on a weekly basis. If you have a secretary of state who drags all the heads of the independent regulators into his office every Monday morning, the whole culture does get more oppressive than it has been for a long time.



They are all working under quite a lot of political duress. But although there are a lot of difficulties at the moment, I'd come back to the fact that it's still fundamentally a really good job and I in no sense regret it at all. I would encourage people to go into it. It is quite stressful and I've been retired for a month now and there is a bit of a feeling of a burden being lifted. But it is one of the most rewarding jobs. It is still a great job to do.

Karen Dowman



Karen Dowman has been Chief Executive of the Black Country Partnership NHS Foundation Trust, and its predecessor organisations, since 1995. In that time she has taken the original Sandwell Mental Health Trust through its subsequent formation as a mental health and social care trust and on to foundation trust status while absorbing the transfer of multiple services from neighbouring primary care trusts in 2011.

I've been a chief executive here since 1995 and the job is almost indescribably different. Back then it was a relatively new title and a relatively new job anyway. So it was very much about finding your place in the world. The job was much more akin to being a director of operations – which, of course, was also a job that did not exist then!

The regulation we have now wasn't there then. We still had area health authorities and they were sort of the commissioners. It was still quite a tiered bureaucracy, for want of a better description, even though the purchaser/provider split had technically arrived. The area health authority was quite directive from an operational point of view.

You had significant air cover. You were much more beholden around your relationships rather than regulation or contracts or standards. And I can vividly remember sitting in a meeting battling for money, managing to get enough for another consultant in old age and then seeing £2 million happily handed over, on the nod so to speak, to the acute sector. If we think it's bad [for mental health services] today, it was significantly worse then, significantly worse.



You had more time to spend with your staff, you had more time to plan things. So long as there were no significant issues financially – and there wasn't a lot of money around then I hasten to add – you were pretty much left alone to create your own role and deliver. You didn't have all the regulation, and particularly in the early days you had to find your own feet. So in some ways it was easier, in other ways it was more difficult. But it bears absolutely no comparison to the job today.

From the point of view of our services, commissioning really started to bite with the arrival of primary care trusts in the early 2000s. It became much more about performance, much more about activity and being paid for activity, and making organisations more accountable. And at about the same time we had the mental health national service framework which, looking back, was the greatest revolution for mental health services. It wasn't without its flaws. It was very prescriptive – you have to have this many staff, on this grade, and hit this target – but it was a revolution for good because it did not just bring in more resources, it also raised the importance of mental health and learning disability services. And we were able to shut a great many beds and build proper services in the community. It was a really exciting time; a feeling that you could absolutely make a difference. Its only downside was that it was only for adults of working age, and if it had been for everyone, for children and services for older people as well, we would be in a very different place now.

The thing that limits your time to do things these days has been the growth of regulation, and the information demands. I don't knock contracting per se. At the end of the day we spend public money and we should be able to account for what we do. There is a difficulty with our client group in that you can spend all day with one person and stop them going into hospital and that is a good outcome. So it is quite hard to measure; it is quite hard to cost. But we have to find ways to do that.

But when you have a number of different commissioners all wanting the same information in slightly different ways and then the various national tiers – CQC, Monitor, the TDA, NHS England – the regulation and the information demands have got overbearing. A disgraceful waste of money. We are in constrained times financially, and I am sure we could lose 20 posts if it wasn't for this endless different tweaks of information for different things.



We've just had the junior doctors' strike and I must have had six emails wanting to know how many doctors we've got on duty and what they were doing and how many had been out on strike etcetera etcetera. Needless to say, I deleted the lot of them. I just think it's garbage, absolute garbage. Either I am running this organisation or I am not. My duty as the accountable officer, is to keep people safe and that's what I'll do. On the one hand they want us to be independent and free and innovative and the next moment they want to control our every waking moment. They can't have it both ways.

Because I am going shortly I have the comfort of deciding whether or not I am going to play. I'd probably not have deleted those six emails 10 years ago!

And the other revolution over my 20 years as a chief executive has been information technology. It has enabled us to improve what we do internally but actually it's enabled all the regulators to expect all sorts of information in a thousand different ways.

The other thing that has changed is that most people would have passed through different parts of the service on their way up. I was always on the provision side although I worked in the acute sector before mental health. But most people would have done a spell at a PCT, or the region or whatever. To really get on you had to have passed through these different areas.

But now we have got NHS England who are basically civil servants. And they do not operate in any way like the strategic health authorities or their predecessors did. SHAs still looked at things in the round, they still looked at the service delivery, they still looked at the population needs of a patch. The local area teams don't do that as far as I can see.

The SHAs, for all their faults, could 'hold the ring' about big service change. But with NHS England and all the regulators, they all have their own roles, and there are all these conflicting messages, and there has been no one in charge for years now. It is appalling, quite appalling. We seem to be having a little shot at restoring that with the sustainability and transformation plans (STPs).

The [NHS] five year forward view was one of the best reads I've had in a long time. But the ability to implement it in the current structure? I still have no sense how we can work collectively to deliver that.



Who am I accountable to? My chair and my board and the people we provide services to. The relationship with the chair is absolutely vital. You don't have to be bosom pals but you have to get on and there has to be trust. I've been lucky. But I've seen a great many chairs elsewhere who want to be chief execs, and that doesn't work. In a foundation trust you need a good relationship with your council of governors, certainly in mental health. I've seen a lot of things go fairly wrong because the council of governors are treated as a necessary evil, whereas by and large I think in community-based mental health organisations they are seen as a real asset. A lot of our governors, I am pleased to say, are still in services or have used services.

How much of my time I have spent looking up rather than looking out has varied enormously over the years, and sometimes year by year. The last three years have been different. I think the SHAs used to protect us from a lot of external interference, and the last three years have been not so much looking up but trying to translate all the stuff that is coming down on us, and ensuring that the worst excesses of regulation do not impact on your staff.

Where do I look for support? Well, I've been in the same patch for a long time, so I know a lot of people. There is a mental health group of NHS providers and one in the patch as well. The West Midlands is quite collegiate. And I've been fortunate in that we've not had any really serious incidents. But there is always someone to pick up the phone to check you are OK. Or you do, to ask if you can be of support or help. I think from the mental health perspective there isn't quite the machismo of the acute sector. A lot of us when things do go wrong have the 'there but for the grace of God go I' feeling. So I have always felt I could pick up the phone.

Am I confident that there is a strong pipeline of chief executives? Not really. It waxes and wanes a bit. I think in the good times when there are plenty of resources around and things are going well it looks attractive. But I think it is particularly difficult at the moment. You can be pretty well paid now in a number two job, and people will only move to areas where they think it is safe. It is not just chief executives who are difficult to recruit at the moment. It is finance directors and ops [operations] directors as well.

Nationally I don't think there is any acceptance, by any politicians, of just how bad things are. We will have gone from spending at roughly the European average in terms of GDP to what will soon be 6 per cent. And that has happened very rapidly.



For those of us outside the acute sector there has been the destruction of local government, particularly social care. One of our local authorities has pulled all their social workers out – teams that have worked together for 20 years – and now they only do real crisis care. We are left holding the baby in the NHS and there is no acceptance nationally of that at all. We are still expected to make more savings, and we've reached the stage where almost our biggest risks are out in the community rather than on our wards. And the money that has gone across from the Better Care Fund has just gone into local authority cuts. It hasn't preserved or improved services.

We talked at the beginning about avoiding a 'better yesterday' view. But it was only five years ago that it was a better yesterday. It is only the last reorganisation that was so catastrophic. And they won't repeal the legislation around that, so they won't make the other changes. And the introduction of competition, which started under the Labour government, was the biggest mistake. It is not the philosophy as such, although I don't agree with it. It is the cost. The cost of tendering services with people who have no idea how to do it has been devastating. We are going through a three-way merger to make ourselves sustainable, and five years ago we would just have got on with it and done it. Now we are having to go through all these hoops to make sure that we do not fall foul of the Competition and Markets Authority.

Keith McNeil



Professor Keith McNeil has had a long and varied career in health care – as a doctor in the Australian Infantry and Australian Special Forces, as an internationally recognised expert in the fields of cardiothoracic transplantation and pulmonary vascular disease, as Chief Executive Officer of one of Australia's largest district health services and, until recently, as Chief Executive Officer of Cambridge University Hospitals NHS Foundation Trust.

I loved being a chief executive. It's a great job. It's a wonderful opportunity to work with some fantastic people and to do a huge amount in terms of health care for a big population, which is the reason I changed from being a clinician to a CEO.

You can do wonderful work as an individual clinician on the individual patients. But that might be a couple of hundred or a thousand in a lifetime or whatever. But being able to improve the lives of hundreds of thousands of people on a year-on-year



basis – that's very alluring. It's tough though. It is tough managing all the competing expectations, the political ones, the corporate ones, the patient expectations, the public expectations, the expectations of the board, the expectations of clinicians themselves, and the expectations that you have as an individual with a set of values that you've got to live by. Trying to do that in the current climate and juggle all those balls becomes a bit of a challenge to say the least. So you can do good for patients and your staff, and you can do well by your corporate masters, but inevitably as a chief executive in the NHS at this time, you are forced to choose between the two.

As you note, I was a CEO in Australia before I came here, and the challenges were not dissimilar in terms of an ageing population, the lack of investment in community services, an overreliance on acute services and so on. But when I left it was not as difficult a juggle as it is here, certainly in terms of the financial challenge. And we were not burdened by the same amount of regulation and bureaucracy and inspection as you are here, which adds a whole other layer of obfuscation and distraction. So naively I thought coming to the National Health Service I would be coming to a national health service. But in actual fact, over time, it seems to me as though the system has been fractured into many different silos or structured in many different factions – I call them factions, because I don't think there's been any particular plan as to how it's been done, with each one of those almost competing, and certainly not being aligned, and the interfaces between them taking resources away from patient care. So you have Monitor versus CQC versus local commissioners versus specialist commissioners versus health and scrutiny committees and the list goes on and on. You have CCGs doing quality, Monitor doing quality, CQC doing quality. And they don't talk to each other. So it is Kafkaesque, and that's the best word I can think of to describe it.

And of course I had worked in Cambridge before as a clinician. So foundation trusts weren't in being then, and there was, I suppose, a strategic health authority. And I was just a clinician. I don't know how it was really set up then. But it was a simpler system. And whichever way you like to look at it, health is complex, whether you look at it mathematically or sociologically. So the trick is to simplify it; and not to overcomplicate it, which is what we've done. We've just made it harder and harder for the acute hospital sector to the point where I'd ask: 'How long is it going to be before someone says "actually this is not working, we'd better do something different"?' If I, as a consultant physician, was in the position of Monitor and my patient was the system, I'd be had up for negligence, just watching the patient die



in front of me, not changing what I'm doing. People are trying to treat the infection with the wrong antibiotic and all we do is keep increasing the dose of the antibiotic. It doesn't make any sense to me.

I remember saying to the board at Cambridge about three months in when we were putting together a strategic blueprint that, with the tariff deflating and demand going up, 'if you extrapolate we will have to have negative length of stay for our elective patients so we can get through enough elective work to fund the non-elective work', which was being paid at 30 per cent of tariff above a certain level. The nonelective demand was going up, elective capacity was being squeezed and there was going to be a tipping point. Well, we reached that tipping point much sooner than I had expected – demand increased above everyone's expectations – and then of course somewhat later the CQC came in. And in my view – and it is my view – basically they just got it wrong.

The CQC rated Addenbrooke's as 'inadequate'. So you look at a hospital that has:

- one of the lowest hospital standardised mortality ratios or HSMRs – you can believe in HSMRs or not – in the country
- no hospital-acquired MRSA bacteraemia for 17 or 18 months in a row, despite the complexity of things that go on there
- a low, single-figure *C diff* [*Clostridium difficile*] every month
- one of the highest harm-free percentages in the country, certainly one of the top in the Shelford Group
- six out of ten best in Europe cancer outcomes
- transplant outcomes for solid organs, kidney, liver, pancreas, the best in England and up there with the best right across the UK
- colorectal surgical outcomes with a mortality of two standard deviations below the average



- maternity – which is the really galling one – that was rated ‘inadequate’ for safety, when Addenbrooke’s has not had a maternal death in childbirth since before 2007 and has the lowest stillbirth rate in the country; a hospital down the road had had five maternal deaths in childbirth in three years, and it got rated as ‘needs improvement’.

You know, go figure... What’s important? You need to focus on outcomes. So what they were saying to us were things like: ‘You haven’t got enough nursing staff.’ And we knew that. Now if you don’t have enough nursing staff because you’re trying to save money to hit financial targets, then I think that’s one thing. But where you cannot employ enough nurses – and we had been all round the world, so we were stuck with the number that we had, we couldn’t physically find any more – what we should have been told was: ‘Actually you’re doing an outstanding job in keeping patients safe, in what were diabolically difficult circumstances.’ Not saying: ‘You’re inadequate because you haven’t got enough nurses.’ And so the list goes on. Being criticised for our inputs rather than our outcomes. Not even paying lip service to outcome but saying that ‘there’d be a risk if these risks eventuate’. Interestingly, towards the end of last year, the OECD [Organisation for Economic Co-operation and Development] noted the NHS had some of the poorest outcomes in their cohort of countries and opined this was basically because of a focus on process without paying due attention to outcomes.

And the tragedy, of course, is that not long after that proclamation, two patients who had been referred to us for renal transplantation actually said to the renal surgeon when they were being assessed: ‘Is Addenbrooke’s a safe place to receive transplantation?’, when it is right up there with the best outcomes in the country. So that’s the sort of damage that they can do. If I sound a bit emotive about it... well, it just beggars belief that they are making these value judgements on statements people make, not on data.

And from my perspective, from my talking to people around, everybody’s absolutely petrified about getting CQC inspections. People asking: ‘If you guys are inadequate, how can we possibly get through it?’ Peterborough up the road is rated as good, but I can tell you when they’re really sick, where 99.999 per cent of the population would rather go for their care. It is morale sapping.



Addenbrooke's will get over it because the people there are good and because we know we weren't inadequate. I keep saying 'we' so forgive me for that. So they know that and they'll get over it. But it will require investment, money they don't have, and it will require time and energy to put in place the things that the CQC want in place, without producing any material improvement in outcomes. And so that will be money that effectively will be wasted because patients aren't going to see any real benefit from it.

You asked about the relationship with the board. Well I hadn't worked with a board before, they were just starting up in Brisbane when I left. On one level the board was terrific – really good people with an eclectic mix of skills. But as things got tight they became more and more executive, which disempowered people on the ground. And they couldn't make, or weren't allowed to make, tough decisions about stopping services because we were trying to balance an 'unbalanceable' or unsolvable equation. Take one example of many. We kept getting referrals to our surgical orthopaedic list which we couldn't service properly because of non-elective demand, which the CCG was meant to be controlling. And we said: 'We need to say no, we can't take any more patients because we can't physically deal with this number, with the number of orthopaedic surgeons, theatres, and hours in the day, etcetera, etcetera.' But because of NHS Choice we weren't allowed to do that by the CCG and our regulators. So we had to keep taking them onto our books and then, of course, we got fined for not hitting our referral-to-treatment targets. All this whilst a hospital down the road had no waiting list but the patients didn't want to go there.

So the CCG is failing to control demand and all the risk is put on the providers – financially, operationally, safety, quality – which is fine. But then we are shackled in terms of what we can do to address that.

What we need is a system, not this fractured thing that we've got at the moment. What we need is whole systems around sensibly constructed health economies to come together. We need to ask: 'What does that population need in terms of health care', and construct what we provide around that.

And we have got so much resource going into regulation. It is like buying Nero Stradivarius violins to play with, while Rome burns. Monitor can go and refurbish their building down at Waterloo at a cost of how many millions when we have patients with cancer sitting there in diabolical conditions because we can't get any



money for capital funding. I just don't think that's right, it seems to me anyway. I don't think Monitor and NHSE [NHS England] get that they don't add much if anything material to patient care. If they disappeared, patient care would get better. None of those regulators or very few of them, I don't think, have ever tripped over a patient let alone looked after one. We've got people flying the plane who aren't pilots – they're civil servants and bureaucrats.

Where did I look for support when times were tough? Well, there was the Shelford Group, which was a place to informally compare notes, if you like. It wasn't really a deeply personal sort of thing. But discussing with other people and recognising that everybody is in the same boat with the same sort of problems and listening to what their solutions were – that was valuable.

But while my CEO work was much harder in many ways than my clinical work, the clinical work was much more stressful. Given what I did, it was life and death for patients, so I didn't lie awake at night over my work as a CEO, but I certainly lost many nights' sleep worrying about patients. And I always said to the board that if I had to stand up in front of the Public Accounts Committee I would happily do that for the finance, but I wouldn't trade off patient outcomes for that. And that was a line that I wouldn't and didn't cross.

Do I think there is a pipeline of future CEOs out there? Well there are good people around, for sure. And there will always be a few people who are, like me, delusional and think that they'll be able to actually change things for the better and make a difference! But I think you'll find that the prospect of senior clinical people putting their hands up to do this will become vanishingly rare. When you have 90 per cent of hospitals in deficit it is difficult to get clinicians to volunteer for that. It is already hard to get people to step up as divisional directors and clinical directors, because it is a job that is really difficult in the current climate. If you are a clinician you can turn up, do your job, and get your pension. And in times like this you think: 'Cripes, that's not a bad option really.' But we need clinicians to step into leadership roles at a whole lot of levels in the system. They determine where all the money is spent, and if they disengage you can spiral out of control very quickly. However, once you unleash their ingenuity, they'll deliver for you time and time and time again, because they are the rocket scientists. They know how to build and run the rocket ship.



But I loved the job. The best I have ever had. I'm very disappointed with myself that it hasn't worked out. But the system is broken, and there is no question that there is an implied bullying culture in the NHS – and I say implied – that keeps people quiet. They will not speak up against what they all know is an unworkable scenario because they get this feeling that they're going to get retribution – from the CQC included.

So what is needed? Three things. We need to identify who is actually leading the NHS and what is the vision and the strategy that's going to get us there. Number two is to simplify all of the bureaucratic overhead that we're currently burdened with. It is just Kafkaesque. How did we let it get like that? It should be simplified and made flatter. And number three you've got to align everything around health economics to make sure you are doing what the NHS wants to do, which is to deliver care to populations of people in a way they want it delivered. We have got to get the commissioning right because right now it is not working. It is costing an awful lot of money but not giving us any benefit – at least in my opinion.

Mark Newbold



Mark Newbold became Chief Executive of Kettering General Hospital in 2007, after a long career as a hospital doctor and academic. He led the organisation to foundation trust status, and moved after three years to Heart of England NHS Foundation Trust, where he stayed for four years. He is now Managing Director of Our Health Partnership, a GP super-partnership in Birmingham, and Professor of Health Leadership at Aston University, where he is part of the team setting up the innovative new medical school. He continues to be active in medical leadership development.

My slight reluctance about doing this is that when you look back at the negative things about being a chief executive, it sounds like whingeing. It is hard to describe the frustrations that there were in the job latterly, without it sounding like sour grapes. So I hope this can come across as objective observation.

And I have no regrets about being a chief executive. In terms of handling the issues at Heart of England, there are things I would do differently if I did it again. But the job of being a chief executive is endlessly rewarding. You can do a lot of



positive things. You can put great teams together, you can empower clinical teams to develop their services, you can support them personally and with facilities or people or equipment. You can deal with the public who have a problem, and paradoxically the resolving of complaints can be very rewarding. You have real influence in terms of being able to do good things – the sorts of things that anyone who's involved in health would like to do. So I don't hold any bitterness or grudges. But there were issues about how the system worked, which I think are worth talking about.

I was a little unusual in that I'd been a clinician for 25 years as a pathologist. I'd been clinical director in a couple of trusts, then a divisional director, and at Rugby I was half time a clinician and half time a managing director. There was a new aspiring chief executives programme around about 2007, which I got on, and was then appointed as chief executive to Kettering where I was for three years before Heart of England.

They were two very different experiences really. Kettering was a one-site DGH [district general hospital], which was ready to improve and Heart of England was a long-established foundation trust, a once-strong trust that was tipping over from the glory days when it had been Acute Trust of the Year. There had been some serious safety concerns and my predecessor had had a pretty torrid year or so, but the board still held on to the strong reputation and found it hard to recognise that it was a struggling organisation with some fairly deep-seated problems.

Kettering shared many quality concerns with Mid-Staffs. Many of the parameters were the same. Mortality rates were quite high. *C diff* was a big problem, MRSA wasn't very good and the organisation itself was not happy with some of the quality. But there was a sense that they wanted and were ready to improve and did. The staff generally were ready for a better period and they responded really well.

And I felt supported. Barbara Hakin, the chief exec of East Midlands, said to me: 'I'll give you a year and after a year you own all the issues. So in other words, every time something untoward happens, or a bad performance score marks up, I won't be onto you immediately, because we both know there are concerns that need addressing.' And so that seemed fair enough really as it meant I could deal with the problems properly and openly.



Heart of England operated in a very different context. There were some quite deeply ingrained problems, which weren't all known about. I was being told by the SHA and others when I arrived that there were many problems, including the dreaded four-hour wait in A&E, and I said: 'Well I can see some of them, and I'm sure I'll find out more, but I will tackle four hours as a priority.' And I remember vividly the week after I started I got a phone call from the SHA saying: 'You're failing four hours, what are you doing about it?' And I'm thinking: 'Well, we've just had that discussion a week ago. The place has been failing four hours for a long time. Did you think it was going to be solved in one week? You know we're trying to tackle it, so why are you ringing me up to tell me about it?'

Without creating formal turnaround we worked our way back to a green rating over 15 months. The performance held for a bit and then started to go down again, and then we couldn't get it back. And there were other problems emerging. So I think in retrospect if I ever did the job again I would be much more assertive about establishing and externalising the true position of the trust when I started so that it was absolutely clear.

We got continually hit by other challenges including a breast surgeon who had been carrying out an unauthorised procedure and potentially harmed lots of women. I saw many very distressed patients with whom I had great sympathy. We did a full recall of several hundred patients. There were some really distressing personal circumstances, and it was a massive, massive issue. Keeping a promise I made to patients, we invited Ian Kennedy in to do an independent review. He did a good job, but it was a hard-hitting review. And I think it's fair to say that Monitor did not know how to deal with it. To them, it indicated more new issues, whereas to me they were more symptoms of the same underlying issues in the trust. And this is December 2013, about a year before I finished, and Philip Hunt, my chairman, and I had a really difficult telephone conversation with Monitor at which they said: 'We think this shows a whole range of new governance concerns and we're going to take more action.' And we said: 'Well hold on, commissioning this review shows we are working with those affected and being transparent and open. And while it points to a lot of issues, they're pretty historical and we've now laid them bare and dealt with many of them.' But they were majorly spooked by it. And on top of the other performance concerns it became: 'Oh it's Heart of England again, more problems.'

Monitor became so closely involved that they saw day-to-day matters that they were not used to seeing, and did not understand. Every little thing was taken as



evidence in their minds that we had developed more problems. And every time they would ask for another action plan and another spreadsheet to support it, so we'd have to find another team to spend another few tens of hours writing up another plan, to the point where it became almost laughable how many they were asking for. It felt like you were tied to a tree, and each time they just went around with the rope another time, so you were getting more and more tied down. It was all terribly counterproductive and fruitless, not helping patients at all. And it self-perpetuates, because if CQC raised a concern then Monitor would raise that CQC concern as a new concern for them!

My over-riding memory is that the regulatory system was just not willing or able to understand the complexity of what we were dealing with, so there was a simplistic assumption that each new complaint, or newspaper article, was somehow indicative of an additional problem. But most of our performance problems were, of course, interlinked. You miss your elective targets because you cancel operations because you are overloaded on emergencies. So if you have a four-hour problem – and it was a problem across the whole health economy – and then you develop an 18-week or a cancer 62-day problem, they're actually the same problem, but each one is chalked up as another, separate, failing, which further escalates the regulatory action. The fundamental root cause is that the hospital is over-congested, but there is no real pressure on the commissioners, for example, to sort out slow discharges or the lack of intermediate care facilities outside hospital.

And then NHS England called a risk summit, about all the same issues already being handled by CQC and Monitor, with everyone there – NHSE [NHS England], Monitor, CQC, Health Education England. It was the worst moment, I think, of my professional career. It was like a ritual humiliation and bullying session. And the tone of it was as if they thought that we were somehow not sufficiently concerned about the problems, not trying hard enough to sort them, when here was a highly experienced and deeply committed executive team and board that was living and breathing these issues. We all came out deflated and offended by the attitude taken towards us.

They [the regulatory bodies and NHSE] were all duplicating each other. And they were all nervous, I think, that this was a very big trust, one of the busiest in the country, and it is as if they didn't want to be the one that missed a new problem. So they're all over you. There was a real sense of being constrained the whole time – not able to get on with the job really.



So it all left me thinking that if actually what we all want is improved performance and care delivery to patients then there's got to be a better way to do this. And if you want thinking chief executives to take up these roles, then you need to have a thinking regulatory approach – one that can acknowledge some of the real complexities that we face, and work out ways to support the board to deliver rather than to just constrain them and tie them in knots. A more intelligent regulatory system that balances support with sanction.

As a CEO you need to feel that you're fighting to improve care with the backing of the system rather than fighting against it, which is what, by the end, it felt like to me. I found this deeply frustrating; not always, but latterly. But we have concentrated today on the negatives and, all that said, I have no regrets about becoming a chief executive. It can be an endlessly rewarding job.

Sir Robert Naylor



Sir Robert Naylor is in his 31st year as an NHS chief executive and his 16th year at University College London Hospitals NHS Foundation Trust (UCLH). UCLH became one of the first foundation trusts; a new legal entity with devolved powers and greater autonomy. It has been designated as one of the top-performing hospitals in the NHS several times in the past decade. It is part of UCL Partners, one of the world's leading academic medical centres. University College London (UCL) was recently designated the fourth best university in the world by The Times

Higher Education. The trust, UCL and partners have created one of the largest university/hospital complexes in Europe. In April 2012, the trust opened the third phase of development with the new UCH/Macmillan Cancer Centre. Other developments include expansion for specialist cancer care, proton beam therapy and a replacement for the Royal National Throat, Nose and Ear Hospital and the Eastman Dental Hospital.

Sir Robert has been an adviser to various strategy groups associated with health care reform and was recently designated the national czar for NHS Estates. He has a particular interest in leadership development.



Well, I go back a long, long way. Not just personally but my father came into the NHS at about the time it was founded. He went on to be secretary of a hospital management committee and his twin brother a regional administrator in the Midlands.

At Christmas, as a child, I remember being taken around hospitals, some of which I couldn't enter because they were isolation or TB [tuberculosis] hospitals – hardly any of them exist today. My Dad would come out and say: 'Oh I've just seen Mr Smith for the third year running.' And I got the impression that these were places where you went to die. Like many of the large mental health hospitals, once admitted, the likelihood of coming out...

My first ever job, during university holidays, was as a porter at the Royal Berkshire Hospital. West Ward was the cancer ward and most of us found this a really depressing place because patients who went in seldom came out again – essentially there was no cure. The reason I say this is to illustrate that modern health care has dramatically changed. In one sense, 'the NHS is a victim of its own success.' Today, 50 per cent of cancer patients survive more than 10 years, an ambition undreamt of in my youth.

Hospitals today are more like maintenance departments – you get fixed up and sent back out to get on with your life – later to return with even more complex conditions. What has changed is the rate of turnover, the pace of change and the inexorable demand for efficiency. The move towards payment by results and foundation trusts has led us to become far more commercial than ever before. But being business-like is no bad thing – there is so much opportunity for waste and inefficiency, resulting in poor care for those who really need it.

In my first job we had one of the early CT [computerised tomography] scanners. It was a whole floor of technology, like an old IBM mainframe compared to an iPhone today. We are building a proton beam therapy unit at a cost of £150 million, and where is that technology going to take us in the future?

Colleagues I speak to around the world agree that the current models of health care are not sustainable. We're going to have to find a more cost-effective way forward. People will have to take much more responsibility for their own health, with less reliance on hospital care and shorter interventions. At present we have perhaps a third of beds blocked by patients who really don't need to be there, but in alternative less costly and more desirable settings.



And the government is quite rightly pushing seven-day working. How can that be achieved without a radical change in the allocation and distribution of hospitals? We need to have fewer hospitals with 24/7 service for emergency care simply because we don't have and can't afford the diversity of skilled staff needed to cover all the existing emergency departments without significant rationalisation.

You can't make an omelette without breaking eggs, so it looks like the politicians are going to have to make some difficult decisions on the future of the NHS. The public don't like changes to the NHS and the politicians don't like to make them. So the Blair/Milburn attempt to put the health service at arm's length, through foundation trusts, has largely been eroded by the current obsession with micro-management and centralisation – exemplified by almost daily inquiries about four-hour trolley waits or other similar political targets.

The golden period of NHS spending increases to match the European average is a thing of the past. We now fall well behind others and the stress is beginning to tell at the front line. The point of becoming a foundation trust is fast disappearing as we learn to become a directly managed unit again.

However, the NHS simply can't be managed from Whitehall and we will inevitably turn full cycle back to devolution, perhaps through accountable care organisations, such as in 'Devo Manc'. We have to give people like me responsibility for the management of population health, being incentivised to keep patients healthy outside of hospital rather than counting the click of the turnstile as they get admitted. Trusts like UCLH will have an important part to play in this in partnership with colleagues in primary care and the community. The priority for future investment should be in primary care allied to a fundamental revision of the role of GPs as independent contractors.

We are spending £150 million on proton beam therapy, but is this a higher priority than three or four comprehensive primary care centres operating at scale, in modern premises and aligned with social care? And where is the capacity and capability to achieve this? It isn't in primary care or in community services. And it isn't with the commissioners – capitated budgets and accountable care will fundamentally change their role. In practice the leadership capacity and capability normally, but not always, lies in the hospital sector.



So what is the job of a chief executive? I would argue it includes three things. The first is about reputation and motivation, the second is alignment with the local community and the third is knowing how the train set works so that when it breaks down you can fix it. The three skills needed are IQ, emotional intelligence and experience – in fairly equal measure.

When people come and say: ‘So what do we do now?’, I normally have a suggestion. And if it works they often say: ‘That worked great. How did you know what to do?’ The answer, of course, is that I’ve seen the problem several times before and after a while you get to know what works. But quite often if you’ve got evenly balanced choices it doesn’t really matter which one you make as long as you make it with confidence and conviction. In this job there are no perfect answers; normally it’s about compromise, fairness and what’s in the best interest of patients.

How has it all changed? Well when I started my career following the 1974 reorganisation, everything was decided on a consensus basis. If the hospital team couldn’t agree it got referred to the district team, and if they couldn’t agree it got sent up to the area or regional levels. People got used to shuffling decisions up and down the hierarchy and no real decisions were made.

The 1985 Griffiths reforms, which introduced general management (and subsequently chief executives), were seminal. They created a single decision-maker, an accountable officer, who could no longer pass the buck up to the next tier of bureaucracy – this meant that the job changed fundamentally. The role of chief executive has become a much lonelier place than the cosy consensus teams used to be.

Today’s financial pressures, oppressive regulation, increased public scrutiny and the spread of social media means that events are often getting out of control before you even know about them... that was never the case before. So it’s an exposed position to be in, and hence it’s hardly surprising that it’s a more vulnerable job where the average tenure of a CEO is now measured in months rather than years. And that’s one of the reasons why many aspiring middle managers are reluctant to move to the chief executive level – and hence the difficulty in filling many chief executive posts. So I think that the job has become certainly much more difficult, more challenging. To counterbalance that from a personal point of view, these jobs are a real privilege, a real sense of purpose and of course the longer you do them the easier they become because after a time the problems and their solutions come back to haunt you.



The most important rule is to build a great team around you. It's not what you do that's important. It's the extent to which you can motivate and encourage others to do their best. The chief executive is not a lone wolf who makes all the decisions – in reality I hardly make any decisions at all. Virtually everything is devolved down through the clinical management structure, through medical directors to clinical directors with strong clinical engagement. Some of my clinical directors have been doing their jobs now for 10 years. They are very smart people and once they learn their management skills they generally become really good at it.

Is there less support for people on the way up than when I started? Yes, undoubtedly. As a graduate trainee my first mentor was a guy called Ken Lewis. He was very inspirational and a hard task master but he took a real interest in my development. And Ray Lawrence, the regional staffing officer, whose job was to spot talent and steer the most promising through their career. So I'd get a call from Ray to say: 'There's a piece of work that needs doing over there for six months and I suggest you go and do it.' In this way I spent some time in a mental health trust and in community services and in the Department of Health so that by my mid-twenties I'd got experience in pretty much every aspect of the NHS. I got my first acting CEO job at 34 – a lifetime ago.

Little of that exists today. It much more serendipitous. If you are fortunate enough you might get a good mentor and the right sort of support, but lots of talented people lose their way and get frustrated. They either go off and do something else or get two-thirds of the way up the ladder and say: 'I don't really want to be a chief executive. I'm being paid a decent salary; do I really want to spend 24/7, with all that exposure, being a chief executive?' Work-life balance is much more important now than it was in my day, and middle management jobs are relatively better paid.

Most of the recent teaching hospital appointments have been from overseas; indeed it's possible that my successor will come from abroad. So we're clearly not training the next generation and, on top of that, as we said in the inquiry I ran last year [see [Health Service Journal 2015](#)], there are far too many organisations and thus far too many jobs with a chief executive title or equivalent. And so there simply isn't enough talent to go round.

I believe that we need only 30 or 40 commissioning organisations rather than over 200 and London can't support so many provider organisations. There needs



to be substantial rationalisation of NHS organisations and a real push towards developing accountable care organisations. They need to be large enough, perhaps covering populations of a million or so, and provide care across the spectrum of health care. The future is all about collaboration between health care organisations, not competition.

Your relationship with your chairman is crucial. When asked: ‘Who is the best chairman you have ever had?’, the answer of course is your current chairman! If you don’t have a good relationship you have a real problem, but you both have to work at it. A weak chairman or board makes the job even more difficult. I remember one previous chairman who was very executive and good at it too, but not such a competent chairman. So I often covered his back and him mine. So it’s really balancing the strengths of the relationship. It can be very difficult if you have a chair who is too far right or left. And the last thing you want is a public disagreement, which can be pretty terminal. If you need a challenging conversation then it’s back to the chairman’s office, not in the middle of a public meeting.

The regulators? Well, we had a very good relationship with Monitor and Bill Moyes in its early days. That hasn’t changed a lot although it is becoming much more intrusive now that everyone is failing financially. When the minority of hospitals have financial problems it’s probably their fault; when it’s nearly all of them then it’s the system. Real evidence of underfunding rather than overspending.

The CQC has grown out of all proportions and their inspections are really big events. And they can create huge damage. Look at Cambridge. There may have been a number of things wrong in Cambridge, but their ‘inadequate’ report will undermine its reputation for some time to come.

When I was a brand new chief executive up in Birmingham, I’d been there for six months and we got called up in front of the Parliamentary Select Committee for Administration. I’d not done one before and didn’t know what to expect – we got torn apart. Halfway through the hearing, one of the MPs slammed his fist on the desk and said: ‘This sounds like a prisoner of war hospital to me.’ And, of course, that was the headline in all the local papers, and it took us five years to get over it. In fact, one of the reasons we changed the name of the hospital was to get away from the stigma imposed by that one comment. Unfortunately the ‘inadequate label’ is now happening up and down the country. It’s a real problem that has to be addressed.



Finally, I look back with great pride at an organisation [the NHS] that is ‘the nearest thing the English have to a national religion’, as Nigel Lawson famously observed. But like all religions we need to treat it with the care and respect it deserves. Constant changes and political interference gives the impression of continuing crisis – an uncomfortable position for an organisation that commands such high status and national pride. In a similar vein, the role of the CEO is revered in many organisations, but not so in the NHS – here we are often seen as the cause of the problem rather than the solution. Politicians, clinicians and the media are all too eager to criticise NHS management but the reality is that hospitals are as complex as it gets and unless we develop and support their leaders then patient care will be all the poorer as a result.

Steve Shrubbs



Steve Shrubbs has worked in the NHS in mental health services for 40 years as a domestic, health care assistant, nurse, cognitive behavioural therapist, development centre director, mental health network director and chief executive officer. He has experience across the range of mental health services from primary care to high secure and had been a chief executive officer for 20 years in north and east London, mostly recently at the West London Mental Health NHS Trust. He retired in November 2015.

I've completed 40 years in the NHS and it has been quite amazing. I left school without any qualifications and started as a domestic and then a nursing assistant. I then became a mental health nurse and a general nurse and went on to train as a cognitive behavioural therapist at the Institute of Psychiatry.

I had a very low view of management, I have to say. I saw them as obstructive. I saw them as not looking at the bigger picture, and frankly I wasn't sure they were value added. But my mentor at the time and my clinical supervisor one day said: 'Look, we are fed up with you slagging off management. If you think you can do better, have a go.' And that pulled me up a bit short, to be honest. You spend your time treating patients and you get immediate feedback, but in fact there are other people in the system creating the conditions for you to be able to do that.



So I went away and thought about it and, to cut a long story short, I decided I would have a go. So I took a split job, which was half deputy director of mental health and half carrying on as a cognitive therapist. So my motivation, if I am really honest with you, started with me being very frustrated by management. And there is serendipity in this because the year I took this job the health authority was short of people to put into the graduate training scheme, and so they put me into it. And I got on, and over a relatively short number of years got into senior management and became a CEO.

I was in the north-east and Liam Donaldson (now Sir Liam) was the regional director and he had a view that people that had potential should have their pathway structured a little bit. So I became director of ops [operations] at the Northumberland Mental Health Trust – Simon Stevens worked in the same trust. And in those days – I am not sure it happens so much now – your pathway was developed for you and you were given a helping hand. So I was put under a very experienced chief exec, a guy called Dave Anderson, and I spent two or three years with him. He then decided to retire and I was encouraged to apply for this job.

My external assessor was Bill Kirkup and his feedback to me was: ‘We think you’re ready to be a CEO but we think you’re ready to start with a relatively small trust.’ So I think that was a really big advantage. If you like, it was a bit of an apprenticeship. It wasn’t just left to me. There were people around me who were saying: ‘We think this guy has got potential, let’s get him that experience and we now think he’s ready for his first CEO job but maybe not a very big complex one.’ That’s how the system helped me decide I was ready.

Personally, it became very clear to me that if you were going to really change mental health care, which is my passion, which is what I’ve done through most of my career, then the leadership role was critical. Because as a leader I had the opportunity to create the conditions for staff to challenge themselves and be the best they could. I realised that the leadership role actually could create the conditions for quite significant improvements in mental health care. I was relatively young when I became a CEO, I think I was 37 or 38. So it was quite important that both of those things played in, so the system telling me they thought I was ready and supporting me, and me feeling personally I was ready and being very clear what I felt I brought to the leadership role.



Even as a new CEO I was absolutely clear that the way you deliver high-quality, efficient, affordable care is to enable your clinicians to design, develop and to lead the services. At the end of the day, they are the ones that spend all the money, they are the ones that decide the right operations, the right prescriptions, the right care. So the clinical background helped and in my current job we've taken it to where all of our services are run by clinical service line directors who are all clinicians.

As chief executive you have the ability to set the tone, the culture and the values to create the conditions for the organisation to move on. I think that is one of the things that is most attractive about the job. You become an enabler to turn the vision of the staff into a reality. I mean clearly you're not on every ward, not out in the community delivering the care but you are enabling that. And I'm a big supporter of Professor Michael West and he is absolutely clear that the one fundamental factor that decides whether you provide good care or not is how engaged, how supported, if you like how loved, your staff feel. If you can get the staff feeling engaged, informed, involved and cared for then you will deliver good, efficient care and that is what you can do as a CEO. I think CEOs who try to work at a more granular level are probably not doing their job well.

The key for me is about giving your power away. So as a younger CEO, I'm not sure I always got that. So the key is to use the power you have to give it away to the leaders in your organisation so that they can actually create the change process and feel part of it. So for me it is very much a distributive model and that is what I find attractive. The command and control stuff, if it is attractive it's only attractive for a fleeting moment.

The difficulties for leaders comes from the fact that the NHS is never allowed to settle, and it is increasingly difficult to keep your staff engaged when you are trying to navigate change after change after change. The other thing that has become much more apparent in the last six or seven years is the way that CEOs are blamed by the political system. Clearly, if they are not honest or are fraudulent they should be held to account. But what's changed is the way government politicians and the media paint CEOs as negative, as obstructive, and as overpaid – 'you can't earn more than the prime minister'. We are increasingly portrayed as greedy fat cats who would do anything to save their butts. We are much more public property with the social media stuff and I've had some experience of that where the press attacked me and



the organisation, and because of social media that's actually affected my wife and children. I can understand why a number of younger executive directors wouldn't want to put themselves in that position.

Strangely enough, coping with no money is something that most NHS CEOs are accustomed to. Clearly, it impacts on care and is very challenging. I've been a chief executive for nearly 20 years and this is the third recession I've lived through. So coping with lack of resources is not something that I would put at the top of the list of things I don't like about the job, because that comes with the territory and can often drive innovation. For me it is more the way we are unfairly portrayed. Most people who come into the NHS are fully aware that it is a public service and therefore we must be accountable to the public. But it's gone too far when we are portrayed as being dishonest, or incompetent, being only motivated by our own interests. And the Department of Health rarely stands up and says: 'Hang on a minute, that's not fair.'

And I think a number of CEOs feel that the ground they are on is relatively fragile and that, if something goes wrong, the system will offer them up as a sacrifice. Take Keith McNeil at Cambridge – someone who was encouraged to leave their country, to come over and to take on a really tough job, and to find a different way of working. It looked like he was being blamed, that he was being sacrificed. Very few people came forward to put his point of view.

I do think we need to go back a bit and take a more structured approach to developing our leaders and giving them a more varied set of experiences. I was lucky in that after I'd been a CEO for a while I went to the National Institute for Mental Health, which taught me some transformation skills, and then I ran the Mental Health Network at the [NHS] Confederation. And that exposed me to the politics of health and helped me understand how government worked in regard to health and social care. I got to work across a wide range of providers, and across other sectors, not just the public sector, which gave me a better whole-system understanding.

A short while after I arrived here the Jimmy Savile scandal exploded and people often assume this was my most difficult time as a CEO. But although I had not experienced anything like that in my career before, it wasn't as difficult as you might assume because we were clear from the start that we had to be honest and open about it all, with the staff, the public and with patients. I was supported in my open,



honest and frank approach by the system, my chairman and my board throughout. It's been an honour and a privilege to be a CEO in the NHS but I do think we need to do more to prepare our talented leaders early on in their careers to lead in a very challenging environment. Surrounding them with people who can nurture them and can support them from an early stage is key. And we need to apply the same supportive values to CEOs that we seek to apply to the rest of the staff.

Tim Smart



Tim Smart joined King's College Hospital NHS Foundation Trust as Chief Executive in 2008, having worked for BT for 19 years, and before that, Shell, in a variety of general management and leadership roles around the world. He retired in early 2015. He was a founding member of the boards of King's Health Partners, of Viapath, of the Shelford Group and of NHS Providers. During his tenure, King's College Hospital was accredited as a major trauma centre and a heart attack centre, opened a clinic in Abu Dhabi, and acquired the Princess Royal University Hospital in Bromley as part of the trust administrator process, which unwound the South London Healthcare NHS Trust. Tim is now enjoying a plural career, helping start-ups in the health and social care sector.

Well, I think the system was broken by the 2012 [Health and Social Care] Act. And that's a real shame. The Act did do some good things. Clinical commissioning is right, although I think there are too many clinical commissioning groups. London has 32, for heaven's sake.

But the really, really bad thing it did in my estimation is that it dissolved the strategic health authorities. Now I only have experience of the London one under Ruth Carnall. King's was a foundation trust. But Ruth still used to have these quarterly meetings and I remember some foundation trust colleagues saying: 'You are being disloyal, you shouldn't go to these meetings. She can't tell you what to do.' And I was saying: 'But she isn't telling me what to do, and crikey we do need to work together.'

And I do think some of the performance problems of the NHS now are due to the fact there isn't this structure that could bring people together and say: 'We've got to sort this out.' There is nobody to do it. So we end up with this star chamber



approach, where you have NHS England and all the regulators in the room, and everyone is grilling you about why you weren't achieving this, or why you weren't achieving that, and no one is trying to find a solution.

I think the regulators were put in a very difficult position. It was all politically driven. But the SHA in Ruth's day would call everybody together and try to hold the ring, get everybody working together and avert disaster, while making some really good things happen like the stroke reconfiguration and the trauma network.

With the purity of the management model – a separate NHS England, Monitor, the Trust Development Authority, CQC and so on, the different commissioning bodies – all that just collapsed. Who can make the trade-offs between different CCGs and different hospitals and local authorities? They have to try to come together. But there is no place for them to come together and no one to 'hold the ring'.

I'm a bit unusual as an NHS chief executive because I came from the private sector. I'd been with Shell and BT and my role in BT had brought me in contact with the NHS. And I just fell in love with it really. I was at that stage in my career when I could make a step change, and I wanted to do something completely different, and I wanted to make a difference.

And I have to say I have never done anything more rewarding and enjoyable in my life, even given what happened in my last six months. And even compared to running a pretty big part of BT. It is far more rewarding.

I saw my ultimate accountability as being to the patients. And I had the beauty of having George Alberti as my chairman. And he kept saying: 'It's all about Mrs Ishmael in Bermondsey High Street.' So King's had all its international specialities and its goal of being the world's best this, or the world's best that. And all that really mattered. But what George really brought home to everybody was that it was the 75-year-old diabetic in Brixton who was most important. Yes, the liver transplant patient from Aberdeen was really, really, important. But not more important and no less important than Mrs Ishmael from Bermondsey High Street. And that is why the NHS is there.

And I always took the view that, yes, we had to be able to sort the money out. But that was not the main purpose of being there. The main purpose was to make a difference to patients, and to the lives of the people who worked on the front line for the trust.



And I have to say there is no greater talent in the private sector than the public sector. The quality of people you are working with – the clinical professionals whether it is the doctors, the nurses and the allied health professions – are higher quality than any other staff group I have ever worked with. And that's in both Shell and BT. And if you read Shell's recruitment literature it started with the words that: 'Shell only recruits from the top 5 per cent of graduates worldwide.'

Not all the management group in the NHS are as good as their peers in the private sector but the best would thrive anywhere. They achieve so much. Stuart Rose, the former chairman of Marks & Spencer, spent a day with me when he was doing his management report. We went out to dinner at the end of it and he said: 'There's no way I would ever consider coming to do your job. I wouldn't recommend it to anybody.' And I said: 'Why? It's a fantastic job.' And he said:

Look, I've been with you for one day and I've counted dozens of stakeholders. As far as I can see, all of those stakeholders have got slightly misaligned incentives. So your job when you come to work is to decide which of your stakeholders to disappoint.

When I was running Marks & Spencer I had three stakeholders. They were the customer, the shareholder and the employee, and it was quite straightforward. So you are destined to fail.

But the best managers in the NHS, and the best chief executives, and the best clinicians in fact, manage all that to help deliver great care.

Now personally I feel that the chief executive of these organisations like King's ought to be a clinician. I was lucky in having George, and I worked to bring a more clinical focus to the board. But, in a way, I feel the fact that I became chief executive of King's is a bit of failure on the NHS's part. Doctors and nurses are among the most talented professionals in the country. So why are there not 30, 40, 50 of these people running the big organisations? There are some – Jonathan Michael when he was at Guy's and Tommy's, and then Oxford, Julie Moore at Birmingham and some others, of course.

But it is something chief executives should prioritise. Clinicians need some support and mentoring to get there. And Ruth had a programme called the Next Generation CEOs, which included people with clinical backgrounds. And the funding for that



just got cut. It didn't cost that much and it has gone. Who would do it now? There is no organisation to do it, is there?

Did I have support and where did I look for it from? Well I had George and there were very good people on the board who were supportive. And I was a member of the Shelford Group (the chief executives of academic medical centres) so I had Ron Kerr and Robert Naylor and Julie Moore and Len Fenwick, and I worked closely with Ron and Stuart Bell locally because we were part of King's Health Partners. So I had a lot of informal networks that worked.

But when I look back to my time at Shell, they had about 100,000 people working for them. But they managed the careers of about 200 of them. And out of that 200 the top people in the Shell Group emerge, generation after generation. They get moved around the business and supported and coached. And there is nothing of that sort in the National Health Service, and I think that is a shame.

Our problems at the end came when we took over the Princess Royal in Bromley. And there were big problems there, which we were not fully told about, but we felt we had to take it over to do our bit. It caused a lot of heartache. What we thought we'd acquired in May 2013 was performing significantly worse when we walked through the door in October. So we got into a big deficit and NHS England found it impossible to distinguish between what was King's, which was fine, and what was Bromley. The quality of care in Bromley is now materially better than it was, and it will take five years to sort the whole thing out. But south-east London will be a stronger place when that is done.

4 A leadership and organisational development perspective

Marcus Powell



Marcus is the recently appointed Director of Leadership and Organisational Development at The King's Fund. Before joining the Fund in March 2016, Marcus spent seven years as Group Human Resources/Organisational Development Director for Nuffield Health. Before this Marcus was part of the leadership team of Ashridge Consulting. During his time at Ashridge he designed and delivered change and senior leadership development programmes for clients including Unilever, BBC, Jaguar Land Rover, Masterfoods, Grant Thornton and Schroders.

Marcus began his career at Marks & Spencer, where he spent 12 years as part of the clothing buying teams before making the transition into human resources where he held the role of Group HR Strategy Director and then Group Head of Learning and Organisational Development. He holds a Masters in organisational change and consulting and a Masters in executive coaching as well as being accredited in a range of psychometric instruments

I'm reading these chief executive stories as a newcomer to the world of the NHS, having spent my entire career outside the public sector in executive positions at Marks & Spencer, as a change consultant at Ashridge Business School and more recently on the board of Nuffield Health. I'm hearing the warning from Nicholas Timmins that they represent the views of the departed or soon to be departed, perhaps with some reminiscing about the past and grumbings that the role of chief executive is difficult and lonely. I understand that it's never been an easy job, resources are tight and managing the complexity of the duality of legislation and regulation has always required skill and judgement. If I think about the work I've



done with boards and senior leaders in the private sector it would perhaps also reflect the same views, so nothing new so far. However, the underlying issues that these stories point to, feel, even to me, to be signals of a system that's buckling under a heady cocktail of factors that we ignore at our peril. If this was a report that was presented to the leaders of a company in the private sector, it would create the basis for fundamental change and action.

Much has been written about the difficulty of attracting talented leaders into health, but health is no different from any other sector in that respect. All the best organisations are fighting for the best talent – and there is a shortage. Good people can pick and choose and they are better informed than at any other time in history about what it's like to work in a particular sector. It doesn't even work any more to simply broadcast the rhetoric that health can offer the most satisfying and rewarding career. The advent of social media, the constant news about lack of funding and over-regulation can very quickly provide access to a different truth.

I am struck by the consistency of the commentary that the levers to do the job have been nailed to the floor; that the system micro-manages; and that, at times, regulation seems to favour process rather than outcome. This is a toxic combination and one that no talented leader, whether clinical, financial or administrative, would want to endure for long. So something needs to change.

Vibrant and healthy organisations must constantly adapt and change if they are to be able to respond to a shifting context and environment and there has never been a time when change is more needed in health than now. An ageing demographic, increased life expectancy and a better-informed and demanding population all increase the pressure on a system that has not received sufficient funding in recent years to keep pace. In change parlance, first-order change is now not enough. A complete paradigm shift is around the corner and, hearing the views of these chief executives, we don't seem prepared for it.

This shift will need leaders who are confident, competent and have the energy to innovate. They have to be able to take risks to try out the new and experiment with novel ways of providing a service. The environment in which they lead needs to be responsible, responsive and above all supportive to seek out new ways of working that go beyond the current paradigm. Such an environment is exciting and rewarding and will attract the best talent, who will create the change that



is needed. It becomes a virtuous circle that the best will attract the best and the negative contagion that we are currently experiencing will be replaced by one that is positive and innovative.

This report suggests that we have a long way to go.

The experience of high-performing health systems and the work done in understanding the nature of innovation in the private sector perhaps provide some of the clues to what systemically we now need to pay attention to:

- **The role of the regulator.** The burden of regulation and related loss of autonomy were a theme in the chief executives' interviews. We know that innovation appears in the most unexpected places and that regulation is the killer of innovation. It's not unusual for organisations that operate in a regulated environment to cease to be able to adapt because they are strangled by regulation that goes way beyond aspects of the operation that properly need to be regulated. A regulatory environment that is focused on consistency and order goes in the opposite direction to one that values and encourages innovation – it values staying the same rather than changing. In the private sector these organisations simply become irrelevant and are replaced by new ones that provide a new and innovative service. In the context of a national health service this isn't possible. So if innovation and change are essential and over-regulation kills that, then now is the time to stand back and consider what the purpose of regulation is and where it is going too far and exceeding its remit.
- **Innovation and the leadership culture.** When change is needed, leaders need to be at their most confident. They have to relish trying out new things and experimenting, amplifying the best and discarding what doesn't work. The bullying and fear of failure that many health sector leaders experience and that are recounted in this report does the exact opposite. Leaders retreat into what they know and behave in a way that does more of the same and the change never materialises. In the context of this report, bullying is systemic; it comes from all directions externally, not the least of which are the politics of health, the media, regulation and financial constraints. Not only that, the bullying is contagious and soon the bullied themselves become the bullies. So it's not surprising that patient care quickly becomes affected. At some point the system has to collectively address this and recognise that all aspects of the system are contributing to and colluding with this. This is not a utopian dream; it's becoming a necessity.



Shifting this culture starts locally, and much is being done. Most local leaders know that a positive, engaged workforce will deliver higher-quality care. However, this local endeavour has to sit in an environment that fosters and encourages it. So the challenge is for the national bodies, regulators and legislators, the media and the local communities to work together to fundamentally shift their attitude. If we want a vibrant, innovative health sector then the systemic bullying has to stop.

- **Nurturing talent.** The best leaders can lead in many contexts. They adapt their style according to the challenges they face because they can draw on experience – experience that the system nurtures and values. This experience gives them the confidence to innovate; they know the boundaries of what is possible and what is unacceptably risky. The responsibility for individual progression should be with the individual. But when talent is scarce and leadership is the valuable currency, more needs to be done to secure talent, nurture it and provide a leg-up in an increasingly complex and fragmented environment. Resources need to be secured to provide development, establish career pathways and define the ownership of extraordinary talent for those individuals and talent groups that deliver disproportionate value. It is striking how many testimonies in this report lament a lack of support for leaders on their way up.

The role of NHS Improvement here is clear and urgent. While local trusts have a responsibility to develop and nurture their own, we need a national talent strategy that aims to take a broader, longer-term approach. This means that assistance can be properly given to help manage careers and create opportunities so that we have bench strength to serve us well for the future. Funding constraints on developing talent must be addressed to allow The King's Fund and other organisations that have a long history of leadership development to support this area.

- **Can the real experts please stand up.** The mix of issues that face leaders in today's health economy seems more complex than at any time in recent years. Reading between the lines of the interviews, there is a sense that the leadership challenge is almost impossible or at best progressively exhausting, with few accolades when things go well. When things don't go well, however, 'experts' line up to dispense seemingly endless advice.

There needs to be a fundamental reassessment of the attitude in the system and of how we can create an environment where improvement and innovation are the norm. First we need to acknowledge that the expertise to navigate the



complexity of the issues lies first and foremost with those people who face the challenges. If we want leaders to lead then we have to appoint the right ones and let them get on with it. Then those national bodies that aim to intervene should reframe their 'help' as working in partnership.

That's not to say that targets shouldn't be set along with the expectation that they are met. But an environment of co-operation and support that acknowledges what's working as well as what's not is a far more generative culture than the one described by the chief executives in this report. My experience is that the private sector learnt this lesson long ago.

I acknowledge that these four reflections in themselves are simplistic. However, as someone who is looking at this situation fresh, I believe that the consistency of the commentary should be deeply worrying to anyone who has an interest in health. And we all do.

The creation of NHS Improvement gives us a real opportunity for change but the forces at work to keep any system the same are stronger than people acknowledge. Why wouldn't they be since it's the same people doing slightly different roles? The task is to support and encourage them to adopt the paradigm change that's now needed and not just reinvent the past. Government must take its part seriously, attempting to step beyond the short term and be the guiding force for change.



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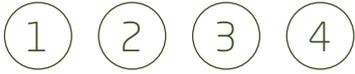
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Nicholas Timmins is a Senior Fellow at The King's Fund where he works part-time on a range of policy projects. He has led a joint piece of work with the Institute for Government using the NHS reforms as a case study of policy-making in coalition government.

Between 1996 and 2011, Nicholas was Public Policy Editor at the *Financial Times*. He has written extensively on public and private health care over the years and has worked with The King's Fund on a number of reports, including *A new settlement for health and social care* and *The practice of system leadership: being comfortable with chaos*.

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There is a widespread perception that there is a 'crisis of leadership' within the NHS, illustrated in part by the difficulties in recruiting and retaining chief executives. What is the cause of that? What can be done about it?

The chief executive's tale: views from the front line of the NHS, jointly published by The King's Fund and NHS Providers, gives a voice to 12 NHS chief executives. What is the job like currently? How does it compare to the past? To whom do they feel accountable? How do they cope? And how far do they feel there is a pipeline of successors to follow them?

The interviewees include some long-serving chief executives and they come from a wide range of backgrounds, including commissioners as well as providers in acute, mental health and community care. They are all hugely positive about the job - most notably the opportunity to improve health care for large numbers of patients. But they are also crystal clear about its current difficulties: the result of financial constraints; what they see as over burdensome, and indeed, constraining regulation; the much greater public exposure that chief executives can face these days and, for some, a culture that is still seen as bullying.

Marcus Powell, the new Director of Leadership and Organisational Development at The King's Fund, draws the report to a close, concluding that a complete paradigm shift is needed in the way the NHS is run - one that will require competent, innovative leaders who can take risks, in a responsible, responsive and supportive environment.

These tales provide an honest account of the realities of leadership in today's NHS and have much to teach others in the system.

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