Perceptions of success within the NHS:

"*We've got a public who are convinced the NHS is absolutely bloody marvellous*"

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Dr Andrew Mason. Having worked alongside Andy on the roadside, in ditches and in the back of rescue helicopters, I know that his attention to detail is second to none. A published author and scholar, I am thankful to his continued support in my endeavours.

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Abstract

The concept, understanding, and determinants of success have not been explored in relation to the British National Health Service (NHS). This historical focus has instead been on effectiveness. While NHS effectiveness is routinely configured in respect of certain performance metrics, success is not something that is easily measured. Nonetheless, and as this research goes on to demonstrate, it is vitally important. Notably, and as one of the chief executives interviewed in this research quipped, the British public "*are convinced that the NHS is absolutely bloody marvellous*". But does this necessarily translate to a broad and sustained perception that it is successful? In order to explore the elusive concept of success, in this research I adopted a social constructionist epistemology and qualitative methodology. I undertook comprehensive semi-structured interviews with NHS chief executives and chief executives of healthcare monitoring services. Notably, my findings reveal that the British government has no definition for, or formal means of evaluating, success in the NHS. The same is true of NHS England, NHS Improvement and the NHS leadership academy. When challenged, NHS Chief executives regard performance measurement targets as proxies for NHS success. Notably, the failure to meet these targets results in NHS chief executive dismissal. However, this staff turnover, rarely – if ever – transforms poorly performing hospitals. The purported institutional solution, then, to poor performance in the NHS is fundamentally ineffective. This thesis concludes that a broader understanding of and deliberate focus on success and how it is perceived (in place of a dogged preoccupation with performance metrics) may go some way to addressing this disconnect.

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Author's declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of East Anglia, University of Suffolk or any other institution.

Signature: 

Printed Name: Keith William Hotchkiss

Chapter 1 – Introduction

> *'Underperforming hospitals or units should accept that they have to improve the service they offer or that patients, quite properly, will go elsewhere'*
>
> Lord Andrew Lansley (Secretary of State for Health 2010-12)

1.1 Overview

The National Health Service (NHS) is viewed by many as a source of British pride (Hiam & Mckee, 2017; Peate, 2018). Its founding principles are to meet the healthcare needs of the British public, to be free at point of delivery and to ensure that delivery is based on clinical need, not ability to pay. If the measurement of success for the NHS is to meet these three principles, then it could be argued that it is successful and has been since its foundation in 1948. But can the success of the NHS be measured solely on its ability to provide free treatment to all at time of need? The NHS is regarded as the world's best health care system based on the polling of patients and staff (The Commonwealth Fund, 2017a). At the same time the NHS appears to perform less well than similar countries on the overall rate at which people die when successful medical care could have saved their lives (Dayan *et al*. 2018). So how is success of the NHS to be measured and does this measurement change depending on the optics through which you view it at that precise moment?

1.2 Why research success in the NHS?

1.2.1 Author positionality

Personal interest in conducting a study into the NHS comes from a position of having been a former employee of the organisation. First as a nurse within a large NHS hospital and, latterly, as a paramedic and senior manager within an NHS ambulance trust. This covered a period of seventeen years from 1986 to 2003. From 2003 to 2016 I held a senior managerial role within a national healthcare charity, with regular engagement with NHS managers and commissioners of NHS services.

In 2001, I suffered a spinal cord injury which resulted in a year-long stay in various NHS hospitals. At that time, I was employed as a clinical performance manager within an NHS ambulance trust. During this period, I found that as a senior NHS manager my view of success was in frequent contradiction to my peers and superiors. These views of success were also different from my perspective as a patient. These contradictions were difficult to explain given the overarching principles of care within the NHS. As a result, I questioned my own understanding of success and how success is viewed by others. I also questioned my own assumptions about leaders and leadership. At the same time this prompted me to reflect on my own professional career as a senior NHS manager and my practice as a leader. In 2004, I left the NHS to work as a senior manager of a national healthcare charity. While no longer directly involved with the NHS I had regular contact with senior managers and decision makers within the wider NHS and as such maintained a keen observation from outside of the organisation. This enabled me to question further how the NHS viewed success and how this appeared to change over time, frequently without any obvious logic.

Reflecting upon my time as a manager in an NHS ambulance trust I would see NHS success measured in the form of government defined performance targets. These performance targets focused on the time it took for an ambulance to arrive at the scene of an incident after the initial call was received by the ambulance control. Known as the ORCON (Operational Research CONsultancy) standards, they required 75% of emergency calls to receive an initial response within eight minutes and 95% of calls to receive an initial response within 19 minutes. These performance targets had no measurement of the care the patient received or the effectiveness of treatment on the arrival of the ambulance. It was widely acknowledged that response times could be altered to increase an ambulance trust performance against the targets, and I witnessed this happening on several occasions by senior managers. I continued to question why success was not measured using patient outcomes, such as reduced mortality and morbidity. I have always accepted that for the victims of many emergency medical

conditions time is critical to their survival, such as in a cardiac arrest, but arriving promptly and providing terrible care is not a marker of success.

This was the situation I observed at the start of the millennium, yet today similar performance indicators continue being used as measurements of NHS success, like the four-hour wait/treatment target used in accident and emergency departments of NHS hospitals. Once again, these targets have no measurement of patient outcome and are capable of being manipulated rendering them of little value in improving care. NHS performance indicators continue to focus on aspects of inputs and processes while avoiding healthcare outcomes. The government, through the Department of Health and Social Care has been unable or reluctant to develop a reliable system to enable the measurement of care delivery and the effect it has on patients. As a result, the NHS does not have a measurement of success for the system as a whole.

One question is whether NHS success is identical to the effectiveness of the NHS to deliver care? While both success and effectiveness have similar connotations, they have subtle differences. I argue that success is more applicable in this research as it focuses on the NHS as a whole. This research aims to capture a wider understanding of how the NHS impacts on people's health. Research exploring NHS effectiveness would observe specific outcomes. One definition of success is "*The accomplishment of an aim or purpose*" (Concise Oxford English Dictionary, 2011: p.1439) and purpose is defined as "*The reason for which something is done or for which something exists*" (Concise Oxford English Dictionary, 2011: p.1167). When we contrast success with the word effectiveness, we see the focus on specific outcomes, "*Producing a desired or intended result*" (Concise Oxford English Dictionary, 2011: p.456), with result meaning "*Consequence, effect or outcome*" (Concise Oxford English Dictionary, 2011: p.1227). This definition is similar to that of Jaskolka, Beyer and Trice (1985) who state success is an evaluative concept which requires evaluation against a clearly defined criterion. In contrast Benson *et al.* (2020) define success as being subjectively determined by

individuals. This view of success has been explored by scholars attempting to define the successful outcomes of medical treatments (Khoder *et al*. 2016; Khatib *et al.* 2020; Tshifularo. 2022).

These definitions transfer to the view of organisational effectiveness which again concentrates on the ability to create acceptable outcomes and actions within an organisation (Pfeffer & Salancik, 1978). If we acknowledge that success focuses on the reason why something exists, it is key for us to understand the aims of the NHS.

The United Kingdom (UK) Government states that the aims of the NHS are to "*improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives*" (The NHS Constitution for England, 2021. Para 1). This statement is important as it describes an NHS which is not totally consumed in treatment of disease and illness. The statement suggests that the NHS has a far-reaching commitment to people's health including prevention and encouraging people to make healthy life choices. This is echoed in the legislative proposals for the 2021 Health and Care Bill which states "*care that focuses not just on treating particular conditions, but also on lifestyles, on healthy behaviours, prevention and helping people live more independent lives for longer*" (The Secretary of State for Health and Social Care, 2021: p.8). Despite this the NHS does not measure its success on changing people's lifestyles or behaviours.

1.2.2 Why the NHS?

Described as a complex system, which can sometimes be difficult to understand (NHS England, 2022) the NHS is the world's largest publicly funded healthcare system (Yang, 2021). Serving a population in excess of 67 million (The World Bank, 2021a) the NHS employs over

1.3 million, with 52% being professionally qualified clinical staff (NHS Digital, 2021). This makes the NHS the UK's largest employer and one of the largest in the world.

The NHS is responsible for providing a variety of healthcare services including primary care (General Practice, community pharmacy, dental, and optometry services) and secondary care, also known as hospital and community care. Secondary care is typically separated into two divisions, planned or elective services and urgent or emergency services. In 2018/19 the NHS had 564 million patient contacts equivalent to each person in England being assessed, treated, and cared for by the NHS 10 times a year (Kings Fund, 2020a). Referrals for hospital outpatient services increased by 42% from 4.1 million in 2008/09 to 5.9 million in 2019/20 (The King's Fund, 2022). During the same time period, attendances at accident and emergency departments increased by 1.1 million to 5.8 million with 4.7 million resulting admissions (ibid.).

In 2018/19, NHS England had a budget of £115 billion (Brien *et al.* 2020) divided across all parts of the service. During this period 46% of NHS trusts had a budget overspend, with acute NHS trusts (hospital trusts) accounting for 67% of these (FullFact, 2019). With a combined overspend of £571 million the number of trusts in deficit increased from 2017/18 (ibid.). In June 2018 the government announced that by 2023/24 no trust should be in deficit (NHS England & NHS Improvement, 2019).

Acute NHS trusts are responsible for the organisational and managerial structure of NHS hospitals. They predominantly encompass the key specialities seen within the NHS. Due to their prominence within the NHS, acute trusts find themselves at the centre of most NHS policy decisions and governmental reforms. This prominence also draws attention to their perceived failures, such as poor budgetary control and increasing waiting lists. Acute trusts are also the subject of several NHS performance measurements, ideally positioning them at the centre of research into NHS success.

1.2.3 Why success?

The term success, in the context of the NHS appears to be ascribed with prior achievements or significant milestones conducted under the NHS banner (Webster, 1998). These achievements include the first kidney transplant in 1960, first heart transplant in 1968 or the first test tube baby in 1978. While these were pioneering medical procedures, they are not indicators of whether the NHS is successful today.

Due in part to these medical and technological advances the NHS finds itself providing healthcare for an increasingly aged population who have increasingly complex healthcare needs (Kulkarni & Shepherd, 2019). The NHS continues to respond to these needs by developing new and improved methods of treatment. However, what are the implications on NHS finances, accessibility to treatments, demand for treatments and length of waiting lists?

In 2018, spending on health care in the UK totalled £214.4 billion, equating to £3,227 spent per person. Total healthcare expenditure accounted for 10% of gross domestic product (GDP). It had more than doubled in real terms, adjusted for inflation, between 1997 and 2018 (Office for National Statistics, 2020). Despite this, the UK's total healthcare spend remains slightly below the average of other rich countries, and considerably lower than Japan, France, Germany, Sweden, Canada and the Netherlands (Chu, 2019). There are continued concerns that the NHS is having to increase the amounts of money being spent in the private sector to provide services for its patients (O'Dowd, 2019). In this scenario NHS patients undergo medical treatment at privately run facilities to reduce the workload on the NHS. This has prompted leading commentators to question if the NHS offers value for money (Smith, 2007), or is able to offer suitable and sufficient healthcare options (Guy, 2019). Others argue that the NHS is fighting a losing battle to meet demand (Scarborough *et al.* 2011; Greenshields, 2014). Rather than look to provide treatment the NHS should be promoting alternative lifestyle choices which encourage healthier living and reduce overall demand on the NHS (ibid.).

In a speech to the Leaders in Healthcare conference in 2018, the former Secretary of State for Health Matt Hancock stated, "*What you do, isn't just the difference between success and failure, it's the difference between life and death*" (Hancock, 2018). During this speech Matt Hancock failed to indicate what success or failure looked like for the NHS. Similarly, he failed to indicate whether the death of patients was considered a failure. It would be unwise to think that the NHS is able to provide endless healthcare solutions for every patient, to cure all illness or prolong life indefinitely, yet the NHS has access to treatments, medication, technology and knowledge to treat a vast percentage of current medical conditions.

The NHS faces the challenge of being able to provide increasingly advanced treatments and care but within the constraint of a limited budget. The NHS therefore finds itself making conscious decisions on what it should and should not provide. It may be incredibly tough to deny a patient the option of treatment, particularly if they are suffering ill health and no other treatment option exists (Brouwer *et al.* 2019). This is compounded by the fact that there is a reluctance of UK citizens to accept negative healthcare choices made due to increased cost or financial reasons (Van Exel *et al*. 2015). So why does the government not increase the NHS budget to allow for a greater range of treatments to meet the needs of the public? This again comes down to opportunity cost. To increase funding to the NHS, funding would need to be reduced elsewhere. There are some who believe that simply increasing the NHS budget would not result in success (Oliver, 2017). Until the NHS can control its spending and waste it will continue to fail some patients, due to a lack of funds (ibid.).

Drummond, (2016) argues that the NHS is already controlling costs through the National Institute for Health and Care Excellence (NICE). Formed in 1999 to create consistent national guidelines for clinical treatment, NICE acts as a gatekeeper for the approval of NHS treatments. One of its primary tasks is to evaluate the relative costs and benefits of interventions when deciding whether to recommend them. Wailoo *et al*. (2004) argue that this is not always in the patient's own interest, but it would be irresponsible to expect the NHS to

fund expensive treatments with limited patient benefit. So, by being unable to offer all patients the full range of treatments and therapies available at that time is the NHS unsuccessful?

If NICE acts as the gatekeeper to approved treatments, then the Care Quality Commission (CQC) acts as the gatekeeper for standards of quality and safety in healthcare services. As the independent regulator of health and social care in England the CQC registers, monitors, inspects, rates and takes action against poorly performing care service providers. This includes individual acute NHS trusts. Once registered the CQC continuously monitors the service provider to ensure it meets their fundamental standards, These include being safe, effective, caring, responsive and well-led. The ratings awarded to acute NHS Trusts are frequently used as indicators of success and conversely indicators of failure (Hazell, 2014). While Rimmer (2019) states that inspections by the CQC have resulted in improved trust performance Smithson *et al*. (2018) suggest that CQC inspections have a limited impact on performance in key areas of NHS trusts. Glasper (2019) claims that CQC inspection regimes have become complex, costly and overly onerous on acute trusts being inspected.

The word success is frequently used in association with CQC inspections of acute NHS trusts. It is used to indicate improvements in the measured performance against the inspection criteria of the CQC. One prominent example of this is the 'successful' transition from an acute NHS trust rated as inadequate to one rated outstanding. Another criterion where success is often used is when measuring the performance of acute NHS trust leadership. As part of their ongoing monitoring and inspections the CQC establish, according to their own observations, if a healthcare provider is well-led. It is suggested that organisations as large and as complex as the NHS cannot function successfully without high-quality interprofessional leadership (McComb, 2013). Scholars have ascertained that the investment and development of leaders has shown to produce positive results in the ongoing running of a successful organisation (Gray *et al.* 2016). If these observations are accepted, then it would make sense for the CQC to examine acute NHS trust leadership closely.

Other scholars question if the success of an organisation has anything to do with leadership, suggesting instead that success through performance is seen as an outcome of exogenous factors over which the leader has little control (e.g., Pfeffer & Salancik, 1978). This is certainly true of phenomena such as winter pressure. This occurs when acute NHS trusts experience increasing demand due to inclement winter weather. This typically results in increased cases of influenza and an increased number of fall injuries. Observers have noted annual decreased performance of acute NHS trusts during these periods of winter pressure despite knowing that it is likely to occur (Lacobucci, 2016; Evans, 2017; Quaile, 2017). NHS leaders are measured on their performance during this winter period despite having no control over the severity of the weather or the willingness of the public to get vaccinated against seasonal flu. So, is the CQC right to look at acute NHS trust leaders and question their ability to lead? Does this presume that leadership has an influence on the success of an NHS trust or its performance? It could be argued that by looking to rate the leadership of NHS trusts the CQC believes that leadership plays a pivotal part in the success of an acute NHS trust. This stance may be described as attribution bias (Heider, 1958). There are those who suggest that leadership is an outcome of attribution where control of one's environment is attributed to the leader rather than its context. Again, this is often without the leader having control of exogenous factors (Pfeffer & Salancik, 1978). Other scholars contend that we cannot know what will happen in the future and as a result we find it difficult to blame someone where there is perceived failure. As a result, we concentrate our attention on (or seek to blame) one person: the leader (Grint, 1997).

The CQC implies that an NHS trust's performance and success is a direct result of the chief executive's ability to lead. They suggest that the leader should be inspiring and motivated while also being infallible (Fourie & Höhne, 2019). What is unclear is whether the CQC is able to remain impartial as the independent regulator of healthcare during their inspection process and if their appraisal of NHS trust leadership is conducted from a position of neutrality. The CQC has in the past been criticised for bias and a lack of transparency when conducting NHS

trust inspections (Hazell, 2015). It is possible that one reason for this may be due to confirmation bias. This occurs where information received prior to any CQC inspection is examined, with a view to seek out evidence during the inspection to support such claims (Nickerson, 1998). With NHS staff and members of the public encouraged to provide feedback on their NHS experience it is possible that these first-person accounts create a vivid picture of an NHS trust for the inspector, even before entering the hospital.

With NHS leaders being monitored and measured for their performance it could be argued that where an acute NHS trust shows signs of improvement the NHS leader can develop an inflated perception of their role in achieving perceived success (De Cremer & Van Dijk, 2005). Some may also engage in self-serving bias where they take credit for successes, while blaming failures on others (Heider, 1958). What continues to be unclear is if the role of the NHS trust leader has any part in creating perceived success for their part of the wider NHS.

While it is feasible to examine success across the entire NHS it is the acute NHS trust which is responsible for hospital centred healthcare. Acute NHS trusts account for the largest number of care facilities and highest number of employees across the entire NHS (Department of Health and Social Care, 2020). Acute NHS trusts frequently find themselves at the centre of political reform and the focus of enhanced scrutiny. This makes the study of success ideally suited to acute NHS trusts.

1.2.4 Alternative measures of NHS success

The NHS does not adopt a holistic approach to the measurement of success, one which truly places the patient at the centre of healthcare (Parnaby & Towill, 2008). Patients are not generic objects and as such have differing needs for even the same health condition. Heart attacks (myocardial infarction or MI) affect people in differing ways. Some patients suffer chest tightness or pain which requires strong intravenous analgesia, while other patients do not.

Measuring the time it takes for all heart attack victims to receive analgesia on arrival at the hospital fails to recognise the differing needs of individual patients.

1.3 Research objectives and research questions

The objectives of this research are to study the perceptions of success to:

- Identify what politicians perceive to be the measurement of NHS success.
- Identify what NHS England and NHS Improvement perceive to be the measurement of NHS success?
- Identify what chief executives of acute NHS trusts perceive to be the measurement of NHS success.
- Investigate why acute NHS trust hospitals are rated as poor or placed into special measures.

The literature generated the research questions which are:

- Research Question 1 – What are the perceived measurements of NHS success from the perspective of the government, NHS England and NHS Improvement?
- Research Question 2 – What do acute NHS trust chief executives perceive measurements of NHS success to be and does their leadership role impact upon perceived success or failure.
- Research Question 3 - What are the reasons acute NHS trust hospitals are rated poor or placed into special measures?

1.4 Justification for the research

No previous studies have been conducted to examine the perception of NHS success from senior leaders of acute NHS hospitals and politicians. While prior studies have explored how effective the NHS is, this has been conducted from single viewpoints using quantitative research methods (Powell, 2014; Brookes & Baker, 2017). This study is therefore important

as it approaches the research from several sources adopting qualitative methods and focuses on success. As a result, the aim is to produce fresh insights to the field of success and how success is viewed within the NHS. Its findings will assist future leaders of the NHS to make informed decisions on how best to measure and qualify NHS success beyond current performance indicators. Designers of NHS leadership and management education may also find this new knowledge beneficial when reviewing and redesigning their existing training courses for future NHS leaders.

1.5 Significance and contribution by the study

This study makes several contributions to the body of knowledge. First, the concept of success is contested and poorly understood, so this study aims to strengthen understanding of the term success. At the same time this study looks to identify and define what success looks like, both as a concept but also confined to the NHS. This has not previously been ascertained by prior studies. This study will explore the use of performance indicators by the NHS and seek to identify any relationship between performance results and success.

Second, no prior studies have examined success of the NHS from several viewpoints, this leaves a potential gap in existing knowledge. This potential gap gives rise to new questions relating to how stakeholders view current performance indicators and hospital ratings. These views have not been sought before by NHS leaders or scholars.

Third, the approaches to leadership adopted by chief executives of high performing NHS trusts have not previously been examined. This research will provide a frame of reference for future NHS leaders to examine their own understanding of leadership and adopt characteristics which may assist them in their own role.

Due to a lack of prior research examining NHS success from several viewpoints there is a definite need for additional research to explore and investigate the perceptions of success. The development of clear definitions of success in this study will ensure that future decision makers and leaders of the NHS have a benchmark to measure NHS success against.

1.6 Outline of the research

This thesis contains six chapters:

Chapter One - Introduction: Provides a brief overview of the background to the research and presents contributions and justification for the research and methodology. The chapter also presents the research aims and research questions.

Chapter Two - Literature Review: Examines literature pertaining to the creation and development of the NHS. It aims to highlights key events perceived as successful during its various stages of development. This cannot be achieved without scrutinising literature exploring success and perception. Further literature relating to the measurement of performance will be analysed. Literature which explores how the NHS is led will be critiqued along with the role played by followership. Finally, literature on NHS failure will be examined.

Chapter Three - Research methodology: Presents justification for the epistemological stance and methodological approach to data collection for this study. Details are presented to set out the research design including research perspective. The role of the researcher is discussed along with reflections of my positionality whilst the study is conducted. A comprehensive description of the research method is provided with particular attention to the sampling strategy, the sample group, recruitment and selection of participants, and the process of conducting semi-structured interviews. Full details are given of the data and theory interplay and how themes emerged from the data codes. Finally, the ethical reasoning and trustworthiness of the study is described.

Chapter Four – Primary findings and analysis: Presents the results of data analysis in this research, including the perceptions of success from the participant groups, their observations and experience of the NHS and how success is related to organisational performance. Results from the interview process and interpretation of the data is also presented in this chapter.

Chapter Five – Discussion: Reviews the original research objectives and debates the findings with regard to the theoretical and practical implications that flow from them.

Chapter Six - Conclusion: Provides the conclusions and implications of the whole thesis along with suggestions for further research.

1.7 Chapter summary

The NHS has undergone numerous reforms and restructuring processes by several governments since its post-war creation in 1948. It has seen demand for its services increase as the population grows and health needs become more complex. Its original design could not have conceived the expansion of technology and the development of expensive new life saving techniques. Yet it has been required to adapt and change how it works to continue delivering free care. Its performance and behaviour have changed over time and cannot be understood by simply understanding the individual component parts of the NHS, but this is what some research has previously tried to do. Has the NHS exceeded the expectations of its adopted father, Aneurin Bevan, or has it still got much to improve upon? Is the NHS successful and who decides?

This introductory chapter has presented the foundations for this thesis and presents an overview of the research. It has described the rationale and originality of the study along with the contribution to existing knowledge.

The following chapter provides a review of the literature relating to the NHS from conception to its structure and function today. Literature is examined which helps define success and perception while further literature is reviewed to assist in defining performance and its measurement. The NHS chief executive, their function and role in leading an NHS trust will be investigated. The antecedent literature will be scrutinised while exploring the role of followers in organisational success. This literature review will assist in identifying current gaps in knowledge.

Chapter 2 - Literature Review

2.1 Overview

In this chapter I explore pertinent literature which assists in answering the three research questions. To facilitate this, academic and grey literature were studied through bibliographic analysis, as defined by Hart (2018). Described as a rigorous method for exploring and analysing large volumes of scientific data (Donthu *et al*. 2021), bibliographical analysis is appropriate to uncover emerging themes and trends in a specific domain (Verma and Gustafsson, 2020). It is also appropriate when exploring the intellectual structure and relationship between different research literature (Donthu *et al*. 2021). Electronic literature searching was conducted using various bibliographic databases, such as ABI-INFO, Elsevier, JSTOR, ProQuest, and Science Direct. With a wide range of available literature, a clear inclusion and exclusion criteria was implemented to ensure relevant literature was selected to assist in answering the research questions. Keywords like 'success', 'perception', and 'healthcare' were employed to electronically trace articles of relevance to the study. The inclusion criteria sought literature pertaining to the history of healthcare in the United Kingdom (UK) since the start of the twentieth century. The intention being to understand how views of healthcare and healthcare success has been shaped and developed. Additional literature was included to explore universal healthcare systems in other countries to identify how success may be viewed outside of the NHS. Literature relating to success and failure, both as concepts and within organisations were included within the criteria. Success and the role of leadership was also included, providing a link to organisational success. The need to explore success and failure is critical to answering the research questions. Aligned to success was literature exploring perception and how this may influence success or failure. Political policy and debate were included to establish the measures and views of NHS success seen within. Finally, the work of those who had previously explored the NHS and measures of success were included. The resulting literature was divided into eight key areas to gain a greater understanding of the scholarly research already undertaken. The key areas are:

The NHS: 'from cradle to grave'

This research examines perceptions of NHS success, so it is sensible to explore its creation and development over the past 74 years. During this period, pivotal events are reviewed to ascertain their effect on perceived NHS success. It provides a framework upon which perceptions of NHS success can be further built and critiqued.

The challenge of defining success

To explore perceptions of NHS success it is important to establish what success is and how it may be observed and measured.

Success is a shift in perception

The way people view success is a key element of this research. Determining how people perceive the world around them is essential in ascertaining whether the NHS is successful or not.

Performance a measurement of success

Most large organisations measure their success against key performance indicators or targets. While the NHS uses performance measurement what appears unclear is how or whether these performance targets relate to NHS success. By closely examining NHS performance measurement this relationship may become clearer.

Leaders: 'the answer to NHS success?'

Leadership is often cited as the key to organisational success but is this true for the NHS? To establish if this is the case a closer assessment of NHS leadership is required.

Leaders need followers

While success is often attributed to leadership, the impact upon success from followership is often overlooked. It is important to investigate how followership is viewed within the NHS and what impact followers have on NHS success.

NHS failure, learning from mistakes?

Exploring success in isolation ignores learning lessons from failure. It is important to define the key events in NHS history to gain an insight into how the NHS deals with failure and whether it prevents future failure.

Comparisons of universal healthcare success

The UK is not the only country to offer universal healthcare to its citizens, as a result it is important to examine whether and how these countries measure healthcare success. Comparing and contrasting these countries with the UK may provide additional understanding of ways in which NHS success may be perceived.

2.2 The NHS: 'from cradle to grave'

Between the start of the twentieth century and the start of World War Two, healthcare in the UK was disjointed, inconsistent and fragmented (Webster, 1998). From 1911 most British working men paid into a National Health Insurance Scheme, as part of the National Insurance Act. However, this only gave access to a doctor for male manual labourers and lower paid non-manual male workers earning under a certain income. The wives and family members of the working man were required to pay for healthcare treatment, which many struggled to do. As a result, most relied on older workers' friendly society insurance schemes (a localised private contribution insurance scheme), free clinics for mothers and children, and visiting pharmacists for advice (Cordery, 2003). Depending on where you lived free treatment was sometimes available from charitable voluntary hospitals. In other areas of the country local authorities operated free hospitals for local ratepayers only (ibid.).

In 1919 Christopher Addison, the first British Minister of Health commissioned a report to highlight how the future provision of medical and allied services should look. The interim report was published in 1920 and provided useful arguments in future debates on the creation of the National Health Service.

In 1941, the Conservative government appointed Sir William Beveridge to lead an inquiry into Social Insurance and Allied Services. The report, known as the Beveridge report, was published in 1942 and formed the basis of decisions on post war welfare legislation. Beveridge recommended a new welfare state consisting of the creation of a national health service, full employment and the payment of a child allowance (Field, 2012). With the election of a Labour government in 1945 the recommendations put forward by Beveridge to tackle 'five giant evils' in welfare, were never fully implemented (Jones, 1992); instead, the National Health Service Act 1946 signalled the creation of the NHS, on July 5th 1948. Despite Beveridge's work the then Labour Minister for Health, Aneurin Bevan, is cited as being 'the father' of the NHS (Sturgeon, 2013).

By creating a National Health Service, the government established a healthcare system with three principle aims or values. These were, firstly, that the services helped everyone within Britain; secondly, healthcare was free at the point of delivery and finally, that care would be provided based on need rather than ability to pay. These principle aims remain at the heart of the NHS today (NHS England, 2021a). It is argued that becoming the first healthcare system in Western society to offer free healthcare to the entire population was a huge leap forward and a significant British success (Klein, 2013). For this reason, the creation of the NHS is quoted by several historians as one of the greatest British success stories of the twentieth century (Gorsky, 2008).

The formation of the NHS saw the removal of local authority and voluntary hospitals from local authority control. Control for these facilities was transferred to the state (Ham, 2009). Webster

(2000) argues that this was unnecessary as local authorities were close to establishing a comprehensive system of healthcare for each of their areas. It is further argued that the creation of a singular controlling body threw healthcare into disarray (idib). This has been disputed with Ham (2009) arguing that the formation of the NHS was essential to remove disparity between quality of care and services provided by local government and the voluntary hospitals.

The new hospital operated under a management triumvirate (Edwards *et al.* 1993), consisting of a lay administrator, a matron and the chairman of the medical staff committee. This tripartite administrative structure ran parallel to the medical hierarchy (Edwards *et al.* 1993; Learmonth, 2017). The Bradbeer Report (Ministry of Health, 1954) on the internal administration of hospitals found the role of hospital coordinator was adopted by the lay administrator and proposed the need for a chief administrator at regional or group level (Edwards *et al.* 1993). Within larger hospitals the appointment of a medical administrator enabled closer working between the medical committee and the nursing and lay administrator. The matron was regarded as the head of the nursing services at local hospital level with group nursing committees gathering the collective advice from matrons and reporting this back to the governing body for healthcare. This saw hospital matrons acting as monitors of care quality and standards.

In the early 1950s, gross expenditure on the NHS was 27.5 percent higher than budgeted (Cutler, 2003). It is argued that the NHS had quickly become a victim of its own success (Ham, 2009). More accurately, the NHS was a victim of the previous inadequacies in healthcare provision. A vast percentage of the population had been unable to afford healthcare and so was in poor health. Those with chronic medical conditions were now taking advantage of the free services of the NHS.

With increasing gross expenditure, the then government set up a committee to explore the financial efficiency of the National Health Service. The subsequent Guillebaud Committee (1956) concluded that financial imbalances were the consequences of a failure to anticipate demographic change and inflation. A significant question asked during the enquiry was what constituted an 'adequate service'. The resulting debate found an absence of attainable standard of adequacy within the NHS (Guillebaud Committee, 1956). The committee therefore concluded that the NHS should deliver an adequate service by providing the best service possible within the limits of the available resources (ibid.). It could be argued that this is an early definition of how NHS success was measured.

The publication of the 1962 Medical Services Review Committee (the Porritt Review) recommended that the responsibility for the administration and co-ordination of all the medical and ancillary services in any area should be in the hands of one authority only, an Area Health Board (AHB) (Porritt, 1962). The aim was to involve General Practitioners more extensively with health decisions in their local communities. This was achieved by removing sole responsibility for healthcare administration from the hospital tripartite administrative structure, transferring responsibility to the Area Health Board. As a result, General Practitioners were opted onto the Area Health Board, increasing their decision-making powers at local level. For the first time the Porritt Review stated how NHS success should be measured: "*The success of the Service will, and must always, be judged by the personal attention given by the doctor to his patients. The individual doctor must be left free to ensure that the service is conducted on a personal basis*" (Porritt, 1962. p. 1178). This statement placed success or failure of the NHS firmly in the hands of the medical profession.

Despite the findings of the Porritt Review mistrust developed between doctors and hospital management. As a result, management and leadership of doctors and their role in managing the NHS was closely examined in 1967 by the then Chief Medical Officer Sir George Godber (Iliffe & Manthorpe, 2018a). A working party produced the Cogwheel Report (Ministry of

Health, 1967) which recommended the creation of medical divisions for each medical speciality with a Chairman and Executive Committee (Edwards *et al.* 1993). This caused some doctors to believe that creating medical divisions would prevent their clinical freedom to treat patients in a way that they believed to be best (BMJ, 1967). This concern failed to accept that clinical freedom to treat may not result in the most successful clinical outcome or successful service.

The first major reorganisation of the NHS came in the late 1960s when Kenneth Robinson, the then Minister of Health, published the first consultative document on the reorganisation of the NHS (Klein, 2013). Identifying that the NHS now had two systems of finance and nearly 700 separate authorities administering the Service, the Green Paper (Ministry of Health, 1968) identified opportunities to improve the service (Powell, 2018). Some clinicians felt that reform was overdue with several stating that the structure of the NHS was out of date and failing to meet new technological innovation in medicine (BMJ, 1968).

The Green Paper (Ministry of Health, 1968) recommended greater collaboration between doctors, nurses and other health service workers, subsumed under one area of administration. Subsequently in 1972 Keith Joseph, the then Secretary of State, argued that significant financial savings could be made by increasing managerial efficiency within the NHS (Sturgeon, 2013). Joseph proposed a comprehensive reorganisation of the NHS (DHSS, 1972) with the view that integrated planning and management of capital projects would produce substantial financial savings. The National Health Service Reorganisation Act received Royal Assent in July 1973, the 25th anniversary of the NHS, and came into operation the following year (Sturgeon, 2013). Despite previously welcoming reform doctors' professional associations now questioned the value in reorganisation stating that the NHS was failing due to a shortage of resources, not the organisation of the service (BMJ, 1970).

A key change to the management and leadership of the NHS during the 1970s followed the publication of '*Management arrangements for the re-organisation of the NHS'*. Published in 1972, this was the result of a multi-disciplinary steering group chaired by the then Permanent Secretary, Sir Philip Rogers. A key component of the publication was the removal of the previous system of management triumvirate. This was replaced by consensus management while also rejecting the introduction of chief executive roles (Edwards, 1993). These recommendations were added to the National Health Service Reorganisation Act 1973 and saw the creation of Regional Health Authorities (RHAs) and Area Health Authorities (AHAs). These new levels of administration took over the management of hospitals at a local level replacing hospital boards and hospital management committees. Some observers applauded change stating the NHS had been failing due to being grotesquely over-administered and dangerously under-managed (Cooper, 1974).

The 1970s were characterised by 'corporate' approaches to the management of health. This saw the needs of the worker ignored as changes to contracts were proposed. This resulted in relations between management and staff deteriorating under powerful and largely disaffected trade unions (Greengross, Grant & Collini, 1999). This deterioration between management and staff was exacerbated in 1975. The then Prime Minister, Harold Wilson, announced a Royal Commission to consider the best use and management of the finances and workforce of the NHS (Edwards *et al.* 1993). Rather than lead to better care morale plummeted with doctors, nurses and ancillary staff all protesting at poor pay and working conditions. Strikes ensued and the overall service offered by the NHS declined (McKie, 1974).

During the 1970s the NHS appeared to fail repeatedly to provide a cohesive service. This was appraised by the British Medical Journal in an article entitled 'The disalienation of the NHS'. It stated "*In 1948 the NHS may have been an example to the rest of the world, but 30 years later it measures poorly against many alternative methods of providing health care, and its medical and nursing staff are disillusioned and depressed. Yet only ten years ago the same staff were*

enthusiastic and optimistic. There is nothing wrong with the concept of the NHS . . . What has gone wrong?" (BMJ, 1978. pp. 12). Despite this assessment of the NHS, its success remained unmeasured.

A major turning point for the leadership and management of the NHS followed the publication of the Griffiths Report (1983). The report criticised the introduction and use of consensus management. The report recommended the introduction of general management and a need for doctors to become more involved in management (Martin & Learmonth, 2012; Thomond, 2014; Lewis, 2014). Commenting in his report, Griffiths (1983) was to identify that despite the sheer number of reports published since the Bradbeer Report in 1954, no one had given the management and leadership of hospitals any thought (Edwards *et al.* 1993). Previous reorganisations to the Health Service had concentrated on creating a top-down managerial structure at regional level. Due to these structures Griffiths highlighted a lack in clearly identifiable leadership and reporting lines (Merali, 2009). As a result, Griffiths called upon captains of industry with business and financial expertise to improve efficiency and productivity of the NHS (Turner-Warwick, 2011). One recommendation of the review was the introduction of performance measurements, in particular measurement of output in terms of patient care (Griffiths, 1983). This was to become the first attempt to measure the impact of NHS services and possibly NHS success.

The National Health Service and Community Care Act (1990) marked the creation of NHS trusts (NHST). These were created independent of District Health Authorities. NHS trusts were able to manage their own affairs, such as setting pay for their staff and generating additional income using their specialist services (Ham, 2009). The Act also created an internal market within the NHS (Merali, 2009). The concept was that money would follow the patient and go directly to the provider of treatment. This afforded fundholders, such as General Practitioners the choice of where to send their patients (Checkland *et al.* 2012). The aim was to create a system of increased efficiency by creating incentives to providers who improved their

performance (Edwards *et al.* 1993; Propper, Burgess & Gossage 2008). The ability to have greater autonomy of running their service was just one such incentive available to efficient providers. The internal market saw NHS trusts able to compete against each other with the most successful being able to prosper while unsuccessful trusts struggled. Cited as being a great NHS success (NHS Executive, 1993), it is argued that there is no evidence to support this claim or demonstrate the NHS internal market improved healthcare in the UK (RSHG, 1995).

The National Health Service and Community Care Act 1990 ushered in possibly the most radical reorganisation of the service since its inception in 1948 (Robinson, 1996). On 1 April 1991 the separation between fundholders and care providers became a reality, with health care delivery becoming a more transactional procedure. It saw an emphasis on the fundholder as purchaser of services while providers competed for business. The resulting sudden and increasing use of commercial language within the NHS produced anxiety among staff and the public. There was a concern that the service was being turned into a business (Edwards *et al.* 1993). This fuelled public perceptions that NHS success was measured in pounds saved rather than lives saved (Ham, 2009).

Throughout the 1990s the structure of the NHS continued to develop. It saw increasing numbers of self-governing NHS trusts being formed and the creation of chief executives to manage them. Several layers of the service were merged, and a generalised streamlining of reporting was introduced (Ham, 2009). Greater emphasis was placed on the use of key performance indicators to highlight the standards of NHS trusts performance and success.

With a change in Government in 1997, came further reforms to the health service. At this time patient waiting lists were lengthening, services were being cut and operations were being postponed across the NHS. These actions were due to purchasers running out of money. It was envisaged that this could be reversed through the creation of Primary Care Groups (PCG)

and Primary Care Trusts (PCT). Each group had responsibility for providing primary health care and commissioning secondary care services for a population of up to 250,000 (Cheater, 2001; Walshe *et al.* 2004). These Primary Care Groups and trusts replaced General Practitioner (GP) fundholders as commissioners of care services. This represented a major move away from the internal market that characterised the NHS in the 1990s (Wilkin, Gillam & Smith, 2001). The Primary Care Groups and trusts were tasked with rectifying the variability and fragmentation of NHS services seen under the internal market system (Ham, 2009). This enabling standardisation of services across the entire NHS (ibid.). Further performance measurements were introduced to evaluate performance of each PCG and PCT, with those performing well being hailed as successful.

In 2008, the Department of Health commissioned Professor the Lord Darzi to publish a review of the NHS entitled 'High Quality Care For All – NHS Next Stage Review Final Report'. Within the final report Lord Darzi stated,

> "*In the 21st century, there remains a compelling case for a tax-funded, free at the point of need, National Health Service. This Report celebrates its successes, describes where there is clear room for improvement, looks forward to a bright future, and seeks to secure it for generations to come through the first NHS Constitution*" (Department of Health, 2008, p. 15).

The final report failed to identify a single NHS success and offered no explanation as to why this may be. It also failed to indicate how future NHS success may be identified. It is unclear if the then Labour government had a definition for NHS success.

During the 2000s, the need to audit and inspect the standards of care provided by the NHS fell to the newly created Healthcare Commission (HCC) (Tingle, 2017). Renamed the Care Quality Commission (CQC) in 2009, the commission failed to stop two high profile public inquiries (ibid.). The first inquiry was set up to examine the death of 29 babies at the Bristol

Royal Infirmary. It found a distinct lack of leadership, monitoring and accountability had led to the deaths at the hospital (Kennedy, 2001). This was highlighted by Professor Ian Kennedy QC who reported "*There were no standards for evaluating performance. There was confusion throughout the NHS as to who was responsible for monitoring the quality of care*" (Kennedy, 2001, p. 2). Kennedy's fierce criticism brings into question the effectiveness of previously implemented performance measurements and the success of the NHS to maintain a safe service.

The second inquiry examined concern of poor care and high mortality rates at the Mid-Staffordshire NHS Foundation trust. In his report, Robert Francis QC stated, "*This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking Foundation trust status to be at the cost of delivering acceptable standards of care*" (Francis, 2013, p.3). This focus on financial management resulted in a lack of effective governance arrangements, reduced spending on safe care provision and poor clinical practice. It concluded that these all contributing to increased patient mortality. In summary Francis highlighted that the NHS had "*failed in its primary duty to protect patients and maintain confidence in the healthcare system*" (Francis, 2013, p.4).

Significant reform was made following the introduction of the Health and Social Care Act 2012. Primary Care trusts were abolished, and their commissioning responsibilities passed to the new NHS England and Clinical Commissioning Groups (CCG). NHS England was set up as a non-departmental body of the Department of Health. Its function was to act as the primary oversight for commissioning NHS services. Strategic Health Authorities (SHA) were also removed with responsibilities for training, educating and workforce development passed to Health Education England. In 2013 another non-departmental body of the Department of Health was established, NHS Improvement. With a primary role of ensuring high quality, safe care to NHS service users NHS Improvement was responsible for overseeing NHS trusts and independent providers who are commissioned and funded by NHS England.

In 2014 NHS England published its five year forward view (NHS England, 2014). The publication stated that there was no appetite within the NHS for further structural reorganisation. It further recommended that local reorganisation and leadership should be changed if there was "*clear local failure*" (NHS England, 2014. p 28). The report did not define what constituted local failure or success. With no published definitions, it is unclear whether the then Conservative government had a measurement for either NHS success or failure.

A series of new performance targets were included within the report. These focused on both clinical treatment and operational finances. The ability of NHS trusts to meet clinical targets were combined with the fiscal pressure of achieving a two percent net efficiency saving (NHS England, 2014: p.36). These new targets were further defined in the publication, 'Next steps on the NHS five-year forward view' (NHS England, 2017). The publication highlighted clear accountabilities for delivering local goals and key national milestones. The need for efficiency savings saw the publication recommending the need to cut waste. The responsibility for ensuring these were met fell to chief executives of NHS trusts. Some had reservations about this approach concerned that chief executives would end up focusing their efforts on improving finances at the cost of providing care (Leahy, 2017). It could be argued that this was at the heart of the failings in the Mid-Staffordshire NHS trust. Within the publication it indicated that success was to be measured through the achievement of results but continued to be unclear on what constituted results.

The range and number of NHS reforms undertaken by successive governments has been questioned by Maynard (2013) who highlights the lack of post implementation assessment against predetermined success criteria. Other scholars suggest that seldom are those working in the NHS consulted on reform; instead, economists, system analysts and consultants are typically brought in to steer change (Mintzberg, 2012). These people believe they understand the system theoretically, which leads to reorganisation and the reinvention of the NHS every few years. Other scholars propose that the succession of politically driven NHS reforms and

policy changes have all been designed to make the NHS more efficient, effective and accountable (Merali, 2009). What remains unclear is whether the NHS is successful and how this can be determined. Despite various reforms limited evidence exists to suggest that consecutive governments have defined NHS success.

Moore (2017) describes how the NHS has and continues to face increasing pressure upon its ability to deliver services with limited funds. These pressures include increasing demand for services, a growing and ageing population, changes in morbidity, cost pressures associated with new technologies and treatments, along with employee pay (Stoye, 2017). It could be suggested that many of the reforms have been implemented to address these increasing pressures faced by the NHS. The difficulty with determining whether these reforms have been effective is the lack of post implementation evaluation (Katikireddi *et al.* 2014). Combined with the absence of reform evaluation, confusion is seen between short- and long-term effects of reform (ibid.). Reforms which combine large scale organisational change typically have an adverse effect on performance in the short term, with positive results not being seen for several years (Fulop *et al.* 2002). Le Grand, Mays and Dixon (2004) observed that there appeared to be virtually no change in efficiency or access to services following previous NHS reforms. One question that needs to be asked is whether efficiency correlates to success and can this be measured and observed within the NHS.

A summary of key reports, Acts, reorganisations and inquiries in the NHS are listed below in Table 1.

Year	Act, Reform, Report, Inquiry	Key points
1941	Beverage Report	Recommendation of a new welfare state
1946	National Health Service Act (1946)	Set out the new National Health Service
1948	National Health Service created	Tripartite management of hospitals
1954	Badbeer Report	Recommended administrators act as hospital coordinators

1956	Guillebaud Committee	Recommends NHS needs more oversight and supervision but leaves administration as is.
1962	Porritt Review	Recommends all administration and control of services should be under one authority.
1967	Cogwheel Report	Recommends the creation of medical divisions with executive committees
1972	NHS reorganisation	
1972	Management arrangements for the re-organisation of the NHS '*Grey Book*'	Recommends consensus management to replace tripartite system of hospital management
1983	Griffiths Report	Recommends general management to replace consensus management
1990	National Health Service and Community Care Act (1990)	Creation of the internal market with greater control for NHS trusts.
2001	Kennedy report – Inquiry into deaths at Bristol Royal Infirmary	Finds lack of leadership, monitoring and accountability at the hospital
2013	Francis report – Inquiry into poor care and high mortality at Mid-Staffordshire NHS trust	Finds managers are more concerned with saving money that providing good levels of care

Table 1.Summary of key reports, Acts, reorganisations and inquiries in the NHS

2.3 The challenge of defining success

The popular literature appears to be awash with books on how managers and leaders can be successful. Yet if you research what organisational success looks like there are few sources of reference. This provides a challenge when attempting to establish what success is and more challenging when specifically looking to establish what success means for the NHS. In the wider business arena success is frequently expressed in terms of greater organisational production (Taslim, 2011). At the same time the terms 'success' and 'performance' are very closely linked and are often conflated in business (Reijonen & Komppula, 2007).

The word production refers to the "*action or process of production*" or "*the amount of something produced*" (Concise Oxford English Dictionary, 2011: p.1145). The assumption is that increased production and productivity translates into greater profitability for a commercial business (Huand & Rust, 2014). Scholars have suggested that organisation performance is determined largely by the qualities and attributes of executive management (Khan, 2012). The result has been a gradual movement over time to define how managers work in different approaches to management (Perry & Christensen, 2015). These have, over time been characterised as either classical or contemporary approaches to management.

While there are several scholars who have defined differing approaches to management, such as Igor Ackoff (1918-2002) these approaches have concentrated on specific business functions. Ackoff is best known for his work on business growth strategies where he developed the Ackoff Matrix (Ackoff, 1957). For this research these have been dismissed as their focus is not on the interaction between managers and employees in the perceived creation of organisational success. There are those who feel that all managerial thinking exhibits an intrinsic life cycle. Starting with theory adoption, followed by the modification and tailoring to the circumstances of the organisation, then eventual dismissal and abandonment for the latest way of thinking (Parker & Ritson, 2005). What is not known is how much emphasis the NHS places on management theory in an attempt to maximise chances of organisational success. It is suggested that organisations, like the NHS, do not develop the environment for success. The argument is that chief executives and senior managers spend much of their time on trivial matters that should be left to middle managers and supervisors (Khan, 2012). So how is NHS success to be defined? Part of the reason for its complexity is due to the wide range of criteria associated with success (Simpson, Tuck & Bellamy, 2004). For organisations such as this it is not possible to define success in just a one-word answer as each person in the organisation may have a different view of what success means to them (Roberts, 2005). For a surgeon of an NHS trust success may be perceived as low mortality rate when compared to other trusts. The surgeon has little concern at the cost of scalpel blades, yet the NHS trust accountant may

measure success as procurement purchasing the cheapest blades. The accountant has little concern for patient mortality as it does not directly affect their work. The chief executive of the same NHS trust is likely to measure success as both low mortality rates from surgery and stable finances as this directly affects their own success as a leader. There is a need by everyone within the NHS to see the wider view of success and understand how their output affects overall organisational success.

In business, successful leaders are frequently seen by shareholders as those who get results (Birshan, Meakin, & Strovink, 2016). This is manifested as financial growth and prosperity or increased market share (ibid.). Little attention is paid by shareholders to the leaders' soft skills, such as their ability to motivate their employees or create a pleasurable working environment. The assumption that soft skills do not attribute to the success of a business is not shared by academics who have established a direct link between increased performance and the skilful use of soft skills (Hirsova *et al*. 2013, Sriruecha & Buajan, 2017, Waters, 2017).

One of the UK government's major challenges is how it enables NHS managers to increase their overall performance, contribution, and commitment (Merali, 2009). Equally how this makes the NHS a more efficient and successful organisation (ibid.). There have been a number of health service reforms implemented over the past decade, such as the Health and Social Care Act of 2012. Many of these reforms have been executed to make the NHS more efficient. The responsibility for implementing and monitoring these reforms has been given to NHS managers. Key performance indicators and objectives are utilised to enable chief executives to monitor service delivery. This has seen chief executives measured against the key performance indicators (KPI) of their hospital trust (Talbot-Smith & Pollock, 2009). With performance targets and quality indicators focusing on statistics relating to clinical and financial outcomes (Appleby & Devlin, 2005), virtually no consideration is given to the executive's ability to produce an effective, and more importantly for the NHS compassionate and caring workforce. This is a major failing of using key performance indicators to measure

hospital performance. Likewise, their publication has a negative effect on the public trust of the NHS and a demoralising effect on staff (Adab *et al*. 2002). There has also been concern at the manipulation or positive adjustment of figures to meet performance targets by several NHS trusts, in the past (Bevan & Hood, 2006).

The NHS does specify the key measures of success within The Government's mandate to NHS England for 2018-19 (Department of Health and Social Care, 2019). The documentation focuses upon the use of performance indicators to demonstrate healthcare improvements at local and national level. As a result, the use of performance indicators and targets enable complex statistical data to be formulated into a simple rating table for policy makers and the public to understand (Merry, 2011). The use of certain key measurements - accident and emergency waiting times being one - act as a barometer for overall performance of the NHS (The King's Fund, 2017). NHS performance on many measurements has, over consecutive years, fallen well below the standards set by the government. This has led to an assumption that the NHS is unsuccessful or failing (Baker, 2019). Others disagree that the NHS is unsuccessful arguing that due to advances in modern expensive treatments there are increasing survival rates and increased demand for the service (Mintzberg, 2012). This increased demand places unrealistic pressures on the health service and gives an unrealistic impression of a failing service. It could also be argued that the use of performance indicators to measure the current success of the NHS is ambiguous. There appears to be little evidence to suggest how many of the performance indicators have been calculated or determined. The key indicator for accident and emergency waiting times of four hours was introduced by the government in 2007 (Department of Health and Social Security, 2007). Nowhere in the government's publication does it state how the figure of four hours, or any of the other performance measurements were determined. It has been argued that the creation of NHS performance measurements by the government are based on political interest, to demonstrate results in policy and create localised accountability (Thomas & Meyer 1984; Brignall, & Modell, 2000). It has been suggested that the use of performance measurement allows the

government to micromanage the NHS through ministerial interference (Dixon & Alvarez-Rosete, 2008). The result is NHS trust chief executives find themselves servants of the government (ibid.) There have also been concerns raised at the use, calculation, and value of the current key indicators (Office for Statistic regulation, 2018). It is argued that those relating to accident and emergency waiting times do not appear to represent a true reflection of the NHS (ibid.). Arguing that '*not everything that counts can be counted*', Regan and Ball (2017: p.154) agree that measuring certain statistics fail to reflect the real state of the NHS. Other observers have commented that those figures that are reported by the NHS are difficult to comprehend and easy to misinterpret (Adab *et al*. 2002). It is argued that this is irresponsible given they are of questionable validity (Kassirer (1994). This is echoed by others who state that health providers struggle to produce meaningful statistics rendering them almost useless (The Health Foundation, 2015).

As highlighted, the overriding measure of success appears to be based on statistical outcomes set by the UK Government along with delivering balanced finances (Ham, 2009). This appears rather unsurprising given that NHS trusts have business-like executive boards (Learmonth, 2001); however, NHS trust chief executives also have a statutory duty for quality of care following the introduction of the Health Act 1999. This leaves the NHS trust chief executive in a precarious position. As the responsible person for overseeing the implementation of care they face possible prosecution. This may arise if the CQC determine a significant breach in care has occurred. Examples include service users being exposed to avoidable harm or significant risk of such harm occurring. As a result, the NHS trust chief executive finds themselves balancing statistical and financial outcomes against safe care delivery. This results in certain treatments or services being cut or restricted to ensure targets are met while maintaining a safe service.

Following the introduction of the Health Acts in 1999 the regulation and assessment of NHS trusts fell to the Healthcare Commission and the Commission for Social Care Inspection.

Monitoring of mental health services fell to the Mental Health Act Commission. On the 1st April 2009 the newly formed CQC took over complete responsibility for monitoring care services including NHS trusts. This was in response to the Health and Social Care Act 2008.

A primary responsibility of the CQC is to inspect and rate care services, identifying good practice and areas of concern (Enston, 2019; Richardson *et al.* 2019). As part of the inspection process the CQC look at several elements to establish the rating for the care service being inspected. Given that the CQC is the independent regulator of health and social care in England, it could be suggested that the success of an NHS service can be measured by the CQC and provides a standardised starting point to this research.

According to The Health Foundation (2015), successful NHS trusts have a committed and courageous leadership structure with leaders who engage and inspire their staff. These leaders act as role models, demonstrating the desired behaviours of the trust. This, The Health Foundation (2015) states, produces a highly motivated and dedicated, caring workforce who deliver excellent service. This provision of exceptional health care can be measured by the CQC, using performance ratings. Those NHS trusts which excel at providing exemplary care are rated as outstanding, rather than good, requires improvement or inadequate.

One of the biggest perceived failures for an acute NHS trust and its leadership is to be placed in special measures, following a CQC inspection. Special measures apply when NHS trusts have serious or far-reaching problems. These problems are also accompanied by concerns that the current NHS trust leadership cannot make the improvements necessary without additional support. Generally, the NHS trust and its leadership are presented with a support package, designed to remedy problems within a reasonable timeframe. The support package will identify the specific areas of concern and highlight how these concerns are to be rectified. To implement the recommendations those trusts placed in special measures will be allocated an improvement director who acts on behalf of the CQC. Improvement directors are tasked

with ensuring the trust are taking measures to rectify the identified issues. For the chief executives of NHS trusts placed in special measures it is a troubling time, either they rectify the issues, or they are replaced (Bevan & Hood, 2005).

The measurement of success or failure within the NHS focuses on accountability for output at local level. In the acute NHS trust this ultimately resides with the chief executive. As highlighted, the inability of a chief executive to turn around a hospital in special measures may result in their removal. The issue of accountability within the NHS is described as a two-way model of responsibility (Chang, 2015). The first responsibility relates to the government's accountability to deliver NHS services as promised to the electorate. The second responsibility relates to the NHS chief executives' accountability for delivering the government's promises at local level. This is seen by some as a power relationship between citizens, the government and local managers (Stewart, 1984). There is an argument that the use of performance measurement in the NHS serves as a device to enable the electorate to visualise the end results of the government's policies (Chang, 2015). Where these policies fail, it is suggested the government can assign responsibility for the failure with the NHS chief executive. This deflects accountability for the failure away from the government (ibid.). Clegg (2010) describes this as a way of the government can distance itself from failure and preserve their own integrity and position. Equally Diamond (2015: p.429) describes this action as "*blame avoidance*". Some argue that this form of performance management is essential in ensuring that someone has proper accountability for success or failure (Read, 2014).

Another difficulty in measuring and defining success in the NHS is the lack of comparable performance data from health care systems in other countries (Ingleby *et al*. 2012).

The measurement of NHS success appears to be ambiguous with no clear universal definition. It could be suggested that the CQC can indicate how successful an individual NHS trust is when measured against its inspection criteria. However, this has never been cited as a

description of success. Where NHS trusts fail a CQC inspection it is often the chief executive who is the focus of attention, and frequently replaced (Wise, 2013). A similar situation occurs in business. Where performance declines, often leaders are removed and someone else put in post to turn around performance (Shlomof-Cohen, 2007; Ndofor *et al*. 2009). This move implies that the leader is responsible for the success or failure of their organisation. It is suggested that many of the issues found within the NHS, including failure, can be resolved by the correct leader (Checkland, 2014). With the suggestion that leadership plays a vital role in creating organisational success we need to establish what leadership looks like and whether NHS leaders influence success.

2.4 Success is a shift in perception

There have been several studies looking at how patients perceive success following medical treatment (Jeffs *et* al. 2016; Khatib *et al.* 2020), but none exploring the perception of success in the wider NHS. To understand why this might be we must explore what perception is and how it is conveyed to others.

Perception is described as central to epistemology (Audi, 2013), helping us make sense of the world around us. One definition of perception is "*A way of regarding, understanding or interpreting something*" (Concise Oxford English Dictionary, 2011: p.1063). This definition does not fully convey the complexity of perception. Perception may be different for individuals even when they are viewing the same thing, due to differing circumstances (Maund, 2003). In this way a patient may view a hospital as a place of treatment while a doctor may view a hospital as a place of work, the same building but differing circumstances leading to different perceptions. Our own perceptions are based on our expectation, prior experiences, mood and cultural norms. This has been shown in clinical studies using placebo medication. These studies see subjects being told that the medication they receive is proven to give a therapeutic benefit despite it having no medicinal properties (Zorjan, Gremsl, & Schienle, 2019). In these

studies, significant numbers of subjects indicated that the placebo medication did have a therapeutic effect upon their medical condition (Moerman & Jonas, 2002). The rationale for the perceived effect of the placebo, in these cases has been linked to the prior expectations of the subjects to the information being given to them about the placebo's effectiveness (Zorjan, Gremsl, & Schienle, 2019). Our own perception of the world around us can be positively or negatively influenced by our personal bias. Those who may be opposed to NHS reforms may state that following their implementation, NHS services started to decline. For these people they may regard the NHS as failing. This introduces an additional element into the understanding of perception, scepticism. But the most commonly held view regarding perception is that seeing is believing, as visual perception is regarded as grounds for belief and knowledge (Audi, 2013). However, it should be remembered that despite two people observing the same thing they may perceive it to be totally different, as previously stated.

In this way, scholars have explored how success is perceived in business. For some, success is growing a business by looking for opportunities to create value; for others, it is just being able to survive in a competitive marketplace (Banerjee, 2013). While financial stability and growth are often cited as perceived measures of success others quote non-financial goals. These goals may include increased motivation and employee satisfaction as a measure (Reijonen & Komppula, 2007). This view of moving away from purely financial driven results is highlighted by some who state that achieving the organisation's goals is more desirable (Weber & Geneste, 2014). These perceptions of success, it could be argued, can be transferred to the chief executive of an NHS hospital. In their role they need to maintain financial stability, need to have an engaged and highly motivated workforce and need to meet the goals of the organisation. What is unclear is whether NHS chief executives perceive these items as measures of success.

One important element of leadership is the ability of the leader to engage with staff and create a positive relationship (Bragger *et al.* 2021). This ability of a leader to cultivate a strong

relationship between them and their subordinates is frequently perceived as leading to a more successful organisation (Marquis & Huston, 2012). There are those who believe that this perception is often incorrect as it is not grounded in reality (Dye, 2016). Citing a hospital chief executive who undertook weekly rounds to engage with staff and patients Dye (2016) describes how the chief executive's perception of success was the opposite of what the staff and patients perceived. Once again, this highlights how perception appears to be multidimensional depending upon your vantage point. In prior studies it has been suggested that nursing staff perceive success as maintaining and promoting health while at the same time protecting themselves and keeping on track (Duprez *et al.* 2020).

The perception of success may be influenced by an individual's beliefs about the degree of control they have over events in their lives. Termed locus of control (Rotter, 1966) an individual may perceive things that happen to them as being due to their own abilities, actions or mistakes. These individuals are said to have an internal locus of control while those who perceive things happening to them as being outside of their control including chance, the action of others or the environment are said to have an external locus of control (Galvin *et al.* 2018). In this way, people perceive events to be either within their control or beyond it. Chief executives of NHS trust hospitals may perceive that they have no control of external factors which impact upon their trust hospital. They have no control on the lifestyle and health choices that the public make, yet those choices have a direct impact on their hospital. In this scenario, chief executives may perceive success as unrealisable. Locus of control can be applied to all persons coming into contact with the NHS. Prior studies have found that patients perceive their ability to control their own health as variable (Rotter, 1966). Some patients strongly indicate an internal locus of control while others strongly indicate an external locus of control (ibid.). It has been observed that those patients who have a strong internal locus of control are more likely to do better following treatment (Rideout, Tolmie, & Lindsay, 2017). This leads us to question whether patients with internal locus of control perceive NHS success differently from those with external locus of control.

It appears that patients' perceptions of NHS success are not based upon hospital performance or league tables as they confuse patients (Wise, 2014). Scholars suggest that it is often the level of compassion shown to patients that determines the overall hospital experience (Vine, 2022). Yet there is no performance measurement for compassion within the NHS, if in fact, it is possible to measure. But are patients' perceptions of NHS success driven indirectly by hospital performance? The requirement to meet or exceed performance targets sees some medical professionals having limited time to deal with patients. It could be argued this challenges clinician to meet patient expectations in a limited time.

2.5 Performance a measurement of success

The use of performance measurement is seen in virtually all organisations (Group, 2004). Performance measurements have long been established as a method of monitoring and controlling organisations so they can be directed towards achieving specific goals or objectives (Nani *et al*. 1990). Performance measurement allows organisations to continuously check their output against desired objectives and compare their performance against other organisations or standards. Performance measurement is not isolated to just the organisation but encompasses the individual performance of those who manage, lead and work within it (Landy, Zedeck & Cleveland, 2017). In this way individuals are directed to achieving specific objectives which are combined to form part of the wider organisational goal.

The measurement of performance is relatively straightforward when counting units or time. Measuring performance becomes increasingly difficult when recording non-tangible items, such as feelings or emotions. This leads to disagreements and ambiguity when attempting to define performance. While defining performance Sink *et al.* (1984) conclude that it consists of seven dimensions, they are effectiveness, efficiency, quality, productivity, quality of work life, innovation and profitability.

The perceived measurement of success for patients has predominantly focused upon performance targets (Edwards *et al.* 1993; Propper, Burgess & Gossage 2008). The use of the four-hour accident and emergency waiting time for treatment is frequently quoted as one such performance measurement. Several time-based performance measurements were implemented following the publication of the NHS England document 'Five year forward view'. Scholars have indicated that the use of time-based performance targets, in the NHS, is sensible. This is due to the possibility that protracted waits for routine and planned medical treatment may have a negative impact on a patient's health and satisfaction of the NHS (Leiba *et al*. 2002; Conner-Spady *et al*. 2004; Huang *et al*. 2018). Other scholars argue that patients would measure performance and NHS success differently yet are seldom given the opportunity to do so (Footman *et al*. 2013). This view is echoed by Beaglety *et al.* (2019) who established that patient empowerment through their own experience is not a priority in most countries. It could be suggested that due to this NHS success appears to focus on time-based performance targets.

The use of performance targets has been implemented across most public services with a variety of consequences. One noticeable impact of using performance targets is the focus of managers to meet the required target at all costs. This may be at the cost of improving the overall success of the public service (Loveday, 2005). This was highlighted by Francis (2014) as a major cause of the failings in the Mid-Staffordshire NHS trust.

Since 2004 a key objective for all NHS trusts has been to gain Foundation trust status. This allows greater autonomy over finances, management, and a reduction in external governance. In essence NHS Foundation trusts can operate as independent not-for-profit public benefit corporations whilst remaining part of the NHS. To achieve this NHS trusts are required to demonstrate consistent improvements in performance measures (Verzulli *et al.* 2018). The overarching aim is that by having greater autonomy Foundation trusts could make enhanced

decisions on how best to provide care to their stakeholders. In turn this should drive improvements in quality of care and patient satisfaction.

It is argued that the only way to see how good healthcare is and improve upon it is by measuring performance (Institute of Medicine, 2006). This echoes the cliché 'what gets measured gets done'. Unfortunately, this statement makes no reference to how well performance is to be measured or how well something is done. Some have criticised the approach adopted by the NHS to performance measurements stating that data is often manipulated to achieve targets while poor performance which is unmeasured goes unchallenged (Bevan & Hood, 2006). The use of performance measurement is also challenged by scholars who conclude that there is little empirical evidence to suggest that NHS Foundation trusts who meet the highest performance standards deliver better patient care (Verzulli *et al.* 2018). There are those who criticise governments attempting to measure public sector performance, stating that the number of variables possible within each measurement makes the task virtually impossible to undertake and unreliable (Halachmi, 2005).

As previously described, there is an emphasis for clinicians to treat some patients as quickly as possible to meet NHS performance targets. Nowhere is this more evident than in accident and emergency departments with the four-hour treatment target. According to Stern (2005) it is the duty of medical professionals to always act in the best interests of the patient, this is what makes them professional. But are professionalism and performance in opposition within the NHS? What appears unclear is whether being directed to meet performance targets sees professionalism become devalued. It is suggested that this is the most prominent reason why doctors are leaving the NHS (GMC, 2021). This tension between professionalism, performance and success is not isolated to doctors, it is also seen in student nurses. Traynor and Buus (2016) identify that student nurses adopt professional idealism upon entering the

profession but becoming disillusioned after observing the realities of the system they work within.

A difficulty faced by the NHS is how it measures performance of ambiguous information. The provision of care is a very personal process which is viewed differently by individuals. Each individual has very different needs and expectations from the NHS. What is viewed as acceptable to one person may be viewed differently from another. It is this which the NHS struggles to measure effectively. For this reason, it is suggested that public sector organisations like the NHS concentrate on measuring performance of areas which can be clearly defined rather than those areas which are less tangible (Wankhade, 2011).

2.6 Leaders: 'the answer to NHS success?'

Above all other factors the quality of leadership has been cited as the determining factor between organisational success and organisational failure (Fielder & Chalmers, 1984; Nixon, Harrington & Parker, 2012).

The debate regarding the differences between management and leadership are numerous (Weathersby, 1996; Kotterman, 2006; Toor & Ofori, 2008), but most scholars agree that they are different. One view of differences between management and leadership is,

> "*The word 'manage' has its roots in Latin from the word 'manus' meaning 'hand' and can thus be equated more as a 'hands-on' or measurement-related concept. The origin of the words 'leading' and 'leadership' derive from the old German word 'lidan' (to go) and an old English word 'lithan' (to travel). In this sense, leadership means 'leading the way' through one's own actions*" (Brookes, 2011: p.179).

As with management, scholars have attempted to define leadership through a history of leadership theories. The predominant theme of early theories has been to explain why people

become leaders and identify their characteristics and behaviours. As a result, some theories have put forward differing rationales for what makes a successful leader or how to become one. It is felt by some scholars that individuals can visualise what leadership is but are unable to give a concise description of it when asked (Barker, 2001). Even if a singular description of leadership were agreed upon, it is suggested that leadership would continue to mean different things to different people (Northouse, 2016). It is suggested this is due to factors like organisational differences (ibid.). Given that leadership appears to be complex to define there is an argument that we do not need to agree on a definition of leadership, we simply need to understand each person's position so we can make sense of their claims (Grint, 2010).

With leadership being described as decisive in improving performance in the NHS (Shipton *et al.* 2008), a leader is liable to be judged according to whether they live up to expectations. But should we be attributing the collective success of an organisation like the NHS to just one person and their leadership abilities (Grint, 2010). This has caused some to ask, "*what types of leadership does the NHS need to prosper now and in the future?*" (McLellan, 2014: p.16).

With such a perceived weight of responsibility placed upon the senior managers of the NHS it is not surprising that several academics have studied the leadership qualities of NHS managers over the past 20 years (Flanagan & Spurgeon, 1996; Alimo-Metcalf & Alban-Metcalfe, 2001; Hamlin, 2002; Hardacre *et al.* 2010; McComb, 2013; McDonald, 2014; Martin *et al.* 2015). Even outside of the UK, scholars have explored the leadership styles of managers within their own healthcare systems. These studies have aimed to determine which styles of leadership produce results (Shipper, Pearson & Singer, 1998). Some have concluded that the delivery of high-quality care requires good medical leadership (Warren & Carnall, 2011). Others believe that leadership is observed to have less credence than technical or academic ability within healthcare (ibid.). This has been disputed by others who see that leadership is used as the predominant term of choice for policy makers within the NHS (Peck, 2006; Martin

& Learmonth, 2012). Some believe that the complexity of leadership is often ignored resulting in failures to define leadership clearly within NHS policy (Harley & Benington, 2010).

Naylor *et al.* (2015: p.6) state that literature is "*awash*" with differing definitions of leadership, yet there is a lack of understanding about leadership within the NHS (Edmonstone, 2013). Leadership in the NHS has been described as focusing on the development of the individual leader rather than on developing leadership (ibid.). This gives the impression that leadership only exists within the individual (ibid.). This focus on development fails to make any reference to the leader's role in organisational success. It is assuming that organisational success will follow as an effect of leadership. One of the issues when examining how the NHS developed its leaders, is that it concentrated on leadership competencies. This approach sees the NHS reduced leadership to a set of fragmented skills (Edmonstone, 2011). Several scholars have commented that leadership takes many forms and varies hugely according to task and context (Barr & Dowding, 2011; Hewison & Morrell, 2014). They argue that leadership cannot be measured against a rigid criteria or list (ibid.). Due to this complexity, it is necessary for the NHS to move to a broader system of leadership development which provides a wider range of leadership skills and considers organisational success.

While current leadership styles adopted by the NHS are inspired by conventional management and leadership theories (Towill 2008; Shapiro & Rashid 2011; Turner-Warwick 2011; The King's Fund 2011; Ham 2014; Coleman *et al.* 2015) there has been little research conducted into their use and organisational success, in the NHS. As a result of this it could be argued that finding a leadership style that is suitable for NHS leaders is difficult due to the lack of empirical evidence. According to Jones (2015), successful leaders have one thing in common, their ability to keep their teams engaged. In the work of Towill (2008); Shapiro and Rashid (2011); Turner-Warwick (2011); The King's Fund (2011); Ham (2014); Coleman *et al.* (2015), there does not appear to be a single clear description of what constitutes successful leadership within the NHS. A possible explanation for this is how academics have struggled to identity a

single definition of success. They have opted to use several differing definitions from prior research (Bennett & Langford, 1983; Hamlin, 1988; Flanagan & Spurgeon, 1996; Hamlin & Reidy, 1997).

When comparing the success of leaders in one NHS hospital against leaders in the British Civil Service, Hamlin (2002) discusses the notion of the 'universally effective manager'. This is someone able to be successful regardless of their organisation. The view of a manager able to move between private and public sectors, while remaining successful is not supported by Harrow and Willcocks (1990). Their argument is that public services require different managerial behaviours, by the nature of their differing contexts and pressures. In the same way, Flanagan and Spurgeon (1996) argue that a successful manager in one organisation may be viewed as less successful in another. This may be due to inconsistences in what constitutes success between organisations. Despite both pieces of research being somewhat dated the arguments in both can be transposed to managers today. According to Binney *et al.* (2012), the success of a leader has little to do with the qualities or abilities of the leader but rather the political, economic and cultural effects upon the organisation.

While the NHS continues to look towards existing management and leadership theories, through the work of the NHS leadership academy, it has been indicated that several leadership theories are outdated and do not fit with the modern NHS. For this reason, some feel that there is a need to design a leadership model specifically for the NHS (Storey & Holti, 2013).

It has been argued that any role involving management in the NHS comes with preconceived misconceptions of its true function (Clark, 2012). It is suggested that because of negative views of managers within the NHS, those clinicians who take on managerial roles do so only where that role can be seen to directly link to improving clinical care outcomes (ibid.). Some have argued that there is a need to remove the word management from the NHS vocabulary as it acts a barrier to clinicians wishing to progress (Martin & Learmonth, 2012).

The culture of the organisation is important in creating a common goal for workers to aim for. It is suggested that the leader has a vital part in creating the conditions for this to develop (Škerlavaj *et al*. 2007). Research has found that leaders who display positive behaviours cultivate a positive organisational culture, where workers are satisfied in their jobs and highly motivated (Tsai, 2011). This view is echoed by scholars who describe the feeling of belonging employees get from working in an organisation with a positive organisational culture (Denison & Mishra,1995; Scott-Findlay & Estabrooks, 2006). It has been noted that there have been numerous empirical studies that have sought to identify a positive relationship between organisational culture and organisational performance and success (Jacobs *et al*. 2013). While it is the perception of managers and leaders that a positive culture can increase organisational performance and success very few empirical studies have provided detailed insight into the relationship (Gregory *et al.* 2009).

While researching organisational culture the phrase to 'build a culture' is frequently seen in literature (Beswick *et al.* 2016; Tan *et al.* 2019). This, it could be argued, is a controversial statement as it assumes that cultures can be built. Cultures are naturally occurring phenomena which emerge over time, so how much control does a leader have on their organisations culture? It has been stated that corporate culture is a critical part of organisational success (Barney, 1986) with leadership viewed as a driving force in recognising this importance (Ionescu, 2014). Kennedy (2001) was highly critical of the inability of leadership at the Bristol Royal Infirmary to foster an organisational culture safe for patients and suitable for clinical staff to work effectively. Identifying a negative workplace culture based on fear, bullying, disengagement of managers to lead, low staff morale, the lack of openness and acceptance of poor behaviours, Kennedy (2001) commented it resulted in avoidable deaths. During the inquiry into deaths at Mid-Staffordshire Foundation trust Francis (2013) found the same issues with organisational culture as found by Kennedy (2001). It has been stated that following the inquiry into Bristol Royal Infirmary nothing has changed within the NHS and lessons have not been learnt, resulting in more avoidable deaths

(Newdick & Danbury, 2015). This systematic failure of the NHS to protect vulnerable people in its care is the result of cultural dysfunction. This is identified by a lack of openness and ability to speak freely (Pope, 2019). This inability of staff to speak freely when they know that things are drastically wrong has also been described as organisational silence (Morrison & Milliken, 2000). In this situation it is suggested that NHS leaders fear and reject negative feedback and tend to respond by making centralised decisions (Pope, 2019). This results in a lack of value being felt by their employees, decreased trust in the leadership, demotivation, and reduced job satisfaction. Within the NHS there appears to be a denial that negative behaviour exists in the organisation and a strong reluctance to label or class any adverse behaviours of managers as bullying (Pope & Burnes, 2013). It is argued that given confusion over the term bullying, often employees view a single episode of disagreement or altercation with a manager as bullying rather than high levels of conflict (Jenkins, 2013). Despite confusion over whether a leader's behaviour is seen as bullying or not the result is the same. There is a detrimental effect on employees which results in decreased effective functioning of the organization and its success (Naseer *et al*. 2018).

2.7 Leaders need followers

Kelly (1988) suggests that there exists a common misconception that organisations succeed or fail depending on how well led they are. Consequently, we typically spend time studying old and new leaders and their leadership in the hope of finding the recipe for organisational success. Yet according to Meindl (1995: p.331) "*Leadership cannot and does not occur without followers*", while others describe being a leader as someone who has followers and without them there can be no leadership (Drucker, 1996).

One description of a follower is someone who pursues a course of action in common with a leader to achieve an organizational goal (Kelly, 1988). It could be argued that the common

goal for the NHS is to care for people, yet it is unclear if leaders and followers consider this to be the organisational goal by which they are measured.

Until recently the vast body of literature on leadership has ignored followers (Kelly, 1988; Uhl-Bien *et al*. 2014; Ford & Harding, 2018). Those studies that have examined the relationship between leaders and followers see followers as passive, helpless, conforming individuals showing little or an absence of drive until persuaded to act by their leader (Uhl-Bien & Pillai, 2007). Kean *et al.* (2011) indicate that it is naïve of leaders to consider followers as homogeneous groups who simply follow the directions of the leader. This approach fails to consider the impact that followers have on the success (or failure) of the leadership process and ultimately on an organization's ability to achieve goals. In the NHS it is suggested that senior managers fail to acknowledge this in their junior colleagues (Kean & Haycock-Stuart, 2011). This relationship between colleagues is essential as leaders alone do not have enough information to solve complex organisational problems (Grint, 2010; Pietraszewski, 2019). One approach is where the leader describes the issues to their followers, while also offering possible solutions. By seeking the cooperation of their followers, a consensus is formed which benefits all. For this to work effectively the process must result in a net benefit which appears balanced to both leader and follower (Price & Van Vugt, 2014; Glowacki & von Rueden, 2015). Chaleff (2009) argues that many organisational failures could have been prevented if followers had been able to communicate better to their leaders. This highlights that leadership/followership is a two-way process which requires effective and active channels of communication to prevent failure. Many of the NHS inquiries into failures in care at NHS hospitals have highlighted the lack of communication between leader and followers within their findings (Francis, 2013).

While examining the concept of followership, scholars have explored why followers 'follow'. For some, the act of followership is as a result of wanting clear direction (Burns, 2010) or

security (Lapierre & Carsten, 2014; Mayseless & Popper, 2019), while others see this as a need for a parental type of figure (Freud, 1939).

To get the best from their followers it is suggested that leaders utilise psychometric testing, like the Myers-Briggs test, to ascertain the personality types of their followers (Hetland, Sandal & Johnsen, 2008; Kumar, 2013). In doing so leaders can tailor their leadership to suit their followers. Other scholars believe that followers can be categorised, depending on their engagement, into 'isolate', 'bystander', 'participant', 'activist' and 'diehard' (Kellerman, 2008) or 'passive', 'alienated', 'conformist', 'exemplary', and 'pragmatist' (Kelly, 1988). Due to the differing labels given to follower types by different scholars, is it safe to suggest that using psychometric testing to identify followers is reliable or valid? I would argue that the use of Myers-Briggs tests places followers into one of sixteen categories, in the same way that trait leadership theory implies that leaders can be identified through traits. Similarly, every person on the planet can be categorised into one of twelve astrological star signs. I would disagree that individuals share the same predefined characteristics as set out in Myers-Briggs tests. At the same time, it is difficult for a leader to adjust their approach to leadership to meet the best match for their followers, while remaining authentic. The approach of conducting psychometric testing focuses on the leader and their ability to alter their leadership. This concentration on the leader again shows how we appear fixated with leadership as the source of organisational success rather than followers (Kelly, 1988). The apparent obsession with leadership as the answer to organisational success fails to acknowledge that followers contribute an average of 80% to the success of their organisation (Koonce *et al*. 2016). Followers are, it is suggested, often the most creative part of an organisation and most able to produce success in line with the organisation's goals (Cooper, 2003). This leader-centric approach to leadership research has recently been moving away to focus on followership. Rather than exploring which leadership style is most effective research is attempting to establish why people follow leaders (Popper & Castelnovo, 2019). Followership research has been conducted in organisations such as the military, team sports, religion, and politics (Canter, 2006). While these studies

have sought to establish how leadership can increase followership success it should be remembered that follower performance can also be adversely affected by the actions of the leader (Hotchkiss, 2017). Research has indicated that frequently leaders are so concerned with the pursuit of positive outcomes, like financial gains and increased productivity, they often adopt approaches to leadership which neglect the follower (Mesdaghinia, Rawat & Nadavulakere, 2019). Scholars have argued that the ability to improve a follower's performance relies on the leader persuading them to change on the emotional grounds of utility, identity, and values (Valikangas & Okumura, 1997). This is of interest to the NHS where there appears to be an acceptance of unity and values by those with professional identities, such as doctors and nurses (Mazhindu *et al.* 2016). So, what type of leader do followers wish to follow?

It has been suggested that followers are drawn to those leaders who act decisively, regardless of if they make the right or wrong decision (Riggio *et al*. 2008). This is echoed by Grint (2010) who describes how co-pilots have followed the instructions of their captains despite knowing the action would lead to their aircraft crashing. This leads us to question if followers in the NHS are unwilling or do not feel able to highlight possible mistakes when given instructions by their superiors. The ability to question or challenge the leader's decision is explored by Chaleff (2009) who indicates that the 'courageous follower' must, at times actively oppose their leader. This is reported as increasingly challenging in large organisations, such as the NHS, where followers do not have direct relationships with the senior leaders (ibid.). In these situations, good followers are expected to trust, follow, and rely on the leader while following their ideas (Salas-Vallina, 2020). This ability to place trust in the leader is often referred to as a sign of commitment (Cooper, 2003). This is not to be confused with followers who simply conform and are compliant (Ogbonna & Wilkinson, 1990). To ensure that followers are fully committed and able to become exceptional followers some have attempted to provide guidance on how employees should approach their work (Mellinger, 2012). These include not blaming the boss for unpopular decisions or only disagreeing with the boss in private to avoid embarrassment

(ibid.). These statements continue to place the leader at the centre of the organisation by preventing them being publicly undermined to the workforce. It may be questionable if these statements demonstrate commitment or subservient behaviours. For some scholars the presence in followers of commitment is an essential precursor to high performance and success in organisations (Walton, 1991). While others highlight that commitment is reliant upon employee satisfaction and motivation (Cooper, 2003). While the chief executive of an NHS hospital is the prescribed leader it should be remembered that they are also a follower of leaders in NHS England and vicariously the government. This leads us to ask in what context do NHS leaders view themselves, as leaders, as followers or both?

2.8 NHS failure, learning from mistakes?

Since its creation, the NHS has experienced numerous structural reforms. The primary aim of these reforms has been to redistribute healthcare services, across the country to ensure greater efficiency and universal availability to those in need (Talbot-Smith & Pollock, 2009). Most reforms have been preceded by a reporting committee putting forward recommendations, leading to Acts of Parliament (NHS Primary Care Act, 1997; Health and Social Care Act, 2012). Several reforms have followed public inquiries and reports into failures of the NHS (Francis, 2013). The NHS has experienced several high-profile inquiries since 1967, predominantly resulting from failures in care (Walshe, 2003b). These retrospective investigations look to establish what went wrong, why it happened and how the NHS can make sure it does not happen again. Prominent inquiries have included the Allitt inquiry in 1992, the Royal Liverpool Children's Hospital (Alder Hey) inquiry in 2000, the Bristol Royal infirmary inquiry in 2001, and the Shipman inquiry in 2001.

To explore success in the NHS we must examine what constitutes failure. Failure can be defined as a "*lack of success*" (Concise Oxford English Dictionary, 2011: p.511) and traces its etymology to the 1640s and the Anglo-French word "*failer*", "*a failing, deficiency*" (etymology

dictionary, 2021). The association with the word deficiency is interesting as this implies a "*lack or a shortage*" (Concise Oxford English dictionary, 2011: p.376). If an NHS trust hospital experiences a shortage of available beds to admit patients, would it be correct to assume the hospital is failing? It could be argued that the wider NHS may have capacity across all its hospital sites to accommodate all patients just not at one hospital. Would it be unfair to suggest that the NHS is failing if this were the case? Some advance the argument that having fewer hospital beds does not necessarily result in poorer care or treatment outcomes (Easton, 2006). It can be argued that having more beds allows patients to remain in hospital longer when they can and should leave. Some even go so far to argue that the NHS has too many beds (Davies, 2006), and creates an over reliance in their use when alternative treatments are available. In this situation there is a conflict between what constitutes failure.

There are alternative arguments put forward that suggest the lack of available hospital beds are not the fault of the NHS but are a failure of social care. With changes to social care there now appears to be a lack of facilities for patients to be discharged to following treatment. This predominantly effects the elderly who cannot return home due to requiring further convalescence (Moore, 2007; Jasinarachchi *et al.* 2009). It is argued that this is not a new phenomenon with its identification being noted several years ago (Neill & Williams, 1992). This inability to discharge patients is termed 'bed blocking' and sees a patient who no longer requires the services of the hospital occupying a potential empty bed, thus preventing the admission of a sick patient for treatment. The net result is that patients often find that their planned admission for planned surgery is cancelled. This increases the waiting lists for operations which is often cited as a hospital failing. Bed blocking also prevents seriously ill patients who are treated in the accident and emergency department being admitted to a ward promptly (Gaughan, Gravelle & Siciliani, 2017). This results in queues forming for treatment within the accident department and breaches of the four-hour treatment target. This again is often used as an indicator of success or failure for an NHS Hospital.

Like business the inability to maintain finances has been cited as a source of failure within the NHS with administrators able to take over the management of failing NHS trusts (Kmietowicz, 2014). Even where privately financed companies have ventured into the running of NHS hospitals, they have found that maintaining solid finances are difficult, with some stating that there is no money to be made by running a hospital (Limb, 2015b). This has forced many in the NHS to look for quick fixes to maintain financial stability and prevent perceived failure (Kmietowicz, 2014). This move, it is argued, does little to tackle the real issue of poor accountancy within the NHS, rather it tackles just one small part of a far greater problem (Murray, Imison, & Jabbal, 2014). Despite this the NHS continues to view poor financial accountancy within NHS trusts as a serious concern and looks for simple solutions to resolve financial difficulties.

Some scholars believe that the cause of several failures within the NHS are due to poor leadership, both at national and local levels (Badrinath, Currell, & Bradley, 2006). Some suggest that poor local leadership within the NHS produces the conditions for toxic cultures to develop and systemic failures to emerge (Goodwin, 2019). Others suggest that poor local NHS leadership has resulted in failed patient care and subsequent public inquiries (Ham, 2008; Smyth, 2014). But there are some who suggest that failures of care should not reach the point where a public inquiry is required as it is the duty of clinicians to deliver the highest level of care available while feeling empowered to report possible concerns to their NHS leaders (Newdick & Danbury, 2015). The question is whether clinical staff do feel able to report concerns to their managers without fear of reprisal or victimisation. It is also unknown if they feel their concerns will be taken seriously. It has been stated that leaders across the NHS must take all reports of clinical concerns seriously as not to may result in costly negligence claims (Yau *et al.* 2020).

Not everyone places failures in financial control and patient care at the door of local NHS leadership. Some have suggested that NHS failure is the fault of consecutive governments

and their almost continual reforms and restructuring of the NHS (O'Dowd, 2010). While governments have stated that NHS reforms ensure patients receive better care commentators have noted that their implementation often comes with little additional financial commitment or clear lines of accountability for their completion (Kmietowicz, 2010). It has also been suggested that several reforms have been ill timed, with some taking place as significant public inquiries into system failings are ongoing. This leads some to question if these reforms are fit for purpose and able to resolve systemic failures (ibid.). There are also those who feel that government policy makers have been unable to justify the rationale for large scale NHS reforms. Some scholars believe this has left NHS leaders without a sense of purpose (Limb, 2011). Many leaders have therefore become uncertain about how NHS reforms should be implemented and what their overall objective is. An area of concern for some is how NHS reforms are evaluated to ensure they are not a failure; however, governments are reluctant to produce robust evaluations to verify each reform (Vittal Katikireddi *et al.* 2014). Without any evaluation process, the success or failure of each reform is difficult to determine.

2.9 Comparisons of universal healthcare success

While the NHS is free at point of delivery, its provision is of course only possible through taxation. Comparable systems exist in 115 other countries. Defined as universal healthcare systems those countries which offer free healthcare at point of delivery are listed in Appendix 9. Typically, these countries follow one of four models of healthcare (Reid, 2010). The commonality of each system is the aim to provide healthcare which is free at delivery regardless of how the funding of each is achieved. Only those countries which adopt one of these healthcare systems have been included in this section. Countries, such as the United States of America (USA) which see provision of healthcare being separated into several differing systems for separate classes of people have been excluded from this section.

In order to compare the NHS in the UK with other universal healthcare systems, it is important to firstly examine those systems which serve a similar population size. In 2020, the UK recorded a total population of 67,215,290. Of those countries listed in Appendix 9, France (67,391,580) and Italy (59,554,020) have populations closest to the UK (The World Bank, 2021a). Having established the countries which closely match the UK for population it is worth examining the amount of money spent by each country on their universal healthcare system. Most figures relating to government expenditure are expressed in percentage of Gross Domestic Product (GDP), therefore each country's GDP must be obtained. The GDP for each country is collated by the International Monetary Fund (IMF) and can be compared year on year. The data for the counties of France, Italy and the United Kingdom is presented in Chart 1.

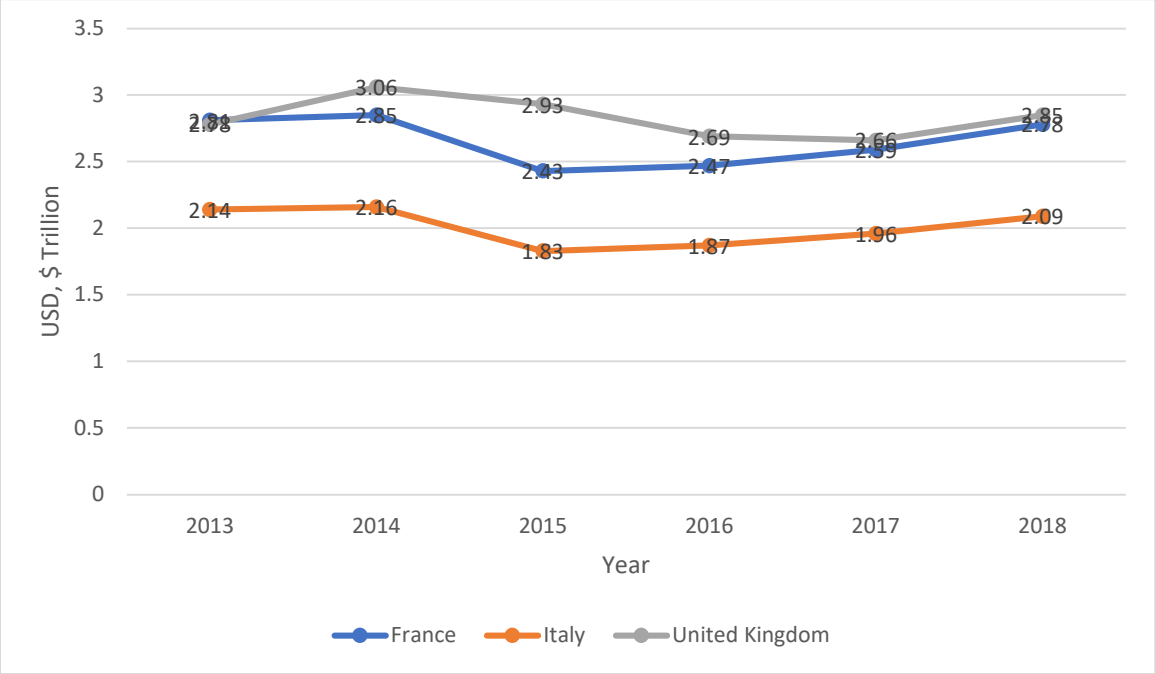

Chart 1. Annual Gross Domestic Product per year 2013-2018(GDP) per country in US Dollar (USD, $ Trillion) (IMF, 2021)

While current data is difficult to collate relating to global and individual country healthcare expenditure, in 2018, global spending on health reached US$ 8.3 trillion. This equates to 10% of global GDP. 2018 was the first year in the past five years that health spending grew slower than GDP (WHO, 2020b). Prior to the COVID-19 pandemic global spending on healthcare was recorded as rising year on year. Each of the countries identified as having universal healthcare

systems serving a population closest to the UK all spent differing amounts of their annual GDP on healthcare. The percentage of annual GDP spent by each country on their universal healthcare system is shown in Table 2 and as a monetary value per capita in Chart 2.

Country	2013	2014	2015	2016	2017	2018
France	11%	12%	11%	12%	11%	11%
Italy	9%	9%	9%	9%	9%	9%
United Kingdom	10%	10%	10%	10%	10%	10%

Table 2. Current Health Expenditure (CHE) as % Gross Domestic Product per year 2013-2018(GDP) (WHO, 2021)

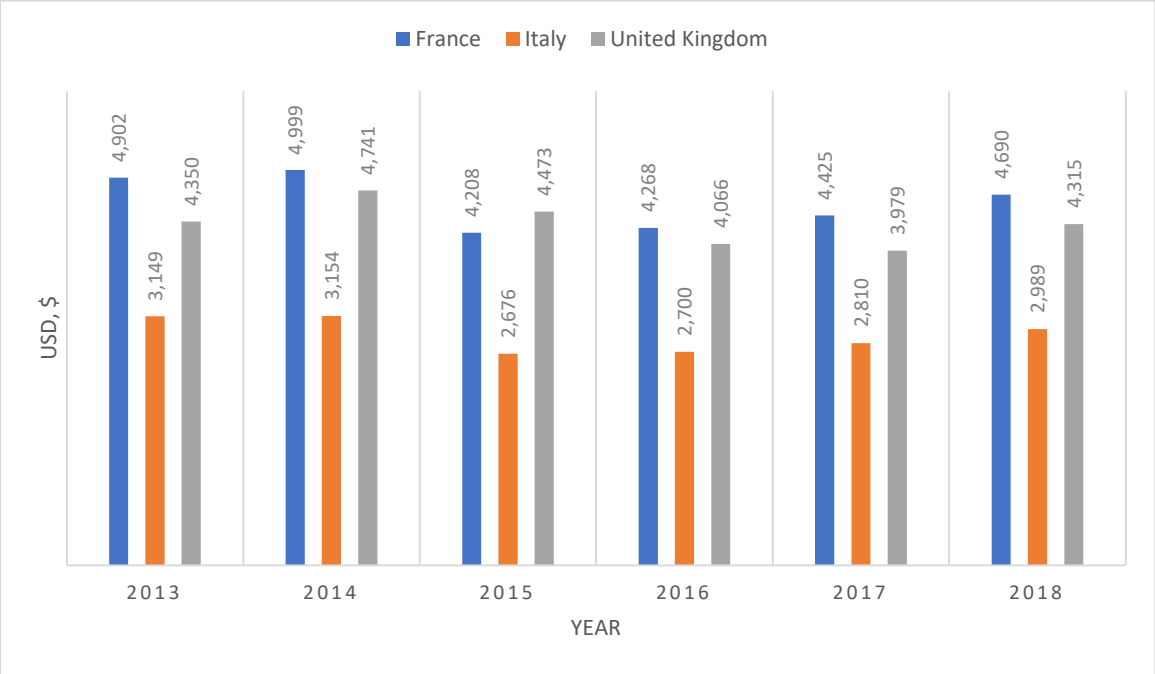

Chart 2. Current Health Expenditure (CHE) per capita in US Dollar (USD, $) (The World Bank, 2021b)

This data comparison shows that both the UK and France generate similar figures for GDP and spend similar percentages of their GDP on universal healthcare. It also shows that Italy, with a smaller population, generates a lower GDP and spends less of its GDP on its universal healthcare. These figures alone do not provide additional data to suggest that one country's healthcare system is more successful than another. It could be argued that the amount a government spends on its healthcare system is an indicator of the value it places upon caring

for its population. What is unclear is whether the amount spent on healthcare equate to improvements in care or the health of the population.

One measurement of healthcare and the health of a nation is through the examination of data which indicates the number and cause of deaths in a country's population. While the possible causes of death vary considerably when comparing developed and developing countries, the differences seen within the same region or continent share similar properties. These figures are collated by the Central Intelligence Agency (CIA) for all countries, so are available for examination and comparison. The top ten causes of death for the UK have been compared with those of France and Italy and presented in Table 3.

Condition	United Kingdom		France		Italy	
	Ranked	Deaths	Ranked	Deaths	Ranked	Deaths
Alzheimer's and Dementia	1	82,461	2	49,553	3	35,443
Coronary Heart Disease	2	76,365	1	61,854	1	112,229
Stroke	3	38,649	4	33,843	2	62,229
Influenza and Pneumonia	4	37,494	7	17,851	10	14,149
Lung Disease	5	37,384	6	20,365	5	31,191
Lung Cancer	6	36,549	3	34,013	4	34,188
Colon-Rectum Cancers	7	18,798	5	20,706	7	21,326
Breast Cancer	8	13,274	8	14,434	11	13,828
Prostate Cancer	9	12,987	13	10,384	19	8,290
Lymphomas	10	9,393	14	9,405	16	9,812

Table 3. Causes of death and ranking by country (CIA, 2021)

From this data it is notable that the UK has the highest mortality rate for Alzheimer's and dementia when compared to both France and Italy. It also has a higher mortality rate for coronary heart disease and stroke than France. However, Italy has a higher mortality rate for coronary heart disease and strokes than both the UK and France.

The UK government pledged in 2015 to become, by 2020, the best country in the world for dementia care (Department of Health, 2015). However, there appears to be no tangible performance measurements or targets for the NHS to demonstrate how this has been (if indeed it has) implemented or affirmed. It could be argued that the lack of a method of measuring this prevents the UK government from directing the NHS to achieve this pledge. Without direction from government the NHS is unable to demonstrate if it has been successful in increasing its care to those with dementia. The French government undertook similar commitments to the care of its citizens with dementia, producing in 2014 the Plan Maladies Neurodégénétives (Neurodegenerative Diseases Plan) and committing a budget of EUR 1.6 billion to its implementation. It is also noted that France, like the UK, has no performance standards to demonstrate how they would measure the success of their dementia care program.

Patients with cancer can expect referral to an NHS specialist within 14 days while patients with Alzheimer's have no specified time for referral. The NHS Constitution does set out that all patients should wait no longer than 18 weeks from GP referral to treatment (Department of Health and Social Care, 2021). It is suggested that this time varies from between one week and twenty-one weeks (Royal College of Psychiatrists, 2013). When compared to patients in France the wait for first appointment with a consultant specialist is much longer in the UK (Papanicolas *et al.* 2019). It could be argued that this irregularity in referral time demonstrates a failure in the NHS to recognise the leading cause of death in the UK. While it may not appear to make much difference in terms of treatment for patients suffering from Alzheimer's or dementia, as there is no cure, what is important is allowing patients to make informed choices about their care while they have capacity. The ability to have capacity does diminish over time so it is beneficial for patients to receive a specialist consultation as soon as possible. This brings into question whether the NHS fails to place dementia patients, and their relatives needs at the forefront of care provision.

Once diagnosed by a specialist in dementia care, patients in the UK can receive medication approved by the National Institute for Health and Care Excellence (NICE) to help with their condition. The same is not true in France where in 2018 the French government declared that it would no longer pay for patients to receive some types of dementia medications, due to doubts over their effectiveness (Walsh, King & Brayne, 2019). In the UK, NICE took the stance to fully support the continued use of dementia medications through the NHS prescription service, despite questions about effectiveness. This is seen as an area of success for people with dementia treated by the NHS when compared to those treated by the French healthcare system.

The most significant area of difference in the treatment and care for those suffering from Alzheimer's or dementia is the use of multiple treatment pathways. In France clinicians can call on multiple agencies, both within its health service and within its social care systems to offer the most appropriate help and support to patients and their careers (Cantegreil-Kallen *et al.* 2006). Choice of healthcare provision is not isolated to state run hospitals but due to its funding patients can opt to be seen in private hospitals at no extra cost. This raises the question of whether the French healthcare system is less successful than the NHS as patients may opt to go to private hospitals due to the lack of available care at their state-run hospital. Conversely is the French healthcare system successful in offering patients the opportunity to receive quicker care at private facilities?

While researching the performance measurements adopted by the French government and their healthcare system it becomes apparent that there are very few. Exceptions include figures relating to averting deaths from a range of curable cancers, pneumonia, ischemic heart disease, maternal deaths in childbirth, and a host of other causes of mortality considered to be "*amenable to health care interventions*" (Rodwin, 2018: p.49). Other universal healthcare systems adopt different performance measurements to indicate how successfully they provide care to their populations. As has been seen the NHS adopts various time measurements as

key performance indicators while Canada focuses on the use of metrics, health indicators and health system performance indicators. These can be divided as shown in Table 4.

Measure type	Description	Examples
Metric	Information that is quantifiable and is reported as a number. Has value and many uses but cannot be compared.	• Total Health Expenditures • Inpatient Hospitalizations for Medical Assistance in Dying • Number of Emergency Department Visits Due to Opioid Poisoning
Health indicator	Puts metrics into some kind of context, usually using a ratio (per X) and is designed to ensure comparability (e.g., by being risk-adjusted or standardized). Directionality may or may not exist.	• Cost of a Standard Hospital Stay • Cardiac Revascularization Rate • Proportion of Physicians in Rural Areas
Health system performance indicator	A health indicator that has a desired direction (e.g., lower is better).	• 30-Day Surgical Readmission Rate • Percentage of Residents in Daily Physical Restraints • Hospitalizations Entirely Attributable to Alcohol

Table 4. Canadian health indicators (CIHI, 2021)

A significant difference in the Canadian healthcare model, compared to the NHS is the lack of time measurements used in assessing system performance. Instead, the use of data relating to specific types of illness or injury are adopted. A major focus of the Canadian healthcare system is its emphasis on the reasons for admission and the care patients receive while an inpatient. This movement away from time measurement places the patient at the centre of care provision. Performance indicators include the number of patients with repeat hospitalisations for mental illness, 30-day acute myocardial infarction (AMI or heart attack) in-hospital mortality and hospitalised hip fracture events. Since 2003 the Canadian Institute for Health Information (CIHI) has championed the use of patient centred performance measurements as a benchmark for the success of the Canadian healthcare system. It has advocated for measuring performance that improves the patient experience of care, improves the health of the Canadian population while also helping to reduce the per capita cost of health care (CIHI, 2017). This is in opposition to those performance measures adopted by the NHS, which focus on time periods to treatment rather than outcomes. The Canadian Institute for

Health Information makes it very clear that on their own, performance data is of little value, it requires health system decision-makers, managers and analysts to have the skills, competencies and abilities to use performance management data to improve the populations' health (CIHI, 2014). In the UK data analytics are primarily used by the NHS to create dashboards for benchmarking against the key performance measures set out by the government. The same is true of chief executives in the NHS who appear to focus their analytics on data which explains why their trust has or has not met the required performance targets.

In Canada, to assist in the data collation process, a decision was made to create a system-wide repository of health system performance indicators that standardised indicator definitions and methodologies, helping to prevent '*indicator chaos'* (CIHI, 2014: p.14). The term *'indicator chaos'* has been used to define the general disorganisation and uncoordinated way in which many healthcare systems generate and collect performance indicators without any consistency. The net result has been a sense of confusion seen by stakeholders when attempting to interpret the data (CIHI, 2014). This confusion has been seen within the UK with patients unable to understand ratings of NHS services, including General Practitioners and hospitals (Wise, 2014).

While the Canadian Institute for Health Information states that Canadian healthcare focuses on the patient, research has determined that patient satisfaction is low (The Commonwealth Fund, 2017b) with an average satisfaction rating of 76 percent. This places the Canadian healthcare system eleventh behind the healthcare systems of Australia, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom (ibid.). Reasons for this low satisfaction rating included three out of five Canadians waiting longer than four weeks to see a specialist. Eleven percent of Canadians stated they received conflicting information from different health providers and twenty five percent of patients stating they were unable to have someone review their medication (ibid.). One possible reason

for the delay in receiving treatment may be due to the increasing number of Canadians now living in remote rural areas. In 2017 this figure was 6,815,698, a 0.94% increase from 2016, while in 2020 this figure grew to 7,007,406, a 0.66% increase from 2019 (Macrotrends, 2021).

Further research has ranked the Canadian health system tenth (Schneider *et al*. 2021). The country with the top-ranked healthcare system was determined to be Norway with high scores in accessibility to care, administrative efficiency and healthcare outcomes. However, Norway's healthcare system was ranked eight for its care processes, below that of Canada, Australia, the Netherlands, New Zealand, Switzerland and the UK (ibid.). This continues to highlight the difficulty in determining a universal matrix for measuring success for healthcare systems.

According to Fineberg (2012) successful healthcare systems contain three attributes:

- healthy people, a healthy population served by the healthcare system
- superior care, which is effective, safe, timely, patient-centred, equitable, and efficient
- fairness, treatment is applied without discrimination to its population.

These differ from those stated by Schneider *et al*. (2021) who indicate that top performing healthcare systems:

- provide universal coverage and removed cost barriers
- invest in primary care systems to ensure that high-value services are equitably available in all communities to all people
- reduce administrative burdens that divert time, efforts, and spending from health improvement efforts
- invest in social services, especially for children and working-age adults.

With Norway's healthcare system being rated as one of the most successful in the developed world (Schneider *et al*. 2021), it is important to explore its inner workings to contrast it with the

NHS. It is also worth investigating how it compares to the descriptions of successful and high performing healthcare systems as described by Fineberg (2012) and Schneider *et al*. (2021).

Norway's expenditure on healthcare in 2018 equated to 10.05 percent of its GDP ($8,239 *USD,* per capita) compared to the UK spending 10 percent GDP ($4,315) (The World Bank, 2021b). Like the NHS the Norwegian health system provides universal coverage to its population through general taxation and employee payroll contributions into the National Insurance Scheme (NIS), or Folketrygd. The notion of a Norwegian universal healthcare system dates back to 1900 with the Act of Health Insurance coming into force in 1909 (Tikkanen *et al.* 2020). It was not until 1956 that all Norwegian citizens had access to universal healthcare, eight years after the creation of the NHS. Initially the Norwegian healthcare system and the NHS appear to be very similar in design and structure, even with Norway opting for Regional Health Authorities (RHA), a structure removed from the NHS in 1982. A significant difference in the two care systems is that Norwegian citizens are made to make co-payments to access some elements of their care. A visit to a primary care centre (hospital or doctor) is charged at 155 to 334 Norwegian krone (NOK) equivalent of 19 to 41 USD. This payment is capped at 2,258 NOK (281 USD) per person. Where specialist treatment or specialist consultation is required, it is charged at 245 to 370 NOK (30 to 46 USD). This is also capped for individuals at 2,025 NOK (199 USD) (Tikkanen *et al.* 2020). The combination of GDP spend and service user co-payments results in a vastly increased expenditure by Norway on its healthcare system. Like the NHS, Norwegian citizens are expected to pay for prescription medicines and eyeglasses, while hospital inpatient stays are covered under the National Insurance Scheme. The thought of citizens in the UK paying for their in-hospital treatment, as they do in Norway is considered unpalatable (White, 2015). This is reflected in the NHS being ranked first on affordability of its citizens to access care (Schneider *et al*. 2021).

Increasingly, the views of service users are being utilised to measure a healthcare system performance and perceived success (Footman *et al.* 2013). In a recent global survey of service users, when asked to rate the quality of healthcare they and their family have access to in their country, Norway did not rate in the top five countries (IPSOS, 2020). Those categorised as top-rated healthcare countries included Australia (81% very good/good), Netherlands (76% very good/good), Great Britain (74% very good/good), Saudi Arabia (73% very good/good) and Canada (72% very good/good) (ibid.). A difficulty with interpreting this data is that it does not represent patient satisfaction rather the perceived quality of care service users believe they have access to in their country. In reality, the expectations of services users may be different to those they experience. This is observed in the satisfaction figures presented by The Commonwealth Fund (2017b) who state that patient satisfaction in the Canadian healthcare system is low. The patient experience is focused on what actually happens during their medical intervention whereas patient satisfaction focuses on whether a patient's expectations of the care they receive are met. Research conducted in 2019 showed that the countries of Saudi Arabia, Singapore, Belgium, United Kingdom and China recorded the highest level of service user satisfaction in their country's healthcare system (Statista, 2019). Despite featuring in the top five countries for healthcare satisfaction the NHS saw just over fifty percent (53%) of service users stating that they were very or fairly satisfied with the healthcare they received. The remaining service users stated that they were neither satisfied or dissatisfied (24%), not very or not at all satisfied with the service they received (ibid.).

Scholars have examined those factors which affect health service user's perceptions of satisfaction and have determined that the length of time to receive treatment can adversely affect patient satisfaction levels (Leiba *et al*. 2002; Conner-Spady *et al*. 2004; Huang *et al*. 2018). It is suggested this may be one reason why those who can afford to, choose to seek private treatment. Private healthcare can offer treatment for elective procedures sooner than a country's public health service (Conner-Spady *et al*. 2004). Alternative studies examining the satisfaction levels felt by parents of children who received healthcare found that the most

prominent factor was they want to experience a cheerful and collaborative medical team caring for their child (Davis *et al.* 2017). This view is reflected by Vine (2022) who observes that the non-clinical aspects of care are what patients value the most. A similar study conducted in intensive care units examined the level of satisfaction relatives felt for the healthcare their loved ones received. It reported that the driver of satisfaction for relatives was staff competency and the overall quality of care their relative appeared to receive (Sarode *et al.* 2015). This raises the question of why the NHS does not have any performance measurements relating to how well patients and their loved ones felt care was delivered. It may be argued that the delivery of good care in the NHS is simply assumed or because it is perceived to be free at point of delivery it is never examined or measured. One area where prolonged waiting times resulted in increased dissatisfaction in healthcare was in the diagnosis and management of malignant melanoma (skin cancers). Combined with extended waiting times patients recorded lower levels of dissatisfaction if their initial treatment was conducted by a specialist dermatologist rather than a General Practitioner (Sheth *et al.* 2010).

Studies conducted by the Organisation for Economic Co-operation and Development (OECD) have determined that not every country considers waiting times for treatment a priority (OECD, 2020). While many countries consider some elements of waiting times for treatment within their healthcare system a problem, Japanese authorities state that they have no problems of waiting in general or disease specific areas of diagnosis and treatment. This contrasts with the authorities of Canada, Latvia, Lithuania, Mexico and Poland who consider waiting times a significant issue in all areas of patient care. The NHS shows waiting times for elective treatment, diagnostic tests, treatment in hospital emergency departments and the diagnosis and treatment of cancer as significant issues. Conversely the NHS does not believe that waiting times for primary and specialist care, mental health and cardiac care are of issue (OECD, 2020). With Japanese authorities stating that they had no issues with waiting times for any of their healthcare services, it is noted that satisfaction in the service is amongst the lowest internationally (Masako & Bing, 2019). This low satisfaction rating comes despite of

Japan reorganising cancer care delivery to improve service user efficiency (Schneider *et al*. 2021).

The primary cause of extended waiting times appears to stem from demand for healthcare services being greater than supply. The underlying reason for a lack of supply may be due to issues with capacity constraints (lack of clinicians, beds, hospitals) or inefficiencies in referral pathways and healthcare delivery. This results in patients being forced to wait or queue for treatments. For the service user they may experience a number of waits along their care pathway, as was suggested in the delay in referral to treatment for dementia care. This may include, in the wider healthcare setting delays in obtaining an initial doctor appointment, delays in being referred for tests or specialist consultation, delays in receiving an appointment for consultation, requests for further tests, delays in diagnosis and finally waiting for an appointment for elective treatment (OECD, 2020). Each wait can compound the perception of prolonged waiting and reduce the patient's satisfaction in the healthcare system.

Service users across the world have predominately seen an increase in the time they are waiting for appointments to see healthcare specialists. This is echoed in most countries with few exceptions, as can be seen in Table 5.

Country	2010	2013	2016
UK	28%	17%	23%
Switzerland	17%	17%	23%
Netherlands	30%	19%	25%
Australia	46%	45%	39%
New Zealand	39%	41%	48%
Sweden	50%	48%	52%
Norway	49%	55%	61%
Canada	58%	61%	61%

Table 5. The share of people waiting one month or more for a specialist appointment (OECD, 2020)

Australia, while still showing a high percentile of people waiting for specialist appointments, has shown a reduction in waiting times for treatment over the three-year period measured. This appeared to be one of the few healthcare systems which saw a decrease in waiting times. Research has shown that despite this just short of twenty three percent (22.7%) of the Australian population felt they had to wait longer than acceptable for a specialist medical appointment (ABS, 2021).

Like the NHS, the Australian healthcare system offers its citizens universal healthcare through the national health insurance scheme Medicare. Unlike the UK where thirteen percent of the population have additional private healthcare insurance over fifty-three percent of Australians pay for private health insurance (ABS, 2021). This large number of private health insurance holders may explain why waiting figures are falling as more Australians opt to have their treatments conducted at a time to suit them, privately. Additionally, eight percent of Australians state that a major reason for not visiting a medical specialist was the cost involved where it did not fit within the Medicare scheme (ibid.). This suggests that despite Medicare insurance patients are not fully covered for all their medical and healthcare needs.

As has been seen, many healthcare systems have a variety of performance indicators, and the Australian Medicare system is no exception. The Australian government, through the Australian Institute of Health and Welfare (AIHW), have a comprehensive health performance network which collates data from across the healthcare arena. Separated into three main groups (Determinants of health, Health system and Health status) each one is sub divided into additional data sets. Just like the NHS, Australian Medicare has performance indicators which utilise time as the measurement of success. Both the NHS and Medicare record the percentile of service users who wait over four hours for treatment. In the UK, during 2019, seventy nine percent of patients attending an accident and emergency department were seen within the four-hour waiting standard (Stoye, 2020). During the same year Australian patients attending a Medicare emergency department, who were seen within four hours varied between seventy

five percent and fifty eight percent, depending on the location of the department (AIHW, 2020). This variation in waiting time may be explained by the remote location of many Australian towns but fails to explain why the NHS waiting time figures are comparable with the worst figures from Australia.

One area which appears to have a positive impact on the number of service users not requiring a visit to an emergency department and admission into hospital is the access to convenient and timely primary care (Schneider *et al*. 2021). The availability of alternative avenues of clinical advice, triage and appropriate timely treatment can reduce unnecessary visits to seek care at a hospital emergency department (OECD, 2018). The Netherlands healthcare system offers access to primary care via on call telephone triage at nights and weekends with in-person appointments if required. This echoes the NHS 111 system which provides out of hours access to primary care in the UK. In addition, in the Netherlands General Practitioners (GPs) are obliged to undertake at least fifty hours out of hours care annually to maintain their clinical practice and licence. These episodes typically occur between 5pm and 8am when medical practices are closed to appointments. Again, this is similar to the NHS where out of hours services are run by clinical cooperatives to provide urgent primary care. The main difference is that GPs in the UK are not mandated to undertake any set hours of provision, per annum to maintain clinical competence. It is suggested that this approach to an integrated primary care system, as is being proposed in the UK, results in fewer hospital admissions and those who are admitted spend few days as an inpatient (OECD, 2018). The healthcare system in the Netherlands also performs well on its percentile of population waiting in excess of one month for access to specialist treatment appointments, but worse than Switzerland and the UK (OECD, 2020). Unlike citizens of the UK those living in the Netherlands are required to purchase healthcare insurance which covers their medical needs (ibid.). Insurers must accept all applicants to their scheme with the government seen as a gatekeeper who make certain that insurance premiums are maintained at a manageable level for all service users. This results in the Dutch population having access to one of the top-rated healthcare systems in

Europe (Schneider *et al*. 2021). In the UK there is no regulation of healthcare insurance by the government, with insurance providers able to set the premiums at a level they choose. When the performance of healthcare systems is measured against affordability the NHS ranks first followed by the Netherlands, even when factoring in the amount Dutch citizens spend of private healthcare insurance (Schneider *et al*. 2021). It is suggested that Dutch healthcare spending, in 2015 equated to 10.7% of the country's GDP, mainly attributed to increased spending on long term care programs (OECD, 2018). This placed spending on healthcare by the Dutch just behind that of France and the UK (WHO, 2021).

Predominantly, success of a healthcare system appears to focus on its performance in several measurable areas. While each healthcare system may select differing performance indicators it is observed that some commonalities exist between the worlds' healthcare systems. One area of performance which is seldom measured relates to the impacts on health and well-being from the perspective of the people they serve (OECD, 2019). The majority of healthcare systems measure and report inputs and outputs. This is frequently time related and seldom any matrix which relates to those things which may matter to patients. This sees healthcare systems, like the NHS, failing to give a full overview of the accessibility and care delivered by hospital trusts. It could be argued that due to this the patient becomes a product of a system which fails to focus upon their true needs. Without the input from the service user healthcare systems are unable to continuously improve.

A starting point for the observation and measuring of the patients' needs may be in line with those described by Maslow (1943). World healthcare systems seldom measure the needs of the patient from a psychological stance, rather from a physical perspective. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys are an example of one system which does measure the needs of the patient. HCAHPS are predominantly used in the USA and sent to randomly selected patients between two- and forty-two-days post hospital discharge (CSM, 2021). The overall aim of HCAHPS is to measure and

compare the patient experiences of their care and treatment This offers hospitals the opportunity to learn and improve their care delivery. While the opinions and experiences of patients are sought the number of returns is relatively low. In 2019 the average number of responses received from all US hospitals was 25% with the lowest being 19% and the highest 34% (HCAHPSonline, 2020). Within the UK patients are requested to give limited feedback on a few NHS services they may have recently used. These include accident and emergency departments, ambulance services, community services, inpatient services, outpatient services, maternity services and mental health services. Described as the NHS friends and family test, it requires patients to rate how they felt their interaction with the NHS was for them. While offering some feedback to the NHS the friends and family test only offers the service user the opportunity to state how likely, they are to recommend the service to their friends and family if they needed similar care or treatment. Unlike HCAHPS the NHS friends and family test fails to provide the NHS with a broader understanding of the patient experience. It therefore prevents a greater understanding of ways to improve healthcare which meets the needs of service users. While available each month, the data generated by the NHS friends and family test appears to be of limited value. In June 2021 it is noted that a total of 763,647 responses were received, but there is no indication as to the total possible responses that could have been received (NHS England, 2021b). This would be of value in determining the respondent ratio as a percentile, as seen in the HCAHPS. It could be argued that the NHS friends and family test is pointless as a measurement of success given that the majority of UK citizens have no option but to use the NHS for their healthcare needs. During a medical accident or emergency there is no alternative to using the services of the NHS.

The use of person-centred care certification (PCCC) has been adopted in pockets of healthcare around the world to gain a greater understanding of those key priorities patients and their families have when receiving medical services (Guastello & Jay, 2019). Adopters of PCCC have seen improvements in patient care, service user satisfaction scores, increased staff motivation and the nurturing of positive cultures for both service users and medical staff

(ibid.). The use of PCCC sees the patient as an individual and equal partner in the business of healing rather than a product of the healthcare process (Coulter & Oldham, 2016). It has been argued that when the NHS was created patients were grateful of the free care they received, having had very little prior to its foundation. As time has passed patients are now better informed about their own health and their options for healthcare. This results in the need to include service users far more in key decisions about their care (ibid.). With service users being seen as equal partners in their own care the suggestion is that citizens must also take responsibility for their own health and wellbeing. However, the current way healthcare is structured leads people to view healthcare systems as a right for which they have dependency upon for their care needs (Coulter, 2012). In a study of healthcare and patient services in nine countries it was determined that while patients and patient groups are involved to some extent in health policy development, patient empowerment is not a priority in most countries (Beagley *et al*. 2019). One country highlighted as providing greater patient involvement was Germany. The need for patient-centred care is enshrined in law within Germany and is a priority area for healthcare research (ibid.). While the countries of France and the UK have strong enabling policies to include patient centric care within their healthcare systems, this is let down by a general lack of understanding of patient centred healthcare by clinicians and patients (ibid.). Research has shown that clinicians frequently assume that patients require a predetermined course of treatment or procedure without asking the patient for their preference (Mulley, Trimble & Elwyn, 2012). This extends beyond treatment to clinical outcomes where doctors frequently assume patients desire a particular outcome post treatment (ibid.). Studies have shown that patients with advanced cancers, when asked to contemplate how they wished to be treated in cardiac arrest, increasing numbers preferred to not have aggressive resuscitation performed upon them (Volandes *et al.* 2012). This goes against the assumed thoughts of doctors.

2.10 Chapter summary

This chapter has reviewed the relevant literature surrounding the creation and development of the British NHS and the measurement of perceived success. It has established that pertinent literature fails to provide a conclusive definition of NHS success. It also determines that there is no suitable definition of whether or how NHS success is measured. This presents a void in current knowledge surrounding perceptions of NHS success. This research aims to address these gaps by exploring NHS success from the perspective of politicians and political parties, governing bodies and senior NHS leaders.

The literature has shown that over the past 74 years, the NHS has been in a state of almost constant reorganisation. It has described how each reform is more detailed than its predecessor. To implement the changes required, the NHS has re-examined its organisational structure and over time redefined the role of its leaders and managers. But the literature indicates that these changes are seldom evaluated post implementation, the reasons for this remains unanswered. During this research the experiences of NHS leaders will be sought in an attempt to fill this gap in knowledge.

The way that NHS success is viewed appears to be no different from how people view success in the everyday world. We have seen that perception, like success, is a complex concept. The literature describes how the same event can be perceived differently by individuals or groups, making the ability to measure success difficult, if indeed possible. What remains unexplored is whether perceptions of success are different when looking at the NHS. This is a key area that will be explored during this research. By examining NHS success and its perception new knowledge will be generated, adding to this unexplored area.

The literature describes the introduction of key performance indicators and their continued use as benchmarks of NHS service provision. Performance indicators are offered as tangible

measurements of success or failure for NHS trusts. Within pertinent literature the use of these key performance indicators is not without controversy. Gaps exist in current knowledge surrounding the effective use of key performance indicators in the NHS to demonstrate success. There appears to be no consensus on their use or suitability made by senior NHS leaders, which this research aims to address.

Literature suggests that the key to reversing challenges within the NHS is having the most appropriate person managing the service. This is one possible reason why the NHS has seen many different approaches to management and leadership. It is suggested that the biggest indicator of success is where an NHS trust is rated as good or outstanding by the CQC; conversely being rated poor or inadequate is an indicator of failure. In both scenarios the focus for success or failure resides with the trust's senior leader. It is unclear from literature if this is a true reflection as observed by senior NHS leaders. This research will examine this more closely to ascertain whether CQC ratings are indicators of NHS success.

Within NHS leadership literature, we find little mention of followers or followership. It is suggested that followership is seen to play a much smaller role in organisational success than leadership; however, data suggests the opposite. Possibly due to this perception of followers adding little to organisational success we note that literature appears to ignore the leader/follower relationship, opting to focus on leaders and leadership styles. During the course of this research, views will be sought to establish how followership is viewed within the NHS. This will facilitate new understanding of the part followership plays in NHS success.

While reviewing perceptions of success we have also explored the meaning of failure. Like success, failure is subjective, being affected by personal bias and interpretation. The NHS has seen several high-profile events, as the culmination of system failures. These often-tragic events have resulted in costly public inquiries. Within the literature we find that management and leadership has frequently been criticised for its failings to prevent these events. The

literature fails to explain why these system failures continue to occur and why appropriate learning has not been able to prevent them from occurring. This will be explored in more depth within this research with the view to establish connections between NHS success and NHS failure.

Literature suggests that the inability to define healthcare success is not isolated to the UK and the NHS. The examination of similar healthcare systems in other countries has demonstrated a wide range of measures used to indicate perceived success. This adds an additional dimension of complexity in establishing what NHS success may look like or how it may be perceived. The lack of uniformity in how healthcare systems are rated or assessed produces conflicting views on deliverable standards of care in many countries. These conflicts will be explored further in this research to help answer the research questions.

Chapter 3 - Methodology

3.1 Overview

This study adopts a social constructionist epistemology and a qualitative methodology sensitive to grounded theory. Data were collected via semi-structured interviews with the study participants. This approach was adopted to investigate the perceptions of NHS success from several viewpoints including senior leaders (chief executives) in acute NHS trusts. A discourse analysis of governmental and NHS policy documents and guidance was also conducted to ascertain the viewpoint of NHS success from the perspective of politicians and policy makes. Discourse analysis, like social constructionism accepts that language is not simply a neutral means to reflect or describe the social world, rather it helps construct it (Gill, 2000). This was a rationale for selecting a discourse analysis, given the complexity and technicality of language used within governmental, parliamentary and NHS policy documentation. It is this complexity which may give rise to multiple ways of expressing what is attempting to be conveyed to the reader and multiple interpretations (Grice, 1975; Georgakopoulou and Goutsos, 2004).

Parliamentary white papers, green papers and select committee reports were searched along with NHS England policy documents including 'Five year forward view' (2014), 'Next steps on the five year forward view' (2019b), 'We are the NHS: people plan 2020/21, action for us all' (2020a), 'The NHS constitution for England' (2021a) and 'An introduction to the NHS' (2022). All failed to define NHS success or alternative evidence of NHS success, making the data search challenging.

The emphasis for the study was on personal accounts generated by participants in one-to-one interviews with the researcher. The methodology chapter provides justification for the epistemological stance, full account of the use of semi-structured interviews, and grounded theory analysis. It justifies the rationale for using purposive sampling (also known as judgmental, selective or subjective sampling) to gain access to six NHS chief executives and

five chief executives of independent healthcare monitoring services. An explanation of how raw data were collected through interviews with participants is provided. Details of how these data were cross referenced against existing theories, post engagement is also supplied. To extract themes an inductive approach to analysis was adopted. This provides a systematic procedure for analysing qualitative data that can produce reliable and valid findings (Thomas, 2006). Immersion in the data enabled the researcher to generate initial codes which were categorised into ordered themes. This process resulted in the identification of one predominant theoretical construct relating to the role of the NHS chief executive. Two further constructs were established, linked to the definition of success within the NHS and the leadership of troubled NHS trusts.

3.2 Research perspective

This research examines the perceptions of NHS success as viewed by government, political parties, senior leaders within acute NHS trusts and those who monitor NHS services. It seeks to understand the ways these groups view NHS success and whether these views are shared collectively. Perceptions of NHS success are explored with all participants, with the objective of gaining an insight into their definition of success. The adoption of a social constructionist (interpretivist) perspective is beneficial where the aim of a study is to emphasise the world of experience as it is lived, by people in social situations (Schwandt,1997). This approach accepts that there are many views of reality, with each participant having differing perspectives of the same subject area. The result is that participants construct 'reality' and communicates this to the researcher. The use of social constructionism suggests that knowledge is not taken for granted rather it is viewed critically through our observations of the world. It requires us to challenge conventional views of knowledge (Burr, 1998). This epistemological stance is distinguished from positivism, the latter based on the assumption that there is one single reality. It also assumes that in order to know this single reality the study of a phenomenon must be undertaken with objectivity and detached impartiality. To discover a view of reality in

an unbiased way, positivist research is approached from an experimental position. Contrariwise, for interpretivists, it is not possible to remain unbiased as a researcher. Once engaged in the study, the researcher finds it impossible to maintain a dispassionate stance (Schulz, 1995). Typically, positivist studies will endeavour to test a predetermined hypothesis or theory (deductive reasoning), utilising strict quantitative research methods (Robson & McCartan, 2016). Unlike the positivist approach, an interpretive approach utilises inductive reasoning. Here researchers do not start with a fixed theory or hypothesis; instead, theories are developed from specific observations. This occurs, predominantly adopting qualitative research methods.

3.2.1 Why a social constructionist epistemology?

An objective of this research was to explore how NHS chief executives perform their leadership role and whether this affected their perceptions of NHS success. It also aimed to investigate how others view NHS leadership and success, with a view of providing a deeper understanding of the current state of the NHS. It was intended that through the narrative process each participant would share their own real-world experience of leadership and perceptions of NHS success. This real-world view may vary significantly depending upon the individual and their circumstances. To ensure that the research could adapt to the possibility of variants in participants a social constructionist perspective was adopted. This allows for a plausible individually constructed version of reality (Young & Collin, 2004; Bryant & Charmaz, 2007).

Social constructionism is founded upon the view that meaning is constructed through the social interaction of people. It accepts that the result is that individuals construct meaning or reality in different ways. Without individuals and their interaction meanings do not exist in their own right (Robson & McCartan, 2016). Similarly, without conscious thought and social interaction a person may take their reality and knowledge for granted. It is argued that only by

social engagement and interaction can an individual develop an understanding of what is real and meaningful (Berger & Luckmann, 1967). For this to be accepted there needs to be an acknowledgement that social realities and identities are created and maintained in conversations with others. As primary data were to be gathered through social interaction between the participant and research, social constructionism was an appropriate choice of methodology.

During this interaction the researcher is not a casual observer but becomes integral to the study through their presence. This results in the researcher assisting the subject of the study to rethink and re-evaluate their understanding of reality and knowledge or constructing meanings and realities within the interaction process (Lock & Strong, 2010; Losantos *et al*. 2016). Social constructionism acknowledges this, encouraging the researcher to become transparent in their data collection and subsequent analysis (ibid.).

Research, which is sensitive to social constructionism, views the use of language as a central part in the creation of knowledge and understanding. The way individuals use symbols, terms and language enables them to construct an overarching knowledge of the world they inhabit (Stob, 2008). In this research the use of technical and detailed terminology is important in gaining a richer understanding of the complexities of defining NHS success.

People socially construct reality by their use of agreed and shared meaning communicated through language (Berger & Luckmann, 1967). Social constructionism identifies the creation of knowledge through language but also acknowledges the social interaction in which language is generated, sustained and abandoned (Gergen & Gergen, 2012). The most important social interaction between individuals takes place in face-to-face scenarios, which is the classic case of social interaction. During face-to-face interaction communication is not isolated to just voice but volume and tone of the voice, facial expressions, hand gestures, eye contact and other subliminal actions. No other social interaction can realistically produce the

degree of actions experienced by those present than in a face-to-face scenario (Berger & Luckmann, 1967).

By interacting with others and sharing information knowledge is generated. Individuals construct an understanding of their world through shared experience and are able to view them as real and meaningful. This aligns closely to the social constructionist epistemology which views communication, interaction, and power relationships as a vital part in the generation of meaning (Cunliffe, 2008). As individuals socially construct reality using language and meaning, beliefs about the world are viewed as social interaction.

The social constructionist approach is suitable for research that seeks to examine the way individual leaders (chief executives) see their role in the social setting of an acute NHS trust hospital. It is also suitable when seeking the perceptions of NHS success from alternative viewpoints as it recognises the importance or validity of conflicting views. The use of social constructionism accepts that similar context and environment may produce differing effects in several different individuals. The social constructionist attempts to understand and clarify why people have different experiences, rather than search for external causes and laws to explain behaviour (Easterby-Smith *et al*. 2008). This approach allows individual subjects to arrive at their own moral sense of self from a social constructionist perspective.

3.2.2 The role of the researcher

The research embraces an interpretivist approach where meaning is constructed through social interaction. This approach accepts that the social involvement of the researcher has an impact upon the creation of knowledge (Bryant & Charmaz, 2007). The challenge for the researcher is to accept that their pre-existing theoretical ideas and assumptions have the potential to influence the collection of empirical materials (Robson & McCartan, 2016). With this knowledge, it is for the researcher to explore the participant's prior experiences, by

interacting with them, to generate meaning jointly with them. During this process the researcher is seen as the primary instrument of qualitative data collection (Pezalla, Pettigrew & Miller-Day, 2012). Through the researcher's interaction with their subject a conversational space is created, one where an opportunity to develop a strong connection with participants is seen. This allows participants the space to speak openly and share rich information about their lives.

While it is important to understand how the researcher's own values and pre-existing theoretical ideas can impact upon the study, it is important to remember that a researcher is unlikely to be able to completely dismiss their own thoughts during the data collection process. The ability of researchers to reflect upon their impact within the data can be addressed through a reflexive approach (Bryant & Charmaz, 2007). Observational notes were used to reflect upon the researcher's feelings before, during and after each interview. This reflexive practice was adopted to identify any potential bias or effects the researcher may have had on the interview and subsequent data. To enable these reflections to be used during the data analysis phase, the observational notes were added to the transcripts of each interview. The transcriptions and observational notes were entered into the data analysis software QDA Miner.

3.2.3 Researcher positionality

Novice researchers frequently struggle to comprehend what positionality is and how to explain their own (Holmes, 2020). Positionality describes a researcher's ontological and epistemological assumptions. It acknowledges that the researcher should identify these beliefs throughout the research process. This process of reflexivity sees the researcher exploring preconceptions brought into the research. These may include past personal or professional experiences. This is important to accept given my prior experiences within the NHS.

Once identified, self-reflection should be conducted to continually critique, reconstruct, and communicate the positionality of the researcher. The researcher should remain aware that their own values and beliefs can frequently change over time. This requires the researcher to acknowledge that their positionality is not static, instead situation and context-dependent (Holmes, 2020). The use of self-reflection is not alien to me given the requirement for reflective practice while I was a healthcare professional. I had previously engaged with the works of Kolb (1984), Gibbs (1998) and Rolfe *et al*., (2001).

For qualitative researchers, reflexivity is encouraged to deconstruct how their own positionalities, biases or preferences impact how they conduct their research (Thurairajah, 2019). This qualitative research applies grounded theory, a process which acknowledges a researcher's experience and encourages reflexivity (Subramani, 2019). It is important for the interpretivist to reflect upon their own personal position and how this may impact upon their research (Ormston *et al*., 2014). It is possible that different researchers, or the same researcher in a different mind-set, might produce a different report from the same data (Brown, 2010). This approach acknowledges that the researcher is part of the social world being studied. This is in opposition to positivism and the concept of objective reality. Positionality therefore accepts that social research is not separate from the researcher's biography (Holmes, 2020). The interpretivist also accepts that positionality is not isolated to the research being undertaken but may influence the interpretation and understanding of other's research, used within the study.

Reflexivity and the process of being and becoming transparent about the methodologies can strengthen the credibility of the research (Cutcliffe, 2003). By demonstrating an open and honest expression of positionality the interpretivist can indicate how they might have influenced the research. This allows the reader to make an informed judgement on how reliable the research data is (Holmes, 2020). Likewise, it ensures research is conducted ethically through bias reduction. While acknowledged that potential bias may remain in

interpretivist research, the process of reflexivity will assist identification of these. While not eradicating bias it may help ensure the researcher avoids obvious, conscious, or systematic bias. This sees the researcher adopting 'empathetic neutrality' (Ormston *et al*., 2014).

I consider reflexivity an iterative activity undertaken to bring meaning to the construction of themes, ideas, and concepts. It assists in creating awareness of my role as researcher and how this may influence my research. I also accept that reflexivity is not a universal solution in the research process. There remains an awareness of the limitations of self-reflexivity (Holmes, 2020). Despite our best intentions there may be elements of ourselves which we remain unaware of. While Berger (2015) states that reflexivity enhances the quality of the research but that this is no guarantee of more honest, truthful, or ethical research (Holmes, 2020). Neither is it a guarantee of good research (Delamont, 2018).

It is suggested that the interpretivist adopts a research structure built on flexibility (Carson *et al*., 2001). This is unlike positivists who employ a rigid structural framework. This degree of flexibility enables the researcher's personality to be conveyed within the final research. As a result, I have chosen to adopt first-person pronouns and adjectives where appropriate.

3.3 Grounded Theory

To conduct this study, I adopted a qualitative research methodology premised on grounded theory. Grounded theory is categorised as an inductive method, which starts with a number of individual cases and extrapolates from them to form a conceptual category (Charmaz, 2006). Grounded theory research is suitable for the study of social interactions or experiences. The aim of its utilisation is to explain a process, not to test or verify an existing theory (Lingard, Albert & Levinson, 2008).

As previously stated, a social constructionist epistemology places emphasis upon creating a conversational space where subjects can express their thoughts and ideas. From these conversations rich data can be collected and coded, allowing theory to emerge (Bryant & Charmaz, 2007). In keeping with this stance, it was therefore appropriate to adopt grounded theory research, which reflects social constructionist philosophies.

3.3.1 What is Grounded Theory Research?

Grounded theory is a widely used research methodology (Chun Tie *et al*. 2019). It is used to explore how people experience and act within their everyday worlds. Grounded theory provides the researcher with a method for discovery or construction of theory from data. The systematic collection and comparative analysis of data enables the researcher to make new observations, conclusions, or theories. The generation of theory that is 'grounded' in the data is a key characteristic of grounded theory (ibid.). Grounded theory is directed towards hypothesis generation rather than hypothesis testing (Corbin & Strauss, 2015). The use of grounded theory cultivates meaningful understanding from a variety of sources, including transcripts of interviews and field observations. In doing so the researcher is able to group meaningful characteristics of reality to form new meaning to complex social phenomena.

A key feature of grounded theory is the iterative process by which data is repeatedly compared and sampled to form new meaning. Through comparison and theoretical sampling, integrated theories are developed, which makes grounded theory unique when used in combination with other qualitative research methods (Corbin & Strauss, 2015). The process of utilising grounded theory typically begins with a defined research problem. This leads to the collection of relevant data and continues onto providing a provisional clarification of the initial problem. To reach this point sample categories are formed through continual data comparison. Through the cycle of continual comparison, the properties of the initial concept are challenged and see the researcher returning to redefine the original problem or seek new data to analyse. This

process is called theoretical sampling (Corbin & Strauss, 2015). The researcher is engaged in a process of moving repeatedly between collecting new data, coding and the interpretation of all data until a point of saturation is reached. This is called analytical induction (ibid.). The resulting theory that emerges from within is therefore 'grounded' in the data.

3.3.2 Why is Grounded Theory Research appropriate for this study?

"*Grounded theorists explore the inner experiences of participants, explore how meanings are formed and transformed, explore areas not yet thoroughly researched, discover variables that can be tested through quantitative forms of research, take holistic and comprehensive approach to the study of phenomena*" (Corbin & Strauss, 2015: p.5).

Previous studies of leadership have adopted grounded theory due to its suitability in collecting data to understand the lived experiences of participants (Hamlin, 2002; Brien, Andrews & Savage, 2019; Lorello, Cil & Flexman, 2020). In these studies, grounded theory was appropriate as meaning and knowledge were understood as socially produced through social practices and social interaction. These studies all acknowledged the importance of the word 'social', as it emphasised that structures and actions could not be disconnected from each other (Charmaz, 2006).

This research acknowledges that the exploration of success is complex. The use of grounded theory is ideally positioned to enable the discovery of how people manage challenging situations in their life (Schreiber & Stern, 2001). Grounded theory is an exploratory method of investigation which allows the research to develop without pre-conceived theories or ideals. This research aims to gather the lived experiences and knowledge of its participants without bias or influence. Grounded theory accepts that collected data generates the research outcomes impartially. This makes the adoption of grounded theory suitable for this research.

3.3.3 Approach to Grounded Theory analysis

While grounded theory was first described by Glaser and Strauss (1967), this research adopted constructivist grounded theory as described by Charmaz (2006, 2014). The work of Charmaz applies a modern approach to grounded theory, acknowledging the interaction between the researcher and the subject of the research (Farragher & Coogan, 2020). The overall aim remained to construct theoretical reasoning from the collected data, adopting comparative methods, phases of coding, and interpretations as the primary analytical strategy.

In this study, it is assumed that the role of chief executive is embedded within a larger social setting with prevailing political, cultural and historical factors. Because of this, the study viewed each participant as a unique and independent social actor who shared meaning and knowledge socially. The resulting data collection was seen to be mutually constructed by the participants and researcher.

3.4 Research method

Data collection took place between December 2019 and March 2021. Semi-structured interviews were selected as the primary data collection method. These initial interviews took place face-to-face, but due to the COVID-19 pandemic subsequent follow up data were collected through telephone interviews with participants or via email. Five participants were interviewed via a teleconference interface using Microsoft Teams due to COVID-19 restrictions.

3.4.1 Justification for selecting semi-structured interviews

Interviews are the most frequently used data collection method when conducting qualitative research (Taylor, 2005). Within health research semi-structured interviews feature as the preferred choice of interview method (Gill *et al*. 2008). A reason for their popularity is their proven ability to be both versatile and flexible (Kallio *et al.* 2016). The ability to use semi

structured interviews with groups or just one individual makes them versatile while offering the researcher the option to be flexible in approach depending upon the study purpose and research question. The use of semi-structured interviews enables the interviewer to respond with improvised follow-up questions, to seek clarification or draw out new data. Where structured interviews are adopted, the interviewer asks pre-determined questions with no ability to deviate or seek clarification from the participant (Gill *et al*. 2008). The argument against using structured interviews is their inability to gather in depth data for analysis, due to limited participant response (Rubin & Rubin, 2005; Gill *et al*. 2008; Polit & Beck, 2010). Conversely, unstructured interviews have no pre-determined questions or organisation. Starting with a single introductory question unstructured interviews progress based upon the participants initial response. It is argued that unstructured interviews are time-consuming, confusing for participants and can be difficult to manage (Gill *et al*. 2008). As this study centred upon interviewing chief executives, time was limited given their busy schedules. For this reason, unstructured interviews were ruled out as a suitable method.

Previous studies examining leadership styles of NHS managers have adopted Multifactor Leadership Questionnaire (MLQ) (Alimo-Metcalfe & Alban-Metcalf, 2001). The use of MLQ is claimed to measure the full range of leadership styles and behaviours, by participants answering set questions. Questions focus on transformational leadership, transactional leadership, passive/avoidant behaviours, and outcomes of leadership (Avolio, Bass & Jung, 1999). MLQ is often criticised as the transformational leadership styles stated cannot be empirically distinguished (Heinitz, Liepmann & Felfe, 2005). As the MLQ is primarily a self-assessment tool with additional input from the leader's peers and subordinates, it could be argued that it can be easily manipulated and open to bias. Where the input from others is not gained the validity of results is weak (Bass & Avolio, 2004). For these reasons the use of MLQ was discounted for this study.

3.4.2 The interview process

Interviews were conducted with eleven chief executives, six of which were chief executives of acute NHS trusts, while the remainder were chief executives of independent healthcare monitoring services. Semi-structured interviews are a common data collection method in qualitative research (Kallio *et al.* 2016), as they enable the researcher to maintain a degree of consistency for each interview (Corbin & Strauss, 2015). The main aim of each interview was to allow each participant to express, through personal narrative accounts, their experiences of NHS leadership along with their perception of NHS success. During the interviews, I aimed to collect data on how each NHS chief executive viewed their own leadership and how they employed this in the modern NHS. At the same time, I aimed to collect data on how the same chief executives perceived success and the measurement of success in the NHS. Chief executives from the independent healthcare monitoring services were interviewed to collect similar data but from the viewpoint of outsiders to the NHS. Views were also sought from them on how their service users (patients) have expressed their thoughts about interacting with the NHS and their perceptions of its success.

Through one-to-one interviews, participants were asked to provide accounts of the attributes required to successfully lead an acute NHS trust along with perceptions of NHS success. Inviting participants to describe their own, and others' leadership enabled participants to think about and communicate their real-world observations of leadership. The aim was to produce free dialogue where the participants were able to use their own words and phrases to express their thoughts.

To facilitate this free flow of dialogue I elected to use a semi-structured interview format. The use of semi-structured interviews does require the interviewer to have prior knowledge of the research topic area (Kelly, 2010). Prior knowledge enables the interviewer to determine a list of question topics before the interview. The use of the semi structured interview enables the

interviewer to improvise follow-up questions based on the participants' responses, making for a more fluid exchange between interviewer and interviewee. It is also important to acknowledge that prior professional knowledge may unconsciously interpret data incorrectly (Corbin & Strauss, 2015). As I had previously held a senior managerial role within an NHS trust, this was monitored as part of the reflexive approach. During the interviews I posed only open-ended questions with minimal prompting or direction. Open ended questions allowed me to probe deeper with follow up questions to check the participant's knowledge or clear up potential misunderstandings (Robson & McCartan, 2016).

It is important to remember that the behaviour of the interviewer has a major influence upon the willingness of the participant to open up and provide unrestricted information (Robson & McCartan, 2016). This does not just mean the way interviewer behaves during the interview but also, the way they present themselves. The way an interviewer is dressed has an influence upon the participants willingness to engage with the interviewer (Bryant & Charmaz, 2007). As the participants were all chief executives of acute NHS trusts I took a conscious decision to dress formally, matching the attire of the participants. This decision was made as clothing is viewed as a form of nonverbal communication which sets the stage for dialogue, future engagement, and projects a professional image (Kalisch & Kalish, 1985). Being perceived as a professional, competent and trusted researcher was important as it gave interviewees confidence that the information they shared would be kept secure and anonymous. This was of vital importance if participants were to share their honest personal views and experiences, leading to richer data.

3.4.3 Impact of COVID-19 upon the research method

In the week commencing January 27, 2020, the first two cases of coronavirus disease 2019 (COVID-19) were diagnosed in England (Moss *et al*. 2020). By March 16, 2020, confirmed cases and reported deaths form COVID-19 resulted in the Prime minister advising against

'non-essential' travel and contact with others. By March 26, 2020, England had been placed into 'lockdown', with a stay-at-home order.

The first six interviews with NHS chief executives had taken place between November 2019 and February 2020 and were unaffected by the government's advice on COVID-19. Further interviews with NHS chief executives scheduled for March were cancelled indefinitely by the participants. While the participants were offered the option to interview via telephone, they declined stating the need for them to focus on dealing with the evolving pandemic.

Given the unusual nature of the pandemic I felt that it was essential to conduct follow-up data collection and triangulation from the earlier participants. On August 2, 2020, I sent a letter and short questionnaire Research COVID-19 Letter V1. (Appendix 1) to all participants. This initially produced two written replies and the invitation to discuss the questions with one participant over the telephone. This initial response produced a variety of data which is discussed within the findings chapter. Further requests were made to the three participants who had not responded. This took the form of contacting each chief executive's personal assistant and attempting to schedule a suitable time to speak with the participant.

The other five interviews with chief executives from independent healthcare monitoring services were conducted via teleconference and apart from not being conducted in the same room, were unaffected by the COVID-19 lockdown.

3.5 Sampling strategy

This study focused on chief executives currently employed to lead one, or a group of acute NHS trust hospitals in England. Given the large number of acute NHS trusts (152) the decision was made to adopt non-probability purposive sampling. Purposive sampling is useful where the researcher has a clear idea of the sample units required to undertake the research

(Easterby-Smith *et al*. 2008). It involves the researcher purposely selecting participants who are pertinent to the research question. Research has also demonstrated the greater efficiency of purposive sampling when compared to random sampling in qualitative studies (Van Riinsoeyer, 2017). After selecting non-probability purposive sampling, I made initial formal contact with chief executives of 36 acute NHS trust hospitals.

The selection of chief executives from independent healthcare monitoring services was undertaken to mirror the final selection of NHS chief executives, whereby geographical hospital sites were matched to the independent healthcare monitoring services residing in that county.

3.5.1 Why acute NHS trust chief executives

To gain an insight into how leadership and success is understood within NHS hospitals I looked to recruit the most senior hospital leaders who had overall charge of an acute NHS trust hospital. The responsibility for running, leading and managing an acute NHS trust hospital resides with the chief executive. The rationale for selecting acute NHS trust chief executives was that they would be most likely to have progressed to their role from other senior leadership and management positions within or external to the NHS. It was therefore probable that they would have significant professional experience of both the NHS organisation and NHS leadership. The option to recruit senior managers of acute NHS trusts was dismissed as they were unlikely to have the same degree of responsibility for leadership as chief executives or the degree of exposure to the wider workings of the NHS.

Previous studies have examined leadership within the NHS, but these have focused upon junior, middle and senior managers, not chief executives (Willcocks, 1998; Alimo-Metcalfe & Alban-Metcalf, 2001; Hamlin, 2002; Merali, 2009). It was therefore appropriate to conduct this

research with chief executives of NHS trusts to expand our understanding and knowledge of this area of NHS leadership and perceptions of success.

3.5.2 Accessing the sample

The main criteria by which participants were selected was that they should be in post as either a substantive or interim chief executive of an acute NHS trust hospital. Initially the criteria for recruitment focused on selecting substantive chief executives who led an NHS trust with a CQC rating of Good or Outstanding. The rationale behind this was to explore how successful NHS trusts were led. On reflection, this would have excluded experienced chief executives who were attempting to turn around failing trusts. For this reason, the criteria were amended to widen the depth of study. At the same time this eliminated selection/participant bias by potentially including all chief executives (Smith & Noble, 2014). Having previously held a senior managerial position within an NHS trust I excluded any potential candidate with whom I had a previous working relationship. This was important to prevent unconscious bias, based on social influence. This occurs where either interviewer or participant agrees with the other based on socio-psychological and, or emotional factors (Baddeley, 2015). The sample group is listed in Table 6, below.

CEO Identifier Number	Participant	pseudonym	CQC trust rating
23	Male	Colin	Good
15	Male	Tony	Requires improvement
83	Female	Sarah	Inadequate
31	Female	Kate	Good
77	Male	Peter	Requires improvement
63	Female	Rachael	Requires improvement
11	Female	Paula	
16	Male	Ben	
92	Female	Jenny	
50	Male	Simon	
44	Male	Trevor	

Table 6. List of participants

3.5.3 Sample size and saturation

Researchers who adopt a qualitative methodology have been criticised for their inability to justify their sample size (Boddy, 2016). However, the minimum size sample needed to reach theoretical saturation is difficult to estimate (Suddaby, 2006). At time of commencing this research the total number of chief executives employed in acute NHS trusts was one hundred and twenty-nine. As the study did not aim to produce generalised results, the intention was to realise a sample size capable of capturing a wide range of experiences and of significant richness without becoming repetitive. It was also important that the sample size was able to produce a range of data to address the research question.

Doctoral students have also been criticised for trying to justify their sample group size while failing to fully understand the concept of saturation (Mason, 2010). The suggestion is that students select large sample groups either to produce large amounts of defensible data or to be 'on the safe side' when it comes to numbers of participants (ibid.). Others suggest that sample sizes are pre-determined in the form of an estimate to justify the requirements of their universities ethical committee (Guest, Bunce & Johnson, 2006). While at the conceptual level the idea of saturation is acknowledged, it provides little guidance in estimating the sample size required to conduct meaningful research (ibid.)

Knowing when a sample size has reached saturation, as previously stated, is difficult to establish but the sample size must be capable of representing the target group under study (Bryant Charmaz, 2007). The argument against large sample groups for qualitative research focuses upon the researcher becoming overcome with the volume of data requiring processing or left unused (Glaser, 1998; Mason 2010). Larger sample groups also compromise the depth of analysis. The suggestion is that rather than studies with large numbers of participants, researchers may find a study with smaller participant numbers more productive in discovering social reality as experienced by the participants (Stebbins, 2006). When conducting qualitative

research, it is argued that a point is reached where more data collection does not necessarily produce more information (Ritchie, Lewis & Elam, 2003). In this scenario it is argued that large amounts of data become repetitive and eventually unnecessary (Mason, 2010).

The study was conducted in a way which allowed for participant data to be analysed after each interview. While the first interviews produced new themes, as the interviews progressed the frequency of new themes emerging dropped rapidly. By continuous analysis it was noted that themes and codes became repeated. This enabled the emergence of new themes and confirmation of prior themes. The ability for a small sample group of experts to all produce similar responses is described by Romney, Batchelder and Weller (1986). Their observations concluded that a sample group of experts, in a particular speciality will agree more with each other than novices. They continued to observe that small sample groups can be sufficient in providing complete and accurate information as long as the participants possess a certain degree of expertise within a particular domain of enquiry (ibid.). As the focus for this research are chief executives leading an acute NHS trust it could be argued that they are suitably positioned to offer expert information on the subject of NHS leadership.

3.6 Data collection

Theoretical saturation is an important characteristic of grounded theory (Bryman, 2004). Saturation represents the point when the researcher determines that further data collection is fruitless, as new data would no longer add any new information. The ability to establish saturation is challenging as is determining how and when this is achieved. Typically, data analysis in grounded theory occurs simultaneously with data collection and provides constant evaluation of new emerging phenomenon. As a result, I collected data from each interview, interspersed with the transcription of the audio recording from each. This enabled me time to reflect upon the data collection process and the data being collected. Where time allowed between interviews data was analysed and the subsequent themes established. The reflection

of collected data and emergence of new themes allowed me the opportunity to seek similar views in subsequent interviews.

3.6.1 The interviews

Having received confirmation from participants that they would be willing to take part in the study, the choice of allocating a convenient location to conduct the interview was left to each candidate. The decision to allow participants to select an interview location was made to accommodate their busy schedules and the constraints these produced. All NHS chief executives arranged for the interviews to take place at their offices, within their hospital. Due to the lockdown restrictions put in place due to COVID-19 all interviews with chief executives from the independent healthcare monitoring services had to take place remotely via teleconference. The time and date of these remote interviews was left to the participants to decide upon, again to fit around their work schedule.

The identification and selection of interview location is often neglected by researchers as an integral part of the interview process (Herzog, 2005; Gagnon, Jacob & McCabe, 2015). It can be viewed as both a physical space and a place where social relationships and meanings emerge (Gagnon, Jacob & McCabe, 2015). While the location of the interview should be convenient to both interviewee and interviewer the subject of the interview should determine the most appropriate location (Adler & Adler, cited in Herzog, 2005). Despite this it is argued that the location of the interview has the effect in constructing both power and position of interviewee and interviewer, throughout the interview (Elwood & Martin, 2000). It is further argued that by allowing participants to choose the location for each interview their choice is influenced by the multi-layered social meanings assigned to the location and enables participants to demonstrate their position in society (Herzog, 2005).

Prior to each interview participants were asked to give written consent to the interview and give consent to the interview being audio recorded. I explained that by recording the interview it would enable them to focus fully on the interview, without the need to write detailed interview notes. It was also emphasised that the audio recording would allow truthful recall of the interview in the ensuing analysis. I felt it important that the analysis could make full use of all data collected, given that the participants had taken time out of their busy schedules to participate in the study. All candidates agreed and signed the Research Informed Consent Form V1.4 (Appendix 2).

The object of each interview with an NHS chief executive was to encourage the participant to discuss freely their own experiences of their leadership and success as a chief executive. I took the conscious decision to select a semi-structured interview approach as this would provide greater flexibility for participants to discuss their experiences while being guided by me. To facilitate this a series of questions had been agreed upon, by me, in advance to the interview process (Appendix 3. Interview question guide). To enable the free flow of dialogue between participant and I, each interview started with an open question with subsequent questions probing upon the information provided by the participant. This approach produced a freely flowing, rich dialogue with the participant leading most of the conversation. My input appeared to be minimal with the occasional open question being asked to move the conversation into another topic area. In total the majority of interviews lasted sixty minutes with one continuing longer, as the participant wished to expand upon their experiences further. None of the participants demonstrated an unwillingness to participate or discuss in detail their experiences of leadership and the NHS. The same pattern was followed for the interviews of chief executives from independent healthcare monitoring services.

3.6.2 Data and theory interplay

Unlike quantitative research, which typically follows a linear structure, qualitative research sees findings develop through a complex process of evolution. This utilises the interaction or interplay between theory and data (Sinkovics & Alfoldi, 2012). This continual iterative process of interplay is considered the cornerstone of qualitative research and grounded theory (Dubois & Gibbert, 2010).

During this study, my use of interviews enabled time between each to engage with academic theory. This further guided the subsequent data collection process. As new data were collected, I was able to connect with scholarly theory. This allowed me to enhance my own understanding and influence approaches to subsequent data collection. I had examined a range of theories prior to the start of the interview and data collection process, these included leadership theory, management theory and organisational theories. After each interview and transcription of the data collected, analysis took place. As themes developed from the generated codes, I was able to engage with academic reading and theory, guided by the emerging themes. In this way I was able to alternate between the data and theory over the duration of the data collection phase. This can be seen in Figure 1.

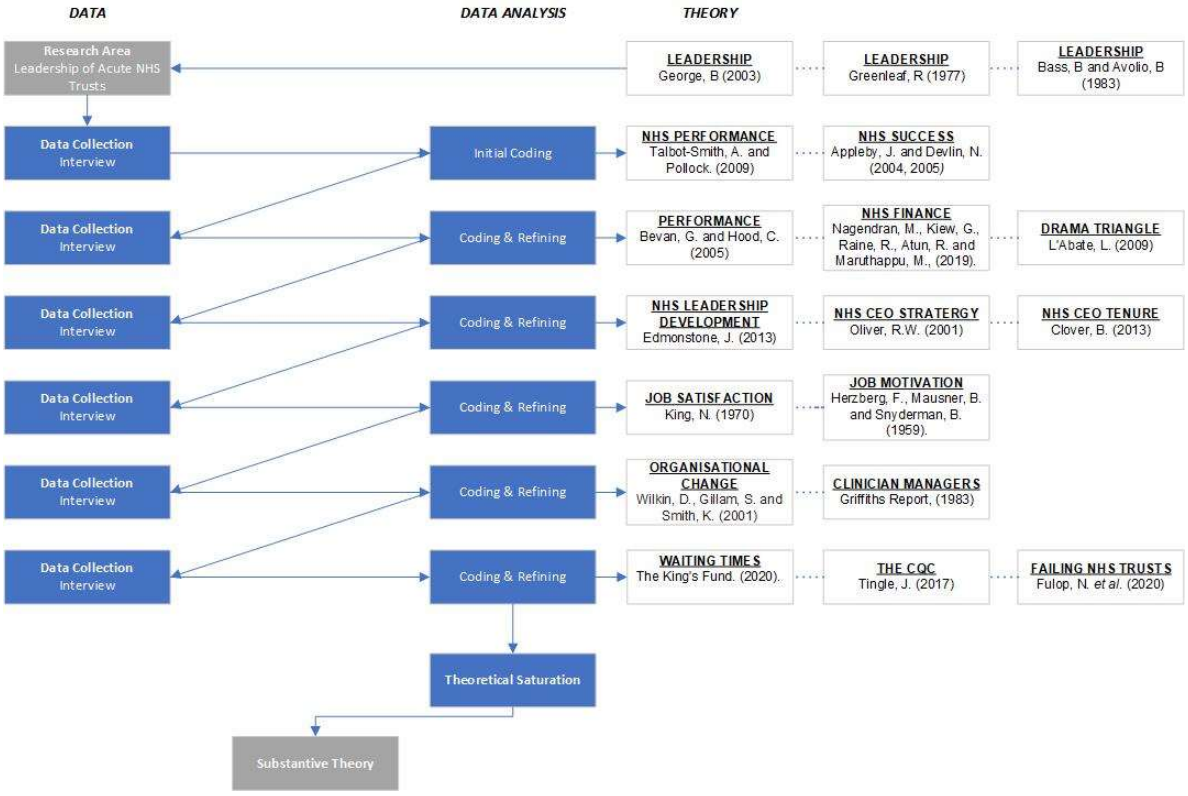

Figure 1. Data and theory interplay

My prior reading of literature examined several leadership theories currently advocated within the NHS. Of note was the use of authentic leadership (George, 2003), servant leadership (Greenleaf, 1977) and more recently transformational leadership (Bass & Avolio, 1993). These served to frame the initial question set used in the first interview.

During the first interview the participant described their route into the role of chief executive. They expanded further to discuss their view of their current leadership role. As the interview progressed the participant described various measures used to rate the success of an NHS leader. The predominant view was that the NHS measures success through performance targets and this led discussion around failing NHS trusts and chief executives. As the discussion began to focus on performance measurement and the affect this appeared to have on NHS leaders, I was drawn to read literature around NHS performance, post interview. Noteworthy was research conducted by Talbot-Smith and Pollock (2009) who determined the

importance of performance as a measurement for the NHS. This theme continued in research conducted by Appleby and Devlin (2005). Referring to these studies I amended subsequent questions to include the use of performance targets as a possible measurement of success within the NHS.

During the second interview the participant reaffirmed that the use of performance targets was often perceived as a measurement of success, by government and stakeholders. Expanding further the participant drew upon personal experience to describe specific measurements of perceived NHS success. These included the use of finance, safe care and key performance targets. This enabled me to examine research which explored the relationships between NHS leadership and financial targets. Prior studies conducted by Nagendran *et al*. (2019) observed how financial targets, clinical care and NHS leadership were interlinked and affect performance. This provided me with additional information relating to performance, which was used to tailor subsequent questions. The participant also spoke of cultural issues found within poorly performing NHS trusts. They described complex cultural elements within hospitals. This included staff in denial, staff lacking empathy and staff dismissive of criticism. Their view was that those working within the hospital, including NHS leaders often felt victimised. This prompted me to seek theory relating to victimisation and its link to poor organisational culture. Subsequent reading focused upon the 'drama triangle', as described by L'Abate (2009) and Hicks and McCracken (2014). This theory sees the regulator as persecutor, the staff as victims and the chief executive as rescuer. This view was taken forward as a point of discussion in the following interviews.

As with previous interviews the third interview followed a semi-structured approach with questions being adapted following theoretical reading. The participant drew similar conclusions to the questions asked. One area of interest surrounding the perceived failure of the NHS to adequately provide suitable and sufficient candidates for vacant chief executive roles. The discussion centred on the apparent inability of the NHS to equip failing NHS trusts

with a chief executive able to 'turn the trust around'. This prompted me to examine theory which had explored links between NHS chief executive tenure, strategy and development. These included studies conducted by Edmonstone (2013), Clover (2013) and Oliver (2017). These studies were also used to reflect upon previous comments made during the first two interviews. In this way additional codes were produced and linked within all three interviews. This linking of data to form codes confirmed my choices of questions and appropriateness of method.

During the fourth interview the participant spoke of the personal and career risks often seen by NHS chief executive. Their view was that while the risks were always present these were outweighed by the degree of job satisfaction they received. The research chose to engage with academic literature which examined the risks to NHS chief executives and job satisfaction. The two-factor theory of job satisfaction (King, 1970) was examined along with theory of motivation to work (Herzberg, Mausner, & Snyderman, 1959). Both reflected the views of the participant that job satisfaction was closely linked to more than financial reward. Previous interviews had reflected upon the rewards available to NHS chief executives including financial renumeration.

As the interviews progressed participants referred to the organisational structure of the NHS and the need for transformation and change. These views echoed those made previously but gave additional examples of how the organisation needed to change. I sought clarification of prior organisational changes within the NHS by examining studies conducted by Wilkin, Gillam and Smith (2001). Clinical oversight was discussed along with the need for more clinicians in senior managerial positions within the NHS. My prior reading had explored the recommendation to see more doctors leading NHS organisations (Griffiths Report, 1983). This report was used to ask participants how its publication had affected the number of clinicians seen within NHS senior managerial positions.

Participants also described the role of the CQC in monitoring and rating NHS trusts. Their descriptions of the CQC varied as did their thoughts on its value. I explored the links between the CQC (Tingle, 2017) and their impact on failing trusts (Fulop *et al*. 2020). The academic literature also highlighted links to poor performance in the NHS and protracted waiting times for treatment. This had previously been highlighted by participants, so I sought to clarify their claims by reading research conducted by The King's Fund (2020b).

In addition to studies mentioned, I revisited the work of Berger and Luckmann, (1967) on the social construction of reality.

The themes generated by the interviews with NHS chief executives formed a starting point from which questions could be presented to those chief executives from the independent healthcare monitoring services. The resulting data was used to examine the original themes and reaffirm prior findings or generate new areas requiring further investigation.

3.7 Data analysis

Grounded theory studies are characterised by theoretical sampling, which requires data to be collected and analysed (Sbaraini *et al*. 2011). Adopting an iterative process, the analysis and theorisation of raw data can extract differing themes which serve as a starting point to explain empirical findings. This process of analysis commenced following each interview where the recorded dialogue was transcribed verbatim. The resulting text was imported into QDA Miner Lite qualitative analysis software package. QDA Miner Lite has been widely used since 2004 by qualitative researchers who wish to undertake coding of textual data or retrieving and reviewing coded documents. Its choice was suitable for this study given its simplicity of use and ability to allow me to categorise and order data from interviews in a structured manner. I opted to transcribe all six interviews. During the first transcription Olympus DSS Dictation software with voice recognition module was used to speed up the process. The subsequent

voice recognition process failed to identify words and phrases, producing highly inaccurate results. Voice recognition software does not offer time or accuracy benefits over the listen-and-type methods of audio transcription (Johnson, 2011).

Primary analysis, during the open coding phase, required me to search each transcript for emerging and pertinent codes. This took the form of examining the transcripts for recurrent topics which could then be coded. "*Coding is the pivotal link between collecting data and developing an emergent theory to explain these data. Through coding, you define what is happening in the data and begin to grapple with what it means*" (Charmaz, 200: p.46). Initial coding was performed inductively rather than deductively. Inductive coding allows the data to dictate the emergence of codes, rather than trying to find codes which support a pre-determined social theory, as found in deductive coding.

To identify codes transcripts were read multiple times within QDA Miner Lite, enabling the categorisation of meaningful patterns from each interviewee's comments. I noted the differing metaphors and other verbal descriptions used by interviewees for similar events. This enabled emerging themes to include semantically related words and phrases. By using the terminology and language of the interviewees I was able to apply in-vivo coding (Corbin & Strauss, 2015). This approach avoids the researcher designating any predetermined understanding to the interviewee's own world experiences. The use of interviewee's own language, to express their own voice, was one way I set out to ensure trustworthiness in the data collection and analysis phase of the study. This also explains why some transcribed text contains profanities.

The initial transcription of the six interviews produced 34,566 words of dialogue and once initially coded produced 68 codes. The second set of five interviews produced 28,870 words of dialogue and produced 41 codes. I was aware that the first phase of data analysis may generate an overwhelming number of codes with me feeling lost within the data, but as analysis continues codes may merge as similarities become apparent (Gioia, Corley &

Hamilton, 2013). Following the open coding phase, related codes were grouped into sub-categories during the axial coding phase. This process aggregated the initial 68 codes into 17 themes, by searching for relationships between codes. As initial coding had included the interviewee's own words, I examined the data for instances where similar ideas were expressed in slightly different words, phrases, or language.

It is argued, it is not possible for the researcher to begin examining the data without existing assumptions or conceptual understanding from related literature (Corbin & Strauss, 2015). It is necessary for the researcher to remain focused on what is emerging from the data and manage their own preconceived assumptions (Bruscaglioni, 2016). I managed the process by remaining grounded in the interviewee's data, seeking to draw out codes and themes that the interviewees were referring and elaborating to.

During the selective coding phase sub-categories were integrated into theoretical constructs. Both the axial and selective coding phases were used to discover the relationships between sub-categories and link the concepts together to generate a conceptual framework. This was achieved through the use of comparative analysis (Corbin & Strauss, 2015).

The first concept identified related to the recognition of success within the NHS. Interviewees expressed varying views of success and how it was likely measured within the NHS. They described the context of success from their own perspective as leaders within the NHS. Further concepts identified, included how troubled or failing NHS trusts are led and the relationship this had to NHS success.

3.7.1 Coding, themes and conceptual framework

The initial coding, secondary themes and final conceptual framework is summarised in Table 7 below.

Initial Code	Themes
Public expect to be treated quickly	Performance Targets
Government set targets to demonstrate improvement in health care policy	
Organisational reputation is based on levels of performance	
The measurement of 4-hour A&E and cancer waiting times held up to demonstrate success	
Department of Health targets are a barometer of how well a trust and the NHS are performing	
Targets are the focus for politicians and external stakeholders	
We only measure what happens when people are in hospital, not the number we stop from coming in.	
If we continue to reward organisational success rather than system success, then we are going to miss something	
Reduced patient harm results in financial rewards	Safe Care
When people come into the hospital, I have to make sure they get the best possible care	
Government expects all trusts to remain financially stable	Financial stability
Strong financial governance is required to become a Foundation trust	
Most of the NHS is driven by a set of financial incentives which make no sense at all	
Those trusts rated as good or above are held up as beacons of the NHS	CQC rating
Trusts which have poor CQC ratings are difficult to turn around	
Large amount of the management teams time is spent ensuring performance is met	Managing performance
Chief executives are seen to fail if they cannot turn a failing trust around quickly	Targets
Chief execs are given unrealistic targets to achieve	
COVID-19 disrupted all aspects of the NHS	COVID-19
Performance targets were disregarded by the NHS during COVID-19	
There was minimal oversight from external bodies during COVID-19	
The NHS was ill prepared for a pandemic	

Table 7. Initial coding, secondary themes and final conceptual framework

These initial themes and concepts were utilised during the second phase of interviews with chief executives of independent healthcare monitoring services. This enabled them to explore their perceptions and views of NHS leadership and success. In this way existing themes were expanded upon and new themes emerged.

3.8 Trustworthiness

At the end of a research study the researcher aims to produce findings which are worth the merits of peers, experts, and scholars (Cypress, 2017). It is therefore the researcher's responsibility to ensure that their findings are credible and trustworthy (Chiovitti & Piran, 2003). While previous terms for achieving valid research have included rigor, reliability, validity, dependability, credibility, and transferability, trustworthiness is widely accepted as the terminology of choice in qualitative research (Guba & Lincoln, 1989; Chiovitti & Piran, 2003; Morse, 2015). The primary focus on achieving a trustworthy study sees the researchers concentrating on the process of data collection and analysis (Kitto, Chesters & Grbich, 2008; Morse, 2015).

Ensuring a study is trustworthy requires the phenomenon under investigation to be accurately identified (Chiovitti & Piran, 2003). In a qualitative study, which adopts semi-structured interview methods this can be achieved by allowing the interviewees to guide the inquiry process. As data is collected and subsequently analysed, codes are generated which reflect the language used by the participants. The use of the participants' own language at all levels of coding can further ground the generated theory and enhance the credibility of the findings (Corbin & Strauss, 2015).

To check the participants' meaning of the phenomenon under study, subsequent questions were adapted to validate previous responses. This enabled participants to redefine, develop and revise the emerging theoretical structure. The process of allowing the participants the opportunity to guide the inquiry helps to enhance credibility. In a similar way I sought verification of the developing theory in subsequent interviews by performing 'member checks' (Lincoln & Guba, 1986). Member checks provide the informal testing of what has previously been conveyed to the researcher in preceding interviews and the researcher's own understanding of the data. Participants are provided with the opportunity to confirm or deny

the accuracy and understanding of prior data (Candela, 2019). This process also provides triangulation by gathering multiple perspectives from several different sources and forming a complete picture of the phenomenon being studied (Shih, 1998). Where data collected from multiple sources is found to be consistent, increased confidence in the credibility of findings can be achieved (Knafl & Breitmayer, 1991).

Aware of how my own interaction could bias the research and invalidate any findings, I consciously attempted to adopt a neutral stance during the interview phase. This was achieved by asking open questions and avoiding leading or closed questions. I also completed a field memo for each interview. These contemporaneous notes enabled me to reflect on the participants and their surroundings, along with my own thoughts. Using reflective practice, I was able to monitor my own observations and thoughts for potential bias (Van Hilten, 2018).

3.9 Ethical considerations

A formal application for ethical approval was made to the University of Suffolk Research Ethics Committee on the 19th February 2019. This was made prior to their meeting of the 11th March 2019. The research study was granted and confirmed ethical approval in a letter on 12th March 2019 (Appendix 4. Ethical approval letter)

As the research study was to focus on chief executives within the NHS additional approval was sought from the NHS Health Research Authority (HRA) and Health Care Research Wales (HCRW). This was conduction using the Integrated Research Application System (IRAS) with approval granted on the 22nd March 2019 (Reference: 19/HRA/2966 /Project ID: 261951). With approval granted I was further required to make a formal application to each NHS trust's research and development lead to gain approval and access to conduct research within their trust. While a singular NHS research passport was completed (Appendix 5. NHS research passport application) several NHS trusts required additional information and training to be completed prior to granting approval. All trusts required a valid and 'clean' enhanced

Disclosure Barring Service (DBS) check. One NHS trusts research and development lead required me to undertake additional online learning to cover good clinical practice (GCP) despite the study having no clinical element. I completed this requirement and was issued with certification by the National Institute for Health Research (NIHR) on the 3rd June 2019 (Appendix 6. NIHR GCP Research certification).

While the process of gaining ethical approval from both the university and each individual NHS trust may appear complex and time consuming, I regard the due process of obtaining correct ethical approval essential. Those researchers who disregard the correct process for ethical approval risk the ethical integrity of their study along with the ethical rights of their participants (Sellman, 2016). The process of obtaining ethical approval acts to protect the rights of participants and ensure they are not exposed to unnecessary harm (McKenna & Gray, 2018).

Within the healthcare environment approaches to ethical decision making are based on the consequences or outcomes of research participation (Long & Johnson, 2007) or the principles of respect for autonomy, non-maleficence, beneficence, and justice (Beauchamp & Childress, 2001). This study adopted the four principles, as described by Beauchamp and Childress, due to the possibility of ethical medical dilemmas appearing during the study (Page, 2012).

The principle of respecting autonomy centres around the notion that a potential participant can give 'informed consent'. In doing so they do not feel compelled to take part in the study (Wilson, 2007). It is argued that autonomy is where an individual can self-rule, free from controlling interference by others (Varelius, 2006). Autonomous individuals are able to act freely. They can follow their own chosen plan, free from limitations such as inadequate understanding which prevents meaningful choice. A person with reduced autonomy is vulnerable to control by others or incapable of following their own chosen plan. It is therefore important that informed consent is employed to avoid deception and coercion (O'Neill, 2003). This principle was employed at all stages of the study.

During the initial stage of recruitment, potential participants were sent an Invitation Letter V1.2 (Appendix 7) and a Participant Information and Consent Sheet V1.5 (Appendix 8). These documents provided details of the study and its relevance to them as leaders within the NHS. Participants were therefore aware of the area of study and the broad topic areas that would be discussed. Participants were informed that there was no obligation to take part in the study. They were assured that should they commence then decide to withdraw, this would be granted, and all data collected destroyed, should they so wish. Contact details were also provided for both the academic supervisors and I, should the potential participants require further information or clarification about the study.

An ethical dilemma I faced was how to respond should a participant divulge during interview, information which could be perceived as fraud committed against the NHS. While I had an ethical responsibility to keep the dialogue from each participant confidential there was an opposing responsibility to report potentially fraudulent activity to the NHS Counter Fraud Authority (NHSCFA). The strategy to resolve this dilemma was to inform all participants, at the start of the interview, of my obligation to report (Resnik & Randall, 2018). This enabled participants to be fully informed and able to choose if they wished to continue. Only once this had been explained were participants given the opportunity to sign the informed consent form and participate in the main body of the interview.

The principle of non-maleficence focuses on avoiding harm to all parties involved in the study (Saunders, 2017). Asking participants to recall personal and sometimes sensitive information about them and their life can be emotionally sensitive (Peled & Leichtentritt, 2002; Clarke, 2006). This may occur during interviews, where participants are asked to reflect on their role and how they perceive their performance has impacted upon that role. In this scenario there is a risk of psychological harm to participants from their self-perceived failures (Sinding & Aronson, 2003). It was therefore important to adopt an interview strategy which enabled all participants the opportunity to control the degree of exposure to their life. The decision was

made to provide participants with the opportunity to decline answering each question through process consenting (Munhall, 1989). Time was given to allow participants the ability to exit the interview at any opportunity. Harm to participants may not occur at the time of interview but as a result of identification once their data is published. Where the study group is small or well known, researchers should take care to protect the identity of those participating in the study (Polit & Beck, 2014). As a chief executive could be easily identified by the data they provided, I chose to remove the possibility of identification by allocating a non-sequential number to each participant during the data collection phase. I then selected random names to act as pseudonyms when including participants quotes in the findings chapter. This would allow those reading the study to form a connection with each participant as a person rather than a number. This approach maintaining the participant's anonymity. To further prevent identification, within the transcript data any identifiable information about the hospital, such as hospital name, location or speciality, was redacted.

All researchers have a responsibility to always favour the well-being and interests of the participants of their study. By doing so researchers adopt the principle of beneficence (Kinsinger, 2009). Closely linked to non-maleficence, beneficence centres on minimising possible harm to participants while maximizing possible benefits (Hemmings, 2006). It is down to the researcher to assess the possible risks which may adversely affect participants and reduce them. It also requires researchers to communicate such risks to participants, ensuring informed choices can be made.

The principle of justice suggests that all participants of the study are treated fairly (Townsend, Cox & Li, 2010). Applying this principle all those chief executives who agreed to take part in the study were selected. This gave each respondent an equal voice to share their own experiences to me. It was also my responsibility to be aware of the potential influence I could impose upon an interview. This may result from the subtle use of language and content choice which may unfairly distort the views of the participants (ibid.).

3.10 Chapter summary

This chapter has advanced the rationale for the specific methodology and methods employed in this study. It describes why a social constructionist epistemology and qualitative methodology sensitive to grounded theory was appropriate for a study exploring real life narratives. The rationale for adopting grounded theory as a suitable research method is described. Its suitability in generating theory from collected data rather than attempting to answer a predetermined hypothesis is ideally suited to this research.

Conducting research which involves employees of the NHS incurs additional levels of ethical approval. Not only had I gained ethical approval from the university, but I was required to gain ethical approval from the NHS Health Research Authority (HRA) and Health Care Research Wales (HCRW). The HRA and HCRW also required me undertaking additional NHS research training and education prior to applying for approval. Once obtained I was then able to request access to the sample group. This demonstrates a level of scrutiny which is above those of studies conducted outside of the NHS.

My role as researcher has been defined as the conduit between the research participants and the collected data. While accepting my need for neutrality in this process I have also demonstrated my awareness of potential bias from preconceived ideas and experiences. This is reflected in my positionality to the research as a former healthcare professional, senior manager within the NHS and a patient. My application of reflective practice enabled me to assess my role as researcher, interviewer, and participant within the study. Reflecting upon my possible influence upon the research allowed me to consciously adjust my positioning and reduce possible bias. Its application allowed me to reframe my previous assumptions about the subject area, allowing changes in views to emerge.

The decision to recruit chief executives from acute NHS trusts enabled views from the most senior level of hospital management to be obtained. The recruitment of chief executives from independent healthcare monitoring services enabled a wider exploration of the NHS from stakeholders with whom they had regular contact with.

The use of face to face semi structured interviews enabled me to collect data from the participants in their own words. Participants were able to articulate their own stories and experiences during these exchanges. This allowing for a meaningful exchange of ideas and knowledge which gave me a greater understanding around NHS leadership and success. The experiences of stakeholders, like patients, were conveyed to the me through the chief executives of independent healthcare monitoring services.

A detailed description of the iterative process used to undertake the theoretical sampling of collected data is given in the chapter. It sets out the emerging codes and themes which produce the theoretical concepts of this study.

The next chapter provides the findings from the data collection process described within this chapter.

Chapter 4 – Findings and Analysis

4.1 Overview

In this chapter, I present the key findings from my data. These findings followed the interview process and subsequent analysis of the data. Within the methodology chapter, coding produced key themes and these themes form the structure of the findings explored here. At the outset of the study the COVID-19 pandemic had yet to impact the NHS. As the pandemic developed additional data were collected to explore the effects on perception of NHS success. The subsequent data are also examined within this chapter. The key themes presented in this chapter are:

1. A lack of clear definitions concerning NHS success

   The government, political parties, current and former Secretaries of State for Health, declined to state how NHS success could be defined. Likewise, chief executives leading acute NHS trusts are reluctant to identify a specific indicator for NHS success.

2. The use of performance targets to identify and measure NHS success

   NHS performance targets are frequently used to assess perceived NHS success, yet chief executives of acute NHS trusts question the validity of using performance measurement as an indicator of perceived NHS success. There does appear to be a correlation between three main performance targets and perceived success which has not previously been identified. It has been observed that many of the measurements of perceived NHS success were disregarded during the COVID-19 pandemic.

3. Financial efficacy is used to measure success

   Maintaining stable and sustainable finances are used as a marker of acute NHS trust success yet trusts constantly waste money.

4. The role of chief executives in meeting or failing success measures

   Chief executives of acute NHS trusts perceive a key criterion of NHS success is the achievement of an outstanding CQC rating; however, the combination of the CQC and performance measurement have introduced added layers of bureaucracy which

prevent NHS chief executives fully leading their acute trust. As a result, chief executives of acute NHS trusts equate perceived poor hospital performance with the loss of their job. This fails to identify that troubled acute NHS trusts fail due to complex organisational challenges. Changing chief executive is only one part in resolving the situation. Where chief executives are appointed to transform troubled acute NHS trusts they are seldom given the time or resources to succeed. One of my subsidiary findings has enabled me to chart the operational ramifications of the monopoly status of the NHS, principally, that low service standards continue to prevail as patients have no real alternative.

5. NHS success went unmeasured during the COVID-19 pandemic

   During the pandemic there was an assumption that NHS performance was assured, while simultaneously having no routine inspections or scrutiny of services from regulatory authorities like the CQC. Possible measures of NHS success were therefore unrecorded.

While each theme is presented under its own section heading, the reader may note that some components of key themes appear to occur in more than one section. This is due to the interaction of some themes upon others. These repetitions are included to provide the reader with additional detail of the key theme under discussion.

4.2 The challenges of defining success in the NHS

A significant and major finding of this study was the impossibility of participants to accurately define success in the NHS. This formed a recurrent and significant key theme across all aspects of the study. This, in turn made identifying successful chief executives difficult as there was a lack of a measurable benchmark for success. During the research, participants appeared unable to state what they perceived NHS success to be. Likewise, participants were

unable to define what constituted success for NHS leader. One interviewee highlighted this by stating,

> *'I think a measure of what good looks like depends on the individual and the experience they receive.'* (Monitoring CEO Jenny)

As part of the research several requests were made to current and past Secretaries of State for Health and government Health Ministers, to seek their views of NHS success. The aim was to establish a consistent definition of success for the wider NHS which could then be used to measure chief executives' leadership against. Without exception all requests were declined with no current or past government health official prepared to state how success in the NHS was or could be identified. This lack of clarity for success in the NHS was not reserved for the current serving government but also the main opposition parties who also declined to respond. The same was also true of retired politicians who had held a position within the health department.

When questioning the interviewees about what they thought the government may consider the marker of success to be, one chief executive stated,

> *'From the politician's perspective, they're looking to minimise the noise and maximise the success out of the NHS. Minimise the noise, that tends to revolve around, shall we say notions of the NHS failing or struggling'*. (NHS CEO Colin)

They continued,

> '*From a political perspective what you're trying to do is be seen as the party best placed to manage the NHS. And something about how you shift public opinion and communicate that effectively to the public'*. (NHS CEO Colin)

The use of performance indicators is just one way that the government may shift public opinion of success. For another participant they felt that the government's view of the NHS was problematic as it failed to adopt any form of prolonged strategy,

> '*The issue with the government's view of NHS success is it's all about short term and we really need a long-term plan*.' (Monitoring CEO Paula)

While chief executives found defining success in the NHS complex, failure was confined, primarily, to the loss of their job as a result of leading a poorly performing NHS trust. One interviewee stated that,

> '*We reward them* [chief executives] *in terms of them keeping their job*' (NHS CEO Tony)

Another chief executive highlighted the reason why chief executives lose their job,

> '*People* [chief executives] *are moved on because of poor results. It's not that people have chosen to come and go it's because they have failed to get results that people need nationally and been moved on.*' (NHS CEO Sarah)

The dismissal of a poorly performing chief executives comes with few consequences for the individual. Unlike a poorly performing registered health care professional, chief executives are not reported to a governing body with a view to have them 'struck off'. Typically, the dismissal of an NHS chief executive comes with a substantial severance package. One example is highlighted by Madden (2009), who describes how an NHS trust's remuneration committee decided that their chief executives' contract of employment should be terminated. This followed an outbreak of the 'super bug' Clostridium difficile which resulted directly to a significant number of patient's deaths. A subsequent published health service report was

highly critical of the trust's leadership, in particular that of the chief executive. The committee decided to seek early terminate of the chief executive's employment by way of a negotiated settlement. The terms of the settlement provided for a payment of £250,000, representing £75,427 in lieu of six months' notice and a compensation payment of £174,573 (which approximated to one year's salary) (Madden, 2009). While the terminating of an employment contract and subsequent renumeration is not afforded to other employees of the NHS, severance clauses are common for chief executive in business and industry. The use of severance clauses within chief executives' contracts of employment are associated with higher levels of managerial risk taking (Brown, Jha, & Pacharn, 2015).

The majority of chief executives interviewed for this study appeared to be risk adverse while a few highlighted areas of their leadership where risks were taken to achieve results. One chief executive made it clear that the risks taken, when taking over their NHS trust. They described a scenario where they could have been dismissed had they not transformed their trusts performance. When asked how employees of the trust felt about these risky decisions the chief executive stated,

> '*People think I'm a shit! I'm kind of not, but if I need to be I will, because that's kind of the job*.' (NHS CEO Tony)

It is suggested that without risk a chief executive is unable to demonstrate their full potential to the management board, opting to take the safe option at every opportunity (Bushman, Dai & Wang, 2010). The difficulty with Bushman, Dai and Wang (2010) findings is that they focus on the results seen within the financial sector, a sector where success is measured by increased monetary value not patient care. It could be argued that the actions of an NHS chief executive are difficult to compare to those of a chief executive within finance. A poor decision made by a chief executive in the financial arena may result in substantial monetary loss while a chief executive in the NHS may see lives adversely impacted.

4.3 Performance targets as a measurement of success

During interviews, chief executives were reluctant to identify a specific indicator for success in the NHS, opting instead to describe the measurement of performance as an accepted barometer of success. It was widely noted that participant felt that performance targets were routinely and systematically used as a measurement of both NHS success and their success as NHS leaders.

Previous research has suggested that NHS chief executives are evaluated by their key performance indicators, above all other measurements (Talbot-Smith & Pollock, 2009). During the interviews, chief executives consistently highlighted three main targets which they needed to maintain in order not to be perceived as failing in their role. These included financial stability, achieving performance standards and delivering safe care. This was highlighted by one chief executive who stated,

> '*We have to have the strategic discussion on how we are going to deliver the quality of care our patients need in the constraints of the finances against the KPIs we are being measured against*'. (NHS CEO Kate)

The discovery and correlation between the three main targets enabled me to develop a triangular model, which when in balance is equilateral. A failure of any main target causes the triangle to become acute, shifting away from the failure. Having searched academic literature for previous mention of this model I have been unable to establish it as a documented model. As this discovery has not previously been documented it has been defined by me as the trigeminal care model (Figure 2.)

Figure 2. The trigeminal care model

The trigeminal care model can be directly influenced by conscious decisions from the chief executive. If they wish to improve or increase performance and improve safe care, then they can achieve this by increasing financial spend. As one chief executive stated,

> '*You can deliver good care and performance by swamping it with staff and resources which cost'* (NHS CEO Rachael)

None of the chief executives questioned declared that they had issues maintaining a balance between the three main targets. However, it was noted that some continued to lead poorly rated NHS trusts.

While exploring the conflict that the trigeminal care model may cause chief executive, one participant stated,

'*There is a tension around hitting performance targets which is what we are currently regulated on, hitting financial targets but maintain the right quality. That is the tension for any CEO*.' (NHS CEO Kate)

It was clear from discussions with the chief executives that the trigeminal care model placed severe pressure on them all. It also became apparent that within each of the three targets were sub targets which also needed to be maintained. I explored these in closer detail with each participant. During one interview a participant described how finances played a small part in achieving successful performance,

'*Let's take an example of safer staffing. That needs money. You need to have adequate funds to fund a safe number of bodies on that ward, so yes there is an interplay there. But performance is down to so much more than money, culture, education, leadership a whole raft of holistic care that goes into the staff*.' (Monitoring CEO Jenny)

One participant felt strongly that the way performance targets were met forced chief executives to make conscious decisions, as described in the trigeminal care model,

'*The way we measure targets is unsophisticated, now the worst example of that was the way in which NHSI* [NHS Improvement] *and NHSE* [NHS England] *led on separate targets rather than collectively. That was absolutely bonkers. As a relatively seasoned chief exec it was bonkers for me so I don't know how it must have felt for an inexperienced chief exec with the pressures and stresses they would have. What you do find is that most chief execs fail on one or two targets, but you have to realise you cannot fail on everything. So, you need to make choices on how you can keep at least one target in check. If you have a dashboard which is entirely red that is a very bad place to be.*' (NHS CEO Peter)

While trying to ascertain the most frequently quoted NHS measurement of performance one chief executive felt that pressure upon the government to deliver other key policy decisions eased pressure upon the NHS to deliver key targets,

> '*I think 2019 has been a really peculiar year because of politics the focus has been Brexit. So, the focus on the NHS has been slightly removed, I think. Rewind a couple of years ago it was all about four-hour targets, waiting lists, CQC issues and people were much more publicly humiliate in difficult trusts. So now the press hasn't been hounding so much.*' (NHS CEO Sarah)

The most frequently quoted measurement of performance by chief executives were those targets set by the Department for Health, in particular the four-hour accident and emergency (A and E) waiting time. Introduced in 2004 they have not been met in the UK since July 2015, leading some chief executives to question their validity as a benchmark of success. When questioned about this lack of validity one chief executive stated,

> '*The four-hour wait is a finger in the air job, there is no science behind why it should be four hours*!' (Monitoring CEO Ben)

Exploring if these accident and emergency waiting times were import for patients one chief executive commented,

> '*I think if you took a person at random in the street and asked them what was a reasonable A and E waiting time, I'm not sure people would have any idea.*' (Monitoring CEO Trevor)

Going further the participant stated,

'*I doubt they are aware or even concerned at the numerous performance indicators that hospitals have to meet*.' (Monitoring CEO Trevor)

One interviewee suggested that the use of performance targets as a measure of success failed to take into account the level of care received,

'Those clinicians who are meeting their targets are the ones who have no time for patient care; they just push patients through to meet targets. From an NHS perspective they are doing really well but if you listen to their patients, I'm not sure they will think they were so good.' (Monitoring CEO Jenny)

For one NHS chief executive they did not consider the use of performance targets, particularly accident and emergency targets to be particularly difficult to achieve,

'*A and E performance is pretty simple actually, there's about five or six questions you ask and if they are all ticked you should be delivering performance*.' (NHS CEO Tony)

While one participant felt that the four-hour accident and emergency treatment target was acceptable. They felt the issue was why people went to the department in the first instance,

'*Four-hour wait at A and E would be fine if people used A and E for actual accidents and emergencies. I feel that A and E should be able to kick people into touch, you know you've broken a fingernail so bloody what quite frankly it's not killing you. We are dealing with somebody in the cubicle next door who has been in a major RTA* [Road Traffic Accident] *and has a bit of pipe sticking through their leg and we are prepping them for theatre*!' (Monitoring CEO Simon)

But this view does suggest that there is an alternative place for people to go and receive treatment. The real question must be why do they decide to go to the accident department rather than seek treatment elsewhere? The overriding view from participants was that despite the use of performance targets, such as the four-hour accident and emergency waiting time, the public had no interest in them and considered them unimportant. One participant explained,

> '*We actually asked people about the four-hour wait in A and E and they told us that actually they feel there were more important things about their visit to A and E than waiting times. They want good communication, so if they have to wait they are told why. If they can see a place is busy and someone explains where they are in the process, then they will wait all day if they have to. They also feel that having respectful and caring reception staff is more important that waiting times and finally if they need to wait, they want to wait in comfort, not standing or sitting on the floor*.' (Monitoring CEO Ben)

This observation raises the question of why the NHS uses the four-hour waiting time as a measure of perceived NHS success when the public appear to care so little about it. Based on the comment from the previous participant maybe a marker of NHS success would be the level of comfort experienced by those waiting for treatment?

Another chief executive described the consequences of failing to deliver the required four-hour performance standard,

> '*If I said we had achieved 75 percent I'd have been rung up and told to go over to NHS England or a conference call with the health minister saying what are you doing, it's not right!*' (NHS CEO Sarah)

This quote highlights the importance placed on individual hospitals to achieve the government set performance targets. It also demonstrates the use of intimidation by government to get results from chief executives. But the consequences of using performance targets to measure success was not isolated to chief executives, as one interview suggested,

> '*It demoralises hospital staff, a stick to beat them with and has less meaning to patients than you think*.' (Monitoring CEO Jenny)

When asked to state the one thing that kept a chief executive awake at night one participant identified,

> '*The emergency pathway and how are we going to deal with the number of patients who are coming through our A and E and those not able to offload ambulances and those who are waiting at home for an ambulance*.' (NHS CEO Kate)

The emergency care pathway is dependent upon an adequate patient flow from initial arrival at the accident and emergency department to being discharged home. Within this pathway are several key performance indicators including the four-hour performance standard for A and E waiting to treatment. The issues around the four-hour performance targets were shared by another chief executive who stated,

> '*I know that sometimes I can't get patients off ambulances into my ED* [Emergency Department] *because someone hasn't been able to be discharged as there is no social care bed available. It seems mad to say I can't offload that ambulance because of social care as there are ten steps between the discharge. When patients need to be in hospital, they should have access to that bed but when they are well to discharge, they should be able to leave as soon as possible.'* (NHS CEO Rachael)

This statement was explored further, and most chief executives stated that the four-hour standard was unfairly applied as a measurement of success to single hospitals rather than an overall measurement of success in the wider NHS. Expanding further chief executives described how the four-hour waiting time could be affected by changes in activity in other parts of the NHS. Pressure upon primary care services, such as the ambulance service and social care facilities can have a marked adverse effect on patient flow in hospitals, leading to extended waits for treatment within accident and emergency departments (Kings Fund, 2020). The result, chief executives felt, was a move away from being a leader within a hospital to a systems manager for the wider heath community. Describing this change in direction one chief executive stated,

> '*If you can get primary care right people will be kept well and not need to access the service of our trust.'* (NHS CEO Rachael)

Chief executives spoke of now leading joint working projects (Local sustainability and transformation partnerships, STPs) where multi-agencies worked collectively to reduce the impact upon hospitals. One chief executive explained in simplistic terms why this was necessary,

> '*We are quite good at fishing people out of the river we need to move up the bank and find out why they are falling in*.' (NHS CEO Tony)

But one participant highlighted what they felt was the major issue with getting hospital CEOs to think about integrated care pathways,

> '*The problem with asking CEOs of NHS hospitals to try and think about integrating services and relinquishing some of their budget to provide services in the community is never going to work. These CEOs have always been concerned with making their own*

hospital trust successful, that's what they are programmed to do so I don't think they will ever change.' (Monitoring CEO Paula)

Examples of other ways chief executives are thinking was by working closely with social enterprises and the charitable sector to enable patients to be treated at home rather than being admitted to hospital. One chief executive interviewed felt that this move to an integrated system of care was much needed because,

'*I think what we have done over the last twenty years in a corrosive way is erode the concept of a national health service and create a number of islands connected sometimes by a bridge or an infrequent ferry service. I think it has been destructive in delivering the best possible care but has also been destructive in terms of talent. We haven't been able to move our talent around to develop them.*' (NHS CEO Peter)

Exploring how these new integrated partnership systems would be managed, one participant explained how this may impact on future NHS leaders,

'*The true leaders of the future will be the people working with other determinants of ill-health looking at people's economic aspirations looking at their educational attainment looking at their housing and poverty because they are the drivers of ill health*.' (NHS CEO Tony)

Despite this, chief executives indicated that they were still measured on accident and emergency waiting times rather than the number of people they had prevented from being admitted to the department through integrated partnership working. One chief executive expressed,

'*So, if I'm serious about supporting our community with acute illnesses, measuring how many of them spent four hours in an A and E department that I'm accountable for is not a measure of success!*' (NHS CEO Tony)

This brings into question whether chief executives of the future will be measured differently than those currently employed. If this is the case, then those currently in training along with potential NHS leaders need to be guided on how to manage across organisational boundaries and not within a single organisation. To highlight what the measurement for future leaders may look like on chief executive stated,

'*The measurement should be, per hundred thousand population how many people needed the use of A and E in the first place?*' (NHS CEO Tony)

For another chief executive, the subject of four-hour accident and emergency waiting time were important, not necessarily for the NHS but the public. They stated,

'*A and E performance are things that the public is very concerned about. Quality is taken for granted, it's about whether people get fast access*.' (NHS CEO Colin)

Another interviewee disagreed suggesting that not all patients place fast access to care at the top of their priority list,

'*We have patients with complex needs and emotional challenges what they need is not about being seen in 4 hours but not having to relive and repeat their story to different carers as they are passed through the hospital. It's a lot more about holistic patient care are less about quantifiable measures. It is certainly demoralising where you have a target which you just never meet.*' (Monitoring CEO Jenny)

The question remains whether the public are actually concerned with receiving fast access to care at a hospital emergency department or just receiving fast access to appropriate care. This could be in the form of a General Practitioner (GP), ambulance paramedic, dentist, pharmacist or physiotherapist. It could be argued that if fast access to alternative care is available within the community, then admissions to hospital emergency departments are likely to be reduced. It is more likely that those attending emergency departments would also be those members of the public who genuinely required the prompt treatment that only a hospital can provide. A possible result maybe an overall reduction in attendances at emergency departments for inappropriate ailments and a reduction in waiting times for those who need treatment. According to one participant patients require simple solutions to their healthcare needs but also require assistance to make appropriate treatment choices,

> '*The people we encounter simply want to receive good healthcare. But I think there is a big piece of work to be done in educating people to look after their own health and the realities of what the NHS can realistically offer.*' (Monitoring CEO Paula)

It could be suggested that overall satisfaction in the NHS and healthcare system would increase as the public received timely and appropriately directed treatment. Only one participant expressed a view highlighting these points during or after the interview process,

> '*I tell new staff as part of their induction that as a chief exec of an acute trust I spend a lot of my time outside the hospital. I believe that to deliver the best care inside the walls of the hospital, it can only be achieved by having excellent primary care and only those who need care in hospital arriving at our front door and there being the correct care for others in the primary care setting. Things like social care available so patients can leave our care at the right time.'* (NHS CEO Rachael)

While several chief executives spoke about measurable performance targets, another of the indicators that the NHS uses as a marker of success is the 'Friends and Family test'. This is where service users are asked to rate how good the service is that they are receiving. The question being that if the service is good would you recommend it to your friends and family? One participant described what they saw as a problem with the way this test is performed and the subsequent outcomes.

> '*It's an utterly pointless measure! The positivity is so high, partly because it doesn't ask the right questions, partly because it asks people the questions when they are in situ* [as an inpatient or receiving treatment] *it's crazy. Would you go to a restaurant and halfway through the meal the chef sits down with you and asks what do you think of the meal? be honest. I know you've got your pudding to come but what did you make of the meal? Are you going to say the food was cold, the service was slow? No, you are not. But if you are asked afterwards, you are more likely to be honest and fair. But the NHS doesn't ask afterwards so it get unrealistic results.*' (Monitoring CEO Ben)

Other performance targets, quoted by chief executives as likely indicators for a hospital's success, included those for cancer treatment. The government requires hospitals to start specialist treatment within sixty-two days for at least eighty five percent of patients referred. Nationally this target has been missed consecutively since 2013/14 (NHS England, 2019). One chief executive described this as,

> '*unacceptable*' (NHS CEO Tony)

They then continued to highlight how GP referrals for people with suspected cancer had grown year on year. For these people the hospital must provide an appointment, with a specialist within fourteen days of referral (NHS England, 2019). One chief executive questioned if the fourteen-day referral target was detrimental to patient's mental health. Expanding the

conversation, the chief executive felt that a person who has been told by their GP that their symptoms may be due to cancer, ideally needed an appointment within days to reduce their stress and suffering. The participant then described how the needs of the patient were different from the need of the NHS, stating,

> '*Ok, so how long did you wait when you found that lump where it shouldn't have been, how long did you wait? Two weeks. And how was that for you? Absolute hell! Yeah and that's our target so we can congratulate ourselves*.' (NHS CEO Tony)

The chief executive highlighted,

> '*So, the measures for cancer should be the number of people who are diagnosed early because we know that's the best prediction of survival. And all we do is say did we see you in two weeks or 31 days or 62 days once you've got to us, that's not the important measurement*.' (NHS CEO Tony)

This opinion led to the question of how the public and service users rated the NHS against success, and how success could best be measured.

While several studies have determined that delays in treatment for cancer have an adverse outcome in survival for patients (Brazda *et al*. 2009; Gore *et al*. 2009; Kulkarni *et al*. 2009; Yun *et al*. 2012; Elit *et al*. 2013), there are similar numbers of studies finding little or no changes in outcome from delayed treatment (Lee *et al.* 2006; Nielsen *et al*. 2007; Raptis *et al*. 2010; Sharpe *et al*. 2010). For patients with suspected cancer these studies may do little to ease their worry while waiting for treatment. Studies confirm that the longer patients wait for treatment the more anxiety they experience (Thorne *et al*. 1999; Hodges, 2011; Elit, 2015). The comments of the chief executive echo previous studies findings. It could be argued that for people with a suspected cancer their measurement of NHS success would be a swift initial

referral. This followed by an appointment with a cancer specialist, rapid definitive treatment and best possible prognosis. Likewise, a person presenting at accident and emergency may view success as being quickly triaged and treated. This is something which the four-hour waiting time aims to achieve.

While chief executives spoke of waiting times for routine elective surgery as a possible measurement of NHS success, several chief executives were concerned that the NHS does not measure treatment outcomes by hospital or clinician, unlike several other health services. One chief executive explained,

> *'I've got to make sure that when people come to this hospital, they get the best possible clinical outcome which we seldom if ever measure, which is interesting, in the most timely way with the best staff and ultimately to be as cost-effective as we can be. But do we measure what's important to patients? Do we measure the clinical outcomes? If you need an operation do you know where the best place to get it? You would in the States because you'd be able to look at every single consultant that does that operation, what their length of stay was, what their infection rate was, etc, etc, etc*.' (NHS CEO Tony)

Within the United States of America, it is possible to determine a physician's and medical facilities patient outcome (30-day mortality and 30-day readmission rates) from publicly available data. While considered a worthwhile tool to provide better patient choice and driver for health care improvement (Campanella *et al*. 2016) others suggest it has limited benefit (Fung *et al*. 2008). Despite several chief executives stating that the NHS does not measure treatment outcomes, the Health Quality Improvement Partnership offers links to data from clinical audits for both consultant physician's and NHS medical facilities. This freely accessible data separates treatments into surgery groups and offers comparable data to those in the United States. It is therefore possible for members of the public to examine each hospital and

consultant surgeon. This could be conducted prior to undertaking treatment to determine the highest level of care they could receive. Despite this data being collected it is not utilised by the NHS to officially rate or rank medical facilities or as an indicator of NHS success. It could be argued that if the data demonstrates post-operative side effects are reduced and treatment outcomes improve then the NHS is successful, despite the existing use of time as a measurement.

During the interview process I asked whether clinical staff were concerned with the national performance targets, as much as chief executives. One chief executive explained,

> '*Most people say it's just government targets. I say yeah, it's been a government target for fifteen years. And actually, we know that crowded departments increase mortality. So, if you're telling me it's not important then you're happy for patients to die in your department*.' (NHS CEO Tony)

Leading on from this I questioned participants about their true view of government set performance targets. One chief executive commented,

> '*The thing that's fascinating is the centre* [government] *gives conflicting information on which targets are important at that moment. So currently we are being told that the 92% occupancy target is really important, and we need to keep open all the winter beds we have. Now I have no intention of doing that because if you keep all your winter beds open you have nothing to open up when winter comes. We know that we expand our occupancy as much as we can, but I will close my beds and meet my targets. Because we are all complicit in this sophisticated game the centre will not performance manage me on that.*' (NHS CEO Peter)

It would appear, based on this quote, chief executives go directly against the government to maintain their agenda. Typically, this manifests as the ability to maintain financial targets.

When questioned on the validity of measuring patient care and outcomes based on government set performance targets one chief executive was suspicious of their value, especially when applied to a government measurement dashboard,

> '*It's all smoke and mirrors, isn't it, you can make a performance dashboard say whatever you want it to say*.' (Monitoring CEO Paula)

While another chief executive spoke of their usefulness in proving data to facilitate additional funding. The ability to present data to the funding bodies, which demonstrated reductions in performance due to inadequate funding was, as the chief executive suggested, helpful. Chief executives were now able to demonstrate, through tangible data, that patient care and patient safety was at risk through funding gaps. Despite this use of data, the quality of care and patient safety are not consistent across NHS trusts (Tingle, 2020). Some chief executives agreed, described inconsistent levels of care even within their own hospital. One chief executive describing the care received as being down to,

> '*luck*' (NHS CEO Tony),

with variations of care between wards and clinicians. The use of performance data, for one chief executive, assisted them to highlight areas of poor care and inefficiency,

> '*There is no way I can put my hand on my heart that we are working as efficiently as we can as an organisation to do the most for patients. The targets are a useful way of drawing attention to some of those inefficiencies*' (NHS CEO Kate)

While examining the effects of care upon the success of the NHS and their individual trusts one chief executive believed that the NHS is in a unique position of having no competition for its services, it is a monopoly. The lack of competition, they believed attributed to an attitude of having very little consequences for poor service or poor performance. Continuing the interviewee stated,

> '*We've got people queueing up outside the door to come in even if the service is crap! And they keep coming back for more, because there is nowhere else for them to go!*' (NHS CEO Tony)

This view was shared by another participant who described the effects of access to free care in the NHS,

> '*People will go wherever they can get in. If they can't get a GP appointment for two weeks and they don't understand how the 111 service works or have no confidence in it because people see it just redirecting them elsewhere then guess where people go. The front door of A and E'* (Monitoring CEO Paula)

This was not an isolated view with several participants describing situations where the public automatically choose the hospital accident and emergency department over all other treatment routes. One chief executive gave an explanation as to why this may be,

> '*There is this view that people will go to A and E, they may need to wait a bit, but they will see a doctor, it saves them waiting a week to see their GP. We have seen where GP practices which are close to large hospitals change their practices suddenly patients start going to A and E to get their minor ailments seen*.' (Monitoring CEO Simon)

Arguing that there was private healthcare that patients could choose instead of hospital emergency departments, one chief executive responded that private care does not provide accident and emergency services and,

'*Private healthcare doesn't exist for quality reasons.'* (NHS CEO Tony)

It could, they suggested, be argued that private healthcare exists because the NHS is unsuccessful in delivering treatment to patients in an acceptable time period. It also suggests that the public are prepared to wait a reasonable duration to receive free treatment rather than pay privately.

The measurement of success for private healthcare providers is different from that of the NHS as they are not measured on their performance, in respect of waiting times. Their only benchmarks for success are their financial profits and their CQC rating. One chief executive, when discussing private healthcare believed that,

'*Healthcare is no better, in fact it's possibly worse in terms of quality. It's the same people delivering healthcare in a different building with less resources and less emergency support*.' (NHS CEO Tony)

Despite this statement private hospitals and clinics are inspected and rated by the CQC using the same criteria as NHS trust hospitals. This process ensures that regardless of who is providing care their services are safe and well led. It could therefore be argued that from the customers viewpoint where a private hospital rates 'Good' or 'Outstanding' they are better than many NHS trusts. It could also be argued that if this is the case then private hospitals are able to achieve levels of care and leadership seldom seen within NHS trust hospitals.

Chief executives did comment on the use of safe care and patient safety as another target which was often used as a measurement of success within their NHS trust. It was widely suggested by participants that NHS success was measured in the provision of safe care. Throughout the NHS, patient safety is defined as the avoidance of unintended or unexpected harm to people during the provision of health care (NHS Improvement, 2020). Chief executives highlighted the financial cost which resulted from litigation against NHS trusts as a result of medical errors or malpractice. They cited this as a growing concern. This concern is echoed by NHS Resolution (2020: p.9) who state that "*In 2018/19 the cost of harm was approximately £9 billion*", with a rise of compensation of over 13% from the previous year.

For one participant poor care was unacceptable in any NHS trust. They stated,

> '*There's a phrase, I think it's a military phrase, what you walk past is what you accept. So, if you walk past poor care you accept it. And there is no point saying well yeah, I can't say anything, well if you walk past it you accept it*.' (NHS CEO Tony)

While all chief executives spoke of the increasing costs of unsafe care upon their trusts none spoke of the humans behind the claims. There was no mention of the impact of unsafe care on patients, relatives and families of those affected by unexpected medical harm or loss. There was no mention of the impact upon their staff involved in such cases who may have faced disciplinary action or been required to appear at lengthy malpractice tribunals. It is acknowledged that the personal cost to individual healthcare staff involved in an incident can be significant (NHS Resolution, 2020).

Several chief executives commented on how avoidable patient deaths reflected badly upon a hospital trust and the public's perception of the care delivered. When looking at deaths judged to have been avoidable within hospitals, studies have shown that mortality was unlikely to reflect the quality of care at any hospital trust (Hogan *et al*. 2015). Their findings were attributed

to the small proportion of deaths found to have been avoidable. The findings of Hogan *et al*. (2015) may be considered questionable given the findings of the Francis Report (2013) which directly attributed avoidable deaths with poor quality of care and poor leadership. Other studies have concluded that the care given to those with a possibly avoidable death was of poorer quality (Rogne *et al*. 2019). Citing the Francis report, one chief executive felt that any suspected avoidable death brought into question their leadership and ability to manage a safe NHS trust. This manifested as increased monitoring and observation by external regulators.

The perception of increased scrutiny was shared by several NHS trust chief executives, interviewed by Iacobucci (2016). This research describes chief executives feeling a sense of pressure and constraint, in some cases bordering on bullying. Similar studies have found that those chief executives employed in healthcare adopted a leadership style linked to patient safety outcomes (McFadden *et al*. (2009). For one chief executive they suggested that the patient and their safe care was paramount in their leadership values,

> '*First and foremost, the patient always comes first, in everything I do. It's interesting to work in a challenging trust where I talk about the patient, I don't talk about the four hours, I don't talk about 62 days, I don't talk about money I talk about delivering good care to our patients. Actually, if we do that, nine times out of ten the other things fall into place. You've got to make sure everything you do and say you are thinking about the patient, it's really simple.*' (NHS CEO Sarah)

This view of putting patients first and providing good care and treatment triggered this response from one chief executive,

> '*Most of the concerns we get as an independent advocate for care are not about treatment, they are not about their confidence in clinicians, they are more often about cancelled appointments or when they have been discharged from one service to another*

and things weren't properly in place. Sometimes it's about them being treated discourteously by a member of staff. A lot of it is where people have not been happy due to poor administration or not being informed and aware of what is happening.' (Monitoring CEO Trevor)

While the NHS focuses on performance targets which concentrate around measurements of time, no targets focus on the dissatisfaction service users feel at the end of their patient experience. It could be argued that because of this NHS success from the patient's perspective is not being recorded, monitored or acted upon.

4.4 Financial stability as a measure of NHS success

All participants made it clear that stable finances were a measure of NHS success. All chief executives interviewed agreed that their ability to create and maintain a financially sustainable NHS trust was adopted as an indicator of NHS success. Not only was it seen as a measurement of a trust's success, but it also implied that the chief executive was a successful leader and manager. One chief executive highlighted this by stating that they needed to ensure they were,

'*Meeting the financial plan, it's not always about resulting in a surplus but you have a grip of the money*.' (NHS CEO Kate)

The ability to maintain financial solvency was seen by many of those interviewed as frequently commanding greater importance than safe care and performance targets. One participant highlighted that focusing on finance had a detrimental effect on staffing levels and patient care,

'*We've come through a decade where the NHS has struggled to get the finances right and while we started the decade with a few troubled trusts we've ended the decade*

with virtually all trusts failing to deliver their services with the resources they have.' (NHS CEO Rachael)

One chief executive stated that while performance and quality of care may slip below an acceptable standard, finances would not be sacrificed. Similar studies have found the NHS to be obsessed with cost while not being focused on efficiency savings (Pope & Pope, 2017). This is of interest given the generalised assumption that efficiency savings produce cost savings. This approach fails to acknowledge that efficiency is different from efficacy.

One chief executive described how they perceived the NHS to waste money,

'*Let me give you an example of how wasteful we are. How many sheets of paper do you think we used as an organisation last year? 40 million sheets of paper. This organisation alone, we are one of 250 trusts. So, when people say there is no money in the health service, I say there is plenty of money in the health service. But we will admit 10 people tonight that don't need to be in this hospital at a cost of £237 a night. And that's for the want of someone making sure that they have a cup of tea when they get home, or the lights are on. A bit of befriending. Or a district nurse who can look after five people in the community and we admit somebody here. And we admit five people for the cost of a district nurse in the community. So, we waste money every single day*.' (NHS CEO Tony)

This chief executive suggests that people are admitted into hospital where it could be better and cheaper for them to remain or return home with suitable safeguards put in place to ensure they are cared for. Another chief executive suggested that,

'it's difficult to deliver safe care and performance but not deliver finances unless you are completely incompetent.' (NHS CEO Rachael)

One chief executive questioned the rationale of maintaining financial solvency stating,

> '*You know we* [The hospital trust] *are running a deficit this year of £32 million. We don't say we've got no money so you will have to have your chemo every other week rather than every week. We don't say to our staff you will have to take a 10% pay cut because we've got a cash flow problem. So, there is no consequence for our patients or staff if we go bust, so why save money then?*' (NHS CEO Tony)

With NHS Resolution (2020: p.19) identifying the financial impact of unsafe and poor care, the use of financial rewards has been introduced for trusts who can demonstrate improvements in the delivery of safer care. The overall aim is to encourage chief executive to focus on the safe delivery of care. In turn this leads to a reduction in costly litigation and compensation claims. The risks associated with chief executives focusing on meeting financial targets is highlighted by Dixon and Warburton (2016). Citing the 2013 Francis inquiry into Mid Staffordshire NHS Foundation trust Dixon and Warburton (2016) emphasize the failings in care and preventable deaths that were attributed, in part, to chief executives' fixation with cost saving and financial stability. One chief executive expanded on this by stating,

> '*We have a few examples in trusts where they have delivered finances, delivered some performance but lost the plot when it comes to delivering good patient care. I certainly won't be a leader in one of those trusts.'* (NHS CEO Rachael)

While chief executives have responsibility for their trust's finances, it is suggested that the rationing of some services are being used as an additional source of cost saving within NHS trusts (Pillutla, Maslen & Savulescu, 2018). These measures have included the restriction of elective surgery for patients who either smoke or are obese. There has been a perceived unfairness of targeting certain health states and lifestyle choices to save public money (ibid.). One chief executive described how this is seen from the patent's viewpoint,

'*The management and balance of finance against care can be hard from the patient's perspective. For example, we have people who look at the NICE* [National Institute for Health and Care Excellence] *guidance and say this service is available in the next county on but it's not available in my own county and may not understand why that is. It may be down to a particular need in that county or how the money is divided around the counties*.' (Monitoring CEO Trevor)

This view was shared by another participant who stated,

'*The system raises patients' expectations of the care they may be entitled to only for them to receive a letter stating that they are not. And this is all because different parts of the system keep passing the buck to another part just so it doesn't come out of their budget. Sadly, the only people to suffer are the patient*.' (Monitoring CEO Paula)

This approach has been outside of the chief executive's control having been implemented by Clinical Commissioning Groups (CCGs). There appears to be substantial variation around the country, with different criteria being applied by different CCGs (Iacobucci, 2017). This seeming inconsistency in care provision has been defined as a 'postcode lottery', where the ability to receive care depends on the region where you live (Tingle, 2020).

The issue of how funding was calculated for each NHS trust was discussed as it was unclear if this affected a chief executive's ability to maintain financial stability. One chief executive described the system of funding as making,

'*no sense*' (NHS CEO Tony)

The rationale for this statement is due in part to the multiple ways in which hospitals can be funded. The different contract types are listed in table 8 below

Contract type	Description of contract
Block	A block contract is a payment made to an NHS trust to deliver a specific, usually broadly defined, service. For example, a hospital could be given a block contract to undertake acute care in a particular area. How the value of a block contract is calculated varies widely. It can be set through a measure of patient need or it may be based on the historical spend of a particular service.
Capitation	Capitation is a payment system where lump-sum payments are made to NHS trusts based on the number of patients in a target population, to provide some or all of their care needs. The capitation payment is not linked to how much care is provided. Capitation is used to determine core funding for UK General Practice. However, most sustainability and transformation plans in England also aim to move towards an outcome-based capitated budget.
National tariff	The national tariff currently dominates payments made to the acute sector in England. HRGs (health resource groups) are used to determine the pricing for health care services. The national tariff currently dominates payments made to the acute sector in England. HRGs are used to determine the pricing for health care services.
Payment for Performance	Payment-for-performance schemes refer to payment arrangements where NHS trusts are financially rewarded for achieving high performance or quality. Each scheme rewards NHS trusts in a unique way.

	Quality metrics or indicators can be broken down into three categories: • patient outcomes (such as mortality and readmission rates) • process measures (such as waiting times and screening rates) • clinical process measures (such as measuring blood pressure).

Table 8. NHS contract types

One participant described how the funding of NHS trust hospitals appeared to be counterproductive, stating,

> '*Because of the way that hospitals' were previously funded and many still are, if your income is dependent on the number of people that come through the front door every day, then there is this perverse incentive to keep the place busy*.' (NHS CEO Tony)

This system of funding is not applied uniformly across the NHS with some trusts having a guaranteed income, through block contracting. In this situation the chief executive has no incentive to keep the hospital busy, rather an empty hospital is good for financial stability. Regardless of the contract used to fund NHS services one participant felt,

> '*you've still got most of the NHS driven by a set of financial incentives that make absolutely no sense*.' (NHS CEO Tony)

If this statement is true, then it would appear that NHS trust chief executives must be financially astute. They must also have the ability to calculate and negotiate the best contract options for their trust. These are the type of skills often required by chief executives of large businesses. Closely linked to finance is the ability of business leaders to manage a variety of portfolios

including property. One chief executive highlighted how the financial success of an NHS trust could be influenced by the property portfolio it held,

> '*There are some trusts I can think of like the Chelsea and Westminster which have been financially stable for as long as I have been in the NHS. Brand new buildings, extremely valuable land, been able to sell off prime land to keep them afloat. That's not the situation for all trusts.*' (NHS CEO Peter)

This clearly gives some chief executives a substantial financial buffer which they can utilise to support their NHS trust. Some chief executives may view this as an unfair advantage, especially if they have no property to sell in times of financial pressure.

4.5 NHS Chief executives as facilitators of NHS quality and perceived success

4.5.1 The Care Quality Commissions ratings

The use of CQC ratings was frequently given by participants as an illustration of how NHS success was measured. This developed into a recuring theme where chief executives explored their role in achieving good CQC ratings and delivering perceived NHS success. All chief executives spoke of the CQC and their inspection rating of NHS services as a possible benchmark for success. The CQC use five key questions to rate a care provider, including acute NHS trusts. The CQC ask if a care provider is:

- Safe.
- Effective.
- Caring.
- Responsive to people's needs.
- Well led.

For each question, a rating is applied which can range from:

- Outstanding – the service is performing exceptionally well.
- Good – the service is performing well and meeting the CQC's expectations.
- Requires improvement – the service isn't performing as well as it should and the CQC have told the service how it must improve.
- Inadequate – the service is performing badly and the CQC have taken enforcement action against the provider of the service.
- No rating/under appeal/rating suspended – there are some services which the CQC cannot rate, while some might be under appeal from the provider. Suspended ratings are being reviewed by us and will be published soon.

During their rating inspections and reviews the examination of whether an NHS trust is well led focuses heavily on financial and resource governance (CQC, 2019). This does support the previous comments of those interviewed when they stated that finances were given greater priority than patient care and performance targets.

One chief executive indicated that,

> '*The key criterion of NHS success probably now is very much focused around achievement of an outstanding CQC rating*' (NHS CEO Colin)

Expanding further the chief executive described how the CQC rating system had taken over from other markers of NHS success,

> '*Previously becoming first an NHS trust and then a Foundation trust were seen as key marks of organisational success and they historically required both strong performance, strong financial performance and strong governance*.' (NHS CEO Colin)

It was felt by one participant that the awarding of a poor CQC rating to an NHS trust had positive effects, especially where that trust had a perceived elitist reputation,

> '*Actually, I think sometimes a hospital or trust receiving a poor CQC rating is a wake-up call for them, especially for those hospitals regarded as more prestigious. All of a sudden they are brought down to earth and realise that they are just like the rest and nothing special*.' (Monitoring CEO Paula)

This statement suggests that not all NHS hospital trusts are perceived to be equal, with some trading from their organisational reputation.

Several chief executives felt that while it stimulated hospitals to strive for excellence in delivering safe clinical care it was also destructive to staff morale when services were ranked as poor, inadequate or requiring improvement. Chief executives felt that the press did not help with morale of staff or chief executives. One participant felt that,

> '*The media doesn't help with CQC, they are after heads it makes good media.*' (NHS CEO Sarah)

This view was shared by another interviewee who stated,

> '*If a trust goes into special measures and there is a big press campaign about it then it impacts on people. If there is little press coverage, then it is unlikely to register on people's conscious.*' (Monitoring CEO Trevor)

While chief executives suggested that staff felt that poor CQC ratings were a reflection of them, this has been refuted by some researchers. Examining the CQC's adult inpatient survey of 2018, it was noted that most patients had confidence in the doctors and nurses treating

them (Mahse, 2019). This is despite overall satisfaction in service delivery falling (ibid.). One interviewee felt that this may reflect long held beliefs about a particular hospital and their reputation,

> '*For example, an acute trust with a well-known history of pioneering work, even when it struggles with CQC ratings and failing performance targets, patients continue to have confidence in its services. Compare this to other smaller trusts where concerns have been prolonged, that reputation can take a while to shift. This is regardless of what the data shows. So, people would say yes, the performance looks great, but it's always been a poor hospital, it wasn't good 20 years ago I'm sure it's no better now*.' (Monitoring CEO Trevor)

Studies suggest that CQC inspections have marginal mixed effects on trust performance (Hawkes, 2018; Smithson *et al*. 2018). There is also little evidence to suggest that patients use CQC ratings to help them choose which NHS trust hospital to receive treatment at (ibid.). This was reflected in the responses of several chief executives from the independent health monitoring services. Their responses highlighted that,

> '*Generally, patients who go into hospital, they are less concerned at the CQC rating unless they are an expert patient*.' (Monitoring CEO Jenny)

The term 'expert patient' implies that a person has undertaken prior research into a particular hospital or service prior to receiving treatment. The previous response was echoed by another participant who highlighted how little attention was paid to poor CQC ratings when deciding where to go for treatment,

'*We find that people want to go to* [name] *hospital, and that has nothing to do with the quality of care but everything to do with reputation. Even when they had a shocking CQC report people still wanted to go there if they had a choice*.' (Monitoring CEO Paula)

The public's perception of the CQC was discussed with chief executives. Views were sought that looked at whether the public found CQC ratings of NHS services useful or of value. While some participants stated that the public did not take particular interest in CQC ratings one participant described an alternative situation,

'*I remember talking to a CQC inspector who had been lambasted by the local residents at a public meeting after the CQC rated the local hospital as poor. The public were stating 'you don't know what it's like dear, our hospital is wonderful, the staff are lovely and they look after us' and they hadn't got a clue about the purpose of the regulator. Again, I think it is an organisation or the public's perception of the role and responsibilities of the regulator are. I think if the CQC's role was clearer then the public may take more interest in the ratings*.' (Monitoring CEO Simon)

4.5.2 The delivery of safe and effective care through engagement

While discussing the perceived reflection of services, as measured by a CQC inspection, and the level of care delivered by staff, one chief executive explained how they had needed to be frank with medical staff. This followed an inadequate CQC rating. Describing staff as feeling like,

'victims' (NHS CEO Tony)

Previous chief executives had stated that inadequate care ratings were not the fault of the staff. This chief executive disagreed and clarified how, upon their appointment, they had arranged group meetings with all trust staff to,

> '*set the record straight*' (NHS CEO Tony)

The view of the chief executive was that the staff had become complaisant with poor care and failed to acknowledge that they,

> '*weren't good enough!*' (NHS CEO Tony)

The aim was for the chief executive to remove the feeling that staff were victimised by the CQC. Instead, they needed to acknowledge that the content of the CQC's inspection reports were factually correct and patient care needed to improve. According to the chief executive,

> *'At no point did I say we've got to do this because of the CQC. I banned the word CQC. If anyone said it's because of the CQC I said its nothing to do with the CQC.*' (NHS CEO Tony)

This, according to the chief executive, provided a clear starting point for future engagement with staff to build better, safe care upon. This is a very risky action as it is possible that demotivated staff will continuing to remain demotivated. It is also possible for those staff who are not demotivated to begin feeling undervalued. This sees motivated staff feeling that they are being treated in the same way as those who have no desire to care. This compounds the situation, resulting in more staff becoming demotivated. One chief executive described how previous chief executives of their trust had adopted this approach and the result was,

'*They had been told so many times how shit they were, they started to believe they were shit.*' (NHS CEO Sarah)

While potentially risky, this managerial move is supported by studies which show that poorly performing NHS trusts saw better CQC ratings following enhanced staff engagement between senior management and clinical staff (Wake & Green, 2019). The work of Wake and Green (2019) does not indicate how confrontational engagement between management and clinician affects workforce motivation or performance. The view of having a motivated and supported workforce was shared by one participant who described how they achieve this,

'*I spend a lot of my time doing. It is about walking the floor, going back to the floor and communicate with staff. Understanding what their issues are fears are, and also pride in their job is and make sure that is celebrated, and if there are issues, they are addressed.*' (NHS CEO Colin)

For one chief executive, who led a good CQC rated hospital, the ability to be seen by the workforce was dictated by the size and complexity of the hospital which a chief executive managed.

'*We are lucky here to have a smallish hospital site, so I am able to get out and around the wards and departments fairly quickly, compared to those CEOs who have multiple site trusts.*' (NHS CEO Kate)

Two differing approaches to staff engagement and motivation. The question is whether either approach is wrong if they achieve the same final result. It could be argued that the second approach of engaging with staff on the wards may have been adopted prior to the first chief executives' appointment. If this is the case it appeared to be ineffective in turning the fortunes of the trust around. Does supporting and motivating staff only work in NHS trusts which are

good or performing well? For one chief executive who took up post of an NHS trust placed in special measures they indicated that they did feel it was important to engage with staff,

> '*I'm either shadowing someone for a couple of hours every other week, going down to a clinic watching it, talking to people, coming in at weekends.*' (NHS CEO Sarah)

And when asked to describe how the clinical staff viewed this, the chief executive stated,

> '*They like it. They understand it. I think they were shocked when I came to a special measures trust where no one had done it previously.*' (NHS CEO Sarah)

Again, highlighting that a failing trust had previously seen no engagement between senior management and those working on the front line.

It is essential for NHS trust leaders to focus on care of patients or service users as the organisation's top priority, with this conveyed clearly to staff (Wake & Green, 2019). This view was disputed by one chief executive who stated,

> '*I'm trying to lead an organisation that looks after the staff as they are key to providing good services. Some people can't understand why I focus on staff as they think I should be concentrating on the patients, but I say if we look after the staff, they will deliver good care to the patients.'* (NHS CEO Rachael)

This view of focusing on staff to achieve good care was shared by another participant who stated,

'*So, my job is to make sure I can facilitate that people feel motivated, that they are developed and that they are kind to each other. I think if you've got that you start to deliver better care.*' (NHS CEO Sarah)

Staff engagement and collaboration can accelerate motivated clinicians to drive quality care improvement and spread the adoption of improvement programs with their peers and others (Lalani, 2018). To achieve this one chief executive explained how they use social media to engage with staff and increase accessibility,

'*I do use twitter as a way of engaging with staff and colleagues. I also use it to post news from the wider twitter such as developments in the NHS that affect our hospital. I find that staff that are on twitter interact with me more than they might*.' (NHS CEO Kate)

4.5.3 The impacts of poor performance upon success

Describing the pressure placed upon them as leaders to achieve and maintain good service ratings, several interviewees felt under constant scrutiny from the regulators. One chief executive described the process of a CQC inspection as,

'*forensic*' (NHS CEO Colin)

In addition, chief executives spoke of the fear felt from the CQC imposing regulatory action upon their trust and the perceived damage this would have on their trust, staff and themselves. To explore the incidents of enforcement action being taken by the CQC a Freedom of Information (FOI) request was made to the CQC by the me in December 2019. I asked the CQC for data relating to enforcement action. The CQC responded that in 2018 and 2019 they had inspected a combined total of one hundred and sixty-eight acute NHS trusts. During this

period, they issued three warning notices and one condition of service to trusts of concern. The CQC did not issue any enforcement notices which resulted in legal action being taken against an NHS trust chief executive. Despite this several chief executives spoke of being fearful that they could face criminal prosecution for breaches in care at their trust.

For one participant there were concerns regarding the validity of some CQC inspections and the subsequent reports. They believed that,

> '*What we've seen lately is sometimes the balance is a bit skewed especially getting the experts from the NHS. When you get more inspectors and fewer NHS people it can skew the inspection.*' (NHS CEO Kate)

They continued,

> '*The biggest thing for me is amount of work they have to do and the time they have to do it in, the timeline is too short. They need more time to pull their thoughts together and this leads to better consistency. Ratings in regions appear to be consist but it does vary across the country*.' (NHS CEO Kate)

With chief executives' reputations and careers balanced against the CQC rating of the NHS trust they lead; this is a concerning statement. It also brings into question if the criteria used by the CQC to rate care providers is too complex, resulting in variable results. Ultimately there is a question of whether the public actually care how their NHS trust hospital is rated by the CQC when they need care. This is evident when someone suffers an acute medical condition and are taken by ambulance to the nearest appropriate hospital. In this situation the public are unable to specify which facility they attend based on CQC rating or care performance. Again, this highlights the monopolistic position of the NHS and healthcare in the UK.

During the interviews it became apparent that the fear of prosecution was combined with a very real fear of leading a failing NHS trust. One chief executive stated that it was not a chief executive's intention to perform badly:

> '*People generally do not come to work to do a bad job, even though the Daily Mail likes to print that some shite chief exec has done X*' (NHS CEO Sarah)

Expanding on how the risks were stacked against a chief executive one participant stated,

> *'So, the risk issues, interesting so I only heard about this last week. There are eighty reasons, there are eighty issues I currently manage on a day-to-day basis which if they do go wrong, I can go to jail. So, whether that's something happens in and around nuclear medicine, which is quite high risk, that is quite high because the health and safety issues, right down to someone giving the wrong drug. I kind of wish someone hadn't told me that*.' (NHS CEO Tony)

The mention of prosecution was not isolated with another chief executive commenting,

> '*When you step up to the board table you have to accept that you are legally responsible for actions and as a chief executive I could to prison for things, and I'm comfortable with that'* (NHS CEO Rachael)

Several chief executives spoke of how their careers could be destroyed following an adverse CQC inspection which forced their NHS trust into special measures. NHS trusts are put into special measures where there are serious failings in the quality of care and the trust leadership appear unable to resolve the problems without external support and input (Fulop *et al.* 2020). The criteria for an NHS trust being placed into special measures include the NHS trust being rated inadequate in at least two out of the five key questions, with one rating of inadequate for

well-led (Care Quality Commission, 2020). With a focus on inadequate and poor leadership it is clear why chief executives may feel that leading an NHS trust placed into special measures may irreversibly damage their career. Since July 2013, more than forty NHS trusts have been placed in special measures with 63% being placed in special measures for quality reasons, 15% for financial reasons and 22% for both (NHS Providers, 2020).

When asked if a chief executive who is dismissed following an adverse CQC inspection could rebuild their career and start again one participant stated,

> '*So previously under strategic health authority guidance, I think there was an opportunity for or a degree of both rehabilitation and second chances. But it was always a struggle to do that because the politics of the Daily Mail is such that a failed chief exec returns, so you've always got that headline'* (NHS CEO Colin)

They continued to describe an NHS which no longer appears to support failed chief executives to repair their careers and return to senior management, stating,

> '*The consequence of all that is the proper appetite to protect NHS leaders, I think has gone*.' (NHS CEO Colin)

This view was shared by another chief executive, when questioned about support for failed chief executives,

> '*I can't really think of many recycled chief execs which I think is unfortunate. I feel strongly in not losing talent. You need to help move people on to a more appropriate role rather than just ditch them. You need to look at where people can go to still fulfil a worthwhile role.*' (NHS CEO Peter)

These views were again shared by another participant who felt that times had changed for chief executives who were dismissed,

> '*Time was that people were made scape goats and you could come back but as an interim or temporary on a day rate. I think it depends on who you have as your allies.*' (NHS CEO Sarah)

These three statements suggest that the NHS, while depicting itself on the provision of care and compassion have little care or compassion for their chief executives. This appears especially true if they appear unable to meet inspection standards set by the government or external regulators. If this is factual, then it is questionable why someone would wish to take on a chief executive role if there is an absence of support.

Over the past five years failing NHS trusts have seen an abnormally high turnover rate of chief executive when compared to successful trusts (Anandaciva *et al.* 2018). It could be argued that this is not isolated to the NHS and many industries have seen a high turnover of senior managers.

Those interviewed acknowledged that turnover of chief executives in troubled trusts did appear to be greater than those leading trusts rated good or outstanding. During the interviews chief executives were asked to give their thoughts on why this might be. One chief executive suggested a series of possible reasons why their NHS trust had seen several chief executives over the last 10 years. These included,

> '*All first-time jobs. They didn't have the experience of running difficult organisations. They had come from really successful organisations. I think they weren't supported enough by externals.*' (NHS CEO Sarah)

The interviewees echoed the suggestions made by the chief executive along with other sub-themes. It was felt by several interviewed that,

> '*The average tenure of a trust chief exec is shorter than most Premiere league managers*.' (NHS CEO Colin)

It was also suggested that this short tenure was not limited to just those chief executives leading failing NHS trusts. According to research a third of England's hospital chief executives had been in post for less than a year (Clover, 2013). Some may argue that what the NHS is experiencing is nothing new and not isolated to healthcare (Oliver, 2017). Studies have shown that an NHS trust chief executives' average tenure had risen from two and a half years in 2014 to three years in 2018 (Anandaciva *et al*. 2018). The difference in tenure between NHS trusts rated outstanding compared to those trusts rated inadequate or requires improvement was more noticeable. The median tenure of a chief executive of an 'outstanding' trust was more than seven years, compared with just eleven months for a chief executive of a trust in special measures (Brennan, 2017). The findings of Clover (2013), Brennan (2017) or Anandaciva *et al*. (2018) do not explain why turnover of chief executives in failing NHS trusts is so high. Several chief executives, when interviewed felt that the reasons for the high turnover of staff included the government's desire to see failing trusts transformed rapidly, upon appointment of a new leader. One participant spoke of an area of difficulty which impacted upon the timescale to implement change. They highlighted how the negative reputation of those trusts, perceived to be failing, makes sustained staff recruitment and retention difficult,

> '*When it comes to failing trusts, I think a huge problem is around the workforce, not being able to recruit and retain good staff. Nobody wants to go to a poorly performing trust and very few people want to stay in one*.' (Monitoring CEO Paula)

The dynamics upon a troubled NHS trust and its staff, following almost constant turnover of chief executives was mentioned by several interviewees. There was a feeling that rather than making things better within a failing hospital the cycle of dismissing and then appointment of chief executives had a negative impact on that trust. One chief executive spoke of the disruption, they believed turnover caused,

> *'What we do know is that each time we get a new director or CEO you have a change of direction and focus. Those under them have to change in order effectively please their new boss which certainly doesn't help the recovery of that organisation. I feel that stability with external support is far more important that just changing the senior management and executive team'* (NHS CEO Kate)

4.5.4 Failing to deliver success

The perception from those interviewed was that NHS trusts don't just fail because they are poorly led but because they have deep rooted, complex issues. One chief executive described a situation where a trust enters a

> '…*vicious downward spiral and the consequence of that is leadership and management is ineffective, you try and bring in new leadership. You make a decision that the current leadership is quite weak, you need to change that, you need to change that quickly*' (NHS CEO Colin)

Research suggests that long-tenured chief executives increasingly narrow their perspectives and become less open minded, especially to strategic change (Hambrick & Fukutomi, 1991). Organisations led by long-tenured chief executives continue to follow existing strategic directions rather than exploring new approaches (Weng and Lin, 2014). Strategic change is

most likely when a new chief executive is appointed, and the likelihood of changes gradually decreases as the incumbent chief executive remains in post (ibid.).

It was felt by some chief executives that failing trusts were not places for new or inexperienced chief executives to,

> '*cut their teeth*' (NHS CEO Colin)

As the consequences are,

> '*You appoint an inexperienced chief executive, to address some quite difficult strategic issues. That inexperienced chief exec then probably doesn't have the experience to deal with the issues and challenges, which are likely to be more deep-seated and cultural. They fail, they don't make the progress the regulators or public or stakeholders would like*.' (NHS CEO Colin)

The feeling was that failing trusts typically have complex organisational, strategical and cultural problems. Typically failing NHS trusts require complex transformation. Implementing transformational change is always a complex and difficult business (Best *et al*. 2012). For one chief executive they indicated that the challenge was to get staff to accept that transformation was required before their trust was placed into special measures. At this stage the hospital would have seen an NHS management team come in and run the hospital. For this chief executive they stated,

> '*I turned round to staff and said the destiny of their hospital wasn't in my hands but in theirs.*' (NHS CEO Sarah)

One chief executive felt that there was a lack of appetite for staff within a failing NHS hospital to transform,

> '*There is no incentive to transform, if this organisation fails the only person to lose their job is me! Maybe a couple of other directors, so why would anybody change what they do?*' (NHS CEO Tony)

Transformation is made harder where an organisation has deep rooted, long standing cultural problems. Cultural issues are often the primary cause of many failed business transformations (Papegaaij, 2017). At least one chief executive, when questioned, described situations of accepted cultural norms in a trust they had been appointed to transform. They described individual managers,

> '*turning a blind eye'* (NHS CEO Peter)

to practices which were clearly unacceptable and irresponsible. Continuing to describe their own observations they stated,

> '*I found a management team on the take. The management team had given themselves fuel cards to fill up their private cars and their relative's cars. A management team who were acting in a way that was grossly irresponsible.*' (NHS CEO Peter)

The practice of ignoring obvious issues were key findings of both the Bristol Royal Infirmary inquiry (Kennedy, 2001) and the Mid-Staffordshire NHS Foundation trust inquiry (Francis, 2013). In exactly the same way both inquires highlighted that the cultural issues were visible for people to see, the chief executive stated,

'*I observed lots of people stating that they should do something but no one actually doing something.*' (NHS CEO Peter)

The issue of culture within a troubled NHS trust does not just originate with the chief executive, according to one interviewee. To illustrating this, the chief executive described taking up post of a failing trust where the culture was to blame external regulators and organisations for their own failing. Despite consecutively poor CQC ratings and failing to meet all performance targets hospital staff failed to accept that they were to blame. This situation was fuelled further by the previous chief executive and management team agreeing with the staff. In this scenario, described as the drama triangle (Karpman, 1968; L'Abate, 2009; Hicks & McCracken, 2014), it sees the employees as victim, the CQC as persecutor and the chief executive as rescuer. The situation develops where the victim can identify the persecutor as the cause of their problems, and the rescuer can reinforce the victim's target of blame and helplessness and then step in to save the day. During interview the chief executive explained how they had become unpopular when they chose not to act as the rescuer, as previous chief executives had. The decision was made to take a more candid approach where the findings of the CQC were accepted by the chief executive and staff educated on why the hospital was rated as requiring improvement. The chief executive then engaged staff to find solutions to the issues highlighted.

Chief executives highlighted how executive and non-executive boards of failing NHS trusts were less than convinced when new chief executives took up post and described their plans for transformation. It is suggested that some chief executives were faced with governor's who challenged cultural change. For one chief executive,

'*When the governors here didn't like it, I said that's absolutely fine, I'll go. You'll all be out of work because you'll go into administration, and if you think I'm horrible when*

> *PwC* [PricewaterhouseCooper] *come in and run you I'll look like bloody Mother Teresa!*' (NHS CEO Tony)

Prior studies have determined that NHS hospital staff do not believe that they are able to affect change, due to their organisational culture. One study found that seventy two percent of NHS staff surveyed did not feel their organisational culture encouraged them to contribute to changes that affect their team within their hospital (Forbes, 2014). A major contributing factor for this was a lack of engagement and dialogue between senior managers and their staff. It is stated that the NHS must try harder to learn from other organisations and business in its approach to staff engagement (Limb, 2015a). While describing staff engagement as a multidimensional construct with various definitions other studies have concluded that positive staff engagement produces better regulatory ratings for acute NHS trusts (Wake & Green, 2019).

While exploring the cultural factors which impact upon the ability of chief executives to lead and transform a failing trust, one interviewee suggested that the NHS celebrates mediocrity by failing to change. The participant stated,

> '*So, I said the NHS is perfect for the people who work in it, but people say oh how can you say that? I say well try and get your results on your phone, try and get an appointment at the weekend, try and contact anybody involved in your care*.' (NHS CEO Tony)

Probing deeper the chief executive described a health service which is stuck in its traditional ways of working and because of this it never significantly improves. The implication was that there is a systemic denial of criticism of the NHS which is not helped by the public's perception of hospitals and their staff. One chief executive highlighted an issue which they believed exacerbated this apparent reluctance to change,

'*There is a particular kudos around hospitals fuelled on by TV shows like 24 hours in A and E, which give the public the confidence that when things go wrong, or they are ill A and E is the place to go to get sorted out. Some members of the public may say I don't want to see a pharmacist if I'm ill I want to see my own GP, I like him, he knows and understands my needs.*' (Monitoring CEO Trevor)

While another participant stated,

'*Just drive around and you will see rainbows in peoples' windows, graffiti that once was now says 'I love my NHS', they are a patriotic people who believe in the NHS.*' (Monitoring CEO Jenny)

Despite this there remained a distinct undercurrent that the public perceive nurses, doctors and those who are connected to care seldom do wrong while managers and chief executive just spent money and achieved very little. These views are not new, as stated by Keogh (2013) within his review into the quality of care and treatment within NHS hospitals. From these findings a significant challenge for chief executives of failing trusts is the ability to effectively change the status quo when there is no desire to change. This was highlighted by one chief executive who stated,

'*In the decade we have just come through some people think that if you keep your head down the NHS will not change and you can keep on as you are'* (NHS CEO Rachael)

4.5.5 The perceived disconnect between chief executives and care

One area which appeared multiple times within the interviews was the reluctance of senior clinicians (consultant doctors) to change. One chief executive described the attitude of

clinicians in a similar way to those of the public, doctors are for patients and managers are for admin. Going further the participant stated,

> '*we've got a public who are convinced the NHS is absolutely bloody marvellous and the only bad people in the NHS are people like me!*' (NHS CEO Tony)

Unperturbed, the chief executive stated that the aim of everyone working within a hospital should be to work collectively for the best patient outcomes, a view shared by several academics (Davies *et al*. 2003; Nash *et al*. 2003; Waldman, Smith & Hood, 2006; Kuhlmann *et al*. 2013). Despite this, interviewees also spoke of a,

> '*them-and-us*' (NHS CEO Tony)

culture which appeared more prevalent within failing NHS trusts. One chief executive suggested the way in which healthcare was structured and operated did little to help improve working relationships between doctors and managers,

> '*That is one of the issues of healthcare. They are clinically led and clinically delivered but management supported.'* (NHS CEO Rachael)

Those chief executives who had followed a career path from a clinical background felt that this gave them an advantage when communicating with clinical staff, especially senior doctors. These chief executives felt that they were less likely to be troubled by clinicians who attempted to confuse conversations with medical terminology. One chief executive, who had previously held a clinical position within the NHS stated,

> '*I'm really not frightened of clinicians. I've seen other chief executives not being able to have those difficult conversations. Some of my colleagues say you relish in it. But*

I've not got a problem saying that our medics aren't good enough or not doing what's right for patients. I've not got a problem looking at data and information around clinical outcomes because I understand it.' (NHS CEO Sarah)

There was an indication that those from a medical background may be questioned by other clinicians as to their suitability to understand the business aspects of being a chief executive. For one chief executive this challenge was made shortly after taking up their post. Describing the encounter at a meeting of clinicians one senior doctor questioned the newly appointed chief executive's acumen to lead a failing NHS trust given their previous medical background. The chief executive felt able to highlight that they had achieved an MBA,

'*So I understand this stuff and know what I'm on about*.' (NHS CEO Sarah)

Going into more detail about the conversation the interviewee continued,

'*You've* [clinician/doctor] *got your medical degree but I've got my Masters in understanding how to manage a budget, so don't give me any of that rubbish*' (NHS CEO Sarah)

4.5.6 Managing performance

With performance being used as the possible measurement of NHS success interviewees were asked about the time required to manage performance. Several different views were recorded with the majority indicating that it took up a considerable amount of their teams' time. The view of one participant when asked how much time commented,

'*A huge amount, if they want it to be or not. I think all CEOs are mandated that they have to spend time and effort looking at performance and quality*.' (Monitoring CEO Jenny)

One NHS chief executive indicated,

> '*I'm very clear that the leadership role is to very much focus on the things that report to external stakeholders and regulators and politicians.*' (NHS CEO Colin)

This view was shared by another who stated,

> '*So yes, we do have to chase the targets but that is part of the role of a CEO.*' (NHS CEO Kate)

To ensure that performance could be measured chief executives spoke of the need to create a large team of senior managers who were able to manage their individual area of performance. This was highlighted by one chief executive who stated,

> '*I spent more time concentrating on performance 18 months ago, but I now have a really strong exec team in place, that makes a difference. Mind you they spend a vast amount of time managing performance and targets*' (NHS CEO Peter)

The creation of an additional layer of performance management was, for the same chief executive, an unnecessary distraction from offering leadership. The indication was that they spent much of their time,

> '*Assuring the bureaucracy to confirm that our performance is alright*' (NHS CEO Peter)

A compounding issue for several chief executives was the increasing number of official organisations who now required statistics to measure performance. One interviewee noted,

'*We also appear to have a large number of, far too many assurance organisations to answer to, the CQC, Royal Colleges, NHSE and NHSI*' (NHS CEO Peter)

The impression was that rather than allowing chief executives to lead their trust it took them further away from leadership and closer to performance managing the collation of statistical information. This does not appear to have changed since Greener (2005), found similar results in his research. Chief executives express that performance management had resulted in junior managers becoming fixated with numbers rather than patient care. One participant expressed,

'*If we have a really reasonable day in A and E or bad day, I say what happened yesterday? Why did 90 people wait more than four hours, I need to understand that. And they go, well there were 200 breaches down at [another hospital]. I'm not running bloody [another hospital]! And you don't say to the patient, I know it was shit but if you had gone to [another hospital] it would have been worse!*' (NHS CEO Tony)

The view that chief executives are forced to concentrate on measuring performance was highlighted by one chief executive. For them a major concern was that the view of measuring performance and its link to success failed to accept that healthcare and healthcare performance is not linear. This, they felt resulted in patients becoming an afterthought in the provision of healthcare,

'They manage performance yet have no concept that people are all different. For example, we could both go in for a knee operation and one of us could have a difficult procedure, bleed more than the other, react differently to the anaesthesia, require more pain relief post op. Yet we are both supposed to be in and out in an allotted timeframe. I feel that for most management they view us [the public] *as units and numbers. Unit one and unit two go in for knee surgery, should be in theatre by nine o'clock, in recovery by nine thirty, back to ward by ten and discharged by eleven thirty. The reality is the*

*human body doesn't work like that. Management try and pigeonhole people as a unit of delivery rather than an actual human.' (*Monitoring CEO Simon*)*

Discussion around the challenges faced by NHS trust chief executives to manage performance produced additional insight. Closely linked to success and failure chief executives spoke of elements surrounding troubled NHS trusts. As previously indicated, troubled NHS trusts are those who are rated inadequate and placed into special measures by the regulators of healthcare. While some of the chief executives interviewed were in post at NHS trusts rated good others were leading NHS trusts rated inadequate and in special measures. This mix gave a broad coverage and range of views from chief executives engaged in leading all levels of NHS trusts.

Exploring the possible reasons why NHS trusts fail produced a variety of possible reasons. One participant pointed blame at the government,

'*Somehow the government has made managing healthcare so ridiculously complicated. It's now so complicated it's a surprise they all* [NHS trusts] *don't fail. I think it's a bloody miracle!'* (Monitoring CEO Paula)

Several of those interviewed spoke of how the NHS had suffered a decade of austerity, command and control and performance indicators. Suggestions were made that all had an adverse impact on NHS trusts and their leadership. Reviewing previous reports into failing trusts, chief executives spoke of the difference in leader turnover when compared to those trusts which were perceived to be good (Anandaciva *et al*. 2018).

4.5.7 Facilitating perceived success. The risks and rewards

Several chief executives spoke of the risks involved with taking on a failing NHS trust. Primarily their concerns focused on the risks to their own reputation, especially if they moved from a successful NHS trust. One chief executive described the prospect of leading a failing NHS trust as,

> '*Russian roulette*' (NHS CEO Sarah)

where you may possibly survive. This chief executive continued to state,

> '*Why would you come to a place like this* [a failing NHS trust] *if you thought they were going to put a bullet in your head if you don't deliver?*' (NHS CEO Sarah)

This view was repeated by another participant who stated,

> '*Why would I go and take on that risk of running an organisation when there's probably yep a little more money, maybe ten or twenty grand but you have a huge reputational risk?*' (NHS CEO Colin)

Another chief executive who had moved to a troubled trust described their own worries,

> '*When I came here, I doubled my mortgage to buy a smaller house here, moved my family including my small children and I had no contract for 18 months. Genuinely every day when I walked my dog in the morning, I was working out what the payoff would be if I lost my job and what the outstanding mortgage was*' (NHS CEO Peter)

The issue of moving their entire life to a new town just so they could take up running a troubled NHS trust was expressed by one interviewee. The chief executive had decided to keep their existing family living in their home and commute several hundred miles each week, to prevent disruption. They explained,

> '*I've got a* [age] *year old whose doing her GCSEs in* [city], *I'm not going to move her, she don't want to live in* [town]. *I've got a partner whose got a job up there and I'm making it work*' (NHS CEO Sarah)

The impact on their family was seen as undesirable for many interviewees, despite any relocation payments.

The lack of financial incentive was also mentioned as a reason for deciding not to lead a troubled trust. Chief executives described a minimal increase in salary to move to a failing trust. One chief executive didn't feel that money was the motivator for moving to a failing trust,

> '*I don't think that for most people the salary is the issue, sometimes it's about fear, the risk of being exposed as a chief exec, the risk associated around the post*' (NHS CEO Peter)

While discussing the rewards that chief executive gain from leading a successful NHS trust most spoke of the enormous job satisfaction, they felt from leading a team dedicated to providing their community with quality clinical care. Highlighting this, one participant stated,

> '*I lead a team of people who improve 10,000 lives every day. And that's what I say, there are 10,000 people that touch our organisation every day, and that's the team that I lead*.' (NHS CEO Tony)

Another chief executive expressed similar sentiments, stating,

> '*It's an incredible privilege to lead a healthcare or a health and care organisation, and you can make a massive difference to people's lives by improving the quality and responsiveness also improving the morale and confidence of staff, so it's a tremendous opportunity to make the world a better place*.' (NHS CEO Colin)

In studies of NHS chief executives, it has been noted that they felt that their role was both a vocation and a privilege (Anandaciva *et al*. 2018). While several described their role at times as mentally and physically challenging, they felt that this was necessary to achieve the overall aims of the NHS and their trusts. Acknowledging that as chief executive they were well remunerated chief executives stated that it was comparable with the degree of risk involved,

> '*I'm quite clear that if I don't do what I've committed too then I have to leave, that's what I get paid the big money for.'* (NHS CEO Rachael)

Only one chief executive interviewed suggested that their renumeration was not reflective of the degree of responsibility or risk required to fulfil the role. Making a comparison between their own salary and those of executives in other health systems the chief executive stated,

> '*If I was working in America for an organisation this size, I'd be earning in excess of six million dollars a year!*' (NHS CEO Tony)

Despite making this statement, the NHS chief executive indicated that they would not want to work in this type of healthcare system as there was too much of an imbalance in care between those with money and those without. The salary figures quoted by the chief executive appear to be overly high based on those found by Kramer and Santerre (2010). Despite being ten years old the research found performance related pay for American health care executives to

be between one hundred and thirty-six thousand dollars to just over two million dollars. This still represents a vast difference between chief executives in American and chief executives in the NHS who earn between two hundred and fifty thousand and three hundred thousand pounds per annum (Ellwood, Garcia-Lacalle & Royo, 2020).

While questioning the salaries of NHS chief executive one participant stated,

> *'It would be interesting to see if you were running an organisation with the same complexities as an NHS trust and 8,000 members of staff what you may hope to earn.'* (Monitoring CEO Trevor)

One chief executive discussed the question of whether NHS chief executives are undervalued, commenting,

> '*I think chief executives' remuneration is about right. If it actually reflected the demands placed on the job, then I think you may have grounds to argue that it wasn't enough. But given the public sector aspect to the role then it about right. But it has to be remembered that unlike most businesses the chief executive is unlikely to be the highest earner in the hospital. People like the medical director are likely to be earning more given their role and connection to patient care and safety*.' (Monitoring CEO Trevor)

The subject of pay disparity caused one chief executive to comment on the way the NHS treats senior clinicians compared to NHS trust chief executives.

> *'So, you would have heard about all the pension stuff that's going around and on Friday Simon Stevens* [CEO of the NHS] *wrote and basically said doctors you can work as much as you like, we will sort your pensions out don't worry about it. He hasn't written the same letter to me and I'm in exactly the same position with my pension. But*

because I don't get paid for doing any additional lists or anything else, I get paid for a thirty-six-hour week, and I work slightly more than that. So how valued do we feel as leaders?' (NHS CEO Tony)

This raises the question of how the NHS rewards non-clinical leadership and whether the government and NHS England view clinicians more importantly than chief executives? For one chief executive the disparity appeared to extend to all levels of senior staff within an NHS trust. They highlighted how financial reward was preventing suitable candidate to progress within the NHS,

'*I think we also have a structural problem in the health service. If we take my divisional managers, they are all on band 9 so earning about a hundred thousand a year and becoming a director will take them up forty thousand a year more. With becoming a director come greater exposure. So middle managers in the NHS are well paid to the point that there is little incentive to progression.*' (NHS CEO Peter)

But for another participant money plays a tiny part in why a person, especially a clinician works in the NHS,

'*Money is one motivator, but no one would work as a nurse if money was their sole motivator. They do it because they care and want to make a difference*.' (Monitoring CEO Jenny)

Financial reward was not the only reward mentioned by chief executives. Several interviewees spoke of official recognition from the government in the form of appointment to the Order of the British Empire and the awarding of a Commander of the Order of the British Empire. Identifying it as acknowledgment of the hard work they undertook to create a caring organisation, chief executives felt they accepted it on behalf of the wider hospital and their

staff. This view is not shared by some academics who conclude that within the NHS there appeared to be a culture of self-interest with leaders looking to "*Create a name for themselves*" (Pope & Pope, 2017: p.589). NHS leaders are reported to adopt widespread ego-defensive behaviour, where there is wilful blindness to bad behaviours or organisational failure (Heffernan, 2011; Pope & Pope, 2017). Other academics have found the NHS to have a culture of authoritarian leadership which resulted in organisational failures being ignored or dismissed (Pope & Burnes, 2013). The results of such behaviours by NHS chief executives can be seen within the Francis Report (2013).

Chief executives spoke of the way the NHS had been managed and how this has impacted on new chief executives' ability to achieve results. One interviewee stated,

> '*The management* [Government] *of the last decade have tried to run the NHS through command and control by telling people what to do and being autocratic. Certainly, the regulators of the last decade with the NHSE and NHSI, with commissioner and provider split have tried to dictate to leaders that they must improve things in unrealistic timescales*' (NHS CEO Rachael)

The participant went on to highlight the differences between the structure of the NHS and that of industry,

> '*I have a friend who works for a pharmaceutical company and when they tell people to do things, they have to do it as they are working towards a profit. In a hospital or an academic institution, you have professionals who are working autonomously, the way you persuade and influence people to change their actions is a far more complicated way. It is not a direct command and control structure.'* (NHS CEO Rachael)

The influence that NHS England and NHS Improvement had over chief executive and their abilities to manage and lead the success of their trust was described by one participant. They viewed both organisations as doing little to promote quality patient care rather they implemented the wishes of the government,

> '*We know that the agenda pushed down to NHS trusts from NHS England, who we know are politically driven by the government, appears to have virtually nothing to do with patient care but more to do with successful implementation of the government's messages*.' (Monitoring CEO Paula)

One chief executive, who was leading a failing trust confirmed that there was a lack of time allowed for a newly appointed chief executive to turn a troubled trust around. This unrealistic expectation often saw chief executives being pressured into giving impracticable guarantees that they could achieve results within twelve months of appointment. This was highlighted by one participant who expressed,

> '*If you are a CEO of a failing organisation don't say that you will sort out the staffing, the finances and the performance in 12 months as its going to take far longer than that to sort them out. They need to state what they can realistically achieve and what they need from people to meet that*.' (NHS CEO Kate)

There have been concerns that the government is pretending that the NHS can deliver the impossible with senior managers within the NHS unable to say that targets cannot be delivered (Lock, 2017). The inability of a new chief executive to make progress, to the level desired by the regulators and public stakeholders, see confidence in the chief executive fall and questions asked about their ability to transform their failing trust. During interview one chief executive described a perpetual circle of failures, appointments, and further failures. In business stakeholders frequently demand the swift dismissal and replacement of perceived poorly

performing chief executives (Jenter & Kanaan, 2015). The answer, according to a couple of those interviewed is to negotiate realistic timescales with NHSE, NHSI and the trust board as part of the pre-appointment process. One chief executive spoke of a discussion with their board regarding the time required to turn the fortunes of the trust around. The chief executive highlighted that the trust had been in trouble for the past ten years so it was not a quick fix and the board must accept that. Another chief executive, when asked if a chief executives lack of ability to negotiate a realistic timescale made them a poor leader stated,

> '*I took on this job knowing that if I failed to deliver, I would lose my job. But it didn't mean I was a poor NHS leader or NHS chief executive, it just meant I had to take responsibility for something or failed to change something else as quickly as others may have wanted.*' (NHS CEO Rachael)

After all attempts to negotiate realistic timescales for the gradual improvement of services and the turnaround of a poorly performing trust, one chief executive stated that it just may not be possible for the appointed management team to transform a failing NHS trust,

> '*Maybe the maturity and experience of some CEOs and the teams around them are just not able to meet the challenges of those failing trusts, what we do know is that each time we get a new director or CEO you have a change of direction and focus*.' (NHS CEO Kate)

4.5.8 Absence of experienced leaders to deliver success

Examining further the reasons why the NHS appears to have a lack of experienced chief executives able to lead and transform failing trusts, those questioned indicated several possible reasons. One chief executive described senior managers being content to remain in their current role,

'*I think there are a number of people who don't want it and are happy to be a good number two. I spent twenty years prior to this as a good number two happy to be a deputy and a director, not sure if I wanted to be a chief or not. Over the last two years I found myself saying I could do that and wanting to be a chief exec. I think there are those happy to just work at board level, those who are fast tracked who don't realise what it's going to be like and lack experience so hold back.'* (NHS CEO Rachael)

Other chief executives described a lack of clear direction in recruitment and development as a major concern. One participant stated,

'*I think that the NHS is right on the cusp of what good looks like in terms of being a leader in an organisation. I think the NHS is behind the curve about where we need to be. So, we continue to develop and train and support people to be chief executives*.' (NHS CEO Tony)

The inability of the NHS to agree on the best way forward, for leadership development is rarely agreed upon (Percival & Best, 2019). This is reflected in the views of those interviewed. While some spoke of work conducted at local level many described an absence of direction from within NHS England and NHS Improvement. One chief executive openly stated,

'*I will be candid with you, Simon Stevens* [CEO of the NHS] *is a brilliant policy wonk, and should be praised to the skies during a period of austerity for getting good settlements for the health service, hasn't got a clue how to motivate leaders and doesn't talk about leadership development, nor does anyone else in the health service.*' (NHS CEO Peter)

These findings go against those of Monkhouse *et al*. (2018) who state that there have been many NHS programmes of leadership development implemented over several years. Disputing this one chief executive described how currently the NHS is unable to produce any form of effective systematic training for prospective chief executives or is able to produce any mapping of talent from within the NHS to predict the need for future leaders.

Going further chief executives spoke of an absence of a,

> '*pipeline of talent*' (NHS CEO Kate)

from which experienced chief executive could be selected, due to the lack of suitable and sufficient leadership development. Reviewing the NHS England people plan for 2020/21 (NHS England, 2020a), to establish how the NHS views talent management produced limited results. Within the fifty-two-page document the term talent management appears only three times. Searching for anything relating to pipeline of talent only produces reference to clinical staff not management. This again echoed the views of a few chief executives when interviewed. One chief executive felt that no senior decision makers within the NHS spoke of leadership development and added,

> '*I think that's different from private sector and other parts of the public sector like the civil service. So, we have a problem'* (NHS CEO Peter)

The absence of a clear pipeline of leadership and leadership development had also been noted by Lord Rose in his review of leadership in the NHS (Rose, 2015). Lord Rose's findings came three years after the creation of the NHS leadership academy, an academy created to develop outstanding leadership in healthcare.

To establish how successful the NHS leadership academy is in creating chief executives I made a freedom of information request to the academy in early 2020. I requested the academy to indicate the number of chief executive candidates that had commenced and then completed the aspiring chief executive training scheme. I also asked the academy to indicate the number of candidates who had then continued to become employed as a chief executive leading an NHS trust. The aims were to firstly establish the dropout rate for candidates embarking on chief executive training programmes. Secondly, calculate the percentile of candidates who transition from successful completion to role. The objective was to determine if the course offered by the NHS leadership academy was of value. No response was received to my FOI request, despite a follow up request. It is therefore not possible to calculate how successful the NHS academy training program is in developing chief executives. It can be implied that possibly the NHS leadership academy does not record or collate such data to demonstrate success of their educational programmes. If this is true, then why is no one else questioning their value?

One chief executive described their interaction with the leadership academy when looking to appoint a new director for their own trust,

> *'I approached the leadership academy to enquire about the pipeline, talent mapping, there must be someone who you can suggest that may be ready for this role and they were unable to identify anyone. Now I think they should be able to point to people who are ready now and looking for an opportunity to take up the role. That left me thinking that I wouldn't ask again in the future'* (NHS CEO Kate)

A view echoed by another chief executive who stated,

> '*The NHS is appalling when it comes to finding and managing talented people to work in this organisation. We fail to progress our abundant talent and that's because we do*

> *not track it. Most of the private sector tracks its talent but the NHS doesn't do that. We are crap at talent management and it's no surprise that we have a senior leadership cadre that lacks diversity. If you don't have formality of process you have an informal system that just keeps working on a way that has gone before.* (NHS CEO Peter)

As no tangible data is available from the NHS leadership academy relating to training outcomes it is also not possible to establish if the training it provides offers good value for money. Prior studies have established that the return on investment in NHS leadership training programmes remains largely unmeasured (Iliffe & Manthorpe, 2018b). Discussing costs in respect to NHS training "*Understanding costs and cost-effectiveness is essential in guaranteeing value-for-money in healthcare spending*" (Banke-Thomas *et al*. 2017: pp.403). Once again, this links back to previous suggestions that the NHS is wasteful with its capital.

One chief executive spoke of an aspiring director program offered by the leadership academy costing thirty thousand pounds per candidate. They stated that,

> '*We don't know how many people have been on that program and progressed to director posts. We don't know where they are now*' (NHS CEO Peter)

Questioning the cost effectiveness of the program the interviewee continued,

> '*Can you imagine that being in any other part of the public sector or even the private sector where you spend thirty thousand pounds and you don't know how successful it actually is'* (NHS CEO Peter)

They continued,

'*I think it is fascinating to see that we can't give you any return on investment analysis on the Bevan program* [leadership training] *or in fact anything else*' (NHS CEO Peter)

This point was echoed by another participant who stated that the NHS did not,

'…always properly evaluated return on investments of some of those [Leadership academy] *leadership programs*.' (NHS CEO Colin)

When asked to indicate their thoughts of the NHS leadership academy, views varied. One chief executive described the leadership academy as,

'Candidly, a complete waste of time' (NHS CEO Tony)

To enforce this one participant indicated the inability of the leadership academy to help grow talent withing their own trust,

'*So locally if I think how the directors have come up through this organisation, I know we have grown our own rather than had the pipeline through the leadership academy. It's almost despite!*' (NHS CEO Kate)

The leadership academy, according to those interviewed, appears to be failing to produce any suitable results. This may, in part be due to their inability to sell themselves to the wider NHS. One chief executive stated,

'*I don't think their profile is very high. If you asked me what I'd seen or read about the leadership academy in the last twelve months, I'd say very little.*' (NHS CEO Sarah)

Those chief executives interviewed describe how the leadership academy has failed to acknowledge the populations future health care needs. Instead, the leadership academy continues to create the wrong type of leaders. Expanding further, one interviewee explained that the NHS does not require chief executives who can lead in isolation (within a hospital), rather system leaders who know and understand about working collaboratively with other organisations.

> '*The true future leadership should be the people who have the ability to manage across organisational boundaries across sometimes county boundaries*.' (NHS CEO Tony).

In their view the leadership academy was spending,

> '*huge amounts of money*' (NHS CEO Tony)

to create leaders of a system that is not fit for purpose. This view was shared by another interviewee who indicated that the NHS was changing to,

> '*a new world with an integrated system. We don't know if the role of chief execs still exists; however, the number of sites must require some sort of senior management position, but it may not be called a chief executive*.' (NHS CEO Rachael)

Very similar views came from another participant who stated,

> '*As hospitals and trusts get bigger and joint how do you get the support seeing that it's getting bigger and more difficult. Along with that how do we get from being an acute CEO to being a systems CEO? Maybe that's something we can gather from other industry and business who have already gone through those sorts of challenges*.' (NHS CEO Kate)

While the feeling of several chief executives was that the leadership academy had limited impact a survey of clinical commission group chairs, found thirty-four percent believed the leadership academy was having a "*very beneficial impact*" in their area. It also found a further fifty-two percent indicating that it had a "*slight beneficial impact*" (Williams, 2014). This research reflects the thoughts of commissioners surveyed and not those of chief executives. Commissioners are responsible for contracting healthcare services, including awarding contracts to private health care providers. Private healthcare providers are unable to access the NHS leadership academy.

It was argued by one chief executive that the question of how successful and beneficial the leadership academy is in generating new chief executives is unfair. Stating that the responsibility to generate an adequate pipeline of candidate to take up posts in troubled trusts was unfairly directed at the leadership academy. They believed that,

> '*it's the responsibility of the senior leadership of the NHS and also frontline chief execs for not taking a view that leadership development is the most fundamental responsibility. I think as a cadre of NHS leaders we aren't involved enough in bringing through the future NHS leaders*.' (NHS CEO Peter)

This view of a multi-professional and multi-agency leader development program for the NHS had previously been suggested by Edmonstone, (2013).

For some chief executives they felt that the NHS leadership academy did little to assist candidates who enter the aspiring chief executive programme. They suggested it set candidates up to fail. One chief executive stated that the NHS leadership academy is ruling out potential candidate who do not have NHS management or leadership experience. This chief executive argued,

'*Everybody has NHS experience as a patient, and that's the most valuable thing*.' (NHS CEO Tony)

When explored further one chief executive described the range of skills and knowledge, they felt a prospective chief executive should have,

'*Understanding patient care and the drivers of good patient care is a good start. Having a good business mind and understanding how to get things done through people. Taking the time to understand the change and transformation of the modern health care system and how to influence people to change.'* (NHS CEO Rachael)

Another chief executive went on to describe the leadership qualities and attributes which a potential chief executive should possess, all of which are difficult to quantify,

'*There is something about a clear vision, a clear strategy, a clear set of values and a sense of humour. An open and transparent personality that I think comes through. Ambition I think is everything, so it's important to be ambitious, be clear about what you want to achieve but also I think, thinking about the way in which you want to achieve that is incredibly important*.' (NHS CEO Colin)

It was the view of one chief executive that given the high demand for so few places, those who are selected gain a sense of arrogance.

'*The brightest and best get on there so there is a slight arrogance. If you are told you are bright and brilliant and told you've got a one in twenty chance to get on and you get on the course, you're going to think you're pretty good. So, I don't think this is helpful. And I think some of the people from the centre are a little unrealistic.*' (NHS CEO Sarah)

However, as one chief executive indicated those successfully completing the NHS leadership academy's chief executive programme should accept,

> '…*entitlement to a post is never guaranteed.'* (NHS CEO Rachael)

A view shared by another participant who stated,

> '*I think just because you've been on a course doesn't make you a chief executive. I think we should manage talent like they do in industry and we've done very badly in the NHS over the last few years.*' (NHS CEO Sarah)

Again, another chief executive described the reality for some candidate who had completed their NHS leadership academy chief executive programme,

> '*it's really interesting because I know people who have been through that process and then they have been told that they can be chief execs only to spend the next three years trying to get a chief exec job and don't. They go through ten or twelve interviews only to get nothing. It's difficult to demonstrate passion if you are just trying to get a chief exec job*.' (NHS CEO Kate)

So how does a candidate for a chief executive role demonstrate passion. It would appear that having been through a rigorous selection process, where only those considered to be the best are selected, is not enough. Is it possible that candidates believe that the achievement of completing the NHS leadership academy chief executive program gives them automatic entry above all others. This was reflected upon by asking participants their views.

Those interviewed felt that upon completion of the program, candidates were confident but not yet competent. One chief executive described candidates they had come into contact with,

'*We have graduates, people just finishing and they have this real perception that in twelve months' time they are going to be a director or a chief executive. I think I am a good chief executive because of the experiences I've had. I think what we need to do is encourage these folk to have experiences.*' (NHS CEO Sarah)

Chief executives who display over confidence and a sense of arrogance adversely impact upon their management team's engagement, cohesiveness, collaboration and consensual decision-making (Toscano, Price & Scheepers, 2018). These views confirm previous research conducted by Dotlich and Cairo (2003); Resick *et al*. (2009) and Hogan *et al*. (2011) and raise the question, whether new chief executives emerging from the aspiring chief executive program should be placed into troubled trusts. For several chief executives the feeling was that new chief executives should not be appointed to lead troubled NHS trusts as it was likely that they would fail due to inexperience. The consequences of graduates from the NHS leadership academy chief executive program not being appointed to run failing NHS trusts was highlighted by one chief executive,

'*I think some of them get disillusioned because, again its force fed into them and they come out saying yeah I'm ready for a CEO role when actually they need a bit of experience and some scars. They need to understand and feel the health service, they need to have a feel of what's good for patients. Some of them think they are going to come out and run the NHS!*' (NHS CEO Sarah)

Continuing to question the value of the NHS leadership academy, one chief executive indicated that they had applied to join the aspiring chief executive program only to be turned down during the final shortlisting. This resulted in them feeling demotivated while questioning the value and worth of the courses offered by the academy. They stated that having failed to be selected,

'*You know that felt awful. Because it didn't matter that I'd got down to the final 30 there was nothing left for me*.' (NHS CEO Kate)

For this chief executive and several others interviewed they had decided to undertake further and higher education outside of the NHS. The most common of these was a Master's in Business Administration (MBA) through a university. Reasons for doing so included the lack of availability to study at the NHS leadership academy and a feeling that the MBA offered a broader set of skills than those courses offered by the leadership academy. One chief executive spoke of their ability to question different department heads within their team having undertaken the MBA. Asking for an example, the chief executive described how having studied finance as part of the MBA they were confident to ask probing questions to their finance director. The feeling was that possibly those who had not undertaken courses with broader subject areas may be less able to ask appropriate questions. While there are those who suggest that doctors should undertake a joint medical degree with MBA (Bhogal & Bhogal, 2009; Cork & Devine, 2015); and nurses with combined nursing degree and MBA (Aylott & Montisci, 2017), there appears to be no recommendations that NHS chief executive attain an MBA. The previous chair of NHS Improvement, Dido Hardin found a lack of basic people management within the NHS (Moberly, 2018).

The topic of external degrees emerged when exploring differences between the United Kingdom healthcare system and that in the United States of America. One chief executive described from their own experience,

'*In the States there were quite a lot of clinical leaders that also went on to be chief execs. They all had MBAs but also they were highly remunerated. So that was a great career progression whereby they understood the industry but also they were extremely well remunerated for taking on leadership responsibilities*.' (NHS CEO Colin)

This response led the interviewer to explore clinicians becoming chief executives within the NHS.

4.5.9 Clinicians transitioning to facilitators of perceived success

While questioning the pipeline of chief executives and the development of individuals ready to step into post, probing questions were asked concerning the movement of clinicians into management roles. This line of enquiry followed comments made by participants and also recommendations found within the Griffiths Report (1983). There is an underlying assumption within the Griffiths report that the chief executive who comes from a clinical background will be more concerned with quality care within their hospital. As one participant stated,

> '*You have this belief, completely nonsense and nothing irritates me more than its the clinicians that care while the rest of us are only interested in money and targets. Nothing can be further from the truth. But it's often the optics isn't it, if you have a doctor as a chief exec, then the doctors will listen to him or her, and actually there's not a great history of that being true*.' (NHS CEO Tony)

Expanding further on this view another chief executive stated,

> '*I think clinicians are told that they are there for patients and managers aren't. That's true for all clinical roles, doctors, nurse, physios. What we should be saying is that we are all working towards the patient.*' (NHS CEO Sarah)

While probing deeper to explore the assumption that clinicians may have a more caring attitude as chief executive one interviewee, who had been a clinician stated,

'*What it did give me was an understanding of what it's like to be up at 3 in the morning wiping someone's backside. The connection with the front line is not there, as senior leaders we forget that sometimes.*' (NHS CEO Peter)

It is unclear from this statement if the chief executive was advocating that all chief executives should have exposure to working in a clinical setting to become sympathetic to the needs of their staff. One participant highlighted what they felt was an advantage of a chief executive having a clinical background,

'*I'll give you an example of one chief executive who is a clinician by trade. She walks onto the ward at four in the morning and if she hears a patient's bell ringing she waits a couple of seconds then tries to find out why it's not being answered, she tackles the issue head on and is making people accountable for the care they deliver. Likewise, she is happy to put on a uniform on a Sunday and pitch in on a ward. A true board to floor understanding of what care is all about*.' (Monitoring CEO Simon)

While there may be several challenges to achieving a system where incumbent chief executives undertake clinical placements, there is an argument that prospective chief executives and senior managers should undertake placements within clinical settings as part of their development. It was also made clear by one participant that despite having been a clinician they needed to accept that over time their view of clinical care may be different from the reality of the modern NHS,

'*I think there is a bit of realism that actually when I was on the wards 25 years ago now, I have to continually remind myself that the world has moved on. I've got two really poorly relatives in hospital at the moment and the delivery of care is so very, very different from the way I did it. So, there is something about, if you do move along this career line you have to keep reminding yourself that it is different.'* (NHS CEO Sarah)

Several interviewees felt that there was an increasing number of clinicians now in senior management posts within NHS trusts, with a few of those interviewed fitting into that category. One participant disagreed with colleagues regarding the number of clinicians in senior management positions within NHS trusts,

'*it's rare to find people from clinical backgrounds as chief execs*' (NHS CEO Peter)

This view is also shared by some academics who state that it is becoming more difficult to recruit into clinical director posts and even more difficult to persuade people to step up from clinical director to chief executive (Timmins, 2016). One chief executive gave one reason why this may be the case,

> '*When I talk about them* [clinicians] *leading they go through their entire career geared up to lead a team of clinicians. They lead the teams around them in delivering clinical care. So, I think it comes easy to them as they come up through the hierarchy of doctor training and career progression. What I don't think comes easy to them is clinical leaders then stepping into management'* (NHS CEO Rachael)

Other possible reasons clinicians did not appear to migrate into managerial or chief executive positions was further explored. One chief executive noted,

> '*Historically it has been possible to become a senior, well paid medic in the NHS without needing to formally climb the leadership ladder. And equally if one does jump on the leadership ladder it's not clear that there's a significant financial reward, although there is both an intellectual reward and public service reward in doing and taking on that job*.' (NHS CEO Colin)

If this is a true reflection of why clinicians choose not to progress into management then it brings into question the importance placed on financial reward for ambitious doctors to enter non-clinical leadership and management roles. It could be argued that this is not isolated to the NHS but all public and private sector jobs.

While questioning the possible reasons why more clinicians appear not to have transitioned into chief executive roles, risk again featured highly as a probable reason along with a lack of incentive to drive individuals to progress. One participant expanded on this from their own experience,

> '*Some of this is about risk. I have some excellent directors certainly my director of nursing who I don't think wants to progress to chief exec. But what is there to motivate people to progress, what incentive is there? She knows that she is absolutely secure to continue in her role if not here in one of the top London teaching hospitals. We just don't incentivise those in the medical staff to cross over?*' (NHS CEO Peter)

Interviewees spoke of differing risks that clinicians faced if they became chief executives. For some interviewed they perceived that the personal risk to a clinician's reputation as a doctor was not reflected in the salary. One participant stated,

> '*I get paid a salary and its comparable with anybody of the senior doctors here, but it's very high risk. I can upset somebody, and has happened to me in my career, Friday afternoon you aren't coming in on Monday!*' (NHS CEO Tony)

The risk to a clinician choosing to move from senior clinical management into the role of NHS trust chief executive was also highlighted by another participant, who stated,

'*If you're a medic with a career reputation you can ruin that reputation both with your colleagues locally and also nationally that can then make it difficult to recover. You know if you've got a family and a career and you've invested in an area and so forth, that's a huge risk with very little upside or marginal upside*.' (NHS CEO Colin)

Several spoke of a senior clinician being able to have a far greater earning potential and less personal risk if they continued in clinical practice, rather than following a managerial pathway. This was identified by one participant who indicated,

'*We have some senior clinicians in my organisation paid the same, possibly even more with working both extra lists and doing extra clinics than I can probably earn.'* (NHS CEO Colin)

They continued to explain,

'So, the most highly paid jobs are arguably some of the most difficult jobs, so are the leadership jobs but they're not necessarily the most highly paid and or highly valued, possibly as a consequence in the NHS, such that the risk and reward of taking on those leadership roles as a medic are not as clear cut as for other staff groups.' (NHS CEO Colin)

While those interviewed could identify some doctors who had transitioned into senior management the majority felt that more nurses and midwives had entered senior management. This does not appear to echo previous studies which have shown four times as many doctors as nurses sitting on the highest-level NHS boards in England (Jones-Berry, 2018a). Further research shows that the turnover rate of nurses in senior management positions is high with only twenty percent of nurse directors having been in post for five years or more Jones-Berry (2018b). This figure appears to have fallen since 2013 when the figure

was forty percent (Gillen, 2013). The high turnover of director nurse posts and vacancies brings into question the demands of the role, but also the support mechanisms in place (Foster, 2016). One contentious point was made by a participant who reflected on the difference between poor clinicians and poor chief executive. They stated,

> '*We very seldom if ever dismissed doctors who aren't very good. But we do that quite regularly with chief executives*.' (NHS CEO Tony)

A few chief executives suggested that clinicians, while highly skilled in medicine were lacking in their ability to lead an NHS trust without considerable management training. As one interviewee stated,

> '*With management responsibility comes a responsibility for not just clinical care but employing staff, staff welfare, employment HR, business and finance, and other responsibilities. That is not something that all clinicians what to be involved in, there are generally only a few that do*' (NHS CEO Rachael)

It has been argued that clinicians are not comfortable with the legal and regulatory requirements that are required in modern healthcare (Fibuch & Arif, 2018). While this may be true other academics suggested that the 'managerialisation' of medicine has demoralized doctors and disengaged them from all types of healthcare management (Greener *et al*. 2010). This has created a 'divide' between clinicians and managers (ibid.). This view may go some way to help understand why clinicians are less keen to transition to director or chief executive level within NHS trust. The view of one chief executive was to question the benefit to a senior clinician in making the transition to a senior leadership role. The interviewee suggested that managers work life balance was worse than those of a senior clinician,

'*I can guarantee the car park this evening at seven o'clock won't have any consultants' cars, but lots of managers cars. And at seven o'clock tomorrow morning there won't be any consultants in that car park, lots of the managers cars*.' (NHS CEO Tony)

For one chief executive they felt that the role of chief executive appeared to be more concerned with performance management of statistical information. They thought this did little to encourage clinicians into the role. While discussing performance management they expressed,

'I don't think it prevents us doing the important stuff but may confirm to medical professionals that there is little point becoming a chief exec if that is all the job is about' (NHS CEO Peter)

4.5.10 Who are the NHS attracting as chief executives?

The question of whether the NHS is attracting external candidates from business to fill the vacant roles and pool of chief executives was also asked. Without exception all chief executives interviewed had a long career within the NHS, either clinically or administratively. While a few had undertaken spells in organisations external to the NHS all had been connected directly to healthcare or the NHS. One participant expressed how the central management of the NHS had a direct impact on the type of candidate seen coming forward from within the NHS to become chief executives,

'*If you go back to probably 15 years ago when Foundation trusts first came in, it was all about the market, it was all about purchaser and provider, it was all about independence and having autonomy as a Foundation trust an enormous amount of finance directors became chief executives because it was financially driven. Then we shifted into operational delivery with the original NHS plan with targets, then people*

like me who were ops directors came in to be the chief execs because we could deliver A and E, we could deliver waiting times. I think since then there has been a shift again with quality now being front and centre. and so over the past few years have seen the emergence of clinical leaders, so more nurse directors becoming chief executives, although sadly still rare.' (NHS CEO Tony)

Chief executives felt that the NHS was a very different organisation to any business and as such candidates would need to understand its complexities. Those who had transitioned from clinical roles felt that they had a distinct advantage when it came to understanding the culture of care within the NHS. Those who had previously held administrative roles felt their advantage was understanding the inner workings of the NHS. Both groups of chief executives felt this level of understanding would be a challenge for anyone joining from an external organisation. This was highlighted by one interviewee who stated,

'*there's a variety of organisational dynamics and there's also been several chief execs who have come in from outside and not necessarily survived in the NHS*' (NHS CEO Colin)

To have a clearer understanding of how the dynamics of the NHS could specifically affect a candidate from outside of the organisation, chief executives spoke of the challenges they may face. One chief executive commented,

'The skills that you have as a private sector chief exec, for example are very distinct from the skills that you need in the public sector. Because the nature of the NHS and the British medical profession is such that there is a highly regulated and contractually governed set of working relationships that both mean that the industrial relations aspect of healthcare is both incredibly complex and technical' (NHS CEO Colin)

This statement does not explain why senior managers from other highly regulated industries, such as telecommunications, aeronautical, pharmaceuticals, rail, financial and banking sectors are not suitable for an NHS chief executive post. Another participant disagreed that the NHS was unsuitable for candidates from outside of the organisation by stating,

> '*It's about understanding why people would want to be a chief exec*.' (NHS CEO Kate)

I attempted to explore whether the NHS had seriously tried to attract external candidate and if so, how successful those interviewed felt it had been at attracting suitable candidates. One chief executive stated,

> '*We have had a go at getting people to cross over at chief exec level but there are relatively few who have made that transition. There have been some and Jeremy Hunt did try and implement a system of crossover training so people could make that transition. A year's training after already been at senior management level in the private sector then into post as chief exec. Interestingly the uptake was low from commercial sector positions, most who applied were from within the NHS. We just haven't been good at bringing in talent.*' (NHS CEO Peter)

When probed to suggest why the uptake had been small from external candidates the participant commented,

> '…*because at the age you think about making the switch you are either flying in the private sector or perhaps you are not for a variety of reasons.*' (NHS CEO Peter)

Suggesting that those suitable candidates would be successful in business and the NHS would offer very little incentive for them to cross over.

While those interviewed had varied views of the success of the leadership academy most chief executives felt that the graduate training scheme was successful. Most suggested that it did attract talent from outside of the NHS and preparing candidate for chief executive roles. One of the interviewees stated that the graduate management program was an,

> '…*unqualified success'* (NHS CEO Colin)

while another expressed,

> '*The graduate scheme is fantastic but there's a very high dropout, and then we don't look after people*' (NHS CEO Tony)

Support for the graduate scheme was evident from the comments of another chief executive who stated,

> '*The graduate scheme is fabulous. I'm a big advocate of it*' (NHS CEO Sarah)

While most interviewees expressed that the graduate scheme was good one participant was not convinced and stated,

> '*I can't recall the last person I knew had come up through the graduate training scheme*.' (NHS CEO Kate)

Positive views of the graduate training scheme have been echoed by researchers who conclude that NHS graduate management trainees brining added value to the NHS (Huggins (2011). NHS graduate management trainees have shared their views of the scheme, stating, "*The challenge for us has been translating the theoretical learning and personal development into the 'live' environment of a hospital trust*" (Roueché & Smith, 2011: p.349). Upon reflection

this echoes previous comments from chief executives who questioned the ability of external candidates to understand the complexities of an NHS hospital trust. One chief executive felt that the complexities of the NHS and the difficulties in having a clear career route for aspiring chief executives compounded the lack of suitable chief executive to take up post. They stated,

> '*There isn't a huge pipeline of chief execs out there and we really aren't making the role attractive, so we are not creating a pipeline for ourselves either*.' (NHS CEO Kate)

While the role of the Acute NHS trust chef executive is described by some participants and scholars as vastly different from other leadership roles one participant expressed their thoughts on where future NHS leaders should come from,

> '*I don't think we should be hung up on the routes that people come through, I think it's what drives them, what motivates them and can they lead.'* (NHS CEO Tony)

A similar observation came from another chief executive who stated,

> '*It's about recognising and acknowledging that it's the leadership skills that are important not the route or career pathway that is important for CEOs*.' (NHS CEO Kate)

And another participant gave similar thoughts,

> '*We need chief executives to come into post from a variety of routes and not everyone will be a young and inspiring candidate, some will be like me a mature and experienced manager.'* (NHS CEO Rachael)

With three participants expressing very similar views on career routes for chief executives not being important, why does the NHS still seek to promote and appoint chief executives from

within. Why not look to industry or business for successful leaders to fill posts. Is it that the NHS is, as has been suggested by participants, a complex organisation and those from external organisations may struggle to understand its complexities quickly? If this is the case, then the NHS will continue to look for people willing to offer assurances that they can transform poorly performing trusts in unrealistic timescales, based on their prior knowledge of the NHS.

4.5.11 Supporting chief executives to deliver NHS success

It was indicated by those interviewed that NHS Improvement (NHSI) and the Department of Health failed to adequately support chief executives appointed to failing trusts. Other researchers have noted the distinct absence of support offered to directors of nursing in NHS trusts (Foster, 2016). This lack of support became more critical where inexperienced chief executives took up post. One chief executive, when asked if this lack of support was setting new chief executive up to fail, they responded by stating,

> '*It sets them up for a stressful existence and decreases their chances of success, unless you have a strong system of support*' (NHS CEO Peter)

The same chief executive felt that their predecessors had failed to achieve their goals, in part due to a distinct lack of support. The interviewee spoke of the inability of chief executives to see the wider view of the NHS and seek support,

> '*I think sometime as chief execs we are insular and make the mistake of thinking that we operate in isolation as separate organisations. I'm really running an outpost of the NHS, a half million-pound superstore*.' (NHS CEO Peter)

The lack of a formal support network appears to have driven the creation of an informal chief executives' network. These networks provide much needed peer support and advise. Informal

networks can enable participants to gain a greater understanding and knowledge of their role (Guven-Uslu, 2017). One chief executive highlighted the failings of the NHS and their colleagues to provide support to new and inexperienced chief executives,

> '*It's a huge challenge if you are an unknown coming in. If they don't know much about the organisation it's a huge learning curve. And how much support do we give to new chief execs to? There are support networks through NHS confederation and NHS providers. I don't know how many chief execs have mentors. I have built up a nice network of NHS chief execs who I can talk to but that's been done by me*.' (NHS CEO Kate)

This was again highlighted by another participant who indicated new and inexperienced chief executives needed experienced guidance,

> '*They need to be supported by being buddied with an experienced chief exec. They need to be buddied with a coach, it's the investment in the talent. We are investing in getting people to these positions and board tables, but the NHS needs to continue investing in them once they become a chief exec.'* (NHS CEO Rachael)

NHS England (2020b) clearly recognises the importance of staff networks stating that "*people who work for NHS England are our greatest asset*", and continues to list four official networks within the NHS, these are:

- Black and Minority Ethnic (BME) network
- Lesbian, Gay, Bisexual and Trans+ (LGBT+) network
- Disability and Wellbeing Network (DAWN)
- Women's Development Network

While there appears to be no formal internal NHS networks for chief executives there also appears to be no support network offered to NHS chief executives from outside of the health service. This was made clear from those interviewed when questioned. With the role of the NHS trust chief executive focusing on performance, finance, and safety there appears to be similarities to those of chief executives in business. One chief executive indicated that undertaking external degree courses may enhance a chief executive's exposure to external sources of support and help,

> '*Well that's the benefit of doing the MBA or something like that as you are with a group of people from outside the NHS. My coach works with people outside of the NHS and she will share things with me from industry and business. Leadership principles are the same for all organisations*.' (NHS CEO Kate)

The benefit of chief executives receiving mentorship from someone with the experiences of working in commercial business was highlighted by one participant. For this individual they identified that a great source of support came from their trust board chairman,

> '*My chairman was an ex-oil man, corporate lawyer a man of absolute integrity and principle. He supported me but at the same time challenged me. My performance reviews were interesting. He would defend me to the hilt. So, I think we have to support our leaders and the mechanisms of support, including mentorship.*' (NHS CEO Peter)

From the comments of those interviewed it is clear that a robust network of mentors is essential for chief executive to receive support. This includes guidance and help in improving their leadership skills, especially within difficult and challenging NHS trusts.

During interviews participants described changes to the structure of the NHS as a barrier to developing new confident and competent chief executives. Following the publication and

implementation of the NHS Five Year Forward View (NHS England, 2014), several hospitals were clustered together to create larger trusts. One participant described their own experience,

> '*My first CEO job was in a small trust, there are relatively few small acute NHS trusts now. This is a significant point as it affects the ability for new CEOs to progress.*' (NHS CEO Peter)

This reduction in the numbers of smaller trusts has, as the chief executive described, prevented new chief executives from gaining valuable experience in a more controlled environment. Several chief executives felt that they had made mistakes early on in their management careers. The majority of these occurred in smaller district general hospitals. Expanding further one of those chief executives was concerned that,

> '*Those I am working with on the aspiring chief execs program will not have the opportunity to enter a small trust and make those mistakes. The nature of movement now, many will end up in organisations that are quite large but also quite troubled.*' (NHS CEO Peter)

This view was not shared by one of the participants who was leading a trust placed in special measure. They did not feel that small poorly performing NHS trusts were suitable for new chief executives,

> '*This is the smallest trust I've run as a chief exec but it's the hardest one I've run. So, this perception that OK we'll put X in their new chief executive job into a district general hospital, £200 million budget and nearly 3,000 staff is easy. This is far harder than running* [large NHS trust hospital] *where you have a billion-pound budget, you had better infrastructure, you had more things to support you. More departments, people*

to write business plans for you, brighter people who have been on training scheme to get the numbers right, etc, etc.' (NHS CEO Sarah)

The consensus view from those interviewed was that new chief executives lacked the knowledge to make decisive, sometimes risky strategic decisions. This was certainly true in challenging trusts, which required transformation. Researchers have suggested that chief executives are unable to adopt complex business strategies due to a lack of industry knowledge and prior experience (Boling, Pieper & Covin, 2016). There appears to be a willingness of new chief executives to implement strategic change and achieve results but find they are unsure how to achieve such strategies (ibid.). This view is challenged by researchers who argue that new chief executives are not shaped in a vacuum but are embedded with prior experiences and relationships (Weng & Lin, 2014). This argument accepts that not all new chief executives are created equally as each has varied life experience which they may recall to fulfil their role. Finding the person with the right skills, experience and knowledge to manage a challenging organisation is one of the most difficult parts of any transformational process (Bititci, 2007).

One chief executive indicated that above all, when appointing a chief executive to transform a failing NHS trust, commissioners needed to select someone who had tangible evidence of success in strategic change and improvement.

'*You can put a first-time chief exec in but for me it's around looking for someone who is able to demonstrate change and success in change, turn around, improvement anything that shows success. Their track record needs to show more than just staying at a successful trust*.' (NHS CEO Kate)

This was echoed by another chief executive who highlighted how a senior leader had left their trust to become the CEO of a failing trust of similar size. They explained,

'O*ur chief operating officer went there, first chief exec job lasted probably about eleven months. And that's a good example of someone who did a good job here goes to another more challenged organisation, on the face of it looks quite similar, but ongoing financial and operational issues such that regulators lose confidence and deliver structural change in bringing in an interim to steady the ship and so forth*.' (NHS CEO Colin)

When interviewing those chief executives who were leading a failing NHS trust or had transformed a troubled trust, they indicated that they had not volunteered to take up post rather they had been asked by NHS Improvement. The feeling from these individuals was that they were just one of many chief executives, put in post to turn the fortunes of their trust around. One chief executive described that in the past twelve years their trust had appointed ten chief executives to transform the organisations performance. All twelve had failed to achieve an upturn in performance. For some of those interviewed they indicated that their appointment followed the exit of an interim chief executive.

4.5.12 The use of interim chief executives to deliver success

The use of interim chief executives was mentioned several times when looking at the leadership of troubled NHS trusts. Several possible reasons were cited for the appointment of interims, but the lack of other suitable substantive candidates featured most prominently. Because of the absence of a suitable candidate to take up post, one participant explained,

'*The only way to get an experienced chief exec in is to pay a premium. You pay a premium that chief exec might come in*.' (NHS CEO Colin)

This view was echoed by another interviewee who stated,

'*What you end up with are chief execs who have retired or retire early who then earn around three hundred and fifty thousand pounds a year as an interim chief exec.*' (NHS CEO Peter)

The use of short-term chief executives has been noted by academics who found that of twenty-four trusts in special measures seven were being led by interim or acting chief executives (Clover, 2013). Only one of the trusts in special measures has a chief executive who had been in post for over five years (ibid.). The use of interims within other trust board positions is also high with a third of NHS director posts filled by interim appointments or vacant (Cabral, Oram & Allum, 2019).

Described by two participants as,

'*a hired gun*' (NHS CEO Colin and Sarah)

the perception was that frequently interim chief executives are appointed to remove members of the trusts management team who are seen to be underachieving or not adding value. There appears to be a culture, within the NHS, where rapid staff turnover is the result of bringing in interims to tackle problems at the top and turn around troubled NHS services (Lipley, 2011). Another view from a chief executive was that interims do not always do as expected by those appointing them. The chief executive explained,

'The consequence of that [appointing an interim] *is that they will probably address the things that they want to do. Sometimes they can be quite difficult, take quite brutal decisions. But they know they are only going to be around for a short period. And they've not necessarily always got the long-term interests of the organisation at heart. They are brought in to deliver short term fixes and that then, can result in them moving on after a short period.*' (NHS CEO Colin)

A similar view was presented by another participant who stated,

> '*I think historically we would see a report stating that an NHS trust was failing. They* [NHS England] *would jet in someone highly qualified, highly motivated for money as opposed to looking after the local population, who lived in hotels or nice apartments for six months to a year. Then would be helicoptered back out again. It never gave time for anything to bed in or settle. I don't think they led by example. So, you would have someone swanning around in their beautiful Armani suit walking the walk talking the talk but achieving very little and then leaving the poor buggers to pick up the pieces once they had gone.*' (Monitoring CEO Simon)

Within the sample group of chief executives there were a number who had taken up substantive post following their initial appointment as an interim. This finding led to the question of whether interim chief executives do get results and turn around failing trusts. For most of those questioned, they did not feel that there were any guarantees that an interim chief executive could turn around a failing NHS trust. To the contrary, it is suggested that performance is significantly harmed by the selection of an interim during the tenure of that interim (Ballinger & Marcel, 2010). One explanation for this may be the view that for interim chief executives they had very little to lose and would often make radical decisions which a substantive chief executive may find too risky to undertake. Because of this, interims were, felt by those interviewed, more likely to exit voluntarily if things started to go wrong in an attempt to save their reputation. This view was not shared by one participant who stated,

> '*I see some real change in terms of putting in a strong and mature chair, a strong and mature chief exec who then build their team around them producing good results in some poorly performing organisations*.' (NHS CEO Kate)

It was important to explore what actions are open to troubled NHS trusts where they employ an interim on a short-term contract. One chief executive spoke of a scenario where there is an attempt to recruit a new chief executive into the trust. They continued to describe the issues as,

> *'If it's again a small district general hospital the pool of applicants might have slightly improved, but again you are more likely going to be taking a risk and you get back into this cycle*.' (NHS CEO Colin)

In this scenario the trust never gains a chief executive with the skills and knowledge to maintain any form of standards. This was described by a couple of chief executives who had taken on failing trusts after a long string of prior chief executives. For one of the participants who had firstly taken on the chief executive role as an interim position, they felt it had been most beneficial.

> *'It gave me the opportunity to take up the CEO role as an interim and enable me to see if it was a role which I could do*.' (NHS CEO Kate)

While probing deeper to explore the complexities of taking on a chief executive role as an interim the participant explained that they had previously held a director role within the hospital, and as such,

> '*I had the advantage of knowing the running of the hospital I hadn't had the exposure of the external partners, so a steep learning curve there. There was also a steep learning curve for people to get used to me and my way of working. There were some bumps in the road, but you would get those if a new chief exec came in and started taking control*.' (NHS CEO Kate)

If as this participant highlights there are advantages for directors taking up chief executive roles with their own NHS trust, should interim or prospective chief executive only be sought from within a trust's own executive team rather than externally? There must be a risk by recruiting an internal candidate, especially within a poorly performing trust. Are internal candidates likely to continue adopting the previous leaders' strategy, with no improvement of service? This suggestion was offered to one chief executive, and they stated,

> '*I did at points think that the trust hasn't always delivered that they may want someone new as I may be part of the problem. But then having led the merger of two boards together and made the interventions for that merger I was overwhelmed by the support that staff and teams gave me as I thought they may need someone new. The staff said that they didn't want anyone new they wanted someone who knew where they had come from and what issues they had been through. A new person may have been advantageous, but they may have not fully understood the past difficulties and the way staff had been treated by consecutive management structures.'* (NHS CEO Rachael)

While this chief executive questioned their own suitability to take up post for fear of being part of the problem, did the response of the staff demonstrate true support or relief that things were unlikely to change. Had a new chief executive been appointed, this would have resulted in a change of direction and pressure on staff to perform.

4.6 Perception of NHS success during a pandemic

This research took place during an unprecedented pandemic which placed the NHS at the centre in preparing for the rapid increase in demand for care (Ham, 2020). Hospitals reorganised their services to facilitate increased critical care capacity and support patients with COVID-19. So serious was the treat of NHS services being overrun dedicated 'Nightingale

hospitals' were setup in major cities to avoid patients being denied care at the peak of the pandemic.

During this period communication with participants ceased as chief executives focused upon the demands required of them to maintain functionality of the NHS. Given the unparalleled nature of the pandemic it would be remiss of me not to explore the experiences of chief executives and their leadership during a pandemic. To facilitate this, follow up questions were asked during the month of August 2020. This period fell between the end of the first wave of the pandemic and the start of the second wave. Several responses were received. These responses are categorised in the following sections.

It has been indicated that much of the world's governments were ill prepared for a pandemic like COVID-19 (World Health Organisation, 2020). The UK had already identified in 2009 that a Pandemic influenza (flu) could threatening to overwhelm health and social care services in the UK (Department of Health, 2009). As a result, the World Health Organisation stated that the United Kingdom had done much to prepare for an influenza pandemic (The House of Lords, 2009). Preparations include the procurement of a stockpile of antivirals, face masks, respirators and antibiotics.

For chief executives they indicated that while they had undertaken training for major incidents nothing had prepared them for a pandemic. One participant stated,

> '*We, as the NHS weren't really prepared for a pandemic, despite it being on the list of risks to the NHS and GB Plc.*' (NHS CEO Peter)

Unlike the major incidents the NHS typically trains and practices for, such as terrorist incidents and large accidents, COVID-19 was a protracted incident placing strain upon the NHS for

several months. Two participants both commented on the lack of training to prepare chief executive for a pandemic with one stating,

> '*Preparing for an emergency situation seems to be undervalued and underappreciated in many leadership courses in the NHS*' (NHS CEO Colin)

Describing the COVID-19 pandemic as a,

> '*Once in a lifetime experience*' (NHS CEO Colin)

two participants stated that much of their learning came from,

> '*doing'* (NHS CEO Colin & NHS CEO Peter)

as the pandemic evolved. This approach saw many individuals stepping-up to meet the challenge supported by their respective senior management teams (Halliwell, 2020). Probing further to see how NHS chief executive had adapted to the challenges of leadership during the pandemic, one participant was vocal in their views of the self-preservation which chief executives appeared to adopt,

> '*I think they are listening to what Sir Simon Stevens* [CEO NHS England] *is saying and some of them are very keen to preserve their reputations. So, if he says jump they say, 'Yes Simon how high do you want me to jump?'. That is being translated down into the regional stuff that I attend. Very much back to a centrist approach at the moment*.' (Monitoring CEO Simon).

This view suggests that NHS chief executives were vastly underprepared to lead in a scenario of a protracted pandemic, rather relying on central advice to ensure they acted correctly.

One participant commented,

> '*One thing that this pandemic may achieve for NHS leadership is the shake-up of management to readdress the apparent imbalance of power and bureaucracy*.' (NHS CEO Peter)

This is not new and stems from a legacy of over 30 years of market-oriented reforms, all of which have made it difficult to plan for the needs of the whole population (Ham, 2020). Researchers have expressed that NHS chief executives have stated that after COVID-19 the NHS cannot return to its previous structure of bureaucracy (Cavendish, 2020). This was echoed by one chief executive who felt that during the pandemic a lack of bureaucracy had given them,

> '…*the ability to take action at speed rather than taking months to implement*.' (NHS CEO Sarah)

Other observers have stated that the pandemic produced a unique environment where change at pace was permitted, and mistakes were acknowledged and learnt from rather than any hint of blame (Graham & Woodhead, 2020). One participant indicate that the pandemic required all members of the hospital team to identify and correct mistakes quickly,

> '*I don't like surprises at all, and I think most people don't. I expect us as a team to be open and honest, there is a caveat if someone comes to me, I want to hear what's wrong and what they are doing to sort it out and what help they want from me*.' (NHS CEO Kate)

Participants had expanded upon the need for greater local leadership by describing the lack of a defined role for commissioners and regulators during the pandemic. One chief executive stated,

> '*I have been on conference calls with twelve managers, of which three were working at the sharp end of the pandemic. The rest were regulators trying to establish what their role was!'* (NHS CEO Peter)

It is suggested that the initial response to the pandemic taught the NHS that local clinicians and operational management have led most of the measures that have worked (Oliver, 2020).

It is stated that in March 2020 the NHS underwent sudden change as local and national leaders prepared for the consequences of COVID-19 upon its services (Ham, 2020). Commentators reported that the NHS saw a rapid growth in collaboration between government departments and local leadership to increase its resources (Halliwell, 2020). Participants expressed varying views to the support received by the government, during the pandemic. The initial message communicated down from central government to hospital leaders was, as one participant stated,

> '*Prepare for the worst and hope for the best!*' (NHS CEO Colin)

Another participant stated that they had,

> '*Good support received from regional teams as part of collective leadership*.' (NHS CEO Sarah)

Another chief executive described,

'*Regular briefings from the regional team and weekly national calls with Keith Willetts, the person who led the emergency response*.' (NHS CEO Colin)

For one participant they felt there had been,

'A lot of mixed messages around COVID which has confused people, an almost information overload in terms of what has been coming out from public health.' (Monitoring CEO Simon)

The theme of localised leadership managing the pandemic, within NHS hospitals was highlighted by another participant. This participant described the early stages of the pandemic and how the pandemic would be led from government. They stated,

'*In early March we were told that this would be controlled centrally, and that hospitals and local partnerships would be told what was required, from the centre. The reality has been that the pandemic has been controlled locally by partnership working*.' (NHS CEO Peter)

This expression of chief executives working in partnership with local partnerships echoes previous findings from interviews held prior to the COVID-19 pandemic. During the interviews chief executives described the changing landscape for NHS chief executives from hospital leaders to system leaders and managers.

One of the participants described the difficulties experienced by chief executives when trying to seek assistance from the government. They stated that,

'*What was different about COVID is that it hit right across the NHS and therefore, there was no dedicated support given*.' (NHS CEO Peter)

During the initial interviews participants were asked to define what success may look like in the NHS. The use of performance was often stated as a benchmark utilised to indicate how successful an NHS trust was. Participants spoke of waiting times for treatment in accident and emergency departments along with cancer treatment times as key performance indicators. These were also seen as indicators to the successfulness of the chief executive as a leader, with those chief executives leading trusts with low waiting times held in high esteem. This need to meet NHS key performance targets appears to have been removed from the beginning of the pandemic in the United Kingdom. The narrative of the NHS had changed during the pandemic with efforts focusing on meeting the spike in COVID-19 cases and preserving life (Vaughan, 2020). NHS hospital chief executives were forced to stop all but essential care services, including postponing all non-urgent elective operations and urgently discharge all hospital in-patients who were medically fit to leave (Stevens & Pritchard, 2020). This caused one participant to express concern at the possibility of patients missing out on care,

> '*We know that waiting times for cancer consultations and treatments is going to get worse as during COVID everything has stopped while the NHS concentrates on the pandemic. My fear is that we will fall back and forget these waiting times and people will get lost in the system*.' (Monitoring CEO Simon)

In an attempt to direct all operational resources to the preparedness of increased COVID-19 cases, on 17th March 2020 the government instructed NHS England and NHS Improvement to cancel all routine CQC inspections, with immediate effect (Stevens & Pritchard, 2020). According to one respondent,

> *'Many CEOs said thank God for that*' (NHS CEO Peter)

highlighting their dislike of scrutiny from the CQC. This view was not shared by all participants with one describing the need for additional scrutiny rather than an absence. Expanding further they stated,

> '*At the most difficult time in the history of the NHS, when we needed some form of scrutiny there has been none. We have seen no regulatory inspections or critiquing of our services'* (NHS CEO Peter)

This lack of regulatory oversight, the participant felt, had,

> '…*resulted in poor care and poor practice*.' (NHS CEO Peter)

What is unclear is whether the lack of scrutiny did have an adverse impact on care and clinical practice. Without any external inspection of services there is no way of measuring clinical outcomes and care. There is also the question of the response from chief executive to the possibility of poor care and practice due to the lack of external scrutiny. It is not clear if chief executives felt driven to report their concerns to the regulators, NHS England, NHS Improvement of central Government. As it is implied that many chief executives welcomed the lack of regulatory inspection it is probable that they did not express their concerns, as this might lead to a reversal in the CQC audit visits.

A public inquiry into the United Kingdom's response to COVID-19 is likely to involve the NHS being scrutinised closely so lessons can be learnt. It will see NHS leadership at all levels being challenged to identify both those things that went well along with those that did not. Asking those chief executives interviewed initially to reflect on the pandemic and identify learning points for future NHS leaders produced various responses.

Chief executives all stated that there was a need to re-evaluate how the NHS serves its communities and how the chief executive becomes an integral part in this process. Throughout the study acute trust chief executives have stated that the traditional role of a chief executive as hospital leader is transforming, with a move towards a system orientated manager. This theme continued with one participant stating that as a result of the pandemic it has confirmed that,

> '*The wider NHS is not responsive to the needs of the local community in its time of need and this needs to be addressed*.' (NHS CEO Peter)

This view saw others highlighting what they believed needed to be addressed in the future,

> '*The challenge of local management to account to local people*.' (NHS CEO Sarah)

With a disconnect between the NHS and the wider community, there became a visible void in care within the social care network (Pollock, Clements & Harding-Edgar, 2020). This resulted in local leaders unable to resolve such issues locally (ibid.). The effects of this void in services emerged during one interview where a participant described trends their organisation is now seeing in the community,

> '*What we are finding now is that we are seeing a number of people suffering from PTSD* [Post Traumatic Stress Disorder] *due to the inability to get local treatments, due to COVID*.' (Monitoring CEO Trevor)

Despite this observation, the NHS did quickly adopt new technology to maintain services to patients. However, this was not without difficulties which need addressing in the future,

> '*I think one of the things that has happened amazingly is the increase in digital technology like virtual clinics. Telemedicine has taken off big time, but what the NHS*

has I fear failed to understand is that a large percentage of the population do not have any access to digital technology. There is this assumption made that those people are either poor or elderly. That couldn't be further from the truth, it is right across the board. It's also down to a lack in digital infrastructure such as fast and reliable broadband that allows patients to use telemedicine effectively' (Monitoring CEO Simon)

Another chief executive also commented on the rapid uptake of technology due to the pandemic,

'*Up to the pandemic there was a very slow drawn-out program of adopting digital referrals, be that moving from face-to-face consultations with your GP or talking to a hospital consultant as part of a referral. In the first three months of 2020 we saw it move forward the equivalent of five years as the necessity to adopt the system became reality. There was no other option but to do it, to the point that we think that around eighty percent of the population are now using digital platforms to communicate with the NHS, as part of their healthcare needs*.' (Monitoring CEO Ben)

But there were also concerns that prevented patients using these new NHS services,

'*People are still a little bit fearful of technology and who is listening in or who can access your data*.' (Monitoring CEO Simon)

Again, similar views were shared by another participant,

'*The issue of using digital technology is not without problem. Can the person afford it, are they literate in the new technology, and do they have the technology or infrastructure, like high-speed broadband? So, issues of digital poverty, digital literacy, digital exclusion*.' (Monitoring CEO Ben)

One area which participants commented upon was the large number of managers in other parts of the NHS who were trying to lead the pandemic response at a local level. For one participant this manifested itself as a large number of disfranchised managers trying to give direction without knowing the real state of play within hospitals. The participant stated that,

> '*There has been a lack of situational awareness and as a result the support hasn't been freely available to support staff and patients*.' (NHS CEO Peter)

This saw chief executives being required to challenge decisions more than they previously had, to ensure the message was clearly communicated. Other chief executives found the need to step back from their leadership role. This allowed those with clinical experience to have greater autonomy for care decisions. The fluidity of the pandemic meant that life or death decisions relating to the possible rationing of life saving treatment had to come from clinicians, supported by their chief executive. One chief executive explained,

> '*I have been keen to take a step back, respect, listen and take advice from colleagues. So, I think COVID has made me more coaching, more curious, more compassionate and want to empower, respect and provide greater autonomy to our outstanding workforce*.' (NHS CEO Colin)

This comment provides an insight into the requirement for future NHS leaders to have a wider understanding of the skills and expertise each member of their team has.

A positive effect of the COVID-19 pandemic has been the increased profile of the NHS and its staff (Marlow *et al*. 2020). While there was a significant disruption to recruitment within the NHS there was also an increase in staff numbers in critical areas of care, as a response to the pandemic (NHS Digital, 2020). For one participant they expressed that this was a good thing

as they felt that more people were now looking to join the NHS as nurses, an area typically under resourced. The also expressed how this shift in profile may affect the potential pipeline of chief executives,

> '*Maybe managers who have found themselves on the edges of the pandemic* [non-hospital managers] *may wish to move into leadership roles closer to the front line?*' (NHS CEO Peter)

Their closing comment relating to the effects of COVID-19 and chief executive recruitment was,

> '*I do hope out of this we see some suitable candidates coming forward.'* (NHS CEO Peter)

4.7 Chapter summary

This chapter has reviewed the data collected from the eleven chief executive interviews. The data has provided a rich insight into perceptions of success. While views of success were sought from the government and opposing political parties no responses were obtained. This was also the case for care regulators the CQC and the NHS leadership academy. This limitation will be further discussed in the conclusion chapter.

While previous studies have examined what success may be this study appears to be the first in which the perceived success of the NHS has been explored, making this research unique. It appears that prior studies have not sought the views of NHS chief executives, rather those of middle and junior managers. Again, this brings a new insight to the study of perceived NHS success.

In the next chapter all findings will be analysed and discussed. This will help answer the original research questions which were set out at the start. This will assist in bringing this research to a rounded conclusion.

Chapter 5 - Discussion

5.1 Overview

In this chapter I will discuss the original research objectives and debate the findings with regard to the theoretical and practical implications that flow from them.

This research has examined perceptions of success in the British NHS from the perspective of the government, regulatory organisations, chief executives, and service users. I have collected and examined narrative accounts to generate a collection of findings relating to the subject area. These form the basis for this chapter's discussion.

5.2 Reviewing the purpose of this research

At the outset of this thesis, I advanced a rationale for my interest in studying perceptions of success in the NHS. This originated from my own background as both a former healthcare professional, health service senior manager and as a long-term NHS patient (service user). When I began the research, the NHS could not have predicted the challenge of dealing with a global COVID-19 pandemic and find itself at risk of being overwhelmed by increasing levels of demand. Early in the pandemic, emergency 'Nightingale Hospitals' were swiftly constructed in anticipation of increased numbers of patients with COVID -19 who would require specialist intensive care facilities. Thankfully, in the event, these facilities were not required and were duly decommissioned a few months after being built.

In a sign of support for the NHS, the public started a social movement where rainbow posters and signs were placed in windows thanking the NHS for all it was doing during the pandemic. Accompanying this, every Thursday from March 26th, 2020 to May 28th, 2020 many members of the public went out onto their doorsteps at 8PM and clapped for the NHS staff, as a gesture of appreciation. Even a World War Two Spitfire emblazoned with 'THANK U NHS' on its underwing was flown across the UK so it could fly over almost every NHS hospital. With so

much appreciation for the NHS and the lifesaving work it undertakes the question is does this not demonstrate the NHS to be a resounding success, one which is clearly loved and cherished by the UK population? But what for those who now find themselves as part of the 6.1 million people waiting to start NHS treatment, how do they rate the success of the NHS?

The research findings have highlighted the differing ways in which success is viewed and how these perceptions are frequently not agreed upon by stakeholders of the NHS. This conflict between competing views sees the NHS in a state of perpetual friction, with stakeholders vying for their view to be a priority. Even the same group of stakeholders can hold opposing views based upon their own needs at that moment of questioning. This makes defining whether the NHS is successful acutely difficult. It may be possible to gain a consensus view of NHS success from each stakeholder group based upon the personal experiences gathered during this research, but as stated even the same group of stakeholders can express differing perceptions. To establish how different groups of people, who interact with the NHS view its success three research questions were defined at the inception of the research. Despite the COVID-19 pandemic these questions remained relevant and valid throughout the duration of the research.

5.3 Discussion: What do politicians think NHS success is?

Following the review of the extant literature, it became apparent that the concept of success in respect of the NHS was under-researched. Historically, we tend to regard the very fact the NHS was established in the first place as the 'success story' (Klein, 2013). This position is seen repeatedly in government publications to date, including very recent ones such as the NHS five year forward view (NHS England, 2014), The Government's mandate to NHS England for 2018-19 (Department of Health and Social Security, 2019), The NHS long term plan (NHS England, 2019b) and The NHS Constitution for England (NHS England, 2021).

But the NHS was created in 1948 and though a remarkable achievement it seems rather dogmatic for the discourse to obsess over this. Instead, perhaps success – and the measure thereof - needs to find more contemporary traction. Not one participant was able to articulate with clarity what they believed the government's view of NHS success to be. To address this, formal approaches were made to the current Conservative government, opposition parties along with former health ministers from the Conservative, Labour and Liberal Democratic parties. Despite following these letters up with emails not one person was willing to speak with me. Several letters and emails went unanswered while others were replied to stating that the recipient was unable to comment or too busy to engage with me. This absence of engagement makes the process of defining success from a political and government perspective extremely difficult. It may also go part way to suggest why there is a lack of prior literature which gives political views of NHS success. The lack of willingness to engage with me and give any definition of how NHS success can be perceived prompts the question of whether politicians know what NHS success may look like.

The majority of chief executives interviewed believed that politicians do not know what NHS success looks like. While this may possibly be correct it is not based on empirical evidence, so remains an assumption. While it may be that politicians do not know what NHS success is or how it might be measured, an alternative explanation may be that they are unwilling to place on record something which they could later be challenged upon. Had a current government minister suggested a measurement of NHS success which they were later unable to demonstrate their party had achieved, this could be repeated back to them indicating that both the NHS, they and their party had failed. The same could be true for all political parties who may also have been challenged if they failed to mention these measurements within their next election manifestos. During this research participants were asked to suggest what politicians may perceive NHS success to be. Some NHS chief executives indicated that politicians in government, rather than focusing on NHS success concentrated upon removing anything which suggested that the NHS was failing or struggling under their leadership. In essence

each political party wishes to portray that they are best placed to manage the NHS while other parties are not. During the literature review this finding did not appear as part of any previous academic study or commentary.

In business, success is often demonstrated by increased productivity and organisational efficiency (Taslim, 2011) and the findings of this research suggest the government appears to have a similar view, when focusing on the NHS. Prior research has indicated that successive governments have undertaken frequent restructures and reforms to the NHS to improve organisational production through increased efficiency (Ham, 2009). Early NHS reforms were driven by a desire to implement administrative changes that produce efficiency savings (Webster, 1998; Klein, 2013). During this research some participants felt that the government viewed success purely in the measurement of increased performance. NHS trust chief executives who were interviewed expressed how NHS England were quick to question and penalise them if they failed to meet performance and finance targets. This finding echoes those of Talbot-Smith and Pollock (2009) and Appleby and Devlin (2005). NHS England does support the claims made by NHS trust chief executives as it describes the use of performance indicators to demonstrate healthcare improvements at local and national level, within the Government's mandate to NHS England for 2018-19 (Department of Health and Social Care, 2019). This is further supported by the findings of Ham (2009) who suggests that success appears to be based on statistical outcomes set by the UK Government. Given the findings of previous studies and those from this research it is likely that the government views NHS success in terms of statistical outcomes based on treatment times above all other measurements. The same is true when examining healthcare systems in other countries. It is observed that the governments of France, Italy, Norway and several other countries also report similar performance indicators to demonstrate success. Despite this there appears to be no consistency with the types and quantity of data collected in each country to demonstrate healthcare success. This finding supports previous research which has shown a lack of similarity in performance measurements (Ingleby *et al*. 2012; The Health Foundation, 2015).

The inconsistency in healthcare data results in an inability to accurately compare healthcare systems and their success.

During this research it has been identified that political parties in government appear to concentrate of those health issue which can be resolved within their tenure. These are typically published within NHS England documents, such as the NHS five year forward view (NHS England, 2014) and the NHS long term plan (NHS England, 2019b). Previously these have included changes to administration as part of the Bradbeer Report (Ministry of Health, 1954), Further changes to hospital administration as part of the Porritt review (1962a), the creation of NHS trusts following the National Health Service and Community Care Act 1990 and in recent years the creation of the Care Quality Commission to oversee standards of healthcare. Each of these reforms and restructures to the NHS have occurred within the tenure of a government and have enabled the party in power to highlight these changes as key improvements to the NHS, prior to the next general election. Despite these claims there is little evidence to suggest that these reforms have had any impact on improving the performance or success of the NHS.

It has been suggested, by the participants of this research that politicians perceived the NHS as a political football kicked between parties to highlight the shortcomings of each party's health policies. One area where political parties appear to try and suggest their election into government will result in greater NHS success is by promising higher spending on healthcare than their opposition. This serves no purpose in resolving underlying issues within the NHS, rather it deflects from taking any meaningful action on the most challenging or wicked problems of the organisation, as highlighted by Ritte and Webber (1973); Grint (2010); Senge, Hamilton, and Kania (2015). Appropriate funding should be made available by UK government to solve and correct those issues which stop the NHS appearing to constantly 'firefight' problems which continue to consume the limited NHS budget.

Statements made by participants in this research indicated that in their view politicians, and certainly those in government, predominantly focus on resolving healthcare issues which secure their re-election. These findings support those of Grint (2010), identifying the inability of politicians to tackle long term projects. The result is that governments do not embark on tackling the most complex issues within the NHS which are likely to take many years to resolve. It is therefore not a priority of any government to think past the four years they are in power, opting to leave the challenging issues to their successors. One example of this is the inability of successive governments to address the high levels of wastage found in the NHS. This was highlighted by one participant who had identified the amount of money wasted within their own NHS trust every day. This has caused governments and the NHS to look for quick fixes to maintain short term financial stability and prevent perceptions of failure (Kmietowicz, 2014). As Murray, Imison, and Jabbal (2014) state this simply tackles one small part of a far greater problem. Likewise in his report, Griffiths (1983) identified that despite numerous reports published since the Bradbeer Report in 1952 no government had attempted to address the management and leadership issues of NHS hospitals in the interim thirty-one years.

With the perception that consecutive UK governments only focus upon policy which can be implemented during their parliamentary tenure, it could be suggested that those NHS issues which require extended time to resolve rarely, if ever get tackled by any government in power. The long-term effect of this reluctance to address the most challenging issues or wicked problems of the NHS is a continued avoidance to make change which resolves any complex organisational and structural problem (Grint, 2010). While each consecutive government decides not to take decisive long-term action, many deep-rooted systemic problems in the NHS continue to go unresolved. One decisive way to address the continual avoidance of government to commit to long term change policy in the NHS would be by the appointment of a Royal Commission focused exclusively on reforming the NHS. This is not without difficulties, starting with the acceptance by the government in power that change is required and alone they are unable to either define or enact such change. This may see opposition parties

highlighting the appointment of a Royal Commission as an inability of the government to run and manage the NHS. It would be advantageous to ensure that the commission is conducted with joint party acceptance. To facilitate this agreement would need to be sought from all political parties as the outcomes of the commission would benefit the UK and not just isolated political parties. As part of the Royal Commission detailed terms of reference would explore what NHS success should look like and gain the expert opinion from a broad spectrum of contributors. A Royal Commission takes an apolitical stance with a clear focus on producing recommendations that result in an NHS fit for purpose. Much like this research it will be able to explore healthcare services from across the globe to ascertain what success looks like, how it is measured and how it can be achieved in the UK. Royal Charters are typically conducted over several years and as such will require adequate funding. This is another reason why an all-party agreement should be sought to ensure funding is accepted and protected for the duration of the commission and the subsequent implementation of the recommendations. The implementation of a Royal Charter requires strong political leadership not departmental management, departmental oversight or revised scientific process. Without a Royal Commission that acknowledges that the NHS requires significant and substantial reform the status quo will continue, and the NHS is unlikely to address its most difficult problems.

During this research it has been suggested that the government puts forward, to the electorate, changes it has implemented during its term in office to demonstrate improvements in the NHS (Veronesi *et al*. 2013). Participants highlighted this as commonly involving commissioning a new regulatory body to oversee or monitor care or the restructuring and reforms to the NHS. This research ascertained that there is a political perspective that improvements to the NHS oversight equate to better care and greater success; however, this research disputes this notion. The Care Quality Commission was established in 2009 to oversee and monitor care services, including the NHS. Since its creation the CQC has failed to prevent several deaths at the Bristol Royal Infirmary and the high mortality rate and poor care seen at Mid-Staffordshire NHS Foundation trust. It could be seen to be questionable if the creation and

implementation of commissioning bodies do improve NHS services and lead to greater success. Trying to establish the success of these reforms and reorganisations is also difficult due to the lack of post change evaluation (Maynard, 2013; Katikireddi *et al.* 2014). For participants of this research, they frequently questioned the value of such regulatory bodies, especially during the COVID-19 pandemic where the CQC suspended all inspection visits and oversight of NHS services. Participants suggested that during the pandemic it was essential that the NHS had external scrutiny from a body like the CQC to ensure that a safe service was maintained. This finding raises the question of whether the CQC is of value in monitoring the UK healthcare systems.

Many participants during this research referred to performance targets as a way the government perceive NHS success to be measured. This research agrees with Merry (2011) that government set performance targets enable complex statistical data to be formulated into a simple rating table for policy makers and the public to understand. Their ability to indicate success is questionable.

All participants stated that performance targets were closely monitored by NHS England and NHS Improvement and used to highlight the best and worst performing NHS trust hospitals. This supports previous assumptions made on how the government utilises performance data (Ham, 2009). The most frequently quoted performance target was the four-hour accident and emergency treatment time. While there is clearly a need to be treated as soon as possible in many cases of sudden medical emergency the four-hour performance indicator is used universally in the NHS to indicate success in treating emergency patients. Its introduction as a performance measurement in 2004 appears to be based on no scientific criteria. During this research it has been observed that the use of the four-hour waiting time has no scientific rationale for use as a marker of success, which supports results from previous studies conducted by Neill and Williams (1992), Moore (2007) and Jasinarachchi *et al. (*2009). This raises the question why the UK government continues to see its use as a viable measurement

of NHS success. Most participants felt that the four-hour target was little use given the unpredictable internal and external pressures on accident and emergency services. This research has explored how performance targets are used by governments in other countries and whether they are used as an indicator of healthcare success. As part of this process, it has been established that those governments who adopt patient centric performance targets see better performance and treatment outcomes than those who adopt time measured targets, like those of the four-hour waiting time in the NHS. This finding leads us to question why the UK government continue to focus on time measurements of performance if they are less effective in indicating healthcare success?

It has previously been argued that governments use performance targets in healthcare to demonstrate results arising from their policy changes (Thomas & Meyer, 1984: Brignall & Modell, 2000). In this way governments can show that they are capable of improving healthcare for its citizens. This research disagrees with this argument based on the following observation. If this was correct, then politicians would certainly consider changing the performance target from one which is repeatedly missed to one which is eminently achievable. This again raises the question of what the government and political parties perceive success to be?

It is not only politicians and political parties who appear unable to define NHS success but also NHS England and NHS Improvement. Similar formal approaches were made to both organisations' chief executives, without any response. As researcher I have established that within literature, NHS England prescribes the use of key performance indicators as the measurement of NHS improvement and in turn NHS success.

While this research has concentrated on seeking the perceptions of NHS success it has also raised further questions which are closely linked to this topic. One relevant question which appears to be absent from previous studies is what the government believe the purpose of the

NHS to be. As has been seen, the initial purpose of the NHS was to make healthcare provision widely available to the British population while being free at point of delivery (Klein, 2013). This is repeatedly held up as the greatest success of the NHS; however, it is seldom mentioned that the NHS became quickly overspent in the 1950s with many questioning its purpose and administration (Webster, 1998; Cutler, 2003; Klein, 2013). Reflecting on the observations and perceptions of those who took part in this research several indicated that the NHS appears to be in a similar situation today. Once again available NHS resources, in all areas are outstripped by increased demand from the population. This, it could be argued will only worsen unless the UK government clearly defines what the overriding purpose of the NHS is and communicates this clearly to the population.

Despite there being no clear political definition of NHS success, politicians appear content with the use of performance targets and performance measurements to indicate healthcare success.

5.4 Discussion: Success and leadership of acute NHS trusts

Within the literature it was observed that the perception of success from the position of NHS chief executive can be vastly different from others inside and outside of the organisation (Dye, 2016). This research found similar findings, when looking to establish if chief executives were able to identify what NHS success looked like. Unlike politicians, NHS chief executive were able to define, what they perceived to be, key indicators of NHS success.

Prior studies of business environments have suggested that success for business is closely linked to organisational performance (Reijonen & Komppula, 2007), and this research has found a similar perception for managers and senior leaders within the NHS. All stated that currently key performance indicators were used to benchmark individual NHS trust success and the associated success of them as chief executives. This link between poor trust

performance and the leadership of chief executives echoes those found by Ham (2008) and Smyth (2014). While most chief executives stated that performance targets were used to indicate NHS success few agreed that their use was an accurate way of defining success. Those interviewed described the use of most performance targets as meaningless, especially where they have been repeatedly missed for several years. In the case of the specialist cancer treatment target of 62 days, this has been missed consecutively since 2013/14 (NHS England, 2019). Some chief executives regarded this as unacceptable and empathised with those who required swift potential lifesaving or life extending cancer treatments. The impression given to me in these exchanges was that NHS trust chief executives felt that they had failed the public vicariously. This gave an important insight into the human side of chief executives who at times felt privately opposed to the NHS using performance targets rather than patient-centred outcomes.

Most NHS chief executives interviewed did not feel comfortable with publicly challenging the use of performance targets. This echoes those findings of Lock (2017) who found a reluctance of NHS managers to question the government's use of certain performance targets and measurements. As a result, this raises the question of whether NHS trust chief executives feel that publicly questioning the validity of performance targets would jeopardise their employment. Do NHS chief executives feel there is a better way to measure the success of the NHS but feel unable to state what they may be?

The perceived measures of success for chief executives are not isolated to performance targets set by government but encompass two other key features: financial budgets, and safe care. As has been described within the findings, I have defined this combination as the Trigeminal Care Model. Chief executives describe the components of the model as each having an impact upon how they are assessed and impact on how successful they are perceived by NHS England and NHS Improvement. As this model has not previously been documented in literature there is a question as to why this may be so. One possible

explanation may be that the three components are often examined in isolation and seldom as a collective, with each having an impact upon the others. When critiquing NHS trusts, performance is generally viewed as a strategical element while safe care is seen as an element falling to the clinical directorate and sustainable budgets being part of the finance function. The result is that the correlation between each element of the Trigeminal Care Model is seldom viewed. It is suggested that NHS trust chief executive concentrate on just one element of the Trigeminal Care Model and focus their initiatives on improving finances at the cost of providing care to demonstrate NHS success (Leahy, 2017). This research disagrees with Leahy as chief executives indicated during interview that they were acutely aware of the implications that unsafe care and poor performance have upon their own perceived success and that of their trust hospital. This research did detect that given a choice between each element NHS trust chief executives would sacrifice care and performance to maintain stable finances but as a last resort.

Having examined performance measures and perceptions of success in other healthcare services it is apparent that the Trigeminal Care Model can be applied to many countries, especially those who operate a universal healthcare system. The Trigeminal Care Model does not appear to work in private healthcare systems where typically high levels of care are funded. This has been disputed by one chief executive in this research who felt that private healthcare did not offer improved clinical or outcomes. This chief executive felt that private healthcare did not exist for quality purpose so implied that outstanding clinical care was secondary to profit. This assumption is disputed as part of this research as it has established that in several countries of the world where universal healthcare is offered a large percentile of the population choose to pay for additional private healthcare. This is seen in such countries as Australia and the Netherlands, despite these countries having good universal healthcare. Analysis of global universal healthcare systems shows that one of the best performing healthcare systems in the developed world is in Norway where citizens have access to universal healthcare supplemented by private health insurance (Schneider *et al*. 2021).

This research also disputes that care is poorer in private healthcare given that both the NHS and private healthcare in the UK are regulated and measured to the same standards through the CQC. This sees the NHS and private healthcare being required to meet the same criteria for safe care, performance, leadership and patient outcomes. It was determined through the examination of other systems of universal healthcare that other countries do not have one overarching authority which maintains scrutiny of both public and private healthcare. In France, it could be argued, there is no perceived difference in care provision between state hospital and private hospital as patients are able to choose where they receive treatment from as part of universal healthcare. In the UK this is only possible if the public pay or the NHS direct patients to private treatment facilities to reduce their own waiting times.

For several chief executives there was an indication that a major cause of poor performance in the NHS was due to the lack of social care and alternative care pathways for patients. As a result far too many patients resorted to attending accident and emergency departments for their primary care needs. Chief executives who were questioned did not perceive the NHS to be successful in its approach to collaborative working with other parts of the wider NHS. This was highlighted by NHS trust chief executives who described the disconnect between acute hospital care and social care. This saw chief executives arguing that without a clearly defined strategy for all elements of the NHS to work together several of the challenges faced by NHS trusts would continue. It was noted that some chief executives of the independent healthcare monitoring services also felt that there was a sizable lack of joint partnership working across the NHS. This generated several discussions around how collaborative working would be funding with some chief executives from the healthcare monitoring services arguing that funding would need to come from existing budgets held by chief executives running acute NHS improvements in trusts. The question is whether NHS trust chief executives would be willing to relinquish some of their funding without a guarantee that diverting it to social care would improve the challenges they face running an acute NHS hospital? It could be argued that removing funding from an NHS hospital to fund social care assumes that less funding

would be required to run a hospital accident and emergency department if the volume of patients is reduced. This fails to consider that the overhead costs to provide an accident and emergency service remains constant regardless of the number of patients seen. The cost to provide the building, the staffing level, equipment, heating and lighting remains exactly the same while the cost of consumables to treat patients is negligible in comparison.

During interview chief executives of the independent healthcare monitoring services felt that NHS trust chief executives are reluctant to look at integrating care services as they are only concerned with how they are measured, and this is by making their own hospital a success. This led one NHS chief executive to highlight that future NHS leaders need to look beyond the boundary of their own hospital trust to ensure that the integration of care in the community results in a global success for the NHS.

The examination of universal healthcare in countries where collaborative care pathways are embedded sees reductions in hospital admissions by directly tackling the causes of those admissions. This is seen in Canada and reflected in improvements to the health of the Canadian population while also helping to reduce the per capita cost of health care through the reduction of long-term hospital admissions (CIHI, 2017). While the movement of the NHS towards an integrated care system where primary care, social care and acute hospital care are closely aligned chief executives remained sceptical of its implementation and overall success. Despite this scepticism almost everyone interviewed explained that something was needed to reduce the pressure on acute hospitals. The real test will be whether integrated care systems offer greater levels of care to the population and are deemed successful.

During this research it has become apparent that chief executives of acute NHS trusts are perceived by several stakeholders to be the difference between success and failure of their hospital, echoing those comments of Bevan and Hood, (2005). This manifests itself in the short tenures of chief executives who are dismissed when their trust is rated poorly or fails to

transform (Anandaciva *et al*. 2018). As has previously been discussed those NHS trusts which are rated poorly or stated to be failing have deep seated and complex issues. These NHS trusts do not appear to fail overnight rather because of protracted poor leadership and management of the trust. The failure of NHS trusts as a result of longstanding poor leadership was a key observation during the Francis Report (2013).

This research has concluded that it is not only poor leadership that results in perceived failure of NHS trusts but a culmination of events which ultimately sees chief executives failing to positively transform or continue on a downward spiral of failure. As those interviewed indicated the NHS sets up many chief executives to fail through poor training and education, inadequate support and assistance, unrealistic timescales and expectations. It could be unfair to place the perceived failure of NHS trusts solely with the leadership of chief executives. As has been suggested by those interviewed several troubled trusts have failed for many years and regardless of the number of chief executives put in place to lead and transform those trusts they continue to perform poorly. This suggests that for some troubled NHS trusts the leader has minimal if any impact on success. This leads to an issue with the perceived impact on success that changing the chief executive of a troubled NHS trust will make. This research suggests that for some of the most challenging NHS trusts simply replacing the leader and expecting things to positively change is not realistic. This suggestion may also go some way to help explain why Anandaciva *et al*. (2018) found such high levels of chief executive turnover in poorly performing or troubled NHS trusts. To turn around these trusts it must be acknowledged by those in overall control of the NHS that either those chief executives put in charge of failing trusts seldom have the skills, knowledge or experience to affect positive change or the skills and knowledge they possess are poorly suited for the conditions found in problematic trusts. This again highlights the prior suggestion made in this research that the NHS prepares new chief executives to fail through inadequate education and support. Once again this brings into question the value of the NHS leadership academy.

Within the literature review it was highlighted that the NHS exists using a two-way model of responsibility (Chang, 2015). This model sees the government delivering on its promises to the electorate and chief executives acting to implement those promises. During the interview process it was suggested that in poorly performing trusts the chief executive has little control on what they implement rather they do what they are told to implement. If this is true, then chief executives have very little input on what they do to turn a poorly performing or troubled trust around. This research suggests that in poorly performing trusts newly appointed chief executive who possess limited skills and knowledge become an instrument of the government's instructions. It could be argued that this often sees new chief executives following orders based on governmental and departmental perceptions, rather than acting autonomously on the issues they observe.

5.5 Discussion: Is the measurement of success based on CQC ratings?

At the outset of this research, a freedom of information request was made to the CQC to establish the various ratings of acute NHS trust hospitals. Data was requested to show how those ratings had changed over several years and in what areas that change occurred. What became apparent was that the change in rating was unpredictable with some NHS trusts showing a constant rating while others fluctuated between poor and outstanding. Just by analysing the data it was not possible to predict how an acute NHS trust would be rated in its subsequent years.

This inability to predict a trust's rating was echoed by chief executives, when questioned on the subject. One chief executive felt that the government had made managing an NHS trust so complicated that it was a surprise that all NHS trusts are not failing. This theme continued with several chief executives defining the leadership of an acute NHS trust as one of the most challenging jobs today. A couple indicated that the result of perceived failure was the termination to a chief executive's contract and their replacement. This mirrors the suggestion

of Jenter and Kanaan (2015) who describe a demand by stakeholders to dismiss poorly performing chief executives quickly and the swift appointment of a suitable replacement. Yet when examining the data of poorly performing NHS trusts even when the chief executive is replaced the rating continues to be poor, often over many years.

When exploring this with chief executives many expressed that those NHS trusts perceived to be failing have deep rooted cultural issues. This is also suggested by Best *et al*. (2012), indicating that this is not a new concept. Going further chief executives describe how these NHS trusts require an experienced and skilled NHS chief executive to turn their fortune around. Expanding further, the one element that is also required to improve a trusts rating is time, and this appears to be seldom given by those appointing new chief executives. A proposed reason for not giving new chief executives time to transform an NHS trusts rating was that new chief executives are unrealistic in their abilities and the time required to improve a trust with cultural problems. This is combined with pressure being placed upon a new chief executive from NHS commissioners, NHS England, NHS Improvement and the government. It is suggested that this culminates in a lack of quick results and the continued poor performance and subsequent rating of the trust. For those NHS trusts perceived to be failing it is essential that a realistic timeframe with achievable milestones is provided to the new chief executive as without this the trust enters a downward spiral of failure followed by dismissal of chief executive and appointment of another to achieve results. The inability to provide a chief executive with a realistic timescale for transformation is cited as being the primary because of business failure (Papegaaij, 2017), so it would make sense that this is also true when attempting to transform the success of an NHS trust.

Those chief executives who participated in this research highlighted that the NHS is not successful in developing adequate numbers of new chief executives with the skills and knowledge to transform poorly performing and perceived failing NHS trusts. This is nothing new and has previously been highlighted by Lord Rose in his review of leadership in the NHS

(Rose, 2015). While the NHS leadership academy was created to do this most chief executives felt that the academy was not achieving this, rather it created a small number of new chief executives who lacked the tools required to perform to the standard required. Having requested data from the NHS leadership academy to show the number of candidates who have progressed through the academy and onto chief executive roles it was of note that this was not supplied. This supported suggestions from those chief executives interviewed that they had not seen data giving the success rate for those entering the leadership academy chief executive pathway training program. Previous studies have concluded that there is a lack of tangible data available to suggest that the NHS leadership academy offers good value for money (Illiffe & Manthorpe, 2018). This supports the comments made by those interviewed as part of this research. This research raises concerns that the NHS leadership academy is not fit for purpose as it is not able to demonstrate its value in providing training and education to enhance the leadership of the NHS. If the leadership academy produced suitable and sufficient numbers of highly skilled chief executives, then it could be argued that NHS trusts would not continue to fail or have a rapid turnover of chief executives leading failing trusts.

5.6 Discussion: Does measuring NHS success really matter?

During this research it has been suggested by some NHS chief executives that measuring NHS success is of little value given that patients have nowhere else to go at time of greatest need. This monopolistic system sees patients suffering medical emergency at home summoning assistance from their NHS GP, the NHS ambulance service, the NHS non-emergency 111 service or visit an NHS hospital accident and emergency department. It could be argued, as has been seen within the findings of this research, that even if NHS care is substandard there is no free alternative for patients. Despite this the public perception of the NHS is that it is second to none and should be protected at all odds.

The NHS has taken on a quasi-religious status with the public seeking to defend it at every opportunity. This was seen with chief executives commenting on how the public demonstrated support for the NHS during the COVID-19 pandemic. When compared to other universal healthcare systems the NHS performs poorly against many health outcomes (Statista, 2019). Examining the French and Italian universal healthcare systems it is observed that both countries have significantly fewer death per population from Alzheimer's and Dementia, Coronary Heart Disease and Stroke than the UK (Papanicolas *et al.* 2019). Regardless of this it is suggested by those interviewed that the public continue to believe the NHS is the best healthcare system in the world. I suggest that regardless of what evidence is placed before the public, their perception of the NHS will always be of an outstanding healthcare service. I question if this makes the public complicit in the continued mediocrity of the NHS as they fail to acknowledge that the NHS could be much better.

5.7 Chapter Summary

I have discussed how perceptions of NHS success vary without any universal definition being found. The fact that politicians are unable or unwilling to express a view of how NHS success may be defined is of concern. As custodians of the NHS, it raises further questions about their abilities to maintain a universal healthcare system.

Chief executives who lead acute NHS trusts are willing to suggest how NHS success can be measured opting for the use of key performance targets. Yet we have seen that many of the performance targets adopted by the NHS are not based on any scientific reason for their use. This raises further questions about the validity of using non-science-based performance measurements in healthcare.

The use of CQC ratings has also been put forward as a measurement of NHS success with successful NHS trusts being led by successful chief executives. But CQC ratings appears to

be of little interest to patients as they find themselves within a monopolistic healthcare system with little choice at time of need. This raises questions about the suitability of using CQC ratings as a perceived measurement of an acute NHS trusts success.

In the final chapter I state the recommendations that come from this research while providing guidance for future research into NHS success.

Chapter 6 - Conclusion

6.1 Overview

In this chapter I reflect upon my research and give indications on how politicians, NHS leaders and members of the public may change their perceptions of the NHS. In doing so it is anticipated that clearer definitions of NHS success could evolve.

The chapter expands to discuss the limitations of this work and how future research might build upon them to further enhance knowledge in this subject area. It takes a holistic approach to the subjects examined and draws from the findings new areas which add to the existing knowledge of the NHS, perceptions of success and the challenges faced by chief executives of NHS trusts.

6.2 Recommendations

This research has challenged the conventional rendering of 'success' in the NHS (as an abstract single-faceted metric). It has ascertained that despite the publics' persistence to say that the NHS is wonderful, it could be better. Therefore, this research has revealed a disconnect between the realities of the NHS and the publics steadfast support of it. A reason for this continued support may result from the notion that the NHS is free. The fact that the NHS is paid for through individual taxation appears to be forgotten.

When comparing other universal healthcare systems, it is noted that the NHS does poorly in preventing death in a number of key disease categories. The NHS also compares less favourably than other countries for treatment waiting times, access to care and patient satisfaction. It would appear that the UK is falling behind other countries for its provision of universal healthcare. It is evident that current performance measures are not fit for purpose. They are not founded upon any scientific rationale and appear to have no impact on improving patient care. But measuring success in the NHS is difficult and complex. Success, as has

been demonstrated in this research, depends upon a person's perspective. For this reason, there is a need for clarity on what NHS success is and how it can be observed.

If, as this research has shown, the continued use of performance measures is utilised to provide a matrix for NHS success, these performance measures should be carefully selected so they include a wide range of outcomes. As a result, there are implications for practice if the NHS is to develop and adopt new methods of measuring performance and success. It requires policy makers to acknowledge that existing performance measures are not suitable for determining NHS success and that new methods must be sought. This would see the government communicating widely the need to revisit NHS performance and linking performance to the delivery of increasing levels of care. The need to acknowledge that the NHS is not as good as some universal healthcare systems requires transparency, not only by government but also opposition political parties. There is a risk that without this acknowledgement opposition parties may politicise the need for change as an example of how government is failing to manage the NHS.

With a need for suitable measurements to be based on clear scientific foundations, additional research is required to ascertain the most appropriate and credible measures to adopt. They should include patient centric performance standards which measure treatment outcomes. In addition, research should explore the numerous measures of performance and success adopted by other healthcare systems. This would enable best practice to be determined, with a view to apply them to the NHS.

The NHS is an emotive institution which sees the UK population defending its existence and services. There is a need for the public to understand that the NHS is providing inconsistent levels of care and varied outcomes. This is in opposition to the belief that the NHS is wonderful. An implication of determining the most appropriate measures of NHS performance and success will see the publics perceptions of the NHS challenged. While accepting that

perceptions of NHS success are frequently based on an individual's own personal interaction with the service, statistics demonstrates that the NHS provides poor outcomes for several treatments.

6.2 Limitations of this research

This research was undertaken using eleven participants, as outlined within the methodology chapter. This was partly due to the poor response from potential participants (political parties, politicians, NHS leaders, regulatory bodies) but also due to the COVID-19 pandemic. Due to the pandemic planned interviews were immediately cancelled by some participants so they could concentrate on responding to the pandemic. It is worth remembering that even two participants, when questioned, may produce variance in their responses. While the sample group is appropriate for a study of this kind as it enabled views to be collected from a number of different stakeholders, it should be taken into account when contemplating the generalisation of the findings.

This research concentrated on the narratives of chief executives. As a result, it may be argued that the participant group is too narrow. It fails to seek out the views of success from others within the NHS. While clear rationale for selecting chief executives is given within the methodology chapter, I accept that wider participation may lead to differing views of NHS success. Given that success can be perceived differently by individual within the same environment, the outcomes seen within this research may have varied had front-line workers been interviewed. This research could be repeated either with participants taken from various NHS roles. Alternatively, it could be replicated multiple times using specific roles each time.

I took the conscious decision not to conduct this research within the UK NHS ambulance services. I made this decision early on as I felt I had significant bias having worked within an NHS ambulance trust. I considered my prior detailed knowledge of the ambulance service

may impair my ability to conduct an impartial research study. While I believe this was a valid reason it has limited the research area. To establish a wider understanding of NHS success I could have explored other areas. This may have included GP practices, mental health hospitals, community care, and ambulance services. As a result, it may be an argued that the findings of this research are limited to just one NHS group. While I accept this, I also consider that gaining the views of success from multiple NHS sources across multiple parts of the NHS may have produced confusing data. By selecting acute NHS trust chief executives and chief executives from independent monitoring services I was able to compare data. Had I interviewed chief executives of NHS ambulance trusts, their views would reflect the challenges they face. The challenges faced by a chief executive leading an acute NHS trust hospital are different from a chief executive leading an NHS ambulance service. While an acute NHS trust hospital site may cover 10 to 50 acres (40,000-202,000 square metres) serving a population of 400,000, an NHS ambulance trust may cover 7,500 square miles, serving a population of over 6 million. Any repeat of this research should consider exploring success from multiple parts of the NHS. I would suggest that it is replicated several times. On each occasion the selection should be isolated to just one part of the NHS. In this way comparisons are made across the same areas of service.

While invitations to participate were sent out widely across the UK, all respondents came from the south of England. This limited the research to parts of the UK which did not have high levels of social and economic deprivation. This is a reasonable factor when assessing the results of this research. It could be argued that NHS chief executives in northern towns and cities may have different challenges than their peers in the south. This could result in the perceptions of NHS success being expressed differently in the north. What has been achieved in this research is a comparison of views from chief executives all in similar social and economic areas. Should a similar study be undertaken in the future it would be prudent to ensure a consistent coverage of participants from all social and economic areas.

A significant limitation to this research was time. The process of obtaining ethical approval from the NHS was protracted. While the university had some experience of assisting researchers to achieve NHS approval it had not encountered the additional steps I had been asked to complete. To assist researchers who may wish to undertake studies involving the NHS I suggest that they visit the NHS Health Research Authority (NHSHRA) prior to starting their research. This will enable them to establish what information they are required to provide and how they register for an NHS research passport. This may reduce the length of time required to obtain ethical approval.

6.3 Future research

Several questions have arisen during this research which would benefit from further research in the future, including:

- What does the UK government believe the purpose of the NHS to be?
- What would be the effects on patient care if the NHS was privatised?
- What influences a patient's choice of primary care pathway?
- Is the NHS a learning organisation?

6.4 Final words

This research has enabled me to examine and re-evaluate my own beliefs and understandings, not only about the NHS but about success and how we view concepts such as success in our everyday lives. I have also been required to reflect critically at the way I have managed and led people in the past. Rather than being an endpoint, I believe that this research is the beginning of a longer journey of personal discovery. While I accept that perceptions of success appear to be extremely personal, I hope that the conclusions I have produced in this research may be used by those empowered with leading the NHS now and into its next seventy-four years.

I was extremely proud to have been both a registered nurse and then a registered paramedic, working on the frontline of the NHS. During my employment I witnessed extraordinarily talented professionals performing the impossible daily. I had the unrivalled privilege to enter people's lives at time of great joy and deep sadness and be part of their life story. I have been fortunate to train and educate future healthcare professionals across the UK and watch as they embark on their NHS career, unaware that one day I was to require their care myself. It is a twist of fate that my own life was saved by the NHS in 2001 when I suffered a cardiac arrest.

For me the NHS is sometimes taken for granted with most people paying little attention to its success or failure until they need it most. To this end, there is an assumption that it will be there for you, a safety net to meet your healthcare needs. In reality, there is no such guarantee. However, a keener, more nuanced, understanding of success in the context of healthcare provision may go some way to preserving an institution so close to British hearts.

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8 - Appendices

Appendix 1: Research COVID-19 letter V1.1

University of Suffolk
Waterfront Building,
Neptune Quay,
Ipswich IP4 1QJ
k.hotchkiss@uos.ac.uk
www.uos.ac.uk

<NAME>
<ADDRESS>

12 August 2020

Dear <SIR/MADAM>,

RE: Academic research into leadership styles of NHS Chief Executives

Earlier in the year you very kindly took time out of your busy schedule to discuss your leadership role with me. The information you provided has been incredibly valuable for my research.

Following our meeting the outbreak of the Covid-19 virus has put great pressure on the NHS and I would like to ask you just a few follow up questions relating to the effect of the pandemic upon your leadership role. These questions will enable me to examine how leadership in the NHS has been affected.

Questions:

1: What leadership development had your received to prepare you for an event specifically like the Covid-19 pandemic?

2: Had you skills, knowledge and attributes from your previous roles that prepared you for the Covid-19 pandemic

3: How much support have you received as an NHS leader from the Government, before and during the Covid-19 pandemic?

4: How has the Covid-19 pandemic affected your role as a leader?

5: What do you think the NHS needs to learn from the Covid-19 pandemic for the development of existing and future NHS leaders?

6: Does the NHS significantly prepare leaders for events like the Covid-19 pandemic?

7: Is there anything that you feel is important to mention with regards to leading and NHS Trust during a pandemic?

I understand that you are incredibly busy so would suggest that your response is fine via email or by post to my home address:

[redacted]

Once again, I thank you for your support and I look forward to hearing from you in the very near future.

Yours sincerely

10/08/2020 V.1.1

Yours sincerely

Keith Hotchkiss
Research Student
Suffolk Business School

10/08/2020 V.1.1

Appendix 2: Research informed consent form V1.4

University of Suffolk

Informed Consent Form

The University of Suffolk expects all research to be carried out in accordance with the following principles:

- The emotional well-being, physical well-being, rights, dignity and personal values of research participants should be secured.
- Research participants and contributors should be fully informed regarding the purpose, methods and end use of the research. They should be clear on what their participation involves and any risks that are associated with the process. These risks should be clearly articulated and if possible quantified.
- Research participants must participate in a voluntary way, free from coercion. Participants have the right to withdraw at any time.

This research has been approved by the University of Suffolk Ethics Panel. Should you have any concerns about the Ethics of this research, please feel free to contact the Chair of the Ethics Panel, Professor Emma Bond e.bond@uos.ac.uk (01473 338564) or the Research Development Manager, Andreea Tocca a.tocca@uos.ac.uk (01473 338656).

Study Title: Leadership Styles and their effectiveness in the NHS: A study of Chief Executives in Acute Trusts

Main Investigator: Keith Hotchkiss
Academic Supervisor (for Student Research): Professor Penny Cavenagh

Please initial the boxes below.

I confirm that I have read and understand the information sheet/letter (delete as applicable) dated _____ explaining the above research project and I have had the opportunity to ask questions about the project.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without there being any negative consequences.	☐
I understand that my responses will be anonymised and any personal or identifying information removed from published materials	☐
I give permission for members of the research team to have access to my anonymised responses.	☐
I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	☐

University of Suffolk

I understand that the data I provide will be used solely for the purposes of the research study outlined and will not be used for any other purpose. I also understand how long my data will be stored for.	☐

I agree to take part in the above research project.

_____	_____	_____
Name of Participant (*or legal representative*)	Date	Signature
_____	_____	_____
Name of person taking consent* (**if different from lead researcher*)	Date	Signature

To be signed and dated in presence of the participant

_____	_____	_____
Researcher*	Date	Signature

To be signed and dated in presence of the participant

**Delete as appropriate*

Copies:

Once this form has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/information sheet and any other written information provided to the participants.

A scanned copy of the signed and dated consent form should be placed in the project's main record by the student/researcher/PI. This must be kept in a secure location.

Appendix 3: Interview question guide

University of Suffolk

Interview Questions

Based on research question: *What are the perceived measures of NHS success?*

1. **Tell me about your career so far.**
2. **As a CEO how do you define success?**
3. **Reflecting on your role, how is NHS success measured?**
4. **In your view has the definition of NHS success changed?**
5. **In your experience is the current measurement of NHS success correct?**
6. **Thinking of your peers, do you feel they share your views of NHS success?**
7. **What do you believe the political measurement of NHS success to be?**
8. **What do you believe the publics measurement of NHS success to be?**
9. **Are there any conflicts in perceptions of NHS success?**
10. **What would you describe as the barriers to perceived NHS success?**
11. **Could you give me your thoughts on performance targets, like the 4 hour A&E treatment target?**
12. **How are poorly performing NHS trusts perceived?**
13. **What is the role of NHS England in measuring NHS success?**
14. **What are your views of the NHS leadership academy and their development programs?**
15. **What part does NHS leadership play in NHS success?**

All questions may require additional probing questions after each answer.

Appendix 4: Ethical approval letter (University of Suffolk ethics committee)

University of Suffolk

Waterfront Building,
Neptune Quay,
Ipswich IP4 1QJ

+44 (0)1473 338 000
info@uos.ac.uk
uos.ac.uk

Tuesday 12th March 2019

Project Lead: Keith Hotchkiss
Subject: Leadership Styles and their effectiveness in the NHS. A study of Chief Executives in Acute Trusts
Type of study: Postgraduate Research
Start Date: 1st September 2019
End Date: 30th September2020
Primary Supervisor: Professor Penny Cavenagh
Second Supervisor: Dr Tom Vine

Dear Keith,

Following the resubmission of your application for ethical approval to the Committee for the 11th March 2019 meeting, the University of Suffolk Research Ethics Committee have reviewed the amendments to your application.

The Committee have approved your application to conduct research for this project with the following recommendations:

- The Committee suggest that the researcher includes participant involvement information in section 4 rather than section 2 of the application.
- Dr Sarah Richards is referred to as Dr Richardson, this should be amended.

The University Research Ethics Committee expects to be informed about the progress of the study, any revision in the protocol and participant information/informed consent or participant related documents and ask to be provided a copy of the final report.

This Ethics committee is working in accordance to the University of Suffolk research governance guidelines, policies and procedures.

Yours sincerely,

Emma Bond

Professor Emma Bond
Director of Research and Chair of the University Research Ethics Committee
University of Suffolk

Appendix 5: NHS research passport application

Research Passport Application Form – Version 4.0 02/04/2019

Please refer to the guidance notes before completing the form.

Section 1 - Details of Researcher *To be completed by Researcher*			
1.	Surname: Hotchkiss		Prof☐ Dr☐ Mr☒ Mrs☐
	Forename(s): Keith William		Miss ☐ Ms☐ Other☐
	Contact Tel: [redacted]	Contact Email: k.hotchkiss@uos.ac.uk	
2.	Date of birth: [redacted]		
3.	Professional registration details, if applicable (Doctors undertaking any form of medical practice should confirm they have a licence to practise). N/A ☒		
4.	Employer: NA	or place of study: University of Suffolk	
	Work Address/Place of Study: Waterfront Building, 19 Neptune Quay, Ipswich, Suffolk, IP4 1QJ		
	Post or status held: Doctoral student		
Section 2 - Details of Research *To be completed by Researcher*			
5.	What type of Research Passport do you need? Project-specific ☒ Multi-project ☐		
	If you will be conducting one project only please complete the details below. If you anticipate that you will be undertaking more than one project at any one time, please give details in the Appendix.		
	Project Title: Leadership Styles and their effectiveness in the NHS. A study of Chief Executives in Acute Trusts		
	Project Start Date: 01/10/2019	End Date: 01/10/2022	
	Proposed start and end-date of 3-year Research Passport: Start Date: 01/08/2019 End Date: 01/10/2022		

NHS organisation(s):	Dept(s):	Proposed research activities:	Manager in NHS organisation:
[redacted]t	CEO	Interview with CEO	[redacted]
[redacted]	CEO	Interview with CEO	[redacted]
[redacted]S	CEO	Interview with CEO	[redacted]

Section 3 – Declaration by Researcher *To be completed by Researcher*		
6.	Have you ever been refused an honorary research contract?	Yes ☐ No ☒
	Have you ever had an honorary research contract revoked?	Yes ☐ No ☒
	If yes to either question, please give details:	

I understand that my data will be used for the purposes described in section 6 of the Information for researchers, R&D and HR staff in Higher Education Institutions and the NHS guidance document. I warrant that the information provided as part of this Research Passport application and the attached documents are a true and accurate reflection.

Signed: [signature] Date: 4/9/2019

When Sections 1-3 have been completed, the researcher should forward the form to the appropriate person to complete Section 4.

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Section 4 - Suitability of Researcher
To be completed by researcher's substantive employer, e.g. line manager, or academic supervisor

7.a	Will this person's research activity mean that they may be undertaking regulated activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012)? (please use the Research Passport algorithm to make this judgement)	Yes ☐ No ☒

7. b I am satisfied that the above named individual is suitably trained and experienced to undertake the duties associated with the research activities outlined in this Research Passport form.

Signed: Penelope Lawenagh	Date: 4/9/19
Name: PENELOPE CAWENAGH	Job Title: Professor - Graduate School
Department and Organisation: GRAD SCHOOL, University of Suffolk	
Address: UoS Neptune Quay Ipswich IP4 1QJ	
Tel No: 01473 338000	Email: pcawenagh@uos.ac.uk
Managerial responsibility for the applicant:	

When Section 4 has been completed, the researcher should forward the form to the appropriate person to complete Section 5.

Section 5 - Pre-engagement checks *To be completed by the HR department of the researcher's substantive employer or registry at place of study*

8.	Does the above named individual's research involve Regulated Activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012)?	☐ Yes ☒ No
	If yes to the above, has the above named individual been checked against ISA barred lists for adults and/or children, as appropriate and have you received confirmation via the criminal record disclosure that the person is not barred from working with adults and/or children? (*NB individuals who are barred from working with adults or children must not undertake a regulated activity in the NHS with the vulnerable group from which they are barred, and you must not submit a Research Passport form in such cases).*	Checked against: ISA Adults List? Yes ☐ No ☐ N/A ☒ ISA Children's List? Yes ☐ No ☐ N/A ☒
	Can you confirm that a clear criminal record disclosure has been obtained for the above-named individual, with no subsequent reports from the individual of changes to this record? *NB for Regulated Activity this must be an enhanced level criminal record check. For non-regulated activity, ensure the criminal record check is at the mandated level.*	Yes ☒ No ☐ N/A ☐

If yes, please provide details of the clear disclosure:

Date of disclosure: 05/07/2019	Type of disclosure: Enhanced
Disclosure No.: 001664469628.	Organisation that requested disclosure: University of Suffolk.

9.	Have the pre-engagement checks described below been carried out with regard to the above-named individual and is confirmation of the necessary checks, including any required satisfactory documentary evidence, available in the employing organisation's/place of study's records?	
	▪ Employment/student screening:	
	o ID with photograph	Yes ☒ No ☐
	o two references	Yes ☒ No ☐
	o verification of permission to work/study in the UK	Yes ☒ No ☐
	o exploration of any gaps in employment	Yes ☒ No ☐
	▪ Evidence of current professional registration	Yes ☐ No ☐ N/A ☒
	▪ Evidence of qualifications	Yes ☒ No ☐
	▪ Occupational health screening / clearance	Yes ☐ No ☒

Is the named individual on a fixed term contract or is the contract end imminent? Yes ☐ No ☒
Please indicate current contract end-date Date: n/a

Signed: J Kessler	Date: 04/07/19
Name: JANE KESSLER	Job Title: H.R. ADVISER.
Organisation: UNIVERSITY OF SUFFOLK	Department: H.R.
Address: Waterfront Building, Neptune Quay, IP4 1QJ	
Tel No: 01473 338000	Email: j.kessler@uos.ac.uk

Please return the form to the researcher.

Section 6 - Instructions to applicants *To be completed by Researcher*	
Please indicate which of the following documents are attached to this Research Passport:	
Current curriculum vitae, including details of qualifications, training and professional registration (please use the template C.V. at http://www.rdforum.nhs.uk/docs/template_cv.doc)	Yes ☒ No ☐
Researcher's copy of criminal record disclosure. NB where research involves regulated activity with children and/or adults as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012), the disclosure must include confirmation of a check against the appropriate ISA barred list(s).	Yes ☐ No ☐ N/A ☒
Evidence of occupational health screening / clearance	Yes ☐ No ☐ N/A ☒
Appendix – List of projects and amendments	Appendix numbers: N/A ☒

Please send the completed form and original documents to the Lead R&D office. The completed form and original documents will be returned to you. This package of documents will be used to validate your completed Research Passport form. You may then, and where relevant, provide the Research Passport to other NHS organisations.

You must inform all NHS organisations that have received this Research Passport of any changes to the information supplied above. Failure to do so may result in withdrawal of your honorary research contract or letter of access. As part of the quality control procedures for the Research Passport, random checks on the accuracy of the information held on this Research Passport may be made.

Section 7 **This section should be completed by HR in the Lead NHS organisation, only if additional checks are undertaken**			
The following additional checks have been completed:			
Having confirmed that the necessary additional pre-engagement checks have been completed, I am satisfied that the above named researcher is suitable to carry out the duties associated with their research activity outlined in this Research Passport.			
Signed:		Date:	
Name:		Job Title:	
Organisation:		Department:	
Email:			
Section 8 - For Office Use Only			
This section should be completed by the NHS R&D office that received the initial application. The NHS R&D office must countersign and date retained photocopies of the documents. The grey section must be completed before the form is returned to the applicant.			
CV reviewed?	Yes ☒ No ☐	Training?	Yes ☒ No ☐
Evidence of qualifications?	Yes ☒ No ☐	Appendix pages reviewed?	Numbers:
Professional registration details reviewed?	Yes ☐ No ☐ N/A ☒	Occupational health clearance reviewed?	Yes ☐ No ☒ N/A ☐
Criminal record disclosure reviewed?	Yes ☐ No ☐ N/A ☒	Date of disclosure: Disclosure No:	
For regulated activity as defined in the Safeguarding Vulnerable Groups Act 2006, as amended (in particular by the Protection of Freedoms Act 2012), did the criminal record disclosure confirm a satisfactory check against the appropriate ISA barred list(s)			Yes ☐ No ☐ N/A ☒
Enter Electronic Staff Record Number (if issued):			
Confirmation of valid Research Passport: Project specific ☒ Three-year ☐ Other End date ☐ Date:			
Signed: [redacted]		Date: [redacted]	
Name: [redacted]			
NHS Organisation Name and contact details REDACTED			
Date ~~Honorary Research Contract~~/letter of access issued *(delete as appropriate)*	10/9/2019		

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If required, this section should be added to the Research Passport Form and completed by each NHS R&D office receiving the valid Research Passport. The original Research Passport form and documents should be returned to the applicant.			
Has the Research Passport been validated by a Lead NHS organisation and is this validation acceptable to this NHS organisation? Yes ☑ No ☐			
CV reviewed?	Yes ☑ No ☐	Training?	Yes ☑ No ☐ GCP
Evidence of qualifications?	Yes ☐ No ☑	Appendix pages reviewed?	Numbers: 0
Professional Registration details reviewed?	Yes ☐ No ☐ N/A ☑	Occupational health clearance reviewed?	Yes ☐ No ☑ N/A ☐
Criminal record disclosure reviewed?	Yes ☐ No ☑ N/A ☐	Date of disclosure: Disclosure No:	
For regulated activity **as defined in the Safeguarding Vulnerable Groups Act 2006, as amended by the Protection of Freedoms Act 2012**, did the **criminal record** disclosure confirm a satisfactory check against the appropriate ISA barred list(s)			Yes ☐ No ☐ N/A ☑
Checked Electronic Staff Record: Yes ☐ No ☑ N/A ☐			
Signed: [redacted]		Date: 15th October 2019	
Name: [redacted]			
NHS organisation name and contact details: [redacted]			
Date honorary research contract/letter of access issued *(delete as appropriate)* 15/10/2019			

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Passport Appendix. List of projects and amendments

Appendix Number:

If you are applying for a three-year Research Passport, please use this section to enter details of projects and activities that will be covered by this Research Passport. Once you have a validated Research Passport, you may add details of subsequent projects during the three years that this Research Passport is valid.

If you are applying for a project-specific Research Passport, but need to add further sites to the project, please enter the details below.

Whenever you add further details, the full Research Passport and accompanying documents must be submitted to the relevant NHS organisations.

Title:		Start Date:	End Date:
NHS organisation(s):	Dept(s):	Proposed research activities:	Manager in NHS organisation:

Amendments to the Research Passport

Please state what these are, e.g. they might be a change in name or employment details, or a change in research activities.

Please check with the NHS organisation where you are undertaking your research if you are unsure whether you will need to submit new evidence of pre-engagement checks on a new Research Passport form, which will need to be validated by the NHS organisation(s) hosting your research.

Date	Old Details	New Details	Office use only NHS R&D contact details and signature

To add more projects please copy this page or download further blank pages. Each appendix page should be numbered.

For office use only:
A photocopy of the appendix should be retained whenever any amendments or additions to the appendix are made.

Appendix 6: NIHR GCP Research certification

NIHR | National Institute for Health Research

CERTIFICATE OF ACHIEVEMENT

Keith Hotchkiss

has completed the course

Introduction to Good Clinical Practice (GCP) eLearning

June 3, 2019

Modules Completed:

Introduction to Research in the NHS and other settings

Good Clinical Practice and Standards in Research

Study Set-up and Responsibilities

Informed Consent

Data Collection and Documentation

Safety Reporting

Summary

This course is worth 4 CPD points.

CPD The CPD Certification Service

Appendix 7: Invitation letter V1.2

University of Suffolk
Waterfront Building,
Neptune Quay,
Ipswich IP4 1QJ
k.hotchkiss@uos.ac.uk
www.uos.ac.uk

Chief Executive
<NAME>
<ADDRESS>

<DATE>

Dear <NAME>,

RE: Academic research into leadership styles of NHS Chief Executives

I am a mature student undertaking a doctoral degree in business management at the University of Suffolk and University of East Anglia. An essential and significant part of my degree is the undertaking of academic research and the production of a substantial thesis.

My specific field of research looks at the management and leadership styles adopted by NHS Chief Executives working within acute trusts. My research aims to examine how Chief Executives engage with stakeholders and the effectiveness of this engagement. I also intend to compare the leadership styles adopted by Chief Executive who have entered their post from organisations outside of the NHS, and those who have taken up post from within the NHS career pathway.

This research is very significant given the lack of any previously published academic literature examining this topic. While there is much written about NHS management and leadership there appears to be an absence of research contrasting prior leadership experience and NHS Chief Executive effectiveness.

Given the importance of this research on NHS leadership development I would like to ask for your assistance in enabling me to collect my raw data. Clearly the best source for this will be gained from interviewing you, to do this I would like to ask if I could visit you at a mutually convenient time and location.

My research will collect anonymous data from a number of NHS Chief Executives across the UK and should not disrupt normal activities as it can be conducted in a very short time.

At the end of my research I would be very happy to send you a full copy of my work in the hope that it may assist you and your team in the future.

I would welcome the opportunity to discuss this in more detail should you require any clarification; alternatively you may contact my research supervisor Professor Penny Cavenagh, at the university or via email p.cavenagh@uos.ac.uk .

I look forward to hearing from you in the very near future.

Yours sincerely

Keith Hotchkiss

17/05/2019 V.1.2

Research Student
Suffolk Business School

17/05/2019 V.1.2

Appendix 8: Participant information and consent sheet V1.5

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Participant Information and Consent Sheet

Study Title: Leadership Styles and their effectiveness in the NHS: A study of Chief Executives in Acute Trusts

Main Investigator: Keith Hotchkiss

Academic Supervisor (for Student research): Professor Penny Cavenagh

You are invited to take part in a study on the leadership styles employed by Chief Executives working in acute NHS trusts.

This Participant Information Sheet will set out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends. We will go through this information with you and answer any questions you may have. You do not have to decide today whether or not you will participate in this study. If you agree to take part in this study, you will be asked to sign the Informed Consent Form. You will be given a copy of both the Participant Information Sheet and the Informed Consent Form to keep. Please make sure you have read and understood all the pages of the Participant Information Form.

1. What is the purpose of the study?

The study forms part of a doctoral study into how Chief Executives lead in the modern NHS. The study aims to explore the leadership styles used by Chief Executives who operate in acute NHS trusts.

2. What will my participation in the study involve?

You will be asked to take part in a confidential interview about management and leadership styles. The interview will take place at a time and place to fit around your schedule. It is anticipated that the interview will last no longer that 60 minutes. As a result of the interview subsequent follow up questions may be required but this may take place over the phone or in person, depending on your availability.

3. What are the possible benefits of this study?

The study will look to benefit future leaders of the NHS by expanding the current knowledge base available to those who wish to undertake NHS leadership. Your experience as a Chief Executive will potentially assist the development of leadership in the NHS.

4. Who pays for this study?

The researcher is funding his doctoral study himself.

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5. What if I feel uncomfortable with an aspect of the study?

Should you feel uncomfortable at any stage then you should inform the researcher who will ensure that your concerns are addressed.

6. What if I don't want to answer a question being asked of me?

There is no obligation for you to answer any questions. If this is the case then simply inform the researcher.

7. What are my rights?

The University of Suffolk is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Suffolk will keep identifiable information about you for 1 year after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by visiting https://www.uos.ac.uk/content/data-privacy .

8. What happens after the study?

After the study all data gathered will be used to compile a doctoral thesis. Elements of the study may be used to write academic research papers, which may be offered for inclusion in academic or professional publications.

9. Who do I contact for more information if I have concerns?

You are free to contact the researcher Keith Hotchkiss at any time should you have concerns or feel you require further clarification. To do this email k.hotchkiss@uos.ac.uk

10. How will my data be stored and for how long?

Anonymised raw data will be stored for 5 years after the research study is completed. Raw data will be kept within a private FIPS 197 certified AES 256-bit hardware encryption system. Access and password are restricted to the researcher only. Any unauthorised attempt to access the data will result in lockout of data which requires a further unique password to unlock. This system is GDPR data compliant. No paper data records will be stored.

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11. How will my data be destroyed?

Part of the private FIPS 197 certified AES 256-bit hardware encryption system is the facility to securely erase all data. The researcher is able to delete all data held at the end of the study.

Appendix 9: Countries offering universal healthcare to their citizens

- Albania, Algeria, Andorra, Antigua and Barbuda, Argentina, Armenia, Australia, Austria, Azerbaijan
- Bahamas, Bahrain, Bangladesh, Barbados, Belarus, Belgium, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso
- Cabo Verde, Canada, Central African Republic, Chile, China, Colombia, Congo, Cook Islands, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic, Cote d'Ivoire
- Democratic Republic of the Congo, Denmark, Djibouti
- Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Estonia, Eswatini, Ethiopia
- Fiji, Finland, France
- Gabon, Georgia, Germany, Greece, Guatemala, Guernsey, Guyana
- Honduras, Hong Kong, Hungary
- Iceland, India, Iran, Ireland, Isle of Man, Israel, Italy
- Jamaica, Japan, Jersey
- Kazakhstan, Kiribati, Kuwait, Kyrgyzstan
- Laos, Latvia, Lesotho, Libya, Liechtenstein, Lithuania, Luxembourg
- Macau, Macedonia, Madagascar, Malawi, Malaysia, Maldives, Malta, Mauritius, Mexico, Moldova, Monaco, Mongolia, Montenegro, Morocco, Myanmar
- Namibia, Nauru, Nepal, Netherlands, New Zealand, Nicaragua, Niue, North Korea, Norway
- Oman
- Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal
- Qatar
- Romania, Russia, Rwanda

- Saint Lucia, Saint Vincent and the Grenadines, Samoa, San Marino, Saudi Arabia, Serbia, Seychelles, Singapore, Slovakia, Slovenia, Solomon Islands, South Africa, South Korea, Spain, Sri Lanka, Sweden, Switzerland, Sao Tome, and Principe
- Taiwan, Tanzania, Thailand, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Tuvalu
- Uganda, Ukraine, United Arab Emirates, Uruguay, Uzbekistan
- Vanuatu, Venezuela, Vietnam
- Yemen
- Zambia

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