The King's Fund

HSJ FUTURE OF NHS LEADERSHIP

Leadership vacancies in the NHS

What can be done about them?

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1 Foreword

The *Health Service Journal (HSJ)* Future of NHS Leadership inquiry, which I chair, has been running throughout this year and will come to a conclusion early next. We have heard evidence from a range of individuals and organisations but no matter their background one theme has always quickly emerged: the problem the NHS has in retaining leaders.

The purpose of our inquiry is to outline the leadership the NHS will need to thrive in the future. What is crystal clear is that we cannot continue with this constant 'churn' of leadership. Equally clear is that we need to encourage the abundant talent we have in the NHS – particularly our clinicians – to take up senior-level roles.

This report, produced by The King's Fund in collaboration with the inquiry, highlights the scale of the problem. It reveals that more than a third of our provider organisations have at least one executive-level post either vacant or filled by an interim.

In common with The King's Fund, we believe that incentives or, perhaps more accurately, removing the extensive disincentives will be key to increasing the uptake of leadership roles.

This report provides some ideas on how we might do that, and the inquiry's final report next year will provide many more. In the meantime, I welcome this paper as an important part of the discussion and hope it encourages you to share your own thoughts. You can do so via www.hsj.co.uk/future-leadership

Sir Robert Naylor
Chair, *HSJ* Future of NHS Leadership inquiry
Chief executive, University College London Hospitals NHS Foundation Trust

The evidence presented in this paper highlights worryingly high levels of board-level vacancies and some of the underlying causes for these. It is particularly concerning to read stories from senior leaders who feel personally exposed in the very top-level positions. In an increasingly complex health system, there is a danger that this situation could worsen unless NHS organisations and the system as a whole takes action. For organisations, the crucial step will be ensuring they have a leadership strategy that describes all the elements needed to ensure a strong pipeline of future leaders. There is also a clear link between engaged and happy staff (including senior leaders), a culture that is supportive, learning and nurturing, and safe patients. For the system as a whole, if the most challenging and demanding roles are to be attractive, there is a need for national bodies to create space for providers to operate with autonomy. Sometimes this may mean getting themselves out of the way and trusting local leaders to do the right thing. There is also a danger that leadership and culture is unlikely to change if we continue to recruit in the old familiar model that does not reflect the diversity of our communities. Women and black and minority ethnic people are under-represented among staff, including senior staff – an issue that must be addressed as a priority. Part of the solution lies in values-based recruitment which can help to create the right culture by selecting with values as the most important determinant.

Talent management is key. The responsibility for developing future leaders needs to be taken seriously. The very best leaders will see it as their responsibility to develop individuals for the greater good of the NHS. But this is often not the reality as people who move among organisations to progress their career can be seen as disloyal. It is also the role of senior leaders to take risks and develop people in role rather than expect them to be up and running from day one.

Finally, it is important that a culture of development and support should pervade – one that allows senior leaders the time and space to try new things, to learn from others and to lead and embed innovation, and one where they are free from the weight of scrutiny and blame that dominates today.

Nicola Hartley
Director, Leadership Development
The King's Fund

2 Key messages

- Almost one-third of all trusts had at least one vacancy or an interim executive board member. Most vacancies were for finance director roles and nursing director posts were vacant for the longest.
- Board-level vacancies have a negative impact on an organisation. They affect staff morale and engagement, cause strategic instability and waste human and financial resources.
- A number of key factors make board-level posts unattractive. These include a perceived blame culture where executives feel exposed if anything goes wrong – even over situations where they have little control; unrealistic expectations of how quickly change can be achieved; and excessive regulation.
- There are specific disincentives for clinicians to take up board positions. These could be the risk of de-skilling their clinical practice; the mismatch in skills and experience between clinical and management roles; limited financial incentives and perceived job insecurity.
- Gaps in leadership result in part from the size and complexity of the NHS in England and the absence of a systematic approach at all levels to talent management, succession planning and leadership development.
- Individual NHS organisations should be chiefly responsible for filling these gaps, taking into account that people must be developed for future roles in the wider NHS.
- NHS organisations may benefit from collaborating with other organisations in developing future leaders in situations where the NHS lacks the necessary expertise and resources.
- Every NHS organisation should have a leadership strategy and a leadership development plan describing how many leaders it needs and how they will be developed.
- Any national development programmes should focus only on those functions that cannot better be undertaken by NHS organisations working either individually or collectively.

- Concerted action is needed at all levels to support more women and people from black and minority ethnic (BME) backgrounds to take on leadership roles.
- National bodies like Monitor, the NHS Trust Development Authority (TDA) and Care Quality Commission (CQC) have a key role to play in creating the culture and context conducive to recruiting and retaining board-level leaders, removing barriers such as excessive regulation and modelling the kinds of leadership behaviours needed in future.

3 Introduction

There is a growing awareness that NHS provider organisations have more vacancies at senior levels, are increasingly reliant on interims and are experiencing a greater 'churn' of senior leaders. This is important because of the potential negative impact of vacancies on staff morale and engagement, on costs and on performance. Research by The King's Fund shows that leadership is the most important influence on organisational culture (West *et al* 2014). Ensuring effective leadership will be crucial to developing organisations that deliver high-quality compassionate care.

The King's Fund decided to look at these issues in partnership with *HSJ* as part of its Future of NHS Leadership inquiry, chaired by Sir Robert Naylor. *HSJ* carried out a freedom of information (FOI) request in July 2014 to obtain an accurate picture of current board-level vacancies. The data gathered was supplemented with in-depth interviews and a literature review. Further details about the methodology are set out in the Appendix.

4 Findings

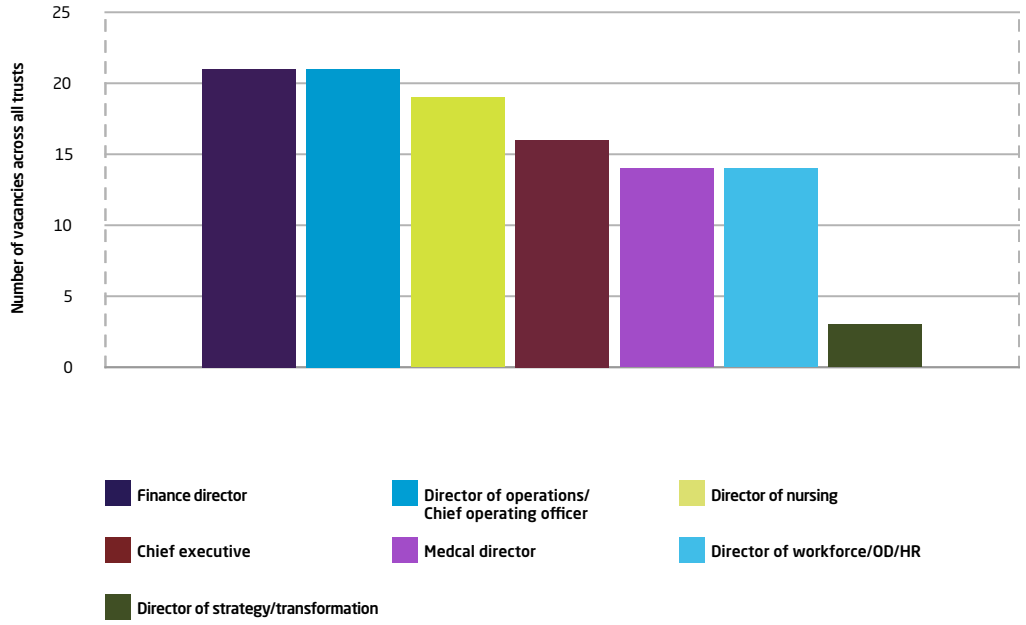
The FOI request was sent to all acute, mental health, community and specialist acute providers in England. Responses were received from 134 acute trusts (94 per cent), 56 mental health trusts (100 per cent), 19 community trusts (100 per cent) and 18 specialist acute trusts (100 per cent).

The survey was limited to voting executive-board roles in order to be able to compare data. However, we recognise that many trusts may have vacancies or interim arrangements for non-voting board members of their executive team.

Level of vacancies

In relation to specific roles on the board, the breakdown of vacancies by job title is illustrated in Figure 1.

Figure 1 Vacancies by job title



Across all types of trusts almost one-third reported having at least one vacancy or interim executive board member, broken down as follows:

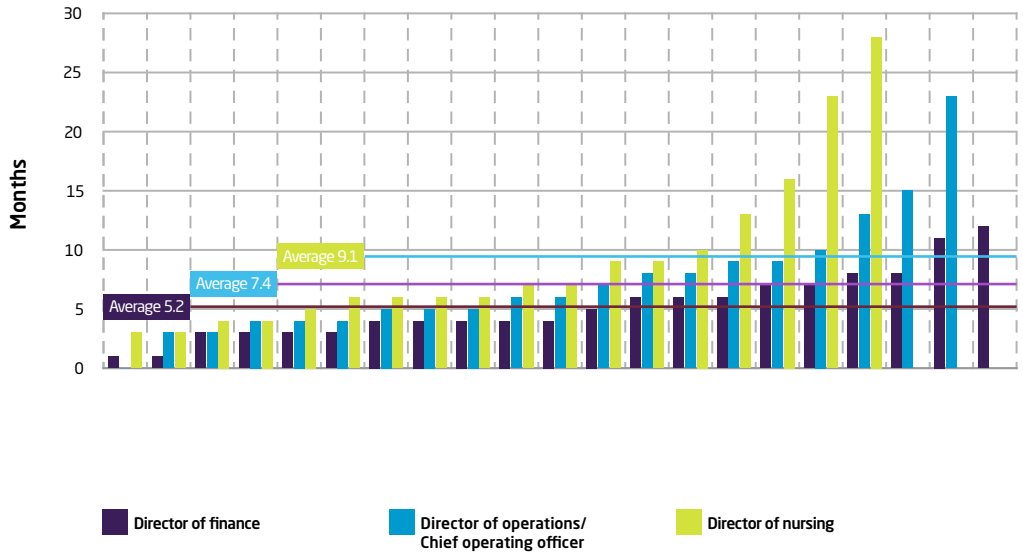
- acute 33 per cent
- mental health 37 per cent
- specialist 17 per cent
- community 21 per cent.

The FOI request also highlighted the following:

- 9 per cent of all trusts have no substantive finance director
- 12 per cent of acute trusts have no substantive chief operating officer (COO)/ director of operations
- 16 per cent of mental health trusts have no substantive director of nursing and 14 per cent have no substantive finance director
- 16 per cent of community trusts have no substantive chief executive officer (CEO).

Figure 2 highlights the length of vacancies for three posts. Although finance directors make up the largest proportion of vacancies, the data we gathered suggests that nursing directors may be the hardest to recruit, given that their posts remain vacant for longest on average.

Figure 2 Length of vacancies in months



There is a lack of consistent data tracking senior board vacancies over time and this makes any robust analysis of changes in vacancies difficult. However, many of those we interviewed reported that the situation is worsening.

Impact of senior vacancies

Our research highlights the negative impact that a high level of executive vacancies and turnover has on individuals, trusts and on the wider health system. There were very few examples of positive impact of high executive turnover and vacancies. These included the introduction of new ideas, removal of established (and sometimes 'toxic') ways of working, and space for organisational and staff reflection.

Negative impacts have been documented in the literature we reviewed. Research by Ballantine *et al* (2008) showed 'strong association between poor Trust performance and CEO turnover'. High turnover of staff at executive level can also contribute to staff feeling less secure and it can be a risk factor in ensuring quality of care and staff engagement (McKee *et al* 2010). The evidence also suggests that high executive turnover 'has a chilling effect on the willingness of Chief Executives to take bold initiatives and encourages a passive and responsive culture' (**Edwards and Lewis 2011**).

Our interviewees reaffirmed the negative impact of vacancies on their organisation. We spoke to people currently in senior positions in trusts, often facing high turnover of fellow executive board members. They said one of the most significant impacts of vacancies on a trust was the loss of strategic direction. A leadership vacuum also increased clinical and strategic risk with potential loss of accountability.

This loss of accountability places interim executives in a difficult position where expectations can conflict with circumstances. They may not be able to implement solutions as quickly as they had hoped. Lack of experience or tenure in a similar role and the time needed to establish relationships make it difficult in some cases for interims to hit the ground running. Often, the main focus for interims is on the need to demonstrate immediate impact rather than longer-term strategic change. They are often recruited to fill a gap and may be used as a quick fix as opposed to the organisation putting significant extra effort into finding the right person. They are also less likely to be appointed on the basis of particular values.

Some interviewees suggested that interims may have fewer incentives to try to implement transformative change and may instead 'pass the buck'.

> *It creates a leadership vacuum which means that people then play up which sets the organisation back.*
> (CEO)

Respondents substantiated the negative impact of senior vacancies on staff morale and engagement, especially if interim appointments have been made.

> *People below, the general managers, they don't buy in to interims, don't invest the time in relationships because they're thinking well, they'll be gone soon.*
> (Director of finance)

Respondents also highlighted the not insignificant resource implications, saying appointing an interim was 'a waste of human and financial resources'.

The impact of vacancies is likely to be worse in the context of a challenging external environment where NHS organisations need experienced senior leaders more than ever.

Barriers and enablers

Personal and career risks

Respondents from our stakeholder interviews highlighted reasons for high executive turnover that can be broadly characterised as relating to the risk/reward ratio of these roles. While the public, politicians and the media all have a legitimate role to play in scrutiny and accountability, when things go wrong, this scrutiny can become intense and be accompanied by blame and disproportionate consequences.

> *People who are confident in themselves accept there will always be a Mid Staffs – but the criticisms are more personal – people want someone to blame and have your head on a pole, and the government encourages this.*
> (National stakeholder)

The clinicians (and national stakeholder bodies representing them) we spoke to told us that the clinical roles on the board often felt even more exposed personally and professionally. As one medical director suggested, this may be because of more formal clinical accountabilities that these roles carry such as the Caldicott Guardian role, responsible officer role and the responsibility of representing the clinical workforce. The possibility of losing clinical registration as a doctor or nurse if serious failings occur was also an added risk for clinicians thinking of taking a board-level position.

Both our research and the literature also pointed to a lack of incentive for those currently below board level (for example, assistant directors) to make the 'step up' to a position on the board. Interviewees felt the salary increase was often not worth the increased exposure and risk, with senior roles below board level already providing a good remuneration package and high levels of job satisfaction, as is the case with senior managers running large clinical divisions in provider organisations.

Inverse leadership law

Interviewees also highlighted difficulties in recruiting executive roles in smaller organisations and in those with poor performance. This was described in the literature as the inverse leadership law where those organisations that most need strong and effective leadership were least likely to attain this (Chambers *et al* 2011). Many respondents referred to the growing polarity between trusts that were seen to

be effective and stable and thus attracted good executive candidates; and those that were unstable or poorly performing which suffer from high executive turnover and rely heavily on interim executives.

Our FOI data corroborates this. It shows that trusts in special measures have a higher number of vacant executive posts and/or high use of interims. The percentage of trusts in special measures without a substantive CEO (17 per cent) is well above the average across all respondents (7 per cent). However, this does relate to a relatively small number of trusts in total.

> *One of the problems with organisations that are struggling is that we create a toxic brand. Therefore all the things that are challenges for the industry are even more so for these struggling organisations. There are a number of toxic brands that make it difficult to fill any positions in those organisations.*
> (National stakeholder)

One possible explanation for this inverse leadership law was that the NHS currently delivers inadequate solutions to poor performance – moving individuals on as opposed to realising there might be a system problem. The 'heads will roll' attitude where poor performance is resolved by removing some or all of the board may not be helpful in dealing with organisational issues, or indeed issues that may be related to the wider local health and care system.

> *If someone fails their A&E target for a few quarters, and the politicians get angry… it's too easy for people to think the answer is to shift the CEO or director of operations, as opposed to acknowledge that there may be a local system issue.*
> (National stakeholder)

Structural uncertainty

As well as smaller trusts and those perceived to be failing, some respondents suggested a difference in vacancies depending on the type of provider organisations. For example, community trusts may have more difficulty attracting good executives as they face greater competition with other providers such as independent or social enterprise organisations. The long-term financial viability of community trusts and whether they have reached foundation trust status may also make it harder for them to recruit good executives. With acute trusts they 'have more stable income' but

'they get segmented according to whether they are good or bad', according to one national stakeholder. This is supported by the FOI data.

One chief executive we spoke to highlighted the increased level of senior leadership vacancies in his trust due to a potential merger and acquisition – 'as you get near a transaction, people do move on'. This is destabilising for the board and the organisation as a whole.

> *The dilemma I have is that my board is making decisions now [that] they know they won't be there to enact … as the acquisition is next year. How do you keep them enthused to carry on?*
> (CEO)

This also applies to system-wide structural uncertainty; the consequence of change can be difficult.

> *The system's been through so many reorganisations, and the last one especially we lost a lot of people. There are 200-odd CCGs [clinical commissioning groups], we can't reasonably expect to have good people to run all of these organisations. There are too many organisations.*
> (National stakeholder)

Regulatory burden

Some respondents felt there was an unrealistic regulatory burden with increased accountability even on issues where executives had little influence. Linked to this was a feeling that the NHS, regulators and other national bodies were overly focused on short-term outcomes and quick wins with high or unrealistic expectations of change.

> *The idea of providers 'getting on with it' is less the case. It is now more micro-management, and being held to account for performance issues that they [board members] may not be able to influence.*
> (National stakeholder)

We identified two different types of regulatory burden that can affect boards and the potential attractiveness of taking on these roles. One is where senior leaders are so heavily audited and reviewed that it distracts them from getting on with the job.

The other is where the board does not set its own priorities but adopts those of the national organisations. This, along with the significant obstacles to making any changes to services, adds to a feeling of limited autonomy in these roles – cited as a reason why they may be unattractive to those with a strong drive to achieve change.

Personal incentives

Other factors identified by interviewees included the geographical pressures of those who need to relocate for a senior position, the longer hours causing a poor work–life balance and, for a smaller number of people we spoke to, inadequate financial rewards.

> *In the NHS there's lots of commuting, living away from home, so people don't stay long. A great job may keep someone going for a year in that situation but not long term.*
> (Finance director)

The career choices for board-level clinicians are limited and it may be difficult to return to full-time clinical practice due to de-skilling. Medical directors may also be undertaking their board role in addition to maintaining some of their clinical practice. The dilemma facing medical directors is whether to invest more in their board role leaving them less time to practise as a clinician or to maintain their clinical expertise for fear of losing clinical credibility among their colleagues.

Within some parts of the NHS there is a perception that the medical director role is best suited to the later part of a clinician's career before considering retirement. This can limit the availability of a wide pool of applicants for medical director vacancies. One medical director told us:

> *[T]he question is why would you bother? As a doctor you did have a job where patients and staff tell us we do a fantastic job, and you can earn extra money in the private sector. So why would you go and earn less money?*
> (Medical director)

Revalidation may also affect how attractive board roles are for clinicians (Nath *et al* 2014). The call to professionalise medical management and leadership roles has put some willing candidates off the medical director role as they see this as more

work on top of what most already feel is a burdensome job – juggling clinical input, management and leadership with no extra time given for this. In some cases, organisations have made a reduction in the Supporting Professional Activity sessions for doctors in order to cut costs.

There may be further disincentives facing senior nurses considering taking up a board-level position. Our FOI data shows that nursing directors may be the hardest to recruit, given that their posts remain vacant for the longest time on average. Gender may play into this; our recent women and leadership survey (Read 2013) highlighted the difficulties of working in a culture of old boys' networks, nepotism and prejudice, and in a 'macho', pace-setting environment, compounded by unhelpful attitudes towards women leaders. Almost a third of respondents highlighted difficulties in juggling child care and work commitments. Many added that family responsibilities limited how much they could join in work-related social events, making it even more difficult to break into senior leadership positions.

Organisational culture

Many boards have not invested adequate time and resource in improving the culture of their organisation, to make it one that nurtures talented people. A crucial part of this culture change is engaging staff all the way through the organisation, having an open culture committed to learning and innovation, where leaders are developed through a systematic approach to talent management.

The prevailing organisational culture can skew perceptions of how board members are valued and influence willingness to apply. For example, one respondent below board level felt that the culture of that trust prevented people from within the organisation applying for board positions.

> *It certainly feels like the CEO has no interest in developing people like me and that he has no intention of appointing internal people to a board-level position… There's also a preoccupation with recruiting internationally – 'we want the best in the world'. Makes the middle to senior management layers think 'there's no hope here'.*
> (Divisional manager)

Others highlighted the bullying or blame culture within an organisation and across the whole NHS that can affect people's desire to take up executive positions. This can also produce behaviours that are reactions to the blame culture. A recent *HSJ* survey of CEOs highlighted that 'many have experienced bullying. Significant numbers report that they are preoccupied with avoiding blame, with over a third saying that they feel unable to take risks or speak out…' (Lintern 2012).

Individual personalities or dynamics of established teams that are unsupportive of challenge or new approaches can also adversely impact executive turnover. The literature highlights difficulties in personal relationships within a trust as a contributory factor causing executives to leave positions (Hoggett Bowers 2009).

Capability and career development

Many of the people we spoke to said that the knowledge and skills gap between those below board level and what is required to fulfil a board-level role is a key reason for high vacancies. This includes understanding the leadership challenge of being on a board, the enhanced technical knowledge needed in areas like governance, quality or finance, skills around networking and relationship-building, and understanding the new strategic responsibilities.

These skills were seen to be underdeveloped among potential senior leaders both nationally and within their current organisations. A few people highlighted the lack of experience that aspiring senior leaders have – either a lack of experience 'on the job' from a leadership (especially clinical leadership) perspective or a lack of experience in other non-NHS sectors. Good development exposes the sub-board level posts to the different requirements of the role through, for example, acting up, shadowing and so on. Much more could be done to prepare people when appointed such as through the training offered by the Institute of Directors, alongside coaching and development.

These findings are supported by a recent survey of NHS trusts by the NHS Leadership Academy which found that four in ten respondents said the quality of CEO talent had dropped and almost four in ten said the quality of COO talent had worsened. Perceptions of directors of finance, nursing and medical lead roles were marginally more positive – one in three said that applicants for finance and nursing had worsened, a comment echoed by one in five respondents regarding medical directors (NHS Leadership Academy 2014).

Talent management and succession planning

Most respondents told us that talent management and succession planning were often poor or carried out on an informal basis. This was seen as a key reason for an inadequate pipeline of aspiring senior leaders. Whereas succession planning and talent management may have previously been undertaken by the strategic health authorities, there is now no single organisation fulfilling this function at a regional or national level – though the NHS TDA, Monitor and the NHS Leadership Academy were highlighted for starting some good work in this area.

It is important to acknowledge there have been various attempts over the years to run talent management programmes at a national level by the NHS Leadership Academy and its predecessors. Their aim has been to provide a cohort of people ready to take on the most challenging and demanding CEO roles. While these have undoubtedly been of benefit to many individuals who have taken part, they have not been able to deliver the pipeline of talent at senior levels that they aspired to, which helps explain the gaps identified in our survey.

There are lessons to be learnt from outside the NHS where talent management and succession planning are seen as core business, not an add-on. A board member we spoke to who had moved from the private sector to the NHS told us:

> *[The company I worked for previously] used to identify the top 200 people with the highest potential, and they manage their careers from the start to get you into a senior post. There is no process like that in the NHS.*

One of the reasons for this is that the NHS today is much more an industry than a company. This means that talent management and succession planning are the responsibility of the many organisations that make up the NHS in England. There is no equivalent to the organisation-wide approach to leadership development found in the most successful companies in the private sector.

Interviewees told us that they struggled to identify talent within their organisations. 'There is a suspicion there's lots of people out there who may be really good and we haven't spotted them yet,' a medical director said. Even in high-performing organisations, there may not be talent management strategies in place: one CEO told us, 'almost everything I do is unstructured and on the basis of human relationships.'

Poor talent management was highlighted as applying throughout a career pathway, with many noting the lack of career support given to recent graduates to help them become senior executive leaders.

> *The only way to be a great leader is to move around and learn it on the job. So [this] needs someone to help facilitate this. In time the market should do this. But it's not happening at the moment.*
> (National stakeholder)

Festing and Schafer (2014) highlight that talent management processes have not taken account of multigenerational diversity and this contributed to the failure to keep good people in the job. The NHS has a highly rated graduate management training scheme but when people come off the scheme there appear to be gaps in supporting them into more senior roles and ultimately into board-level positions.

Difference between roles

Our data shows that there are more vacancies for finance directors than for other board-level posts. This may be because there is a range of alternative senior positions for finance specialists outside the NHS. In the current complex environment of the NHS, the finance director post may also seem more unattractive, especially where financial leadership may not be perceived by the rest of the board to be a shared responsibility.

Interviewees felt that recruitment was particularly challenging for medical director roles. A recent NHS Leadership Academy survey (2014) suggests reasons for this.

- Most board vacancies resulted in between three and five candidates being invited to the panel interview.
- Medical director vacancies were, however, more likely than others to have resulted in a smaller number of candidates being short-listed.
- In almost 40 per cent of recruitment rounds for medical director roles there was only one appointable candidate.

The same survey also found difficulties in attracting strong candidates for CEO posts.

Differing career pathways may partly explain the difficulties in appointing to clinical senior roles:

In some areas there is a more normal progression, eg, finance director, there is an obvious deputy role. Other roles such as the nursing director and medical director, there is much less movement between organisations, and [these] are more likely to be internal. There is less of a succession plan for MDs because of this.
(Finance director)

CEO tenure and development

Our survey found that:

- the average tenure for CEOs is just over two and a half years
- 65 CEOs have been in post for less than a year (33 of whom have been in post for less than 6 months)
- 45 have been in post for between 5 and 10 years
- 20 have been in post for more than 10 years (4 of whom have been in post for more than 20 years).

Retention rates are important, and especially crucial for the CEO post. 'The issue is in [the] CEO post – the average tenure is patently not commensurate with doing a proper job,' according to one national stakeholder we surveyed.

Our research highlighted that tenure needs to last long enough to build long-term relationships and to deliver results. The evidence is clear that culture change takes a long time – at least three years, and more likely five. At the other end of the scale, it has been suggested that an ideal maximum length of senior-level tenure would be 8 to 10 years 'as after this the member of staff may have lost enthusiasm and be keen to move on to new challenges' (NHS Leadership Academy 2014). However it is important not to generalise: there will be some CEOs who can make an impact in a short period and those who are still driving significant improvement after more than 10 years in post.

Having a CEO who has been in post for a substantial amount of time was seen as crucial in supporting the retention of senior leaders, as was the quality of wider board interactions. This support was highlighted as particularly important for clinical roles such as the director of nursing, where those coming in seek commitment from the CEO and the board to support them in developing the nursing workforce.

Some respondents mentioned the unspoken expectation that CEOs should start in a smaller organisation before running a large teaching hospital.

> *My COO's role – if he wants to run this hospital at some point, it is considered necessary for him to run a smaller hospital, which is not helpful.*
> (CEO, large teaching hospital)

Diversity and values-based recruitment

The research evidence highlights the current failure of providers to recruit diverse boards that reflect BME groups and ensure adequate representation of women. A particularly damning report by Roger Kline states that:

> *the proportion of senior and very senior managers who are BME has not increased since 2008… and has fallen slightly in the last three years. The report found that women make up 40 per cent of boards and are particularly under-represented at chair and chief executive level.*
> (Kline 2014)

The report emphasises the fact that that a diverse membership and a board that reflects the population it serves are important to achieve culture change.

Some encouraging progress is being seen where boards are increasingly considering using values-based recruitment (VBR) to find the right candidates for board-level positions. There is clear national support for this approach, with VBR identified as a core objective in the Health Education England Mandate. There were very few examples of consistent or regular use of VBR in NHS provider organisations currently. One person we spoke to however, found it invaluable, albeit difficult to do:

> *If we strictly considered functional capabilities, there probably were appointable people [in] each round. But last year we introduced a big emphasis on our transformation plan, developing our culture and values. So there were many instances of recruitment rounds coming up blank because they didn't have the right values. In the meantime we filled with interims which was expensive. But we are not going to compromise on this aspect for the sake of saving a few months of resource.*
> (Chair)

5 What can be done?

Action to reduce high levels of vacancies in board-level posts in the NHS is needed both in NHS organisations and in national bodies. Such action is required to support the emergence of collective leadership – rather than heroic leadership – whereby many staff at all levels of the NHS take responsibility for and are involved in leading change and improvement. Much more also needs to be done to ensure greater diversity in the leadership community both for women and candidates from black and minority ethnic backgrounds.

In parallel to this, the role of clinical leaders as well as leaders from other backgrounds needs to be recognised and valued. The obstacles to doctors taking on leadership roles must removed. A much more systematic approach must be adopted to support doctors throughout their careers to move into these roles where they wish to do so. Skilled clinical leaders need to work with experienced managers in the partnerships that can be observed in high-performing organisations in the NHS and other health care systems.

More also needs to be done to encourage leaders from other sectors to come into the NHS. Some progress has been made in this regard through initiatives such as the Gateway programme. We hope that the review led by Sir Stuart Rose will make further recommendations to make the NHS more permeable to outside talent. Providing high-quality mentoring and support to leaders who move into the NHS from other sectors and ensuring they work in receptive organisations are prerequisites.

The next generation of NHS leaders needs to move beyond the pacesetting style that has dominated in the recent past and embrace a wider range of styles including coaching and facilitation. Only in this way will it be possible to fully engage the 1.4 million staff in the NHS in England and draw on their intrinsic commitment and motivation to provide high standards of patient care. Leadership development must enable current and future leaders to adopt the behaviours and live the values on which the future NHS needs to be built.

The challenge in converting these aspirations into practice is the sheer size and complexity of the NHS and the large number of organisations involved

in commissioning and providing care and in regulating performance. As we noted earlier, the NHS today is more akin to an industry than a firm, and there are therefore limits to how far lessons can be drawn from the approaches used in successful companies in other sectors. For this reason our recommendations start from the position that every organisation within the NHS must redouble its efforts to develop leaders for the future, working in collaboration with other organisations where appropriate, and with support from national bodies.

NHS organisations

The main responsibility for leadership development, talent management and succession planning rests with NHS organisations themselves acting individually and where necessary collectively. As we have argued elsewhere, each organisation needs to develop a **leadership strategy** supported by a leadership development plan. In practical terms a leadership strategy makes explicit how many leaders an organisation needs, of what kind, in which positions, with which skills, and how they should behave to achieve high-quality and compassionate care.

The process of developing the strategy must begin with the board, and it will require the engagement of all key stakeholders and leaders throughout the organisation. Our work has proposed three stages for the development and implementation of the strategy, namely:

- the **discovery phase**, which requires a thorough analysis of the current situation and an informed view of what is needed in the future
- the **design phase**, which specifies the requirements for individual and collective leadership in the next three to five years
- the **delivery phase**, which details the strategies and programmes that will build the capability needed (West *et al* 2014).

The leadership strategy sets the direction and context for a **leadership development plan**. This describes how the organisation will develop the behaviours and competencies that are needed to deliver its strategy. It includes what needs to be done to develop partnerships and alliances with other organisations in a context where working across organisational boundaries in local systems of care is becoming more important. Talent management, succession planning and recruitment to fill

gaps in leadership will be central to the leadership strategy and development plan. Such an approach ensures that a health care organisation becomes sustainably well led with a healthy and strong culture, focused on the core purpose of delivering continually improving, high-quality and compassionate care.

Organisations lacking the resources and expertise to implement the leadership development plan themselves will need to work with other NHS organisations or seek external support to do so. Options include working through leadership academies in local health systems or through regionally based collaborations and also through the emerging academic health science networks. Development programmes tailored to the needs of the organisations and systems involved are likely to be particularly beneficial. Any national programmes should focus only on those functions that cannot better be carried out by NHS organisations working either individually or collectively to strengthen leadership.

National bodies

At a national level, bodies such as Monitor, the TDA and CQC have a key role to play in creating a culture and a regulatory context that removes the barriers to attracting, recruiting and retaining board-level leaders. This means reducing the regulatory burden on NHS organisations and tackling the blame culture that deters senior leaders from stepping up to executive director roles. It also means providing appropriate space, time and support to organisations and systems facing performance challenges, and intervening to replace chief executives and their board-level colleagues only as a last resort. The assumption should be that NHS providers operate with presumed autonomy within a proportionate regulatory regime (Review of Staff Engagement and Empowerment in the NHS 2014).

Research by the Nuffield Trust on the response to the Francis Inquiry has highlighted the urgency of addressing these issues (Thorlby *et al* 2014). This research has raised concerns about the pressure exerted by regulators and performance managers in seeking to assure quality of care and the way in which a burdensome regulatory approach is at odds with efforts to develop an open, quality-focused culture. At worst, this regime felt punitive and based on attributing blame rather than seeking to offer practical support at times of organisational distress. Some of those interviewed by the Nuffield Trust reported that efforts to bring about cultural change within their organisations could be undermined by the wrong kind of regulation and performance management.

We know that excessive top-down intervention runs the risk of disempowering and disengaging the leaders and staff who will ultimately be responsible for making a success of any turnaround plan. Many NHS organisations have now been the subject of repeated interventions, yet they continue to face financial difficulties and in some cases have concerns about the safety and quality of care. Regulators should use more supportive interventions rather than adding to the pressures already felt by providers in difficulty. Far from being a 'soft' response to problems in the delivery of care, supportive intervention would be one way of modelling the kinds of leadership behaviours needed in future.

The new approach to inspection adopted by CQC examines leadership and culture within NHS organisations. This is a step in the right direction. We are also encouraged by the growing interest on the part of Monitor and other national bodies in working together to intervene in challenged health economies and in widening the repertoire of interventions available to them. The recently published review by Sir David Dalton on organisational models for the NHS highlights the need to develop the requisite skills and experience to lead organisations in difficulty, and potentially to lead multiple organisations (chains of providers). It emphasises that regulators should give leaders who have taken these roles a period of 'grace', which may remove some of the pressure to turn around the performance of a challenged trust in an unrealistic period. The recently initiated review of the work of the NHS Leadership Academy, NHS Improving Quality and similar sources of expertise is a timely opportunity to align the work of these bodies behind the changes outlined in the NHS five year forward view.

The point to emphasise here is that reforming the NHS needs to rely much more in future on change occurring from within organisations and systems and less on performance management and regulation (**Ham 2014b**). This means rediscovering the value of real trust as opposed to regulated trust (**Smith and Reeves 2006**) and recognising the downward spiral that results from excessive regulation. Strengthening leadership is essential if these ambitions are to be realised because in the absence of a large pool of able leaders in different functions, the NHS is unlikely to be given the headroom by politicians and regulators on which reform from within depends. High-performing health care organisations around the world recognise this and have made a sustained and deep commitment to the development of their leaders in a way that needs to be emulated across the NHS in England.

Appendix

Methodology

The data-gathering was carried out between July and October 2014 and included:

- a freedom of information (FOI) request by *HSJ* to NHS providers across the country for data on vacant board-level executive posts
- a non-systematic literature review
- 18 in-depth semi-structured interviews with board members and national stakeholders. This included a range of board roles from acute, mental health and community trusts.

The FOI request asked the following questions:

- Which of your organisation's board-level executive posts are currently vacant (please include posts which currently have an interim in place)?
- How long have these board-level executive vacancies existed (again, please count posts which currently have an interim in place)?
- How many of your organisation's non-executive director posts are currently vacant?
- How long have these non-executive director vacancies existed?
- How long has your organisation's current chief executive been in post (please note if this individual is an interim)?
- List the last three board-level executive roles to which appointments have been made, and note whether those individuals appointed were from inside or outside the trust.

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About the author

Ayesha Janjua joined The King's Fund in April 2013 as a programme manager in the Leadership Development team. She joined the Fund from the Office of Public Management, where she was a fellow in the health and social care team and led research, organisational development and engagement projects across health, children's services and local government.

Ayesha has extensive experience of project management, stakeholder liaison, policy development, qualitative analysis and reporting. She has particular expertise in facilitating a range of patient, public and service user focus groups and consultation events across health and social care as part of acute service reconfiguration exercises, paediatric cardiac surgery service review and child and adolescent mental health services. She also has experience in engagement with clinicians, staff and professionals involving practical workshops and large scale events on issues such as integrated care and commissioning. Ayesha has developed tools and toolkits to support professionals in relation to issues such as commissioning and prevention services for older people.

Ayesha has worked as a senior policy adviser at Turning Point, covering learning disability, substance misuse and the criminal justice system. She also has a BA (Hons) in Politics, Philosophy and Economics from the University of Oxford and is a PRINCE2 qualified practitioner.

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Ideas that change health care

There is a growing awareness in the health service that NHS provider organisations are experiencing a high number of vacancies at senior levels, are reliant on interims and are experiencing a greater 'churn' of senior leaders. This situation could have a negative impact on staff morale and engagement, on costs and on performance. But why are NHS organisations finding it so hard to recruit and retain effective senior leaders?

Leadership vacancies in the NHS, produced by The King's Fund in collaboration with the *HSJ* Future of NHS Leadership Inquiry, highlights the scale of the problem. The research conducted for the report suggests a worryingly high level of board-level vacancies – more than a third of our provider organisations have at least one executive-level post either vacant or filled by an interim – and the report identifies some of the underlying causes for this.

In-depth interviews conducted with board members and national stakeholders suggested a number of key factors that make board-level posts unattractive, including:

- a perceived blame culture where executives feel exposed if anything goes wrong – even over situations where they have little control
- unrealistic expectations of how quickly change can be achieved
- excessive regulation.

The report recommends that every NHS organisation should have a leadership strategy and leadership development plan that include talent management, succession planning and investing in developing future leaders. National bodies have a key role to play in creating an environment conducive to recruiting and retaining board-level leaders, including removing excessive regulation and modelling the kinds of leadership behaviours needed for the future.

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