

Supporting the role of the chief operating officer



We thank all the chief operating officers (COOs) who took the time to respond to our questionnaire. The results are an invaluable insight into COOs' day-to-day working lives and the support they feel should be put in place to develop sector expertise.

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Main findings

The role of the chief operating officer (COO) is highly varied, challenging and often misunderstood. A COO's responsibilities are broad ranging, and COOs have to balance multiple competing priorities such as improving quality of care and efficiency, while reducing costs.

Our survey highlights the following characteristics of COOs and aspects of their role:

- COOs are ambitious individuals who enjoy working in varied and challenging environments
- COOs enjoy having a positive effect on patient outcomes
- many COOs see the role as a stepping stone to becoming a chief executive in the near future
- COOs feel their work is occasionally under-valued and they are under-resourced
- the role can be lonely and requires significant personal resilience
- meeting targets, standards and financial restrictions are COOs' biggest challenges
- the amount of support and resource available to COOs – both formal and informal – varies greatly across the sector.

COOs are a valuable resource in the NHS and are uniquely positioned to affect the day-to-day operation of every part of a healthcare provider. COOs should be nurtured. Moreover, they are ambitious and are likely to form a significant proportion of future chief executives. Therefore, Monitor and the NHS Trust Development Authority (TDA) are providing further support and education for COOs. This will begin with a bespoke conference on 9 December 2015 that addresses some of the major concerns highlighted in this report.

Support requested by COOs

Our survey respondents were relatively new to the position, with most having been in post for less than three years. This fact, combined with the challenging nature of the role, may explain their strongly expressed need for more support. Many COOs felt it would be useful to have one or more of:

- a buddying or better networking system to be able to connect with their peers
- a coaching programme
- formal action learning sets
- a mentoring programme
- seminars and educational conferences.

1. Introduction

The role of the chief operating officer (COO) of an NHS trust or foundation trust is critical to ensuring consistent quality care for patients. An effective COO combines broad operational knowledge with strategic planning, and many have the ambition to become a chief executive. However, while Monitor has explored how to support medical directors and trust governors, we have not previously turned the spotlight onto COOs.

Monitor and TDA are developing support for COOs. This forms part of the support we are offering leaders of health sector organisations with the aim of benefitting patients. To understand the challenges, we surveyed COOs in the NHS provider sector between June and September 2015. The aim of our survey was to gain insight into the:

- characteristics of today's COOs, including their motivations for taking on the role
- challenges they face
- support they have
- additional support they would find helpful.

We sent our survey to all NHS trusts and foundation trusts in England. In total, 103 questionnaires were completed. This document summarises the responses.

1.1. Using the results – what next...?

...for the sector

We are sharing our findings with the sector so that we all have a clear view of the challenges faced by COOs across the spectrum of NHS trusts.

We are using the information to address specific issues through a targeted support programme, but we hope our colleagues across the sector will assist if they are better placed to do so.

...for provider boards

The report allows COOs and their executive colleagues to compare themselves with peers across the sector and to review their approach to supporting COOs.

...for Monitor and TDA

Monitor and TDA are hosting the first event for COOs on 9 December 2015. We developed the content according to the needs of COOs as identified in the survey and will use insights from the event to develop further support.

2. Survey findings

2.1. Profile of trusts employing the respondents

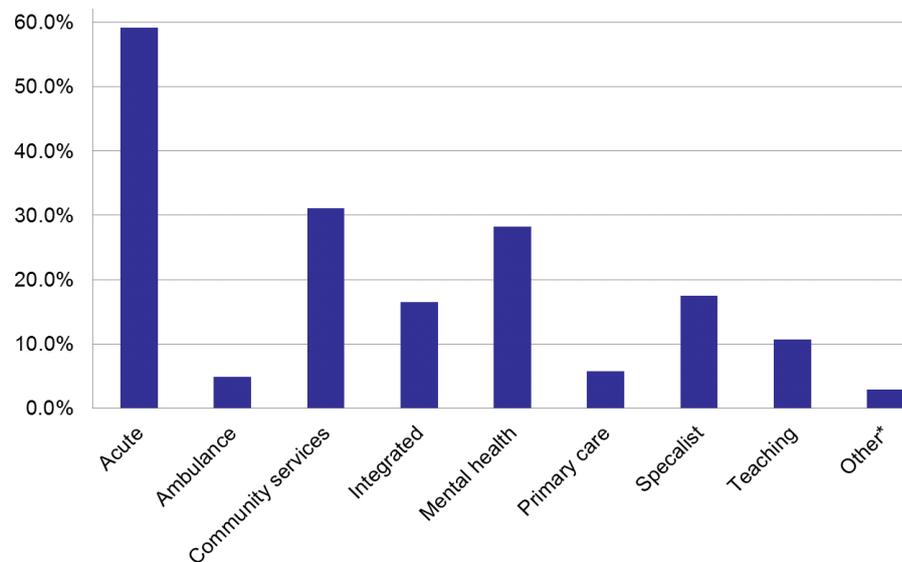
Of the respondents, 37% were employed by NHS trusts and 63% by foundation trusts. Most were employed by providers of acute services, although all sectors were represented (Figure 1).

The turnovers of the trusts employing the respondents are given in Table 1.

Table 1: Turnover of trusts employing the respondents (n = 100)

Turnover (£ million)	Number of trusts
0–150	16
151–300	44
301–500	21
501–800	16
Over 800	3

Figure 1: Respondents by services provided (n = 103)



*One was an integrated acute and community trust, one provided children and learning disability services only and one provided maternity services only.

2.2. What are the characteristics of COOs and what is their background?

Gender and ethnicity

The numbers of male and female respondents (n = 102) were almost equal. This contrasts with a 2014 Ernst

& Young (EY) survey¹ of COOs from a variety of industries in which 90% were male.

The overwhelmingly predominant ethnic group among the COOs was white (94%).

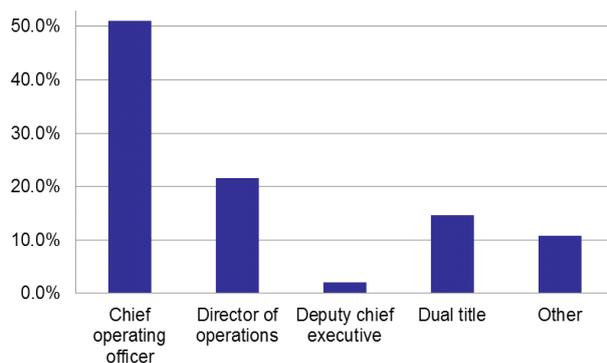
¹ Available from: www.ey.com/GL/en/Services/Advisory/The-DNA-of-the-COO---Time-to-claim-the-spotlight

Job title

Responses to the question asking about job title are shown in Figure 2: 51% reported their job title was 'chief operating officer' and 22% referred to themselves as 'director of operations'. These results align with the EY survey¹ of operational professionals in other industries: 47% and 27%, respectively.

This variation in job title may reflect differences in responsibilities, and highlights the broad and sometimes misunderstood role of the COO.

Figure 2: What is your current job title? (n = 102)



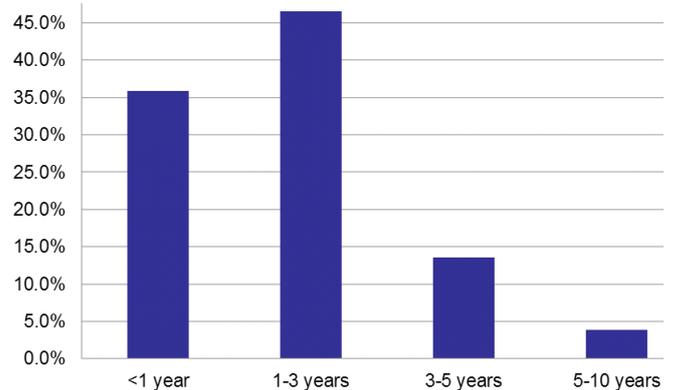
'Other': includes 'director of delivery and improvement' and 'executive director for patient services'

'Dual title': most commonly 'COO/deputy chief executive' (8% of all respondents), but also included 'chief nurse/director of operations' and 'director of operations/deputy chief executive'

Length of time in current post

The most frequent response was '1 to 3 years' (47%) (Figure 3). Interestingly, no COO had been in post for longer than 10 years. This contrasts with COOs in other industries,¹ where 29% have been in post for 10 years or more and over 60% for over four years.

Figure 3: How long have you been in your current post? (n = 103)



Role immediately preceding current one

The most frequent response (27%) was some form of director role, eg 'clinical director', 'finance director' and 'director of specialist services'. A significant number had previously held other COO (23%) or director of operations (19%) roles (Figure 4). It is assumed that most of these were within the health sector.

2.3. Responsibilities and challenges

We asked COOs to indicate the two main challenges they faced on being appointed to the role (Figure 5). Over half mentioned targets (eg referral to treatment), managing finances and tackling problems in the acute or emergency pathways.

The breadth of responses illustrates how challenging and varied the COO role can be. The EY survey¹ reported that executive colleagues saw the COO role as one of the toughest board-level roles and tougher than COOs themselves would admit.

Figure 4: What role did you have immediately preceding your current one? (n = 102)

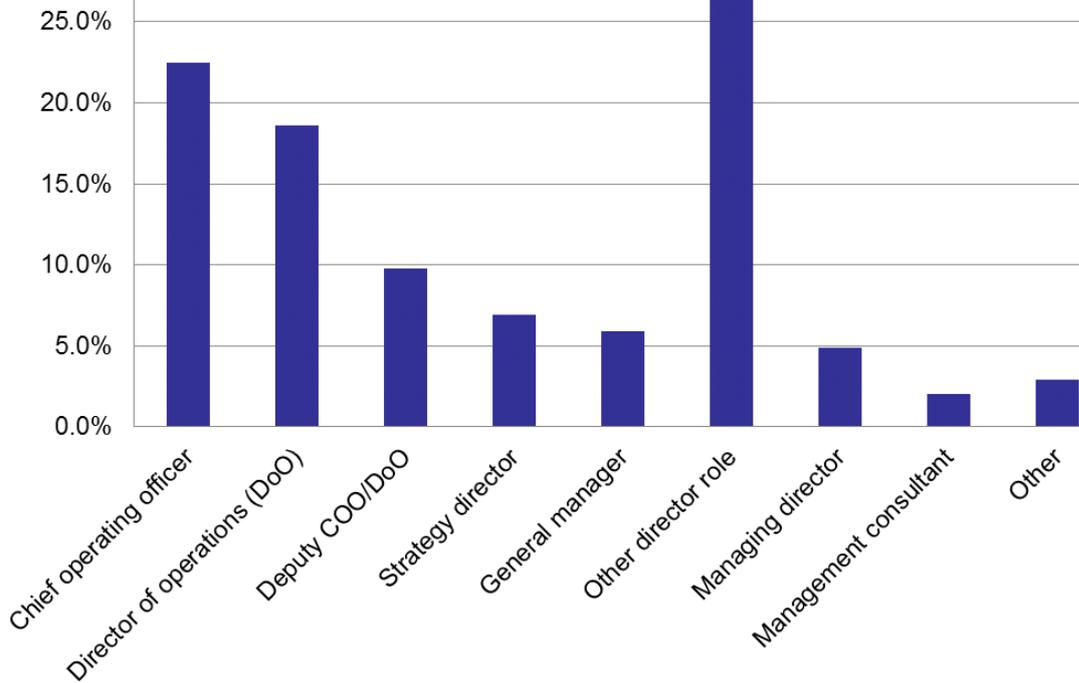
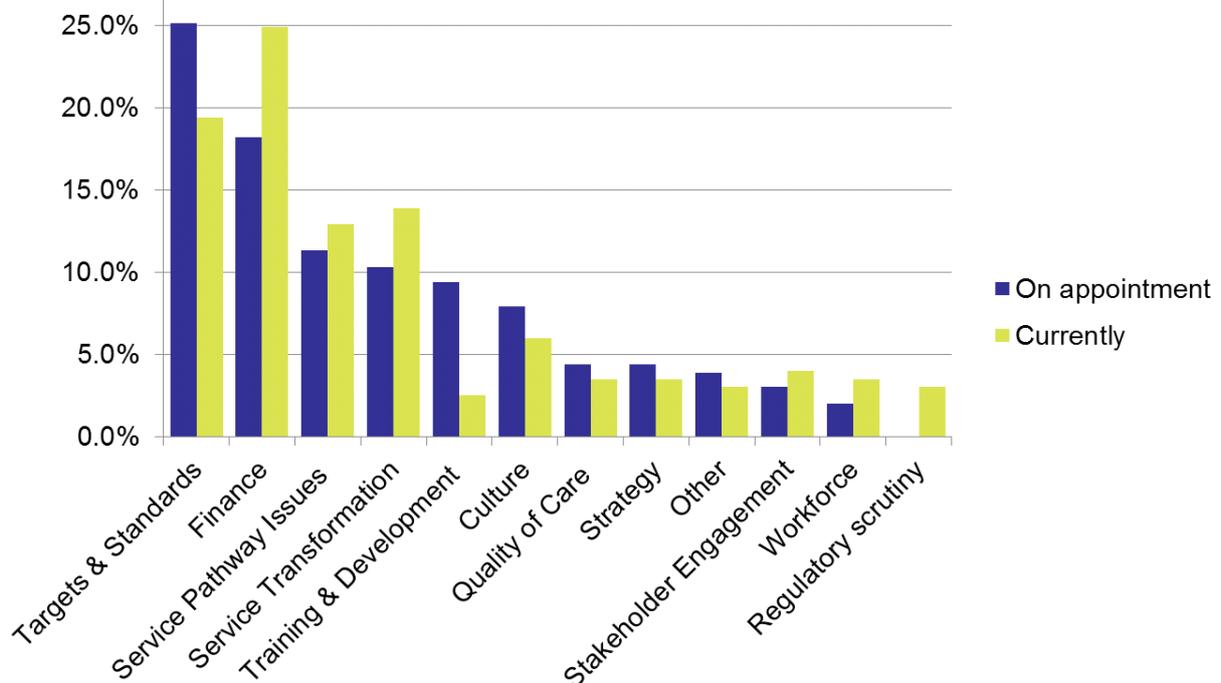


Figure 5: Main challenges faced by respondents on appointment and currently (n = 102)



Responses categorised as 'other' included preparing an application for foundation trust status, responding to patient complaints, merging two organisations, managing a trust in special measures, improving collaboration across health and social care and delivering sustained performance.

COOs may therefore need to be encouraged to be more vocal in highlighting to their colleagues any difficulties they face.

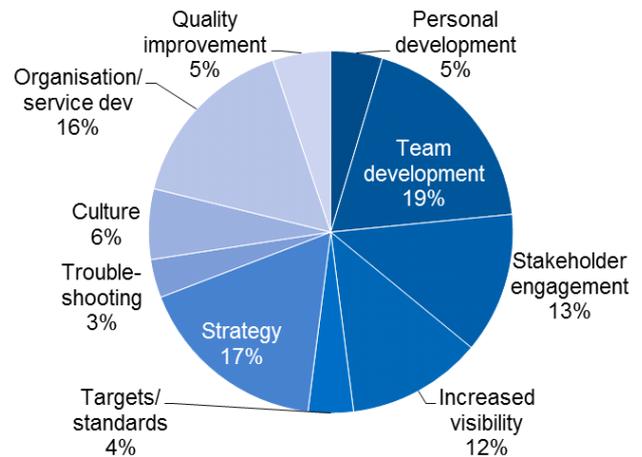
Many of the reported challenges are linked. For example, many respondents were trying to improve quality of care and overall performance on ever-tightening financial constraints. Others reflected on the relationship between being able to identify and troubleshoot service pathway issues and subsequent transformation projects.

Most respondents face the same challenges now as when they were appointed. However, finance has now overtaken performance as the number one concern for COOs today, reflecting the increasingly challenging financial climate in the NHS.

We asked respondents where they thought their time would be best spent if given the opportunity. The results are shown in Figure 6. Only 5% wanted more time to develop their own skills but 19% wanted more time to improve their team’s capabilities. Over 30% wanted more time to develop strategy and plan service developments.

Perhaps most interesting is the 25% who would like to spend more time increasing their ‘visibility’ both internally and externally by cultivating stronger relationships with key stakeholders (particularly commissioners). When this response is considered with the reported importance given to strategy, it

Figure 6: What respondents would like to spend more of their time on (n = 99)



appears COOs are looking towards the future and to align themselves and work more closely with their partners.

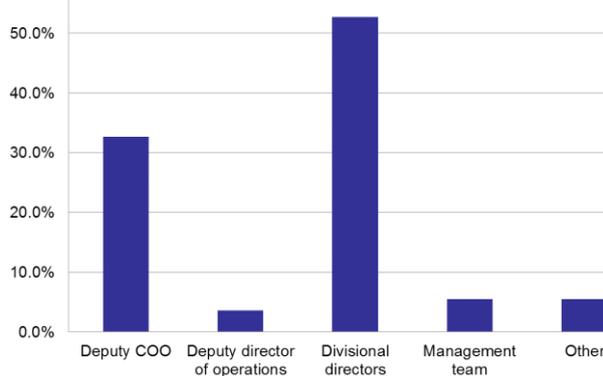
2.4. Resources and support networks

Support networks

We were interested to establish whether COOs felt they had a support network – both in their workplace in the form of a deputy, and more generally through interaction and communication with others in similar roles.

Among the 57% reporting they had some support, the form of this support varied enormously: 53% specified having one or more ‘divisional directors’, 33% a ‘deputy COO’ and 4% a ‘deputy director of operations’ (Figure 7). Within the first and largest of these groups, however, support ranged from a single ‘urgent care lead’ to a team of ‘six directors of operations’.

Figure 7: Deputy or other support among COOs who report having some form of support (n = 57)



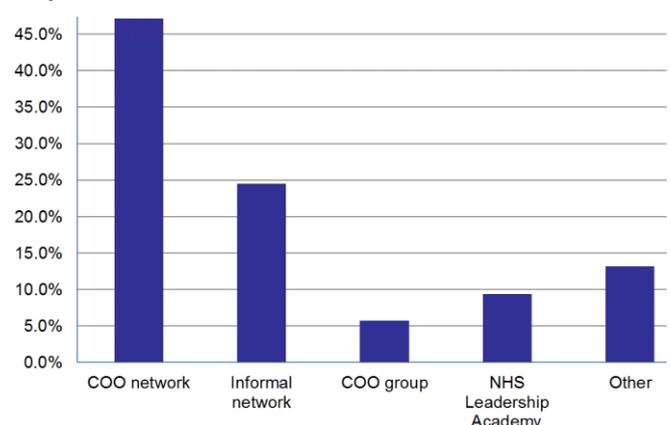
Regarding peer support, 58% reported they had a network, with the largest number (47%) making reference to a formal COO network (both local and regional), group (including national groups) or forum (Figure 8). Almost 25% of those with peer support mentioned the importance of an informal network – from an informal local support network of colleagues to links to friends in similar roles in different parts of the country.

Regardless of the type of support network, there was general consensus on its importance. Respondents consistently described their peer support as useful, and in some cases ‘invaluable’ to the role. This chimes with research from other industries,¹ where an ability to share ideas between organisations and discuss innovative solutions to challenges affecting whole sectors is seen as very helpful.

“The Impact group from Top Leaders is my most critical support – eight people from different parts of the country and healthcare sectors along with a fantastic facilitator has helped my resilience in what has been the

most difficult year of my career. In addition [I] have used informal peer networks built up from people I have worked with over the last five years.”

Figure 8: Type of peer support (n = 59)



Other included non-COO groups and forums such as the Chief Nurse Network.

Dedicated resources for service improvement

We wanted to establish what formal support COOs have in delivering service improvement. Of 102 respondents, each of whom could select more than one option, 64 (70%) reported they have a specific project management office (PMO), 27% that they do not and almost 11% that they have no dedicated resource for service improvement.

Only about half of those with a PMO gave further information on staffing type: 25% have permanent staff only, 6% temporary staff only and 19% a mixture. The whole-time equivalents (WTEs) dedicated to service improvement among those with a PMO range from 1.6 to 20.

Among respondents with a dedicated resource for service improvement but no PMO, 41% have permanent staff

only, 11% temporary staff only and 4% a mixture. Again around half of these did not describe their staff mix.

Interestingly, the WTEs are very similar to those with a PMO (1.6 to 25).

With regard to the structure of the service improvement resource, among those with a PMO, 30% have a central team, 16% service line or directorate teams and 22% a combined central and devolved approach, in contrast to 33%, 26% and 41%, respectively, among those without a PMO.

2.5. Learning and development

To appreciate what resources COOs have drawn on in their roles, we asked about the learning and development they have found most useful in performing their duties.

A significant majority (91%) felt that experiential learning in the role had been the most useful. Interestingly, less than 10% felt in-house training had been most useful and 14% their experience outside work (Figure 9). Again, respondents were able to tick more than one option.

Participants were given the option to write free text to describe other learning and development resources they have found useful: 14% cited non-academic management and leadership courses such as NHS Leadership Academy programmes and the King's

Fund Top Manager Programme, 9% executive coaching and 5% mentoring.

When asked about the usefulness of extra support, 73% felt this would be useful, 24% that it might be and only 3% that it would not (n = 101).

Preferred form of support

Among those who felt that additional support would be helpful, the most popular form of support was buddying with peers who have similar issues (71%), with action learning sets on key topics (68%) and coaching (65%) also attracting significant interest (Figure 10).

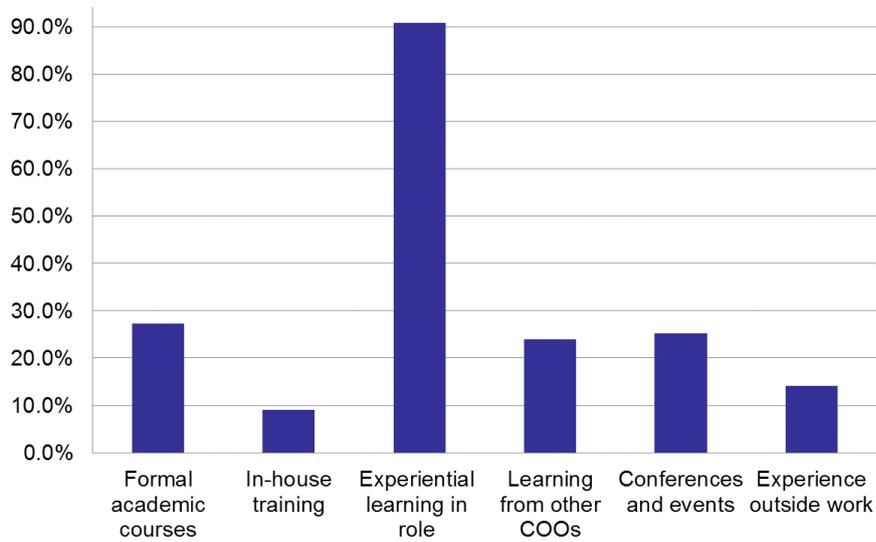
Preferred topics to be covered in support

Improving culture (74%) and effecting change in the organisation (70%) were the two most popular topics.

Respondents were also interested in learning about delivering quality and finance together (66%), personal resilience (54%), and board relations and influencing colleagues (53%) (Figure 11).

Other topics that COOs felt would be useful included the transition to chief executive, specific service improvement tools, improving particular elements of the service (eg 'improving theatre efficiency') and how to develop and implement clinical strategies.

Figure 9: What learning and development has been most useful to you in carrying out your role as COO? (n = 99)



Experience outside work includes management consultancy, having been an engineer running large commercial divisions and frontline experience as a nurse.

Figure 10: What is your preferred form of support? (n = 101)

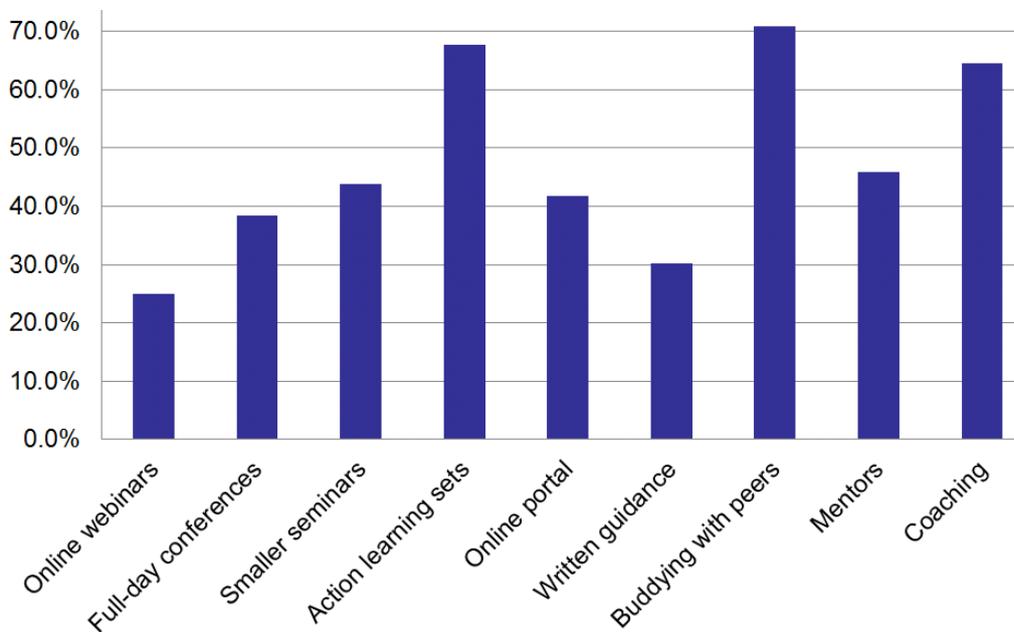
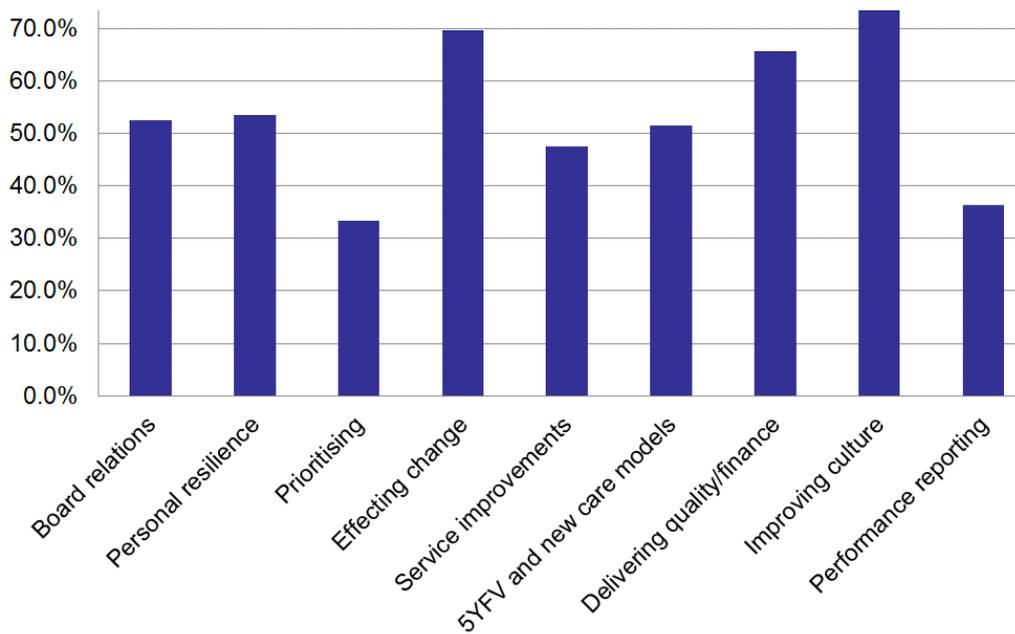


Figure 11: What topics would you like to be covered? (n = 101)

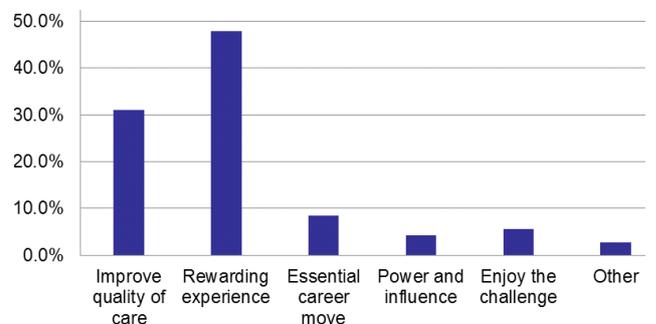


2.6. Motivations, career ambitions and making the role more attractive

Just over 90% of respondents would choose to work as a COO even with the benefit of hindsight. When asked to give their reasons, nearly half indicated they found the role rewarding or enjoyable, with being able to improve the quality of care for patients and career progression the second and third most common reasons, respectively (Figure 12).

The fact that ‘power and influence’ ranks low as a reason for continuing job satisfaction may expose the reality of the role – despite carrying significant responsibility, the COO still feels second to the chief executive in visible areas such as strategy development and decision-making.

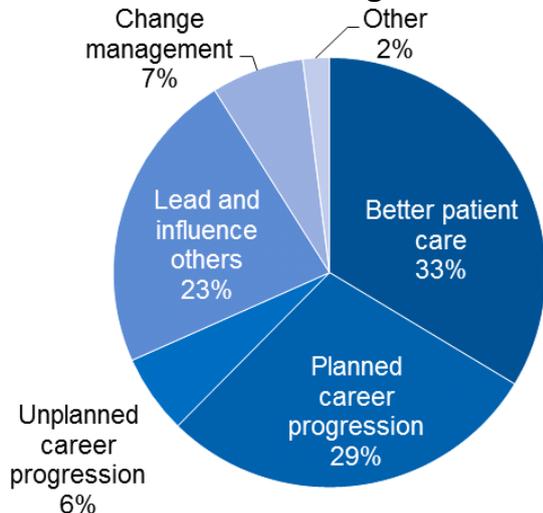
Figure 12: Reasons for continuing job satisfaction (n = 71)



COOs are motivated by improving quality of patient care just as much as by career advancement. A significant proportion of respondents also highlighted the opportunity to show leadership as well as exert influence over the organisation as a driving force behind the decision to take on such a

challenging role (Figure 13). This is in contrast to the reasons for continued job satisfaction highlighted above.

Figure 13: Principal motivating factors behind becoming a COO



We asked what would make the role more attractive to aspiring COOs. The two most commonly expressed recommendations were reduced regulatory burden and more resources (Table 2).

Responding to mandatory and ad hoc requests for information from a variety of organisations (including regulators and commissioners), often simultaneously, was reported to be particularly burdensome.

A significant number of respondents wanted to be better valued and have their efforts recognised by both the wider organisation and their executive colleagues. Responses included:

- “board understanding the breadth and diversity of the role”
- “additional support across divisions”

Table 2: Top 10 recommendations for making the COO role more attractive (n = 96)

Recommendation	Number of respondents
Reduced regulatory burden	31
Better resources*	28
Better recognition	16
Better C-suite support	14
More time to achieve targets	14
More coaching/development	13
Better stakeholder engagement	11
Other	9
Better remuneration	8
Better organisational culture	6

*Resources encapsulated anything from having more money for projects to being given a deputy to share the burden of responsibility with.

- “recognition for what I have contributed/achieved”
- “stop the role being that which is blamed for everything that goes wrong”.

Remuneration was not high on the list of priorities.

The order of the recommendations confirms that COOs perceive their work to be under-valued and under-resourced. Coupled with the perception that they lack visibility, this suggests low morale may be a significant issue for COOs, and that without support there may be a growing temptation to look for another job outside the health sector.

2.7. Advice to new COOs

There was reasonable consensus on what advice to give new COOs, as shown in the following quotes, which are organised by theme.

Relationships

- *“Relationships are key – build them well as you will need them when the ‘chips’ are down.”*
- *“Develop good relationships with your executive director colleagues.”*
- *“Build your CCG relationships.”*
- *“Network lots!”*
- *“Make sure you can work with the CEO before you take the post.”*
- *“Develop strong relationships with the doctors in particular.”*

Resilience

- *“Be resilient.”*
- *“You require stamina and resilience.”*
- *“Personal resilience is key.”*

- *“Look after yourself, stay resilient – no one else will care much.”*

Invest in people

- *“Develop leadership skills and capabilities of the teams around you.”*
- *“Pick a good team under you.”*
- *“You can achieve nothing without taking your people with you – invest in them.”*
- *“Enable others to achieve.”*
- *“People are the solution and not the problem.”*

Other comments

- *“De-personalise criticism – see it for what it is and use it to create opportunities to improve.”*
- *“Get out to services every week to make sure you know what life is like for frontline staff.”*
- *“Listen more, and talk less.”*

2.8. Future career plans

Nearly half of the respondents aspire to become a chief executive (Figure 14), as also found in the 2014 EY study. Over a quarter planned to move job within 12 months, with 72% planning to do so within two years. What is clear is that COOs are ambitious individuals who enjoy working in varied and challenging environments (Figure 15).

Figure 15: Approximate timescale for moving on (n = 96)

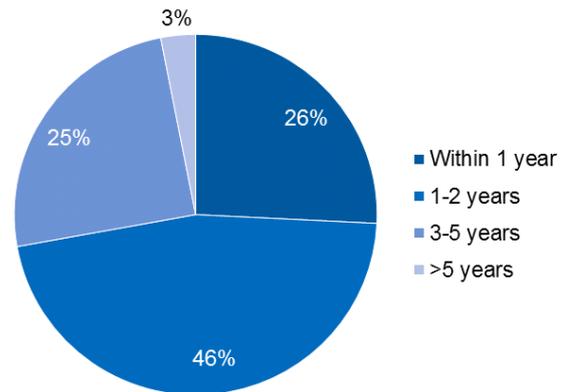
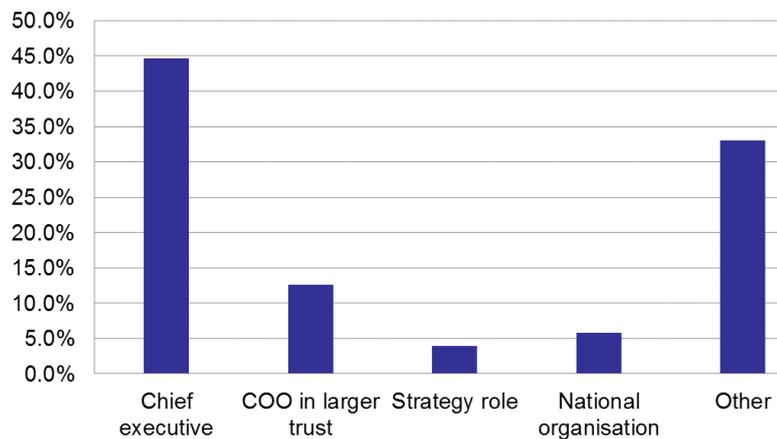


Figure 14: Respondents' future career plans or trajectory (n = 103)



Thirty-six responded 'other': nearly half (n = 15) were unsure of their next career move, six were approaching retirement and nine wanted to continue as a COO (but over half of the last intended to move outside the NHS to do so).

Appendix: General comments on the COO role

Respondents were asked whether they would like to make any general comments on the COO role. These have been grouped into themes.

The comments align with COOs in other industries.¹ In a recent survey of over 300 international COOs from various sectors, 36% felt coping with diversity and new challenges made the position worthwhile, while 16% felt having a direct impact on the operating result was important. Variety, challenge and a sense of having affected outcomes are perceived as positive aspects of the role.

It's enjoyable and rewarding

"Potentially the best executive role because you get to be a part of everything."

"So far enjoying the role and the challenges especially working at a more strategic level..."

"It is very rewarding if you are able to put in the hours and able to be very focused and self-managing."

"Fantastic job."

"It is an exciting and stimulating role. No two days are the same and the variety keeps it alive. It can be very challenging at times but that also keeps the role interesting and exciting."

"They're great jobs – best place to make changes with a direct impact on services to patients, care pathways and use of resources..."

"It is rewarding when the plan comes together and you know you've made a positive difference to quality and safety."

"Difficult but highly rewarding job, fills me with energy each day."

"Had huge opportunity to be involved in major service reconfiguration and very rewarding..."

"An effective COO is one of the most influential people on the trust board. It is a difficult job but in general I love it."

"Being a COO is a really interesting and varied role, it's extremely demanding and sometimes these demands are in conflict with each other...the opportunity to change services and deliver something special for patients is amazing. Being able to influence how a whole organisation approaches care is a privilege and that always outweighs the relentless and often impossible demands on your time."

It's a tough job and can be lonely

“Increasingly it does feel that the role is becoming more and more difficult as you try to balance the competing needs of hitting quality standards, delivering large-scale cost improvement plans and driving up quality. Despite the rhetoric at national level, the culture of the NHS feels very much like a blame culture... failure will and does result in people losing their jobs. This increases individual stress as well as encouraging people to move frequently (leading to organisational instability) as well as discouraging risk taking....These issues need to be taken seriously and addressed if the NHS is to make this and other senior roles attractive and to keep talented senior managers within the NHS...”

“I feel alone. There seems little in the way of any peer support ... This is unlike other executive directors such as nurse executives and DOFs. When I achieve great things, the rest of the board takes all the credit and I don't get a mention! When the service operations are struggling for whatever reason, the COO is always blamed.”

“It is easy to criticise operational managers when things go wrong and easy to praise clinicians when things go well!”

“The role of COO is unfortunately no longer attractive in the NHS, the pressure on new COOs alongside those stepping into a large or complex trust with significant challenge can make it impossible to deliver what is being asked for and most delivery requests are usually expected in unrealistic timelines... The current situation has to change, I am not convinced that it will and therefore recruitment into these roles which is currently difficult in many trusts will be virtually impossible....”

“It's a tough role, it's unforgiving sometimes and like a football manager it often feels like you're only judged on your last set of results...”

“Delivery against the 'three-card trick' (quality/finance/performance) is close to impossible and COOs need to have that acknowledged and system changes must recognise this.”

“The COO role is often seen as unattractive as the hours to do the job are enormous when operationally things are not going well – many say it is the hardest job on the board. We need to turn negative perceptions around if we want managers/clinicians in the future to apply.”

“It's a thankless task sometimes and you can spend as much time explaining decisions to director colleagues as you can to staff as everybody seems to have an opinion on operations so can feel stifling sometimes...”

“Can be lonely. Everybody wants a piece of you.”

“It is an exciting and challenging role which can however be very isolating...”

Importance of the team

“Equally important is the performance of the board. Being part of a united, functional and intelligent team makes a big difference to what the COO can achieve in any given organisation. The whole is greater than the sum of its constituent parts.”

“I work with a great group of director colleagues and my CDs and GMs are excellent. It is really important to me to work as part of a team so I am very fortunate...”

“Take the responsibility for the workforce to ensure full establishment of numbers and skill. Have a good relationship with all board members but predominately the quality and finance directors.”

“The COO role is not for the faint hearted! Long hours, immense pressure at times but very rewarding at other times. A good deputy is imperative to survive as well as a good CEO and support network.”

Resilience

“On a personal level you have to be resilient and be willing to do way more than the 37hrs per week to have any chance of covering all the bases.”

“Excellent role requires determination and resilience...”

“It requires a level of resilience that is rare and this is not sufficiently considered when appointing COOs into post.”

“The work we lead matters so it is a significant responsibility – maintaining personal resilience in order to operate effectively at this level is crucial and this is where I feel additional networks and support would be hugely beneficial.”

There's opportunity and a need to develop and nurture

“The COO role requires individuals that have a wide range of skills and knowledge broader than just service delivery and developing these leaders in the future needs to ensure career pathways build individuals up to do this.”

“You need high level personal resilience and strong leadership skills to ensure you continue to motivate teams to deliver the highest quality of service that they can, no matter how difficult it may be. You need to be able to identify talent and nurture it.”

“We need to do better at succession planning – this has improved but still more to do...”

“...People need space to make changes...there is a huge amount of benefit to be gained by supporting COOs to be brave and to change and challenge...”

Misunderstood and often varied and undefined

“Often the COO role is undervalued and seen as less important than CNO and MD, when in fact the posts contribute as much to delivery of quality and safety.”

“The role can clearly be significantly different, between organisations, dependent on a number of variables, having worked in what outwardly would appear to have been two equivalent roles in two very similar FTs.”

“I'm not sure there is such a thing as a generality. The role is so varied and diverse.”

“The COO role is not always understood by people – is it essentially the same as or different to the director of operations role? Also some organisations don't have COO/director level...the same competencies and skill set could be provided by others within the executive and wider senior leadership team. Often one has to negotiate the role with other executive director members so as not to be seen to 'dominate' or 'tread on toes'...”

Challenging

“Tough role in stable operating environment. [It] can become impossible if unsupportive team; demands become too great or too many services needing additional support.”

“COO is one of the most challenging roles and is fast paced. If operating correctly it is the key executive role to enable performance within any organisation and should be remunerated as such...”

“The role can be stressful and challenging, but I am from a nursing background and through this role I have been able to use my nursing and subsequent experience to really make a positive impact on patients and my staff.”

“It's tough, rewarding and no two days are the same.”



Making the health sector
work for patients

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.gov.uk/monitor

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