WHAT MAKES A TOP CHAIR?

/2015

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This report is the first in a series looking at the qualities, behaviours and skills of top leaders in the NHS. It focuses primarily on chairs within the acute trust setting, but it will be relevant to chairs in other NHS organisations since many of the challenges are the same. It is based on interviews with more than 30 chairs (split equally between foundation and non-foundation trusts) and other senior leaders within the health service. It is not intended as an improvement manual, rather as an insight into what top chairs in the NHS are doing to ensure the long-term survival of their organisations.

NHS acute trust chairs are in a unique position. The role of chair is fundamentally different from that of the chief executive, or non-executive directors. It combines the everyday governance aspects of leading a board with having a long-term vision for the organisation and being able to communicate this effectively to the executive team, the local community and partner organisations.

Much has been written about what makes an effective NHS board and the role that chairs play, but here we attempt to tease out some of the ways that chairs are meeting the challenges they face. As well as talking to chairs, we look at what Sir Robert Francis, Sir Bruce Keogh and Professor Don Berwick have said about leadership and the role of the chair in their recent high-profile reports. These reports have helped shape a new environment in the NHS and chairs now need more support than ever before, both formally and through more informal networks.

We also look at the private sector to see whether any lessons can be learned in terms of governance and behaviours. Here, we have often seen the role of chair and chief executive combined. However, it is generally accepted that the two roles should be separate but complementary. We have also seen the development of a senior non-executive role, for shareholders who wish to raise concerns about the performance of the chair or chief executive.

Besides the existence of shareholders and the power they have in shaping the senior leadership team, there is one further important difference between chairs in the private sector and chairs in the NHS. The average earnings for a chairman in the private sector are considerably higher than those for chairs in non-foundation trusts. However, foundation trust chairs earn more than twice as much as their non-FT counterparts, which brings them more in line with the private sector. Given how much is at stake, there is an argument for increasing the remuneration for both FT and non-FT chairs – something with which many of our interviewees concur.

THE AVERAGE EARNINGS FOR A CHAIRMAN IN THE PRIVATE SECTOR ARE CONSIDERABLY HIGHER THAN THOSE FOR CHAIRS IN NON-FOUNDATION TRUSTS

This report was produced with the support of Hunter Healthcare, specialists in providing management talent to the healthcare sector. You can find out more about Hunter Healthcare here: www.hunter-healthcare.com /

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/Executive summary

The role of the chair is unlike any other. Chairs need a range of skills to ensure board meetings are run effectively and that the board discharges its responsibility from a governance perspective. In addition, chairs need to have a vision for the organisation and be able to share this in a way that local communities understand. In short they are ambassadors with the strategic insight and boardroom competency that allows them to get the most from their non-executives directors and ultimately from the chief executive.

There are additional considerations for NHS acute trust chairs. They need to have a vision for delivering patient-centred care in a sustainable way so the long-term future of their trust is secure. This requires partnership working across a range of organisations and, in some cases, building bridges where none have previously existed. They must be adept at navigating their way carefully through a multifaceted health and social care system.

At the same time, chairs have to take a range of external stakeholders with them – including of course the public, whose trust is always in the balance. We now put greater emphasis on safe and compassionate care, but as we have seen in the wake of events at Mid Staffordshire NHS Foundation Trust, this requires a culture shift.

Good chairs understand their role in helping their trusts embrace this culture shift. They lead by example; they are a critical but supportive friend of the chief executive and make sure they do not get dragged into the detail. The new duty of candour places even more weight on the shoulders of NHS trust chairs. There is no hiding from mistakes and top chairs recognise this and use candour as a driver for improvement.

Above all, chairs need to understand that success is about relationships, whether this involves creating the right environment for an effective board meeting, or helping clinicians understand management processes. The best chairs understand this and will invest time in developing and nurturing their board members.

Each chair has a different style and there is no single formula for success; the factor common to top chairs is the ability to adapt their approach to the circumstances and the people they find themselves working with.

Although the rhetoric of today's NHS is about moving away from a centrally controlled, top-down system with greater local accountability, in reality many chairs still find themselves at the heart of a politically charged environment where mistakes can lead to external involvement from a range of bodies. /

ALTHOUGH NHS BOARDS CARRY OUT THE SAME FUNCTION AS THEY DID TEN YEARS AGO, THE DECISIONS THEY HAVE TO MAKE ARE SET AGAINST A MORE COMPLEX AND POLITICALLY CHARGED BACKDROP AND THE BOARD'S DECISIONS CARRY GREATER RISKS

/The evolution of the NHS chair

Ten years ago, a code of conduct for NHS chairs was drawn up by the Appointments Commission and the Department of Health. The code outlined the role and responsibilities (see box, page 12). The latest version of this outline comes from the Trust Development Authority (TDA)[1] and is almost the same. It encompasses: board leadership; provision of accurate and timely information to the board; effective communication; board evaluation; and ensuring the effective contribution of non-executive directors. As the TDA points out, this role is very different from that of the chief executive and other non-executive directors on the board.

For Baroness Tessa Blackstone, chair at Great Ormond Street Hospital, the distinction between the roles of chair and chief executive is clear. The chief executive runs the hospital. "She is responsible for day-to-day issues, for implementing the hospital strategy and for making sure that clinical care is of the highest possible quality. The Chair is responsible for working with senior management and the other non-executive directors to define the strategy, making sure we're clear about our aims and objectives and that we have the resources to implement them. Above all, we must be effective in looking after our patients, ensuring the child is first and always."

BOTH PROFESSOR BERWICK AND SIR BRUCE KEOGH HIGHLIGHTED THE NEED FOR IMPROVED LEADERSHIP, LEADERSHIP BEHAVIOURS, VALUES AND COMPETENCIES

Although NHS boards carry out the same governance function as they did ten years ago, the decisions they have to make are set against a more complex and politically charged backdrop and the board's decisions carry greater risks. This in turn has led to a dramatic shift in terms of what is expected of chairs in today's NHS.

You don't have to look far to find the reasons for this changing environment. The poor care highlighted by the media at Mid Staffordshire NHS Foundations Trust and the subsequent public inquiry have heightened public awareness of NHS failure and given politicians an opportunity to become more involved in the way the NHS is run.

In his final report[2] Sir Robert Francis described a range of concerns. There was a preoccupation with targets, data on outcomes were ignored and patients were not listened to. There was a widely perceived culture of fear and this, coupled with a poor leadership style, meant nurses, doctors and managers lost sight of patient safety and quality. The Francis report added a new narrative to the role of NHS chair, which is less about the nuts and bolts of chairing a board or performance and more about the leadership behaviours, values and competencies.

Sir Robert recommended a series of actions, which included openness, transparency, candour and strong patient-centred healthcare leadership. He called for a leadership college to be set up to offer potential and current leaders the chance to share in a common form of training to exemplify and implement what he called a common culture, code of ethics and conduct. He also asked for the promotion and research of best practice in healthcare.

The government's response was to ask Professor Don Berwick to look at the lessons that could be learned and set out proposed changes. In addition, Professor Sir Bruce Keogh, chief medical officer, was asked to conduct a review into the quality of care and treatment provided by hospital trusts with persistently high mortality rates. ›

Both Professor Berwick and Sir Bruce highlighted the need for improved leadership, leadership behaviours, values and competencies. In Professor Berwick's report[3] there is a section devoted to leadership in which he talks about a 'set of leadership behaviours' that could be used in recruiting and developing NHS leaders.

In his recommendations he says: "Leadership requires presence and visibility. Leaders need first-hand knowledge of the reality of the system at the front line, and they need to learn directly from and remain connected with those for whom they are responsible. Culture change and continual improvement come from what leaders do, through their commitment, encouragement, compassion and modelling of appropriate behaviours."

This focus on improved leadership, leadership behaviours, values and competencies is now accompanied by regulations. The Health and Social Care Act Regulations 2015 include not only the requirement that directors of NHS bodies meet the fit and proper person test, but also the new duty of candour.

Foundation trusts are already required to ensure that governors and directors meet health sector regulator Monitor's test as part of their licence. However, the Monitor test is less demanding than the fit and proper persons test (FPPT) under the new regulations. These place the burden on employers to ensure any person who is appointed as a director or who fulfils the role of director meets the FPPT.

According to the Care Quality Commission[4], the provider "must carry out all necessary checks to confirm that persons who are appointed to the role of director in an NHS trust or NHS foundation trust are of good character, have the appropriate qualifications, are competent and skilled (including that they show a caring and compassionate nature and appropriate aptitude), have the relevant experience and ability (including an appropriate level of physical and mental health, taking account of any reasonable adjustments), and exhibit appropriate personal behaviour and business practices".

The duty of candour is an attempt to ensure providers are open and honest with people who use health and care services. When things go wrong with care and treatment, NHS organisations are expected to provide reasonable support, truthful information and a written apology.

In its guidance, the CQC says that in order to meet the requirements, providers have to ensure there is an open and honest culture within their organisation. According to the CQC, providers must ensure they have systems in place for knowing about notifiable safety incidents and must inform the relevant people when such an incident has occurred.

> THE DUTY OF CANDOUR INCLUDES PROVIDING A TRUTHFUL ACCOUNT OF THE INCIDENT, PROVIDING AN EXPLANATION IN WRITING ABOUT THE ENQUIRIES AND INVESTIGATIONS THAT WILL BE UNDERTAKEN AND OFFERING AN APOLOGY IN WRITING. IN ADDITION, THE PROVIDER MUST MAINTAIN APPROPRIATE WRITTEN RECORDS AND OFFER REASONABLE SUPPORT IN RELATION TO THE INCIDENT
>
> Guidance on the fit and proper persons requirement for directors and the duty of candour, CQC 2015

So what does this increased focus on improved leadership, leadership behaviours, values and competencies and the new regulations mean for NHS chairs? One answer to this question may come from another sector. In 2007 there was a near-collapse of the banking sector and the ensuing financial crisis dragged the global economy into what some economists have described as the worst financial crisis since the Great Depression of the 1930s. In the UK, the government asked former banker Sir David Walker to look at what the banking sector might do to prevent a similar crisis happening again.

In his review[5], Sir David suggested a combination of tighter controls and a review of the role of boards and their chairs. He highlighted the behaviours of high-performing chairs, saying some are innate and others can be learned. The list included facilitation, empathy and coaching, as well as inspirational behaviours such as influence, building confidence and communication.

However, he said the demand for these behaviours and traits will vary depending upon the mix and maturity of the business and the mix and maturity of other board members. "Leadership research from as far back as the 1950s has shown that traits do not influence leadership ability as much as a person's ability to learn rapidly... and facilitate behavioural development in others. Behaviour is the clue to performance because it is learnable and therefore can evolve with the demands of the context. A chairman's behaviour must operate at number of levels – task, group and systemic."

LEADERS CAN HAVE A DISPROPORTIONATELY LARGE IMPACT ON THE CULTURE OF THEIR ORGANISATION

This view is echoed by NHS leadership consultant John Deffenbaugh, who says the pendulum swing towards operational effectiveness and issues around patient safety and quality post-Francis needs to be balanced by the need for chairs to ensure their organisation has a secure future within the system. "Top chairs might tick all the boxes in terms of quality, safety and engagement with employees, which are of course essential, but ensuring the organisation has as sound financial position within the health and care system is equally important. There is a tricky balance between the two. Issues of viability have as much to do with the system in which trusts operate, as they do with their operational effectiveness."

David Welbourn, visiting professor at the Centre for Health Enterprise at Cass Business School, agrees, but remains unconvinced about the direction of travel. He says: "Francis demands a new culture which is dominated by patient outcomes, and does not tolerate harm to anyone caused by failure to implement known practice. It is astonishing that these recommendations then are designed to reinforce that purpose with an unprecedented level of micromanagement and imposition of a regime in which the centrality of that purpose is threatened by total emphasis on compliance."

As for the regulatory changes that will be introduced, specialist healthcare solicitors Hempsons say the FFPT is a checklist that most employers would consider on recruitment. "There is no power in the regulations enabling the CQC to remove a director. The method of enforcement will be for the CQC to impose conditions on the registration of the provider requiring the removal of the director. A failure to comply with the condition will be an offence," the firm says. However, it recommends that NHS trusts consider amending their employment contracts as there is value in making it clear that a finding of unfitness is a ground for dismissal without notice. ›

The new duty of candour is aligned with a culture shift that chairs should not ignore. In a recent report *Building a culture of candour*[6], Royal College of Surgeons president Professor Norman Williams and Salford Royal Hospital chief executive Sir David Dalton say: "Leaders within health and care organisations have a responsibility for ensuring that both the organisational commitment and the resources for building a culture of candour as part of a wider culture of safety, learning and improvement are in place."

The authors believe the CQC will have an important role to play in ensuring that it regulates care providers in respect of candour "in a thorough and proportionate manner". The report suggests this will mean looking at different sources of evidence, such as how well an organisation identifies and responds to harm, and how it supports staff to disclose harm to patients and their carers.

The report's authors make it clear that legislation alone will not bring the sensitive, clear and candid conversations that patients deserve. They believe this is most likely to happen as part of a wider commitment to having good communication with patients. They also see a mutual relationship between a culture of candour and a culture of improvement. "By being honest with patients and carers, providers of care are far more likely to be honest with themselves and that is the foundation for a culture of improvement."

Leaders can have a disproportionately large impact on the culture of their organisation and top chairs will recognise that their behaviours can help to drive a culture of candour and improvement. Of all the recommendations and legislative changes we have seen in the past few years, culture change is perhaps the most important. Dr Helen Bevan, chief transformation officer at NHS Improving Quality, says: "One of the differences I see is that in some trusts the senior team will tell you how they are meeting target X or Y, but in others you get the sense the leaders are building an organisation with a higher purpose and they do it is such a way as to link in with the profound values of their workforce."/

> LEADERS AND MANAGERS NEED TO CREATE SUPPORTIVE, CARING CULTURES, WITHIN TEAMS, WITHIN ORGANISATIONS AND IN THE SYSTEM AS A WHOLE, IN THE WAY THAT ORGANISATIONS RELATE TO EACH OTHER. LEADERS AT EVERY LEVEL HAVE A RESPONSIBILITY TO SHAPE AND LEAD A CARING CULTURE
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> Compassion in practice – nursing, midwifery and care staff, Department of Health 2012

THEN AND NOW: THE ROLE OF THE CHAIR

2004/

Code of conduct (Appointments Commission and Department of Health)

- Leadership of the board, ensuring its effectiveness on all aspects of its role and setting its agenda
- Ensuring the provision of accurate, timely and clear information to directors
- Ensuring effective communication with staff, patients and the public
- Arranging the regular evaluation of the performance of the board, its committees and individual directors
- Facilitating the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors

2015/

Trust Development Authority

- Provide leadership to the board, the trust, the other non-executives, the chief executive and executive directors; and ensure the effectiveness of the board in all aspects of its role and agenda; including directing the organisation towards achieving the government's objective of all trusts achieving foundation trust status
- Ensure the provision of accurate, timely and clear information to the board and directors to meet statutory requirements
- Ensure effective communication with the board, staff, patients and the public in a changing healthcare environment
- Arrange the regular evaluation of the performance of the board, its committees and individual non-executives, directors, and the chief executive
- Plan and conduct board meetings, with the chief executive. Facilitate the effective contribution of non-executive directors and ensure constructive relations within the organisation and between executive and non-executive directors. Share and use relevant expertise of all members of the board

MANAGEMENT TODAY'S DOs AND DONTs FOR CHAIRS

Dos

- Pick non-executive directors who are sufficiently diverse and strong-minded to challenge the executive directors
- Maintain a five-year perspective. The executive directors are focused on this year, the senior managers on this month. Your job is to take a longer view
- Support chief executives as best you can, know their personal circumstances, priorities and how long they want to stay
- Put your network and wider business experience at the disposal of the board

Don'ts

- Hand out non-executive jobs to your friends
- Get too friendly with chief executives: if you go on family holidays together, it will be much harder to sack them if and when the time comes
- Pull rank on a director in front of their boardroom colleagues
- Ever let the words: 'This is how we did it when I was the chief executive ...' pass your lips in a board meeting

WHAT ARE THE MOST PRESSING CONCERNS FOR NHS CHAIRS?

- Knowing whether the trust is providing a safe service and is doing the right things by its patients in a sustainable way
- Ensuring there are assurance processes in place that will give the board early warning of any safety concerns
- Delivering safe care when there are more patients to be treated and trusts have fewer resources
- Encouraging clinicians and management to work well together. Senior clinicians are in the driving seat when it comes to taking services forward but need to be working in partnership with managers who know how to manage processes
- Changing the culture of the organisation so it is patient-centred
- Working in cooperation with GPs and other community providers, such as mental health and housing services

/Qualities for success

In the same way that successful NHS trusts exhibit common qualities and characteristics, top NHS chairs tend to share similar traits. However, the difference is that top chairs have to tailor their approach to match the individual requirements of a trust. This is because every NHS trust is at a different stage of strategic development, with different and often difficult relationships with commissioners, community service providers and the local community.

Top chairs therefore call on a core set of qualities and skills in different measure. When we surveyed our cohort of top chairs they talked of five such attributes: courage; curiosity; tenacity; and emotional resilience, together with the ability to communicate well.

Courage is a necessary quality for any chair. In its guidance for chairs, the NHS Trust Development Authority says they should hold the chief executive to account for the effective management and delivery of the organisation's strategic aims and objectives. Management consultant and former government health adviser, Professor Paul Corrigan, prefers to talk of strength and agility. He says: "The leaders best equipped for the challenges ahead will need a combination of strength and agility: strength to pilot more change over the next decade than we have had in the past three and agility to ensure healthcare organisations will be able to evolve quickly."

The 2009 Walker Review recognised a similar requirement for the chairs of banking and finance companies. It found inhibiting factors in terms of performance included "a degree of hubris or complacency about the board's strategy which makes a chairman or CEO reluctant to spend time on challenge from one or more institutional shareholders whose interests may not necessarily coincide with those of other shareholders".

The second quality cited by top chairs is curiosity. Chairs who are curious without being too hands-on will investigate any concerns that the board may have. The catalyst for investigation invariably comes from data and it is important for chairs to ensure their boards have access to timely and relevant information.

According to the 2013 report *The Healthy NHS Board*[7], boards should be provided with information that is timely, reliable, comprehensive and suitable for board use. The report says the intelligence that boards need falls under two headings. First they need performance information, including information about quality, finance and staffing, and second intelligence on the external local environment. Although this information should be provided, it is up to the board to question and probe and the chair inevitably plays an important part in this discussion.

Tenacity is another important quality for any top chair. Board meetings are often a place where ideas and initiatives are born and yet they can also be the place where momentum is lost. David Wakefield, chair of Bolton NHS Foundation Trust, says the ability to see actions through is absolutely essential. "As I chair I need to know that if people say they are going to do something, that it will happen and if it doesn't, why."

The fourth quality named by our cohort of top chairs was emotional resilience. This is the ability to keep going in the face of stressful or traumatic events. Resilient people are able to cope with adversity and, importantly, it is something that can be learned. Writing in a blog for the Work Foundation, Cary Cooper, professor of organisational psychology and health at Lancaster University, says: "It is important to understand that resilience is not fixed in individuals. While we have a natural predisposition to draw on different areas of our personality for resilience, it is also something that can be developed."

Professor Cooper points to the link between resilience, morale and engagement. In other words, by developing resilience it is possible to realise the individual and organisation benefits that high levels of morale can achieve. He says: "We must not forget that challenging experiences can benefit people - the idea that 'what doesn't kill you makes you stronger' can be broadly true, allowing individuals and organisations to face the future with higher levels of resilience." ›

AS WELL AS COURAGE, CURIOSITY, TENACITY AND EMOTIONAL RESILIENCE, THE ABILITY TO COMMUNICATE EFFECTIVELY WAS SEEN AS AN IMPORTANT QUALITY FOR CHAIRS

Professor Cooper's one caveat is that three conditions have to exist: first, goals that are challenging but realistic; second, that the individual feels that what they are doing is worthwhile; and third, resilience is supported by a person's sense of well-being, which can be depleted by excessive strain.

One chair we interviewed believes resilience is essential because of the environment in which NHS trusts operate: "There is a great deal to cope with as an NHS chair in such a political atmosphere that together with the glare of the media spotlight, the ability to keep going and rise above it cannot be underestimated."

In a recent blog post former NHS trust chair Roy Lilley emphasises the need to listen. "Leaders know [that] to succeed they must create more leaders. The fruit of the peach tree is not the peach, it is another peach tree. Leaders have more questions than answers. Leaders listen."

Other qualities were also mentioned by those we surveyed, albeit less frequently. Elisabeth Buggins, chair Birmingham Women's NHS Foundation Trust adds integrity to the list. "If a chair does not have integrity, then it is hard for anyone in the organisation to trust the chair," she says.

> TO CREATE A POSITIVE CULTURE FOR RISK MANAGEMENT, YOU HAVE TO FIRST CREATE THE RIGHT LEADERSHIP. ENSURING THAT EVERYONE WITHIN THE ORGANISATION LIVES AND BREATHES GOOD RISK MANAGEMENT IS SOMETHING THAT HAS TO COME FROM THE CHAIRMAN, THE CHIEF EXECUTIVE AND THE WIDER BOARD
>
> Making risk management a reality, Oxford University Hospitals NHS Trust and the Foundation Trust Network, 2013

Besides courage, curiosity, tenacity and emotional resilience, the ability to communicate was seen as an important quality for chairs. Role descriptions often describe 'the ability to communicate' as being a necessity and the TDA says chairs should "ensure effective communication with the board, staff, patients and the public in a changing healthcare environment". However, communication is two-way and the ability to listen and engage is often missed when talking about the ability to communicate.

Being a good communicator is beneficial when it comes to encouraging managers and clinicians to work more closely together. This is critical for Sir Jonathon Michael, chief executive of Oxford University Hospitals NHS Trust. He says: "I've always been a very strong proponent of integrated clinical management, by which I mean you have clinicians and managers working in a single team. I'm a great believer that the people who know how best to run a service are the people who actually deliver it."

For Carole Taylor-Brown, former chief executive of Suffolk Primary Care Trust and now an executive coach, chairs need to be seen as being approachable. "Whenever I'm asked to work with a challenged NHS organisation, I know that more often than not I will find out that staff feel disconnected from the top of the organisation and in particular the board. This is often because they don't know who is on the board and what non-executives do. I think it helps if chairs and non-executives are visible and get out into the organisation to find out for themselves what is going on," she says.

it's a blend of all these qualities – and no doubt additional ones – that chairs need in order to assess what will help them get the most from the board, the executive team and the organisation itself. Good chairs recognise that a one-size-fits-all approach does not work./

THE NOLAN PRINCIPLES (THE SEVEN PRINCIPLES OF PUBLIC LIFE)

Selflessness

Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

Integrity

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

Objectivity

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.

Honesty

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

Holders of public office should promote and support these principles by leadership and example.

/Skills that make a difference

The skills that prospective chairs are often asked to demonstrate at interview include the ability to lead, being able to communicate effectively with a range of stakeholders and facilitation – to ensure board meetings run smoothly. Yet there are skills that top chairs find they need but that they are not asked to demonstrate – or at least that are not emphasised by the interview panel.

For many top chairs, strategic vision and the ability to see and communicate what the future landscape of might look like is essential. David Wakefield says it is vital to be able to paint a picture of where the trust is going, the type of services the trust will be providing and how these services can be sustained.

This view is echoed by Professor Ross Baker in his report for the King's Fund, *The roles of leaders in high-performing health care systems*[8]. He says: "Much of quality improvement work is project focused, but leaders in high-performing systems help to integrate and align these efforts by creating a view of the whole system and relating local improvements to that picture of the system. Such efforts help to prioritise projects at a local level and to identify the investments needed in supportive activities such as leadership development and human resources."

CHAIR OF THE ROYAL FREE LONDON NHS FOUNDATION TRUST DOMINIC DODD ADDS A FURTHER DIMENSION TO STRATEGY BY EMPHASISING THE IMPORTANCE OF MEASURING SUCCESS

The ability to 'see into the future system' is closely linked with another skill highlighted by consultant Carole Taylor-Brown. She says: "Being able to build bridges is absolutely essential – that is so underestimated in terms of what chairs need to be doing – they are the face of the board. Chairs should not be wheeled in at the last minute when things go wrong, they need to be building relationships at different levels, including political."

In *System Leadership*[9] David Fillingham and Belinda Weir point out that: " Based on our experience of working in-depth with such leaders over the past three years, curiosity, connectivity and coaching capability seem to be far more significant traits of effective leadership in the current health and social care environment."

It's this ability to connect that sets top chairs apart. Professor Clair Chilvers, chair of Gloucestershire Hospitals NHS Foundation Trust, believes this strategic vision and bridge building is more important now because of closer working between health and social care. "If we don't have pathways that encompass all our partner organisations then we are not doing the best by our patients. My own experience is that this is a joint effort between chair and chief executive who both go out to meet chief executives across the whole health and social care system.

Dr Nick Marsden, chair of Salisbury NHS Foundation Trust, and Elizabeth Buggins, chair of Birmingham Women's NHS Foundation Trust, both agree. Marsden says: "There was a time when strategic planning was considered very much the role of the centre and this was then passed down to each satellite organisation. This has now changed and there is a recognition that strategic thinking has to be done at a local level and supported by a greater emphasis on partnerships."

Buggins believes that partnership development is a major part of the role and this means finding the organisation's place in the healthcare system so that it can thrive and grow. "The world simply isn't an insular place any more and a good chair has to make sure the road ahead is clear." ›

Chair of the Royal Free London NHS Foundation Trust Dominic Dodd adds a further dimension to strategy by emphasising the importance of measurement. "It is really important to agree how you will measure success. If you can be clear about your governing objectives as an organisation then you can focus debate on how to achieve success. Also, there is often a huge gap between the fine words about long-term vision and the specific details of short-term priorities. What is often missing is clarity about medium-term strategic themes and spending time agreeing these can help a lot."

Dodd also explains that the board makes the distinction between governing objectives and strategy. He believes that if the governing objectives are clear and the executive team knows how success will be measured, then they will work out for themselves how to deliver the strategy./

PARTNERSHIP WORKING IN THE RAIL INDUSTRY

The dilemma facing the rail industry is thrown into sharp relief when you look at the issue of track repairs. Track is a shared resource. Train operating companies (TOCs) want to move passengers around the network in a timely manner, Freight operating companies (FOCs) want to move freight around the network. At the same time, Network Rail, the company responsible for maintaining the network to keep it safe and operational, needs access to carry out repairs and maintenance.

TOCs would like to increase the number of trains that they can run at evenings and at the weekend, which would reduce the operational timetable for FOCs and give Network Rail less time for repairs. In addition, Network Rail is under pressure from the regulator, the Office of Rail Regulation, to reduce the cost of maintenance, which is linked to the amount of time Network Rail has access for repairs.

The regulator has recognised this challenge and in its 2013 regulatory statement called for new partnerships across the industry – new alliances between rail businesses that would enable enhancements to infrastructure and services that benefit passengers.

It said: "The next phase of benefits requires a significantly greater alignment of incentives between all parts of the industry value-chain, to create more normal commercial relationships and greater joined-up working across the sector. If the industry can operate increasingly on the basis of transparent and commercial arrangements, with effective aligned incentives that deliver benefits for customers, then regulation will change to reflect the different structure of the sector."

Network Rail has now made delivering demonstrated value from working in partnership with both train operators and suppliers one of the key outcomes of its strategic business plan up to 2019.

/Board building and collaborative leadership

NHS chairs are in a unique position on the board of an NHS trust and good chairs will understand their role in creating the right conditions within the board to allow each board member to contribute. This means understanding the dynamics of the board, working out strengths and, where there are weaknesses, coaching that individual to become a more effective board member.

Professor David Welbourn from the Centre for Health Enterprise draws a parallel with chairs of companies in the private sector. "There are a number of different ingredients at play, but if you are the chair of a listed company you need to have a very clear purpose, whatever formula you use. Your objective is to maximise shareholder return and therefore you need to become the architect of the board and ensure the board gives an effective mandate to the executive team. Sometimes we make it more complex than it needs to be."

Maintaining a balance in the boardroom is an important part of the role of chair. Carole Taylor-Brown says: "Effectiveness comes down to how a board is balanced and the chair plays a pivotal role in that." According to the NHS Confederation report *Effective Boards in the NHS*[10]: "To achieve this balance, the chair must be sensitive to team dynamics, recognise each member of the board as an individual and understand the role they prefer to take in a group. For instance, when they are with their board colleagues some people have a tendency to lead, some prefer to innovate and some like to analyse." John Deffenbaugh agrees: "It is essential that a chair knows their board colleagues. For example, less is often more when it comes to contributions from some board members."

> IT IS ESSENTIAL THAT CHAIRS KNOW THEIR BOARD COLLEAGUES. FOR EXAMPLE, LESS IS OFTEN MORE WHEN IT COMES TO CONTRIBUTIONS FROM SOME BOARD MEMBERS

Welbourn believes that achieving this balance means bringing in clinicians at board level, although he has a word of warning. "We are always looking for clinical leadership in the NHS. There is nothing more powerful that a clinical director who understands the role of the board, but there is nothing that can make the board weaker than a clinician who is just giving it a go. We need diversity and the chair's role is to bring the best out of the board; to make sure the board is developed and that it can replenish itself with people who can fill the appropriate skills gaps."

Collaborative or distributive leadership models are often talked about in relation to NHS boards. The dominant leadership style in the NHS is referred to as the pace-setter model. This means leading from the front, setting out targets with little room for collaboration. However, successful leaders in the NHS adopt a more inclusive style of management. There is also evidence that the pace-setting approach can be detrimental. The NHS Confederation report *Delivering Dignity*[11] identified this as a one of the main causes of poor care: "If senior managers impose a command and control culture that demoralises staff and robs them of the authority to make decisions, poor care will follow."

The Chartered Institute of Personnel and Development has described a more engaged leadership approach in its report *Engaging leadership: Creating organisations that maximise the potential of their people*[12]. It says: "Gone is the heroic model, along with the notion of one person – the solipsistic leader – with a monopoly on the vision; it is replaced by a commitment to building shared visions with a range of different internal and external stakeholders. It exploits the diversity of perspectives and the wealth of experiences, strengths and potential that exists within the organisation, and with partners and other stakeholders."/

COMPARE AND CONTRAST: BOARD DIVERSITY

> GUIDANCE AND RESEARCH SUGGESTS THAT ORGANISATIONS ARE BEST SERVED BY BOARDS DRAWN FROM A WIDE DIVERSITY OF BACKGROUNDS AND SECTORS. THIS INCLUDES THE EXPECTATION THAT BOARD COMPOSITION REFLECTS THE DIVERSE COMMUNITIES THEY SERVE
>
> The Healthy NHS Board, 2013

> RECENT RESEARCH IDENTIFIED A TENDENCY TO 'OPAQUE AND SUBJECTIVE' BOARD APPOINTMENT PROCESSES. TO COUNTERACT THIS THE RECOMMENDATIONS INCLUDE PROACTIVELY PUTTING DIVERSITY ON THE AGENDA IN THE RECRUITMENT PROCESS, FOCUSING MORE ON UNDERLYING COMPETENCIES THAN PRIOR EXPERIENCE, CREATIVELY EXPANDING THE TALENT POOL AND OFFERING SUPPORT THROUGH THE APPOINTMENT PROCESS
>
> Towards a Framework for Enhancing the Performance of NHS Boards: A synthesis of the evidence about board governance, board effectiveness and board development, 2013

/The chair as a critical friend

The *Healthy NHS Board* tells us that the chair and chief executive should have complementary roles in board leadership. Again this comes back to balance and chairs will need to tailor their approach according to the style and personality of the chief executive. The chair should understand the chief executive's leadership style and adapt their approach.

However, challenge is an important part of the chair's role. Ruth Carnall, managing partner at healthcare management consultancy Carnall Farrar, says: "The expectations on chairs are increasing and their accountability is sharp. This can lead to chairs becoming more and more drawn into the business such that they in effect become the CEO. This is a mistake. Chairs need to retain a degree of independence. Chairs need to be able to rise above the needs of the organisation and act in the interests of patients. Above all they need to retain the ability to challenge the CEO and the rest of the executive from their own experience inside and outside the NHS."

Professor Clair Chilvers agrees the relationship with the chief executive has to be worked at and concurs that being supportive while at the same time questioning and challenging is a good approach. She believes that chairs have to work out the best way to work with their chief executives. "There is also an element of how I can be most useful to the chief executive and that is a very personal thing," she says.

CHAIRS NEED TO RETAIN A DEGREE OF INDEPENDENCE. CHAIRS NEED TO BE ABLE TO RISE ABOVE THE NEEDS OF THE ORGANISATION AND ACT IN THE INTERESTS OF PATIENTS

Deffenbaugh has a word of warning for chairs about overstepping the mark when it comes to questioning and challenging. "If a chair has too much time on their hands, then the danger is that the role becomes executive, and gets in the way of the chief executive's ability to implement board decisions," he says.

The *Higgs Report*[13] is very clear on what is at stake if the chair and chief executive do not have a strong working relationship that lies at the heart of an effective board. "The relationship works best where there is a valuable mix of different skills and experiences which complement each other. The chairman should not seek executive responsibility and should let the chief executive take credit for their achievements. The chairman can be an informed, experienced and trusted partner, the source of counsel and challenge designed to support the chief executive's performance, without becoming an obstacle to questioning of the chief executive by the non-executive directors."

Carole Taylor-Brown provides a useful perspective from the view of the chief executive. She says: "What you want as a chief executive is a healthy, open relationship built on shared values and vision for the organisation and within that, the capacity for the chair to be constructively challenging and a critical friend. Chairs can be invaluable in providing an independent sense-checking role and challenge from an external perspective."

Jennifer Sundberg of board information consultants Board Intelligence says being a good listener and understanding group dynamics will help a chair ensure the smooth running of board meetings. "Chairs need good judgement and they need to be close to the CEO, but not too close." ›

Although there is an emphasis on partnership working, David Welbourn reminds chairs that their private sector counterparts operate within a different context and without political interference. This means the chair, who is ultimately accountable to the shareholders, decides whether the chief executive is no longer the right person for the job. "If you look at the private sector, the turnover of chairs is relatively controlled. What happens is a chair decides the chief executive needs to go and then usually steps down. Ultimately the whole dynamic is controlled by the chair."

> WE ARE COMMITTED TO GOVERNANCE UNTIL THE POINT AT WHICH WE DECIDE TO USE THE BACK CHANNELS TO SUBVERT THAT GOVERNANCE. THIS IS WHEN OTHER ORGANISATIONS OR EVEN POLITICIANS STEP IN AND MAKE CHANGES, ACTING IN EFFECT AS A SHADOW BOARD

The Walker Review provides a private sector perspective. "The CEO will need to establish and maintain his authority in the company – and failure to do so may mean that he or she is not up to the job. But if the embedding of authority, perhaps based on some early success or reputation, makes the CEO become effectively unchallengeable, the CEO will be a major source of risk and will probably need to be removed. Albeit with the support of the board, this would be a matter ultimately for the chairman."

Welbourn argues that the NHS has a different culture where chairs do not often get to exercise this option. "We are committed to governance until the point at which we decide to use the back channels to subvert that governance. This is when other organisations or even politicians step in and make changes, acting in effect as a shadow board."/

/Reputation matters

THE RISK OF LOST REVENUE RESULTING FROM DAMAGES TO REPUTATION

With the glare of the media spotlight firmly on their organisations, many NHS trust chairs have begun to ask themselves whether the personal reputational risks are too high. However, the counter position is that a chair who is overly concerned about their reputation shouldn't be in post.

When asked whether the personal reputational risk was becoming too great for high-performing individuals to apply to be a chair in the future, many of the chairs we spoke to felt this wasn't the case. One of the chairs we interviewed says: "It is not something that personally ever worried me. There are so many other things that are more important and chairs should understand they are putting themselves in the firing line."

Dominic Dodd agrees and says: "There is an aspect of the role where you have to accept that you are going to be held accountable and have to accept accountability for things that went wrong where there was not much that you could have done about it."

He points out that chairs are inevitably in a difficult position where not everything is within their control. "If you think you are in control, you won't succeed. Every chair needs to be realistic about this."

The link between motivation and reputation is made by Elizabeth Buggins, who says: "Reputation has to loom large, but being driven by fear of losing it is the wrong motivator and means you might avoid a particular course of action when it is the right thing to do. You can't be too concerned about what your neighbours think in this respect. I would not actually consider reputational risk as a motivator for keeping the organisation safe."

The idea that reputational risk might drive chairs and the board to be less forthcoming or truthful about incidents of harm is highlighted in *Building a culture of candour*. The report examines candour and reputation from the point of view of the provider organisation and recognises that a "likely inhibitor of candour is the potential impact of the disclosure of harm on the reputation of the organisation".

The authors say this is not a valid justification for avoiding or underplaying candour. "A good organisation is not one that never does any harm, as such an organisation is likely to be unable or unwilling to see the harm for which it is responsible. Reputation should not, therefore, rest on being free of harm, but on swift, thoughtful and practical responses to cases of harm."

Dame Julie Moore, chief executive of University Hospitals Birmingham NHS Foundation Trust, voices her concern about the impact of reputation on recruitment of NHS leaders of the future. "We need to attract the brightest and the best into management and leadership in the NHS, yet too often NHS managers are ridiculed and shamed. If I was a bright young graduate today, would I consider a career as an NHS manager when all I have ever heard has been negative?"/

SOME CHAIRS WE SPOKE TO FELT THE DISPARITY BETWEEN NON-FT AND FT SALARY HAD TO BE SET IN THE WIDER CONTEXT OF THE TALENT POOL

/Remuneration and reward

In our survey of chairs, respondents expressed their concern that foundation trusts were paying their chairs twice as much for the role on average.

The average pay for a non-FT chair is £20,000 compared with an average of £40,000 for an FT chair. NHS leaders questioned in the survey said that not only was there political pressure for pay restraint in a period of austerity, but the FT code of governance states NHS FTs should avoid paying more than is necessary.

However, many also felt that remuneration at non-FTs was insufficient. Furthermore, they said that if non-FT remuneration was increased, these trusts would attract chairs at an earlier stage of their careers with more energy to deliver the behaviours required. In addition, survey respondents also felt different skill sets were needed for chairs of aspirant FTs and this was not being recognised.

Professor Clair Chilvers agrees that non-FTs might struggle to recruit talented chairs because a lower salary does not make the role attractive. However, she points out that chairs with experience coming from the private sector, for example, may not be motivated by pay in the first place because for them the motivating factor is likely to be a sense of altruism. One chair says when you are working seven days a week, you begin to ask yourself why are you doing it and it's not because of the salary; it's because "you have a chance to make a difference".

Some chairs we spoke to felt the disparity between non-FT and FT salary had to be set in the wider context of the talent pool. The view was that if the non-FTs were limiting themselves to a pool of chairs who are financially secure, then the number of potential candidates in the pool would inevitably be smaller. In other words, if the salary was increased non-FTs might find they could attract more candidates at an earlier stage of their career and therefore widen the pool of candidates.

Comparisons are often made with the private sector. Dominic Dodd has experience of working in this sector and says working in the NHS has intellectual and emotional demands that are equivalent to any role in the private sector.

"For me it is about being part of something that is of fundamental importance, something that people care about and an organisation that people are proud of. There is a good combination for me of the inherent challenge and the benefits this brings because it is energising and inspiring place to work."

So do the best chairs come from outside the NHS? This is a question that many of those we surveyed felt strongly about, but there was no clear consensus. Some felt that if an NHS trust is recruiting and has a potential candidate from another sector, then the role of chair should not be their first NHS job.

David Wakefield says he has seen good people come from outside the NHS and adapt well to its unique systems and processes. However, his caveat is that people from smaller organisations may struggle to grasp the complexities because they may not understand the management process in a large NHS trust.

David Welbourn refers to theories of effective boards, which show that the greater the diversity, the broader their experience and the wider the range of options the board will be able to consider.

A word of caution comes from Dominic Dodd, who says that other sector experience does always translate very well in the NHS. "There is often an assumption that when we have an NHS problem we need to look outside the NHS for the solution and that automatic association is, in my view, simply wrong. Indeed, I have found that there is often as much learning that can be exported from the NHS to other sectors as the other way around. As a non-executive director, there is a subtle way of bringing experience from other sectors to bear, and I have observed it to be more effective when it starts from a recognition and respect for the inherent challenge and complexity of the NHS and the strong capabilities of many executive leaders who work in it."/

/Conclusion

In this report we have examined the skills, qualities and behaviours that make a top NHS trust chair. There is arguably no single chair who encompasses all these, but good chairs will have a measure of each of them and good understanding of their importance.

Top chairs are by nature courageous, curious, tenacious and emotionally resilient. Some of these are innate, but others like emotional resilience can be worked on and improved. Whatever mix of qualities a chair brings, they do so knowing that their behaviour is an important signal to everyone else in the organisation, from the porter to the medical director. They are not pace-setters, but instead rely on a collaborative or distributive leadership style.

They also know that their relationship with the chief executive is the key to success. This means understanding what motivates the chief executive and working with their style of leadership. A clash of personalities between chair and chief executive can spell disaster for an NHS trust.

Top chairs place great importance on partnership working and building relationships across the local health and social care community. The doors to the trust are not where their responsibility ends. Good chairs seek out opportunities for closer working and are able to think beyond land grabs.

Finally, chairs do not have to come from outside the NHS and are usually motivated by a sense of altruism. The rewards in the NHS are not an incentive for anyone looking for financial security but top chairs will not be concerned by this, preferring to concentrate on what they can do to ensure the part of the NHS they are responsible for survives and thrives./

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