

An analysis of National Health Service Trust websites on the occupational backgrounds of ‘Non-Executive Directors’ on England’s Acute Trusts

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Abstract

Objectives: To explore the occupational backgrounds of English Non-Executive Directors (NED) on Acute National Health Service (NHS) Trusts.

Design: Data extrapolated from Trust websites of NED’ occupational backgrounds by gender and occupations, and inter-rater reliability test undertaken.

Setting: Data were available on all but 24 of the 166 Acute Trusts’ from all regions.

Participants: Trust Chairs and NED were categorised by their dominant occupation.

Main outcome measure: Differentiating NED with and without health or social care leadership experience.

Results: The ratings of NED’ occupations positively correlated ($p < 0.001$). Occupational categories were Commerce and Finance from private and public sectors or with Medical or Community leadership experience. Only 4% of Chairs were Medical, 2% from Community – the majority (61%) from Commerce and Finance. Of the 1001 NED, 8% and 6% respectively had Medical or Community leadership experience; most (86%) were Commerce, Finance and non-clinical Managerial backgrounds. Females made up 27% of NED.

Conclusions: With a predominance of Chairs and NED without health or social care leadership experience, are current Boards equipped to avoid inadvertently ‘doing the system’s business’ (Francis, 2013) rather than developing a more patient-centred, clinically led and integrated NHS? It is suggested that Boards need more NED with health and social care leadership experience and methods to identify the ‘patient’s agenda’ to create ‘a common culture’ that places ‘patients at the centre of everything we do’ (Hunt, 2012). A key context for Trust Boards operations is funding, which Francis’ terms of reference *excluded*, an issue that is briefly discussed.

Keywords

National Health Service, Trust Boards, culture, Francis Report

Introduction

The main problems leading to the Mid-Staffordshire debacle were succinctly outlined in Robert Francis’ letter to the Secretary of State,

‘they were primarily caused by serious failure of the part of a provider Trust Board... who did not listen sufficiently to its patients... above all it failed to tackle an insidious negative culture... a culture focused on doing the system’s business – not that of the patient... I have made a great many recommendations... essential aims to... foster a common culture shared by all the service putting the patient first’ (our emphasis).¹

Every Trust Board must have a Medical and Nurse executive director, with other Executives being drawn from Finance, Human Resources, Planning, Estates, etc., although the prime responsibility lies with the CEO. This means that Executives with consultant medical or social care leadership experience are always in the minority. Similar to public companies, Non-Executive Directors (NED) are appointed to National Health Service (NHS) Trust Boards with the duty to hold the Executive to account and in doing so contribute to the Board’s overall strategy – thus, NED are those who ‘guard the guardians’ and are now implicitly charged with creating *a more patient-centred culture NHS* (our emphasis).²

This first descriptive study of NED’ occupational backgrounds considers whether the Boards, as currently constituted, appear to have the right balance of expertise to achieve the desired goals.

Methodology

A list of all 166 Acute English NHS Trusts was available from the NHS Choices website.³ Information on

NED' occupational backgrounds was extrapolated from each individual Trust's websites.

There was no uniform method of reporting NED' occupational histories, and on some websites, it varied from being quite detailed to others with only a few sentences. Twenty-four Trusts were excluded from the analysis because they had insufficient data to determine NED' occupations, leaving 142 English Acute Trusts (86%) to report upon.

Inter-rater reliability

One problem in categorising the occupations was the richness and variation of NED' careers, though most tended to maintain their core professional expertise. To test inter-rater reliability, the authors independently rated the first 20 Trusts and Spearman rank order correlation (ρ) was calculated. The authors then jointly categorised the next 30 Trusts, consulting on any problematic assessment, while the last 15 Trusts were tested independently for rater concordance.

It is believed this is the first ever analysis of English Trusts NED' occupational backgrounds, which can provide a comparative baseline of English Acute Trust for future years.

Results

First and final inter-rater reliability tests found significant reliability between the authors ($\rho = +0.978$, $p < 0.001$ and $\rho = +0.9669$, $p < 0.001$).

Data came from 29 London Trusts, 33 Midlands Trusts, 32 Northern Trusts and 48 Southern Trusts (including South East and South West). The NED' main, current or former occupations could be schematically categorised as between those coming from private and/or public sector management and finance and those with health or social care leadership experience.

The 'management/finance' NED consisted of *current* or *former* people from commerce; finance; lawyers and risk management; human resources; public relations and marketing; academic managers; high-status central and local government managers; senior military; former NHS managers and finance officers; and non-health-related scientists.

Those with health or social care leadership experience consisted of *current* or *former* health-related scientists; medical consultants and 'social care' (from housing, social services, probation and voluntary agencies), and because it was assumed the following would have a community and social orientation, we included politicians; equal opportunities, patient representatives and senior Police.

The 142 Trusts contained 1001 NED of which 73% were male and 27% female, while 49% of Trusts had NED from an ethnic minority. Without exception, all NED had current or previous Director/Board/Consultant level leadership experience.

Trust chairs

Chairs were 84% male and one was from an ethnic minority. Table 1 shows Chairs had predominately commercial (38%) or financial backgrounds (23%), with 10% being former NHS managers, 4% of Chairs came from a private legal background and 4% from an Academic managerial background.

Table 1. Occupational background of Chairs of NHS F Trusts ($n = 142$).

Occupation	Numbers	Trusts (%)
1 = Commerce industry	54	38
2 = Accountancy finance banking	33	23
3 = Former health care managers and finance officers	14	10
4 = Academic managers	7	5
5 = Lawyers	5	4
5 = Former senior local/central government managers	5	4
5 = Politicians	5	4
5 = Medical consultants	5	4
6 = HR – recruiting services	3	2
6 = Public relations – marketing	3	2
7 = Community care SSD – housing probation	2	1
7 = Voluntary agencies community care	2	1
8 = Health-related scientist	1	<1
8 = Non-health-related scientist	1	<1
8 = Former police	1	<1
8 = Former senior military	1	<1

Of the 142 Chairs, only 4% were or had been Health care consultants, mostly from the London and Oxbridge teaching hospitals, while 2% were from the 'Social Care' sector, including a former Chief Constable, thus only 6% of Chairs had health or social care leadership experience.

The varied experience of Chairs is exemplified as follows: (1) a former Rear Admiral, eight years Chief Naval Adviser to BAE systems, on the Board of Group 4 Securicor, and Chair of ITT Defence Ltd.; (2) a board member of National Australia Group Europe and Clydesdale Bank and Director of Young Business Initiatives, Prince of Wales Trust; (3) a Marketing Director working with a major Airport, with eight years' government consultancy on transport policy; (4) a Chairman of a county Community Foundation, a University council's treasurer, President of Chartered Institute of Accountants

and a senior partner in Price-Waterhouse-Coopers; (5) a former NHS Confederation CEO and a member of the House of Lords.

Non-executive directors

Table 2 lists the Trusts' 1001 NED backgrounds, 73% were male and 27% female. Only 52% of Trusts had NED with health care leadership experience, which included five former Chief Nurses, four General Practitioners, one radiologist, a psychologist and a private practice Consultant.

Only 8% of NED had front-line health care experience, while 7% came from social care, but only two were 'patient representatives' (both CEOs of 'patient-related' charities). There were 15% health-related scientists, of which nearly half had previous or current links with the pharmacological industry.

Table 2. NED' gender and occupational backgrounds as percentage of all NED $n = 1001$.

Occupation region	Numbers–		Trusts (%)	NED (%)
	Male	Female		
1. Commerce industry	195	56	87	25
2. Accountancy finance banking	155	61	82	21
3. Health-related scientist	134	13	21	15
4. Clinical consultant experience	62	20	52	8
5. Former senior local/central government	48	11	36	6
6. Law and risk management	25	7	24	3
7. Public relations – marketing	17	21	25	4
8. Former NHS managers and finance officers	15	17	22	3
9. Academic managers	23	9	22	3
10. Voluntary agencies community care	15	14	22	3
11. Community care, housing, probation	7	12	15	2
12. HR – recruiting services	8	9	13	2
13. Politicians	10	2	8	1
14. Non-health-related scientist	7	5	8	1
15. Former police	6	3	7	1
16. Former senior military	8	0	6	1
17. Equal opportunities	3	1	3	<1
18. Patient representatives	1	1	1	<1

In addition, it is noteworthy that 137 NED (12%) had current links to the Private Health or Social care sector.

Interestingly, 73 NED came from senior central or local government backgrounds (but not from the health or social care sector), while 38 NED were previous or current employees of the major financial services, i.e. KPMG, including a former CEO; Price-Waterhouse Coopers, Ernst & Young, Merrill Lynch and JP Morgan. Other notable NED were a former CEO of a major pharmaceutical company, a Board member of Serco and a former Lord Mayor of London, typically many worked or had worked for the FTSE 100 companies. Finally, there were two Lords, 25 Knights (including three medical professors), 11 Dames and 41 other assorted Royal Honours.

NED were predominately 'management' from both the private and public sector (73%), significantly outnumbering those with health and social care experience.

Of the female 27% of NED, only 6% came from a health and social care, which, bearing in mind the predominance of female staff in the NHS, was unexpected.

Regional variation

There was little statistically significant variation in the patterns of the NED' occupations between four main regions. One slight variation was that of the 12 NED who were predominately 'politicians', six came from the North, i.e. North East and North West, and though there were no overt indications of any NED' political orientation, it might be inferred from both the North and other Regions from which they came.

One final point of note was that of the 82 out of 1001 NED who had senior medical or nursing backgrounds, the majority belonged to Trusts that included a teaching hospital, only 14 did not. Of this 14, four Trusts were in the North and Midlands regions and six from the South and South West.

This means that a number of teaching hospitals had more than one NED with a senior clinical background and that most clinical NED came from Greater London. Conversely, the majority of Trusts outside London who did not have a teaching hospital had fewer NED with a senior clinical background.

Discussion

These categorisations are indicative rather than definitive (due to a lack of uniformity in available information), but there was significant concordance between raters, and it was easy to differentiate

between NED with and without health and social care leadership experience.

Francis stressed the needs for Boards to 'listen to their patients',¹ which could be a valuable asset for it has been found that eliciting the 'patient's agenda' creates not only a more patient- and family-centred service but is a cost-effective way to improve services.⁴ Yet, the paucity of 'patient' representation on Boards is in marked contrast to the Secretary of State's recent aspiration that the new NHS would be patient centred.²

The high commercial and financial calibre of current NED is undoubted, but with such backgrounds, can they create a culture that the Francis Report demands and to which the Secretary of State aspires?^{1,2}

However, the occupational background of Boards alone does not determine how effective they are at creating a patient-centred culture. Francis sees Boards being responsible for the service, but he ignored the fiscal context in which the Boards operate. Concerns have already been expressed about Trusts facing financial problems, that Mid Staffs was never financially viable and clinical commissioning groups (CCG) are also 'facing financial fears',⁵ suggesting that there is an urgent need for 'a resource allocation debate'⁶; while some think that Francis 'let the government off the hook'.⁷

Francis complained the Mid Staffs Board was too 'target-focused'; however, a survey of consultant surgeons said that targets are invariably laudable, but many were not properly funded, leading to monies being diverted from other clinical activities, which led to problems in other parts of the system.⁸

We do not ignore or absolve the tragedies created by out-layer Trusts such as Mid Staffs. However, there is solid international comparative evidence that the basic model of the NHS is sound in terms of reducing adult mortality,⁹ including cancer deaths,¹⁰ where it was found that the NHS is one of the most effective health care systems in the Western world.^{9,10} Despite the fact that compared to the majority of other Western countries, the UK spends less on health and is currently the third lowest out of the 21 countries,¹¹ the NHS achieves more with proportionately less and we continue to get the NHS on the relative cheap.

If funding is ignored, then it is feared that further 'Mid Staffs' will be inevitable,¹² for what CEO would declare that their budget was inadequate?

Conclusions

Francis asserted that the accumulative pressures led to inadequate care and culture of 'doing the system's

business' rather than being 'patient-centred'. However, as Boards are presently constituted, do they have the experience and understanding to move towards the objective of a more patient-centred and integrated NHS?²

A solution would be to correct these imbalances, by improving ways to identify patients' agendas,⁴ and increase the numbers of NED with health and social care leadership experience and move towards near *parity with* the valuable commercial and financial expertise. Otherwise, the patient and health and social care perspective of Boards will always be a minority orientation.

Declarations

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