The King's Fund> NHS Providers

Leadership in today's NHS

Delivering the impossible

Siva Anandaciva
Deborah Ward
Mandip Randhawa
Rhiannon Edge

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Foreword

Our report on leadership vacancies is full of important findings for the NHS nationally, regionally and locally. The data and insights it contains really matter – high vacancy rates and turnover have a significant impact on culture, staff engagement and performance and disproportionately affect the most challenged organisations in our system. It is somewhat depressing that some of these conclusions could have featured in a similar report published five or ten years ago, although much has also changed. The task, or rather the shared mission, for all leaders should be a commitment to address these issues wherever they operate in the system – as no single action or investment will close the gaps we set out.

Compared 2014, when The King's Fund conducted a similar analysis, the good news is that length of tenure has increased, with the average tenure for a chief executive up from two and a half years in 2014 to three years now. But this is still very short and the level of churn in all the executive director posts we looked at remains worrying; the ability to recruit high-calibre chief operating officers is of particular concern with growing demands on services. Since 2014, things have moved on – a changing of the guard with many of the longest-serving chief executives having retired and a new generation of talented leaders coming through including many more clinical leaders. There have been some positive steps to improve the diversity of leaders, but there is still a huge amount to do before the NHS has leadership teams that truly reflect the communities they serve.

When Aneurin Bevan spoke in the House of Commons during the second reading debate on the NHS Bill on 30 April 1946, he talked about the need to be 'open to take the best sort of individuals on these hospital boards which we can find, we hope before very long to build up a high tradition of hospital administration'. The ambition of employing the best people remains, yet the NHS has changed immeasurably since its birth and new models of leadership are now required. Leadership of complex systems requires different ways of working as organisations move away from operating as separate entities towards working together in systems of care. The ability to work collaboratively across organisations without being defensive about your own is now vital and many senior leaders spend as

much time outside their organisations working with local partners as they do in their own.

We found that the inverse leadership law is still very much in force, with the most challenged organisations experiencing the biggest differences in recruiting and retaining leaders – a new approach is needed to address this, focused on how best to support local teams and systems to develop their workforce. Investment in national programmes should be extended to focus on roles with the most vacancies and shortest tenures. The recent Aspiring Chief Executive and Aspiring Chief Operating Officer programmes, led by NHS Improvement, NHS Providers and the NHS Leadership Academy, are a good start.

Changing requirements mean that leaders themselves need to adapt or be replaced by new leaders with different approaches. But creating and developing effective pipelines of leaders needs investment and not just money. It is crucial that senior leaders across the system invest personal time and influence to embed the necessary collective and compassionate leadership behaviours in their organisations and systems.

Yet exemplary leadership development is not enough on its own to address the issues the NHS faces. If anything, pressures have increased with a cocktail of growing financial and operational pressures, unrelenting media and political attention on the NHS and an increasingly personalised approach to performance and financial failure. The NHS can develop fantastic, diverse leaders, equipped to work in the new NHS, but this investment will be wasted if those leaders are not attracted to senior roles or if those roles are, in reality, un-doable. Removing senior leaders from their roles for failing to manage the unmanageable plays a huge part in putting potential leaders off taking senior jobs and more needs to be done to improve the environments in which leaders are operating.

Responsibility for leadership has to be spread across the system, an overly centralist approach will not work, but as Dido Harding, Chair of NHS Improvement, put it a stronger 'guiding hand' from the national bodies is a promising sign that leadership is now higher up on the national agenda. The NHS doesn't need another review or shake up to address the leadership gaps – there have been enough of those in recent years and *Developing people – improving care* is the national framework to

help guide local, regional and national action on developing NHS-funded staff. But implementation requires ongoing commitment, focus and discussion at every level of the system.

We know how to identify talent and develop it and have plenty of examples from other sectors to learn from. Some local leaders are doing this well already. We hope that this report provides a helpful contribution and added impetus to the discussions that are required to prioritise and invest in effective talent management systems and continuous professional development for leaders of all backgrounds.

When the ink dries on the new ten-year plan for the NHS, we truly hope that the focus on people, leadership and culture is clear and unequivocal.

Suzie Bailey, Director of Leadership and Organisational Development,
The King's Fund

Chris Hopson, Chief Executive, NHS Providers

Key messages

8 per cent	**37 per cent**	**54 per cent**	**3 years**
Executive director posts vacant or filled by an interim	Proportion of trusts with at least one vacant executive director role	Executive directors appointed in the past three years	Median tenure of a chief executive
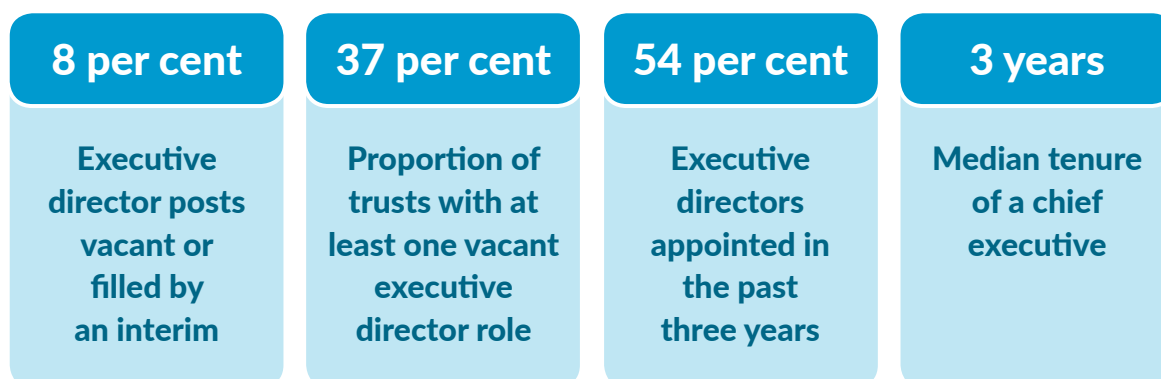
- NHS leaders view their jobs as both a vocation and a privilege. But a near-toxic mix of pressures facing NHS trusts has added to the challenges faced by NHS leaders and, as a result, these roles are less attractive.

- A culture of blaming individual leaders for failure is also making senior NHS leadership roles less attractive. Greater recognition is needed that failure can arise due to system-wide causes rather than the action of individual leaders, and that even the best leaders will encounter difficulties in their careers. More time and support are needed for local leaders taking on challenging director roles.

- The churn of senior leaders in the NHS is a significant problem. Eight per cent of NHS trust executive director posts are vacant and there are particular challenges in recruiting chief operating officers and strategy directors.

- Length of tenure is a concern for all the executive director roles we looked at, but the short tenure of chief operating officers is a particular concern. This reflects the substantial pressure being placed on these positions during an unprecedented period of financial austerity and performance challenges for the NHS.

- Organisations with the most significant performance challenges experience higher levels of leadership churn. There is little evidence that national bodies are tackling this 'inverse leadership law' effectively.

- High vacancy rates and short tenures have a negative impact on the culture and performance of NHS trusts, often leading to less-engaged staff and organisations that are more focused on operational issues than improving services.

- Current pressures in the NHS are making recruiting organisations risk-averse when considering less-experienced candidates and candidates from other sectors. This is exacerbating the existing challenges in recruiting future NHS leaders and risks narrowing the diversity and experience of NHS leaders.

- The leadership of NHS trusts is not diverse and does not reflect the wider NHS workforce or local communities. But there are some promising signs that publishing data on leadership diversity is having a positive impact and leading to a stronger focus on this issue in NHS trusts.

- A new generation of NHS trust chief executives is pursuing the type of collective leadership that The King's Fund and NHS Providers have argued is required in health and care systems. But greater recognition of the importance of systems leadership is needed in appointing future leaders.

- National leadership development programmes should expand their focus to include those board roles that are experiencing particular recruitment challenges. The regional talent management functions formerly performed by strategic health authorities are missing and have not been replaced in the current NHS. Rebuilding this function should be a priority for the new joint NHS England and NHS Improvement regional teams, working in partnership with other regional and local bodies.

① Introduction

In December 2014, The King's Fund reviewed the level of leadership vacancies in NHS provider organisations to support the *Health Service Journal*'s (*HSJ*) Future of NHS Leadership inquiry (**Janjua 2014**). We found that almost a third of all NHS trusts and foundation trusts had at least one vacancy at board level and the average tenure of a chief executive was little more than two and a half years. Our report noted the negative impact that board-level vacancies have on staff morale and the management of these organisations. We recommended that more concerted local and national action was needed to recruit and retain board-level leaders in the NHS.

Over the past four years, much has changed.

At the time of our 2014 review, NHS performance and financial targets were broadly being delivered, the *NHS five year forward view* (**NHS England** *et al* **2014**) was not yet three months old, and the Dalton Review (**Department of Health 2014**) of the future shape of the NHS provider sector had only recently been published. The task facing an NHS trust board remained largely focused on the effective running of its own 'sovereign' organisation.

Fast-forward to 2018 and leaders of NHS trusts are now increasingly expected to look beyond the four walls of their organisation and work as part of local health and care systems to transform how services are delivered. This change has been welcomed by leaders but requires different leadership skills and approaches to the past. And this transformative work is taking place against a backdrop of rising demands on services and prolonged austerity in NHS funding.

Financial and performance pressures and an unrelenting focus from national regulators, politicians and the media all compete for the limited time that senior NHS executives have. Several chief executives have also recently left or been removed from their posts due to the financial or performance pressures that are widespread in the NHS. The task of NHS leadership is not getting any easier.

The NHS has also seen a 'passing of the torch' in recent years as a cadre of experienced NHS leaders retired. Nine of the ten longstanding chief executives of the prestigious Shelford Group of hospitals – which once claimed 200 years of leadership experience between them – have announced their retirement or already left the service since our last report (Hawkes 2013). Our 2016 report entitled *The chief executive's tale* captures the reflections of many of these experienced leaders (**Timmins 2016**).

Since our 2014 report on leadership vacancies, no less than three national reviews (**Naylor 2015**; **Rose 2015**; **Smith 2015**) have attempted to untie the 'Gordian knot' of ensuring that the NHS can build the pipeline of leaders it needs. And a coalition of national bodies has come together to develop a new national framework, *Developing people – improving care* (**NHS Improvement** *et al* **2016**), to guide NHS leadership development and talent management.

Because of the rising pressures and the evolving nature of the leadership task in the NHS, we have chosen to revisit the challenges of recruiting and retaining executive directors in NHS trusts and foundation trusts. This report presents an analysis of data from a recent NHS Providers survey of leadership vacancies in NHS trusts and foundation trusts, and the results of qualitative interviews and a roundtable The King's Fund conducted with frontline leaders and national stakeholders.

The report focuses on executive directors within the NHS trust and foundation trust sector. The challenges of recruiting and retaining both executive and non-executive leaders in other parts of the health and care system are no less important, but the data on this is less readily available. We hope to explore the challenges facing these sectors in our future work.

2 Survey findings

This section summarises data from a survey of NHS trusts and foundation trusts carried out by NHS Providers in late 2017. The survey was sent to all 232 NHS trusts and foundation trusts in England (referred to collectively as 'trusts' throughout the rest of this report) and responses were received from 145 trusts (63 per cent). These organisations are broadly representative of the wider sector, although only a quarter of trusts rated as inadequate by the Care Quality Commission (CQC) at the time of the survey responded.

Responses were received for 897 executive director posts across the 145 organisations. An NHS trust board typically includes the following executive director roles: chief executive, finance director, medical director and nursing director. Larger organisations might have more roles on a board; for example, some teaching hospitals have three medical directors on their boards.

Some trusts have added other executive roles to their boards, for example: deputy chief executive, director of strategy and transformation, director of workforce or human resources and director of operations (the last of these is also known as chief operating officer). Larger NHS organisations that operate across separate geographical sites may also have managing directors who manage these sites and attend board meetings.

Further details about the survey methodology and responding trusts are presented in the Appendix.
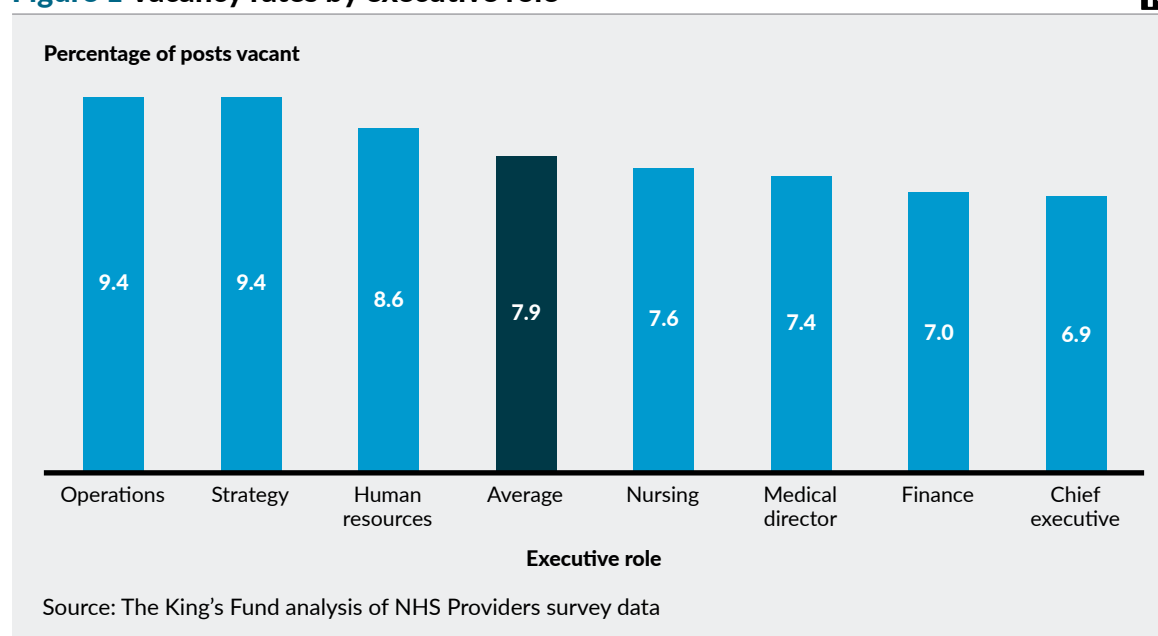
Vacancy levels

Across all types of trust and role, 8 per cent of executive director posts were filled on a non-permanent basis (these include vacant posts and posts filled by an interim appointment and are collectively referred to as 'vacancies' throughout the rest of this report). Not all of these vacancies were due to an inability to recruit. For example, some trusts appoint interim directors during the transition phase of merging with another organisation.

The highest vacancy rates were for directors of operations and for executives performing strategy, planning and transformation functions. Chief executive and finance director posts were the least likely to be vacant (*see* Figure 1). This contrasts with our previous study on leadership vacancies (**Janjua 2014**), which found that the highest level of vacancies was for finance directors and the lowest was for strategy roles.

Figure 1 Vacancy rates by executive role

Percentage of posts vacant

Executive role	Percentage
Operations	9.4
Strategy	9.4
Human resources	8.6
Average	7.9
Nursing	7.6
Medical director	7.4
Finance	7.0
Chief executive	6.9

Executive role

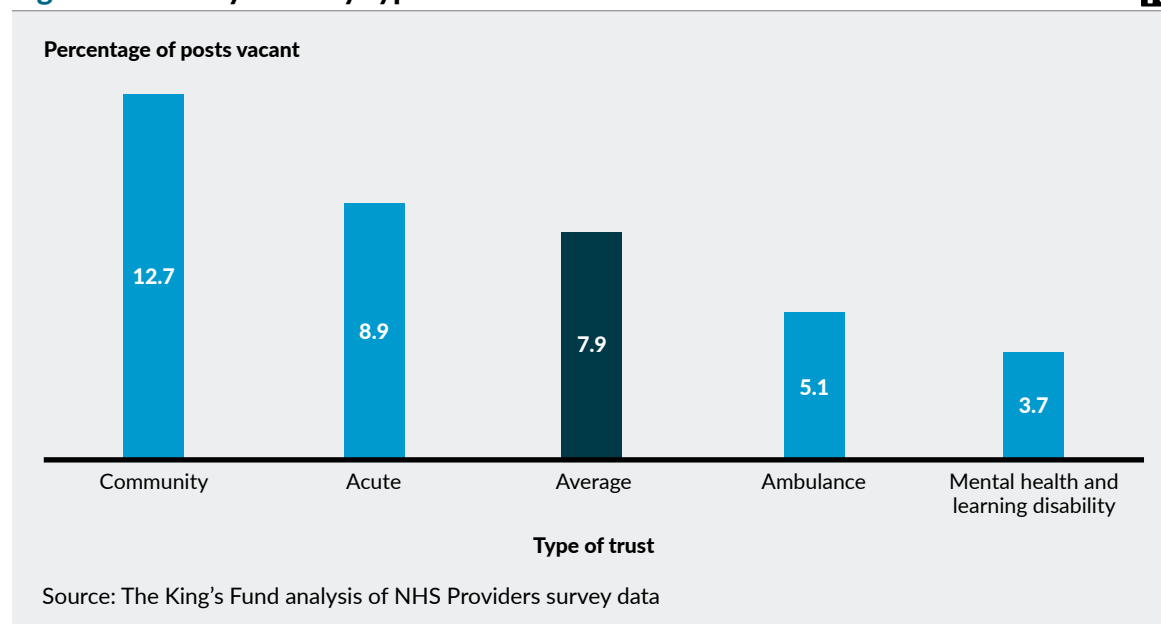Source: The King's Fund analysis of NHS Providers survey data

This pattern may reflect the changing priorities of the NHS over the past four years. The financial health of NHS providers has deteriorated precipitously since 2014 and interviewees for this report suggested that it is less tenable to keep finance director posts vacant or filled on an interim basis. Also, the increasing focus on

strategic transformation through sustainability and transformation partnerships (STPs) and integrated care systems may have increased the demand for directors of strategy and transformation, but there is a limited supply of available people to fill these roles.

Vacancies were relatively widespread across the provider sector, with 37 per cent of all trusts having at least one vacant post for a board-level executive. Trusts providing community services had the highest percentage of vacant posts and mental health and learning disability trusts had the lowest (*see* Figure 2).

Figure 2 **Vacancy rates by type of trust**

Percentage of posts vacant

Community	Acute	Average	Ambulance	Mental health and learning disability
12.7	8.9	7.9	5.1	3.7

Type of trust

Source: The King's Fund analysis of NHS Providers survey data

Our previous report on leadership vacancies (Janjua 2014) noted that community trusts may face greater competition for employees with local authorities and third sector providers. Community services also remain an 'inconsistent priority' for national bodies (NHS Providers 2018a). The continued structural uncertainty and strategic direction for community providers and services may be having an impact on vacancy rates within these providers. As one community services director said: 'Losing just one big contract has a huge impact on our attractiveness as an organisation and employer.'

Tenure of NHS directors

More than half (54 per cent) of substantive executive directors were appointed in the past three years (2015 to 2017), with 18 per cent appointed last year (*see* Figure 3).

Figure 3 **Executive directors' year of appointment**

Source: The King's Fund analysis of NHS Providers survey data
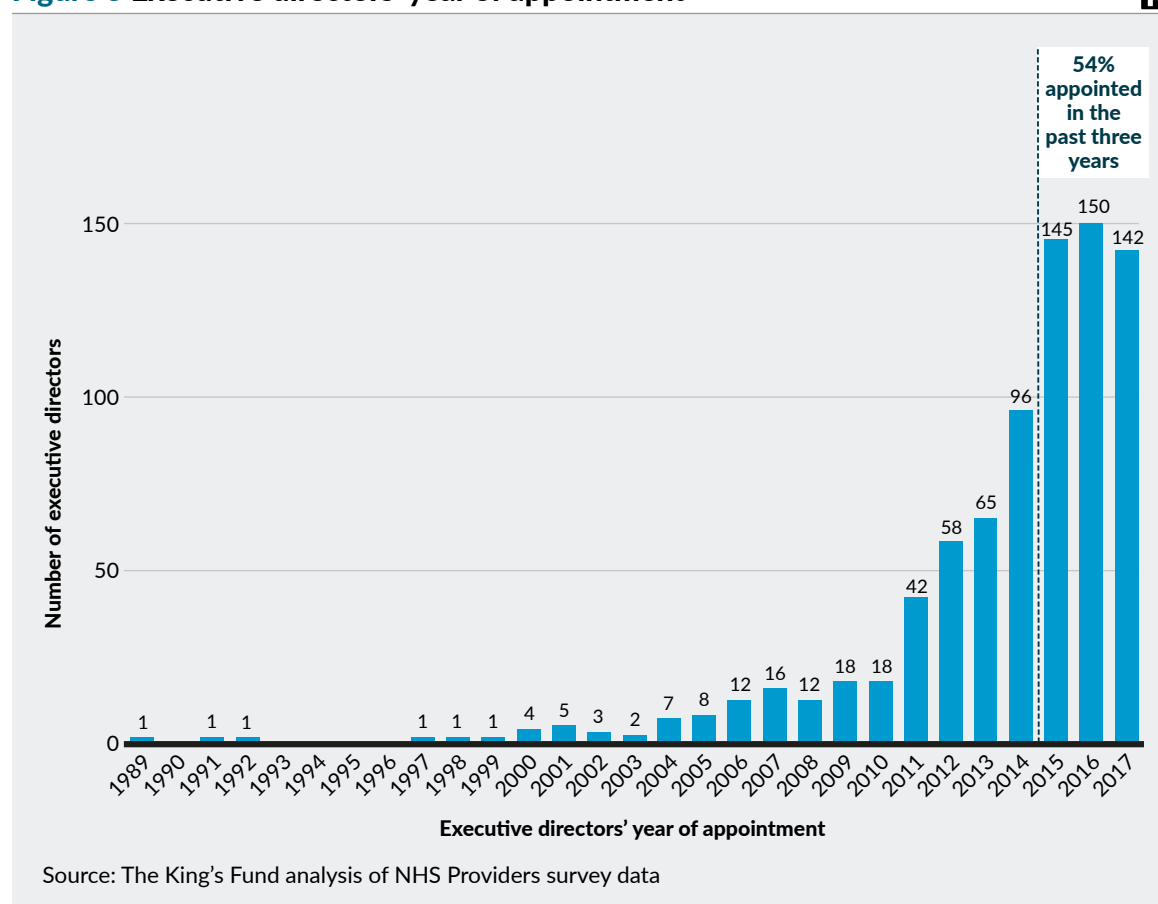
Looking across the different professional roles, operations and finance/commercial directors were most likely to have been appointed in the past three years and chief executives were the least likely (*see* Figure 4). As one national stakeholder said: 'In the last 18 months to two years, the acute chief operating officer has been the toughest post to fill. It vies for top spot with finance directors. This isn't surprising as finance and operations are the areas of greatest angst and pressure in the system.'

Figure 4 Percentage of permanent executives appointed in 2015–17, by executive role

K

Percentage

Operations	Finance	Nursing	Average	Medical director	Strategy	Human resources	Chief executive
63.5	58.9	55.8	54.0	52.6	52.0	50.0	45.1

Executive role

Source: The King's Fund analysis of NHS Providers survey data
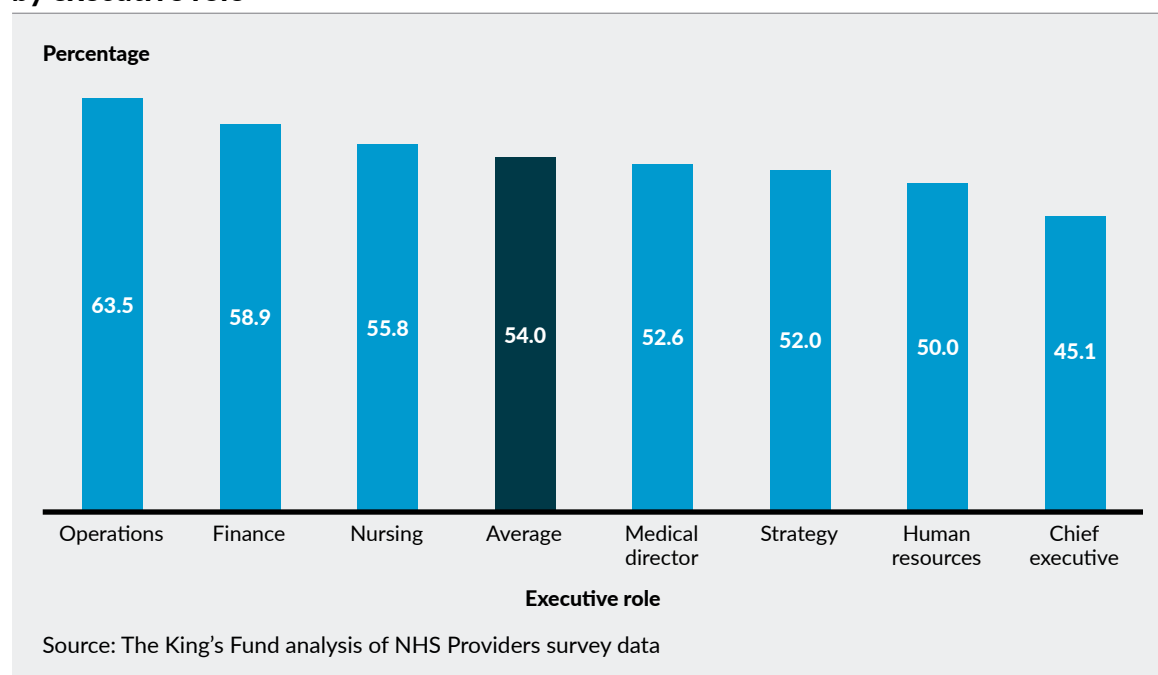
We used data on directors' year of appointment to estimate their tenure. When using the median – the figure that falls in the middle of a range when all tenures are ranked from smallest to largest and that is less affected by extreme values – the average tenure for all substantive executive directors was only two years.

The median tenure for substantive chief executives was three years and the mean average was four years (*see* Figure 5). This was slightly longer than previous estimates of NHS chief executive tenure, which may have been calculated on a different basis or included a different number of NHS trusts. For example, in July 2017 the *HSJ* found that the median chief executive tenure was two years and eleven months (**Brennan 2017b**).

Of the substantive chief executives surveyed, 17 per cent had been in post for less than a year, 19 per cent had been in post for between five and ten years and only 11 per cent had been in post for longer than ten years. More than half (51 per cent) of the 132 substantive chief executives were in their first chief executive role.

Figure 5 Length of tenure by executive role

Source: The King's Fund analysis of NHS Providers survey data
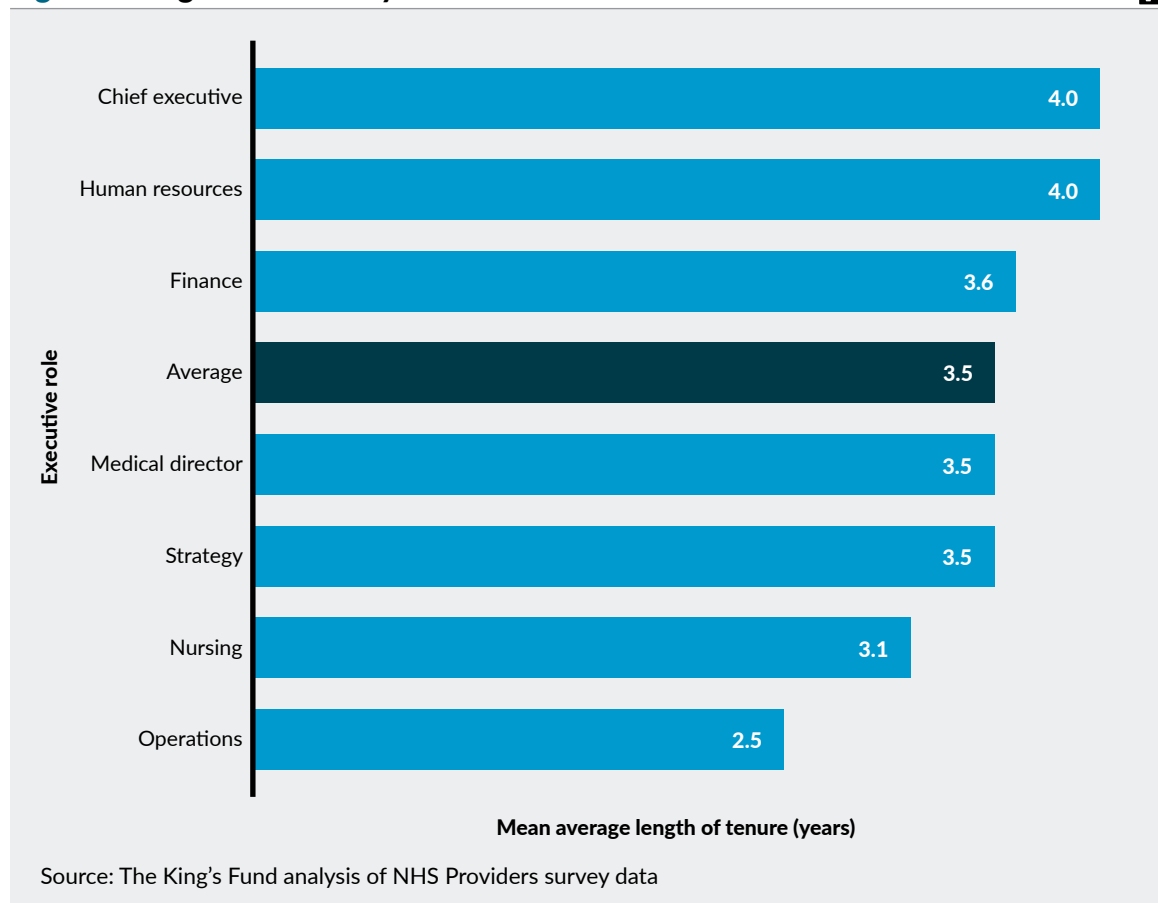
The inverse leadership law

The survey data provides further support for an inverse leadership law in the NHS, with the highest vacancy rates and shortest leadership tenures found in trusts experiencing the most challenged levels of performance.

In trusts rated as 'outstanding' by the CQC (as of December 2017), 3 per cent of executive posts were vacant and 20 per cent of executives had been appointed in 2017. Meanwhile, in trusts rated as 'inadequate' – accepting that a lower proportion of these trusts responded to the survey – 14 per cent of posts were vacant and 72 per cent of executives had been appointed in 2017 (*see* Figure 6).

Figure 6 **Vacant posts in 2015–17 by CQC rating**

Percentage of vacant posts

	Inadequate	Requires improvement	Good	Outstanding
	14.3	8.8	7.7	3.3

CQC rating

Source: The King's Fund analysis of NHS Providers survey data
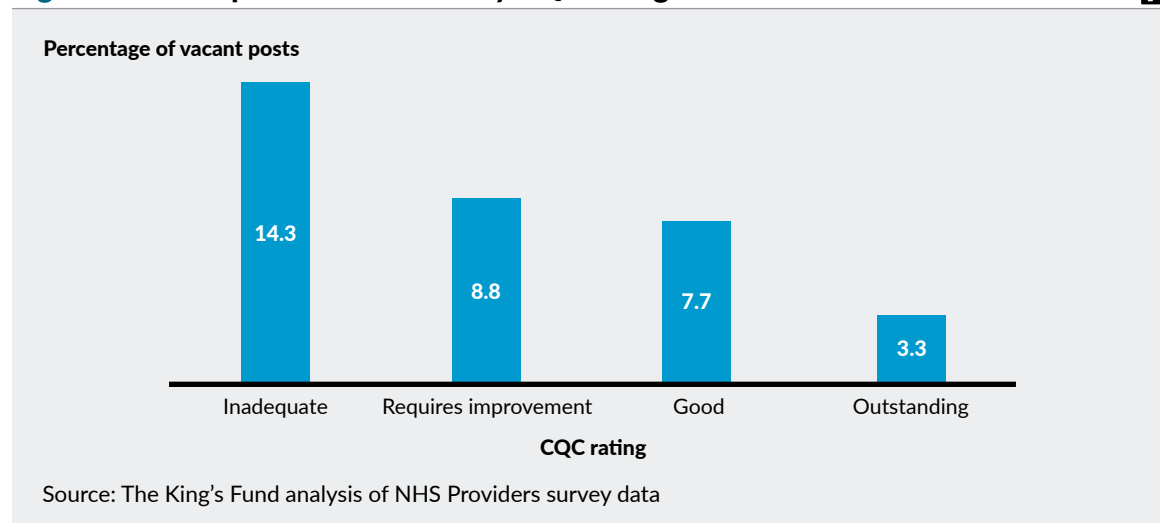
Separate research conducted by the *HSJ* corroborates the pressure on leaders in these trusts. It found that the median tenure of a chief executive of an 'outstanding' trust was more than seven years, compared with just eleven months for a chief executive of a trust in special measures. Eight trusts that were rated 'inadequate' or 'requires improvement' by the CQC had each had four chief executives in just three years (**Brennan 2017a**).

This pattern may reflect both the immediate and subsequent consequences of regulatory action, as directors of challenged trusts are initially removed from their posts, and these director posts then become less attractive and harder to fill on a substantive basis (*see* Figure 7). Interviewees agreed that transparency on the quality of care that trusts deliver is important – and poor quality should not go unchallenged. But they also agreed there should be more focus on supporting challenged organisations to recruit and retain the leaders they need. As one national stakeholder noted: 'These trusts have high turnover because they are challenged, and they are challenged because they have high turnover.'

Figure 7 Interim appointments and tenure of directors by CQC rating

How to read this chart: Each horizontal line represents a single trust. The size of the bubbles reflects the number of directors that trust appointed that year. Hollow circles indicate where a director was appointed on an interim basis.

Notes: Data is for three trusts with an inadequate rating from the CQC (25 per cent of all trusts rated inadequate), and ten trusts with an outstanding rating (67 per cent).

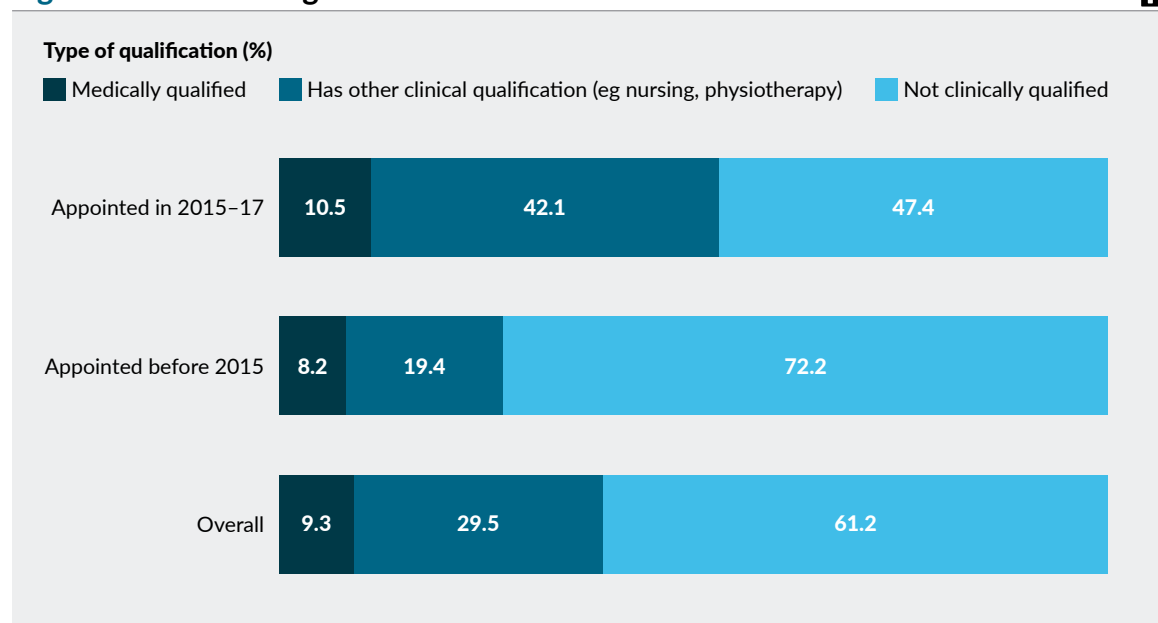Source: The King's Fund analysis of NHS Providers survey data

Clinical chief executives

In the NHS Providers survey, data on professional clinical backgrounds and qualifications was available for 129 substantive chief executives. Of these chief executives, 9 per cent were medically qualified and 30 per cent had another type of clinical qualification such as a nursing or physiotherapy qualification. Some of these chief executives may not be in active clinical practice. Chief executives appointed in the past three years (2015–17) were more likely to have a clinical qualification than those appointed before 2015 (*see* Figure 8).

Figure 8 Clinical background of chief executives

Type of qualification (%)
■ Medically qualified ■ Has other clinical qualification (eg nursing, physiotherapy) ■ Not clinically qualified

	Medically qualified	Has other clinical qualification	Not clinically qualified
Appointed in 2015–17	10.5	42.1	47.4
Appointed before 2015	8.2	19.4	72.2
Overall	9.3	29.5	61.2

3 Why does leadership churn matter?

Previous research has suggested that there are positive links between how long senior leaders remain in organisations and the performance of the organisations they lead. The NHS Leadership Academy has suggested that chief executives should ideally stay in post for at least five years to give organisations the stability they need for effective strategic planning (**Kang 2017**). Other research has found that successfully transitioning into a chief executive role can take between 15 and 32 months, as leaders need time to develop a deep understanding of the culture of their organisations and surrounding environment (**Hoggett Bowers 2009**).

Data from the NHS Providers survey suggests that the NHS is falling short in providing this level of stability and that the level of churn at board level remains relatively high. Our interviews with national stakeholders and local NHS trust leaders highlighted the considerable negative impacts that high vacancies and short tenures at board level can have on organisations. These included strategic paralysis, a loss of organisational memory and diminished credibility of leaders.

Supporting transformation and more strategic decision-making

The NHS is in the middle of a 'strategic ferment' to develop new models of health and care that better meet the needs of local populations. But our interviewees painted a picture of organisations that were placed in 'enforced stasis' by interim appointments, short tenures and short-term decision-making.

Local leaders who had experienced high levels of turnover at their trusts spoke of the 'stagnation' this can bring. One chief executive noted that this is partly because new directors need time to fully understand their new roles and organisations: 'Turnover has a massive impact. A few months before you leave the job, your mind is somewhere else. When you start the new job, you're only just getting to grips with it.'

In other cases, vacancies can disrupt existing ways of working and the focus of the board. Interviewees noted how vacancies in key roles can lead to the whole board struggling, as portfolios for the vacant posts have to be dispersed among the other board members during the interim period.

But most interviewees focused on the impact that leadership churn has on the board's ability to prioritise longer-term strategic objectives.

One director described how a period between chief executives had not had a substantial impact on the trust's day-to-day delivery of services because this was supported by established systems and processes. But the lack of a substantive chief executive stopped the organisation from 'driving forwards'. This was because the focus of the interim appointment was heavily tilted towards achieving short-term goals and existing priorities, rather than developing new opportunities or partnerships to transform services.

> *You can see paralysis in the organisation: an absolute lack of decision-making and an absolute lack of progress.*
> (NHS trust chief executive)

This is in sharp contrast to trusts with stable leadership teams. Dame Julie Moore, who has recently announced her retirement, has noted that her board at University Hospitals Birmingham NHS Foundation Trust has more than 110 years of leadership experience between them. She has suggested that this stability and experience was essential to the success of her organisation, as it allowed her senior team to develop and 'see through' a collective leadership philosophy and 10-year strategy (Moore 2016).

A substantial part of strategic change in the NHS is focused on STPs or integrated care systems (ICSs) that bring all parts of a local health and care system together to work more collaboratively to plan and deliver care. Our previous research on STPs and transformational change suggests that the ability to build and maintain effective, trusting, working relationships between partners is a key ingredient in successful change (Alderwick *et al* 2016). But trusts with high vacancy rates noted that this could hamper attempts at partnership working:

Low tenures mean investment in relationship-building doesn't get done and if it does get done there is no return on it and the next time round people think 'why bother?' It creates a bit of a 'why bother?' culture for both the interim [director] and the organisation.

(NHS trust chair)

Why organisational memory is important

A more practical impact of high churn at the director level is the loss of organisational memory for both 'how things are done' and 'why things are done a certain way' within a trust. One NHS trust chair said:

One of the clear benefits of long tenures is the strength of corporate memory. When I came in, all of the board had been removed so no one knew how things were done. We had implemented a new IT [information technology] system and various other changes started by the previous board, but we needed more details than were included in the business case or formal documentation. All the soft intelligence in the team was lost.

(NHS trust chair)

Another interesting example given of the benefits of organisational memory and experience was a greater understanding of how **not** to spend one's time:

The external requirements of an NHS director role are high, and everyone feels like they need to go to every meeting. I could spend two-thirds of my week in STP meetings if I accepted everything that comes my way, but I took a deliberate decision to be selective in what I went to. I could do that because of my tenure – I felt less need to 'show my face and make my name' because I had the confidence to say no to stuff.

(NHS trust director)

Building greater credibility with staff

Engaged staff are the greatest asset that an NHS organisation can have. The King's Fund has written extensively on the role of staff engagement in supporting both financial performance and high-quality and compassionate care for patients, and on the role of leadership in determining the culture of organisations (**West M 2018**).

Nearly all our interviewees spoke of the negative impact that high turnover can have for staff engagement and the credibility of leaders within NHS trusts. This applied to all types of trust we spoke to, regardless of their context. Directors from high-performing trusts who were trying to further improve services said that stability in leadership teams is needed to engage staff in the benefits of future service change:

> *We already have a very faddy NHS in terms of what the next big thing is, so if you have the next big thing [eg integrating services with primary care or social care] and the next big person, what you get is overall change fatigue. I see and experience that.*
> (NHS trust chief executive)

> *In providers, lots of the game is about getting the doctors and nurses behind you, and what really takes them is if you spend the time. If you look at a consultant of 40 years' standing, why should they invest their time, intellectual and emotional capacity in someone they think is only going to be there for 18 months? And that stuff should not be underestimated.*
> (NHS trust chief executive)

No less important is the need for leaders to 'stick around' and see the impact of the managerial decisions they make. For example, a director who had seen through a merger with another trust said: 'You need to stay long enough to see through [the] impact of a decision and be accountable for it. Senior clinicians and consultants are quite cynical about managers. If they know you are staying you develop a different relationship, you are being part of [the change] all together.'

But it was interviews with directors and chief executives from more challenged organisations that most clearly emphasised the need for stability and building credibility. These interviewees noted the technocratic benefits that stable leadership teams could bring to organisations – such as greater strategic coherence

and focus – but the more 'human and humane' opportunities that stability provides seemed far more important. These included conveying a 'sense of calmness' and dealing effectively with underperforming staff:

> *There were some poorly performing staff – both clinical and managerial – in the organisation who I would call 'cute'. They knew the average lifespan of an NHS CEO [chief executive officer] is two years and would tell me: 'All I have to do is keep my head down and not be found out, and then my clock restarts because a new CEO will come in.' Having a stable leadership team helped us flush out a lot of this behaviour for the first time.*
> (NHS trust director)

The director who said the above emphasised two further points. First, conducting a full and fair disciplinary process for underperforming staff is not a 'short, sharp shock that new directors use to show they mean business'. The process takes considerable time and resources, and directors who are not planning on 'sticking around' in organisations are unlikely to pursue this course of action. Second, several staff had said that this action – difficult as it was for all concerned – was an important part of improving morale and performance at the trust by sending a clear message that the organisation would not tolerate poor-quality care.

Balancing the opportunities and risks of long tenures

Many of the chairs and chief executives of stable leadership teams emphasised that, although high turnover in the NHS is a serious problem that needs to be addressed, longer leadership tenures can be an *enabler* of more effective boards and organisations, but longer tenure itself is not the goal. The chairs and chief executives of stable boards did not agree on the 'ideal' length of time that a director should remain in post for, but they were very sensitive to the risk that their leadership teams were stagnating.

To combat the risk of groupthink, complacency or 'going stale', these chairs and chief executives encouraged their directors to make time to network externally and learn from peers in other parts of the country: 'I get really worried if my board is spending all their time in the trust rather than meeting and learning from other colleagues' (NHS trust chair).

Chairs and chief executives also spoke of how they would enable their board directors to grow in different ways to keep their portfolios fresh. For example, one nursing director was given responsibility for the trust's estates strategy. This allowed the estates strategy to benefit from a clinical perspective and it allowed the nursing director to avoid 'doing the same job in the same way' for more than a decade.

And at least one director questioned whether increasing tenure and stability for NHS leaders indicate that things are moving in the right direction, or whether they simply reflect that both the 'appointees' and the 'appointers' of senior posts now have fewer options:

> *Maybe the level of churn has gone down because there is nothing to be gained from moving people on or people moving on... now deficits have become normalised, so if you are a CEO of a trust with a large financial deficit and 'requires improvement' from the CQC then you are just viewed as being in a more turbulent part of the river. And where do you go for a quiet life now? In the past you could move to a commissioner or SHA [strategic health authority] or 'the centre'. Now, an ICS [integrated care system] or STP is not a stable destination, so maybe there is nowhere for you to go to either.*
>
> (NHS trust director)

But although interviewees sounded a few notes of caution about 'excessive stability', it was clear that this is a danger affecting very few organisations in the NHS. Most boards focused on the harm that leadership churn presented to their organisations. As one trust chair noted:

> *In an integrated [trust] board, part of the trick is to know the strengths and weaknesses of each other and to complement each other as much as possible. It's not about being 'best mates' but you do need to know enough and work together long enough to see how each member of the board operates individually and collectively. That is hard to do if the board is substantially turning over every two years.*
>
> (NHS trust chair)

4 How has the environment changed for NHS trusts?

NHS leaders do not operate in a vacuum. In this section we review how the strategic and operational climate has changed in recent years and what impact this has had on the attractiveness of senior NHS posts.

Unrelenting financial and operational pressures

In the year of its 70th birthday, the NHS finds itself at one of the most significant moments in its history. Years of prolonged austerity in funding, rising demand for services and staffing shortages have taken a profound toll on services. In 2013/14 only 26 per cent of NHS trusts were in deficit. By 2017/18 this had grown to 44 per cent, despite the addition of further funding to stabilise NHS trust finances (**The King's Fund 2018**). Performance against waiting-time standards for both planned and emergency care is now at a record low.

All of our interviewees spoke about how the difficult financial and operational pressures have had an impact on the attractiveness of board director roles. Several interviewees, particularly experienced chief executives, were concerned that these senior NHS roles are no longer 'doable' because of the difficulty in meeting national expectations for financial and operational performance:

> *There is a real challenge with how we reconcile the level of demand, the implied or explicit quality and access targets, the level of patient expectation and the amount of money that we have available. And beneath that is our ability to transform the service at the rate that is needed and reconcile these if they are indeed reconcilable.*
> (NHS trust chief executive)

> *The NHS is underfunded to deliver what is demanded of it. The staffing model isn't right. If you joined the NHS for the right reasons, this is not the service you want to deliver for patients and staff.*
> (NHS trust director)

They [national bodies] are still thrashing us to deliver things that we cannot do without increasing the workforce and we can't increase the workforce because either the money is not there or the people aren't there.
(NHS trust chief executive)

Understandably, finance directors and chief operating officers within NHS trusts often felt these pressures most keenly – the two roles with the highest level of churn in the NHS Providers survey. For example, one director suggested that the chief operating officer role is now 'more of a block than a springboard' for an NHS management career because the 'risk of making a mistake' is so high and there is little tolerance of failure.

A recent survey by the Healthcare Financial Management Association (2016) found that the three most common factors preventing aspiring finance directors from applying for vacancies were concerns over work–life balance, the perceived risk of taking on a finance director role (including the risk of being fired for financial results outside of their control) and the perceived stress associated with the role.

The stress of the finance role is now so intense that some finance professionals feel that their professional standards and ethics are under threat. In 2016, one NHS trust finance director wrote to the Public Accounts Committee to voice concerns about the pressure that NHS finance directors were being put under (Anonymous 2016). The Healthcare Financial Management Association (2018) has also recently published guidelines on ethical standards to support NHS finance staff who feel under pressure to 'make over-optimistic judgements, plans or reports' in the current financial climate.

The combination of prolonged austerity, increasing demand for services and growing shortages of clinical staff has created a near-toxic cocktail of pressures for senior NHS leaders. This is starting to take a toll both on those currently in leadership positions and on future leaders aspiring to these positions.

Regulatory burden and lack of autonomy

> *The NHS is drowning in bureaucracy. This is evident at all levels... The administrative, bureaucratic and regulatory burden is fast becoming insupportable.*
> (**Rose 2015**, pp 40)

The challenging financial and operational climate of the NHS has led to an increase in national bodies' regulatory requests for information. Sixty-seven per cent of respondents to the annual NHS Providers regulation survey reported an increase in regulatory burden over the previous 12 months (**NHS Providers 2018b**). Our interviewees often mentioned a perceived increase in regulatory burden over recent years to illustrate why senior leadership roles may now seem less attractive than in the past – a finding that is echoed in the reflections of retiring chief executives in *The chief executive's tale* (**Timmins 2016**).

> *The national guidance is pouring out and some of it is over trivia. And for some of the things we must respond to – such as 'you have to publicise this, that, et cetera' – it is no longer possible to keep track of everything that comes into your inbox. I just feel like a postman sometimes. And we are under so much pressure that things are starting to fall down the cracks even though we have quite good governance. This concerns me greatly. At the moment it has not been anything that I would consider critical. But one day it might be.*
> (NHS trust chief executive)

In a recent *HSJ* survey, 60 per cent of leaders cited high regulatory burden as a negative pull on job satisfaction (**Pitcher 2015**). Our interviewees noted the opportunity cost of dealing with this increasing burden, including a distraction from the task of leading local organisations and developing their staff. More than one chief executive used the analogy of having to be the 'umbrella' that protects the organisation from all these regulatory requests for information.

There were serious concerns that this additional reporting is for little benefit other than 'feeding the beast':

> *The last year has not been a pleasure. You are being hauled all over the country to go to meetings. Every five minutes you have to drop everything because someone wants to talk to you about the four-hour target, or money – that's all people want*

*to talk to you about. Keep beating us about – it isn't going to improve performance.
Hauling us up and down the country is not going to improve performance.*
(NHS trust chief executive)

Senior leaders also expressed concern over the impact that greater regulatory
controls were having on local autonomy and decision-making. We spoke to
several people who were heavily involved in the early development of foundation
trusts, which gave local organisations (rather than 'the centre' – that is, national
bodies including the Department of Health and Social Care, NHS England,
NHS Improvement and the Care Quality Commission) the control to direct
organisations. They spoke of the significant contrast between that environment
and the current environment:

> *As a foundation trust, the buck stopped with the board and that gave us a sense
> of agency. In the past when we had a sticky situation, we would look upwards to
> 'the centre' to tell us what to do or check that we could do it. Now we looked to
> each other for how to solve problems. It's a shame we are starting to lose that.*
> (NHS trust chief executive)

This poses two problems. First, it is increasingly unclear where accountability for
decisions sits and our interviewees said that this lack of clarity and this uncertainty
are a powerful disincentive for aspiring directors: 'It is becoming an increasingly
murky world of what you are responsible for and how you are held to account'
(NHS trust director).

Second, the principle of subsidiarity (in which 'the centre' only performs functions
that cannot be done more effectively at the local level), and supporting a strong
sense of agency among local leaders, is at risk. As one interviewee said, in the past
a significant attraction of a senior NHS leadership role was the ability to make
decisions on a larger scale to improve services. But now there is a sense that even
in senior, highly paid positions, decisions have to be passed further up the line to
national bodies as 'authority [is being] sucked up to higher and higher levels… we
spend time training and recruiting talented people and then we do not let them
lead' (NHS trust director).

The impact of 'that Act'

If the deteriorating financial and operational performance of the NHS has been relatively gradual, the impact of the Health and Social Care Act 2012 was sudden and seismic. As Lord Prior of Brampton, a current NHS trust chair (and former health minister), has noted: 'We have created something that is almost impossible to manage. Even if God was to run the NHS he would struggle' (**Heather 2018**).

Our interviewees highlighted that the Act had two distinct impacts on the leadership task in the NHS. First, there was a substantial increase in 'transaction costs' for senior leaders. The abolition of strategic health authorities (SHAs) and primary care trusts, and the introduction of new bodies such as clinical commissioning groups and health and wellbeing boards, brought a host of new relationships to develop and accountability lines to manage.

The second impact was more clearly understood as the years went on: the loss of proactive regional talent management functions that were performed by SHAs. While interviewees were keen to emphasise that SHAs were far from perfect, they generally agreed that SHAs played an important role in 'spotting talent and moving it around so it developed' at a regional level. We return to this issue in section 9.

5 How has the environment changed for individual leaders?

An increasing risk of regulatory 'decapitation'

A national stakeholder contributing to our 2014 report on leadership vacancies said: 'If someone fails their A&E [accident and emergency] target for a few quarters, and the politicians get angry… it's too easy for people to think the answer is to shift the chief executive or director of operations, as opposed to acknowledging that there may be a local system issue' (**Janjua 2014**, p 12).

This point is also recognised in our recent report with the Institute for Government, in which David Bennett (the former chief executive of Monitor, the regulator for NHS foundation trusts) notes that the Secretary of State for Health had 'a very "hire and fire" view of people management, which can sometimes be right but I felt was often unfair – because it failed to recognise the different circumstances that people found themselves in' (**Timmins 2018**, p 59).

Four years on, our interviews for this report suggest that removing local leaders is still one of the options that local politicians and 'the centre' request too frequently and capriciously. As one NHS trust chair noted:

> *I'm still amazed people are prepared to put themselves forward for these roles. The level of exposure is higher than it's ever been and the knee-jerk response from 'the centre' is one of 'decapitation' as the first option… You're just a quarter away from financial failure and performance failure before you get sacked.*
> (NHS trust chair)

Our interviewees suggested that, despite a greater focus on working together collaboratively in local health care systems and networks of care, the consequences of failure are becoming increasing personalised and laid at the door of individuals:

I think there has been a major focus on leadership in recent years. There is a risk that we default to leadership as the differential diagnosis in the ability of a system to succeed or fail. I do not doubt that that is part of it but I'm a great believer in attribution theory. Where there is a person and a task and an environment, and at the moment the environment is tough, and the task is tough, so to always put it down to the quality of individual leadership I think is doing leadership a disservice. There's a task, there's an environment, and an individual. And I think people are being a bit dismissive of the environment and the task.
(NHS trust chief executive)

Comments on this 'personalisation' of performance by regulators were mirrored in the comments directors made about the impact of social media and journalists. Chief executives in particular said that they felt more personally exposed when taking on these public sector roles than in the past:

Even if I am out with friends after a hard day and having a glass of wine, I cringe if there is a photo taken because it might end up on Facebook or something like that and I will get a ton of abuse for being a fat cat on a night out.
(NHS trust chief executive)

In practical terms, personalisation can lead to a greater unwillingness among people to take these challenging roles on. It can also lead to a lack of bold leadership once in a leadership role. In his review of NHS leadership, Lord Rose (2015, p 31) noted: 'Risk taking within acceptable clinical and commercial parameters is not encouraged, recognised or rewarded. An avoidance of failure is often noticed more than drive for innovative success.' This is a sentiment that Dame Julie Moore echoed, when she warned against a culture where 'no decision is better than a wrong one… you can't be held to account for "no decision"' (Moore 2016).

In human terms, the section of our interviews on the current performance management environment was often the most emotive. The language used was the language of violence – of regulatory firing squads and politicians swinging axes – and the language of vulnerability – of leaders feeling exposed and isolated.

Our leadership model at the moment seems to be: 'You must do everything and will be judged on your ability to achieve it and you have no friends'.
(NHS trust chief executive)

We have had a few deeply shocking moments of poor behaviour… the finger-pointing and personalisation and making public examples of people.
(National stakeholder)

I can understand it when the politicians come for you, but the lack of support from the regulators sometimes is what gets you. There are lots of people in the NHS who now look upwards, not outwards, because you know you are going to get a beating.
(NHS trust chief executive)

Before being a CEO I never heard the phrase 'career-limiting' and I'm just really shocked. It makes people vulnerable and timid. If we put careers first we might not be making the right decision for patients and our population.
(NHS trust chief executive)

Interviewees noted this was not a simple issue to address. The term 'regulators' was used flexibly to include national and local bodies, and a mix of commissioners, regulators, and politicians. Sometimes leaders were removed through formal processes, while in other cases there was pressure through more informal channels which led to individual leaders deciding it was untenable to remain in their posts.

The new chair of NHS Improvement, Baroness Harding, recently said that she will place greater emphasis on developing and supporting the career paths of senior leaders (Heather 2018). Building on the publication of a new leadership framework for the NHS – *Developing people – improving care* (NHS Improvement *et al* 2016) – and the appointment of a chief people officer shared across NHS England and NHS Improvement, may provide some hope for a more proactive support of NHS leaders.

Baroness Harding has also said that she will tackle the perceived 'recycling' of senior leaders (West D 2018). Our interviewees noted that the NHS all too often 'decapitates' a senior leader and rehabilitates them through 'sinecures and soft landings' (Vize 2018) that lead to future director positions. They perceived this as doubly unfair, as leaders are removed too hastily in the first place, and then parachuted back into the service 'over the heads' of other candidates.

There will clearly be times when senior leaders should leave, or be removed from, their posts. None of our interviewees suggested otherwise. But a common thread

through the interviews was the need for a more finely calibrated and transparent judgement of when this is appropriate. NHS trusts are incredibly complex organisations – some have a turnover of more than £1 billion a year and employ nearly 20,000 staff. They are operating in a very difficult environment where leaders need to balance staffing shortages, in the most austere period in NHS funding history, and the desire to transform how services are delivered. In this context, a default approach of 'change the leader, solve the problem' is unlikely to work. Some of the most longstanding and successful directors we spoke to mentioned a sense of 'protection and understanding' in the past, which was notably absent in how the NHS currently supports its leaders: 'I've had a few bad bumps in my career. But in each case there was support and understanding. I felt protected because people understood the bumps came from trying to take the right decision, but the task is not always easy to pull off' (NHS trust chief executive).

More financial disincentives

Alongside changes in the wider strategic factors that affect the NHS leadership climate, there are factors that affect individual leaders. One example of this is pension reforms across the wider public sector, which have reduced lifetime allowances and tax relief. These significant changes have dampened the enthusiasm of staff who might apply for more senior roles, and staff already in these roles (**Collins 2018**).

> *I couldn't explain to my family why we are taking a financial hit, so I can move up and take the chief operating officer position at my trust.*
> (NHS trust director)

> *I have seen more CEOs opting for retirement because the job can be a bit joyless, and if you have accrued your maximum pension, some of those other incentives dissolve.*
> (NHS trust chair)

> *There's not much difference, let's face it, with all the changes with tax and pensions, the pay of CEOs, execs and band 9s [staff on Agenda for Change band 9 salaries]. A post would have to be really attractive and really secure for someone to give that up, so why on earth would you?*
> (NHS trust chief executive)

NHS directors were under no illusions that this could be perceived as a 'nice problem to have', given that many staff in the NHS will have no hope of building a pension pot of this size. But interviewees argued that these are examples of a system that is not trying to remove every barrier to senior leadership and they highlighted the importance that personal circumstances play in their decisions to take on more senior roles. 'It feels like everything is conspiring against you moving up in the NHS' (NHS trust director).

A difficult balance between strategic and operational issues

Reviewing the changes over the past four years suggests that the leadership task has become both more difficult, as financial and operational pressures mount, and more complex, as NHS trust leaders increasingly work with local partners and STPs. Attempting to deliver today's performance targets while transforming services for tomorrow is a high-wire balancing act: 'You are expected to and want to fundamentally create a better future, but the demands of the day job are really quite intense' (NHS trust chief executive).

Looking across our interviews, there was a fundamental mismatch between what people said they wanted to achieve in senior roles and the reality of how they spend their time. They said that they want to focus on the strategic transformation of how services are delivered, for the benefit of patients and staff, but instead they spend their time trying to deliver current performance standards and appease requests for information from national regulators. They want to improve outcomes for patients, but instead must focus on keeping services 'clinically safe' as funding and workforce pressures increase. They want to use the platform provided by a senior role to effect change on a larger scale, but feel increasingly 'boxed in' by regulators and time pressures the higher up the organisation they get:

> *Being a finance director at the moment is like holding organisations in perpetual administration or stasis. It's not as attractive a job as in the past.*
> (NHS trust director)

> *In my view these jobs are tougher than they have ever been. The level of resilience people need, the level of scrutiny and regulation they are under on a daily basis, the demand coming through the doors is relentless. People look at these jobs and think: 'Is this what I want to be doing?'*
> (NHS trust chief executive)

6 How are organisations and leaders reacting?

The environment for NHS leaders has changed substantially over the past four years. This section reviews how both organisations wishing to recruit leaders and individual leaders themselves are reacting to the changes.

The quality of candidates

It is difficult to assess the extent to which the quality of candidates for director posts in the NHS has changed over the years. Three years ago, the NHS Leadership Academy found that 90 per cent of responding trust chairs, chief executives and human resources directors had reservations about the available talent pool for board roles (NHS Leadership Academy 2015). While respondents were confident that they had made the right eventual appointment, they had often gone to market several times and still had 'little choice or flexibility' when appointing (Scales 2014).

Several of the chairs and chief executives we spoke to suggested that there has been a reduction in the strength of candidate shortlists for board-level positions:

> *Candidates generally don't have the same level of experience as they did say ten or even five years ago. I often find myself in the position of thinking this candidate is good, a hard-working individual, but they lack that something extra that you could be confident that they could do the role and to cope.*
> (NHS trust chief executive)

> *There was a time when you could put a finance director job out for advert and get three established finance directors, three deputies chancing their arm and a few wider public sector candidates. Now you get a few deputies applying because there is not a lot of strength in the market.*
> (NHS trust director)

Both aspiring and current chief executives also noted the impact that the changing shape of the NHS provider sector has had on leadership development. The number of NHS trusts fell from approximately 250 in 2009/10 to 232 trusts by 2017/18. Some of these organisations will also share a single leadership team (such as Colchester Hospital University NHS Foundation Trust and Ipswich Hospital NHS Trust), be in the process of merging (such as City Hospitals Sunderland NHS Foundation Trust and South Tyneside NHS Foundation Trust) or becoming part of a hospital group (such as Mid Essex). As one experienced NHS chief executive memorably put it: 'The provider landscape is becoming more of a portrait.'

Because particularly smaller NHS trusts are being 'hoovered up through integration or merger', one experienced chief executive reflected: 'When I started, CEO jobs were smaller as trusts could be £100 million in size so there were more jobs but also a training ground. Now we have mergers, chains and other things, there are less but bigger and more difficult jobs so this has an impact too.'

But there were some counterpoints to the view that leadership candidates have declined in quality. First, there was a suggestion that new reservoirs of talent have been discovered in recent years:

> If [you] go back five years, there was an era of white men of [a] certain age in power who were the centre of gravity and had a big influence on the type of leader who came through. With [the] departure of SHAs [strategic health authorities] and a generation of senior executives there has been an unleashing of a new generation of talent that is bringing genuinely fresh thinking. If you look at the graduates of the Aspiring CEOs course, that's an extraordinary group of individuals who have been incubated.
>
> (National stakeholder)

One national stakeholder suggested that the real issue is not that aspiring leaders are becoming less talented. Instead, they suggested that leadership roles are becoming more complex, and that the height of the step up from deputy director posts to full board roles is increasing:

> I don't think it's the quality of the candidates coming through that's the issue. I think it's that the gap between the board and what's below the board is becoming

ever greater. I don't think aspiring directors have less talent than they had previously. It's more that the roles are becoming bigger, they are becoming more complex, they are becoming more system-wide, so expecting someone to make that transition from where they are in an often-operational role to one that is system-accountable, it's about that gap and it's getting bigger and bigger.

(National stakeholder)

A reducing appetite for risk

Bold decisions carry risk.

(Douglas 2017)

We have already discussed how the risk of 'regulatory decapitation' and current operational pressures can potentially make individual leaders more risk-averse in their decision-making. But our interviews also suggested that senior leadership teams have a lower appetite for risk than in the past when it comes to the task of selecting their future leaders. This has manifested as a greater desire for appointing leaders who have 'done the job before' and a reduced interest in appointing leaders from outside the NHS or even from different sectors within the NHS.

Have you done the job before?

Many of the national stakeholders and local leaders we spoke to indicated that boards are placing a greater premium on recruiting experienced candidates who already have an existing track record at the director level. This is particularly the case for chief operating officers and chief executives because of the current focus on delivering challenging performance targets and pressure to achieve them:

They are looking for someone who is really experienced, and they are not going to get someone like that for all these jobs. What you are going to get is recycling the same people. We need to take a chance on someone who is going to be really good, but they haven't ticked the box of longevity or been a CEO before.

(NHS trust chief executive)

The most difficult roles to fill are the medium-to-large trust COO [chief operating officer] where you are not really looking for a first-time appointment and are

looking for a bit of experience. These roles are actually very difficult and are actually becoming unmanageable. For some it's because of the pressure that org [the organisation] is under, meaning they don't want to take on someone inexperienced. But sometimes these orgs are so troubled that you can't attract an experienced person there, so you end up with a vacancy.
(National stakeholder)

Interviewees perceived that even if less-experienced candidates were given the chance to take on a post, they would still be disadvantaged in how much time they would be given to make an impact: 'It's like football management in that if you don't have the heritage you won't be given time to deliver, and to change anything in a trust is a year-long job at least' (NHS trust director).

But some of the organisations we spoke to had taken a different approach. One trust had actively looked for a first-time chief executive because the board wanted to bring fresh ideas and a sense of positivity into the organisation. Another had sought out someone from outside the region to help 'reset' relationships within their STP.

For some boards, the increasing ambiguity in local leadership, first introduced by the Health and Social Care Act 2012 and then compounded by the emergence of STPs, has meant that boards are 'looking for something different and more collaborative in our leaders, and you don't get that if you only appoint the same type of people' (NHS trust director).

Many of the interviewees mentioned the need to 'take the risk out' of appointing a first-time chief executive or director. In some trusts this had led to more ongoing support programmes being put in place around candidates, such as buddying arrangements with more experienced directors in other organisations. In other trusts there was an understanding that appointing first-time candidates is an investment in the future, as candidates would need time to fully develop into their role. We return to this issue in section 9.

Outside experience

Over the history of the NHS there have been several attempts to proactively bring leaders from 'outside the NHS' to lead NHS trusts. While national programmes have often focused on bringing in leaders with private sector backgrounds (**Department of Health 2008**), local NHS boards have appointed senior leaders from local authorities, from military backgrounds or with health care experience from other countries.

There is still some evidence of this 'outside experience' being pursued. For example, the new chief executives of two trusts in the Shelford Group were recruited from overseas, and the chief executive of the London Ambulance Service was recruited from Transport for London. But chairs and chief executives of the organisations we interviewed suggested that the desire for outside experience is at a relatively low ebb.

Several different factors are at play. First, there is a reduced focus on competition and commercial freedoms in the NHS compared with four years ago. As one finance director noted: 'NHS trusts are now more like directly managed and regulated units of the state than commercial autonomous beings. So, I need people who can manage the regulators more than someone with commercial nous in my team.'

Second, the increasingly complex and rapidly changing nature of how health care is organised and delivered puts leaders from outside the sector at a disadvantage. The pressure is on for leaders to 'not hit the ground running – they need to hit the ground sprinting' (national stakeholder). New leaders coming in cold are also confronted with an evolving alphabet soup of three-letter acronyms and relationships to navigate, and an expectation that they can 'rapidly learn to speak "NHS" fluently' (national stakeholder) to build credibility within and outside their organisation.

> *In a plural management environment... those leaders who are best able to read the rules and interpret the system will prosper.*
> (**Rose 2015**, p 30)

> *We are leaning back towards 'hard-bitten NHS people' because the regulatory system is so tough at the moment, and unless you know how to navigate Whitehall*

and 'the centre', and know how to work your networks, the NHS can be a very
uncomfortable place to be.
(NHS trust director)

However, some chairs noted that it was still possible to bring this 'outside
experience' through non-executive roles to bring greater balance to trust boards:

It's about having a board of all the talents and that reflects the wider world. Is it
important to understand how to grow market share and rebuild an estate? Maybe.
But it's probably more important to know how social care works and how primary
care works because those are our strategic partners. Having an ex-GP and an
ex-director of social services on our board helps build our understanding.
(NHS trust chair)

The ghettoisation of leadership backgrounds

Even for experienced NHS professionals, the heights of NHS trust leadership can
prove a tricky ascent. Among our interviewees there was still a perception that the
summit of NHS trust leadership is a 'Shelford-Group-style' large complex teaching
hospital, and to get there you need to 'establish your credibility by working up from
a small to medium to large acute trust. Ghettoization has changed a bit but not
across the piece. Acute trusts still look down their nose at mental health trusts, who
look down their nose at others' (national stakeholder). But this is also an area where
our interviewees noted that some progress is being made. One chief executive of a
medium-sized acute trust noted:

There are still latent issues that if you didn't earn your spurs in an acute trust but
personally I look to build a team of talent. It isn't 'a risk' to take people on when
you look at it like that because I don't necessarily want someone with 10 years'
unstinting service in an acute. I want someone who will bring the skills and values
I am looking for.
(NHS trust chief executive)

Other interviewees noted recent examples where an NHS trust chief executive had
come directly from a commissioning post, or where an acute trust chief executive
had come from a mental health background (although there were few examples of

movement in the opposite direction). The boards of these organisations described their decision as being 'consciously bold' and a desire to bring a set of skills and perspective to the organisation that would have been missing if they had appointed a chief executive with a background purely in the acute sector. The chair often led this, with one national stakeholder noting that such bold choices happen 'because the chair has the breadth of vision and personal weight to say this is a good idea and it gets my full support – so someone needs to tell me why this isn't a good idea'.

Trust leaders also suggested that executives with a background in mental health and community trusts may be better placed to function in a future NHS that is more focused on local collaboration and the integration of care through STPs. As Bev Humphrey, former chief executive of Greater Manchester Mental Health NHS Foundation Trust, noted: 'Mental health has a hell of a lot to teach the acute sector… it needs to sit up and listen' (**Bawden 2018**).

> *Mental health and community trusts are further along than acutes in this regard as they already have a very complex world to deal with. You have to work with more partners, such as the voluntary sector, work with patients to have a deeper understanding about what their life is about, and you see how multifactorial their health and wellbeing is. And you work with different aspects of the wider system like housing and primary care – people in mental health and community live and breathe this in on a daily basis and already have that mindset.*
> (NHS acute trust chief executive)

While some progress is being made if leaders are effectively transcending ghettos, these ghettos still clearly exist. One national stakeholder also spoke of the difficulty they had in recruiting leaders into the English NHS with NHS experience from high-performing organisations in Scotland. It was also noted that even for large teaching hospitals, which are both academic and clinical organisations, it is incredibly difficult to get leaders from local universities to interview for NHS posts.

Any organisation would want to ensure that it has access to the widest talent pool possible. Our interviews suggest that the NHS could do more to find different ways of bringing leadership into NHS organisations.

Personal characteristics of leaders

Leaders in the NHS are operating in extremely pressurised conditions. Many spoke about their inability to switch off from their duties: 'I am always thinking of the hospital – all the time. On my daughter's birthday, on holiday, I am always thinking of the hospital' (NHS trust chief executive).

Unsurprisingly, several interviewees mentioned the need for current NHS leaders to be resilient. But a few said that the NHS needs to be clearer about what constitutes 'resilience' and how much emphasis is placed on it as a leadership trait:

> *Resilience has never been more fashionable. But sometimes people are being recycled and pop up again in the service because they are resilient – which means they are people who can weather the storm of financial pressure and deliver horse-whippings to staff.*
> (NHS trust director)

> *'Resilience' is often misused as a term. It's not about increasing your tolerance of poor care. It's about holding onto your values through thick and thin and not becoming blind to poor care.*
> (NHS trust director)

Interviewees often talked about the personal toll that 'appearing resilient' could have on them: 'I am viewed by everyone around me as resilient. I'm the CEO with a smile on her face. The happy, steady, calm CEO. But that's not what's always going on inside.' And it was clear how essential it is for leaders to have strong support networks:

> *It's about having that strong executive team and the support from them – that's where I get my resilience. We are a unitary team, we are a unitary board. I have NEDs [non-executive directors] coming to me asking how I'm dealing with all of this and asking if they can help. People genuinely want to help you.*
> (NHS trust chief executive)

Resilience is not the only characteristic that organisations are looking for in their leaders. Compared with four years ago, our interviews suggested that an ability to 'handle' regulatory relationships is increasingly important. One chief executive noted that this is not a positive development as 'COOs [chief operating officers] are now often judged on the basis of how well they perform in a regulatory accountability meeting, rather than how they work with nurses, doctors and patients in a hospital. That is completely wrong.'

Other interviewees said that they were looking for 'creativity and charisma' to a greater degree than in the past:

> *One of the key attributes I am looking for is charisma. We are trying to transform services, not just improve them. To win hearts and minds you need to be able to convince by more than rational argument – people need to want to follow your vision. You need to be the sort of person that others want to follow.*
> (NHS trust chair)

Given the focus on building collaborative relationships in STPs, leaders are also expected to be more 'humane and approachable' than in the past:

> *You talk to people about former directors and people were quite frightened of them; they were unapproachable and distant. Now there is less of an 'us and them' distinction and we need to be much more collegiate as leaders.*
> (NHS trust director)

> *What I focus on now, is absolutely the person. What makes them tick, what are they like, how will they fit in this organisation? Are they going to live the values of this organisation? We have a good culture here: holding to account where needed but generally being kind to each other and I need to know that. So, I don't want Attila the Hun pitching up as COO [chief operating officer].*
> (NHS trust chief executive)

Reversing the inverse leadership law

As noted in our previous report on leadership vacancies in the NHS (Janjua 2014), the NHS still struggles to find a coherent strategy for supporting the leadership of the most challenged trusts. As a result, the trusts with the greatest leadership challenges are those most in need of great leadership. In the NHS Providers survey, trusts in special measures for financial or quality reasons had far higher levels of vacancies and churn than their 'outstanding' peers. Several interviewees mentioned the risk that these 'hard jobs' presented:

> *If you are an executive whose career is in the NHS or who is not in the NHS and is thinking about the NHS, then you might be thinking you are going to be doing your CV harm by coming here because they worried about [the] scale of our financial deficit.*
> (NHS trust chair)

One national stakeholder noted that the recruitment challenges facing poorer-performing trusts often leads them to look to fill vacancies with less-experienced talent. This approach could bring greater risks of a 'downward' spiral if these new directors are not sufficiently supported.

The greater leadership churn in poorer-performing trusts again reflects the tendency to personalise failure in the NHS. One trust director said: 'There is a marked tendency to move people or sack them when problems emerge, rather than seeking to understand and address the underlying issues. Despite the rhetoric of a "no blame" culture, blame continues to be heaped on senior leaders for any perceived failure in performance.'

> *The way the regulators are personalising things and getting rid of people means that they are unattractive roles... we have also seen a lot of CEOs getting chopped off at the knees haven't we? The irony of the [Secretary of State] saying we need to give people gongs for doing these roles as they are so difficult, coming from an org that sacked two CEOs who were doing these roles was extraordinary.*
> (NHS trust chief executive)

In his review of NHS leadership, Lord Rose (2015, pp 44, 60) noted that the more challenged trusts were seen as 'isolated outposts with no central protection' and recommended the development of an 'elite cadre' of turnaround specialists with minimum-term, centrally held contracts to support these providers. Our interviewees agreed that a new approach to managing the most challenged trusts is needed, although they focused more on supporting local teams than the deployment of central resources.

Some suggested that challenged trusts could be more effectively supported by expanding 'buddying' arrangements for professional roles. This had worked effectively for finance directors in some trusts in financial special measures according to one chair, and could be extended to chief operating officers and medical and nursing directors.

Interviewees were keen to distinguish this support as being individual and peer-based, rather than an organisation-to-organisation buddying arrangement. This could counter the suspicion in some quarters that buddying or asking chief executives to lead two separate organisations is 'more like a precursor to a formal merger or acquisition, rather than a sense of partnership to stabilise a struggling organisation' (NHS trust director). Interviewees also recognised that more formal recognition or regulatory leniency would be required for the higher-performing partner in these buddying relationships.

Other suggestions were more radical, such as forced rotation of chief executive posts so that the best and most experienced leaders are deployed to spend time in the most challenged organisations. A softer version of this proposal was for boards and regulators to foster a greater expectation that successful leaders in the NHS need to spend time in challenged trusts at some stage in their careers. The new chair of NHS Improvement has noted: 'In other industries the only way you get promoted is if you do some horrible jobs. That's the way of earning your stripes. In the NHS the opposite has been true. If you do the hard jobs, then you are likely to be decapitated' (West D 2018).

But the most compelling suggestions came from directors who had direct experience of working in trusts in special measures or supporting these trusts.

These included greater support and understanding from peers and national bodies, even if this is no more than a supportive phone call or email. As one chief executive noted: 'When you get put into special measures you find out who your mates really are.' And most importantly, interviewees emphasised the desire for space and for people to understand that sustainably improving challenged trusts is a difficult and time-consuming process:

> *This is a really difficult process. When I came in, staff would go to external meetings with their badges turned around because they were ashamed of working for [this trust]. It takes time to turn that around.*
> (NHS trust director)

> *People need to be supported. They need to be given time. Because some of these organisations are becoming career graveyards. And it takes a long time to turn an organisation around.*
> (NHS trust chief executive)

> *You could spend 10 years somewhere taking [the organisation] from 'inadequate' to 'requires improvement'. Is that okay? There is no story on what happens to you as a leader if you take on these challenges.*
> (NHS trust director)

> *Leaders don't want gongs for taking on challenged trusts – they want a bit of support and their back covered when they do difficult things.*
> (NHS trust chief executive)

> *We need to make these roles more attractive. We need leadership roles that are demanding but doable. We need the autonomy, not regulatory control, to do them. We need national support and air cover for difficult tasks if we are going to have a chance of turning things around.*
> (NHS trust director)

7 Diverse leadership

Our 2014 report on leadership vacancies highlighted the failure of providers to recruit diverse boards that reflect their workforce, their staff and the public they serve (**Janjua 2014**). Since then there have been significant national efforts to improve this situation. In 2015/16 the NHS Workforce Race Equality Standard (WRES) was mandated through the NHS standard contract, to set an expectation that NHS providers would show progress against indicators of workforce equality. In 2016, the chair of NHS Improvement set an ambition for 50 per cent of board members to be women by 2020 (**Sealy 2017**). And this year saw the first mandated reporting of gender pay gap data for public and private sector organisations.

A challenging picture

National data on these issues shows some promising signs, but they paint an overall picture that remains deeply sobering. The 2017 WRES data shows that only 7 per cent of very senior managers in the NHS (250 people) were from a black and minority ethnic background in that year (**NHS Equality and Diversity Council 2017**). This was an increase of 18 per cent (38 people) from 2016 but remains far lower than black and minority ethnic representation in the overall NHS workforce (18 per cent) and in local communities (12 per cent). Of the 224 trusts reporting ethnicity data, 98 had no black and minority ethnic board members (*see* Figure 9).

Across all trusts, the proportion of women in executive director roles was 48 per cent (**Sealy 2017**). There were clear differences across professional roles, with women accounting for the majority of chief nurse and human resources director roles, but the minority of chief finance and medical director roles (*see* Figure 10).

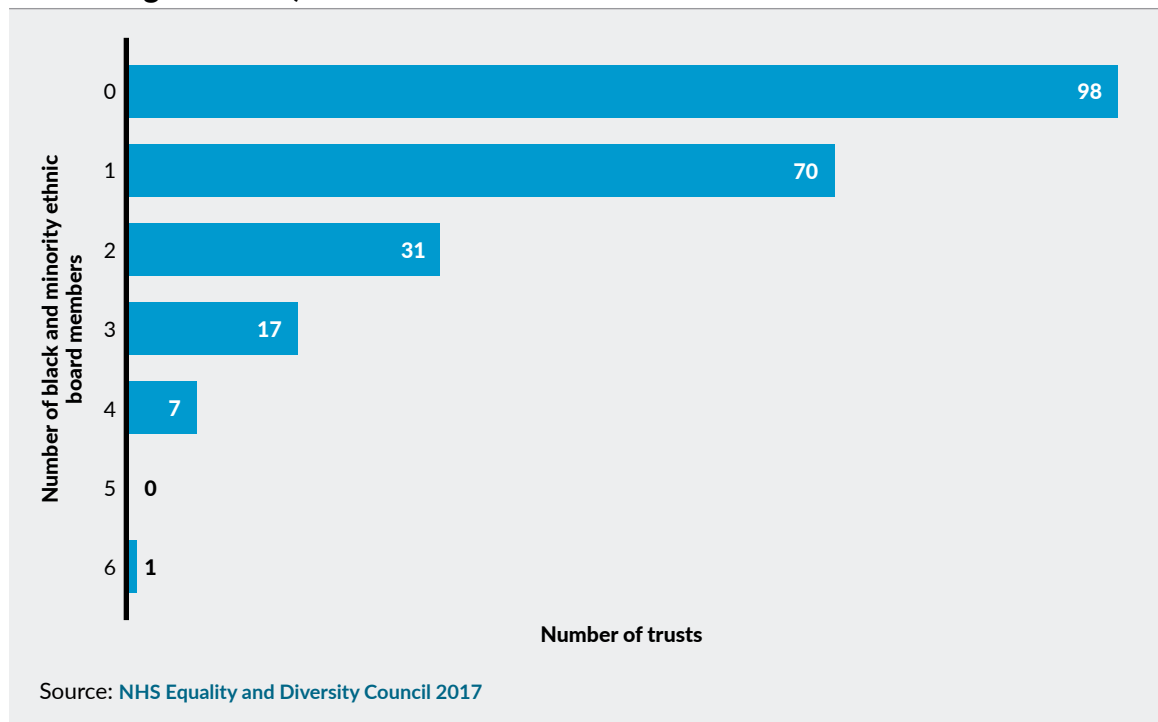**Figure 9** Ethnicity of NHS trust boards (including both voting and non-voting members)
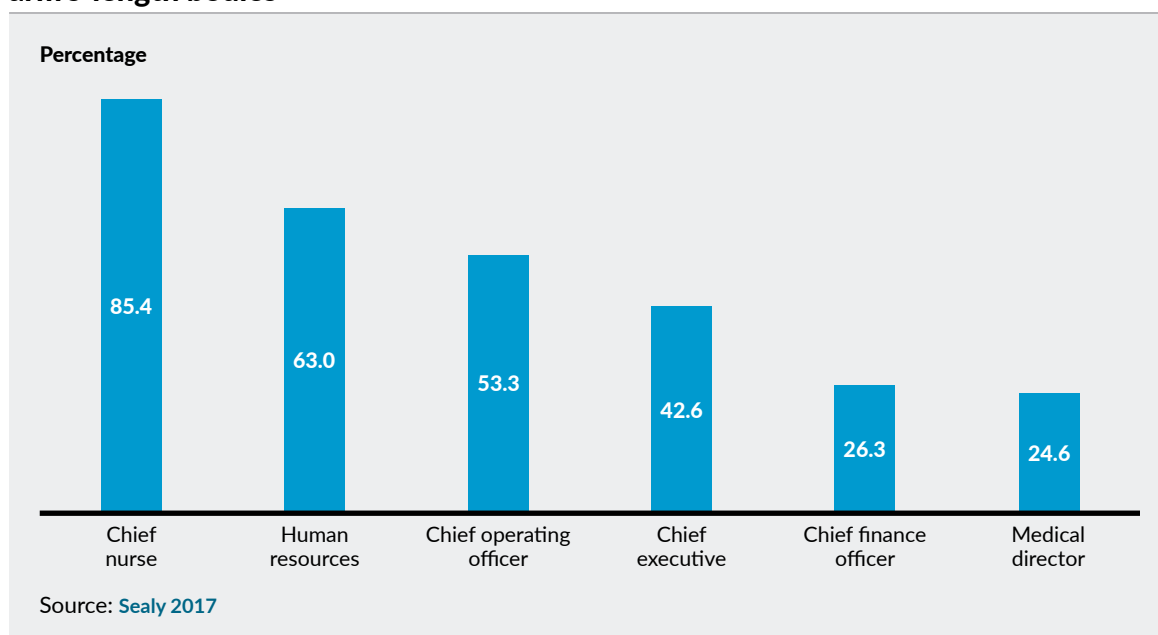

Source: NHS Equality and Diversity Council 2017

Figure 10 Key roles held by women on the boards of trusts and arm's-length bodies

Source: Sealy 2017

The national and local NHS leaders we interviewed recognised that more must be done to improve diversity and equality. Interviewees also noted that the issue of diverse leadership is not confined to ethnicity and gender. They identified the need for boards to not 'recruit in their own image' (NHS trust chief executive) on a range of protected characteristics, and to bring as diverse a set of perspectives and experience to the boardroom as possible to avoid groupthink:

> *If you look at the top tables of the NHS you will see people of the same gender, same ethnicity, same age and even same school profile. That can't be good for bringing new ideas to the table when you are facing new challenges. We need more diverse leadership.*
> (NHS trust chief executive)

> *Every one of us is white. We have a good mix of male and female – about 50/50 – but we are all white. When appointing people, I look at their skills and I will appoint the best person for the job – their [ethnic] background is absolutely irrelevant. But ultimately you will look at our board and say: 'Yes but you are all white.'*
> (NHS trust chief executive)

Improving the diversity of boards

There was some evidence that leaders are starting to pursue greater equality and diversity. This included having more open and honest discussions about diversity at board level and a structured review of what WRES and gender diversity data means for their organisations:

> *The most important thing we do is to talk about it, talk about it openly at the board. The chair and I have listening sessions with staff from BME [black and minority ethnic] backgrounds. It's horrible listening to staff suffering about this. We use the WRES data on a quarterly basis. The way you drive improvement is you bring people together around data and get them to talk about it… and we use it to hold ourselves to account.*
> (NHS trust chief executive)

Boards had also changed their recruitment process to support greater diversity. For example, Sarah-Jane Marsh, Chief Executive of Birmingham Women's and Children's NHS Foundation Trust has said: 'I have taken the decision that I will no longer sit on any interview panel that does not have a BME member. We need to end "the white wall"' (Marsh 2018). Other trusts we spoke to had taken similar action to ensure that black and minority ethnic representation is built into the interview process.

Both national stakeholders and local leaders also recognised that interviews are only the end of the recruitment process and that more effort is needed to give candidates from under-represented backgrounds opportunities for developing experience. It was clear that there is not a single 'glass ceiling' at board level, but multiple glass ceilings that stop candidates from progressing to deputy director or team leader posts.

To help address this, trusts had developed targeted offers for candidates from under-represented groups to take part in projects that would give them the chance to develop or demonstrate the skills they would need at board level, such as building relationships with external stakeholders (**Jarvis and Reeves 2017**). Trusts had also developed in-house mentoring programmes and reverse-mentoring for senior executives.

They also used more formal programmes such as the Insight Programme organised by GatenbySanderson for aspiring non-executive directors, which provides opportunities for under-represented staff to shadow existing post holders. By participating in this programme, aspiring directors become more *au fait* with the relationships, lingo and priorities of boards. It also gives candidates the chance to provide evidence of their experience, so in interviews they can say what they saw or did in a given situation, rather than what they *would* say or do when faced with a board-level decision.

When faced with the task of promoting more diverse leadership, 'doing nothing' may still be an option, but it increasingly seems a less tenable option. Even boards that confessed to being 'stuck' on what action to take were still attempting to learn from their peers and to challenge themselves to do better:

Diversity is one of the biggest challenges we have got and to be honest I don't have many of the answers. We are going to appoint a diversity adviser to the board, who will attend board meetings to put in an interjection into the debate in terms of: 'Have you thought about this from a diversity angle?'

(NHS chair)

Ultimately, however, interviewees recognised that diversity is a wider issue that requires more coherent and purposeful action, not only by those in board roles but also by those in the wider organisation. As one national stakeholder said: 'Diversity is not just about changing individuals and leadership development. It is about changing everybody and creating an inclusive culture in the NHS.'

8 Looking to the future – different styles of leadership

Clinical leaders

Clinical leadership has been established as a critical factor for improving the performance of health care organisations. Studies have suggested that the increasing presence of clinicians in leadership positions can lead to more credibility with frontline clinical staff and a greater emphasis on patient care (**Sarto and Veronesi 2016**).

Meaningful clinical leadership clearly extends far beyond having a clinically qualified individual leading an organisation. It includes the work of nursing and medical directors on boards and the leadership of teams below board level within trusts. But the notion of the 'expert boss' continues to hold substantial allure, and there has been considerable national investment in encouraging more clinicians to take on chief executive positions:

> *Given that one of the most important roles of a chief executive is to motivate a large number of able, smart but – let's be honest – often quite headstrong clinicians, we should today ask whether the NHS made a historic mistake in the 1980s by deliberately creating a manager class who were not clinicians... I would like to see a greater proportion of clinician chief executives raised in the next decade.*
> (Hunt 2016)

To support the ambition to see more clinicians in leadership positions, Jeremy Hunt (then Secretary of State for Health and Social Care) commissioned the Faculty of Medical Leadership and Management to review the issues that might stop clinicians transferring into management roles (**Hunt 2016**). A new clinical executive fast-track scheme has also been developed by the NHS Leadership Academy to support clinicians who wish to develop their leadership capacity.

The NHS Providers survey data shows that 39 per cent of surveyed chief executives had a clinical background. Many of the chief executives with clinical backgrounds who we spoke to talked about how their training and experience had benefited their managerial careers:

> *I use my nursing background every single day for something. It gives me a broader understanding and empathy for people who are working in my organisations. It gives me credibility when I am talking to clinicians because I can ask questions from a clinical perspective, which gains a different level of respect – and they know they can't pull the wool over my eyes.*
> (NHS trust chief executive)

Other chief executives from medical and nursing backgrounds mentioned empathy with staff and an ability to view things from a patient's perspective:

> *My clinical background does give me some understanding of how clinicians function in my trust and how they see the world. It also gives me confidence when doing 'back to the floor' type sessions.*
> (NHS trust chief executive)

> *I feel really sad when I hear fellow CEOs demonise consultants and talk about the consultant body as a problem to solve. Being a clinician myself helps me keep an ear closer to the ground with consultants.*
> (NHS trust chief executive)

Interviewees noted that, compared with managerial colleagues, clinicians stepping up to board roles are generally less steeped in the legal and corporate governance requirements of board-level positions. Organisations that had prioritised the development of clinical leaders at the top of the organisation often targeted considerable support at deputy medical and nursing directors, including setting them projects to develop corporate skills.

Most of the clinical leaders we spoke to were from nursing or medical backgrounds. Chairs of trusts noted that physiotherapists, pharmacists and health care scientists are also incredibly capable individuals but for them there is no clear route to a board-level position unless they become a chief operating officer. One chief

executive noted that the NHS could look at using non-voting board roles in a more versatile way to tap into the wealth of experience that allied health professionals could bring as leaders.

But not everyone we spoke to was prioritising the recruitment of clinical chief executives, although they clearly supported clinical leadership more broadly. One NHS trust chair noted that after the care failings at Mid Staffordshire NHS Foundation Trust (**Mid Staffordshire NHS Foundation Trust Public Inquiry 2013**), there had been a conscious effort for trusts to focus on quality of care 'at all costs' and appoint clinical chief executives to reflect this focus, but that now it is more important to have leaders who can balance the finances and quality agendas of organisations and collaborate with local partners in STPs.

And very few of our interviewees suggested that clinical experience was a prerequisite to be an effective chief executive. As one chief executive with a nursing background said:

> *Success as a CEO is not predicated on your clinical exposure or clinical experience; it is predicated on [a] set of core skills and values around inclusive leadership, listening and engaging, creativity in forming partnerships inside and outside the NHS and understanding the evolving balance between your responsibilities to the trust and your responsibilities to the wider system. Clinical experience is not enough to prepare you for all that.*
> (NHS trust chief executive)

An emphasis on systems and collaborative leadership

We have defined systems leadership before as 'seeking to make change across organisations where people did not have a direct, line management responsibility' (**Timmins 2015**, p 7). It is an example of the collective leadership that is needed to support organisations to work collaboratively to deliver better care to the populations they serve.

As we noted in our previous work on changing leadership styles: the old model of 'heroic' leadership by individuals needs to adapt to become one that understands other models such as shared leadership both within organisations and across

the many organisations with which the NHS has to engage in order to deliver its goals. This requires a focus on developing the organisation and its teams, not just individuals, on leadership across systems of care rather than just institutions (**The King's Fund 2011**).

The emergence of STPs and integrated care systems has brought the need for systems leadership to the forefront of wider debates on NHS leadership. Both NHS Improvement and NHS England have included assessments of it in their regulatory frameworks and ongoing monitoring of progress in STPs.

So, are organisations actively looking for leaders who take a systems leadership approach? The results were variable across the country. Most interviewees agreed that the days of a director's remit being contained within the four walls of their organisation are generally over:

> *My expectations of exec colleagues now extend their portfolios beyond the organisational boundaries of the trust. A finance director needs to be engaged in the wider financial sustainability of our local system. My COO's [chief operating officer's] portfolio is not restricted to emergency care in the hospital but the entire urgent and emergency care system.*
> (NHS trust chief executive)

This has led to a desire for directors who have a different approach that includes a 'transformational mindset' and the ability to form effective collaborations with local partners:

> *I want people with the ability to see wider than the boundaries of their own organisation and understand we can't be islands in our own little world. The focus is not just about today, tomorrow and the next day. Of course, it should have always been about that, but it hasn't – the focus before has been about getting through the next year. We need to think of what the future might hold. When recruiting, this is now one of the key big features, whereas before it was further down the list.*
> (NHS trust chief executive)

Interviewees said, however, that this type of collaborative leadership approach is not easy to demonstrate, particularly as many of the structures and policies put in

place by the Health and Social Care Act 2012 are based on competition between autonomous, individual NHS trusts. As one chief executive said: 'Some creatures of "foundation trust land" are not suited to the new world of STPs and integrated care because they don't have a collaborative bone in their body.'

Interviewees noted that, in reality, although boards may talk about systems leadership, current operational pressures might discourage this:

> *Are we looking for a different type of leader? There is lots of rhetoric of looking for 'systems leadership' but is that really what people are looking for in filling current exec vacancies? You need to be a strong and confident leader to break out of the cycle, because requirements of running a sovereign organisation so keeps forcing you back into that standard and approach.*
> (NHS trust director)

> *Organisations say they want radically different things but the language in the job description is all about looking for someone who still runs a tight ship. The reality is it is still all about [a] portcullis coming up and [a] fortress being established for some organisations who are fixated on the current legal requirements, and not the mood music of policy going in a different direction.*
> (National stakeholder)

And there were widespread doubts that systems leadership is being taken seriously enough as a future career path or priority for leadership development:

> *Are we investing enough in developing system leaders? At the moment STP and ICS [integrated care system] leaders seem to be retired leaders and grandees. Is that sustainable going forwards?*
> (National stakeholder)

> *How do we ensure we are developing the leaders of tomorrow when the world is changing so fast in the NHS? The pressures mean we are just too focused on making a board appointment that is right for now and not on what this organisation is going to look like in five years' time.*
> (National stakeholder)

The emergence of managing directors

One noticeable change since our 2014 report on leadership vacancies in the NHS (Janjua 2014) has been the emergence of the day-to-day chief executive or managing director role in NHS trusts. We found these most often in hospital groups (such as in Mid Essex or the Royal Free London group) but they also exist in some large, single organisations that operate over multiple sites.

There is considerable variation in what function these roles serve and the type of candidate that organisations are looking for. In some organisations the managing director role is a 'site-level director of operations', while in other organisations the focus is more strategic and concentrated more on partnership working with other organisations and national bodies. Where the managing director is more inward-facing, this has often allowed the chief executive to focus on strategic issues and stakeholder management.

But as one national stakeholder said: 'I'm not sure the organisations really understand what they want from these roles, which makes it hard for the market to supply them.' An NHS trust chief executive looking to recruit managing directors also noted: 'This is a new post in the NHS and so brings with it some uncertainty for people. We don't have people "preparing" for these roles (as you might with CEOs, for example).'

Overall, there was a sense that more clarity and consistency is needed in the purpose of the managing director role, and whether it operates as a training ground for people to step up to future chief executive roles or is a distinct role in its own right. As one chief executive said:

> I think we are expecting people to be great strategic leads and great operational leads. And as we move to groups or bigger, merged organisations, the fact is, not everybody is able to be a great strategic leader. Perhaps we need to reprioritise the value of really excellent operational leadership and see that as being the pinnacle of [a] career for people rather than a 'rite of passage' that you need to go through to get to somewhere else.
>
> (NHS trust chief executive)

The torch has been passed

In our interviews there was a striking divide between the views of experienced chief executives and those of new ones. If the former were cautious pessimists (or, as one said, 'realists'), the latter were cautious optimists who argued that we need to acknowledge the opportunities of NHS leadership roles alongside the challenges.

This is, of course, not to say that experienced leaders were not optimistic or appreciative of the changes in leadership approaches they had seen. One highly successful and experienced chief executive noted: 'It's both the best of times and the worst of times. And in some ways, it's the best of times because 10 years ago we were looking for different things in leaders. Now it's not about big people, and big egos, and measuring yourself by the square acreage you sit on top of.'

Newer chief executives were more likely to use the language of privilege rather than challenge when talking about their roles:

> *We have a moral obligation here. If the job is too hard for me and I can't find solutions, then I should walk away. There seems to be a badge of honour in how difficult things are for you as a leader. And the assumption is the more complex and significant the trouble you are in, the more important you must be – and that's wrong. There is no room for pessimism and cynicism.*
> (New NHS trust chief executive)

It would be too simple to dismiss this cautious optimism as the naivety of new leaders who 'do not have the scars on their back' (NHS trust chief executive). The optimism of these leaders was tempered by the knowledge that they had reached the top of their organisations at a time of unprecedented austerity. And they had a clear sense of the burden of responsibility that had been placed on them. They suggested that one of the key 'things that could be done' to improve leadership development was to reflect the positives of NHS leadership roles:

> *The route through some of these challenges is having an energised group of senior leaders who promote the privilege of taking up these roles. We have the accountability to create the conditions and model the behaviours that will make these roles attractive to the next generation of leaders. If we don't do this as a group, then we risk becoming an old guard who missed the chance to make things better.*
> (New NHS trust chief executive)

1 2 3 4 5 6 7 8 **9**

9 What can be done?

Our research suggests that the attractiveness of NHS leadership roles has been heavily affected by, among other factors, the financial and operational pressures in the NHS, and greater 'personalisation' of performance and attribution of blame by regulators and politicians. This section considers what might be done to tackle leadership churn and ensure that the NHS has a sustainable pipeline of talented leaders through national, regional and local action.

Build on existing national talent management and development programmes

The NHS is one of the largest employers in the world. But many of our interviewees suggested that when managing its leaders it operates more like a collection of individual fiefdoms than a single organisation. The new chair of NHS Improvement, Baroness Harding, recently alluded to this lack of a 'guiding hand' when she observed: 'If I am really honest, I am quite shocked by the absence of the sort of talent management and performance management at the senior levels in the NHS compared to other organisations' (**Lintern 2018**).

Effective management of the NHS talent pool is currently undermined by a lack of detailed data and information. One national stakeholder suggested that this should be addressed early on:

> *We don't have the data currently to know how many CEOs leave every year or we don't know how many vacancies we've got or how many people are coming through. As a health care system we don't know how many future leaders we will need and what types and with what skills... And that's quite a dangerous place to be in.*
> (National stakeholder)

But over the past four years there have been some notable successes in developing future leaders. These include the new Aspiring Chief Executive programme – a collaboration between NHS Providers, the NHS Leadership Academy and

NHS Improvement, created in 2014. The programme has supplied more than 10 of the chief executives currently in post at NHS trusts. Suzanne Tracey, Chief Executive of Royal Devon and Exeter NHS Foundation Trust, has described the programme as the 'best personal development I have undertaken in 24 years in the NHS' (Tracey 2017) for its focus on values and personal development rather than technical knowledge and skills. Interviewees also highly regarded the wider series of national leadership programmes provided by the NHS Leadership Academy, Future-Focused Finance and the Healthcare Finance Management Association. They had little appetite to fundamentally change how these programmes operated, but they offered two suggestions for building on the successes seen to date.

The first suggestion was to expand the aspiring chief executives model to tackle shortages in other key professional roles. NHS Improvement is taking steps to address this through the new Aspiring Chief Operating Officer programme, working in partnership with NHS Providers and the NHS Leadership Academy. Interviewees suggested that other professional roles or functions below board level could also benefit from greater national support, including strategy and transformation, and commercial and estates director roles.

The second suggestion was to shift the balance away from a reactive model of offering programmes at a national level for those individuals with the time, resources and organisational backing to make use of them. A more proactive model based on seeking out and identifying talent – 'talent sniffing', as one person put it – might be needed. But interviewees recognised that this model might be more effectively managed at a regional level or by individual organisations.

Rebuild regional talent management

By far the most common suggestion for improving the development and support of future leaders centred around the need for greater regional talent management. Not all of our interviewees lamented the demise of SHAs, but the loss of the strategic talent management they had provided was keenly felt. Interviewees highlighted three elements in particular that had been lost at the regional level: providing opportunities for development within a local context, being a proactive 'guiding hand' to develop leaders and providing opportunities for peer support networks:

There was definitely more support in the past. There are many flaws with the current infrastructure of the NHS but one of the main ones is there isn't anywhere with the responsibility for ensuring that you've got support, development, leadership focus, like you had when you had a regional SHA. They would be looking and identifying good people to move into leadership roles, they would be developing them, supporting them, through mentors and coaches. I never had an aspiration to be a CEO – someone senior in the NHS identified me, encouraged me and supported me to get here.

(NHS trust chief executive)

Most interviewees felt that the SHA regions provided the right scale for identifying talented individuals (including individuals who may not have thought they had leadership potential) and matchmaking them with potential opportunities for development in the local region. It was also suggested that given the high risk of decapitation, people are less likely to move their families and lives to another part of the country and a greater focus needed to be placed on these local opportunities.

The guiding hand SHAs provided in these regions was clear: 'In the old days, SHAs would move you around from post to post. Someone would call you up and say: "You need to develop board-level skill 'X' so come do a temporary maternity leave cover here and get exposed to these issues"' (NHS trust chief executive).

A further benefit of this talent management approach was the exposure it gave to different aspects of health care, including hospital and out-of-hospital care, and providing and commissioning care. Supporting a better understanding of the context and perspectives of different types of organisation could help build stronger place-based leadership of the type that is clearly needed in STPs. The King's Fund has been running networks and action learning sets on collaborative leadership to support this goal.

Executives also spoke of the additional support and protection that were offered to people who took on challenging roles within a local patch, which made it easier to move people to difficult jobs or areas. 'You would get a call saying: "Can you go and do this job for me because it will be a good experience for you and I need a good person in that trust, and we'll look after you"'. (NHS trust director).

Interviewees considered the convening powers of regional organisations to be important as well and these were much missed by current NHS directors. The increasing challenges facing NHS leaders place them under considerable pressure. As one chief executive said: 'The loneliness of leadership is a big issue, especially when you are being asked to deliver the impossible with little forgiveness.' To share this burden, peer support and networks of support are essential. Even if trusts within a region might compete for services and income, it is still far easier to set up these networks within local geographies: 'We built up our own network. We know each other well, know how we each tick, and we can ring each other up when we've had a bad day. Being a CEO is a very lonely place to be. Having those people makes a big difference' (NHS trust chief executive).

Even if some interviewees confessed that they were looking back at SHAs through rose-tinted glasses, they still viewed these issues with an appraising eye. For example, the talent management functions of SHAs may have been effective but they were often informal and based on 'who you know, and who knows you' (NHS trust director). Relatively little focus or support was given to developing leaders of community and ambulance trusts. And some individual appointments could also feel foisted on boards and organisations by some SHAs.

Interviewees saw the coming together of NHS England's and NHS Improvement's regional teams, and the development of STPs, as opportunities to rebuild regional talent management. They mentioned that the Midlands and East talent pool (**NHS Improvement 2017**), which supports and assesses local leaders for appointment to director-level positions, is an example of good practice that could be followed in other parts of the country. The NHS Leadership Academy plans to establish similar talent boards in every region by the end of 2018/19 (**NHS Leadership Academy 2018**).

Interviewees hoped that formal talent management programmes at a regional level would be developed that were more egalitarian in approach and wider in scope than in the past – for example, looking at integrating leadership development or sharing talent management resources for public services within the region, such as the NHS, social care, local government and police and fire services.

Invest more time and resources in local leadership development

Some leadership development is clearly best resourced and delivered at national or regional levels. But as one chair noted, the responsibility for leadership development exists at all levels of the NHS and should not be abdicated by trusts themselves: 'The talent pool is hugely important. If you only fish in it, and don't put any fish in it, you end up in a sorry state.'

Our interviews revealed a mixed picture of the extent to which trusts prioritised local leadership development. For some trusts, their approach is limited to not saying 'no' when opportunities for leadership development present themselves. These include facilitating mentoring or shadowing opportunities when staff request them.

We also found examples of trusts that had made greater investments in growing future leaders for their trust and the wider NHS. For many trusts this involved 'try before you buy' schemes to give potential directors exposure to the realities of a board-level position. These included offering interim director positions to internal staff rather than recruiting externally. One NHS trust director said:

> *There was a sense of being groomed for a director role, but I was having doubts of the stress of it. I was offered the post on an interim basis, so I could see and learn what the job was genuinely like. It was as stressful and challenging as I thought, but what surprised me was how emotionally tiring it was.*
> (NHS trust director)

Trusts noted that investing in local leadership development is not cheap and not easy – it takes considerable amounts of senior leadership time and external resources such as partnerships with local business schools:

> *I'd love to do a training course. Every year I think about signing up and then I think about work–life balance and how much operational pressure the trust is under. You either can't go to training, or go and get called away, or go and can't concentrate because you're worried about what is going on back at the trust. My appraisal has been cancelled four times this year because of operational pressures.*
> (NHS trust director)

When I first became a CEO I invested a lot of time in team-building with my executive team. We did very bespoke team-building, leadership development and board development. It was residential, and we spent money on it, but I knew it would be worth it.

(NHS trust chief executive)

Interviewees also recognised that investment in leadership is an ongoing commitment rather than a one-off initiative. In one trust, directors' portfolios are reviewed every two years to rotate non-specialist board responsibilities. This means that all directors are exposed to a wider scope of the trust's business and as the chief executive noted: 'This kept my directors interested and challenged – they didn't have to move elsewhere to keep things fresh or to keep learning.'

Think about where the pipeline ultimately leads

In the NHS, significant attention is given to discussion of the process of identifying and developing leaders: the 'leadership pipeline'. Our interviews suggested that more focus is needed on the continuous management and support of leaders once they 'exit' the pipeline and take up management roles. As one national stakeholder said: 'We need to ensure the leadership pipeline doesn't lead directly over a cliff edge.'

Support for new directors and chief executives is vital to avoid 'setting people up to fail once they get in role' (NHS trust chief executive). This is especially important as 51 per cent of chief executives surveyed by NHS Providers were in their first chief executive post. New programmes such as action learning sets developed by NHS Employers and the NHS Leadership Academy's Chief Executive Development Network are starting to fill this gap by providing communities of leadership and practical support to new executives:

I've definitely benefited from national programmes on leadership development, but it is as important to have ongoing support and having opportunities to share challenges and get support from your immediate and more-experienced peers who can give you support and advice when you need it.

(NHS trust chief executive)

When I was a new CEO I walked into a room and felt imposter syndrome. Someone experienced was there to put their arm around me, tell me: 'Have you had a coffee with the editor of the local paper yet, so they know you and you know them and at least there's a relationship there even if you know they will have a go at you in the future?' There was lots of practical support and advice, which was important because there is no manual for how to be a CEO in the NHS.

(NHS trust chief executive)

More immediate and practical support in the early days of an executive taking up a new role would be welcomed. But our interviewees were clear that this, and more intensive work on the leadership pipeline itself, would have a limited benefit if we continue to produce leaders and place them in a 'toxic day-to-day environment' that does not support or care for leaders and is too quick to remove them during difficult periods. One national stakeholder noted that this point was effectively brought home by the second cohort of the national Aspiring Chief Executive programme graduating just as two NHS chief executives were 'selected for ritual execution' over performance challenges that are widespread throughout the NHS.

As we noted earlier in this report, even the most experienced leaders and the most successful organisations can encounter difficult periods. This is especially true given the wider pressures facing all NHS services due to rising demand, financial austerity and workforce shortages. Providing the right support in a timely way to NHS leaders, rather than summarily removing them from their positions, could do much to foster a culture of learning from mistakes and continuous improvement in the NHS. Addressing this issue requires action from NHS trust boards, and the regional and national offices of NHS England, NHS Improvement and the Department of Health and Social Care.

So what might help? First, a greater recognition of the challenging context leaders operate in, which should lead to a more finely calibrated view of when action is needed. This means having more regard to the attribution theory one of our interviewees mentioned, and a more nuanced view on what even the best leaders can accomplish. The quality of leadership is a vital factor that affects the success of NHS organisations, but it is not the **only** success factor. This is especially true as local health and care economies become increasingly interdependent, and the fate

and fortune of an NHS trust can be substantially affected by the effectiveness and availability of primary care or social care, for example.

Second, when action is needed, the NHS should use a broader set of approaches for supporting leaders who encounter difficult periods. Removing leaders should be the last option, when currently it can all too often feel like the first or only option. There needs to be more co-ordinated and practical support for leaders going through difficult periods, including using buddying arrangements and networks to tap into the expertise and experience of other organisations and leaders who have experienced similar issues in the past.

The alternative means proceeding with a 'change the leader, solve the problem' mindset that reflects an overly simplistic view of how to improve the performance of NHS organisations. This approach is unlikely to address the root causes of underperformance, and will inevitably lead to a climate in which future leaders are afraid of taking on more senior positions, and in which current leaders are so fearful of making a mistake that they are unable to take the bold decisions that are sometimes needed.

In addition to further fundamental changes – such as addressing the funding and workforce challenges in the health and care system – there were three things that leaders wanted to help change the leadership climate:

- national bodies modelling the behaviours they expect in local leaders

- clearer expectations of what 'good' looks like in NHS leadership

- to be treated more humanely.

Local leaders we spoke to expressed sympathy for colleagues in national bodies who are 'dealing with intense political pressure and the requests they give us are because they are being asked for the information too' (NHS trust chief executive). But they often also spoke of being put under tremendous personal pressure by national bodies and there were reports of unacceptable behaviour and personal styles that made trust directors question whether national bodies are 'living the values' espoused in the national leadership framework *Developing people – improving care.*

The interviewees also highlighted the 'dissonance' and 'lack of coherence' between NHS England's and NHS Improvement's regional teams. They said that because these organisations often lack a joined-up approach, directors often receive duplicative meeting requests or demands for information and data. Interviewees were (very cautiously) optimistic that the move towards closer regional working, and the recently announced reshaping of NHS England's and NHS Improvement's leadership teams to promote systems leadership, leadership development and talent management (**Dyson and Lawson 2018**), might address some of these issues:

> *We need to role model better leadership at the top of the NHS. NHS Improvement and NHS England say: 'We are not one organisation. It is difficult legislatively to be one organisation.' And then they tell us in STPs that we need to play nicely even though we are all separate organisations. You go from one meeting with NHS England to another with NHS Improvement and it's clear that regional teams have told their staff to stick it to the other national body when you get the chance... there is no consistent leadership message coming through the system.*
> (NHS trust director)

Alongside this was a desire for clearer expectations of what defines good leadership in the NHS, including more credible expectations of what can be realistically delivered by even the best NHS leaders: 'We have got a national NHS at the top of which has got its fingers in its ears saying: "La la la, not listening, just get on with it, just deliver, just do everything." And I think there needs to be an honesty about what is deliverable' (NHS trust chief executive).

Interviewees also wanted greater clarity on what leadership traits and attributes should be prioritised:

> *We need a better definition of what success looks like as a leader in health care. The closest at the moment seems to be pushing STPs forward... but that's only the view from one part of the system. 'Working in an organisation that isn't fundamentally broken' is another definition – but not a good one.*
> (NHS trust director)

Far simpler (in theory if not practice) was a call to treat senior NHS leaders better. It is instructive that this suggestion needs to be made in a report on leadership in a person-focused vocation like health care. Both national regulators and NHS

trust chief executives echoed the sentiment of more humane relationships, both noting that this supportive message may be 'lost somewhere' by the time it reaches local teams:

> *The regulators need to build [a] relationship with us and have good and positive conversations with us. I don't mean stroking us gently and I don't mean praising us. But if we had the relationship with them and more regular conversations with them about things – not just money and not just the four-hour target – I think they'd get a far better contextual picture of what's going on and why. They'd get to know us and get to know our capabilities better. And they would probably get to know how to press our buttons and if they want to fire us up, make us turn it up a gear, they would know how to do that.*
> (NHS trust chief executive)

> *We need to feel safe and nobody feels safe. Everyone is looking behind them and just waiting for the axe to come down. We've been thrashed now to within an inch of our lives. And I think it's cutting to the bone now. They need to be nice to us – it sounds a bit twee – but they do need to make us feel safe.*
> (NHS trust chief executive)

> *Local, regional and national relationships are about culture, which means it's about people. Are we building the culture and relationships we need to? I don't think so. We need to bring people together more – not in cosy roundtables or to have 'I hate you, you hate me' conversations about A&E performance – but to talk as people so we can understand each other better.*
> (National stakeholder)

An *HSJ* report of a recent meeting with the Secretary of State and other national bodies indicates that 'the centre' is aware of these issues. The meeting was called to address concerns that trust chief executive jobs were becoming 'so difficult that only totally exceptional people can do it' (Mclellan and Lintern 2018). The topics covered in the meeting included whether local leaders know what is expected of them, whether they are supported by the centre, how administrative burden can be reduced for local leaders and how these leaders can be recognised and rewarded for taking on difficult jobs. It is important that awareness of these issues is now supported by a deeper understanding of what it *feels* like to be a local leader or aspiring leader in the NHS, and practical action to make these roles more attractive.

A final word – balancing reality with optimism

We find it very difficult to recruit people who want to be chief executives – the average time they spend in post is just 700 days.
(Sir David Nicholson, NHS Chief Executive, quoted in Santry 2007)

Four years ago, a third of trusts had a vacant executive board position. Trusts in special measures struggled most to recruit permanent directors. Four years on, the latest NHS Providers survey data shows that 37 per cent of trusts have a vacancy and trusts in special measures find recruitment little easier. So, a case of *plus ça change, plus c'est la même chose*? Not quite.

The latest NHS Providers survey and earlier research by the *HSJ* (Brennan 2017b) show promising signs that trust leaders are staying in post longer than the 700 days they could have expected in the past. National programmes for aspiring chief executives and operating officers remain heavily oversubscribed – while the pipeline may need strengthening, it is certainly still in place. But these causes for encouragement need to be balanced against the very real risks that high leadership churn continues to present for NHS trusts. The leadership task remains hard – remember the chief executive who was still thinking of his trust during his daughter's birthday. The task is more complex – even God would struggle. But the task also remains rewarding. Despite the current challenges, the leaders we spoke to regard their career as a vocation and their job as a privilege.

But the realism of today's challenging financial and operational climate must be balanced with optimism for the future – optimism based on the success of new programmes to support aspiring chief executives and on a new generation of leaders who believe they must do their bit to make these roles more attractive for those who will follow them. If the 'Gordian knot' of leadership development has not been untied, it has at least been loosened.

The final words in this report rightly belong to the leaders themselves. One contribution comes from Mary Edwards, a leader who created a vacancy by retiring after a successful career in the NHS. The other contribution comes from a director who may one day take her place:

As a recently departed CEO, one recommendation I do offer to the very senior leaders in the NHS is to discourage the constant movement and churn at CEO level – give us time to learn the job (3–5 years) then see the benefits of us staying in one place. I learnt so much from some great CEOs, in all types of organisation, who had been in post for 10 or more years. It is easy to forget that many of our staff join an NHS organisation in their 30's and stay till they retire; these staff think of CEOs as itinerants and therefore don't invest their trust and loyalty in us. Without support for senior leaders (both locally and nationally), large-scale transformation of the service will not be realised.

(**Edwards 2017**)

Being a leader in the NHS – it's bloody brilliant as a job. It really is. There's nothing like it. But imagine if we got rid of all the sh** around at the moment, with being treated poorly and being under constant pressure, how much more brilliant would it be?

(NHS trust director)

Appendix: Methodology

Survey data

NHS Providers carried out the survey described in this report in winter 2017. NHS Providers received data for 1,035 executive director posts. To help with comparability with The King's Fund's 2014 leadership vacancies analysis we excluded those in roles categorised as 'corporate affairs/governance', 'combined' and 'other' which left 897 executive director posts in the sample. NHS Providers has noted that there were a greater number of combined roles – such as a single person holding the nursing director and chief operating officer positions – than in the past.

Table A1 sets out the number and type of trusts responding to the survey.

Table A1 Characteristics of the trusts that responded to the NHS Providers survey

		Trusts reporting data	Trusts in the wider sector	%
Total		145	232	63
Trust type	Acute	100	151	66
	Ambulance	6	10	60
	Care	2	5	40
	Community	9	18	50
	Mental health and learning disability	28	48	58
Region	London	20	36	56
	Midlands and East	48	70	69
	North of England	44	71	62
	South of England	33	55	60
CQC rating*	Outstanding	10	15	67
	Good	67	102	66
	Requires improvement	63	101	62
	Inadequate	3	12	25

* As of December 2017

The tenure of the directors in the survey was estimated based on the year they were appointed. For example, directors appointed in 2017 were assumed to have been in post for six months on average by the end of 2017. Directors appointed in 2016 were assumed to have been in post for one year on average by the end of 2017. Tenure calculations were made for substantive directors only.

Qualitative data

A roundtable event and separate semi-structured interviews conducted by The King's Fund staff between February and May 2018 informed this report. Attendees at the roundtable and interviewees included executive directors and chairs of NHS trusts and foundation trusts and national stakeholders from arm's-length bodies, recruitment agencies and membership associations.

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About the authors

Siva Anandaciva is chief analyst in The King's Fund policy team, leading on projects covering NHS funding, finances, productivity and performance. Before joining the Fund in 2017, Siva was head of analysis at NHS Providers – the membership body for NHS trusts and foundation trusts – where he led a team focused on NHS finances, workforce and informatics. Previously, he was an analyst in the Department of Health working on medicines policy and urgent and emergency care. Siva chairs the NHS tariff advisory group and was a governor of the Homerton University NHS Foundation Trust from 2014 to 2017.

Deborah Ward is a senior analyst in the policy team at The King's Fund with a particular interest in how to communicate data effectively. Before joining The King's Fund in 2018, Deborah was the analysis and research manager at NHS Providers, leading their member survey programme and analysis of NHS performance data. Previously, Deborah worked for GovernWell, the national training programme for NHS foundation trust governors. Deborah has an MSc in forensic and biological anthropology from Bournemouth University.

Mandip Randhawa joined the Fund in 2013 and for the past 18 months has been seconded to Birmingham Women's and Children's NHS Foundation Trust as an organisational development consultant. Mandip has directed numerous development programmes at The King's Fund including the Emerging Clinical Leaders and Release your Potential programmes, both aimed at leaders early in their leadership career. Mandip studied law at Lancaster University, has trained as a facilitator with the Chartered Institute of Personnel and Development and has a certificate in counselling and psychotherapy skills from Westminster Pastoral Foundation. She is also trained in numerous psychometric tools used to support development as well as being a trained action learning set facilitator. She is currently completing the ILM Level 7 Certificate in Executive Coaching and Mentoring.

Before joining the Fund in 2013, Mandip worked as a policy adviser at the Department of Energy and Climate Change; as a policy adviser at the Royal College of Nursing; and as a policy manager at NHS Providers. She has also worked as a policy officer at the Human Tissue Authority.

Rhiannon Edge is a senior research analyst at NHS Providers, the trade association representing NHS trusts in England. She conducts research and analysis on a wide range of health-related topics, including operational performance, regulation, finance and workforce. She also leads on NHS Providers' member survey programme to ensure a robust evidence base underpins their policy influencing work.

Rhiannon holds a BA in geography from the University of Leeds, and has previously worked in a number of analytical roles within the public and third sector, including at the National Society for the Prevention of Cruelty to Children (NSPCC) and the Department of Health and Human Services in Victoria, Australia.

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Leaders in today's NHS operate in a climate of extreme pressure. Staffing vacancies are rife, there are widespread challenges in meeting financial and performance targets and demands on services continue to increase. As the nature of the challenges leaders are facing changes, what can be done to support current leaders and encourage future ones?

Leadership in today's NHS draws on NHS Providers' annual quantitative survey of leadership vacancies, and qualitative interviews and a roundtable The King's Fund conducted with NHS trust directors and national stakeholders.

The report finds that:

- leadership vacancies are widespread, with director of operations, finance and strategy roles having particularly high vacancy rates and short tenures

- a culture of blaming individuals for failure is making leadership roles less attractive

- organisations with the most significant performance challenges experience higher levels of leadership churn.

The authors conclude that national bodies need to do more to support leaders to take on and stay in leadership roles, especially in organisations with significant performance challenges. More attention should be given to addressing the environment NHS leaders operate in. To help ensure these roles are attractive in future, national bodies should better model the behaviours they expect in local leaders, the expectations of 'what good looks like' should be more clearly articulated, and NHS leaders themselves should be treated more humanely.