

Chairing
the trust...

trusting
the chair

SAXTON BAMPFYLDE HEVER

THE AMROP HEVER GROUP

“The twentieth century will be remembered chiefly, not as an age of political conflicts and technical inventions, but as an age in which human society dared to think of the health of the whole human race as a practical objective”

Arnold Toynbee

INTRODUCTION

The statistics surrounding the NHS are impressive by any standards: it employs 1.3 million staff; it is made up of 600 separate employers; it is the largest organisation in Europe. The increase in its budget over 4 years exceeds the total turnover of Tesco. It is complex, diverse and innovative, and touches the lives of every one of us. It is moreover an organisation that has seen many changes in structure, focus and strategy in its near 60-year history – a time during which medical advances and the ever-growing expectations of an increasingly sophisticated public have brought their own pressures.

It is against this background that the NHS recruits the chairs, chief executives and directors of its authorities and trusts and their operating subsidiaries – and since 2003, has done so through NHS Executive Search with the professional support of selected executive search consultants – Saxton Bampfylde Hever (SBH) among them.

There were two reasons why we thought it would be timely and relevant to conduct a survey exploring what NHS chief executives want from their chairs, and the extent to which – at least from this one perspective – NHS chairs are delivering. First, the creation of trust boards and in particular chairs, accompanied latterly by the professionalisation of how these individuals are appointed, represents the largest infusion of experienced leadership from completely different sectors such as banking, engineering or academia into the NHS system. Is the idea working, or do these people just get in the way? Who better than NHS chief executives, speaking in complete confidence, to give us an answer.

Second, we had been conscious for some time that one of the most influential factors for NHS chief executives in choosing where they are prepared to work is the calibre of the chair and the leadership they give to their authority or trust. This emphasis is sometimes stronger than we have seen from chief executives in business, government boards, universities or charities.

So during spring 2004 we spoke to forty-four NHS chief executives about chairing in the NHS context. Our group of respondents – to all of whom we are very grateful - covered a range of authorities and trusts around England – representing the north and the south; the good, the indifferent and the excellent; the metropolitan and the rural. They headed strategic health authorities, hospital/acute trusts, primary care trusts and mental health trusts, and almost all of them had personal experience of several chairs in several kinds of health body.

This report gives the voice which we promised to what NHS chief executives most wanted to say, speaking with complete confidentiality. Of course we are accessing only one viewpoint and so in no sense do we purport to offer a 360-degree view of the role of NHS chairs. However, we

hope it may prove a useful adjunct to conversations between NHS chairs and chief executives as they seek to make their relationships flourish, and useful also to those considering an NHS trust chairmanship for the first time.

In brief and separately identified sections we have offered a few comments and suggestions of our own, drawing on our own firm's experience of more than eighteen years in executive search for executive and non-executive roles across the private, government, university and voluntary sectors; as well as our work for acute, trusts, primary care trusts, strategic health authorities and the Department of Health nationally.

We would like to thank our correspondents for the time they so willingly gave us – and also to pay tribute to the relatively unsung contribution that NHS chairs, of whom there are currently around 600, make to the public good.

THE SURVEY

The survey was based on four questions, around which we discussed with chief executives their thoughts and ideas.

- 1** From your point of view, what three or four things do you most look for in a chair of an NHS trust?

- 2** What characteristics of a chair are particularly important for or peculiar to the health sector as opposed to any other organisation?

- 3** What characteristics of a chair, if any, are particularly relevant to the kind of NHS trust or authority which you lead?

- 4** Do you have any views on the breadth of representation of women and ethnic minorities?

A conclusion and key points summary is provided at the end.

QUESTION 1

From your point of view, what three or four things do you most look for in a chair of an NHS trust?

Since the introduction in 1991 of NHS trusts as individual providers of healthcare services with their own autonomous management, and the subsequent evolution of a partnership-based, performance-driven structure across the NHS, trust boards of management have been visible and accountable in their local community, and the role of the chair correspondingly more important.

Unsurprisingly the qualities/characteristics that were mentioned most frequently during our discussions were:

- a reliable sounding board;
- trustworthiness;
- integrity;
- wisdom;
- breadth of view;
- intellectual calibre to grasp the complexities;
- an ability to handle the politics.

Above all was sensitivity to the delineation between the non-executive role of the chair and the executive responsibilities of the chief executive:

“hands-off but not disengaged;”

“interested not interfering;”

“doesn’t storm into the chief executive’s office if a wall hasn’t been painted!”

In essence, an enabling role that supports the chief executive in doing his or her job, bringing complementary skills and approaches to ensure a well-balanced partnership. Specific qualities required will therefore to a large extent depend on the qualities of the chief executive, and this came across both implicitly and explicitly in responses.

Discussion around specific qualities in the individual inevitably broadened to encompass the relationships that grow out of them, and the stage on which those relationships are acted out.

Where the lines of demarcation between the roles of chair and chief executive are fuzzy, the result can be destructive disharmony:

“Too many chairs feel their comfort zone involves running things rather than standing back. They should understand that their role revolves around support.”

However most chief executives acknowledged that the responsibility for avoiding the pitfalls is a shared one:

“some chief executives think, ‘I’m the boss, I’ll tell my chair what I think he needs to know’.”

The constancy of change is a cliché within the NHS. Nevertheless respondents pointed out to us the potential problems when either the chair or the chief executive (or both) are long stayers. Situations where the chief executive has been in post significantly longer than the chair (or vice versa) are particular danger zones, when the incoming party to the partnership is keen to make their mark. Equally, a situation where both parties have been in post for a long time – which in the NHS might mean three or more years – is potentially damaging:

“organisations develop and need different types of management at different times.”

As the replies given to question 3 illustrate, the chairman who comes in to address a specific set of problems in a failing trust may not be the right chairman to be steering that trust through calmer seas.

Above all, it is evident that this relationship can make or break the chief executive’s ability to perform:

“It is crucial that we see the world in the same way.”

“It would be a disaster if I felt we could not discuss things.”

Many chief executives spoke of the importance and the value to them personally of:

- having time set aside to talk regularly and often;
- a relationship where they could be challenged without being threatened, and coached without being lectured;
- being able to discuss/differ in private whilst presenting a united front to the board and the outside world.

Nobody sought a quiet life: the happiest chief executives were those who engaged in challenging debate with their chair and felt able to use them as an experienced and trusted sounding board – but mutual trust and confidence was a sine qua non for the success of such an approach.

“I am blessed with my chairman. We are totally open with each other, we have no secrets. She can choose which bits to take a personal interest in, but she trusts me to tell her what she needs to be told. The trust is crucial to the good of the Trust and to our ability to work together.”

“My chairman is the only person I can really talk to about issues...”

“My current chairman is the best ever ... ‘working together at the top’ is the key; we face problems together.”

Thus, when the relationship between chair and chief executive works well, it is mutually enriching and adds considerable value to the performance of the authority or trust; when it works less well, the damage – direct or collateral – can be irreparable. An example quoted of the latter was an instance where the chair agreed – without consulting the chief executive – a request for research funding which the chief executive had previously turned down; the ensuing breakdown in relations was finally resolved only by the removal of the chair.

Saxton Bampfylde Hever comment:

Three aspects of these responses strike us. First, that chief executives, speaking privately, do see value in the role which the majority of chairs play. This was not a given. Chairs could have been experienced as an additional, unnecessary layer of structure, at best not contributing directly to patient care, at worst impeding it. Neither branches of supermarkets nor ships at sea have non-executive chairs.

Second, while by comparison with other sectors – for example charities, universities and publicly quoted businesses – these board structures are new, they have taken root quickly. In these responses we can already see patterns which are familiar and well-researched in other sectors (for example on the dynamic between chairs and chief executives). So good practice established in those sectors has something to offer the NHS.

Third, board roles and behaviours within the NHS are still in transition. If patterns seen elsewhere are repeated in the NHS, then we may expect to see increasing weight on the authority of the whole board, and therefore on the chair’s skill in creating frank trust among that wider group, rather than a duo presenting a “united front” to the board. Another milestone in the maturing role of NHS chairs may be reached when the assumption becomes, in the event of breakdown of working relationships, that it is the chief executive who will go and not the chair. Whatever course developments in governance take next, it is clear that the arrival of foundation trusts will accelerate them.

QUESTION 2

What characteristics of a chair are particularly important for or peculiar to the health sector as opposed to any other organisation?

Developments over the years in both the NHS and the commercial sector have brought the two closer together in many respects, and as we have already noted, corporate governance as a concept and as a requirement is now embedded into NHS board structures every bit as much as in their commercial counterparts. The contribution expected from a chairman is more clearly defined - and although the role is likely to vary widely in scope in the commercial sector, its accountabilities are increasingly clearly understood.

In both sectors too, it is imperative that the chairman does not have a latent desire for an executive role. The emphasis given by our respondents to “wisdom” and “breadth of view” as desirable characteristics sits comfortably with the broadly accepted notion, mentioned above, that a chairman should ideally be a complement to the chief executive by bringing knowledge and experience that the other lacks. These issues were covered in relation to boards in general in the report “On Becoming Company Chairman: building the complementary board” by Dr John Roberts of the Judge Institute of Management at the University of Cambridge, published by Saxton Bampfyld in 2000.

In the context of the health sector, this has a further dimension: an NHS trust exists to serve a community. The chief executive of the trust may have wide professional networks in that community but shallower personal roots, having brought skills from another part of the country as a career move. As a counter-balance, the chairman needs to bring the interests of the community to the leadership team:

“The chair is champion of the organisation outside, engaging with local organisations and people in a positive way.”

There is measurable advantage in this connection, as well as a desirable public relations benefit: the chairmanship offers a unique opportunity to assure an active, visible link between a public service organisation and the public which it serves. The better the chairman’s knowledge of the local community, the better they can understand the fit of the trust within the local health economy. Three particular comments serve to illustrate the point:

“Many of the good, community-orientated chairs I have met have been heavily involved in community organisations”

“The chair should use as well as assist in delivering the trust’s services”

“The chair should also understand how issues are affecting other health and care organisations within the community.”

Such unequivocal endorsement of community involvement adds a time-consuming commitment equal to chairing the most demanding national charities or businesses, or national quangos operating in sensitive fields.

Chief executives stressed the significance of politics as another key differentiating factor. The “small p” politics may well have resonances in any organisation, and need similar skills in the chair if they are to be handled with confidence. The “large p” politics, however, add significantly to the complexity of the environment in which an NHS trust operates and demand in the chair well-tuned antennae – an ill-judged public statement can do immense damage in a world where the perception of “ownership” is uniquely wide.

“Everyone feels they could run a hospital better than those who are actually doing it,” observed one respondent, neatly summing up one source of political pressure.

In the NHS ambiguities abound and a chair must be able to handle these: whilst the chair and chief executive are responsible for leading the trust, they must do so in accordance with government directives, nationally driven on a political level. It is not ‘done’ for chairs or chief executives of NHS trusts to criticise publicly national health policy in the same way that – for example – university vice-chancellors let the country know their views on higher education policy. How foundation trusts will redraw these boundaries remains to be seen.

A comment was made that “if politics is the art of the possible, then NHS management is the science of the sellable,” a maze, a minefield of no-go areas, where the ‘right thing to do’ can be beyond the bounds of acceptability. It is important for a chair to know where the management agenda ends and the political agenda begins. There are the niceties of needing to be efficient without wanting to make a profit – an objective that can be almost impossible to maintain when it comes to the sensitivities of, for example, closing a local hospital. A robust constitution can be invaluable!

“You can’t waste emotional energy trying to change something which can’t be changed – you have to work within the system.”

Other complexities revolve around the quasi-autonomous status of key staff (for example, GPs and hospital consultants) and the need to be able to negotiate with rather than dictate to them; the constant imposition of targets and the need to respond to different – and sometimes conflicting – targets at the same time; and the sheer numbers involved in every calculation: staff, patients, external stakeholders, and – not least – budgets. The typical chief executive to whom we spoke is responsible for a turnover equal to a £200 million company.

Bearing in mind these critical factors, our conversations with respondents naturally moved on to the question of where their chairs might come from? The broad public sector, obviously, provides relevant experience, some of which transfers seamlessly to the NHS. In the commercial world, successful chairs from industries as varied as pharmaceuticals, banking and publishing were mentioned during our survey. One significant contribution they can bring is a real understanding of

“business processes in the broadest sense.”

And whatever the chair’s background, a chief executive will be wise to tap into and deploy productively whatever professional skills they are able to offer – be they in finance, IT, human resources or communications.

Perhaps, however, the best clue came from the recognition that in the end, the most important factor was an understanding of people, and that therefore a background in a service industry was especially relevant.

“...He had been chief executive of an airport, so... knew when not to step on toes and give space, but also when to challenge. He also knew the product – people. Health service product is people, so what is vital is that chairs have experience and knowledge of people-oriented organisations.”

In summary, differences appear to be less in the nature of the role than in the stage on which it is played. Interestingly, for every respondent who answered along the lines of,

“Health is less different to other sectors than we sometimes like to believe”

“Trusts shouldn’t be different from any other type of organisation,”

there was another insisting

“The public sector is different from the private sector...;”

“Health is a complex sector with issues and problems not found elsewhere”

or, more explicitly,

“The job is considerably more complicated because of the number of stakeholders involved ... In a commercial world, you can tell people to go away in order to focus on the tasks ahead, but you can’t tell people to go away on an NHS board.”

One respondent summed it up: “The aims are not as straightforward as making a profit; it’s much more complicated than that.”

Finally, in line with the strong focus which the NHS has given over many years to the development of people and of skills, many respondents were keen for trust boards to consider for their members a more structured approach to talent spotting, succession planning, induction, training and mentoring. Voluntary service should not equate to amateurism.

“People recruited from the private sector should be appointed as non-executive directors first, so that they get an understanding of how the NHS works before taking on a chairmanship.”

Saxton Bampfylde Hever comment:

At present, trust chairs are probably the most important channel through which expertise gained elsewhere is drawn into the – relatively speaking – hermetically sealed world of healthcare. These private comments of chief executives support the proposition that the infusion has been, and remains, valuable. In supporting the NHS in looking outwards, we encourage NHS boards to look to the private sector not only for individuals, but also for innovative models of board practice – we have seen too many sets of papers for monthly NHS board meetings that are 3 or 4 inches thick.

We also encourage the NHS to look even more appreciatively at the experience which excellent leaders from local government and the voluntary sector can bring. Of course, the NHS has some familiarity with parts of these latter sectors – and occasionally familiarity gained from being on opposite ends of a tricky negotiation can breed a mild lack of esteem!

QUESTION 3

What characteristics of a chair, if any, are particularly relevant to the kind of NHS trust or authority which you lead?

The kinds of NHS organisation which most elicited comments about their distinctive needs were:

- Failing organisations;
- Strategic Health Authorities (SHAs);
- Primary Care Trusts (PCTs); and
- Trusts seeking foundation status.

Failing organisations naturally demand a tough, results-focused approach from the chair: if improvements are to be made in unsatisfactory performance, goals must be set as must measurable strategies for achieving them. Two examples speak eloquently to this need:

“When I joined, this was a failing trust: it had had an adverse report; it had lost its CEO, Medical Director and HR Director; the local newspaper dubbed it ‘Wards of Shame’; it had a deficit of £12m. The chairman showed real resilience, real integrity – robustness in the sense of not necessarily bowing to pressure, but being focused on the interests of the patients.”

“The ability to scrutinise and monitor performance comes to the fore in failing organisations, where a common feature is lack of control and clarity. In this trust, every time you asked how big the deficit was you got a different number ... and the chairman needed to be able to sort the wheat from the chaff and ask the right questions.”

Both of these chief executives now lead efficient – and improving – organisations.

Challenging situations such as those described demand other skills too – including the ability to inspire the executive; and the will and the political flair to fight the trust’s corner regularly and often.

Where there are failures in the executive team, the chair may of course also need to have a more executive involvement – and here of course the trick is to know when to take a step back if some of the pitfalls already explored relating to the over-involved chair are to be avoided.

Strategic Health Authorities present a different challenge: this is strategy rather than management; big-picture thinking, performance management and building partnerships versus micro management. SHAs need to deal with poorly-performing as well as well-performing trusts in their area and to tackle those difficult financial problems in local health economies which, like bumps in a mis-fitted carpet, are prone simply to reappear somewhere

else if moved without a strategic view being taken. Provided always that SHA chair and SHA chief executive work in the closest harmony, the majority of our respondents felt that the existence of the chair-to-chair channel of communication between an SHA and a trust in parallel with the chief executive-to-chief executive channel was a valuable resource, and a help in times of difficulty.

“They [SHA chairs] have to remind chairs in their Area that they have a dual mandate: to act responsibly locally, and to act responsibly within the system.”

The two may not always be synonymous, and can on occasion feel mutually exclusive. If the chief executive of an NHS trust values a chair who is a representative of and ambassador within the local community, the chief executive of an SHA seeks a chair for that trust who sees that accountability within the broader regional and national context of the system. The SHA chair may need to tackle this tension head on.

By comparison, chief executives from the other end of the spectrum, in **Primary Care Trusts**, appreciate in their chair an understanding of clinical services – an ability to get under the skin of what is going on day to day at the sharp end. And in these circumstances, the desirability of having a chair who has a high local profile and is a part of the community must be tempered with the ability to rise above the minutiae of local politics.

Yet the demands of locality are important – and indeed it is national policy that this should be so! The profile of the local population and its political life can influence the demands made on the chair, and several respondents – especially those in urban areas – commented on their own situations:

“This particular trust is based around several different towns, different county councils, and politicians from all sides of the political spectrum. You have to know how to mine your way through that. We are going through major changes and political acumen is vital.”

“The political environment in this city is very important: we have big financial problems, complexity of region, issues surrounding ethnic minorities – and GP politics is also high on the agenda.”

“We have a hugely diverse population, so it is very important that our chair presents what the trust is about to a very mixed bunch of end users.”

It was under this heading that the issue of trusts applying for foundation status was mentioned by a number of respondents, all of whom recognised that the initiative placed a considerable burden on the chair – politics, governance, getting the message across.

“It’s essential that the chair is fully up to speed with all the issues at policy level; what governance measures need to be put in place. If she is not fully informed on larger national issues, it could be very costly.”

“Going for foundation status as we are gives a totally new dimension to the role. There will be a board of up to 40 people to lead, and potentially public meetings with a thousand or two thousand people present. This isn’t for a chair who wants to keep a low profile.”

“There are a lot of politics to handle – not just party politics, but with local organisations that might be opposed to the principle of foundation hospitals. This is potentially a controversial initiative, and the chair needs to be supportive and to make sure that people understand what it is about.”

In this context – and indeed in the context of merged/merging trusts – experience of leading and managing change is invaluable.

As a final point, it is worth recalling the point that, if a particular chair has been recruited to do a particular job, he or she might not be the right person to continue to lead the trust in the longer term. Comments made in earlier paragraphs about the dangers of people staying in post too long are relevant in this context too, and in an evolving and challenging institution such as the NHS, where success or failure in every trust affects every one of us, the need to have the right leader in the right place at the right time is of critical importance.

Saxton Bampfylde comment:

Health is not the only sector where quite new demands are arising relatively suddenly. These are also ‘interesting times’ for chairs of FTSE companies as they encounter quite different behaviour from the City and other stakeholders, with even the company AGM – which at one time drew the majority of its attendance from the bored and the slightly insane – taking on a new and unpredictable life of its own. What is clear is that in this environment, those proposing individuals to be chairs – for example, of foundation trusts and of strategic health authorities as well as of FTSE companies – need to look carefully at the specific skills each chairmanship requires; and take only so much comfort from the fact that an individual has already chaired important-sounding things.

QUESTION 4

Do you have any views on the breadth of representation of women and ethnic minorities?

This question prompted some heartfelt responses.

Answers to the direct question can be summarised as: “Women are generally well represented – and in some cases very well indeed – but representation from ethnic minorities continues to be a challenge.”

The majority of chief executives we spoke to clearly saw the contribution of board diversity as going well beyond the ‘fairness’ argument, or the point that if a community is to have confidence in the Trust that serves it, that community’s members must all be able to identify with those who run it. In terms of ethnic minority board membership, this can be a very direct and practical contribution, giving an understanding of the health needs of a community whose culture can make healthcare very different. Several chief executives had also found ethnic minority board membership helpful in workforce management and development:

“they understand some of the issues for employees from ethnic communities and can help to ensure that employee and employer expectations are enhanced.”

This can be something as simple as understanding the practicalities of working during Ramadan, but the link is important and positive, as is the role modelling for all staff established by ethnic minority involvement at board level.

Whatever these helpful practical benefits, it remains critical that all board members understand that the contribution and responsibilities of ethnic minority board members are not limited to these issues:

“The issue is tricky when you have an ethnic minority non-executive who feels they are there to represent their ethnic community rather than to do the general work of the board – or if the chairman treats them as an ethnic representative.”

Speaking unattributably and with no need to observe political correctness, many of our responding chief executives (who were themselves 32 men and 12 women) saw an important and distinctive contribution being made by women chairs:

“they tend to avoid the macho characteristics of male colleagues;”

“women tend to be more inclusive, men more businesslike and brusque;”

“women bring the usual female traits: flexibility, and the ability to listen and to negotiate;”

“women have better emotional intelligence, more empathy, are better at engaging with public and staff and are easier communicators;”

or, as one (male) respondent put it more bluntly:

“often male chairmen have retired early from previous roles and their egos are breathtaking; their arrogance is in direct proportion to their ignorance.”

Which might lead one to wonder how the system has lasted as long as it has – though in fairness we should give voice to the (male) respondent who said that:

“you need the people from Mars as well as the people from Venus!”

as well as to the opposite view:

“as far as women are concerned – and speaking as a woman myself – I feel we might almost have gone for overkill.”

The difference between the gender and ethnic balance in PCTs as opposed to hospital trusts gave rise to some interesting reflections – in general, the balance is better in the former:

“they are closer to equality in PCT-land;”

and two reasons were suggested – firstly, that being newer, PCTs have been able to approach their structure with considerations of balance in mind, although

“it can produce an interesting group dynamic in PCT/hospital negotiations when one side of the table is all men and the other all women!”

and secondly that hospitals tend to present a grittier, more male-focused management challenge:

“...this might be because of gender stereotypes about the ‘hard’ and ‘soft’ end of the health sector, as well as a greater need for business knowledge in running a hospital.”

If the concept of diversity is taken more widely than the standard considerations of gender and ethnicity, further thoughts emerge – age, class and professional background among them.

“Issues of diversity are not just about colour or gender but about background and culture, which are entirely different things.”

A number of chief executives noted that class distinction at non-executive level needs to be addressed – the balance is still heavily weighted towards the middle and upper end of the scale. This is a particular problem for PCTs in their aim to reflect the population they serve, and some trusts are striving to redress the balance:

“My chair and I have stood on street corners in less privileged areas to talk with individuals, and have tried to encourage their involvement.”

Many people expressed their concern about the age profile of their chair/boards, and the need to encourage younger people to come forward. There was a strong feeling that this needed to be planned – it is not just going to happen of its own accord.

Concerns were, however, also expressed to us about tokenism. More than one respondent made the blunt point that it was difficult enough to recruit chairs of real quality at all, regardless of their gender or ethnic background, and seeking to discriminate positively towards either group simply narrowed the field still further. Others enlarged on the point with the view that every individual brings a different perspective totally unrelated to either factor:

“Every identifiable group brings something to an organisation. High quality people are what count and what the Health Service needs more of.”

“I would struggle to distinguish any particular characteristics.”

Given that non-executive appointments are made by the NHS Appointments Commission, several people recognised the need for them to be proactive in getting the balance right. Tokenism, however, in any form was widely dismissed as unhelpful:

“...the appointment of ethnic minorities should not take precedence over the qualities you need in a good chair...”

Tokenism clouds the whole issue and was quoted as causing "deep resentment" on some boards.

“It’s not about tokenism, it’s about changing attitudes and values”

said one chief executive. And a number of our respondents went further, suggesting that to address the whole range of diversity considerations, a positive programme of talent spotting, training, mentoring and succession planning was suggested. People need to learn how to be a valuable, contributing member of a board; to recognise that it is in their own interests to be involved in running institutions that affect their lives.

“Chair and non-executive director roles are very time-consuming and complex. They need people of management calibre ... and we need to train people to be able to do these jobs.”

“This sort of planning would be invaluable in attracting the next generation of chairs.”

A concluding example not only demonstrates diversity but, more importantly, provides heartfelt evidence of the contribution which an exceptional chair – regardless of their age, gender, class or ethnicity – can make in today's NHS. It can stand as both tribute to and inspiration for the committed service of hundreds of chairs who, with their board colleagues, are relatively unsung heroes and heroines of modern British public service; and a reproach to the level of political rhetoric which gives that status only to nurses, doctors and their clinical colleagues.

“I have a fantastic chair, a young ethnic minority professional woman with three very young children. She is awesome in what she achieves and the support she gives me. She is also physically very small and people think she is a pushover – I have heard people try to talk over her initially at meetings. She demands such respect that I have heard ‘big stage’ meetings in stunned amazement at her ability, skill and presence – she is a real show-stopper! The Health Services needs far more people like her.”

Saxton Bampfylde comment:

In some ways progress towards diversity targets is meaningless, or worse, without evidence of the good which diversity can bring. And NHS chief executives, who are universally concerned to deliver difficult outcomes under pressure of many kinds, with their own careers significantly handicapped if their boards malfunction, are well placed in conditions of confidentiality to expose ‘political correctness’ as just that. In fact, the balance of their comments strongly support diversity – where it is achieved without tokenism – as a powerful good: a point of which the private sector has taken some notice but could do more.

Conclusion

As we stated at the beginning, the perspective of the chief executive is only one among many perspectives which need to be taken into account in assessing the role and performance of chairs. Without attempting that larger assessment, what is clear is that NHS chief executives are finding considerable value in the distinctive and complementary contribution which good chairs make; and along the way they have many practical things to say about what can make that contribution work well. We hope that collecting their thoughts in this way provides both an encouragement and a practical guide to those who serve, or are considering serving, as NHS chairs.

The key points summary which follows encapsulates the key points of advice to actual and prospective chairs drawn from our respondents and from our own experience.

It is also clear that this is a snapshot taken of a rapidly moving scene. NHS chairs are now selected independently based on merit; the views of chief executives even a few years ago might have been different. The arrival of foundation trusts will change the scene again.

Key points summary for actual and prospective NHS chairs

- Leave your ego in the waiting room
- Give your chief executive every reason to confide in you and to want to be coached by you
- Trust governance arrangements in the NHS are relatively young. Work at the relationship with non-executives and borrow good ideas from other sectors to produce high quality agendas and discussion
- Agree with your chief executive where you can make complementary contributions, for example in building links with the many communities you serve
- Where relevant, use your trust's services
- Keep in touch with a broad range of peers and stakeholders, not simply in your area, to help you sustain a balanced view of local needs and wider priorities
- Identify and deliver the positive contribution diversity – going wider than but not overlooking gender, ethnicity and disability – could make to the quality of your board's work
- The NHS is people.

About Saxton Bampfylde Hever

Saxton Bampfylde Hever was established in 1986. We are one of the top ten executive search firms (measured by fee income) operating in the UK, advising on senior executive and non-executive appointments in the private and public sectors. Within the NHS we have advised on appointments at SHA, trust and PCT level as well as major national appointments within, or on behalf of, the Department of Health. For more information please see

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