New roles and responsibilities of NHS chief executives in relation to quality and clinical governance

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Abstract

The role of the chief executive in the NHS is to act as organisational head, with financial and managerial responsibility, and now responsibility has been extended to include clinical standards as part of the duty of quality and the introduction of clinical governance. These new responsibilities have implications for relations with staff inside the organisation and, in particular, with clinicians, as well as adding to the overall public accountability of chief executives. As well as increasing expectations of chief executives to meet performance objectives and other targets within the organisation, their role remains relatively new and sometimes contentious in the health service, forming part of the history of NHS management reform. The developing role of chief executives and the complex world in which they operate in the health service is discussed. It is suggested that support from colleagues at both the organisational and national levels is required to help them discharge their new responsibilities, together with a greater focus on the development of their role and skills.

(Quality in Health Care 2001;10(Suppl II):ii13–ii20)

Keywords: NHS chief executives; management reform; clinical governance

Chief executives of public services face a very particular set of challenges. They have always operated in a politicised environment and have had to be responsive to and work within the demands and constraints provided through government policy. More recently, however, they have faced increasing public and government expectations of accountability and demands to demonstrate the performance of their organisations, and many are now working closely with the private sector as partners in private finance initiatives or through the contracting out of services. Chief executives are expected to be leaders and managers of their organisations—inspiring cultural change, delivering on policy objectives, and achieving high standards of service in their organisations. Some might say that public sector chief executives are moving towards their private sector counterparts who are held to account for organisational performance and are personally identified with organisational success and failure.

Chief executives of NHS hospitals and other clinical units have also had to take on a further

Key messages

- NHS chief executives are now responsible for clinical standards in their organisations with the duty of quality set out in the Health Act 1999.
- The duty of quality adds to the responsibilities of chief executives and changes relationships with those inside and outside the organisation.
- Chief executives already operate in a highly complex world in a role that remains relatively new and constantly evolving.
- Support for chief executives is required at the organisational and national level so that they meet expectations regarding quality and performance objectives.

new responsibility. Since 1999, as well as being responsible for the financial and managerial performance of their units, they have also been made responsible for the quality of clinical care. The aim, as set out in the document “*A first class service*” that describes “clinical governance”,¹ is to link standards of clinical care with organisational performance, for which the chief executive is ultimately responsible. The implication is that the responsibility is, of course, a shared responsibility with clinicians. Nevertheless, it is a new responsibility and is awesome: the quality buck stops at the chief executive’s desk.

So, who are these people who have jobs that are so demanding? Despite the very distinct nature of their roles, there have been relatively few studies of public sector chief executives. They have been viewed differently by different groups and at different times. Within the NHS they have been looked at somewhat sceptically by some healthcare professionals who view them as “high earners” who are not carrying out the “real work” of the organisation—namely, clinical care—while being in a position, through having financial control, to constrain those who do the “real work”. But the same people are also “advocates” for their organisations in negotiations with health authorities and civil servants for funding. They were viewed by the NHS centre as crucial to the implementation of the series of NHS reforms throughout the 1990s.

Chief executives of hospital and community trusts are commonly described as organisational leaders with responsibility for implementing policy and for meeting targets. This

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includes the motivation and support of a large and diverse workforce and for ensuring the quality of patient care. Although they have all this responsibility, it seems that it is the professionals—and not the chief executives and other managers—who are viewed as the pioneers or instigators of current change. For example, there is no direct mention of chief executive responsibilities in the “*NHS plan*”. The plan describes “clinical and managerial” leadership but the focus of the discussion is on professionals.² Despite the NHS having comparatively low management costs as a proportion of total health costs, the “*NHS plan*” intends to reduce management costs.

The role of the chief executive is crucial to the implementation of new policy including the “*NHS plan*” and the success of quality improvement through clinical governance. But how well equipped are they for the extra responsibilities involved in leading the quality agenda? This paper aims to answer this question. Firstly, it is important to understand the traditional role of the NHS chief executive and how it has developed over the past two decades. Secondly, the new responsibilities need to be clarified and described in terms relevant to role development. Thirdly, chief executives will need to know how to cope with the inevitable changes that will occur in their relationships with both the NHS executive and with some staff in their own organisations as a result of these new responsibilities. Fourthly, if the introduction of clinical governance is to be successful and make an impact on the quality of clinical care, we need to find out the support that chief executives will require to enable them to discharge their new responsibilities. Finally, we will need to be able to describe coherently the role of the new NHS chief executive if we are to recruit and appoint people with the appropriate range of skills.

The developing role of the public chief executive

Hospitals, like other public services, were traditionally administered bureaucracies in the post-war period. They had an administrative hierarchy that ran parallel to the professional medical hierarchy and this extended beyond the individual organisation to national structures. Hospitals were led by a tripartite structure comprising a hospital secretary, a matron, and the chairman of the medical staff committee. Teaching hospitals existed outside the main structures until 1974. From 1974 a system of regional health authorities, area health authorities, and district management teams (still representing, among others, administrative, nursing and medical heads) was introduced. Before the 1980s the system emphasised group decision making, so called “consensus management”. There was an emphasis on representation through a series of local and regional committees and boards. There was little coordination of policies or activities across the system, including monitoring resource allocation. The regional tier of the health service was responsible for allocating

capital and translating national policy objectives for the region.

With the Griffiths report in 1983³ (Griffiths being the head of Sainsbury’s supermarkets at the time), the management systems used successfully in other service industries were brought in to the health service, including the delegation of financial responsibilities and the introduction of line management systems throughout the NHS. The aim was to achieve clear managerial accountability through the system, with someone identified as being “in charge”. Authority was delegated to localities, while the centre could pull levers in order to effect change on the ground. This was fundamental management reform of the NHS system which remains today. Timmins⁴ describes a shift in power structures over this period away from doctors and their views towards “money and numbers” (page 411).

However, the idea of chief executives for NHS organisations was rejected during the management reforms of the 1980s and it is interesting for the current discussion to remember why. Managerial accountability involving professionals was thought not be consistent with clinical autonomy which emphasised accountability in terms of the individual relation between professional and patient. In the reforms of the early 1980s the government believed the appointment of chief executives “would not be compatible with the professional independence required by the wide range of staff employed in the service”.^{5,6} In this context, clinical autonomy was central to preserving the conditions of the doctor-patient relationship and was viewed as incompatible with managerial processes and structures.

Such a rejection of the role of a chief executive—a single person “in charge” of hospitals—ended with wide ranging organisational reform in the early 1990s when “autonomous” government agencies were created right across the public sector and controlled by an executive board that was modelled on private sector corporate governance structures. In central government so-called “next steps agencies” were created in areas such as prisons, employment services, and social security. They controlled large budgets, had significant staff numbers, and brought in newly appointed chief executives who came from both within and outside the public sector. In the NHS the trust model was created. Trusts are independent statutory bodies headed up by a chief executive who reports to a trust board made up of executives and a majority (including the chairman) of non-executive directors. So far, the focus of the role of the NHS trust chief executive has been to ensure financial and managerial accountabilities of their organisations, within which they operate with considerable delegated authority compared with previous organisational heads.

Change is always, of course, politically driven. The Conservative administrations saw the private sector as the model for good practice and saw better management of public services as a solution to its problems. At the extreme, this

policy involved the complete privatisation of public organisations but, for organisations that remained in the public sector, it meant replicating business methods and managerial roles from the private sector, including the transfer of high profile personnel from private sector companies. Examples of changing practice included private sector styled performance appraisal systems, short term contracts, and organisational performance targets which were often directly linked to the performance objectives of the chief executive.

Models of chief executive roles have followed changing practice in this area. Traditional models of managing sought to generalise about managerial work, to define the universal functions of management. Later, systems and contingency theorists highlighted differences in organisational structure that are appropriate to the context in which the organisation operates.⁷⁻⁹ Within the fields of political science and British public administration who traditionally studied public sector organisations, the literature did not begin to conceptualise “management” in similar terms to management studies until fairly recently. Gray and Jenkins¹⁰ document the change from public administration to public management which they trace back to the late 1960s and early 1970s.

In the last 20 years “public management” has developed as a subject of academic discussion and as practice. One of the obvious and enduring debates within this literature is that of the nature of “public” management—how the specific context of the public sector differs from the private sector and makes public management a unique function.¹¹⁻¹⁴ In contrast to the beliefs of politicians at the time, these authors promote a distinct “public” management. Managing in the public sector has a particular purpose. It is complex and political:

“... in the public domain the manager is never the principal actor. The distinctive task is to support and enable others and different kinds of ‘others’; the many (citizens) and the few (elected representatives). The task is to support citizenship and government. This enabling role involves the management of balance between a series of tensions which are intrinsic to the duality of the public domain. The role of the public sector manager is the role of counterpoise.”¹⁴

Within the tradition of management, several authors have sought to document the particular circumstances of managing within the NHS; notable examples are the large body of work by Stewart on various managerial posts including the relationship between chief executive and chair,^{15 16} recent work by Exworthy and Robinson¹⁷ also on the relationship between chair and chief executive, Goodwin¹⁸ on leadership and chief executives, and work by Ferlie and others on NHS boards.^{19 20} Denis *et al*²¹ present a case study of the integration of a new chief executive into a large hospital in Canada and Currie²² has focused on the neglected middle managers in the health service. For a recent overview of managing in the NHS the reader is referred to the case study by Day and Klein as part of the ESRC’s Whitehall programme on British central government.²³

While work that concentrates on the NHS highlights its particular environment, more broadly the ideas of “new public management” have dominated discussion and practice in the public sector in the last 10 years. New public management and managerialism emphasise the transferral of private sector management controls to the public sector and the decentralisation of responsibilities as in the agency model described above (see Pollitt²⁴ and Hood²⁵ on early new public management and Dawson and Dargie²⁶ for a review of new public management in relation to the UK health sector). New public management plays down traditional ideas about the particular circumstances of managing in the public sector. The ideas of new public management form the backdrop to recent changes in the NHS from both the Conservative Major government and in the policies adopted by the Blair government, such as private financing, strict performance management according to targets or indicators, strong financial controls, and the specialist agency model rather than traditional hierarchy in government.

New roles for health chief executives

Clinical governance turns on its head the concept of clinical autonomy and the assumption that the doctor-patient relationship can operate distinctly and separately from managerial processes and accountabilities. It asserts a patient centred approach, but one that is part of the organisational structures and processes where accountability mechanisms flow from the clinical setting to the board room. The management of an NHS trust is responsible for monitoring clinical processes and for putting in place the support systems that contribute to it—namely, research, training and professional development, clinical audit, and risk management. Chief executives will therefore find that clinical accountabilities flow through their office rather than operating in parallel to financial and managerial accountabilities.

The new duty of quality for NHS chief executives is part of clinical governance:

“... a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”²¹

These clinical governance arrangements add to a range of significant new responsibilities for NHS chief executives. They include responsibility for achieving waiting time targets; for performance in the national performance assessment framework (PAF) which covers a

The new duty of quality:

“It is the duty of each health authority, primary care trust and NHS trust to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals.”²⁷

range of clinical and non-clinical measures and where poor results warrant intervention from the centre; for establishing new collaboratives related to national policy objectives such as on cancer that have to be put in place at the organisational level; and for establishing a relationship with national and local modernisation boards responsible for ensuring the development of a patient centred approach in NHS organisations.

Overall, these changes affect chief executives in several ways. Firstly, a whole set of new relationships have to be established outside the organisation. Earlier academic studies of public chief executives played down the external role they played but, with the internal market created in the 1990s, chief executives were encouraged to adopt more competitive relationships with external organisations. The purchaser/provider split, for example, created a market for health services with health authorities as purchasers and trusts as providers. Chief executives were encouraged to act competitively with other organisations in the internal market. Today, in contrast, there are increasing functions which require collaboration or partnership with outside organisations. NHS chief executives are therefore expected to act as liaison with various groups, to be an advocate for their organisation and its activities, and to take on what might be described as a “development” role in local joint policy implementation—in addition to the everyday management functions associated with the role in trusts and health authorities.

Secondly, the chief executive will have new relationships with staff within the organisation. The developments suggest an overall coherence to organisational process; clinical, managerial, and financial responsibilities will no longer be viewed as separate entities. This means that the relationship of the chief executive with clinical staff should be the same as that with non-clinical staff employed in the organisation. The chief executive is responsible for putting in place systems to ensure support for clinical standards including resources and research, training and development opportunities, and is also responsible for monitoring clinical standards and taking action where they are not met. Both professional and managerial staff therefore have new expectations of their colleagues.

The Commission for Health Improvement (CHI) is responsible for assessing the implementation of clinical governance by conducting reviews of individual organisations. Early evidence from CHI reports suggests that corporate responsibility for clinical governance and quality is at its early stages (full reports of the eight clinical governance reviews carried out by the CHI are available at its website: www.chi.nhs.uk). Chief executives first have to acknowledge and assume responsibility for clinical governance when previously clinical issues would have been taken care of by medical staff. Early indications are that medical directors and directors of nursing are assuming operational responsibility for clinical governance. The relationship between chief executive

and medical director will be crucial to the successful development of clinical governance arrangements. Along with chief executives, board members will assume new responsibilities and CHI encourages a non-executive lead on clinical governance at board level.

Thirdly, there are an increasing number of ways in which the organisation—and the chief executive personally—are subject to monitoring, inspection, and review. This creates something of a potential conflict; on the one hand the changes represent more outward focus for the organisation involving collaboration and the outward development of trust activities while, on the other, the increasing external inspection and monitoring will lead to an inward focus for the trust, a narrower focus on objectives and targets that will be appraised.

The chief executive has to manage the dual responsibility of looking outside the organisation to seek new opportunities and new relationships while making sure that internal processes are robust. The interesting and challenging part for chief executives is that these two roles require different skills. Chief executives are already expected to exhibit a range of roles in their jobs. They will not be the same for all NHS organisations since all organisations are different. However, some common themes can be identified. Mintzberg²⁸ in his pioneering work on the nature of managerial work identified 10 characteristic behavioural roles (see box) which he grouped as “interpersonal”, “informational”, or “decisional”. Undertaking an assessment of the roles fulfilled by NHS chief executives would probably reveal that all are relevant.

However, the new responsibilities possibly pull chief executives in two directions. Firstly, interpersonal roles are associated with internal developments such as the cultural change envisaged as part of current NHS reforms—chief executives are expected to be leaders and pioneers of such change. Interpersonal roles are also associated with the external role of

Mintzberg²⁸ identified 10 behavioural roles that characterise managerial work from observing, categorising, and interpreting chief executives at work. They are:

- monitor (seeks and receives information)
- spokesman (transmits information to outsiders)
- disseminator (transmits information to members of the organisation)
- figurehead (symbolic head performing social and legal duties)
- liaison (maintains a network of external contacts)
- leader (motivation of staff)
- entrepreneur (initiates and develops new projects)
- disturbance handler (reacts to organisational disturbances)
- resource allocator (allocates resources and approves decisions)
- negotiator (represents the organisation at negotiations)

chief executives in the form of maintaining external contacts, building relationships with new contacts, and so on.

Secondly, informational roles are associated with the gathering, exchange, and dissemination of the vast amounts of information currently generated both inside and outside the NHS organisation from a range of sources. Chief executives have probably a unique range of contacts and a unique perspective on information regarding policy and operations and so they form a natural information source or “conduit” within and outside the organisation, often being required to translate abstract ideas and broad policy objectives into what they mean for the organisation.

What this all means is a potentially reduced capacity for chief executives to undertake decision making roles—which might cover initiating new projects and developing them, committing organisational resources to new projects, and approving decisions. Chief executives require time to devote to decision making roles (which is not always available), and some freedom to make choices on behalf of the organisation (which is not always possible).

Evaluating new roles for health chief executives

How does the duty for quality differ from the responsibilities of the chief executive in other parts of the public sector or, indeed, with those in the private sector on whom chief executives were originally modelled? The new arrangements raise some interesting questions with regard to the roles and responsibilities of chief executives. The questions are important since the duty of quality and clinical governance arrangements are an evolving concept as are their implications for chief executives; despite their significance, there has been little guidance for chief executives in explaining the changes. For example, within the context of being a public service, is responsibility for clinical quality different from quality in other sectors such as the quality of prisoner care in prisons? The duty of quality places responsibility for the fundamental business of the organisation on the chief executive as the most senior manager. So, to continue the comparison with the prison service, it is not just the conditions within which prisoners are kept, keeping security breaches to a minimum and preventing overcrowding, but also responsibility for ensuring rehabilitation or appropriate health care if these are deemed part of acceptable quality of a prisoner's time in prison.

Yet the chief executive cannot intervene in the clinical setting—he or she is responsible for outcomes but cannot intervene in the process. Historically, the managerial hierarchy in hospitals and health organisations has been further removed from the clinical setting than is the case in other industries because of the strength of professional autonomy among clinicians. The differences may be more of greater complexity in health service matters than differences in kind. The operationalisation of quality, as the CHI reports suggest, is more that the senior managers are required to put the

systems in place to ensure quality outcomes than that they should be held responsible for the outcomes themselves—although the logic is that, with the appropriate systems in place, any poor performance or adverse events will be identified and rectified early, therefore avoiding poor performance.

NHS chief executives are certainly held to account for organisational failures and several recent cases serve to illustrate this. At a trust that was the subject of a routine CHI clinical governance review, the chief executive had already resigned following an incident involving the use of the hospital's chapel as a temporary mortuary which was pictured in the national media. Of the two special investigations carried out by the CHI in addition to their routine reviews, in one trust where there was evidence of staff abuse of patients the chief executive resigned. The *Health Service Journal* regularly reports on the departure of chief executives,^{29–31} and a recent article drew the analogy between NHS chief executives and the notoriously precarious job of a football manager.³²

However, accepting responsibility for operational failures is not confined to NHS trusts. Throughout the public sector the introduction of the chief executive has been a signal for operational responsibility. A high profile head of the Prison Service brought from the private sector left after a series of escapes from Parkhurst and Whitemoor prisons in the mid 1990s, and the first head of the Child Support Agency resigned after its early failings. Both were outsiders to the public service who were replaced by career civil servants. More recently the chief executive of the Passport Agency left his post after computer failures led to severe delays in applications in the summer of 1999, and in 2000 the head of the Scottish Qualifications Authority went after a whole cohort of students received either no results or results that were inaccurate or incomplete. In the private sector chief executives are removed because of poor share performance, as in the case of Marks and Spencer, Sainsbury's, and British Airways. Similarly, outside the UK, companies such as the US National Steel Corporation and the global accountancy firm PriceWaterhouseCoopers have removed chief executives because of poor company performance.

The introduction of chief executives into public sector organisations forms part of a wider debate about relative responsibility and accountability in public service that is not resolved. The debate is about where operational responsibility ends and responsibility or accountability for policy begins. In theory, operational responsibility lies with the manager, chief executive, or public servant while accountability for policy lies with the Minister. The head of the Prison Service argued that the prison escapes were the result of policy failures; the then Home Secretary was resolute that these were operational failures and were the responsibility of the chief executive of the agency. In practice the lines are blurred; senior public servants advise ministers on policy and

chief executives often provide important feedback on the operational consequences of policy. In the Home Office, for example, another head of the Prison Service reported to a parliamentary committee that he frequently advised on policy.³³ More negatively, the former chief executive complained that the Home Secretary interfered in operational matters on a day to day basis.

This discussion has implications for the NHS when performance of NHS organisations across a range of functions is under closer scrutiny. Chief executives are responsible and therefore accountable for clinical as well as financial performance in their organisations, and this opens up an interesting set of questions about responsibility in a public service where the medical profession has its own mechanisms of monitoring and sanctioning poor performance among its professionals. Added to this is the increasing central monitoring and control of all areas of performance of health service organisations while, at the same time, new policies in clinical practice are being developed such as the National Institute for Clinical Excellence (NICE) guidelines on interventions and the National Service Frameworks on cancer, mental health, and services for older people. Relationships between clinical and managerial staff in NHS organisations are crucial to the success of the new arrangements. At the same time, chief executives will require significant support in order to fulfil all that is expected of them.

The Bristol Royal Infirmary case is an important example in this discussion for many reasons, but an aspect that has not been highlighted significantly is the interplay between managerial and clinical responsibilities. The former chief executive of Bristol Royal Infirmary, who retired in the wake of failures in heart surgery on babies that became the subject of the Bristol Enquiry, was struck off the General Medical Council for serious professional misconduct. He then appealed to the Privy Council against the decision because, as chief executive, he was not a practising clinician. However, the appeal was dismissed. The Medical Defence Union advised its members as a consequence that *"doctors with dual roles have duties as a registered medical practitioner over and above their contractual responsibilities and they may be held accountable to the GMC if they fail to take all reasonable steps to protect patients' interests. This applies equally to doctors who have no direct patient contact, for example scientists or managers."*³⁴

This enhances the move to clinical accountability alongside managerial accountability for clinicians in management positions—to be held to account as a clinician for the areas under your managerial responsibility rather than your specific clinical responsibility. It has been pointed out that the UK Council for Nursing, Midwifery and Health Visiting has called nurses to account as managers for patients under their care in nursing homes.³⁵ With clinical governance, managers—whether clinically qualified or not—will be responsible for clinical standards under their authority. This is part of

the statutory duty of quality placed on NHS organisations. However, in addition to parliamentary accountability, chief executives with clinical qualifications may also be held to account by their professional body for care that falls under their managerial responsibilities. This responsibility on clinicians outside the specific doctor-patient responsibility broadens further the accountability mechanisms in hospitals, at least in theory.

The Kennedy report into the Bristol Royal Infirmary case³⁶ concluded that it was caused by a failure of leadership and teamwork where people failed to communicate with each other and to work together in the interests of their patients. The report highlighted a failure of leadership at the top of the organisation where it was felt that problems could not be brought to the chief executive, and the system of separate and "virtually independent" clinical directorates that also hampered communication. The report's recommendations are pertinent to the issues raised here, including (1) that safe care should be promoted and led by a non-executive member of every trust board; (2) that health professionals undergo appraisal, continuing professional development, and revalidation to ensure that they remain competent to do their job; (3) that all employees should be treated in a broadly similar manner, with comparable terms of employment and clear lines of accountability; (4) that there should be published standards of care; and (5) that a systematic mechanism should be in place for monitoring the clinical performance of healthcare professionals or of hospitals. The report draws attention to the new duty of quality for chief executives, stating that they must be "supported and enabled to carry out this duty".

The government's full response to the Bristol Inquiry is expected in Autumn 2001. On publication of the report the Secretary of State for Health made a statement in Parliament which commended the report and highlighted the fact that monitoring of quality of care and national standards in the health service were now being implemented.

How well equipped are chief executives to assume their new responsibilities?

The role of the public sector chief executive has been problematic throughout its short history in terms of the theory and its translation into practice. Chief executives are often envisaged as the entrepreneurial visionary leaders of "industry", especially by politicians who demand delivery from public services, but who then have to operate within public sector mechanisms of accountability and authority that exist to limit the freedom of the organisational head. In an earlier study of public sector chief executives that sought to compare roles across the public, private and voluntary sectors, significant configurations of power and influence were found to operate within the public sector.^{37 38} NHS trust chief executives in the study were found to act as a "bridge" between the competing medical, political, and managerial groups involved in the organisation.

In contrast, private sector chief executives had a more limited range of influences with which to deal and consequently they had more freedom in personal style and time than in any of the other sectors. They were able to initiate projects and commit organisational resources without the levels of consultation that took place in the public sector.

The research found that NHS trusts exhibited conflicting organisational processes where three unique pressures operated around the chief executive. Firstly, there was the push for entrepreneurship and innovation—trusts determined their own strategy and managed independently of departmental structures by, for example, controlling their own finances. Secondly, despite decentralisation, controls remaining with the Department of Health made trusts highly regulated and politically controlled; they remain bound by bureaucratic rules and “red tape”. Thirdly, medical professionals participated in high level decision making in the trust and were able to unite as a professional group to exert control over decisions. One of the trust chief executives in the study said he spent most of his time on “. . . either ensuring that the organisation—its management and administration—is properly sensitive to and directed at helping clinicians deliver good care, and vice versa, ensuring that—trying to get clinicians to work in a way which isn’t completely maverick or does recognise that there are organisational priorities and imperatives.”

On the one hand the current changes mean that organisational leadership is more clearly defined for the chief executive who is responsible for clinical as well as financial performance and who now has the authority and mechanisms to intervene in these processes. This means greater responsibility for chief executives. However, the fact that clinical governance is a “top down” policy initiative and that inspection mechanisms operate from the centre means that the chief executive operates with greater constraints which further erode any managerial freedom that might be considered an important aspect of their drive and enthusiasm and the appeal of the job.

It is therefore apparent that NHS chief executives operate in a highly complex world. In organisational terms, NHS trusts have been identified as being “on the extreme end of many organisational spectra: large size; large number of occupational groupings; heavily professionalised; heavily politicised; service organisations where quality is both important and difficult to measure; non-market based forms of operations”.²⁰ Trusts are organised along medical practices, standards and procedures, but also by bureaucratic rules and procedures in line with their public and political accountabilities. Departments are organised by clinical specialty as well as by function such as personnel or finance. In this context, unifying structures, processes, responsibilities, and accountabilities is a considerable task and one that is likely to take time.

The CHI reports that exist to date provide early evidence of the stages that organisations will have to go through to bring quality and

clinical governance to the heart of the organisation’s systems and processes. If the managerial and clinical accountabilities are lined up in a similar way in the organisation, this seems more likely to lead to success in quality improvement because it may overcome some of the countervailing pressures that currently operate: clinical autonomy acts as a decentralising force—pushing decisions to the individual professional—while, at the same time, the development of trusts as “businesses” with strategic objectives and a corporate board structure are centralising forces. Relationships with the centre are always an important factor and, as mentioned above, the demands made by the centre may constrain the drive and enthusiasm for improving arrangements in organisations at the local level. A balance is required between appropriate accountability mechanisms to the centre and to make managers feel at the local level that they are able to make choices. This may seem a rather glib statement as the NHS has been characterised by countervailing tendencies in central control and local autonomy since its inception.²³ However, if chief executives are expected to operate as chief executives, they need both in order to succeed.

What support is required for chief executives?

The foregoing discussion highlights the increasing expectations of NHS chief executives to deliver on central government policy objectives. This follows a relatively short period of role development for public sector chief executives and existing research on chief executives shows the complexity of the organisational context in which they operate. Given this background, there might be some concern about their ability to meet all that is currently expected without good working relationships and role definitions at the organisational level and also significant national support.

There are several organisations, bodies, or programmes that provide support, guidance, training, or representation for NHS chief executives. NHS trust chief executives can join the First Division Association, the union for senior civil servants. The NHS confederation represents NHS organisations, commenting on and influencing policy and campaigning on behalf of NHS employers. In 2000 the confederation produced its own prescriptions for health authority chief executives in a document entitled “Take me to your leader”.³⁹ The other main professional body for NHS managers is the Institute of Healthcare Management.

The NHS itself provides training and development for chief executives through the Leadership Programme, which is now part of an NHS “Leadership Centre” under the Modernisation Agency of the NHS (further details are available at www.nhs-leaders.org). The centre is currently a commissioner of training and development programmes for chief executives, which includes a programme for newly appointed chief executives and for those 2–6 years into the position. Training and development cover personal development, working

with other agencies, and a mentoring scheme. The centre makes contact with chief executives through the regional offices of the NHS and picks up those newly appointed and those who move to a new organisation. NHS chief executives met as a national group in July 2001 at a conference organised by the NHS.

New activities planned include the "University of the NHS" from the Labour government's second term manifesto which will be modelled on corporate universities in the UK and USA, offering training to a range of NHS staff members. Specifically on clinical governance is the Clinical Governance Development Programme operated by the Director of Clinical Governance for the NHS which promotes clinical governance as organisational learning with top teams from NHS trusts.

As well as representation, development and training opportunities there needs to be closer examination of the current expectations of chief executives and consideration of how they translate into role development. Chief executives need guidance on how to operationalise their new responsibilities.

Conclusion

The role of chief executive in the NHS is still a relatively new and evolving concept. From the origins of head administrator and general manager, the role of chief executive was brought in with the creation of NHS trusts in 1990s. They were modelled on their private sector counterparts—an enterprising, strategic decision maker who would ensure managerial and financial systems within the trust, assume overall managerial and financial responsibility for the trust, and seek new business opportunities in what was the competitive environment of the NHS internal market.

With the new duty of quality, chief executives now have a fundamental new aspect to their role—namely, direct managerial responsibility for clinical standards in the organisation. Chief executives will be expected to be involved more directly in clinical matters within the organisation and here the relationship between chief executive and medical director at the top of the organisation is crucial to the success of the new arrangements. At the same time, examination of the current role of chief executives indicates a complex world and constraints on the chief executive. Development of leaders and support for existing ones is required at the organisational and national level to enable chief executives to meet the new, developing, and wide ranging expectations within the NHS.

Thanks are due to Fiona Moss, Pam Garside and Tom Smith for helpful comments on earlier drafts of the paper and to Marie-Ann Kyne-Lilley for searching on chief executives.

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