The challenges of leadership in the NHS
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<table>
<thead>
<tr>
<th>Contents</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>2</td>
</tr>
<tr>
<td>Summary</td>
<td>3</td>
</tr>
<tr>
<td>Leadership working</td>
<td>4</td>
</tr>
<tr>
<td>Challenges to good leadership</td>
<td>5</td>
</tr>
<tr>
<td>Conclusions</td>
<td>12</td>
</tr>
<tr>
<td>Contributors</td>
<td>13</td>
</tr>
</tbody>
</table>
Foreword
by Sir Gerry Robinson

While making *Can Gerry Robinson Fix the NHS?* I met many managers with the potential to be inspirational leaders. In fact, I was pleasantly surprised by the calibre of people working at Rotherham General Hospital, where the series was filmed.

The NHS is a massive and highly complex organisation, and managing it effectively is a difficult task. You need first-class people to do it. I met managers in Rotherham who, with the right leadership and environment, could have achieved a great deal. But their abilities were not recognised. There was no clarity about their role and there was a feeling that people’s ideas for improving the service would never come to fruition.

I suspect that these problems are typical of the NHS as a whole. There is a sense that chief executives are not really in control of their organisations. There is too much interference from the centre and managers are not left to get on with the job. Clinicians don’t feel management is there to lead or to set the rules.

I think this is partly historical: there is not much history of management in the NHS. It has been about administration rather than leadership. I felt that managers do not believe they have the right to manage. There has never been a clear message from the centre about the role of management – to lead an organisation, not administer it.

Government needs to create the environment in which inspirational leaders come forward. You need clear objectives and a budget for the service, then the Department of Health should take a back seat and not try to manage things on a daily basis. It would help a great deal if the NHS was taken out of the political arena. This would remove the damaging sense that everything might change again tomorrow, so what’s the point? You cannot hold people accountable if you are constantly changing what you are asking them to do.

Management is not an exercise in bludgeoning people. It is about getting people on side, about making them feel important. The secret is to make them feel special, part of an organisation that works, where they play their part.

Without that you cannot manage anything well. The NHS should have a head start here – if you can’t get people excited about working in the NHS, where their work really makes a difference, where can you?

This is not about money. Sometimes, of course, you do need cash. But very often it is about how you do something, how you structure it, how you work together and how you sort the problems out on the ground.

That is what management is – it is about sorting out the problems of the ward, the department, the hospital and the NHS every day. It is about making the right things happen and stopping the wrong things happening. Good managers are out there, walking the shop floor or the hospital ward, seeing the problems at first hand and working with colleagues to solve them.

I think NHS managers are caught in an impossible situation. They are frightened; they feel very vulnerable. It probably feels safer not to do something than to stick your neck out.

I think people thought I would have some sort of miracle solution for all the problems of Rotherham. I don’t – but solutions for each problem do exist. With a mixture of support from those above them and freedom from Government interference, managers could develop and implement them.

I welcome this initiative by the NHS Confederation to look at how management could be more effective.
NHS managers are used to headlines portraying them as incompetent bureaucrats dressed in grey suits and pushing hard-working frontline staff out of a job. Given this, one might expect them to be defensive about the job they are doing and unwilling to accept that they need to change.

But the reality is very different. While NHS managers feel their peers are doing a fundamentally good job in difficult circumstances, they are acutely aware that their performance in some areas could improve – and that this would benefit patients.

This report is the result of a series of interviews with a cross-section of senior managers about what they think about the state of NHS leadership and management today. Some of these commentators preferred to remain anonymous. A list of contributors happy to be named can be found on page 13.

Our findings

Leadership
- the quality of management in the NHS is generally high. Managers have passion for the job and commitment to the NHS
- however, the quality of leadership is not consistent; the acute sector was regarded as well run with some exceptional individuals at the top.

Challenges
- financial pressures and targets encourage short-term thinking
- managers are forced to focus upwards to the Department of Health (DH) and not across their trusts towards the interests of patients and staff
- some policies, in particular payment by results, encourage trust boards to think about the survival of their own organisation rather than the wider health community
- the role of the chief executive, and how success should be measured, is not always clear
- training can be inadequate, or non-existent, at all levels of management
- there is often a lack of evidence about what works; if evidence were available, it could be used to inform decision-making
- decisions take a long time to implement because the NHS is such a consensual organisation
- clinical engagement and managerial engagement with clinicians is key to success and often falls short at every level
- there is a culture within the NHS which encourages bullying, and this stifles leadership potential
- the size of the workload and unrelenting pressure can stop managers from carrying out the work they should be doing
- many managers stay in post for only two or three years, while clinicians tend to remain at the same trust for many years
- while there are good – even exemplary – leaders in the NHS, there are not enough of them
- middle managers, sandwiched between clinicians and senior managers, are often disempowered and need more support
- stability and more autonomy would encourage the development of new leaders
- every leader needs to prioritise supporting leaders in the level below.

Conclusions
- boards must create time to develop longer term strategy while also paying close attention to the detail of their patients’ and employees’ everyday experience. Trusts and Government must focus on clinical engagement, supporting and developing managers, creating stability in managerial roles and dealing with the culture of bullying
- the Government should devolve power to local trusts and cut the bureaucratic burden imposed by central targets and duplication of inspection.
In common with most other NHS staff, managers joined the service because of their interest in improving services to patients. Professor Gerry McSorley, president of the Institute of Healthcare Management (IHM), said managers tend to be sanguine about what is going on around them and have a real commitment to their jobs and to improvements for the patient: “A dogged insistence on sticking in there because there is something worthwhile.”

Many interviewees felt managers had shown enormous resilience in coming through recent service reorganisations with their passion for the job and commitment to the NHS ideal unscathed. They had also, to a large extent, delivered financial and access targets. Andy Buck, chief executive of Rotherham Primary Care Trust (PCT), says: “There is a determination to do the job well almost despite everything – and particularly despite organisational change – which is impressive.”

There was a general feeling that the quality of managers, especially at the highest level, was high. Managers commented that they believed their peers often compared well with those in the private sector – especially given the complexity of the job and the need to satisfy the demands of different stakeholders. Some managers thought that the relative complexity of the job should not be overstated, but there was a subtlety about NHS organisational hierarchies – and the number of different stakeholders – which meant management did not lend itself to ‘textbook approaches’.

The job of managing the NHS has become more complicated. Julian Nettel, chief executive of St Mary’s NHS Trust in London, contrasted the hospital administrator role of the 1970s – when doctors and other professionals ran their own areas as almost autonomous organisations and the administrator largely dealt with support services – with the enormously complex job of running a hospital trust today.

But while management was seen to be generally competent, questions were raised about the quality of NHS leadership; interviewees were very clear about the distinction between the two. NHS managers and other commentators we spoke to were explicit about the qualities they saw in NHS leadership which were important for the success of the organisation. These include:

- having a vision for their organisation which transcends short-term issues and targets
- being passionate about high performance and high quality in their organisations
- being authentic – believing in what they do and transmitting this to their staff and those around them
- having the skills to communicate their vision to others
- building trust among different stakeholders
- being visible to their workforce and to stakeholders: walking the wards or its non-hospital equivalent and knowing many of their frontline staff by name
- being ‘their own person’: “being strong enough to do it your way” as one chief executive put it
- there was a feeling that a more diverse range of leaders and leadership styles are emerging and there is less of a need to conform to a stereotype
- being prepared to shape their own destiny rather than simply feeling deluged by external pressures and initiatives
- building good teams around them – which undoubtedly helps to avoid getting ground down by the day-to-day demands of the job
- being able to read the strategic direction of the service over a longer time framework and translate this into what it means for their organisation – and then communicating this locally.

The key questions are how widespread these characteristics are, whether enough is done to develop them, and whether leaders work in environments which allow them to do this.
Challenges to good leadership

**Short-termism**

Financial pressures, allocation methods, annual contract negotiations and service targets can encourage short-term thinking which permeates all levels. The close connection between NHS leaders and the political process, and the emphasis that this puts on relatively short-term objectives, can encourage a culture of short-termism that may militate against some of the softer management skills, such as gaining trust and respect within an organisation, which can take years to build up. Frequent moves and reorganisations compound this problem, which can lead to a disconnection from clinical staff who are there for the ‘long run’.

The temptation is to concentrate on immediate issues at the expense of the organisation’s long-term interests, and even its viability. Managers felt that they often spend too much time fire-fighting rather than making fundamental changes which can contribute to long-term improvements. As North Tees and Hartlepool NHS Trust chief executive Ian Dalton puts it: “Sometimes the day job squeezes out the strategic. To be an effective chief executive you need to be able to see the future and translate that into something understandable for your staff.”

Rotherham’s Andy Buck says: “One of the challenges for us all is to up our strategic game. I think we have been encouraged to focus on this year’s targets – get the finance right, deliver the targets and don’t drop any huge clangers. That encourages a short-term perspective, a focus on in-year delivery and little else. It is very hard in that context to think and act strategically in the long term. But that is what we should be doing. We can try to rise above it but it is very difficult.”

Boards have an important part to play, suggests Blackpool, Fylde and Wyre Hospitals NHS Trust chief executive Julian Hartley, as they should take a longer-term and strategic perspective. He suggests trusts need “less day-to-day performance management from above, a clear and settled view of the priorities over the next three to five years and the ability to deliver locally within a broad strategic framework” – but fewer emails at year’s end threatening Draconian measures! “I think this is beginning to happen,” he says, adding that the foundation trust application process is encouraging a more rigorous and strategic approach. But managers also need to be able to grasp the opportunity to look further ahead – which may not be easy after so many years of concentrating on immediate goals.

But change will also require managers to reach out and take it. North Tees and Hartlepool’s Mr Dalton says: “We have been an upward-looking service. We have tended to take our cues from the centre. We now need to change our thinking.” While managers need to read the political runes coming from the centre, there is room to improve communication and leadership on local priorities. He argues that the NHS has significantly underinvested in promoting leadership skills compared with many public sector organisations – such as the Army – and this needs to be rectified. Boards would support moderate targeted investment in appropriate training, he argues.

**Insularity**

A common theme was how to keep the wider perspective when so many drivers conspired to push managers into protecting the interests of their own organisation. While many managers undoubtedly want to act for the greater good of their local NHS as a whole, there were numerous pressures to act in a more insular way – particularly the payment by results regime.

Interviewees agreed that leaders in all NHS bodies had to think about the wider health network rather than simply the benefits to their own organisations. “Some boards act solely in the interests of their
own organisations and against the interests of others or of patient pathways, and that in my view is not acceptable,” says one chief executive.

King’s Fund chief executive Niall Dickson points out there is a very distinct NHS culture “which is unlike either the private sector or other parts of the public sector. But managers and clinicians often do not realise that they are part of it. This affects the way NHS interacts with other agencies and how it is viewed by others.”

St Mary’s Julian Nettel points out much has been learnt from the experience of cancer networks which required some organisations and clinicians to withdraw from providing complex uncommon services. But the problems still remain, particularly with the creation of foundation trusts and new sets of ‘ramparts’ to be defended. As the NHS enters another phase of reconfiguration, he says, this dilemma has repercussions for the service as a whole.

**Clarity about roles**

It is hard to be successful if success is not clearly defined. A concern among some chief executives from both PCTs and acute trusts was that their remit was not clear. As a result they sometimes felt disillusioned about their future and were wondering whether to remain in the job. This was exacerbated by the fact that chief executives often felt that they did not know if they were doing a good job as there is little positive feedback. As one commented: “In terms of the frustrations, it’s that quite often it’s difficult to measure progress in a way that immediately speaks to you as an employee.”

Organisational performance is often taken as a measure of personal performance. In reality, however, a manager may be performing exceptionally in turning around organisational performance, but this is not recognised or acknowledged externally. This is compounded as even if a chief executive is newly appointed to a failing hospital they are identified immediately with its current performance and are ineligible for a pay rise. This does not encourage the highest performers to move to the most complex and troubled organisations.

**Skills**

Miles Scott, chief executive of Bradford Teaching Hospitals NHS Foundation Trust, believes that junior and middle managers may need additional training to improve their literacy and numeracy, bedrocks of managers’ skill sets which enable them to act effectively. Numbers are often seen as the responsibility of the director of finance rather than a ‘language’ with which to describe performance. Strategy and planning skills are also in short supply. Engaging with the public is another key area in which managers may not be well equipped at a time when public and stakeholder consultation is becoming more complex.

Building up partnerships with local authorities is another difficult area which requires time and communication skills. Finlay Robertson, chief executive of Lancashire Care NHS Trust, points to the different targets that local authorities and the NHS must meet, and the differing roles of their public representatives which makes this task particularly challenging.

NHS North West chief executive Mike Farrar agrees that there is a need to improve technical skills, but stresses that the new world also demands a range of sophisticated skills to deal with the emotional side of organisational life that are probably even more important. He says many managers need to pay much more attention to developing and using some of these so-called softer skills. Far from being soft, these are actually some of the toughest areas of management. “These skills are essential if we...
want to create sustainable leaders and it’s what differentiates the great from the good because it requires people having honest conversations about really difficult issues,” says Mr Farrar. He believes that these skills will be vital for the complex challenges now facing NHS management – in particular, the need to change behaviour amongst clinicians, service users and even the public.

Using theory and evidence

One issue highlighted was the role that evidence plays in decision-making by clinicians and their tendency to look for the same degree of evidence to support management decisions – which many managers are unable to produce. If evidence is not available, managers will need to find new ways of persuading clinicians to accept and lead change.

But some managers were cautious about accepting arguments for change without an evidence base. One pointed out that there are a lot of ‘fads’ in the NHS about how services should be provided, which become accepted as truisms – but often without an evidence base. “It is largely a matter of faith that investing in X service leads to Y changes in demand,” says Bradford’s Miles Scott. “It can lead to an awful lot of money being wasted.”

There is undoubtedly much more scope for managers to use research to inform decision-making and measure the results of previous decisions. This would be easier if research was delivered in a shorter timescale and made more easily available to the management community.

Management theory was, on the whole, considered to be interesting rather than of practical use. One interviewee commented: “It is intellectually stimulating to understand and useful to critically appraise the practice. I think it is sometimes interesting to try out new practice-based readings – for example, using a tool to make a reluctant group make a change is stimulating.”

However, another chief executive said: “No, can’t be bothered with [theory]. Mental models can be good when they make you ask questions. Some theory is of help, but I am not over-reliant on it. I place greater importance on strategic change based on pragmatic service redesign, not ivory towers.”

A third view was: “No, I find management theory is a regurgitation of what has gone on or been written before. As such there is an element which you need to know about, but then it’s down to experience.”

It is not clear whether it matters if there is a robust theory underlying NHS management, but if the practice of management is entirely empirical it is going to be more difficult to develop and spread excellence.

Change takes time

One of the criticisms made by Sir Gerry Robinson was the time taken to achieve relatively small changes. This is not a major surprise to the chief executives we interviewed who said that they needed to exercise a much wider and more subtle range of influencing and persuasion skills than would be required in some other settings. Consequently, decisions took longer to implement. One acute trust chief executive explains how this way of working in the NHS frustrated him when he arrived from the private sector:

“It’s not particularly a of lack of dedication [that’s the problem] – to me, it’s the business with the NHS that completely dumbfounded me when I got here, about how long it takes to get a decision because the NHS is such a consensual organisation… occasionally I have to remind myself that anyone looking in for the first time who doesn’t know it wouldn’t have done it like
that. And yet knowing because it’s about hearts and minds – you don’t hit people over the head, you don’t have all the levers, it’s still a unionised environment; it’s politically highly sensitive in the profile of the NHS. It just means there are so many different constituencies you have to manage and work with, and views to take on board, that it just takes time to do things. So I think maybe a difference between how I am in the NHS and how I was in the private sector is knowing that I have to play a much longer game. I can’t deliver things as quickly as I would have done; it really does take time to work it all through.”

Engaging clinicians and developing clinical leaders

Clinical engagement is key to achieving many of the NHS’s aims, but there is clearly more that needs to be done. Formulating the issue as one of clinical engagement misses the point that the problem is also one of managerial engagement with clinicians. Many managers were willing to admit that engagement was patchy and much needed to be done to get clinicians on board. National policy and its implementation is clearly part of the problem as many clinicians feel that their views have not been listened to and are either unsure of, or opposed to, the direction of travel.

Top-down direction

A number of interviewees identified cultural issues that stop leaders finding the space to lead. In particular, they pointed to rhetoric about managers being locally accountable and organisations being responsible for themselves, but in reality often being subjected to top-down pressures, diktat and bullying. This included direct threats, described as “insultingly brutal” by one external observer, and “distressingly macho” by another. One chief executive said: “I think there are behaviours which are valued in the NHS which I do not believe would be valued within the private sector.”

This aspect of NHS management is highly visible to medical leaders who might consider becoming a chief executive and seems to act as a major deterrent. One medical director said: “The level of bullying I see in management is far worse than anything I have experienced in medicine, which itself is not the gentlest of environments.”

It seems likely that this type of behaviour stifles leadership skills, discourages risk-taking and sends strong messages about what managers need to do to rise – or even survive – in the NHS: “Keep your head down and do what is asked of you,” says one observer. The King’s Fund’s Mr Dickson points out that “the centre has increasingly managed the service, and that has taken power, innovation and control away from people at a local level.”

Research by Neil Goodwin suggests that the best leaders are those that deal with the top-down pressure and create space in which they can develop and pursue strategy. However, this is difficult and has to be achieved in spite of the system. As the reforms move the NHS on the path to becoming a more locally-led service, the challenge will be for all parts of the system to shake off the expectation that the centre or the strategic health
The challenges of leadership in the NHS

SHA will tell managers what to do. SHAs will need to change their style to reflect this.

Job overload

The unrelenting pressure of the job may contribute to difficulties in exercising leadership, leaving managers feeling unable to take a longer-term view or have the capacity to deal with anything other than immediate priorities. David Fillingham, chief executive of Royal Bolton Hospitals NHS Trust, argues that maturity and experience can also play a part in helping managers deal with what they believe to be important. “There may be an issue about overload and about capacity as well as capability,” he says.

In the Goodwin/Fillingham study published by the NHS Institute for Innovation and Improvement in parallel with this report, it was found that emails, meetings and other demands on chief executives ate into time for ad hoc contact and walking the floor. For the many chief executives who felt it was important to be ‘visible’ around the organisation and make contact with frontline staff, this lack of ad hoc contact represented a major challenge.

The lack of clarity about the role also means that there are large numbers of conflicting demands on their time. In his classic 1970s study, Henry Mintzberg challenged the orthodox view of senior managers as reflective strategic planners engaging in the classical management functions of planning, organisation, command, coordination and control. Instead, he found managerial work characterised by “brevity, variety and fragmentation.” Our work and the Institute’s study confirms that this is a significant obstacle to effectiveness.

Our fieldwork suggests that chief executives underestimate their very long working week. Combined with other issues, this carries not just a risk to current performance but also of future burnout.

Rapid turnover

While a significant part of the rapid turnover of managers which is so often criticised by clinical staff is externally generated, some of it is part of the culture of management. Some managers questioned whether people were left in jobs long enough to build up public trust. In some cases they could be perceived to be making decisions but then leaving the organisation before they had to implement them. This was in contrast to doctors who often remain in one area throughout their career and have a high degree of public trust.

The Institute of Healthcare Management’s Professor McSorley says: “This notion of changing your job every two or three years – or having it changed for you, especially at senior level – is corrosive to public trust. We have to find a mechanism by which the careers of the most senior managers allow them to stick around.”

Capacity issues

While there are good – even exemplary – leaders in the NHS, interviewees were concerned that there may not be not enough of them. “Many managers do no more than manage,” said one respondent.

Despite the turmoil of reorganisation – and what one manager described as a “profligate waste of NHS managers” – there is optimism that the smaller number of PCTs will lead to an improvement in the level of management.

But commissioning remains an area of concern, especially as it is regarded as the mechanism through which many improvements to the NHS are driven. Some SHAs are recognised to be doing good work on this, but it will take some time for the extra training and skills development to permeate the whole service. Overall, however, there has been a lack of investment in developing
strong commissioning compared in the investment made to move acute trusts to foundation status. Some managers argue that developing commissioning should not be seen as just a PCT ‘problem’: acute trusts which are at the receiving end of commissioning have a part to play in encouraging improvement, even if superficially they sometimes benefit from weak commissioners.

The acute sector was considered to be well run, with some exceptional individuals at the top. Relative organisational stability over the last few years was seen as a factor in this. “They are much more businesslike and better at developing their staff, and there is an emphasis on working alongside clinicians. PCTs are struggling to get better at that,” says John Wilderspin, chief executive of West Sussex PCT. Many acute trusts have also been through the rigorous process of assessment for foundation trust status, which may have highlighted shortcomings and prompted improvement. Foundation trusts were seen to offer individuals the chance to exercise entrepreneurial and leadership skills.

The quality of non-executive directors was also seen to have improved recently as new selection criteria have begun to bite.

Middle management

While top leadership often compares well with other sectors, there is much more concern about the quality of middle management and the particular difficulty of being sandwiched between clinicians and the demands of corporate management. This will be the subject of a more detailed NHS Confederation report to be published in the autumn. External studies have shown that middle managers are the most stressed group in the NHS workforce, with a third reporting stress levels that are regarded as pathological.

The managers who spoke to us outlined a number of skills shortages and were particularly concerned about middle managers and the lack of opportunities they were offered to improve their skills.

“You have to have clear goals and achievable goals – and you have to support them,” one says. “My approach is not to make middle managers do the dirty work.” Mr Hartley of Blackpool, Flyde and Wyre advocates a more structured approach to developing middle managers who have come up from the grassroots rather than through formal managerial training. They often have a great deal to offer the organisation, but the future shape of their career is far from clear.

Middle managers often feel disempowered, which may have the effect of making them more likely to use the one piece of power they generally retain – the ability to say no – to avoid risks and create an area of personal control.

Clinicians work most closely with middle managers and many of their impressions of management are influenced by this cohort.

Growing new leaders

Some managers – not all – wanted to see a career structure which allows managers to remain in one area, or post, without having to move around. An end to the ‘Maoist revolution’ of permanent organisational change may assist this: as might allowing chief executives more autonomy in the way they run their organisations – which could make their jobs more fulfilling.

There is also a need to encourage more people to become chief executives – something which is not easy in a system which is often unforgiving of failure. St Mary’s Mr Nettel suggests that there needs to be a more sophisticated way of placing
people in the most onerous jobs – such as running troubled trusts – so that their careers are not damaged by the difficulties they encounter.

One observer commented that the NHS must stop the habit of placing first-time chief executives in the most toxic and troubled organisations. This error is then compounded by providing very little support or help – and not much understanding – when, predictably, they do not succeed.

More basic skills development for managers at a junior level is needed, says Bradford Teaching Hospitals’ Mr Scott – skills development is part of their job. “But most managers and leaders don’t see that as their role – perhaps they should. I think there is something about supporting the next level below you which we don’t do enough of.”

As part of the theme of needing to improve managers’ ability and willingness to have honest conversations, Mr Farrar points out that there has been a long history of failing to help people recognise their strengths and weaknesses and using this to help them shape their career. He says: “People always come second at interview [don’t get this]… it’s too rare that people are told this really isn’t for you or you need to work on these issues.”
Conclusions

There is much that is very good about NHS management and, in general, chief executives enjoy their jobs and believe they are making a difference to patients, staff and the organisation. There are a number of areas that could be improved; some of these are in the hands of NHS leaders themselves and some in the gift of Government.

What would make a difference

- take a longer term view which encompasses the wider system
- create more time for really important activities such as improving the delivery of care and ensuring that there is a clear strategy understood by all staff
- a major emphasis on developing clinical leaders
- do more to develop high-quality middle managers and the next generation of chief executives
- make more use of evidence in decision-making
- pay attention to quantitative and technical skills and the emotional intelligence required to work in a much more complex world in which thinking, listening and influencing will become much more important
- create more stability in managerial roles to improve trust with local people and clinicians
- deal with the culture of bullying that exists in some parts of the system, and other instances in which there is a mismatch between the values espoused by the NHS and behaviours that actually take place.

What the centre could do to help

- follow through on the promise of devolution and ensure that power does not become stuck at the next level down
- take a hard look at the burdens imposed by central targets, ‘helpful’ regulation and intervention by those above or working for regulators
- understand the burden created by policy implementation
- provide more policy and managerial research to support best practice
- put more emphasis on ensuring that behaviours, policies and all aspects of the system really reflect the values people believe should be part of the NHS.

What about the future?

Many managers forecast a change in the NHS over the next few years as major access targets are achieved and funding growth slows down. The NHS will then concentrate on quality issues, patient experience and efficiency. This, in some respects, will be a new direction and one in which success or failure will be determined by different measurements and approaches.

Bolton’s Mr Fillingham comments: “We have to learn new tricks. We have to reflect and improve our own skills.” Managers need to be much more effective about productivity and quality and the links between them. “There has been a bit of an assumption that good quality costs more but the reality is the opposite. But people have to learn the methodologies to use.”

It is clear that there is no magic answer – just a lot of hard work.
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NHS managers are used to headlines portraying them as incompetent bureaucrats. Given this, one might expect them to be defensive and unwilling to accept the need to change. But the reality is very different – managers are aware that their performance in some areas could improve.

This report – the result of a series of interviews with senior managers – examines the current challenges to good management and what might be done to improve it.