Saxton Bampfylde

FROM THE OUTSIDE IN:
A NEW PERSPECTIVE FROM NHS LEADERS

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FOREWORD

After more than a decade advising a variety of NHS organisations on Board-level appointments, the challenges and joys of leadership in the NHS have become familiar, if ever-evolving, territory to Saxton Bampfylde. Through working on over 200 appointments of Chief Executives, Executive Directors, Chairs and Non-Executives, all navigating the changing policy environment and eternally shifting infrastructure through which the services of the NHS are delivered, several key themes have become clear. There are few more fulfilling environments in which to lead; few more intellectually and operationally stimulating organisations in which to stretch leaders' skills; few organisations with the breadth and complexity sheltered under one employee brand.

Despite those great attractions, the NHS is now experiencing a shortage of leadership talent at a time when it is in great need. Whilst pressure on services and finances grows, more and more established leaders are leaving the NHS, and executive team and Chief Executive vacancies are taking longer to fill; high quality individuals are moving more quickly through roles, depriving organisations of longevity of commitment, and themselves of the experience of realising medium to long term achievements; shortlists for critical roles are shorter, and providing real choice in executive appointments is becoming more difficult.

In a situation in which the NHS is neither developing, nor retaining, the number of high-performing executive leaders it needs, we have become particularly interested in the small cohort of leaders who have entered the Service from outside, bringing external perspectives and functional and leadership skills developed in different, often commercial, environments. These individuals are small in number but often high-profile, joining FTs, trusts, the DH and national bodies, CCGs and CSUs from a huge variety of backgrounds. They have faced steep learning curves, and the very particular career challenge of demonstrating their skills and adding leadership value in a new culture and often sector.

Why do established, successful, leaders from the commercial world move into the NHS? What sort of roles do they take on? What do they achieve when they get there? Do different sorts of functional specialists have better, or less positive, experiences? Critically, can these cross-sector appointments be described as successes? Do they signpost us to a potential alternative source of leadership talent? And, if they do, what can we learn from their experiences to maximise the chances of others' success?

"THE NHS IS COLLAPSING UNDER THE WEIGHT OF DEMAND"
The Daily Telegraph, 11th June 2014

"THE NHS URGENTLY NEEDS STRONG LEADERSHIP TO AVERT CRISIS"
The Guardian, 23rd January 2014

"A THIRD OF HOSPITALS HAVE CHIEF EXECUTIVES WHO HAVE BEEN IN POST LESS THAN A YEAR"
Health Service Journal, 12th December 2014

We decided to undertake some research into these questions and have interviewed around 40 Board-level Executive Directors in a variety of NHS settings. All of these individuals joined the NHS at that level from outside, the overwhelming majority directly from the private sector. We put a series of set questions to them, seeking to understand their motivations, their impressions of the NHS prior to joining, their journey through the appointment process, and their experiences in their roles. Where appropriate, we also looked at the career progression they've had in the NHS. Lastly, we spoke to some of the Chairs and CEOs who'd hired them, to hear their verdict.

What emerged was a nuanced picture, in which leaders' roles and the experiences they'd had varied widely. Astonishingly consistent, however, was the success of the appointments, measured in terms of the individuals' enjoyment and fulfilment, the impact they'd been able to have on the organisations they'd joined, and the views of the Boards that had hired them. Such consistency suggests to us that these reputedly difficult appointments can, when well thought through and appropriately managed, work well, and make a contribution to building the future leadership cadre of the NHS.

We hope you find our report an interesting and thought-provoking read.

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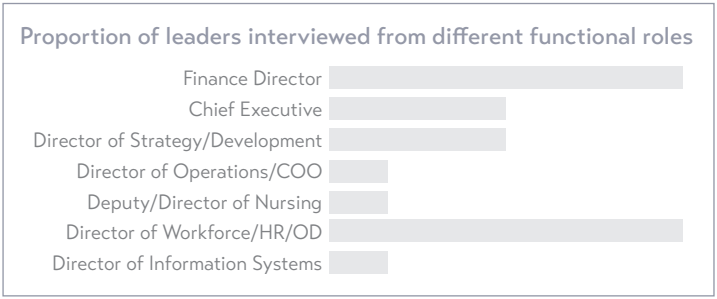
THEMES

In each conversation the following questions were broadly covered:

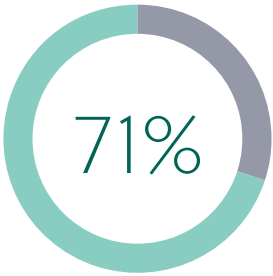
- What attracted you to the NHS?
- What were your concerns about the move?
- What questions would you have asked, knowing what you know now?
- What was it about the circumstances of the organisation that you joined that made your appointment feasible?
- What helped your onboard?
- Did you have a mentor?
- How did you adjust to the regulatory/ clinical environment?
- Has your outside experience been help or hindrance, and in what circumstances?
- Did you meet any resistance?
- What opportunities did you have to shape your role and your team?
- If so, what was the impact of this?
- What advice would you give others planning the same move?
- Would you do it again?
- Do you think the NHS should be making these kind of appointments?
- If so, what should they be doing to facilitate these moves?
- What kind of support/ongoing development is required for external people to be successful?

WHO HAS HIRED WHOM?

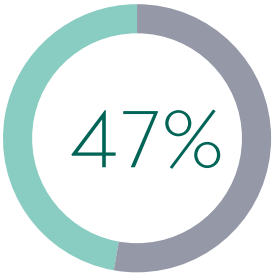
Our 40 surveyed leaders had all moved into the NHS from outside, with more than 90% joining directly from the private sector. They moved into a range of leadership roles across the NHS; whilst the majority took on functional leadership roles in Finance, HR and IT, several were general managers and operational leaders, areas in which the adjustment to the NHS is seen to be greater than in a functional specialist role. Unsurprisingly, there were just two clinical leaders who joined the NHS from outside, and both came from the broader public, rather than private, sector.



JOINED THE NHS FROM THE PRIVATE SECTOR



ARE STILL WORKING IN THE NHS



WERE PROMOTED WITHIN 3 TO 5 YEARS

LEFT THE NHS AND RETURNED TO THEIR PREVIOUS SECTOR

WHY SOME NHS BOARDS ARE SEARCHING OUTSIDE THE SERVICE

We began by trying to understand what had motivated Boards to take the risk presented by external, commercial, appointments. With governance, regulatory and clinical leadership dynamics so specific to healthcare, and such subject matter expertise in the NHS, what makes a board take the chance on an external leader, coming with very different commercial values?

Whilst many of the financial, operational and strategic challenges facing the NHS are specific to the clinical and political context in which healthcare is delivered, others read across to the private sector.

Some of those we spoke to were hired because their own particular part of the NHS was specifically looking for commercial experience. In some cases this was function-specific and task-related – for example, in areas like procurement, IT or logistics – in others, it was a broader commercial, or customer-focused, mind-set that was sought. This reflects in part the current direction of travel in the NHS, and the more competitive landscape in which it now operates, as well as a more general belief that all organisations need to attract fresh talent and new ideas. Equally, in-coming leaders spoke about the NHS's growing recognition that its patients are, in fact, customers, and that bringing in leaders who are instinctively customer-centric in their thinking is increasingly important. To some organisations, the commercial and financial dynamics were even starker. As one of our interviewees put it, "The overriding majority of NHS people don't have any idea about making money. But you do need money to cure people, and a greater alignment between these two things."

In other cases, it was a recognition that world-class leadership existed outside the NHS, as well as within it. One trust CEO who had hired two executive directors from the commercial sector wanted to bring in "best in class HR thinking, which I didn't think I'd find within the NHS", to support a transformation of the whole organisation's way of working.

Organisational change was the specific catalyst for a number of the hires - whether proactive or reactive. Some organisations felt that major change was needed, and would be accelerated and supported by external hires as "grit in the oyster"; others were facing large-scale structural reorganisations. In both cases, change management expertise was at a premium, often driven by the belief that the NHS is "not good at change".

“THEY WANTED TO PUT THE ORGANISATION ON A COMMERCIAL FOOTING”

“HEALTHCARE IS A CUSTOMER-FACING BUSINESS THAT IS VERY HIGHLY CAPITALISED. IT NEEDS QUALIFIED PEOPLE IN AREAS LIKE OPERATIONAL MANAGEMENT AND LOGISTICS. THE NHS HARPS ON ABOUT LEADERSHIP, BUT IT’S TECHNICAL MANAGEMENT THAT IS REALLY NEEDED”

The transition to Foundation Trust status, in particular, often led Boards to take a broader than usual view of the skills required, given the greater autonomy that FT status would provide and demand, and the opportunities that could emerge to leverage profitable opportunities. The most common recruitment to new Foundation Trusts was to the CFO role, in recognition of the fact that FTs are subject to conventional accounting rules, unlike other parts of the NHS, where - as one of our interviewees put it – finance is something of a "dark art".

In almost every case, however, there was one common factor: the vision and energy of the person running the recruitment, whether the Chair or the CEO, was critical in establishing a brief that drew candidates from outside the NHS into the role. They set a tone which recognised the potential value of new skill sets and attitudes, and supported a non-NHS appointee to join their organisation. One of our interviewees described the "infectiousness of the CEO's vision and mission": his words were mirrored across the vast majority of the exchanges we heard. Consistently, the hiring CEOs or Chairs were looking for fresh ideas and a new approach, valued what external experience could bring, and were prepared to take a calculated risk in making a more lateral appointment. Critically, they were consistently advocates for candidates with a wider range of experience as a result, and prepared to flex the appointments process to draw in those external candidates.

Conversely, candidates who went on to join the NHS successfully also described earlier processes in which they felt the relevance of their external experience had not been understood: one had been told outright "you're wasting your time". These experiences had deterred them from pursuing other NHS roles until they were subsequently drawn in by the energy and commitment of enthusiastic advocates in the processes through which they were ultimately appointed.

“WHAT MADE ME APPOINTABLE WAS THAT THEY HAD A LOT OF NON-CLINICAL STUFF TO GET DONE - THEY RECOGNISED THE ORGANISATION NEEDED A LOT OF SHAKING UP”

WHY EXTERNAL LEADERS MOVED INTO THE NHS

Unsurprisingly, none of these leaders moved into the NHS solely for the money, with most moves entailing pay cuts, or the loss of benefits such as share options and bonuses.

So what did inspire them to take the job? In fact, the idea of 'inspiration' is directly relevant in this particular case, as several of our interviewees either accepted or actively sought an NHS job after a very personal experience of NHS care involving a member of their family. Some wanted to give something back; others wanted to help fix what they perceived to be wrong.

But even those without a personal story (who were the majority) saw this as a rewarding sector in which to work, and those rewards were as much about intellectual stimulation, and managing complexity, as they were about making a contribution to the public good.

In parallel, many of our interviewees were attracted by the opportunity to work at board-level, wholly running their own function or area: for divisional leaders in large corporate environments, serving on an NHS organisation's board and reporting to a CEO or Chair, rather than being part of a divisional structure, was often perceived to offer progression of seniority, if not scale. For cross-sector hires later in their careers, this was less of a draw, but it was still important to serve on the Board, in order to maintain the seniority and career path they'd established to date.

Almost all the interviewees shared the same view of the NHS going in – the sheer size and complexity of the organisation, and the strategic and operational stretch of healthcare, offered a new and different challenge from their previous jobs. Those going into Foundation Trusts, in particular, were excited about the chance to bring commercial expertise to that part of the NHS , especially as some of the hospitals concerned were already powerful brands in their own right. On the other hand, many were wary about their ability to make change in an environment perceived to be resistant to outsiders and slow to change: the weight of regulation and public scrutiny were also concerns for some.

“IT SUITED MY PERSONAL CAREER INTERESTS. I WAS INTERESTED IN THE CONCEPT OF PUBLIC SERVICE, AND BELIEVE IT’S AN AREA YOU CAN MAKE QUITE A LOT OF TANGIBLE DIFFERENCE”

“IT WAS FRAMED AS AN IMPOSSIBLE JOB. I BELIEVED THAT IF I COULDN’T DO IT, IT COULDN’T BE DONE”

“PUBLIC SERVICE IS AN HONOUR, AND IT’S POSSIBLE TO DO FOUR OR FIVE YEARS IN THE PUBLIC SECTOR BEFORE RETURNING TO THE PRIVATE SECTOR. BUT IT DOES DEPEND ON WHETHER THIS IS A JOB OR YOUR CAREER”

THE APPOINTMENT PROCESS

For most of the leaders we spoke to, the appointment process itself was the first indicator that they were moving into a different sector, with different ways of making decisions. Panels are unusual in the commercial sector, and for many we spoke to "being interviewed by about 16 people came as something of a shock". For private sector candidates, a two-way, more multi-step, process that gives them opportunities to find out about the organisation they're considering joining, and the chance to probe their fit and connection with would-be key colleagues, is very usual: the formalised stakeholder meetings prevalent in the NHS feel very different to them. Fundamentally, a traditional NHS appointment process is designed overwhelmingly to test candidates rather than to attract them, with the perhaps inevitable consequence that individuals new to its idiosyncracies can feel quite deterred by the process they are asked to go through.

Many of the successful leaders we talked to described the importance of their having informal time, one on one, with key individuals at the organisation they were considering joining, and with key stakeholders. Several particularly mentioned finding the opportunity to meet either the Medical Director or Chief Nurse enriching: the clinical aspects of the NHS's work are often least familiar territory to outsiders, and building an early connection with a clinical leader was helpful in breaking down barriers.

Lastly, the absence of a salary negotiation process is unusual for candidates from the commercial sector, who often expect some flexibility beyond an advertised package. Recognising this is a cultural difference, which candidates need to be guided through, rather than the sign of a grasping individual, can ease some early opportunities for mis-understanding.

Throughout, the role of advocates – for the NHS, for the role, for the candidates themselves – was important. Sponsoring Chairs and/or CEOs were seen to have played a critical role in drawing candidates in and then making the case for them to the panel; others specifically mentioned the role a trusted search consultant played as an interlocutor and intermediary.

THE CANDIDATES' EXPERIENCE

All the leaders we spoke to began their NHS experiences with pre-conceptions about the system they were entering. Did the NHS prove as bureaucratic and resistant to change as most of our interviewees had been warned (including several who had spoken to high-profile NHS CEOs), or was the reality more positive than the prejudice might suggest?

Almost all our interviewees enjoyed their experience, and 90% would do it again. It was an "incredibly rewarding" learning experience that allowed them to use and develop their skills, and "operate on a truly massive scale" while having a positive impact on an NHS for which they clearly felt a deep affection. One described the transition as "a series of pleasant surprises", compared to what he might have expected.

> **"IF THE ROLE IS SOMETHING FUNCTIONAL, YOUR VALUE CAN BE WITNESSED INSTANTLY. BUT GOING INTO OPERATIONS IS A MUCH HIGHER RISK – IT HAS TO BE THE RIGHT ROLE AND THE RIGHT FIT"**

Those who had been concerned that their expertise might not have been transferable were relieved to find that this was generally not the case; indeed, almost all felt their experience outside the NHS made them more effective inside. Specific examples included managing relationships with commissioners, bringing a commercial approach to these relationships, ensuring the right balance of quality and value, and incorporating customer service thinking into day-to-day operations. Others talked about building an effective team, developing a vision that the organisation has subsequently aligned behind, and bringing in new revenue lines.

Most were welcomed rather than distrusted, even though earning that trust could take some time and in some cases was very painful: ""My colleagues didn't really understand why someone with my profile had been appointed – I had to win them over, but I have". Eventually most

succeeded in convincing people they were "different in a good way". Several interviewees said that their outside perspective allowed them to ask questions that desperately needed to be asked, but were hard for insiders to pose.

It's worth noting that our 40 leaders entered very different parts of the NHS, in different, although all senior, roles. As a result they faced different pressures, in terms of financial constraint, operational turnaround, and strategic challenge. They also moved into organisations with subtly different cultures: many of our interviewees were aware of the commercial and people dynamics in different parts of the system, and of how their experiences could have been different in less change-ready organisations, or in a different sort of provider or commissioning environment. Many also noted that "the attitude of the board was crucial" in both enabling the appointment to happen, and then supporting the incoming leader.

Beneath this overwhelmingly positive top-line response were some nuances and reservations. A consistent frustration was with the NHS approach to gathering and using data, for example, with several individuals observing that a huge effort goes into collecting and categorising it, but the protracted analysis that follows can be an excuse for inaction, or a mechanism to protect vested interests, rather than a springboard for change, or a way to improve outcomes.

Another recurring issue was the NHS appetite for change, which appeared to vary widely: some interviewees found their teams keen to take on new thinking – "I radically changed lots of processes and I found them to be adaptable" – whereas others found the NHS bureaucratic, conservative, risk-averse, and trapped in a top-down approach to management in which more junior staff simply waited for orders. One interviewee summed it up by saying said that the issue isn't just the NHS's willingness to change but its capacity to do so: conversely, another individual noted that the nature of the NHS hierarchy actually supports change – "the system is geared up for delivery, so once my colleagues accepted what I was suggesting to them, it happened extremely quickly". Of course, the ability to make change happen says as much, if not more, about the leaders themselves as it does about the institution they are joining, and that may explain some of the divergence in these individuals' comments. Differences in ethos from one part of the NHS to another could also be part of the picture.

As this suggests, the biggest single challenge (at best) or obstacle (at worst) to cross-sector hires was adapting to the NHS culture, which is distinctive, sometimes insular, and often baffling to those with no direct experience of it.

“I USUALLY MET THE MOST RESISTANCE IN THE LIFERS – AND THEY’RE STILL THERE”

“THE MANAGEMENT TEAM HAD GIVEN ME THREE MONTHS, AND ONE WAS RUNNING A SWEEPSTAKE ON WHEN I’D LEAVE. MY DIRECT REPORTS HAD ALL GOOGLED ME AND THEIR ATTITUDE WAS ‘WHO IS THIS GUY?”

“FOR ANYONE DESPERATE TO MAKE RAPID IMPACT, IT WON’T WORK”

“I ACTUALLY FOUND IT A VERY COMMERCIAL ENTITY, AND I’VE LEARNED MORE ABOUT RUNNING A BUSINESS SINCE JOINING THE NHS”

ADAPTING TO THE CULTURE

In cultural terms, the NHS can be at two removes from beyond the experience of many leaders from a commercial background. Healthcare as a sector is very different from any other industry, and being in the public sector makes the NHS different again, so that even those who've worked in private healthcare businesses find it a very different place. Everything from the values to the vocabulary can seem alien: one of our interviewees noted wryly that the in-house terminology doesn't even translate from one part of the organisation to another, and another recalled being puzzled by a conversation that appeared to be about 'gypsies', only to discover afterwards that this was an acronym meaning 'GPs with special interests'. Another noted simply that "the transition to the NHS was the toughest challenge of my career

Some of those we spoke to who'd worked in global companies found parallels between the typical divisional structure of a big multinational and the fiercely independent component parts of the NHS, which helped them navigate their way forward. Most also agreed that building a network and establishing relationships is key, though they tended to receive very little help with this.

Consistently, leaders appointed to senior roles within the NHS from outside experienced induction processes that were, at best, patchy, ranging from nothing at all to a 500-page manual posted to them in advance of their start date - "absolutely rubbish," was how one person summed it up. Luckier appointees were able to shadow their predecessor, but this was rare, and one who wanted to visit wards as part of the on-boarding process found the request met with baffled looks. Most either had to set up their inductions themselves or sink or swim without it – "I put together my own three-month plan, which collapsed at week two".

Several of the leaders we spoke to had created their own induction programmes, having forged informal relationships before they arrived which enabled them to do this – including, in several cases, with the external assessors who'd served on the panels which appointed them. Others used their own periods of leave before joining the NHS to visit sites. Consistently interviewees noted the speed with which they were drawn into the intensity of their roles, and those who had invested time up-front to orientate themselves were glad they had done so in advance of joining their employers full time.

There was general agreement that external hires into the NHS have to adapt, not impose, and the key to acceptance and success is to recognise from the start that they have a lot to learn, as well as bring: "I did arrogantly assume I would be teaching, but it quickly turned out the other way round, and you have to be open-minded about this".

“I ARRIVED AT THE SAME TIME AS THREE OTHERS FROM OUTSIDE – THEY'D ALL GONE BY THE END OF THE YEAR”

“IT WAS A HUGE CULTURE SHOCK, THE BIGGEST I'VE EVER EXPERIENCED”

“IT'S DIFFERENT FROM ANYTHING ELSE. THE MOTIVATIONS OF HEALTHCARE PROFESSIONALS ARE VERY DIFFERENT – THEY'RE DRIVEN BY A DIFFERENT SET OF VALUES”

“I INHERITED 20 PEOPLE WHO DID NOTHING BUT HELP ME WITH THE BUREAUCRACY”

“YOU COME IN WITH A PRIVATE=GOOD, NHS=BAD ATTITUDE, AND YOU WILL FIND THIS IS UNTRUE. THE NHS IS BETTER IN SOME WAYS. BUT YOU HAVE TO BE ATTRACTED TO THE SERVICE ELEMENT AND THE INTELLECTUAL CHALLENGE. IT’S DIFFERENT FROM WORKING FOR A MULTINATIONAL”

“THE NHS HAS GOT SOME WAY TO GO IN UNDERSTANDING THE IMPACT OF A GOOD BOARD, HOLDING UP THE MIRROR TO THE EXECUTIVE TEAM. THERE IS CURRENTLY A SURPLUS OF REGULATION, SO IT NEEDS TO BE THOUGHT THROUGH MORE CLEARLY”

The degree of external regulation was a real shock, even though the interviewees were fully aware of this aspect of the job before they accepted the post. As one said, "I'd worked in highly regulated industries before, but nothing prepares you for regulation in the NHS. It's a whole new level". Another observed that businesses in regulated industries tend to accept the fact and work with it, whereas the NHS, in their experience, is resistant to such oversight.

The weight of external regulation is matched by – indeed leads to – equally high levels of internal governance, described variously as "shockingly overbearing" and "governance gone mad". One interviewee described the NHS as a "bureaucracy and meetings culture", while others contrasted the enormous volume of governance with its relative ineffectiveness.

One interviewee (highly valued by the trust in which they operate and given a hugely positive review by the CEO who had hired him) gave us the startling statistic that 60% of his working time was spent on Executive Director-related governance activity, with 40% of his time remaining for the functional leadership role he had been ostensibly hired to deliver.

If regulation was seen as a necessary evil, the degree of political intrusion was felt to be a decidedly unnecessary one. Few interviewees had anticipated how much impact the electoral cycle would have ("two years before a general election a stultifying hand comes down"), or that the direct intervention of politicians could determine the operational agenda, or provoke a crisis response to relatively mundane issues ("politicians cutting straight across what you're doing with urgency that is self-created divert the organisation from its long-term strategic goals"). One went so far as to say that the political environment "poisons NHS leadership", and results in the wrong metrics, which mean time and resources are directed to the wrong aspects of the service. The interviewees who had already had experience of the parliamentary oversight system were better prepared for this aspect of the job, but it was always a challenge, and a very public one at that.

SURVIVING UNDER SCRUTINY

One of the biggest differences between an NHS and a private sector job is the degree of public scrutiny that comes with the territory. Whilst CEOs in multinationals can also find themselves in the newspapers or before Commons committees, it happens much more rarely, and usually only in cases of negligence, fraud or scandal. In the NHS, senior executives both at and below CEO level can be subject to regular, intense and high-profile examination of their decisions and performance, locally as well as nationally. For some of our interviewees, this started before they were even in post, with media criticism of their appointment and package.

This underlines what a big risk these jobs can be, especially if things subsequently go wrong. As one interviewee put it, "I'm still grappling with the level of public scrutiny, and often by people completely removed from the NHS". This can hamper strategic decision-making and stifle innovation, even though these qualities are precisely what external hires are supposed to bring to the organisation.

> "THERE WAS A LOT OF SCEPTICISM IN THE MEDIA ABOUT MY APPOINTMENT AND THE RELEVANCE OF MY EXPERIENCE. THEY ALSO ATTACKED MY PACKAGE, EVEN THOUGH I TOOK A HUGE CUT, WHICH WAS REALLY ANNOYING"

> "IT FEELS LIKE A FISH BOWL – THE TRADE UNIONS, THE MEDIA, MPS, MY STAFF, THE CARE QUALITY COMMISSION, MONITOR – THEY'RE ALL SCRUTINISING"

THE IMPORTANCE OF CEO SUPPORT

One factor common to all the successful transitions from private to public was the active and ongoing support of the CEO and/or Chair. These individuals had invariably been responsible for the interviewee being offered the job in the first place, and this evolved into both practical and moral support after the successful director was in post.

Perhaps the single most important consequence of this senior sponsorship was freedom to manoeuvre – the ability to set strategy, introduce different ways of working, and shape a team. The latter, in particular, often entailed some hard decisions, making the CEO's endorsement even more important. As one interviewee put it, "You need a strong advocate".

"I WAS LUCKY WITH THE CEO AND CHAIR – THEY GAVE ME THE AUTHORITY TO SHAPE THE ROLE AND THE TEAM"

"I WAS ABLE TO BRING IN SOME REALLY GOOD PEOPLE, FROM BOTH THE NHS AND THE COMMERCIAL SECTOR"

ENABLING CROSS-SECTOR HIRES TO THRIVE

One of the most consistent concerns we heard from our surveyed leaders was the lack of a clear career path beyond the role they had been appointed to, and the absence of anything like a structured approach to talent management, which one interviewee described as either non-existent or "ham-fisted". One mid-career cross-border hire, who has been promoted by the trust he currently works within, volunteered that he expected to leave the NHS with his next move because he doesn't feel his hybrid CV will be valued elsewhere in the Service – "when the chips are down, they want people from the system". These views have real implications for the NHS's ability to retain and develop leaders it has brought in and on-boarded.

Few interviewees felt that the NHS offered them clear long-term career progression: "My Chair and Board are supportive but there's nowhere else to go".

Perhaps the most consistent observation of all was of the power a mentor or buddy could have in helping new arrivals to navigate the system, and understand what would be expected of them. Interesting, many who had thrived had, largely by accident, found mentors for themselves, or, in a couple of cases, been sought out proactively by individuals who went on to help them land well within the NHS. Several forged relationships with the independent assessors from their panel interviews; others forged that relationship with the Chair or CEO who'd sponsored their appointment. The small number of leaders who had been given mentors recognised the contribution those individuals had made to their successful transition.

“WHEN THE CHIPS ARE DOWN, THEY WANT PEOPLE FROM THE SYSTEM”

“BEING GIVEN A MENTOR WAS THE MOST HELPFUL THING MY ORGANISATION DID FOR ME”

“MY CHAIR AND BOARD ARE SUPPORTIVE BUT THERE’S NOWHERE ELSE TO GO”

WORKING WITH CLINICIANS

One of the most distinctive features of healthcare as a sector is the absolute primacy of clinical colleagues who can feel distanced from their organisations' leadership and management in delivering quality services. Many of our interviewees feared that establishing productive relationships with clinicians would be difficult, and guessed that the more senior the doctor, the bigger that challenge was likely to be. In practice, experience varied quite widely.

Some were relieved to find their new clinical colleagues were respectful of their experience, and willing to collaborate; one even felt he had been able to improve significantly the performance of the medical professionals working under him (this was a rare perspective). Others felt they were at best tolerated, and then only because their role didn't have much of an impact on clinical decision-making - "it helped that in my job I was not going to kill anyone. My post was mostly financial, but had the responsibility been greater..."

At the extremes, some leaders noted "an assumption of intellectual superiority" on the part of senior clinicians, who can be not just resistant to change, but active barriers to achieving it. To those leaders the frustration became, "you are almost never going to be able to change things in the NHS, because doctors hamper change". Others noted the role the unions can play in "reinforcing differences between professions".

To the majority of our leaders, however, the challenge of working well with clinicians was part of the stretch that attracted them to the NHS. When they were successful in winning clinicians' support, they found change easy to deliver and exciting to watch. The group also noted positive signs in relationships between clinicians and managers. Several were confident that the next generation of clinical leaders will be more accountable, adaptable to change, and understanding of the roles non-clinical leaders play.

“
WORKING WITH CLINICIANS IS A SKILL. YOU HAVE TO RESPECT CLINICAL DECISIONS, AND INFLUENCE THEM BY PROVIDING THE RIGHT INFORMATION AND SUPPORT
”

“
YOUR OPINIONS AREN’T WORTH MUCH IF YOU’RE NOT A MEDIC
”

“
THE CONSULTANTS AND SENIOR CLINICIANS ARE LEAST ENGAGED WITH EFFICIENCIES – IN FACT THEY SEE NO BENEFIT IN ENGAGING AT ALL
”

“
ONE OF OUR PROCESSES WAS LUDICROUSLY INEFFICIENT AND TIME-CONSUMING, BUT WHEN I EXPLAINED THE ADVANTAGES OF DOING IT DIFFERENTLY, THE CONSULTANTS JUST SAID ‘THAT’S NOT THE WAY WE DO IT HERE’
”

CONCLUSION

New arrivals into the NHS in leadership roles consistently, our research shows, brought skills and external perspectives which have been, in their experience, highly valued by the Health Service. Many have been promoted into either bigger roles in the organisation they originally joined, or through the system itself. Their appointments have also been overwhelmingly positive experiences for them as individuals, and they would encourage others to follow in their footsteps.

Resistance to non-NHS "home-grown" leaders transitioning into the Service persists, however. Our observation is that the NHS needs to be clearer about what it expects those people to do, and stronger in supporting them once they arrive. Otherwise it will fail to attract the best and brightest, and risk losing those it does recruit.

Here are our recommendations for the NHS overleaf, followed by the advice our interviewees would give other candidates considering a similar move.

> "IF THE CONDITIONS ARE RIGHT, THE MONEY, THE ORGANISATION, AND YOUR CONFIDENCE, THEN DO IT. BUT YOU CAN'T ASPIRE TO GREATNESS, BECAUSE THAT'S NOT WHAT THIS IS ABOUT"

PHYSICIAN, HEAL THYSELF: ADVICE FOR THE NHS

Think about your candidates
The first recommendation is to design a recruitment process able to flex to external candidates. The NHS traditionally approaches recruitment very differently from other sectors, and candidates from outside the sector can find the numerous panel interviews and stakeholder groups a deterrent. Using an experienced recruitment consultant can help bridge these two worlds, and ensure applicants are well briefed on what to expect.

Designing an appointment process that gives candidates time with key stakeholders on a one to one, informal basis, separately from panel interviews, is an important enabler. Seeing candidates as just that, rather than applicants – even supplicants – can help re-balance a process to draw in external leaders who are interested but not yet 100% committed.

Induct properly
Once in post, candidates from outside the NHS will need a far more robust and extensive induction than for those who are joining from inside. They need to understand how the NHS works, and be given time to assimilate the culture and recalibrate their own ideas in an NHS setting. Up-front, protected, induction time, even if just a week long, was one of the most consistent observations we heard - "don't throw people in at the deep end".

Be clear about expectations
Ensure there is clarity about roles and responsibilities, both for the new hire and their colleagues, many of who may be wary of 'outsiders'. This should start during the recruitment process but often doesn't. External candidates may well need specific support on dealing with public scrutiny, and tailored training might be a useful option.

Mentors
Support new hires both formally and informally through networking and mentors. All our interviewees valued having a mentor – especially one with NHS experience and contacts – but most either didn't get that opportunity or had to organise it for themselves. Others noted the value of being connected with individuals who'd made the same step into the NHS from the outside.

Talent management
Think harder about career planning and talent management. The NHS could learn a lot from commercial best practice in this area, and needs to do more on all aspects of leadership development, from specific skills to wider issues such as governance.

HYGIENE FACTORS: ADVICE TO CANDIDATES

Do your research
Look at the Chair and CEO's leadership style, the working culture, and what you've been told is needed in the position. Remember that different parts of the NHS have their own ethos and level of energy. Is this particular post right for you at the point you've reached in your career?

Be ready for an appointments process that feels different from those you have more usually been put through – NHS organisations will usually want to seek the views of their stakeholders on candidates. Winning the support of those individuals can be very helpful once you are in post, so keep an open mind to the value of those meetings. On the other hand, you need the opportunity to "kick the tyres" with those who will become your key colleagues: do ask for those opportunities.

Salary expectations
NHS organisations will usually have pre-agreed salaries for roles, and very limited, if any, room for negotiation. If you're told that the upper limit for an appointment is a certain amount, don't move forward expecting that number just to be a starting point for a conversation.

Assess the role emotionally, as well as intellectually
You will need to be extremely resilient, highly motivated, and very persistent: "You'll be disappointing 90% of the people, 90% of the time". You'll also have to work very long hours and take the heat of public scrutiny. The risks are considerable – are the rewards likely to be worth it for you?

Clarify what success looks like
Make your CEO/Chair define it, and assess whether you can deliver it.

Learn the organisation
If a proper induction isn't offered, make your own. Visit wards, talk to clinicians, "Go in at 10pm to A&E – that's where you'll see the real culture". Understand the way things get done (or not), and why. Listen hard.

Avoid arrogance
You need to be open-minded and respectful, and appreciative of the values and the skills of the NHS lifers - all the more so if there is a clear need for change. "Make friends before you make plans".

Build a network
Seek out people doing similar jobs in other parts of the NHS, as well as those with long-term NHS experience, or others who've made the move from the commercial sector.

ABOUT SAXTON BAMPFYLDE

Saxton Bampfylde was founded in 1986 and is one of the leading executive search and assessment firms in the UK. With offices in London and Edinburgh, Saxton Bampfylde is an employee-owned firm of over 70 Partners, recognised as a specialist in the fields of health, education, government and regulation, and not-for-profit sectors.

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