

Long serving NHS CEOs

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Long serving NHS CEOs:

what makes them tick

and what keeps them going?

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Contents

	Page
Executive summary	3
Background	6
Why might longevity on management be an issue?	7
Methods	11
Findings	15
Discussion	25
Conclusions	28
References	30

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Executive summary

Scrutiny of NHS chief executive officers (CEOs) has tended to focus on the generally short tenure of their position. Whilst the implications of high turnover have been assessed conceptually and empirically, there has been limited inquiry into those CEOs who remain in post for long periods, whether in the same organisations or in multiple ones. This study draws on interview data collected in 2019 with 10 long serving CEOs in the English NHS (with an average tenure of 17 years). Whilst heterogeneity was achieved in relation to CEO backgrounds, different types of trusts which they led, geographical location and balance of genders, we note the limitations of an interview study of an atypical sample. We frame the study in terms of an organisational lens, focusing on organisation renewal and networked governance, and a personal lens, focusing on strategic competence and political astuteness. The four research questions are:

- (i) How do long-term CEOs manage to create, develop, disrupt, or maintain their organisation over an extended period?
- (ii) How do they manage the boundary between the organisation and external interests?
- (iii) How do these CEOs build and sustain their personal resilience in the face of internal and external imperatives?
- (iv) How do they exhibit their strategic competence, political astuteness and leadership roles?

There were six main findings, cutting across the organisation and the personal lenses. First, there are three distinct phases as CEOs developed their organisations, bedded down in their roles, moved from new incumbent, through to experienced CEO and on to trusted senior figure, and evolved their personal leadership styles accordingly. Second, they paid attention to shaping very experienced and stable executive teams with some turnover to ensure a degree of freshness. Third, they expressed the importance of prioritising external relations. Fourth, they expressed very strong attachment to the mission of the NHS in general and a fierce loyalty to their own organisation. Fifth, they exhibited very high levels of personal resilience characterised by tenacity and energy, a spirit of optimism, living in the present and ability to overcome setbacks. Finally, these CEOs emphasised the importance, to them, of continuous personal learning and development, and, for some, the significance of having a coach or mentor, and membership of peer networks.

Organisation ambidexterity is the ability to cycle between modes of exploration and exploitation, improvement and efficiency, in order to achieve goals (March, 1991). We suggest that the main learning from this study is that NHS CEOs with staying power may be able to enact an advanced form of organisation ambidexterity, as well as possessing and honing mechanisms to maintain personal resilience. On the former, the characteristics of this duality include both living in the moment and having clear long term sights for the organisation, rigorous delegation of responsibilities whilst maintaining a detailed knowledge about what is going on inside and beyond the walls of the institution, ensuring high levels of stability and also appropriate changes in their management team, and building strong local and national relationships. These all contribute to advanced strategic competence and political astuteness, and support the conditions for maintaining personal resilience, which

included high energy and continued enthusiasm for the job. Supporting new and not so new CEOs to develop organisational ambidexterity, personal resilience and strategic competence allied to effective system leadership, would be a worthy priority for the NHSI Chief People Officer, and others with responsibility for nurturing and safeguarding top talent.

The second learning is for NHS system leaders to resist the temptation to encourage successful CEOs to move on to new roles, in circumstances where they are doing a difficult job very well, and where their personal inclination and preference is to stay put to grow and develop their organisation in the long term.

We recommend that future research should probe more deeply into in the following areas: first, a more granular understanding of notions of organisation ambidexterity for CEOs in the healthcare setting, and framing that in relation to theorising about post New Public Management; second, more detailed insights into the CEO as organisation coach, ie restless for change and improvement; third, exploration of the potentially more ruthless aspects of being a longstanding CEO to understand better the continuum between conditions for staying power and where that might tip over into complacency and hubris; and, fourth, identification of an arc for leadership maturity by comparing the stories of experienced NHS CEOs with those who are new incumbents.

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1. Background

Chief Executive Officers (CEOs) represent a unique category at the apex of the organisational hierarchy. Whilst there is an increasing body of evidence about their work in the public sector (Besley and Machin, 2008; Blacker, 2006; Dargie, 1998, 2000; Learmonth, 2001; Schnarr, Rowe and Snowdon, 2017), relatively little is known about health care CEOs who are long-serving. The gap in evidence about this sub-sample of CEOs is especially pertinent in publicly funded health care systems where new public management (NPM) regimes have put increasing strain on staff through performance management and decentralisation (Hyde and Exworthy, 2016). Moreover, CEOs can become vulnerable as the focal point for failings within organisations, especially those which are subject to media scrutiny. In the National Health Service (NHS) in England, although central records are not kept, the median tenure for substantive chief executives is reported to be three years and the mean average is four years (Anandaciva *et al*, 2018, p.15). What keeps a small minority of CEOs in post for much longer than this?

This paper explores, for the first time, long periods of tenure of some NHS CEOs. We frame the paper in terms of the evolution of NPM and the anomaly that long-serving CEOs present. In addition, we consider organisational behaviours and strategic competencies on the one hand and CEOs' personal traits and actions on the other. We examine these concepts by drawing on data from an interview study of ten long-serving CEOs in the English NHS.

2. Why might longevity in management be an issue?

The era of NPM was premised on organisations becoming disaggregated from larger bureaucracies and the individual worker assuming greater autonomy in their roles.

Organisations become 'free' to be managed and to compete, whilst managerial cadres were responsible for driving organisational performance and being held to account for performance (Hyde and Exworthy, 2016). Throughout the paper, we reflect this dual perspective on organisations and individuals.

(i) Organisational lens

Accounts of NPM and its evolution are numerous and detailed. Whilst much attention has been devoted to managerial implications, there has been less on the apex of the organisation – the CEO, although some NHS CEOs have written their own accounts (eg Dunn, 2019; Homa, 2019; Rodrigues, 2018) and there has been some research into the potential influence of gender (for example, Smith, 2009).

Recent iterations of NPM have emphasised notions such as post-bureaucracy and public value, among others. Pollitt (2009) argued that organisations were increasingly shedding their bureaucratic form and function in favour of post-bureaucracy:

“Post-bureaucratic organizations are supposed to be faster, more efficient, more flexible, more committed and more outward-looking” (p.200).

This was leading to an increasingly rapid turnover of (senior) staff, a greater fluidity of organisational boundaries and lifespans, and a loss of organisational memory. In terms of workforce, the NPM link between short-term contract and performance was intensified. For example, new organisations have been formed from restructuring, meaning that, often, new

CEOs have little connection with the area that the organisation served or the local organisational networks. Lack of organisation memory is problematic for strategic competence; here, taken as “...the ability of organisations...to acquire, store, recall, interpret and act upon information of relevance to the longer-term survival and well-being of the organisation” (Hodgkinson and Sparrow, 2002, xiv-xv). Rapid turnover of managers hampers this.

NPM has subsequently shaped the governance of organisations, internally and externally. To provide safe, effective and compassionate care, Chambers et al (2019) have suggested a repertoire of roles for healthcare boards, including acting as conscience, sensor, diplomat, coach and shock absorber for the organisation. Senior NHS leaders thus need to demonstrate behaviours which exhibit a mix of stewardship (service improvement), agency (holding to account), stakeholder (staff, patient and carer engagement) and resource dependency (building and nurturing external relationships). In the NHS, building rapport with regulators such as NHSE/I, Department of Health and CQC is also a distinct task for CEOs. Locally, organisations are increasingly operating within (mandated or organic) networks, relying on mutuality and reciprocity to achieve individual and collective aims (Ferlie *et al*, 2013) but in ways which can lack legitimacy (Bevir and Waring, 2017). In the English NHS, these have taken the form of clinical networks and more recently, Sustainable and Transformation Plans/Partnerships/Programmes (STPs) about to be replaced by Integrated Care Systems (ICSs) and Primary Care Networks (PCNs). The plethora of organisations, some of which lack legislative foundation, not only add to the existing array of inter-organisational relations but equally, confuse and obfuscate lines of accountability (Checkland *et al*, 2013).

(ii) Individual lens

Whilst managerial cadres were present throughout the organisation, the CEO came to symbolise this new approach. The NPM logic entailed that senior staff would not remain in post indefinitely if performance dipped below acceptable levels. It therefore became a feature in some NHS organisations that CEOs would have time-limited contracts with specific performance indicators to meet (Kirkpatrick *et al*, 2017; Macfarlane *et al*, 2011). This promoted a short-term perspective to organisational change (Pettigrew *et al*, 1992). In England, the apogee of this regime was captured in the term 'targets and terror' (Bevan and Hood, 2006). In addition, there is a tendency for the NHS nationally, arguably influenced by the pace-setting tenets of NPM, to move successful CEOs around to 'fix' other poor performing trusts. This is also supported by the 'planned movement' tradition of the NHS whereby trainee/emerging managers are deliberately moved around the system and the NHS family, which managed staff problems by moving them between organisations (Macfarlane *et al*; 2011)

Hodgkinson and Sparrow (2002) make the case for strategic competence in the utilisation of information, but also in the balancing of analysis with creativity, intuition and flexibility. They also argue for leaders to exhibit a strong (although not excessive) internal locus of control. Chambers *et al* (2018) found that many senior leaders in English hospitals had a sense of an internal locus of control. This enabled them to believe that they could influence events and situations with their efforts and skill. They were likely to have a greater quality and innovation outcomes orientation than those with an external locus of control, who attribute the fortunes of their organisation more to external agencies. This sense of an internal locus of control resonates with managers' political astuteness. This refers to the skills, judgements and capabilities of leaders to understand and influence their informal 'political'

environment. It encompasses the ability to build coalitions, and bargain with other agents to achieve joint goals (Hartley *et al*, 2015; Waring *et al*, 2018). Such astuteness is critical if CEOs are to maintain the balance between internal and external imperatives.

Practising leadership with this kind of astuteness is only possible when leaders experience a sense of self-efficacy, and able to deploy their personal discretionary effort. In health-care organisations, resilient leadership includes the ability to deliver emotionally responsive, patient centred services, in the face of multi-level pressures (Arond-Thomas, 2004). Evidence in the NHS suggests that organisations which enjoy stability of leadership also demonstrate better performance. Conversely, organisations in difficulty find it relatively more difficult to attract and retain suitably experienced CEOs (Chambers *et al*, 2011; Kings Fund/NHS Providers 2018). Furthermore, the ‘CEO paradox’ contrasts the need for stability (which longevity engenders) with the lack of conditions to create it, as generated by the dominant NPM paradigm. Longer tenure itself is not the goal *per se*, but it can be an enabler of more effective boards and organisations (ibid), notwithstanding the potential for the ‘dark side of resilience’ (Chamorro-Premusic and Lusk, 2017; Learmonth and Morrell, 2019) presenting itself as a consequence of strong leadership.

Given that longevity of CEOs in the English NHS runs counter to the dominant NPM narrative, we pose the following two sets of research questions. The first relates to organisational lens in terms of two objectives: to examine (i) how long-term CEOs manage to create, develop, disrupt, create or maintain their organisation over an extended period, and (ii) how they manage the boundary between the organisation and external interests. The second relates to the personal lens also in terms of two objectives: to examine (iii) how CEOs

build and sustain their personal resilience in the face of internal and external imperatives, and
 (iv) how do they exhibit their strategic competence, political astuteness and leadership roles?

3. Methods

The maximum variety sample of ten NHS CEOs was identified from NHS websites and researchers' own networks. Our definition of long-serving was taken to be 10 years or longer as the CEO of either one or of a series of health and care provider organisations (table 1).

Table 1. CEO sample		
Gender	Female	5
	Male	5
Clinical background	Clinical	2
	Non-clinical	8
Length of time as CEO (average of all 10 CEOs was 17 years)	10-15 years	1
	>15 years	9
Career as CEO (single or serial CEO)	Single organisation	5
	Multiple organisation	5
Current organisation	Acute	6
	Community / mental health	2
	Joint acute / community	2
Care Quality Commission inspection rating (at the time of interview) of the organisation led by the CEO	Inadequate	0
	Requires improvement	2
	Good	5
	Outstanding	3

Having secured the appropriate research ethics approvals, we wrote by email or letter, inviting 12 CEOs to take part and 10 accepted. A mutually convenient time and place for the interview was agreed. All took place in the CEO's office except one which was undertaken by telephone. Interviews took place in spring 2019 and lasted between 1 and 2 hours. Interviewees were all given the opportunity to approve the use of direct quotations from their interview for this report, in the knowledge that it would be put into the public domain.

Our interest in CEO careers and roles pointed towards a methodological approach which resembled the Wengraf's (2001) biographical life narrative interview method (BNIM). Such interviews are detailed accounts of the career of participants with little interruption by the interviewer. As our interest was not simply their career, we modified the BNIM to explore relevant behaviours and attitudes of the CEOs. Attention was also given to personal and organisational factors shaping their career and current role as well as any self-defined 'failures' or 'setbacks' (Macfarlane *et al*, 2011). This resulted in the topic guide detailed in table 2. The narrative interview method chosen, and the importance of maintaining the natural flow of the interview, dictated that the researchers did not always follow the precise framing or sequence of questioning.

Table 2. Interview topic guide
<p><u>[A] Career choices / decisions and job as CEO</u></p> <ol style="list-style-type: none"> 1. Can you describe your career to date? 2. In what ways has your job as CEO changed over time? <p><u>[B] Longevity / serial CEO</u></p> <ol style="list-style-type: none"> 3. Why have you lasted [XX years] as a CEO (in this organisation or in multiple

organisations)?

4. Why do you think other CEOs last only about (on average) 3 years in post?
5. Is longevity a 'good' thing for you, the organisation, the NHS?
6. What distinguishes long-serving CEOs in one organisations as opposed to multiple organisations?
7. Has your organisation considered role (CEO) succession or informal mentoring a successor?

[C] Role set

8. How would you describe your relationship(s) with Chair(s) in this (current) organisation?
9. How significant is your board of directors to you/CEO performance?
10. How important is a network of other CEOs and policy-makers to you?

[D] Challenges and advice

11. Have you experienced a major career setback / failure?
12. What advice would you give to a newly appointed CEO?
13. What does the future hold for your job as CEO and CEOs in general?

Interviews were audio-recorded in 8 of the 10 interviews; in one case, the recorder failed and for the phone interview, extensive contemporaneous notes were taken. All taped interviews were transcribed in full. Both researchers read all transcripts and contemporaneous notes repeatedly to achieve immersion in the data. The transcripts were analysed to identify issues and patterns which were then charted using the framework approach (Ritchie and Spencer,

1994) to develop interim themes across multiple interviews. The coherence of themes were thus refined in subsequent transcripts. Discrepancies between transcripts were discussed to refine the theme or to retain as a counter example. As interviews took place over a couple of months, we were able to partially undertake a process of abduction whereby initial analysis of transcripts revealed contradictions and paradoxes which could be explored in subsequent interviews (Korica and Nicolini, 2016). Pseudonyms are attributed to CEO quotes to illustrate the themes.

The method of a single interview carries limitations. First, there was no corroboration. As a small, unfunded study, it was not possible to triangulate the accounts of the CEOs with other stakeholders or public documents. Interviewer experience and knowledge enabled some critical questioning but this was always likely to be partial. Second, some CEOs were adept at presenting specifically public accounts. Interviewing technique and longer interviews did start to reveal some private accounts but CEO availability limited the interview time in some cases. We did not sample our CEOs by their organisational performance (although a cross-section of performance was apparent - see table 1). The sample of CEOs was, by definition, an elite group. We were aware that a non-standard interview might thus be required. Dexter (2012) suggests that elite interviews need to allow 'space' for interviewees to reflect and to 'teach' the researcher what the problems, situations, or solutions are. With limited time for reflection, such interviews can thus be cathartic for the interviewee.

4. Findings

We present the findings using two contrasting lens: the organisational and the personal. These lens intersect but in doing so, cast light on different ways to understand and explain CEOs' longevity.

4a. Organisational lens

(i) Phases:

A consistent theme across all interviews was the evolution of the CEO's tenure in terms of phases. As long-serving CEOs, they had experienced a number of such phases. Sally divided her tenure into three year periods: "first you need to be listening and learning. Then you start doing"; these periods were followed by a merger with a neighbouring organisation. However, these phases prompted her to ask if she had something to offer for the next term? This also linked to phases in her personal development: heads down/imposter phase, standard CEO phase, and then people seeking your advice phase.

These phases often coincided with the expansion of the organisation (in terms of staff and budgets). This growth meant that the initial span of control of the CEO was no longer possible; for example, services were now being delivered in multiple locations and contracts were held with numerous commissioners. One CEO explained her role initially combined another executive role too, but now her organisation was multi-divisional:

"Each of those [three] divisions is the size of a small Trust ... So each of those divisional teams is run by three people – a managing director, a nurse director and a medical director" (Christine).

These phases coincided with an expectation (espoused by senior NHS staff) that CEO tenure would only last for a limited period or that they should move to another post to gain

experience of larger organisations. Many of our sample resisted this because they grew attached to the organisation and each phase entailed new policy and organisational challenges.

“So there’s definitely a link between my leadership and the organisation... it seems that I’ve found a link and it found a link with me, and I haven’t really wanted to break it” (Sally).

“I thought I’d be here about five years, do a good job in a medium sized Trust... and then I’d go and be a chief exec in a London teaching hospital.... you are made to feel that you are not making the right contribution if you stay too long” (Catriona).

Across all these phases and building on their experiences, many of the CEOs referred to the balance between delegation and maintaining an understanding of service delivery.

(ii) Board relations:

CEOs commonly spoke of the stability of their executive teams. These seemed to be more important to the performance of the organisation than relations with their Chairs and Non-Executive Directors, which were occasionally fractious, which chimes with previous studies (Exworthy and Robinson, 2001). As Oscar put it:

“A diverse yet cohesive leadership unit is quite important. The diverse bit is important so that you can reduce the concept of groupthink, and you can get alternative views and opinions going. The cohesive bit is, [because] as a leadership group, we cast a shadow, and I don’t mean shadow in a negative way, but people watch and observe what we do.”

These tensions between diversity and cohesion and between stability and new executives were a common preoccupation for this sample. There was also a widespread recognition that stability of the executive team was vital to the effectiveness of the CEO:

“You can’t do anything, you know, if the executive team’s short term... and if you keep turning over executive teams, you get nowhere” (Don).

Yet, some also pointed to the need for renewed purpose associated with new appointments:

“If you’ve got a long-standing chief exec, some change at exec level is a good thing. So I’ve always enjoyed having a blend of long serving with new fresh ideas” (Catriona).

A strong theme of relations with executive directors was the role of the deputy CEO.

Deputies were important given the growing size of many of these organisations. With many long-serving staff in this group, there was a high level of experience and competency which meant that many tasks could be delegated. The deputy was thus seen as a natural successor to the CEO.

“My deputy – it’ll be 10 years in a couple of months’ time... I’ve needed a deputy who can step up, so he is like a first among equals” (Sally).

“So we’ve worked through a process that my deputy – it’s a big role and he gets a sizeable pay hike because of that...it’s part of the succession” (Felicity).

The effectiveness of this deputy role was evidence, during a period of absence by Felicity, when the organisation continued to run smoothly.

(iii) External relations:

CEOs recognise the networked nature of their external role, as Oscar explained in his focus on making common cause:

“A key theme, certainly in my tenure as being a chief executive, has been about collaboration both inside and outside the organisation.”

Sally described her role “to put up an umbrella over the organisation.” External relations comprised a significant part of the CEO whilst internal affairs were often the remit of the Deputy, Chief Operating Officer or similar. All CEOs recognised that managing local networks took significant efforts and the task was often problematic.

“I think some of the hardest challenges are political relationships and dispersed power challenges” (Christine).

Many CEOs have complained that they invariably look ‘upwards’ to central authorities, for example, at NHS England/Improvement and the Department of Health (see for example Exworthy *et al*, 2002). According to this atypical sample in this study, these ‘political’ relations were less threatening. They had learnt how to cope with such pressures or had high levels of political astuteness, about which more below.

“I’ve only been able to deploy the organisation to best effect in more recent, probably the last five years. So the first ten years felt... we were fighting all the time to tick boxes” (Felicity).

“Nobody bothers me...because our performance is really good” (Don).

However, some, including those managing less well performing organisations, emphasised the importance of maintaining positive and courteous relationships with the regulatory bodies.

A consequence of their longevity was that several of the sample had been invited to play national roles in shaping policy reform or leading wider organisational change. Our sample was thus seen as ‘safe pairs of hands’ to lead these national programmes, in the knowledge

that their 'host' organisation was already well managed and could tolerate their absence for an extended period (as much as 50% of their time for 3 years). Their justification for taking the role was precisely because they too had stability among their executive colleagues.

“And the reason I could take on my national role as well as the chief exec role is precisely because I have got a really longstanding and rather excellent set of executive directors” (Christine).

Some had taken up national roles earlier in their career and felt that this had been of huge benefit in preparing them for their subsequent and current CEO positions:

“Doing both national and local really enhances the CEO role. The ability to pick up the phone – a live line for steering and influencing” (Jane).

Oscar sounded a warning note, however, about circumstances when the national role can take over to the detriment of the day job:

“There are some colleagues that I’ve seen, where being on that national stage has become their job. Whereas I would always comment that everything that I would do nationally, I would always want to be able to relate that back to an individual that lives in the catchment area that I serve, or a member of the group of colleagues that I work with.”

4b. Personal lens

Our second research question was concerned with how these CEOs developed and maintained their personal staying power to carry on. All CEOs demonstrated the ability to reinvent themselves, in order “to adapt to change, to different environments, different contexts” (Oscar).

(i) CEO identity with organisation and the NHS:

These CEOs' backgrounds varied considerably : from those who had become managers from clinical routes (two) and non-clinical routes including those who had been graduate general management trainees (three), those who had previous careers outside the NHS (three), to those who had risen through the ranks (two).

Some, but not all, described strong ideological motivations at the start of their careers to work in the public or welfare sector, a continuing close identification with the mission of the NHS, and later, a love of their own organisation. For example, Miles was "hell-bent on wanting to change the world." Matthew's story also illustrates this well:

"Because I was motivated, in those days I was quite left-wing, and therefore I wanted to work in the public sector."

Matthew goes on to describe a continuing intoxication, 40 years since he first joined the NHS, coupled with an intense dissatisfaction with the current situation: "I absolutely love the NHS...[but] I sit in the 'winter room' and am part of lots of rubbish decisions."

The identity between the individual and organisation was frequently strong. Christine confessed that she would find it hard to leave her post: '

"I've been here [x] years so it's almost perhaps painful to think of not being here....I'm so happy here that they could carry me out in a box."

Likewise, Sally talked about being "the head of a family....it's a big thing to try and pick another family, and will that group of people allow you to be the head of their family?" These expressions are of strong, intimate relations between the person and the organisation. Clearly, these are positive expressions which need to be contrasted with possible malign effects of longevity, and their accounts of career setbacks (see below).

The CEO's mission was also expressed in ways which reflected their longevity and the embodiment of their role as strategic leaders. For example, Miles discussed the importance of setting long term goals that resonated with staff and patients, and not to be too distracted by operational matters. Each had a distinct guiding leadership philosophy. As Matthew, one of the serial CEOs, explained:

“I do not believe in the heroic leadership model... And when I came here [as CEO 3 years ago]....I met with about 30 odd staff, on a one-to-one, asking them what they thought my priorities should be. Everybody mentioned culture.”

Oscar described how his leadership style had evolved over time:

“I've evolved, I think, I've got a much more natural and broader passion for people. You know, if you were describing me in those days [early days of being a CEO], I think I might have had a concept of the sort of heroic leadership model, and I think today I would class myself more as the servant leader type model.”

These CEOs had distinctive leadership styles but in common was a belief in collective leadership. Whilst this was also highlighted by the reliance on senior managers, this was not restricted to board members.

(ii) Personal resilience:

In some respects, the sample of CEOs displayed a *de facto* level of resilience by virtue of their longevity. Their tenure was marked by tortuous changes in government health policy and periods of deep economic austerity.

Most of the interviewees referred to having high levels of energy:

“I’m high energy, I’ve always worked hard....from a good working class stock...but they are punishing hours...” (Christine)

“One of my strengths is that I’m hugely resilient and I get a buzz from the direct impact on people of my hospital job” (Catriona).

Personal resilience became a touchstone during periods of rapid organisational and policy change:

“I think at any one time in the organisation, there’s a great deal of flux and change. So I feel it’s my job to offer some anchor points without becoming stale, an old fossil” (Christine).

Similarly, several spoke to the relatively rapid turnover of their CEO colleagues elsewhere and yet, they could offer long-term commitment to the organisation. This was sometimes compared with senior doctors who might work in the same organisations for 30 or 40 years.

“If you take this organisation, the majority of people work here a lifetime..... the people that you need to lead, you know, in the main, in the consultant body, they will come and give their life to a career. And if you’ve got Chief Executives [coming and going], that’s what they see..... they’re not committed to us, they’re not committed to what we’re trying to do, why should I trust them?” (Sally).

Some, but not all, interviewees were guarded about sharing stories of managing setbacks and failures. Matthew was candid, sanguine and reflective when mentioning that at times in his current job he has been “extremely anxious.”

“I have been fortunate, because I’ve applied for [tens of] jobs and not been given them, and so that’s been good because I’ve always ended up in jobs that seem to have gone well for me. So, one of the questions, I think, is you know, have I had any sticky patches in my career?”

Unable to obtain a unit general manager job in an acute hospital, Matthew ended up taking the equivalent post in a mental health organisation. He subsequently had over two decades as a CEO working in mental health and learning disability services. By way of contrast, Jane described how she has grown and developed when already in her CEO role, and shared her personal mantra for tackling successive setbacks:

“I’ve lightened up. I was very intense. I was very ambitious. I have fun now. I went through pain barriers. I can be who I am. Fake it till you make it, until you convince yourself it’s not about me, and moving on.”

Regrets did not largely feature, although one (Sally), said that they wished they could turn the clock back and ‘do’ an organisational merger differently. Another gave the following piece of advice for a new CEO, which was drawn from personal experience:

“If you find yourself setting the alarm earlier and earlier, not sleeping, and obsessing, you know it’s time to talk to a trusted colleague...” (Christine).

Oscar described the feelings of being in the ‘eye of the storm’, during a crisis:

“There’s a real importance that you first of all understand how you’re feeling about something, and not being afraid to talk to others about how you’re feeling.”

Good luck as well as good judgement was mentioned in how, sometimes, the CEOs came through the difficult times; the terms ‘luck’ or ‘lucky’ was mentioned 28 times across the ten interviews. James, for example, mentioned how “the storm [ie. The specific problematic incident that nearly cost him his job] had moved on.” Also, Miles mentioned the importance of not taking failures personally, and instead of inquiring and reflecting on the causes of the setbacks. The CEOs recognised their own personal emotional reactions to problematic moments in their tenure, and the importance of moving from unproductive ruminating to more fruitful problem-solving. They often managed this with the help of a wider, external

network of colleagues and mentors. A selective long term memory about the more negative experiences could also, clearly, be a form of post-hoc rationalisation.

(iii) Personal development

Half of our interviewees had stayed at the same trust and the other half had been CEOs elsewhere ('serial CEOs') :

"I move because of variety in terms of culture, learning, finances and ways of learning. I like new challenges and variety of the politics" (Jane).

That was not the preference of all: two who had remained in the same trust for a long time spoke of a sense that if you stayed 'too long' in the same place it was somehow bad for your career and for your personal standing. (Of course, what counted as 'too long' was subjective). These CEOs had experienced some pressure from peers and from senior NHS leaders to move to 'bigger' jobs, which they had resisted.

A few of the interviewees had attended senior leadership programmes or obtained higher degrees in later life (eg. MBA or doctorate) in pursuit of formal learning. Others talked about learning from others and from extensive private reading. A final group said that the job itself provided the opportunity for continuous personal development and learning.

The CEOs frequently cited their need for and use of coaching and mentoring. Coaching was mentioned 20 times (by 7 of the 10 interviews) and mentoring 33 times (by 8 CEOs).

"I have a long term coach and I feel very safe with [them]" (Felicity).

"I had a close relationship with the chief executive, which actually has been important throughout my career in having a mentor who's been able to teach me" (Catriona).

There was a good deal of reciprocity for these CEOs in being the mentor for others in the NHS; sometimes, these were other (newer) CEOs, but often they were middle managers.

For those who did not have a coach, they had, on occasion, called on a mentor or senior experienced colleagues during a crisis. However, some spoke also of their personal pride of being CEOs and not needing help or wanting to be a nuisance.

“I’m not a great one for mentoring or coaching personally” (Christine).

However, Christine did cite her experience of a mentor as a middle manager:

“There were things that we did then that still influence me now. It was great. But I think as Chief Exec, doing the job has mainly been my development. We so never stood still. That to be honest, it does just feel like I’ve never stopped learning” (Christine).

Many but not all were members of institution-based networks, such as the New Cavendish Group and Shelford Group. A smaller number remarked that they were not natural networkers, although they learnt from particular mentors, sometimes from outside the NHS.

The interviewees revealed the various ways these CEOs developed and maintained their personal resilience and development. Underpinning their various strategies was a consciousness of needing to attend to a form of preventive maintenance of their leadership. This inwards looking reflexivity is mirrored by the strategic competence they articulated in working as a leader of systems and networks as well as a leader of their own institutions.

5. Discussion

Organisation lens:

It was notable that three out of the five CEOs who had remained long serving in the same organisation had presided over significant growth over time through mergers and

acquisitions. The other two CEOs who had stayed in the same place had invested in their organisations either by building the global brand of their specialist service and or by improving the fortunes of a district general hospital. Their behaviours reflect the managerialisation of the NHS through the New Public Management tenets of performance management and improvement, whilst resisting pressures to jump ship.

Amongst all these CEOs, there were many examples of an articulation of the full repertoire of roles of board level leaders (Chambers *et al*, 2019), including conscience (close alignment with the mission of patient care), ambassador (building the `brand'), sensor (knowing the organisation's performance from board to ward) shock absorber (protecting staff) and, particularly, as coach (restless for quality improvement), for the organisation. By contrast, a stated focus on efficiencies, value for money and cost control was generally absent from the discourse (see below).

The CEOs viewed the NHS as a networked system within the shadow of a strong central hierarchy (Heritier and Lekmkuhl, 2008), whilst exhibiting a sometimes a fierce loyalty to their own organisation. Their deployment of boundary spanning roles (Tushman, 1977; Currie et al 2007) was notable, for example, in taking on regional or national responsibilities, or prioritising the management of the external environment, leaving the internal focus largely, but not solely, to their deputy.

Thus, CEOs embodied many of the tenets of NPM as the apex of the organisations, sometimes blurring the boundary between person and the organisation. They were also the repositories of the organisational memory (either of their organisation or the NHS collectively), seemingly contrary to aspects of post-bureaucratic narrative. The stability of

some of their senior managers and the emergent emphasis on health systems supported this notion. However, repeated re-organisations (internally and externally) counteracted this.

Individual lens:

The dominant themes included a high level of reflexivity amongst CEOs, implying the capacity to be able to examine their feelings, motives and subsequent actions. There was also generally a positive mind-set; significant setbacks were seen as either opportunities or as problems to be solved, rather than worrisome. There was a consciousness of the value of support from senior trusted colleagues, from peer networks and from continuously learning. Underpinning this was a level of self-confidence from having over many years carved out a distinctive personal leadership model, a way of being, acting and performing as the CEO.

The leadership approach of these CEOs resonated with theories of health-care governance: their espoused behaviours exhibited a mix of stewardship (service improvement), agency (holding to account), stakeholder (staff, patient and carer engagement) and resource dependency (building and nurturing external relationships)(Denis and van Gestel, 2015). They demonstrated behaviours that combined strategic competence and political astuteness. Regarding the former, it was striking how focused they were on the delivery of their core mission. They displayed a high internal locus of control (ie. a belief in personal agency) whilst signalling high levels of respect in their attitudes towards national or local stakeholders. We argue that this adds up to an advanced form of organisation ambidexterity, which comprises not only the ability to focus on the present as well as on the long term, but also contemporaneously on internal and on external risks to delivery of the mission. This also speaks to Hodgkinson and Sparrow's (2002) view of the need to stimulate generative knowledge through innovation and creativity, alongside adaptive knowledge through the

exploitation of known best practices and tacit organisation memory around efficiencies and effectiveness.

Regarding political astuteness, we noted the adroitness with which all the CEOs had shaped their personal narrative, seemingly as much for their own personal sense-making, as for our benefit as researchers. On reading a draft of this paper, one of them remarked that they came across as ‘a bit saintly’. This burnishing of their story into a coherent, credible and compelling narrative inevitably meant the foregrounding, to themselves and to others, of some elements and the omission of others. This could potentially develop into a level of self-belief, self-confidence and even complacency that connects with the darker side of resilience, for example, the development of a fixed view that begins to shut out narratives that don’t fit with theirs about what is going on in the organisation. Coupled with a love of the job that could turn addictive, these are some warning signs to which some CEOs themselves alluded.

6. Conclusions

This study explored how some CEOs in the NHS in England reinvented their organisation(s) and themselves over their ‘long’ tenure as CEO, using the conceptual lens of post-bureaucracy and political astuteness (among others). There were some unexpected features of this study which prompts a refinement of the conceptual lens. We were struck by the variety of their backgrounds and career trajectories. There was no one archetypal long serving NHS CEO. We were agreeably surprised about their readiness to give an interview, and the strength of their passion when talking about how attached they were to their organisation and, given how long serving they were, how fresh and enthusiastic they were about their job. We

also considered what these CEOs chose not to discuss. On the organisation side, these included not much on current national health policies, nor cost control, value for money and efficiencies (cornerstones of NPM). This suggests to us that they had constructed their own version of NPM, which incorporated organisation ambidexterity, combined with a degree of personal policy entrepreneurship, which led to a feeling of not being overly constrained by others.

On the personal side, there was little mention of any mental health or family problems, experienced or overcome. There could be a number of reasons for this (in addition to the context of the research interview, conducted by a stranger). Further studies might include questions that overtly ask about mental health challenges or explicitly explore the potentially more ruthless aspects of being a longstanding CEO. All interviewees were highly politically astute (unsurprising given an average of 17 years as CEO); they were self-confident and had generally positive outlooks. Given their strategic competence, it is remarkable that they also lived very ‘in the moment’, neither ruminating much about the past nor particularly focussed on their personal future, say over the next five years. This may be an important resilience mechanism for people doing these very difficult jobs.

We suggest that NHS system leaders should resist the temptation to encourage successful CEOs to move necessarily on to new roles, in circumstances where they are doing a difficult job very well, and where their personal inclination and preference is to stay put to grow and develop their organisation in the long term.

We recommend that future research should probe more deeply into the following areas: first, a more granular understanding of notions of organisation ambidexterity for CEOs in the

healthcare setting, and framing that in relation to theorising about post New Public Management; second, more detailed insights into the CEO as organisation coach, ie restless for change and improvement; third, exploration of the potentially more ruthless aspects of being a longstanding CEO to understand better the continuum between conditions for staying power and where that might tip over into hubris; and, fourth, identification of an arc for leadership maturity by comparing the stories of experienced NHS CEOs with those who are new incumbents.

In relation to advancing theory, we suggest that further testing of propositions around the notion of organisational ambidexterity and resilience mechanisms could form part of future iterations of this study. In relation to learning for senior leadership practice, we also propose that, alongside further inquiry about ambidexterity and resilience amongst long serving CEOs, interviews are carried out with a contrasting cohort of ten newly appointed NHS CEOs. Juxtaposing experiences of younger and newer, versus older and more accomplished CEOs could provide empirical evidence about the potential characteristics of a leadership maturity arc.

7. References

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