Review of centrally funded improvement and leadership development functions

A review on behalf of NHS England, Monitor, NHS Trust Development Authority, Health Education England, Public Health England and the Care Quality Commission

Final

(27th March 2015)

Contents

Foreword

I am pleased to set out the findings and recommendations from the Review of centrally funded leadership development and improvement capability.

The Five Year Forward View (5YFV) described the contours of a sustainable health and care system to meet the changing needs of the population in the future and address the financial challenges with sustainable solutions.

To support the delivery of these changes, there is a need for huge change at both local and national levels to the way in which organisations and people work across the health and care system in England. It is in this context that our recommendations are based so that improvement and leadership development activities will build and embed the capabilities needed to align with our current and future needs.

My preference as Chair of the review was to minimise structural change and only accept it as being necessary when other mechanisms are evidenced not to be capable of working. This report does set out some organisational change; in particular moving more responsibility and resources to local health and care economies for improvement activity and aligning more leadership and management work closely with Health Education England (HEE). Our recommendations also give greater emphasis to whole systems leadership to enhance capability and talent at all levels of our complex and diverse health and care ecosystem.

Much of what is recommended requires very strong and effective collaboration in governance, information, in sharing best practices quickly and generously and in identifying and nurturing our best people to contribute fully to local and national priorities over their careers with us.

The recommendations reduce the amount that is done "at the centre" but increase the critical importance of systems level integration, establishing key principles of leadership throughout the health and care landscape and have a key role in the emergence, development and deployment or our top talent.

There remains work to do to develop a detailed plan to implement these recommendations once they are formally agreed across stakeholders. During that time, we must not lose impetus from much of the existing work and must swiftly transition improvement and leadership and talent activities to support the 5YFV.

This Review would not have reached the conclusion of Stage 1 within this short timescale without the intensive work of Tim Rideout (our Independent Reviewer), David Levy (Lead for the AHSN, SCN and Clinical Senates review) and Karen Wheeler (the Review's SRO) and the extensive and forward looking contributions from our Steering Group and our wider stakeholder communities across England. I thank them all.

Ed Smith

Ed Smith
System Lead for the National Review of Leadership Development and
Improvement, and Deputy Chair, NHS England

Executive Summary

1. The NHS is facing unprecedented challenges. There is a need to continue to improve health and the quality of services at a time of significant rises in demand for care and of financial constraint.

2. A review of the health and care system's current improvement and leadership development capability (as funded by NHS England) was initiated in the autumn of 2014 following the publication of the Five Year Forward View (5YFV). It set out to determine how the resources currently used by NHS Improving Quality (NHS IQ), the NHS Leadership Academy, Academic Health Science Networks (AHSNs), Strategic Clinical Networks (SCNs) and Clinical Senates should be deployed best to improve quality and speed progress towards the broad vision set out in the 5YFV.

3. The summary findings from the Review suggest that the current arrangements for improvement and leadership development do not meet the needs of the health and care system both now and into the future. The findings can be summarised as follows:

   a) The current architecture for improvement is remote, fragmented and unclear. The roles of NHS IQ, AHSNs, SCNs and clinical senates are not understood, nor is it clear how these fit with the improvement work undertaken by the NHS Trust Development Authority (TDA) and Monitor to support providers. As a result the current improvement architecture is difficult to access and navigate. As a consequence, in many cases improvement support has been sought from other sources in a piecemeal fashion;

   b) The system's current leadership and management capability and capacity is insufficient to meet the current and future needs of the system. In particular it is insufficiently system (as opposed to organisationally) orientated; and

   c) There is wide variation in the extent to which leadership development is connected to and aligned with local priorities and deliverables and the focus of local organisations and systems. The work of the NHS Leadership Academy and HEE is not sufficiently connected and aligned between the two bodies;

   d) There is broad support for many of the current national leadership development programmes, although it is too early to determine to their systemic impact. However it is clear that large numbers of staff have participated in NHS Leadership Academy programmes and that there are

currently high levels of satisfaction with the quality of programmes amongst participants.

4. Along with 16 recommendations for change in response to the Review findings, this report sets out the design principles upon which the future architecture for improvement and leadership development should be based. This includes the principle that improvement and leadership development are the responsibility of all organisations and local health and care systems. (The section called 'Future Design Principles' set this out in detail.) With this principle in mind, it is important that work with representatives of local government partners continues as the detailed design of the improvement and leadership development architecture progresses through the implementation stage. It is also important that the service voice is well represented as we transfer responsibility and potentially funding to the front line.

5. All the recommendations have taken into account both the current context in which organisations are delivering services, as well as the need to align to the delivery of the 5YFV. The following provides a summary of the initial recommendations and the detail information behind each is set out in the main body of the report.

6. Initial recommendations which are specific to improvement and leadership development from an overarching system perspective include:

   a) **Recommendation 1 (ref. para 112.a):** National strategies for both improvement and leadership development (including talent management) will be created for the health and care system, developed in parallel and explicitly aligned, in order to support the delivery of the 5YFV;

   b) **Recommendation 2 (ref. para 112.b):** Every NHS organisation should develop strategies setting out their approach to improvement and leadership development (including talent management) which are aligned to the national strategies and the needs of their local systems;

   c) **Recommendation 3 (ref. para 112.c):** The new arrangements for improvement and leadership development should be governed collectively by two national Governing Boards, comprising senior representatives from the six national organisations (NHS England, NHS Trust Development Authority (TDA), Monitor, Health Education England (HEE), Public Health England (PHE) and the Care Quality Commission (CQC) and the Department of Health (DH) in their system sponsorship role. Serious consideration should be given to the most appropriate ways to ensure that frontline service representatives such as (but not limited to) the Local Government Authority (LGA) and NHS Confederation are engaged in the

work of the two Governing Boards. The two new Boards will work together to ensure that the system's approach to improvement and leadership development is fully aligned and with sufficient shared membership to secure the necessary cross-fertilisation of concepts and approaches.

The new governance arrangements will:

- not replace or compromise the sponsorship and management accountability arrangements of existing organisations that will form part of the future architecture; and

- ensure that the design and delivery of national and local priorities, in relation to improvement and leadership development, are connected and reflect the needs of the health and care system at all levels by setting out clear stakeholder engagement arrangements.

d) **Recommendation 4 (ref. para 112.d):** NHS Interim Management and Support (NHS IMAS) comprises the Intensive Support Teams (ISTs) and a core team. The ISTs focus on supporting organisations and health systems to improve or turnaround operational performance and deliver sustainable solutions, specialising in urgent and emergency care, elective care and cancer. The core team concentrates on identifying, providing and managing senior interim expertise, skills and support on behalf of organisations across the healthcare system. The ISTs have been governed jointly by Monitor, NHS TDA, and NHS England since January 2015. The core NHS IMAS team continues to report solely to NHS England. These reporting arrangements should continue whilst consideration is given as to where these functions are most appropriately hosted in future to support delivery of the national strategy for improvement.

7. In specific relation to the health and care system's approach to improvement, the intention is to establish a self-sustaining operating model where organisations and systems build their own improvement capabilities, and are held to account for progress. In this context the following summary recommendations are made:

a) **Recommendation 5 (ref. para 114.a):** Standard operating models should be developed which set out how the different parts of the improvement architecture, at both national and local level, should be aligned and work to support delivery of service improvement, service transformation and service intervention activities. These will be informed by the learning from this Review and the priorities set out in the national strategies on improvement and leadership development;

b) **Recommendation 6 (ref. para 114.b):** NHS IQ, the current national improvement body, will cease to operate. Resources should be retained, and integrated into the revised system architecture at both a national and local level and deployed in line with the priorities outlined in the national strategy (see Recommendation 1).

c) **Recommendation 7 (ref. para 114.c):** To support commissioners and providers to access expert improvement advice and support resources in their locality, the fifteen AHSNs will co-ordinate local improvement activity across England, collaborating with all appropriate local partners with improvement expertise. In this way AHSNs will facilitate the provision of a single point of local access for improvement for commissioners and providers in their local area. Discussions with each of the AHSNs about their readiness and willingness to carry out this co-ordination role within their geographical footprint will be addressed during the implementation phase and alternate local lead arrangements could be established if necessary.

d) **Recommendation 8 (ref. para 114.d):** A 'one-stop shop' should be established to offer access to shared improvement resources that may be common requirements of all the AHSNs. This would provide economies of scale and might include access to research and evaluation advice, spreading learning and best practice across AHSNs and the national improvement team (Recommendation 10) and connecting people across systems at all levels. The hosting and funding arrangements for this resource will be determined through the implementation stage.

e) **Recommendation 9 (ref. para 114.e):** In order to successfully build the improvement skills and the leadership required to harness these skills and effect change across the system, it is recommended that the development of individual and team improvement capability is additionally supported through programmes commissioned by the NHS Leadership Academy.

f) **Recommendation 10 (ref. para 114.f):** At a national level, a small team should be formed, which could be hosted within NHS England (hosting to be determined in stage 2), to provide thought leadership, expertise and support, and play a critical support role for the specific programmes focused on the delivery of the 5YFV. The work of this team would be governed by the national improvement Governing Board.

g) **Recommendation 11 (ref. para 114.g):** Clinical Senates, Strategic Clinical Networks (SCNs) and AHSNs have a role to play in supporting change across the health and care system and should continue. However, changes are needed to clarify their roles, to strengthen accountability and

governance, to ensure relevance to local health economies' and national priorities, and to secure appropriate alignment between bodies:

    i. Clinical Senates' roles should be clarified as: Supporting health economies to improve health outcomes of their local communities by providing evidence-based clinical advice to commissioners and providers on major service changes. They should bring together clinicians and managers, from across a defined geography, with patients and the public, to put the needs of patients above those of organisations or professions.

    ii. SCNs should be renamed Clinical Networks. There should continue to be Clinical Networks in each of the four current priority areas, however networks could be established in other local priority areas. Clinical Network's role should be clarified as: Supporting health systems to improve health outcomes of their local communities by connecting commissioners, providers, professionals and patients and the public across a pathway of care to share best practice and innovation, measure and benchmark quality and outcomes, and drive improvement;

    iii. The fifteen AHSNs should continue, though they should not be discouraged from merging if they decide to do so. Their role should be to: Support health systems to improve the health outcomes of their local communities, and maximise the NHS's contribution to economic growth by enabling and catalysing change through collaboration, and the spread of innovation and best practice; and

    iv. AHSNs and Strategic Clinical Networks should be streamlined and their business plans aligned, so that they operate as a single support entity for their member commissioners, providers and professionals. The AHSNs' work and resources for improvement should be governed by the new improvement Governing Board.

8. In specific relation to the health and care system's approach to leadership development the intention is to establish a self-sustaining operating model where organisations and systems build their own capabilities, but are held to account for progress. In this context the following recommendations are made:

    a) **Recommendation 12 (ref. para 116.a):** The partnership between the NHS Leadership Academy and HEE should be explicitly changed and strengthened, recognising the system leadership and convening role that HEE plays in relation to education and training across the health system. This should also include, where appropriate, moving some activities from the Leadership Academy to HEE's core education role (e.g. uni-

professional programmes). The graduate management training schemes will remain with the Leadership Academy. Both organisations should commit to co-design/co-create management, leadership and improvement capability interventions, across their respective curricula. In addition, it is recommended that HEE chair the new national leadership Governing Board.

b) **Recommendation 13 (ref. para 116.b):** Building on its success, the NHS Leadership Academy's work and funding should be refocused to include the following:

i. Defining great leadership through the continued commissioning of the development of the evidence base through research and development;

ii. Developing a nationally co-ordinated talent management programme to ensure effective succession planning for the most senior roles across the health system which could include c. the top 200 posts. This programme should be relatively small and focused and the detail of the numbers involved will be determined through the implementation stage of the Review.   A number of these senior roles are at risk of not being filled in the future if the right talent is not identified and developed. This work presents a step change in focus for the Leadership Academy;

iii. Developing senior leaders through the commissioning of development programmes. As part of the new arrangements, the Leadership Academy will solely focus on the *commissioning* of programmes. In addition they will cease to commission or deliver uni-professional programmes e.g. the Nursing and Midwifery programme;

iv. Supporting system reform through a shift in emphasis towards systems leadership, to achieve the ambition of the 5YFV across the health and care system; and

v. Ensuring that there are appropriate programmes and activities to support the development of leadership at all levels, working closely with HEE (and its LETBs) and LDPs, to ensure that this is based on the needs of the service.

c) **Recommendation 14 (ref. para 116.c):** To ensure a greater congruence with both the 5YFV and local organisations and systems in England, a number of governance changes should be made including:

i.   The Leadership Academy will be governed by the new national leadership Governing Board (chaired by HEE). The Leadership Academy Chief Executive will account to this Governing Board. A reference group should also be established to ensure that commissioners, providers and other stakeholders are involved in the design of programmes, replacing the Leadership Academy's current Advisory Board; and

ii.   Strengthening the relationship between the Leadership Academy and the existing ten Local Delivery Partners (LDPs). The core purpose of the LDPs will be to work closely with local health and care stakeholders to identify, inform, support and deliver national leadership development priorities in a locally meaningful way.

d) **Recommendation 15 (ref. para 116.d):** Alternative financing and business models for the NHS Leadership Academy should be explored, including membership and subscription options, in order to increase local ownership and to strengthen the Academy's financial resilience. Should changes to the financing and business models be agreed, the Leadership Academy's governance arrangements would need to be reviewed and revised accordingly.

e) **Recommendation 16 (ref. para 116.e):** The NHS Leadership Academy's name should be changed to reflect more accurately its refocused role and the pan-system importance of leadership development. This should be determined by the new Governing Board through the transition period.

9.   The Review's provisional recommendations are intended to address the questions and issues set out in the Review Terms of References (Annex A and B). They are a significant development towards much better alignment across the health and care system. The arrangements will be refined during stage 2 of the Review and as the improvement and leadership development architecture further matures and other key aspects of the 5YFV move forward. The new national Governing Board's role will be to test that the emerging architecture is having the desired impact.   Annex C sets out the detailed response to the questions specifically posed in the Review's Terms of Reference and Annexes D and E set out the stakeholder survey results and the themes arising from the other engagement processes.

Introduction

The introduction sets out the reasons for initiating the Review and proposes shared definitions of critical terms, including 'improvement' and 'leadership development'.

10. The NHS is facing unprecedented challenges arising from the need to continue to improve health and the quality of services at a time of significant increases in demand for care and financial constraint.

11. People living in England face unacceptable variation in the quality of healthcare they receive. Preventable illness is widespread and health inequalities deep rooted[1.]

12. Clinical variation in the quality (and safety) of healthcare has been a longstanding feature, as recently outlined in the Francis, Keogh, Berwick[2] and most recently Kirkup[3] national reports. Similarly, care has often been fragmented within and across different providers and between providers and home settings. This is wasteful and does not meet the needs or preferences of those receiving it.

13. The 5YFV described the contours of a sustainable health and care system that could meet the changing needs of the population and address the financial challenges with sustainable solutions. It highlighted: the importance of involving citizens in service design[4]; the importance of improving health; the need for new models of care to work across organisational boundaries; the need to share and spread knowledge quickly; and the need to transform services at system level.

14. There is consequently a corresponding need to determine how the resources currently deployed by NHS Improving Quality (NHS IQ), Academic Health Science Networks (AHSNs), Strategic Clinical Networks (SCNs), Clinical Senates and the NHS Leadership Academy could be best used to improve quality and speed progress towards the broad vision set out in the 5YFV. A key emphasis in the work of these bodies is on building skills in the workforce to help address current and future challenges.

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[1] *Five Year Forward View* (October 2014)
[2] *The Mid Staffordshire NHS Foundation Trust Public* Inquiry Chaired by Robert Francis QC (January 2013); *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report* (July 2013), Sir Bruce Keogh; *A promise to learn – a commitment to act. Improving the Safety of Patients in England*, (August 2013), National Advisory Group on the Safety of Patients in England
[3] *Morecambe Bay Investigation Report* (March 2015) Department for Health, Dr Bill Kirkup
[4] *NHS Constitution for England* (March 2012 and February 2015), Department of Health

15. Don Berwick's report also advised that the NHS needs to become a 'learning organisation' and that "mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives".[5] Such mastery includes knowing how to use data to measure the quality of care, variations over time and between teams, and to assess the impact of service changes. At present such basic formal 'quality improvement' skills required to improve service delivery are patchy among staff across England, particularly in staff groups providing frontline care. Making recommendations on how such skills could be developed and best used to accelerate necessary change is within the scope of this review.

16. Effective leadership is also needed to improve care. There is clear evidence of the link between leadership and a range of important outcomes within health services. Effective leadership is a highly (if not the most) influential factor "in shaping organisational culture that ensures the delivery of continuously improving high quality, compassionate care"[6]. Determining how effective leadership can be developed is also within the scope of this review.

17. The Review recognises that its proposed changes to the improvement and leadership development architecture will not shift performance on their own. A number of other factors need to be taken into account which **are outside** the scope of the review. These include:

    a) The clinical workforce needs expert and up-to-date clinical knowledge and skills to provide good quality care to patients; and

    b) Those charged with improving clinical care need to be supported by effective operational management[7]. The number of managers across the NHS and their technical skill set to manage key operations, relative to what is now needed is significantly under examined.

18. Academic research and feedback from stakeholders involved in the review confirms that effective leadership, operational management and quality improvement skills particularly among frontline clinical staff are fundamental to delivering better quality care, whether through small changes in frontline care or wider transformational change.

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[5] *A promise to learn – a commitment to act. Improving the Safety of Patients in England*, (August 2013), National Advisory Group on the Safety of Patients in England.
[6] *Leadership and Leadership development in Health Care: The Evidence Base* (February 2015), West et al; *Freedom to Speak Up Review* (February 2015), Sir Robert Francis.
[7] *Safer Clinical Systems – Evaluation Findings* (December 2014), Health Foundation

19. The report defines leadership and quality improvement as follows:

a) **Improvement:** there is no single agreed definition of improvement and so for the purposes of this review improvement means: 'A systematic approach to making changes that lead to better patient outcomes, and stronger health system performance.' This approach involves the application of quality improvement techniques, which provides a robust structure, tools and processes to assess and accelerate efforts for the testing, implementation and spread of quality improvement practices[8];

b) **Improvement capability development** refers to building the knowledge, skills and expertise in improvement techniques that enable individuals, teams, organisations and systems to effect sustainable improvements in patient outcomes and system performance;

c) **Leadership development** refers to the development of leaders at an individual, organisation and systems level who are able to drive through the service and transformational changes required to deliver sustainable services;

d) **System leadership** "is characterised by two key attributes. Firstly, that it is a collective form of leadership – systems leadership by definition is the concerted effort of many people working together, [towards a shared purpose], at different places in the system and at different levels, rather than of single leaders acting unilaterally. Second, systems leadership crosses boundaries, both physical and virtual. It therefore extends individual leaders well beyond the usual limits of their formal responsibilities and authority"[9].

20. The detailed scope of the Review, the methodology used, subsequent findings, recommendations and next steps are set out in the following sections of the report.

21. This report represents the completion of the first of a two stage process. It recognises that further arrangements will need to be in place to oversee detailed further design and implementation of and transition to the recommended arrangements.

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[8] *Quality Improvement Science, Quality Improvement primers.* Health Quality Onatrio 2013
[9] *Systems Leadership: Exceptional leadership for exceptional times. Synthesis Paper* Gate, Lewis and Welbourn, The Colebrook Centre for evidence and implementation and Cass Business School 2013.

Background

This section sets out the context for the review, its scope and the methodology used. It describes the engagement activities that have taken place and the governance arrangements for the work.

22. It is now over two years since the implementation of the 2012 health and social care reforms[10]. The health and care system is settling into its new roles, making this is an appropriate time to review how any hosted organisations are working and the extent to which they are delivering what is required of them. NHS England has been reviewing and clarifying its role as leader of the commissioning system and is considering the effectiveness of the principal organisations it funds in delivering improvement and leadership development across health and social care.

23. In addition, the 5YFV set out a clear vision of how the NHS needs to transform if it is to continue to develop and improve while achieving financial sustainability. In this context, it is critical that we ensure that improvement and leadership bodies are aligned with and focused on the best way to support the leadership and transformation interventions necessary to realise the 5YFV ambitions. Furthermore, we need to ensure that these arrangements can and do deliver good value for money.

Scope of the Review

24. Two reviews have taken place in tandem: one of NHS IQ and the NHS Leadership Academy and the other of AHSNs, SCNs and Clinical Senates. Both reviews have been overseen by one Strategic Steering Group. The findings of each review have informed the other and the conclusions from both have been brought together in the recommendations of this single report to show how the recommended arrangements need to work together to support improvement and leadership development for the future. For the purposes of this report the term "Review" will apply both to the work on NHS IQ and the NHS Leadership Academy and to the work on AHSNs, Strategic Clinical Networks and Clinical Senates.

25. The full terms of reference for the reviews of the NHS IQ, the NHS Leadership Academy and AHSNs, Strategic Clinical Networks and Clinical Senates can be found in Annexes A and B.

26. The review of the NHS IQ and the NHS Leadership Academy has focused on:

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[10] *Health and Social Care Act 2012*

a) System-wide engagement to capture views on the adequacy of current arrangements and future requirements. The processes of engagement have included a system-wide survey (co-ordinated by the NHS Confederation) and a large number of engagement events;

b) The articulation of the core purpose of the improvement and leadership development functions, against which to test the adequacy of current arrangements and any proposed changes to those arrangements; and

c) The iterative development findings and recommendations, which have been tested with key stakeholders.

27. The review of AHSNs, Strategic Clinical Networks and Clinical Senates sought to answer the four questions set out below. The full findings from this review can be found in Annex G.

a) What purposes were SCNs / Senates / AHSNs originally designed to fulfil (for NHS England, for commissioners and for the wider system)?

b) What benefits are they providing currently?

c) What functions are needed in future to support a self-improving system and the delivery of transformational change, particularly in light of the priorities that will be identified through the 5 Year Forward View?

d) How should the architecture be arranged to provide these functions, to ensure maximum value for the £100m investment?

28. In respect of AHSNs, this review has focused on their role in supporting health economies to improve the quality of services. It has not looked at their activities in respect of wealth creation and economic growth, which were subject to a separate review by the Cabinet Office.

Governance arrangements

29. A Health and Care Steering Group was established, chaired by Ed Smith, deputy Chair of NHS England. This will make final recommendations to the NHS England Board. It is hoped that the steering group members will also take these findings and the recommendations to their representative boards and, as necessary, to Ministers.

30. Membership of the steering group is available in Annex A and was drawn from the national bodies with a shared interest in the system including NHS England, DH, NHS TDA, Monitor, HEE, PHE and CQC. The Steering Group met five times between November 2014 and March 2015.

31. A reference group was established and provided several opportunities to sense

check progress and emergent thinking with the organisations subject to the review and key senior stakeholders from across the health and care system. The reference group met on three occasions in December 2014 and March 2015. Membership is listed in Annex D.

Review methodology

32. The working group leading the Review has engaged with health and care stakeholders across England through a structured survey (Annex E), a variety of face-to-face events and meetings, teleconferences and webinars, and by inviting comments via a dedicated email address. A total of 43 individuals and organisations have submitted written responses, and 207 individuals participated in engagement activities, collectively representing 148 different organisations. A variety of groups, networks and organisations responded formally to the review, representing between them several thousands of clinicians and staff members, member organisations, and health commissioners and providers. These included the NHS Confederation, the Royal College of Physicians, Health Education England and NHS Employers.

33. The various engagement events have been iterative, from developing definitions and core purpose and assessing current arrangements against them, through to considering future arrangements and what they might deliver. An important feature of the review's approach has been to test, adapt and re-test emergent findings with a wide range of stakeholders. The engagement events have been led consistently by independent members of the review team, both to promote impartiality and to ensure that all views are considered fairly and equally.

34. Participants have represented a wide range of professional groups including medical and nursing staff, chief executives, chairs and board-level directors, senior management, HR, OD and workforce planning, programme/improvement leads and specialists, and patient/lay representatives.

35. We have actively sought the views of existing customers of NHS IQ and NHS Leadership Academy services to develop a rounded impression of the effectiveness of current arrangements, as well as to identify what they might need in future to deliver both local and national priorities. These customers have included commissioner and provider organisations from across primary, community, secondary and emergency care, and from mental health/partnership trusts. We have also spoken to representatives from local government and social care, as well as key partners from leadership and improvement organisations, including charities and those with special interests. Views expressed during engagement events have been collated and are summarised in Annex F.

36. In relation to specific engagement activities on AHSNs, SCN and Clinical Senates, we received 290 written responses. The working group also engaged with stakeholders by attending over 40 meetings and events and holding two national events, which brought together over 100 stakeholders from across the health economy to consider the four questions set out in the review's Terms of Reference (Annex B).

Current position

> This section provides information on the organisations covered by the Review.

NHS Improving Quality

37. NHS IQ was set up by the Department of Health and NHS England in April 2013 under the terms of a three year collaboration agreement and is hosted by NHS England. It was established by bringing together five national improvement legacy organisations. Its purpose is to support improving quality of healthcare services and transformation by providing improvement expertise.

38. The NHS IQ Programme Board chaired by the Chief Executive of NHS England, provides the governance and oversight of NHS IQ and agrees the work priorities and use of funding. The Managing Director of NHS IQ is accountable to the Programme Board through the Chairman. The senior responsible officer is Karen Wheeler, National Director: Transformation and Corporate Operations, NHS England.

39. The vast majority of current investment is in programme funding targeted at large scale improvement programmes supporting the NHS England outcomes framework: seven day services, patient safety, living longer lives, long term conditions and experience of care.

NHS Leadership Academy

40. The NHS Leadership Academy was established in 2012 and its focus as currently set out is to improve service quality and patient experience by developing outstanding leadership and broadening leadership behaviours. The NHS LA is funded by NHS England, governed by a representative Advisory Board, and hosted by an NHS Foundation Trust.

41. The strategic advisory board provides direction and oversight for the Academy and is responsible for assuring performance, financial delivery and good governance. Chaired by the Chief Executive of NHS England, membership includes DH, arms-length bodies, providers, commissioners and people champions. The national sponsor is Karen Wheeler, National Director: Transformation and Corporate Operations, NHS England.

42. The NHS Leadership Academy works closely with 10 local delivery partners (LDPs). The business models vary for each delivery partner although all receive funding from the NHS Leadership Academy to provide services aligned to their strategy and also to support local priorities.

Strategic Clinical Networks (SCNs)

43. The Strategic Clinical Networks were set up in April 2013 and were established in areas of major healthcare challenge where a whole system, integrated

approach was needed to achieve a real change in quality and outcomes of care for patients.

44. Strategic clinical networks seek to help commissioners reduce unwarranted variation in services and encourage innovation.

45. There are SCNs for the following areas:

    a) Cancer;
    b) Cardiovascular disease (incorporating cardiac, stroke, diabetes and renal disease);
    c) Maternity and children; and
    d) Mental health, dementia and neurological conditions.

Clinical Senates

46. Clinical Senates were established from April 2013 to provide strategic clinical advice and leadership across a broad geographical area to Clinical Commissioning Groups (CCGs), Health and Wellbeing Boards (HWBs) and the NHS England. They are the only bodies in the commissioning system that do this.

47. Clinical Senates take a broad, strategic view on the totality of healthcare within a particular geographical area, for example providing a strategic overview of major service change. They work collaboratively with commissioning organisations.

48. They provide independent strategic clinical advice as part of the NHS England reconfiguration assurance process, having taken on the role of the former National Clinical Advisory Team.

Academic Health Science Networks

49. The 15 AHSN's functions are to align education, clinical research, informatics, innovation, training and education, and healthcare delivery.

50. They are either hosted by a trust or are Companies Limited by Guarantee. They do not have any NHS England staff.

51. In 2013 a five year AHSN licence was agreed with NHS England. AHSNs have four objectives under this licence:

    a) Focus on the needs of patients and local populations;
    b) Speed up adoption of innovations in practice to improve clinical outcomes and patient experience;
    c) Build a culture of partnership and collaboration; and
    d) Create wealth through co-development, testing, evaluation and early adoption and spread of new products and services.

52. All the AHSNs have developed annual business plans in line with their Prospectus and licence and receive some of their funding from NHS England. In 2014, AHSNs took on the Patient Safety Collaborative function and revised their business plans accordingly.

Financial summary

53. The table attached as Annex H provides additional information about the organisations covered by the Review and summarises the financial position of the current architecture. It gives details of headcount as well as funding and expected reductions going into next year.

Findings

Why is there a need for change?

This section sets out the reasons why the approach to improvement and leadership development needs to change, outlining the summary findings from the Review.

Context

54. The unnecessary variation in the quality (safety, experience and outcomes) of the care the NHS provides, the significant increase in demand and significant financial constraints means that the healthcare system has to change. However, these challenges are not healthcare challenges alone: taking action without careful and collective planning could impact on the quality and effectiveness of health and care across local systems.

55. Over the last few years the NHS has faced some difficult truths. The failures of Mid-Staffordshire NHS Foundation Trust, and the subsequent reports (authored by Francis, Keogh and Berwick and more recently the report on whistle blowing in the NHS[11]) have given us insights into what is needed to secure a future health and care system that will be focussed on quality, safety and efficiency. At the heart of these reports is the need to change the culture of the NHS to enable healthcare organisations become learning organisations: removing fear of failure and readiness to criticise and instead focussing on continuous quality improvement.

56. The 5YFV sets out "a compass not a map"[12], an agreed way forward to secure safe, effective, high quality and sustainable health and care services for the future. The 5YFV recognises the importance of prevention and health improvement as well as maximising productivity. Structural changes are not part of the 5YFV. Instead the focus is on devolving responsibility and empowering local individuals, organisations and systems to take the action needed for successful outcomes.

57. The 5YFV also sets out a challenge for leaders, clinical and managerial. They need to be capable of focussing on continuous quality improvement internally and of working in different ways across porous boundaries, aiming for the health and wellbeing of their local populations rather than the success of their individual organisations, which has so far been a priority. Successful implementation of the 5YFV requires excellent leadership, where excellence includes being able to work collectively across boundaries.

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[11] *The Mid Staffordshire NHS Foundation Trust Public* Inquiry Chaired by Robert Francis QC (January 2013); *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report* (July 2013), Sir Bruce Keogh; *A promise to learn – a commitment to act. Improving the Safety of Patients in England*, (August 2013), National Advisory Group on the Safety of Patients in England; *Freedom to Speak Up Review* (February 2015), Sir Robert Francis.
[12] *Five Year forward View*, (October 2014)

Findings from the review

58. Extensive stakeholder engagement has taken place during the Review and details can be found in Annexes E and F. The following represents the views expressed through these engagement activities and draws together implications for the different elements under review.

Culture: the NHS as a learning organisation

59. The evidence gathered through the review shows that we have some way to go in establishing the culture in which the NHS develops as a learning organisation:

    a) The diversity of NHS leadership does not align with the populations the leaders serve;
    b) A blame culture is recognised by many contributors to this review;
    c) Improving quality and leadership development requires dedicated time: many report this as a major block to progress;
    d) A more collective, systems-level approach to leadership is needed; and
    e) We have too many organisations and individuals working in silos[13], which evidence shows has an effect on quality

The current architecture for improvement is too complex to navigate

60. Many reported that improvement and leadership are essential to support the 5YFV and to address unnecessary variation in experience, outcomes and safety of health care. Respondents confirmed that leadership and improvement cannot be separated: at most levels across the system they are intertwined.

61. The current architecture is not sufficiently connected to and aligned with the current national strategic priorities (as articulated in the 5YFV), including the need for a stronger focus on local health and care systems and for improved system leadership.

62. Stakeholders consider the current architecture for improvement remote, fragmented and unclear:

    a) The roles of NHS IQ, AHSNs, strategic clinical networks and clinical senates are not well understood;
    b) It is not clear how the above fit with the improvement work undertaken by the NHS Trust Development Authority (TDA) and Monitor to support providers;

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[13] *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report* (July 2013), Sir Bruce Keogh.

c) Front line staff do not know where they can go for advice or help; and

d) How safety collaboratives fit with the wider ambitions set out in the 5YFV is unclear to many.

Intervention

63. Intervention is an important part of improving services. Current service intervention arrangements are insufficiently coordinated and planned, and do not secure sustainable improvement solutions: intervention is often repeatedly required by the same organisations and systems. Too often intervention brought in from outside an organisation is seen as the solution, and the need for organisations to achieve sustained, continual improvement is not recognised.

Improvement

64. Improvement is currently viewed by some organisations as a 'nice to have'. Where improvement is successfully embedded, valued and supported, organisations can make great progress in improving both efficiency and quality. Data is often used for performance management purposes and less commonly to support improvement. The capacity and capability in analytical skills required to support improvement are also reported as low. Improvement is essential to meeting the challenge set by the 5YFV: embedding improvement skills and capabilities such as flow management and service redesign in clinicians and managers will mean staff at every level are equipped to play their part. The technical capability of operational management to improve services is a key to success.

Securing the leadership for the future

65. In addition to the requirements of the 5YFV, many contributors have highlighted the importance of active succession planning, which aims to build a structured talent management approach within and across the commissioner and provider leadership communities. Berwick echoes the need to "help develop the leadership pipeline by providing support and work experiences to enable others to improve their own leadership capability" and emphasises learning from doing"[14]. The Kings Fund Commission on Leadership and Management identified "the need for leaders to focus on systems of care and to give much more attention to shared leadership between managers and clinicians"[15]. However stakeholders reported a significant gap, with our best talent not

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[14] *A promise to learn – a commitment to act. Improving the Safety of Patients in England*, (August 2013), National Advisory Group on the Safety of Patients in England;
[15] *The future of leadership and management in the NHS – No More Heroes,* (2011), The King's Fund.

necessarily supported in leading within high performing, collaborative systems nor gaining experience of leading within different parts of the system to help them to see the world through different lenses.

Value for money

66. We do not have a good understanding of where investment in leadership development and improvement is made in addition to those parts of the system that are nationally funded. The impact of the investment so far is not well understood.

67. The current arrangements do not support the pace needed to achieve the savings required by the 5YFV by redesigning services to meet local population needs now and in future and to reduce unnecessary variation.

Implications of the findings for the healthcare system

68. The implications include:

   a) There is widespread support for clear national coordination and guidance, but combined with a much greater emphasis than at present on local and regional improvement action;

   b) The new operating model and governance of the new architecture must be aligned to the 5YFV;

   c) Improvement and leadership development need to be accepted as the responsibility of everyone working in the health and care system;

   d) The new architecture needs to be easy to navigate;

   e) Leaders should build a culture that will foster the growth of a learning organisation/system;

   f) Capability building in improvement for individuals and teams should not be separate from leadership development. This includes embedding improvement science capability in clinical curricula at undergraduate and postgraduate levels and throughout management and leadership development;

   g) Evaluation of impact of any changes should be built into the new architecture;

   h) Networking is key to ensuring the sharing and spread of new learning, evidence and intelligence;

i) Urgent action is necessary to understand the current baseline of improvement capability and leadership development and what is required to realise the 5YFV. This action is expected as part of organisations' preparatory work for developing their improvement and leadership development strategies; and

j) Only things that need to be done nationally should be done nationally: local empowerment should have a stronger emphasis.

Implications for NHS IQ

69. The NHS IQ resource is not sufficiently directed to or aligned with local priorities and deliverables and therefore does not adequately support local organisations and local health and care systems. This includes not recognising that many providers have a requirement for support to improve their operational and financial performance (although it is acknowledged that this was never part of NHS IQ's formal remit); and

70. While a number of NHS IQ's specific improvement programmes have been effective and have had impact, in overall terms it has made insufficient impact on either service improvement or service transformation. Within the system, awareness of its work has been low, no doubt affecting take-up of programmes and tools and their impact. As a consequence local and health and care systems needs have not been met despite the considerable resources currently invested in the improvement architecture.

71. The current capacity and capability for improvement across the NHS is not well understood, including variation by geography.

Implications for SCNs, Clinical Senates and AHSNs:

72. These bodies have forged strong partnerships across their geographies and are working through these to spread evidence, best practice and innovation. However, a more consistent approach across these bodies to shared priorities would benefit local systems.

73. They need to give more consideration to measuring impact and the extent to which they are aligned with each other and with the priorities of the 5YFV and local priorities.

Strategic Clinical Networks (SCNs):

74. SCNs are by definition the sum of the commissioners, providers and professionals who come together as part of the network. SCNs have a key role

to play in supporting networking and in spreading evidence, best practice and clinical standards.

Clinical Senates:

75. As Clinical Senates develop, one of their key responsibilities will be to provide advice on the new models of care and service transformation as outlined in the 5YFV: their current level development is very varied;

Academic Health Science Networks (AHSNs):

76. AHSNs' role and remit has not been widely and consistently communicated, and so is not well understood among some sections of stakeholders. It would appear that generally providers tend to be well connected with their AHSNs, with Chief Executives sitting on AHSN boards and leading many of their programmes. All CCGs are members of their local AHSNs, however some are more engaged than others.

77. There could be greater alignment and focus in some areas for the AHSNs and other local bodies such as SCNs. Where AHSNs are actively engaged in their health improvement work streams, they tend to be working well in collaboration with their SCNs, identifying areas of potential overlap and avoiding duplication.

78. Clarity is needed on the role AHSNs will have in the new improvement architecture, particularly how their responsibility for patient safety collaboratives links into it.

Implications for the NHS Leadership Academy:

79. The system's current leadership development and management capability and capacity is insufficient to meet the current and future needs of the system. There is a need to ensure that leadership development is explicitly connected and aligned to the delivery of the 5YFV and, in particular, that it is sufficiently orientated towards the health and care system, as opposed to individual organisations; today's leaders need to work collectively across boundaries. There is also need to concentrate on addressing the wide variation in the extent to which leadership development is connected to and aligned with individual, team, organisation and local system priorities.

80. There needs to be greater ownership of national programmes by local organisations and systems. There is potential for the programmes to be more targeted and focussed on areas of priority as determined by the system as a whole, aligned to the 5YFV, as well as on organisational improvement.

81. There is widespread support for clear national coordination, programme 'brokerage' and guidance from national bodies, but combined with a continued

and increased emphasis on local and regional leadership development action. All parts of the system should be engaged in the development of leaders in accordance with an agreed set of system based leadership principles.

82. The work of the NHS Leadership Academy and that of HEE are not sufficiently connected and aligned.

83. There is broad support for many of the national leadership development programmes, although it is too early to determine to their impact. However it is clear that large numbers of staff have participated in Academy programmes and there are currently high levels of satisfaction with the quality of programmes amongst participants.

84. There is a reasonable level of awareness and understanding of the role of the NHS Leadership Academy and its Local Delivery Partners (LDPs).

85. There should be a greater focus on:

    a) 'Within organisation and system' leadership development;

    b) The development of improvement skills for leaders, clinicians and operational managers and at all levels of the system;

    c) The development of clinical leaders at organisational and system level; and

    d) The development of existing and future leaders who can operate effectively across health and care systems and organisational boundaries.

Future Design Principles

This section sets out the following:

- The core purpose of each of the improvement and leadership development functions within the new architecture; and

- The design principles that upon which the new improvement and leadership development architecture should be based.

86. Academic research,[16] high profile national reviews[17] and feedback from stakeholders involved in the review suggest a need to shift from emphasising national processes and arrangements to expecting far greater local ownership, leadership and delivery, albeit within defined national frameworks and priorities.

87. Review feedback strongly supports a focus on local health and care systems, understanding that the 5YFV cannot be achieved without local collaboration across health, public health and social care organisations.

Recognising Complexity

88. In determining the core purpose of the health and care system's improvement and leadership development architecture it is essential to recognise the complex and dynamic nature of the systems and the organisations that it comprises. A 'one size fits all' generic approach will not work. Improvement and leadership development activity needs to be tailored to respond to the wide variation in the needs of organisations currently apparent across the health and care system

89. It is therefore essential that improvement and leadership development activity is tailored to respond to the wide variation in needs currently apparent across the health and care system (in line, for example, with the Cynefin framework[18] that considers the different needs of organisations according to their different situations – complex, complicated, chaotic and simple).

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[16] *The triple aim: care, health and cost. (2008; 27: 759–69), Health Affairs, DM Berwick, TW Nolan, J Whittington; Leadership and Leadership development in Health Care: The Evidence Base (February 2015), West et al.*

[17] *The Mid Staffordshire NHS Foundation Trust Public* Inquiry Chaired by Robert Francis QC (January 2013); *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report* (July 2013), Sir Bruce Keogh; *A promise to learn – a commitment to act. Improving the Safety of Patients in England*, (August 2013), National Advisory Group on the Safety of Patients in England; *Freedom to Speak Up Review* (February 2015), Sir Robert Francis

[18] *Cynefin, A Sense of Time and Place: an Ecological Approach to Sense Making and Learning in Formal and Informal Communities* conference proceedings of KMAC at the University of Aston, (July 2000), D Snowden.

The new Improvement Architecture

Core purpose

90. The core purpose of the new improvement architecture is to provide specialist improvement science expertise and advice to support individuals, teams, organisations and health and care systems to improve outcomes for patients and health system performance aligned to the 5YFV, and to support capability building in improvement at all levels.

91. Three types of improvement are needed:

   a) **Service Improvement**: The quality (effectiveness, safety, patient experience) and value for money of services can be continually improved by using improvement techniques (e.g. lean, six sigma), to change the way that services are delivered.

   b) **Service Transformation**: This is required when more complex, larger scale change is required, beyond the scope of service improvement and more straightforward (organisational) service redesign. The need for such transformation is explicitly referred to in the 5YFV. Service transformation takes place across a whole system, requiring formal structures in the system to become more 'porous' and transcending traditional organisational boundaries. Such transformational change is difficult: 70% of efforts to transform do not fully succeed. However, when they do, the result is higher performance and better outcomes. The likelihood of success is increased by the use of transformational science and expertise. Such transformation is required to secure a truly sustainable health and care system.

   c) **Service Intervention**: While there are many examples of outstanding care and clinical, service and financial performance across the system, there are also services, organisations and local systems that are inadequate. Services, organisations, and local systems that are failing or on the brink of failure continue to require external intervention to address with pace and urgency such failings. The 5YFV signalled the need to develop a new, collective approach to intervention in the most challenged health economies referring to a "whole-system, geographically based intervention regime" to align the approaches of Monitor, NHS England and the TDA.

Design principles:

92. **Improvement is everyone's responsibility:** Bearing in mind that different improvement activities are required at different levels across healthcare to respond to different situations and degrees of complexity, improvement is a core responsibility of everyone working in the health and care system. Sustainable change is more likely to result from improvement approaches that involve patients and staff in their design and implementation than from a 'command and control' / top down model[19]. Realising the 5YFV depends on system-wide collaboration. So it is important that work with representatives of local government partners continues on the detailed design of the improvement and leadership development architecture as it progresses to the implementation stage.

93. **Improvement capability is needed throughout the healthcare system:** To drive service improvement and transformational change, it is therefore essential to develop and embed formal improvement skills wherever people need them to fulfil their responsibility for improvement e.g. in front-line staff, all clinicians as part of their clinical training, operational managers, organisational leaders and local system leaders and national leaders. Greater benefits can often be delivered by development 'in place' i.e. where individual organisations and local systems undertake much of their own development and improvement, tailored to their need.

94. **Improvement capacity should be distributed across the system:** All parts of the health and care system should have direct access to improvement advice and support.

95. **National improvement functions should be limited:** The improvement functions undertaken nationally should be confined to those that can only be discharged effectively at a national level. Improvement activity should be undertaken at an organisational or local health and care system level wherever possible. Where improvement functions are undertaken nationally accountability for realising benefits and value for money needs to be clear and explicit.

96. **Partnership and collaboration are essential:** Organisations and local systems can only deliver the necessary service improvement and service transformation in partnership with and through collaboration across organisations and sectors, recognising the interdependent nature of the health and care system. With this in mind, the proposed new architecture needs to recognise and take account of

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[19] *Quality Improvement Made Simple*, (August 2013), Health Foundation

the wider quality improvement efforts being undertaken across the system, including the work of the National Quality Board.

97. **Improvement priorities should be fully aligned with strategic service priorities:** At national system and local system level, improvement priorities must be fully aligned with the relevant strategic priorities to secure the best chance of success. In particular there should a clear connection with and full alignment between the national elements of the system's improvement architecture and NHS England's strategic priorities (specifically the ongoing implementation of the FYFV).

98. **Intervention should be targeted and limited:** Intervention capacity will always be required. However its use should be targeted and, from the outset, should be based upon securing sustainable improvement solutions, to avoid the need for repeated intervention (as is currently often the case).

The new leadership development architecture

Core purpose

99. The core purpose of the new leadership development architecture is to do the following:

100. **Improve the capability of leaders and managers:** Ensuring that leaders and managers, including clinicians are equipped for the future. They need to be able to improve service quality, while managing complex and financially constrained health and care systems. Improvement is an essential capability of leaders and managers.

101. **Ensure development support:** Ensuring that the health and care system has the capability to support the initial and continuing development of leaders and managers, including clinicians at all levels across the system. Development support may include, for example, organisational and local system based coaching and mentoring arrangements, workplace based learning, and bespoke development programmes. It should reflect the required standards and expected behaviour and represent best international practice.

102. **Support talent management:** In light of the above:
    a. Ensuring that there are sufficient senior leaders and managers (both in terms of numbers and quality) to meet the dynamic needs of the health and care system, as articulated in the Five Year Forward View, in all circumstances, from organisations and systems that are outstanding to those that are deemed inadequate.

b. Ensuring that leaders and managers are deployed in the most effective way to meet the needs of the national and local systems and organisations.

103. **Promote diversity:** Ensuring that the diversity of the system's leaders and managers reflects the diversity of the population served, in order to ensure culturally competent leadership and management.

104. **Set standards and expectations:** The development and promotion of models of leadership (for example the NHS' Leadership Framework), the promulgation of required standards of behaviour (for example the CQC's leadership domain), and the assessment of compliance with such models and standards. Such activity is a core part of the necessary professionalisation of health and care leadership and ensuring that this represents best international practice.

Design principles

105. **Leadership development is the responsibility of all organisations and local systems:** It is essential that all organisations and local systems across health and care (including public health and social care) engage fully in leadership development, including the provision of work-based learning and coaching and mentoring. In addition, all organisations and local systems should fully own and engage in any nationally commissioned development frameworks and programmes, ensuring that benefit is delivered to both t programme attendees and other colleagues. .

106. **Talent management is the responsibility of all parts of the system:** All organisations, local health and care systems, and the national system need explicit talent management strategies to address their respective needs.

107. **Partnership and collaboration are essential:** Organisations and local health and care systems can only secure the necessary leadership development in partnership and collaboration with other organisations and sectors, recognising the interdependent nature of the health and care system.

108. **National leadership development functions should be limited:** The leadership development functions undertaken nationally should be confined to those that can only be discharged effectively at this level. Leadership development activity should be undertaken at an organisational or local system level wherever there is a genuine opportunity to do so, albeit in a way that makes consistent use of evidence based best practice. "Much of the available evidence, particularly in the NHS, highlights the importance of collective leadership and advocates a balance between individual skill-enhancement and

organisational capacity building"[20]. This would mean that programmes could be commissioned nationally but delivered locally.

109. At the national level, it is essential that there is an ongoing review and management of talent. This is needed to ensure the design and implementation of leadership development interventions are aligned to the strategic needs of the system as currently articulated in the Five Year Forward View. Where leadership development functions are undertaken nationally, there accountability for realising benefits and value for money needs to be clear and explicit.

110. **Leadership development should be fully aligned with strategic service priorities:** At national system and local system level across all the health and care system (including Public Health and Social Care), leadership development must be fully aligned with the clear strategic priorities to secure the best chance of success.

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[20] *Leadership and Leadership development in Health Care: The Evidence Base* (February 2015), West et al.

Recommendations

Based on the proposed design principles, this section sets out the Review's recommendations for the future development of the health and care system's improvement and leadership development arrangements.

111. The following sixteen recommendations for change set out the responses to the Review findings.

Improvement and Leadership Development: Overarching System Perspective

112. The following headline recommendations address improvement and leadership development from an overarching system perspective. The recommendations take account of the new system context, where leaders will be working as part of high-performing collaborative systems:

    a. **Recommendation 1:** National strategies for both improvement and leadership development (including talent management) will be created for the health and care system, developed in parallel and explicitly aligned, in order to support the delivery of the 5YFV.

    b. **Recommendation 2:** Every NHS organisation should develop strategies setting out their approach to improvement and leadership development (including talent management) which are aligned to the national strategies and the needs of their local systems.

    c. **Recommendation 3:** The new arrangements for improvement and leadership development should be governed collectively by two national Governing Boards, comprising senior representatives from the six national organisations (NHS England, NHS Trust Development Authority (TDA), Monitor, Health Education England (HEE), Public Health England (PHE) and the Care Quality Commission (CQC) and the Department of Health (DH) in their system sponsorship role. Serious consideration should be given to the most appropriate ways to ensure that frontline service representatives such as (but not limited to) the LGA and NHS Confederation are engaged in the work of the two Governing Boards. The two new Boards will work together to ensure that the system's approach to improvement and leadership development is fully aligned and with sufficient shared membership to secure the necessary cross-fertilisation of concepts and approaches.

    The new governance arrangements will:

- not replace or compromise the sponsorship and management accountability arrangements of existing organisations that will form part of the future architecture;

- ensure that the design and delivery of national and local priorities, in relation to improvement and leadership development, are connected and reflect the needs of the health and care system at all levels by setting out clear stakeholder engagement arrangements; and

- all organisations, irrespective of ultimate governance arrangements, will be expected to comply with HMT's Managing Public Money, have clear and appropriate asset and liability ownership, and operate in line with the standards expected of public bodies.

d) **Recommendation 4:** NHS Interim Management and Support (NHS IMAS) comprises the Intensive Support Teams (ISTs) and a core team. The ISTs focus on supporting organisations and health systems to improve or turnaround operational performance and deliver sustainable solutions, specialising in urgent and emergency care, elective care and cancer. The core team concentrates on identifying, providing and managing senior interim expertise, skills and support on behalf of organisations across the healthcare system. The ISTs have been governed jointly by Monitor, NHS TDA, and NHS England since January 2015. The core NHS IMAS team continues to report solely to NHS England. These reporting arrangements should continue whilst consideration is given as to where these functions are most appropriately hosted in future to support delivery of the national strategy for improvement.

113. The diagram below sets out the different parts of the proposed improvement and leadership development arrangements

Proposed improvement and leadership development arrangements

National Governance Group (aligned to Five Year Forward View) (NHS England, Monitor, NHS TDA, HEE, PHE and CQC)		
National	**Local**	**Resources**
Leadership development • LA commissions system and organisational leadership programmes • LA talent management of the top senior roles (c. 200) • LA set leadership development standards and framework **Improvement** • Small team to advise on improvement thinking at scale • LA commission programmes for building individual and team improvement capability	**Leadership development** • 10 LDPs work locally to deliver and also commission leadership priorities and programmes in locally meaningful way. **Improvement** • 15 AHSN to provide commissioners and providers access to expert improvement skills and resources commissioners, providers and their partners incl. local authorities and Healthwatch. • 15 AHSNs to link with relevant local bodies within their geography with a focus on improvement including Clinical networks, LDPs, LETBs, CLAHRCs, CSUs, and other improvement agencies across the Health and Care system. • Clinical networks will support improvement across pathways of care, deriving national strategic direction and reflecting local priorities from 5 year strategic plans.	**Leadership development** Range of resources available from the LA for all organisations e.g. • Toolkits and guidance • Mentoring / coaching / learning sets and on-line support **Improvement** Central resources will be available to support the 15 AHSNs to deliver and focus on: • Supporting local networks to flourish • Sharing knowledge, new learning with AHSNs and the national team; • Research and evaluation advice at the local level; • Toolkits, resources & e-learning platforms.

Improvement

114. Concerning recommendations specific to improvement in the health and care system, the intention is to establish a self-sustaining operating model where organisations and systems build their own improvement capabilities and are held to account for progress. The Review's recommendations on improvement are as follows:

   a. **Recommendation 5:** Standard operating models should be developed which set out how the different parts of the improvement architecture, at both national and local level, should work to support the delivery of service improvement, service transformation and service intervention activities. These models will be informed by the learning from this Review and the priorities set out in the joint national strategy on improvement and leadership development. The operating models should be sufficiently flexible to respond to differing needs across the system arising from variations in performance, readiness for change, and scale of change required. Furthermore, they should recognise the importance of developing good local leadership and operational management skills to lead and deliver the required improvement activities.

   b. **Recommendation 6:** NHS IQ, the current national improvement body, will cease to operate, and :

i. National resources should be targeted to support improvement activity to deliver national and local priorities.

ii. NHS IQ's resources and expertise should be retained and integrated into the revised system architecture at both a national and local level. Wherever appropriate, existing NHS IQ functions, programmes and resources, which constitute the majority of NHS IQ's current delivery capability, should be embedded in the new architecture to make improvement expertise and guidance more accessible for local organisations and systems.

c. **Recommendation 7:** To help commissioners and providers to access expert improvement advice and support resources in their locality, the fifteen AHSNs will co-ordinate local improvement activity across England, collaborating with all appropriate local partners with improvement expertise. In this way AHSNs will facilitate the provision of a single point of local access for improvement for commissioners and providers in their local area. They could do this as follows:

i. Facilitate access to a network of appropriate local partners with improvement expertise, who can support commissioners and providers in building the skills and knowledge required to drive change within their organisation and local health and care systems;

Relevant local bodies with a focus on improvement might include Clinical Networks, LDPs, Local Education and Training Boards (LETBs), Collaborations for Leadership in Applied Health Research and Care (CLAHRCs), Commissioning Support Units (CSUs), local improvement agencies (such as the Advancing Quality Alliance (AQuA) and local providers where good improvement practice has been established;

ii. Work with local commissioners, providers and partners within the network to identify gaps in skills and resources and to signpost ways of addressing any gaps through support at local or national level;

iii. Facilitate the creation of a local delivery plan for their local system that both aligns with and reflects the priorities of the national strategy for improvement and leadership development (see Recommendation 1);

iv. Lead the implementation of the necessary 'infrastructure' for developing capability and sharing learning to successfully

implement the service changes required both immediately and to achieve the ambitions of the 5YFV;

v.   Account to both the local and national elements of the health and care system for improvement activities undertaken in accordance with local strategy;

vi.   The ambition is for AHSNs to be augmented with staff experienced in improvement, including measurement for improvement. Some of these staff may be sourced from the current NHS IQ team as part of the transition process. There will be a need for careful handling to ensure that current commitments are met as staff transition into new architecture. The new architecture will entail changes to current ways of working in order to meet local and national priorities as effectively as possible. The ambition is for the new architecture to achieve improvements at a faster pace, than the large-scale national improvement programmes currently commissioned by NHS England;

vii.   The work of the AHSNs and the local improvement agencies will need to take into account:

- Current local landscapes, including areas where there is evidence of existing good practice in improvement and leadership development[21];
- The needs of primary, secondary, and tertiary care; and
- The intervention and improvement activities undertaken directly by IMAS (including ISTs), NHS TDA and Monitor for providers, and NHS England for commissioning organisations.

viii.   AHSNs should be encouraged to consider a membership model (building on their current arrangements), which will enable NHS commissioners and providers, together with health and care system partners, to access specialist advice and support. Consideration should be given to existing membership models such as those used in the North West of England;[22] and

ix.   Discussions with each of the AHSNs about their readiness and willingness to play this co-ordination role within their geographical area will take place during the implementation phase. Alternative

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[21] *Building the foundations for improvement* (February 2015), A learning Report, Health Foundation
[22] *www.aquanw.nhs.uk*

local co-ordination arrangements could be made if necessary. It must be recognised that while AHSNs' power to influence improvement, their good geographical range and their local connections all make them a good vehicle for hosting local improvement capability, their current role is not confined to improvement. Therefore any significant change in their role may require a change to their licence and accountability arrangements.

d. **Recommendation 8:** A 'one-stop shop' should be established to offer access to shared improvement resources that may be common requirements of all the AHSNs. This would provide economies of scale and might include access to research and evaluation advice, spreading learning and best practice across AHSNs and the national improvement team (Recommendation 10) and connecting people across systems at all levels. The hosting and funding arrangements for this resource will be determined through the implementation stage.

   i. Providing research and evaluation advice;

   ii. Curating, sharing and spreading learning and best practice across the AHSNs and, through governance arrangements, to the national team (Recommendation 10);

   iii. Connect people both within, and across systems to support networking and accelerate learning; and

   iv. Provide a digital platform for e-learning, e.g. improvement science MOOC (Massive On-line Open Course), toolkits and improvement resources

   The hosting and funding arrangements for this one-stop shop would need to be determined during the implementation phase and could be created using some of the appropriate staff currently based within NHS IQ.

e. **Recommendation 9:** In order to build the necessary improvement skills to deliver system-wide change, , as well as the leadership required to harness these skills, the Review recommends supporting the development of individual and team improvement capability with programmes commissioned by the NHS Leadership Academy. This is a step-change from what happens currently. The design of these programmes will need to be informed by the baseline assessment of the current improvement capability (see below) to ensure that they will meet local need. These programmes would be delivered locally to ensure that learning and skills

are developed within the relevant operational environment, i.e. 'learning by doing'. Essential requirements are as follows:

    i. Carry out a baseline assessment of current improvement capability and develop a strategy to determine what is needed to address gaps at local, system and national levels; and

    ii. Initiate a substantial programme of quality improvement (QI) skills development, including service improvement and redesign, and leading transformational change. This will be commissioned by the NHS Leadership Academy, working in partnership with the national improvement team based within NHS England (see Recommendation 10 below). The programme's principal requirements will be to:

- Establish sufficient capability across each part of the health and care system, and at each level, to respond to gaps identified;

- Develop curricula and set standards for future capability development in improvement and change leadership; and

- Through strategic alignment with other organisations such as HEE, the professional regulators and professional colleges, work to embed improvement as a core capability, and, in so doing, support the Berwick recommendations[23].;

- Support the development of improvement capability during transition; and

- Embed quality improvement and leading transformational change in programmes on leadership development commissioned by the NHS Leadership Academy.

The diagram below sets out suggested improvement skills for each group in a typical provider organisation[24].

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[23] *A promise to learn – a commitment to act. Improving the Safety of Patients in England*, (August 2013), National Advisory Group on the Safety of Patients in England.
[24] *A promise to learn – a commitment to act. Improving the Safety of Patients in England*, (August 2013), National Advisory Group on the Safety of Patients in England.

Adapted from Kaiser Permanente
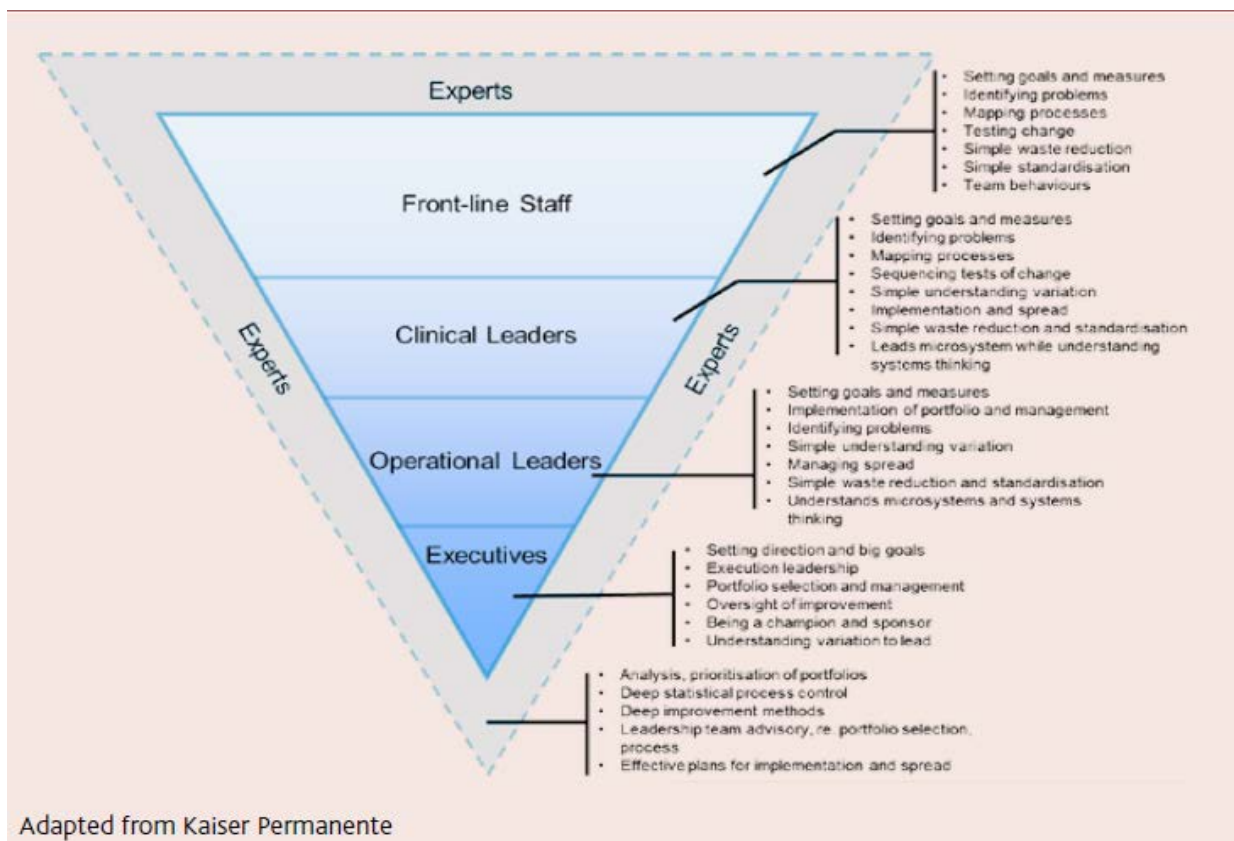
f. **Recommendation 10:** At a national level, a small team should be formed, which could be hosted within NHS England (hosting to be determined in stage 2), to provide thought leadership, expertise and support, and play a critical support role for the specific programmes focused on the delivery of the 5YFV. The work of this team would be governed by the national improvement Governing Board. This team will work in conjunction with the national 5YFV implementation group and could support the 5YFV by:

   i.   Providing horizon scanning and evidence-based thought leadership relating to transformational change and improvement techniques to support delivery of 5YFV priorities;

   ii. Designing and developing appropriate resources and models for improvement across systems;

   iii. Supporting the development of a single national strategy for both improvement and leadership development, which considers the entire health and care system;

   iv. Advising the NHS Leadership Academy on system-wide requirements for the development of improvement skills;

v.　Ensuring that national 5YFV thinking and the local change capability are connected; and

vi.　Working with the AHSNs to develop and share evidence-based best practice, especially practice relating to the work of 5YFV vanguards and new models in the system.

h)　**Recommendation 11:** Clinical Senates, Strategic Clinical Networks (SCNs) and AHSNs today support change across the health and care system and this should continue.　However, their roles should be clarified to strengthen their accountability and governance, ensure their relevance to local health economies' and national priorities, and to secure appropriate alignment between bodies.　Discussed in more detail within Annex G, the Review recommends the following:

　　v.　**Clinical Senates** should continue, but their role should be clarified as:

- Supporting health economies to improve health outcomes of their local communities by providing evidence-based clinical advice to commissioners and providers on major service changes.　Clinical Senates should bring together clinicians and managers, from across a defined geography, with patients and the public, to put the needs of patients above those of organisations or professions.

  In particular the following is recommended:

- The importance of clinical engagement across the geographical areas currently covered by Senates is recognised and this clinical engagement should be retained;

- There should be one overarching governing body per region, accountable to the Regional Medical Director. These bodies should continue to have independent Chairs. Administrative and managerial support should be consolidated where possible and increased to ensure that they are equipped to fulfil their vital role consistently.

- The business schedule should be determined both by the transformation agenda within their region, and by priorities derived from five-year strategic plans. For example, it is expected that in 2015/16 there would focus on urgent and emergency care as a priority.

- The operating model for Clinical Senates should be refreshed, with individual operating procedures developed for each region.

Regional teams in NHS England should oversee their operations and effectiveness.

vi. **Strategic Clinical Networks:** there should continue to be SCNs in each of the four current priority areas. However local priorities could be supported by new Clinical Networks. The existing SCNs should also be renamed Clinical Networks and their improvement role clarified as:

- Supporting health systems to improve health outcomes of their local communities. They will do this by connecting commissioners, providers, professionals, patients and the public across a pathway of care to share best practice and innovation, measure and benchmark quality and outcomes, and drive improvement;

- These networks should derive national strategic direction from the relevant National Clinical Directors. Business plans should reflect national priorities as well as local challenges, drawing from five-year strategic plans. Local priorities could be supported by the new Clinical Networks.

vii. **AHSNs:** the fifteen AHSNs should continue, though if any decide to merge they should not be discouraged.

- AHSN's role should be to support health systems in improving the health outcomes of their local communities, and to maximise the NHS's contribution to economic growth by enabling and catalysing change through collaboration and the spread of innovation and best practice;

- Awareness and understanding of the AHSN role needs to be increased if they are to fulfil their requirements. As part of transition work, it is therefore essential to communicate widely and consistently the role of AHSNs, as outlined above, together with case studies and evidence of delivery; and

- A balance will need to be struck between the improvement part of their role and the economic growth part.

i. **AHSNs and Strategic Clinical Networks** should be streamlined and their business plans aligned, so that they operate as a single support structure for their member commissioners, providers and professionals. The fully streamlined model will require AHSNs to

have the desire and capability to take on the responsibilities of supporting hosted Clinical Networks in their region.

115. The above recommendations relating to the system's improvement architecture are made with a view to:

   a) Retaining the skills needed to support the Five Year Forward View and to deliver continuous quality improvement locally;

   b) Minimising both the risk of losing staff with the expertise and skills needed to deliver future arrangements, as well as the resultant redundancy cost;

   c) Ensuring that the right connections are established between the national team;

   d) Ensuring value for money and return on investment; and

   e) Recognising that Monitor and the TDA will continue to support providers and local health economies through their long-term capability building and service intervention work, using the resources available internally and externally, such as the NHS Interim Management Support service (IMAS).

Leadership Development

116. Concerning recommendations specific relation to leadership development, the intention is to establish a self-sustaining operating model, where organisations and systems build their own capabilities but are held to account for progress. The Review's recommendations on leadership development are as follows:

   a. **Recommendation 12:** The partnership between the NHS Leadership Academy and HEE should be explicitly changed and strengthened, recognising the system leadership and convening role that HEE plays in relation to education and training across the health system. In addition, it is recommended that HEE chair the new national leadership Governing Board. The revised partnership should be based on the following principles:

      i. Each of the two organisations has distinct but related roles in management and leadership development. However, there needs to be greater integration and collaboration between them to ensure that the development of leaders, managers and improvement capability is co-created and also integrated as far as possible into the development of professional skills;
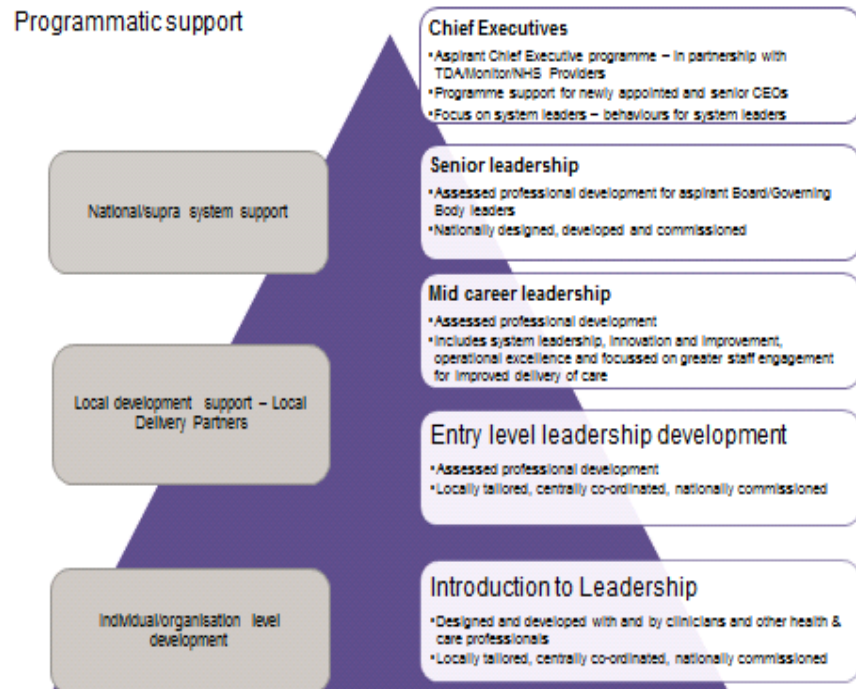
ii. Some activity should move from the NHS Leadership Academy to HEE, where it fits better with HEE's core education role (for examples the Nursing and Midwifery programmes). The graduate management training schemes will remain with the Leadership Academy;

iii. The Leadership Academy should continue to commission the core professional leadership development programmes as part of its role. . The Review concluded that moving responsibility for such programmes would seriously undermine the ability of the NHS Leadership Academy to carry out its core role, and is unnecessary; and

iv. Both organisations should commit to co-creating management and leadership and improvement interventions across their respective curricula.

b. **Recommendation 13:** Building on its success, the NHS Leadership Academy's work and funding should be refocused to include the following:

i. Defining great leadership, including the on-going collation of related evidence through research into and development of the leadership model;

i. Developing a nationally co-ordinated talent management programme to ensure effective succession planning for the most senior roles across the health system which could include c. the top 200 posts. This programme should be relatively small and focused and the detail of the numbers involved will be determined through the implementation stage of the Review. A number of these senior roles are at risk of not being filled in the future if the right talent is not identified and developed. This work presents a step change in focus for the Leadership Academy. This work represents a marked change in focus for the Leadership Academy, which will involve a revision of the existing 'Top Leaders' programme.

In addition to this national programme, the Review expects that the talent management of the next cohort of leaders below this level should be one of the priorities for local arrangements. Every organisation should develop a leadership development strategy, to include talent management, supported by a development plan with clear milestones for delivery;

ii.   Developing senior leaders through the commissioning of leadership development and improvement programmes. (ref. Recommendation 9). These would be tailored to local needs, co-ordinated centrally, and commissioned nationally to ensure that quality programmes are consistently delivered across England. These multi-professional programmes should cover leadership from entry level through to system leaders. They will include a focus on system leadership, innovation and improvement, operational excellence and patient and staff communications and engagement for improved delivery of care. Particular priorities for leadership development identified by providers also include resilience and how to lead turnaround within distressed organisations;

iii.   Supporting system reform through a shift in emphasis to systems leadership, rather than focusing only on individual leaders, to achieve the ambitions of the 5YFV across the health and care system. To support the development of leaders who are capable of delivering change across systems, this would include creating leadership development programmes and activities that include multiple leaders from across systems and take a multi-disciplinary approach, e.g. a mix of clinicians and professionals;

iv.   Ensuring that there are appropriate programmes to support the development of leadership at all levels, working closely with HEE (and its LETBs) and LDPs, to ensure that this is based on the needs of the service;

v.   As part of the new arrangements, the Leadership Academy would cease to:

*   Focus on delivery work; and

*   Commission or deliver programmes for particular health professions, e.g. the Nursing and Midwifery programme.

vi.   The proposed arrangements are reflected in the following diagram:

Programmatic support

Chief Executives
- Aspirant Chief Executive programme – in partnership with TDA/Monitor/NHS Providers
- Programme support for newly appointed and senior CEOs
- Focus on system leaders – behaviours for system leaders

Senior leadership
- Assessed professional development for aspirant Board/Governing Body leaders
- Nationally designed, developed and commissioned

Mid career leadership
- Assessed professional development
- Includes system leadership, innovation and improvement, operational excellence and focussed on greater staff engagement for improved delivery of care

Entry level leadership development
- Assessed professional development
- Locally tailored, centrally co-ordinated, nationally commissioned

Introduction to Leadership
- Designed and developed with and by clinicians and other health & care professionals
- Locally tailored, centrally co-ordinated, nationally commissioned

National/supra system support

Local development support – Local Delivery Partners

Individual/organisation level development

c. **Recommendation 14:** To ensure greater congruence with both the 5YFV and local organisations and systems in England, a number of governance changes should be made including:

   i.   The Leadership Academy will be governed by the new national leadership Governing Board (chaired by HEE). The Leadership Academy Chief Executive will account to this Governing Board. A reference group should also be established to ensure that commissioners, providers and other stakeholders are involved in the design of programmes, replacing the Leadership Academy's current Advisory Board; and

   ii. The relationship between the NHS Leadership Academy and the ten existing Local Delivery Partners (LDPs) will be strengthened. The core purpose of the LDPs will be to work closely with local health and care stakeholders to identify, inform, support and deliver national leadership development priorities in a locally meaningful way; and

   iii. Arrangements for the LDPs will need to be reviewed and reformed to address existing variations in performance and strategic alignment.

d. **Recommendation 15:** Alternative financing and business models for the NHS Leadership Academy should be explored, including membership and

subscription models, in order to increase local ownership and to strengthen the Academy's financial resilience. Should changes to the financing and business models be agreed, the Leadership Academy's governance arrangements will need to be reviewed and revised accordingly.

e. **Recommendation 16:** The NHS Leadership Academy's name should be changed to reflect more accurately its refocused role and the pan-system importance of leadership development. The new name should be determined by the new Governing Board during the transition period.

117. The Review's provisional recommendations are intended to address the questions and issues as set out in the Review Terms of Reference (Annex A and B). They represent a significant move towards much better alignment across the health and care system. The arrangements will be refined as the improvement and leadership development architecture matures and other key aspects of the 5YFV move forward. The new national Governing Board's role will also be to test and ensure that the emerging architecture is having the desired impact. Annex C sets out the detailed response to the questions specifically posed in the Review's Terms of Reference and Annexes D and E set out the stakeholder survey results and the themes arising from the other engagement processes

Next steps

This section sets out the overall route map and timetable for change, highlighting the main questions and risks that will need to be addressed by the transition programme.

118. The Review has involved engagement of multiple health and care partners at senior level, reflecting the importance of improvement and leadership development to support the delivery of safe, sustainable services in the here and now and to support the delivery of the 5YFV. It is essential that such engagement should continue into the next phase of the review and, where necessary, should be strengthened as indicated within Annex F. This will ensure that the implementation plan meets the needs of local health and care systems over the next five years and beyond.

119. Following the Steering Group's approval, the report and recommendations will need to be available to any incoming Administration for their consideration.

120. Stage 2 of the Review will need to start immediately, not withstanding para 119, to avoid the loss of momentum with the establishment of an implementation project team. Next steps will include a pre-transition phase from April to June 2015. This phase will include further work with national partners and local stakeholders on the detailed design of the recommendations and the indicative funding required for the operation of the new architecture, which needs to take place before the suggested changes can be implemented. This work will need to include discussions with each of the 15 AHSNs about their readiness and willingness to act as the lead organisation to drive local improvement development.

121. Activities in the pre-transition phase will include the development of implementation plans which will ensure, inter alia, that we retain essential expertise and skills, minimise potential redundancy costs, secure a minimum saving of both 15% across the improvement architecture, and £2m from the Academy, and continue to support delivery of the Five Year Forward View.

122. During the pre-transition phase a number of risks will need to be managed as follows:

   a) The proposed model is based on shifting from an emphasis on national processes and arrangements to an expectation of far greater local ownership, leadership and delivery, albeit within defined national frameworks and priorities;

   b) The proposed changes will inevitably result in some disruption with a potential impact on delivery and progress in the short term;

c) The proposed changes may result in some loss from the system of scarce expertise, capability and resources. There will also be a transition cost associated with the proposed changes;

d) There may be a loss of confidence in the current bodies as the changes take effect in the short term;

e) As NHS IQ undergoes transition, key skills may be lost and this could have an impact on the capability and capacity needed to maintain business as usual to support transition and for the new improvement architecture; and

f) The recommendations from stage 1 and the detailed design of the future improvement and leadership development architecture may be short lived as the needs of the health and care system evolve. There is a need to future proof the architecture to enable change to take place as the ambition of the 5YFV becomes reality.

123. The risks need to be mitigated and managed with a robust implementation process that includes:

a) A focus on maintaining and integrating as much capability and resource as possible in the new system, to minimise redundancy costs;

b) Considering during transition to the creation of an immediate training and development programme to skill all staff up to a consistent standard so that each local arrangement has the capability it requires, subject to the identification of the necessary resources;

c) Establishing appropriate change programme governance will be established as soon as possible with the six national bodies represented, using existing resources as far as possible, to oversee the changes. These will not happen immediately on 1 April 2015, but will be implemented over a six-month period;

d) Establish a formal programme of communication and engagement, although the relevant parts of the system are aware of the potential changes;

e) Continue to manage the NHS Leadership Academy and NHS IQ via current arrangements in the meantime; and

f) The Governing Boards will need to frequently asses the systems changing needs to ensure that the architecture developed continues to meet the needs of national and local priorities

124. The pre-transition phase will be followed by implementation of the changes through the second half of 2015 and into 2016. This will include:

a) The establishment of the national Governing Board made up of the six ALBs;

b) The development of the single national strategy on improvement and leadership development;

c) The commissioning of the organisation or organisations to host the proposed one stop-shop for shared improvement resources for all the AHSNs to support   local commissioners and providers. Through transition, the identified host will contribute to the thinking on the proposed improvement architecture changes at the local level and work with leads in each of the 15 AHSN geographies to establish their new responsibilities;

d) Commissioning of the 15 lead organisations (AHSNs) for local improvement; and

e) The NHS Leadership Academy working with national partners and their ten Local Delivery Partners to implement the suggested changes for leadership development.

125. Successful implementation will require the ongoing commitment and involvement of all partners at national and local levels. A continuation of the established Review Steering Group is recommended to provide senior multi-agency oversight and assurance relating to the implementation of recommendations. It would be prudent at this stage to undertake a review of the Steering Group's focus and remit, and of its current membership.

126. This reconstituted Steering Group would initially act as the shadow Governing Board for improvement and leadership development until the new governance arrangements are in place.

127. An Implementation Lead should be appointed to coordinate implementation, reporting to the Steering Group.

128. A project group, directed by the Implementation Lead should be set up to work on the pre-transition programme. This group should include senior representatives from the six ALBs involved in the design of the new architecture and include advisors with specialist knowledge on improvement and leadership development.

129. Work is required now to support business as usual for those organisations and programmes that will continue, as well as ensuring HR issues are understood and mitigated.

Annexes

Annex	Description
A	Terms of Reference – NHS IQ and NHS Leadership Academy Review
B	Terms of Reference – AHSN, SCM and Clinical Senate Review
C	Detailed response to questions specifically posed in the Review's Terms of Reference
D	Membership of the Review Reference Group
E	Summary of the structured survey responses
F	Summary themes from stakeholder views expressed through the engagement activities.
G	Review findings and recommendations for SCNs, Clinical Senates and AHSNs
H	Financial summary of all the bodies under the scope of the Review

Annex A

Terms of Reference

for the Health & Care System

Review of Improvement and Leadership Development Capability

Table of Contents

1 Purpose

This document sets out an outline scope and Terms of Reference for a Review of the NHS Leadership Academy (the Academy) and NHS Improving Quality (NHS IQ).

2 Background and Context

The Leadership Academy was established on 1 April 2012 to provide leadership development for the NHS.

The NHSIQ was established in April 2013, formed at the time of the implementation of the NHS reforms, from a combination of other organisations with improvement and change roles in the NHS.

Both organisations are hosted and funded through NHS England, though they provide support to the wider NHS. The Academy's funding has been effectively hypothecated for system-wide activity in relation to leadership, and was originally set up with funding from NHS National Leadership Council, NHS Institute and SHA MPET funds used on leadership development.

Both organisations have a key role to play in helping the NHS to improve.

The context for this review is that it is now one year since the reforms. The system is settling into its new role, and it is time to review how well these hosted organisations are working and delivering what was required of them. NHS England has also been reviewing and clarifying its role, as leader of the commissioning system, and considering how we ensure these two organisations are working effectively and delivering expected outcomes for the wider healthcare system.

In addition, NHS England published a Five Year Forward View, which set out proposals for how the NHS needs to transform if it is to continue to develop and be financially sustainable.   In that context, it is critical that we ensure these two bodies are each aligned with and focused on the best way to support the necessary leadership and transformation interventions, and that we collectively get good value from money from their resources

We have also initiated a review of AHSNs, clinical senates, and networks. The review will consider how this "improvement infrastructure" operates, supports and interacts with the NHS system, and how effectively they drive and support a common and effective improvement agenda across the NHS and Health and care system. The two reviews will be fully aligned to meet the aims of the Five Year Forward View.

3 Scope and Purpose of the Review

While the Academy and NHS IQ are different organisations, there are some major and common questions the review should address for both organisations, as follows.

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Status: Final	Next Review Date:	Page 3 of 8

- Given the requirements set out in the NHS Five Year Forward View published in Oct 2014, how can we best use the capability and capacity in IQ and the Academy to support the necessary transformation?

- What is the most appropriate and effective role for a single national body for each of leadership and improvement?

- How should the necessary interventions for leadership development be determined?

- Is each of the current organisations established and focused adequately to deliver the right interventions effectively for the system?

- How best to assess impact of the organisations in terms of outcomes by producing evidence and fact based data to identify current and alternative models of good practice?

- What scope do the organisations have for supporting major transformational change in the system, and what if anything would need to change to enable that to happen more effectively?

- How should the organisations be hosted, funded and governed to deliver their core purpose most effectively?

In addition, given their different roles, the review will also need to consider some specific requirements for each organisation, which are set out below;

3.1   Specific to the Academy

- How we ensure leadership development and talent management across the system are appropriately managed and supported, and defining the role the Academy can play in that.

- Considering the most effective areas of leadership development to be managed, coordinated or funded centrally – and which should be for regional or other level providers to manage, and how to ensure all providers manage leadership effectively.

- The review needs to take account of

  o Stuart Rose's review of Leadership in the NHS, which is due to be published in late December

  o the outcomes of Robert Francis's "Freedom to speak up" review of whistle blowing

        o the Minister's responses to their conclusions, given DH's policy leadership role.

3.2   Specific to NHS IQ

The review needs to take account of

- the discussion already held with stakeholders about the role of an improvement body and consider its implications for the role of NHS IQ.

- the related review of wider improvement architecture -i.e. AHSNs, senates and networks, and consider NHS IQ's role and functions.

3.3   Specific Content for the Review

The review will need to

- Consider implications of the Five Year Forward View, and consider what role national bodies such as the Academy and NHS IQ could have to play in helping facilitate the transformation work across the system.

- Understand the scope and reach of current Academy programmes and NHS IQ improvement programmes, how these have been commissioned, and how they align with and support strategic priorities of the system

- Engage with a wide range of stakeholders, and customers of NHS IQ and the Academy services, to understand views about current arrangements.

- Consider whether the current "improvement architecture" is delivering effectively against its original purpose, which was
  - o Driving continuous quality and improvement within NHS
  - o To support the transformational change and outcomes Leadership development
  - o Innovation and wealth creation agenda
  - o Clinical leadership to provide cover for major service transformation

  including an evaluation of customers' assessment of the value and success of the interventions, and whether that is what is needed in the future,

- Consider alternative options for delivering those needs by other public and private sector providers, with a view to concluding what can only or best be done by such national bodies?

- Make recommendations about future organisational arrangements, immediate stepping stones, and approach for taking forward, including resources, funding models and governance arrangements.

4 Governance and decision making

Decision making will need to involve DH, who own policy, and national stakeholder organisations.

- NHS England, as host of the organisations, has appointed Ed Smith, Vice Chair of NHS England, to lead the review.

- He will chair a Steering group formed from the key national bodies with a shared interest in the system, including NHS England, DH, NHS TDA, Monitor, HEE, and PHE.

- Karen Wheeler is the NHS England Executive Director responsible for the review. She is also sponsor of the Academy and NHS IQ

- NHS England is also appointing an independent reviewer to carry out the review work on behalf of Ed Smith and under the oversight of the Steering group.

- The steering group will also involve and connect with other relevant governance forums, including the Strategic Advisory Boards of NHS IQ and the Academy.

- The steering group will also oversee the review of AHSN's, Clinical Senates, and Networks to ensure consistent direction and recommendations.

- The steering group will make recommendations to NHS England Board. Any recommendations and decisions which materially affect the system, or funding for leadership activities, will need to be approved by Ministers.

5 Timing

- The review will start from November, and complete by March 2015. This should enable it to pick up and address both the work of the Five Year Forward View and responses to the Stuart Rose review of Leadership, and the Robert Francis review of whistle blowing.
- The AHSN's, Senates and Networks review is currently scheduled to complete in December 2014. We will aim to ensure alignment of recommendations between the two reviews.
- Staff Impacts. We need to provide as much clarity for staff as soon as possible to enable staff who are potentially impacted by the reviews to access redeployment opportunities. Therefore, in both reviews we will aim to provide early findings and recommendations in relation to staff in the respective organisations.

The Steering Group members, at their first meeting on 12 November 2014, agreed the terms of reference, and also contributed additional points of emphasis which are summarised below:

The review needs to

a) Ensure the Leadership and Improvement architecture **works across NHS and wider health system**, and exemplify how the system will work together.

b) ensure the architecture is aligned with and **supports delivery of 5 year forward view**

c) test whether the current arrangements, and ensure future arrangements, deliver **impact and value for money** from investment

d) describe the landscape, address how **relationships work between national system and local delivery systems**, both in infrastructure and clinical settings, and provide a framework to **help local system leaders navigate** and access the support they need; consider role of transformational place – based leadership

e) Cover **The academy and IQ PLUS AHSNs, Senates and networks**, and simplify and clarify their respective purpose.

f) identify what is the **intention for leadership in the system**, what's the best structure and process for delivering that intention. The leadership offer should be flexible and support CCG's and commissioners, as well as providers

g) ensure the new arrangements reflect **effective ways of working** based on porous boundaries between organisations, focus on behaviour vs regulation, right incentives for collaboration between organisations, a system which is not too tight, trust in colleagues

h) ensure the system can carry on for **10 years**.

i) link to and **build on other reviews,** including the Stuart Rose review, the Dalton Review, the RCGP Enquiry into care and the Urgent and Emergency Care review.
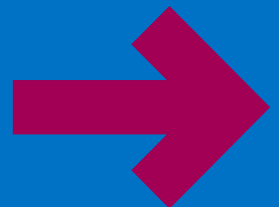
NHS England

SCNs, AHSNs and Clinical Senates Review

Information Pack

October 2014

Contents

Background

- NHS England currently invests circa £100m p.a. in infrastructure at a sub-regional level which is designed to support improvement and change in the health system. Whilst this architecture is funded by NHS England, it provides support at three levels: to NHS England, to commissioners; and to the wider health system. The architecture includes:
    - four Strategic Clinical Networks (SCNs), operating in 12 geographic areas;
    - 12 Clinical Senates; and
    - 15 Academic Health Science Networks (AHSNs).

- This infrastructure plays a vital role in supporting the NHS to be a self-improving system, to harness the best practice and innovation available to improve patient care, and to maximise the NHS 's contribution to economic growth. However, the origins of the different elements are varied, and one year into its existence, there is a need to reflect and take stock of how it is operating, and how the NHS can get best value from this resource.

- NHS England is therefore reviewing this improvement architecture as part of the wider development of an operating model for NHS England, underneath the Organisational Alignment and Capability (OAC) Programme.

- The OAC Programme overall aims to:
    - ensure the organisation is clearer and focused on its core purpose and priority objectives
    - build new capabilities for the organisation, which are critical for it to carry out its role as a commissioning organisation; and
    - streamline and align the functions and structures which support the organisation to work more effectively across the national support centre, regions and area teams to minimise duplication and make more effective use of our resources.

Background

- In this context, the review will be examining the improvement architecture funded by NHS England, understanding what functions are needed in the system and how these can best by provided in the future. The SRO will be Karen Wheeler, on behalf of the Leadership Team.

- There will be a review of NHSIQ and the Leadership Academy, delivered by a separate process and that review will have a Strategic Steering Group.

- This review of Strategic Clinical Networks, Academic Health Science Networks and Senates will deliver early findings, to inform the review of NHSIQ and Leadership Academy, and will be overseen by the same Strategic Steering Group

- The review will also seek to understand and clarify potential staff implications to align with the OAC Programme timetable

Terms of Reference

- To review the purpose, scope and alignment of Strategic Clinical Networks, Academic Health Science Networks and Senates, funded by NHS England, to identify where there is confusion, complexity or duplication of function, with a view to ensuring best value for the resources invested.

- To provide early findings to the Strategic Steering Group in December, with input from key stakeholders and other arms length bodies, and to understand and clarify potential staff implications

- To inform and align with the review of NHSIQ and the NHS Leadership Academy, with a view to informing the NHS England programme budget and business plan decisions for 2015/16.

Governance

The SRO for this review is Karen Wheeler on behalf of the Leadership Team. It will be guided by a Operational Steering Group, comprised of:

- Commissioning Operations Directorate: Richard Barker (Chair), David Levy, Nigel Acheson, Damian Riley, Andy Mitchell, Wendy Saviour

- Medical Directorate: John Stewart

- Nursing: Hilary Garratt

- Finance: Sam Higginson

- Patients and Information: Giles Wilmore

- NHSIQ: Steve Fairman

- Commissioning Strategy: Michael Macdonnell

The review will be conducted by a working group with resource from the National Support Centre and each regional clinical team: David Levy; Nigel Acheson, Lauren Hughes; Simon Bennett; Genevieve Dalton; Jane Dunning; Pat Hayes; and Lucy Grothier.

Governance

Operational Steering Group

Strategic Steering Group
(including NHSIQ, NHS LA Review)

Working Group
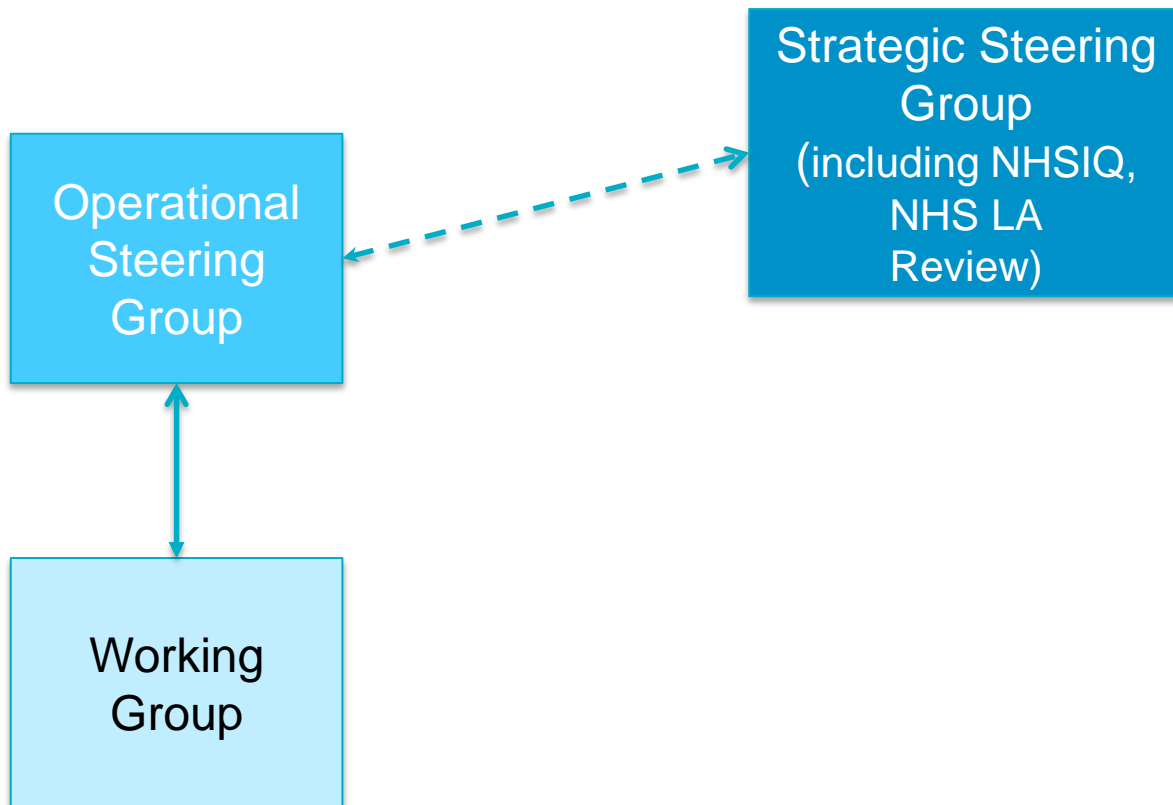
Key questions for the review

The review will consider what improvement support is needed by a) NHS England, b) commissioners and c) the wider system. It will seek to answer a set of key questions:

A. What purpose were SCNs / Senates / AHSNs originally designed to fulfil (for NHS England, for commissioners and for the wider system)?

B. What benefits are they providing **currently**?

C. What functions are needed in **future** to support a self-improving system and the delivery of transformational change, particularly in light of the priorities that will be identified through the 5 Year Forward View?

D. How should the architecture by arranged to provide these functions, to ensure maximum value for the £100m investment?

These questions will need to be considered in the context of wider improvement and collaborative roles and organisations in the health system such as Operational Delivery Networks, the National Clinical Directors, Commissioning Support Units, NHS Improving Quality, NHS RightCare, the NHS Leadership Academy, Intensive Support Teams and others.

Phases and timing

1 — Mid – end September 2014
Desk based work to gather and map information
Prepare for phase 2

2 — Early – end October 2014
Engagement with stakeholders to test and build on information gathered in phase 1

3 — Early – mid November 2014
Development of early findings for the Strategic Steering Group
Understanding and clarifying staff implications

4 — November – December 2014
Testing options with stakeholders and informing / aligning with the review of NHSIQ and NHS Leadership Academy

Key stakeholders

There are a range of key stakeholders which the review will seek to engage with and gather and test views, these include:

- Leaders, staff and members of AHSNs, SCNs and Clinical Senates
- Networks working with and as part of the above
- NHS England directorates with an interest
- National Clinical Directors
- CCGs, Providers
- Department of Health
- Other arm's length bodies, particularly CQC, Monitor, and NHS TDA

Dependencies

There are various fixed and moving points which this review will need to take account of including:

- **Forward view** – the Five Year Forward View is being developed for publication in mid-October. Its content will impact on the Early Findings which the review will develop for the future improvement architecture

- **Running costs reductions** – the 15% running cost reductions which are being made across NHS England will apply to the admin funded elements of SCNs and Senates. How these are taken account will <u>not</u> be within scope of this review, but this review will need to take account of the shape of the structures once the running costs have been reduced

- **Developing a new Operating Model for NHS England** – this review is one component of wider work to develop a coherent operating model for NHS England. This review will need to take place in the context of and respond to other elements of the operating model as they develop.

- **AHSN Licence** – AHSNs were created in 2013 and were given a five year licence from NHS England which is contractual. A contract is signed on an annual basis between NHS England and each AHSN to reflect their priorities for the coming year and their funding allocation.

Annex C

Summary of findings against key requirements as set out in the TOR of the review
Requirements of the review
Engage with a wide range of stakeholders and customers of NHS IQ and the NHS LA services to understand views about current arrangements
The approach to review involved a stakeholder survey with over 800 responses received about NHS IQ and the NHS Leadership Academy. In addition 200 individuals/ organisations / networks responded regarding NHS IQ and the Leadership Academy and 290 responded regarding the AHSN, SCN and Clinical Networks part of the Review. 17 engagement events have taken place involving representations from AHSNs, Strategic Clinical Networks, Clinical Senates, Medical/nursing professionals HR/OD specialists, patient and public involvement representatives, programme leads, Chief Executives, membership bodies, regulators, aspiring leaders, Healthwatch and customers of NHS IQ and the Leadership Academy services. A good balance of geographical spread has been achieved across England and views expressed during engagement events have been collated and are summarised in annex F.
Consider whether the current "improvement architecture" is delivering effectively against its original purpose, including an evaluation of customers' assessment of the value and success of the interventions
This was covered through the survey, the dedicated inbox and engagement events. In summary the NHS Leadership Academy was better understood and NHS IQ, AHSNs, SCNs and senates less so. For AHSNs, Senates and SCNs respondents recognised it was early days and progress was being made and although there was variation across the system there are examples where there is good alignment and benefits of this are experienced. Although NHS IQ has delivered against what it was commissioned to do, it has not delivered what respondents say is needed: many respondents were therefore also unaware of NHS IQ. In relation to customers of NHS IQ and the NHS Leadership Academy, the majority were positive about their experiences: customers of the NHS Leadership Academy were in the main more satisfied than customers of NHS IQ.
Make recommendations about future organisational arrangements, immediate stepping stones, and approach for taking forward, including resources, funding models and governance arrangements.
The review makes 16 recommendations based on the evidence that has been generated. The recommendations include proposals on governance arrangements and the report also includes information on how current and future resources can best be deployed and governed to support the health and care system. Some immediate steps are needed such as establishing system wide understanding of current improvement and leadership capability. Once this phase of the review is complete there will be a need for an implementation phase where further work will be done to develop the detail around the agreed recommendations and to focus effort on building capability at pace to support the new architecture.

The current situation
Consider how is it best to assess impact of the organisations in terms of outcomes by producing evidence and fact based data to identify current and alternative models of good practice
This review has not involved an in depth evidence based analysis of international and national practice. Instead it has focussed on the wealth of knowledge and understanding and notable practice that already exists in the UK. The review adopted a mixed approach to gathering evidence on impact from more formal means through a standardised stakeholder survey, and less formal opportunities offered by a dedicated email inbox and stakeholder engagement events. An iterative process meant that the review group was able to test new and emergent thinking as the review progressed with stakeholders. Individuals and organisations were invited to contribute evidence which included examples of alternative models in England and elsewhere. All submissions were analysed and the synthesis tested with stakeholders.
Understand the scope and reach of current NHS Leadership Academy programmes and NHS IQ improvement programmes, how these have been commissioned, and how they align with and support strategic priorities of the system
The review gained an understanding of scope and reach through the stakeholder survey, the dedicated email inbox and engagement events as well as through detailed discussions with executive members of NHS England board and the managing directors of the NHS Leadership Academy and NHS IQ.
Consider if each of the current organisations is established and focused adequately to deliver the right interventions effectively for the system
The review has found that all parts of the improvement and leadership development landscape need to refocus to effectively support what is needed for the improve quality across health care and support the ambition of the 5YFV. In the instance of NHS IQ a more transformative approach is needed to ensure the resources are available to the system where they are most needed. The recommendation is for NHS IQ to cease to exist in its current form. Refocussing and improving alignment are recommended for AHSNs SCNs and the NHS Leadership Academy and in addition changes to the role of the NHS LA have also been recommended so it can best support the 5YFV.
Understand the scope the organisations have for supporting major transformational change in the system, and what if anything would need to change to enable that to happen more effectively?
The review has found that not enough is known about the current position in this regard and so recommends that work is started soon to build a picture of what is in place now, identify the gaps against what is needed locally and nationally and address this gap as a priority. This will be addressed through a single improvement and leadership development strategy that brings together national and local perspectives.
Future State
The whole system
Given the requirements set out in the NHS Five Year Forward View published in Oct 2014, how can we best use the capability and capacity in NHS IQ and the NHS Leadership Academy to support the necessary transformation?

- Leadership development and improvement are necessary to support the changes required to reduce existing clinical variation and the 5YFV;
- The requirements of the 5YFV include understanding the new context in which leaders find themselves and they will need new skills to support them working as part of high performing collaborative systems;
- Leadership development and improvement capability is the responsibility of all organisations and the leadership development and improvement architecture is there to provide the support, training and expertise to help organisations meet this principle;
- Resources to support the system level work need to sit close to local systems;
- A single national strategy for both improvement and leadership development (including talent management) will be created for the health and care system, aligned to delivery of the 5YFV;
- Every NHS organisation should develop an improvement, leadership development and talent management strategy that will inform the single national strategy aligned to their priorities and the delivery of the 5YFV;
- Governance of the new arrangements should be alignment to the governance being established for the 5YFV.

Consider the effectiveness of the NHS Leadership Academy and NHS IQ in delivering what is needed now and into the future, including an evaluation of customers' assessment of the value and success of the interventions

A large number of views have been received throughout this review (survey, dedicated email in box and engagement events). There were differences in the views expressed about NHS IQ and the NHS Leadership Academy.

The NHS Leadership Academy was valued, its purpose was understood and the programmes were strongly valued by those who experience them. It was recognised that it is too early to assess the benefits of the new programmes. A stronger focus was needed on:
- System leadership, supporting health and care, commissioners and providers;
- 'Within' organisation leadership development;
- Greater attention to talent management is needed with a strong focus on diversity; and
- A national body is needed and Local Delivery Partners need to be more closely aligned to the national body.

NHS IQ was less well understood it was described as too distant and did not meet the needs of respondents. When people had worked with NHS IQ the experience was good. The current focus of NHS IQ was not felt to support the 5YFV and it was recognised that service improvement and transformational leadership capability is important to deliver the 5YFV. A greater focus was needed on:
- A simplified easy to navigate architecture;
- Expertise sitting close to where change was happening;
- Prioritising available resources to meet **both** local priorities and the 5YFV;
- Building capability at pace and scale;
- Limiting national functions to strategic roles;
- The share and spread of learning; and
- Supporting networking and signposting.

How should the organisations be hosted, funded and governed to deliver their core purpose most effectively?

Recommendations support the following:

- The new arrangements for improvement and leadership development should be governed collectively by the six national organisations (NHS England, NHS TDA, Monitor, HEE, Public Health England (PHE) and the Care Quality Commission (CQC). This will form a national Governing Board;
- The new system should be streamlined and where appropriate, use structures that exists already: duplication should be avoided;
- Central resources will be maximised to support health and care systems; and
- In the future membership models should be considered to support sustainability.

How best to assess impact of the organisations in terms of outcomes by producing evidence and fact based data to identify current and alternative models of good practice?

The review has highlighted the importance of evaluation and outcomes and being clear at the outset what success will look like. Before this an improved understanding of the current baseline and variation across England is needed.

In the future measures of success will emerge from the organisational, system level and national leadership development and improvement strategies.

The leadership architecture

How should the necessary interventions for leadership development be determined?

The review recommends that:
- Leadership development is refocused and aligned to the needs of the 5YFV. This is likely to mean a stronger focus on system leadership and within organisation leadership development;
- Healthcare organisations develop their leadership development strategy which in turn will play into a system level strategy;
- A national strategy will take account of these strategies and ensure alignment with national priorities of the 5YFV; and
- The NHS Leadership Academy will commission leadership development to meet the needs identified in the system level and national strategies.

What is the most appropriate and effective role for a single national body for leadership

The review recommends that a national leadership development body should do the following :
- 'Within organisation and system' leadership development;
- The development of existing and future leaders (clinical and managerial) who can operate effectively across health and care systems and organisational boundaries;
- Active succession planning and building a structured talent management system within and across the commissioner and provider leadership communities;
- Focus on coordination of the national elements of leadership development, namely:
  - Senior talent management
  - The development of standards and frameworks
  - The commissioning of national programmes and resources,
  - The commissioning and standard setting for improvement capability development and building capacity for local development

o Strategic alignment • Address the variation in performance and strategic alignment of Local Delivery Partners.

The review needs to take account of: • **Stuart Rose's review of Leadership in the NHS, which is due to be published in late November;** • **the outcomes of Robert Francis's "Freedom to speak up" review of whistle blowing; and** • **the Minister's responses to their conclusions, given DH's policy leadership role.**

The **Rose Review** of NHS Leadership has yet to be published, however, in so far as we understand, the emerging high-level findings from both the Rose Review and this Review are broadly aligned. Throughout this review we have heard from stakeholders about the importance of leadership in setting the right culture where **"freedom to speak up"** becomes a reality. Leadership development, underpinned by the right values and behaviours, setting the right culture and supporting organisations become learning organisations are all key recommendations in "Freedom to speak up" and are supported by the recommendations in this review.

The improvement architecture
The review needs to take account of the discussion already held with stakeholders about the role of an improvement body and the review of the wider improvement architecture (AHSNs, senates and networks) and consider the implications for the role of NHS IQ.

The findings of the review support that improvement expertise is needed to support unnecessary variation in healthcare and the system level transformation described in the 5YFV.
• Improvement expertise and guidance should sit close to where it is needed and only what must be done at a national level should be done at a national level; and
• The new architecture needs to be easy to understand and access: duplication should be minimised.
 	
The implications for **NHS IQ** are that:
• The review recommends NHS IQ ceases to operate;
• The resources available to NHS IQ should be redistributed, with the majority of these resources supporting local improvement and system transformation through:
    o The creation of 15 improvement coalitions (LICs) to coordinate improvement activity, coterminous with the current fifteen AHSNs with the implication that AHSNs will lead their development; and
    o A single resource hub, commissioned by the LICs to provide support across all 15 LICs where it make sense to do so.
• A small national team will be established within NHS England with a clear focus on providing advice on system level transformation; and
• Capability building in service improvement and transformation will be embedded in leadership development and seen as a core capability across the healthcare system. This will move to the NHS Leadership Academy.
 	
Further implications for **AHSNs and SCNs** are that:

- There will be greater alignment between CNs and the improvement elements of AHSN work programmes;
- AHSNs and Strategic Clinical Networks should be streamlined and their business plans aligned, operating as a single support entity for their member commissioners, providers and professionals;
- There should continue to be SCNs in each of the four current priority areas: Cancer, Cardiovascular, Maternity and Children, Neurological conditions. In the future they will be called Clinical Networks; and
- These networks should derive national strategic direction from the relevant National Clinical Directors. Business plans should reflect national priorities.

Clinical Senates should continue, reduced in number and their role is to provide clinical advice rather than to manage improvement activity.

Annex D
Membership of the Review Reference Group

First name	Last name	Title	Organisation
Nigel	Acheson	Regional Medical Director (South)	NHS England
Charles	Alessi	Chief Executive	National Association of Primary Care
Sharon	Allen	Skills For Care	Skills for Care
Eliat	Aram	Chief Executive	The Tavistock Institute
Ann Marie	Archard	Head	Leadership Academy
Deborah	Arnot	Lead	Leadership Development Experts
Suzie	Bailey	Development Director	Monitor
Helen	Bevan	Director	NHS Improving Quality
Nicholas	Bradbury	Head of Systems Leadership	Leadership Academy
Helen	Buckingham	Chief of Staff	Monitor
Adrian	Bull	Managing Director	Imperial Health Partners AHSN
Liz	Butler	Chair	Lewisham and Greenwich NHS Trust
Eden	Charles	Executive Director of People Opportunities	The King's Fund
Neil	Churchill	Clinical Director	NHS England
Sheena	Cumiskey	Chief Executive	Cheshire & Wirral Partnership FT
David	Dalton	Chief Executive	Salford Royal Hospitals
Erika	Denton	Clinical Director	NHS England
Jennifer	Dixon	Chief Executive	Health Foundation
Caroline	Dove	Chief Executive	NHS Elect
Mike	Durkin	Clinical Director	NHS England
Ratna	Dutt	Chief Executive	Equality and Diversity Council England
Nigel	Edwards	Chief Executive	Nuffield Foundation
Steve	Fairman	Managing Director	NHS Improving Quality
Dean	Fathers	Chair	Notts. Healthcare NHS Trust
David	Fillingham	Chief Executive	AQuA
Malte	Gerhold	Director of Policy and Strategy	CQC
Chris	Ham	Chief Executive	King's Fund
Tracy	Hill	Director of HR & OD	5 Boroughs Partnership NHS FT
Chris	Hopson	Chief Executive	NHS Providers
Celia	Ingham-Clark	Clinical Director	NHS England
Sue	James	Chief Executive	Derby Hospitals NHS FT
Bart	Johnson	Chief Executive	Virgin Healthcare
Nikki	Kanai	CCG representative	CCG representative
Jinjer	Kandola	Director of Workforce & OD	Hertfordshire Partnership
Suzanne	Kirwan	Director	NHS Improving Quality
Chris	Lake	Head of Professional Development	Leadership Academy
Peter	Lees	FMLM	FMLM
Moira	Livingston	Clinical Director	NHS Improving Quality
Geoff	Alltimes	Executive Director	LGA (Mike Lockwood leaving on 3 Feb)
Karen	Lynas	Leadership Academy	Leadership Academy
Martin	Marshall	Lead	Improvement Science London
Carolyn	May	Senior Development Advisor	Monitor
Deborah	McKenzie	Director Organisational Development	Public Health England
Martin	McShane	Clinical Director	NHS England
Steven	Michael	Chief Executive	South West Yorkshire Partnership FT
Stephen	Bubb	Chief Executive	ACEVO
Andy	Mitchell	Regional Medical Director	NHS England
Julie	Moore	Chief Executive	University Hospitals Birmingham NHS FT
Tim	Moorhead	Chair	Sheffield CCG
Danny	Mortimer	Chief Executive	NHS Employers
Steven	Ned	Director of HR & OD	Sheffield Children's NHS FT
Rachel	Newson	Chair	LDP
Rachel	Pearce	Managing Director	Arden CSU
David	Pearson	Director of Adult Social Care	ADASS
Katrina	Percy	Chief Executive	Southern Health NHS FT
Maxine	Power	Director of Innovation and Improvement Science	Salford Royal NHS Foundation
Mike	Prentice	Medical Director	NHS England

Annex D
Membership of the Review Reference Group

Mike	Richards	Chief Inspector of Hospitals	CQC
Damian	Riley	Medical Director	NHS England
Damian	Roland	Consultant and Lecturer in Paediatric Emergency Medicine	Inaugral NICE Scholar
Martin	Stephens	Chief Executive	Wessex AHSN
Rick	Stern	Chief Executive	NHS Alliance
Kevin	Stewart	Clinical Director	The Royal College of Physicians
Geraldine	Strathdee	National Clinical Director for Mental Health	NHS England
Suzanne	Tewkesbury	Managing Director	NHS Central Southern Commissioning Support Unit
Heather	Tierney-Moore	Chief Executive	Lancashire Care NHS FT
Rob	Webster	Chief Executive	NHS Confederation
John	Wilderspin	Chief Executive	Central CSU
Keith	Willett	Director for Acute Episodes of Care	NHS England
Andrew	Williams	Chief Executive	HSCIC
Giles	Wilmore	Director for Patient and Public Voice and Information	NHS England
Lynne	Winstanley	Director	NHS Improving Quality
Alan	Wood	President	ADCS

Annex E

Reviewing improvement and leadership development capability across health and care in England: Report 1

Stakeholder Survey Findings
February 2015

Analysis and reporting by:
Research Evaluation Analysis & Measurement Team
Improvement Capability Directorate, NHS Improving Quality
Contact: Grace.sweeney@NHS IQ.nhs.uk

Summary

The survey was open between 7 January and 1 February 2015.

As requested by the review team two reports have been produced. The first analysing data from the original NHS Confederation sample (n = 197) and the second report analysing all data including the first 197 responses (n = 837)

This report details findings of the NHS Confederation sample of 197 responses.

Responses are dominated by NHS Trusts/ Foundation Trusts and NHS England. In addition there is potential regional bias with 25% of responses from South Central

The national support and landscape

Many respondents reiterated the importance of leadership development and support for quality improvement, particularly in challenging times.

However, in terms of both leadership development and quality improvement, a recurring theme was the desire for greater local and regional focus, alongside 'a national steer' in the form of policy, guidance and co-ordination.

Summary (2)

Respondents expressed criticism of the national quality improvement and leadership development landscape and asked for coordination and clarity in terms of the remits and relationships between the national bodies

Engagement with NHS Leadership Academy and NHS Improving Quality

Respondents were asked about their level of engagement with both NHS Leadership Academy (NHS LA) and NHS Improving Quality (NHS IQ). For the purposes of analysis, data was explored according to whether respondents had *'engaged' or 'not engaged'.*

Taking the **NHS LA** first, two thirds of respondents had engaged with the NHS LA, 50% through involvement in a programme or course.

- One third had not engaged; 36% of these (12% of the total sample) reporting that it wasn't relevant and 20% (7% of the total sample) reporting that they were unaware or unclear as to what was on offer.

- Over two thirds (68%) of respondents reported being clear about the aims and purpose of the NHS LA, and this increases to 82% for those who have engaged with the NHS LA.

Summary (3)

- Although the numbers here do not indicate a significant issue, they do highlight potential room for action by the NHS LA moving forwards.

- A key theme arising in the open text responses, was that 'leadership is everyone's business' and that there should be an accessible and inclusive offer to all, including junior staff.

- Several respondents reported a perception that the NHS LA offer was not relevant to junior staff. There may be some work to do by the NHS LA to improve awareness and clarity of offer in some areas.

Moving to the **NHS IQ** data, just over two thirds of respondents had engaged with NHS IQ, largely through involvement with a specific programme or attending/ helping at events.

- Just under one third of respondents had not engaged; 68% of these reporting that they were not aware of NHS IQ and 30% stating that they did not think it was relevant to them.

- A large proportion of respondents reported not understanding the aims and purpose of NHS IQ making it difficult for this group to judge relevance. Responses to open questions strongly confirmed a lack of clarity.

Summary (4)

Knowledge, use and perceptions – NHS LA

- Respondents rated six statements relating to their knowledge, use and perceptions of both organisations. The first four statements reflect on current or previous experience; the last two reflect on future support needs.

- Taking the **NHS LA** first, points of particular interest are:

- More people report having been able to make use of the NHS LA than report the NHS LA has been valuable to them (62% compared to 51%) this jumps to 80% and 71% respectively for the engaged group.

- We can only speculate why this might be the case; it may be simply too early for judgements on value/impact.

- There were a lot of comments around the value or potential value provided by the NHS LA, but also lack of return on investment (ROI) /evaluation to really evidence value.

- There is variation across the board by organisation type, with more ambivalence from commissioners, although the numbers by organisation type are quite small here so any conclusions need to be treated with caution.

Summary (5)

- There is ambivalence (37% of responses are neutral) around whether the NHS LA supports leadership development effectively across the system.

- This decreases to 24% for those who have engaged with the NHS LA; however, for the engaged group, this statement has the most active disagreement at 17% (almost 1/5 of those who have engaged).

- We don't know why this is; it could be about perceived lack of coverage or feeling unable to comment on support outside of their own organisations, rather than the quality of the support provided by the NHS LA. Responses to open questions back up some concerns about accessibility.

- When data was explored according to organisation type, for all statements there was strongest agreement from *'other'* organisations (albeit numbers were small); least agreement and more ambivalence from commissioning organisations; and strongest disagreement from commissioning organisations (expect for the statement *'effectively supports leadership development across health and care'* where the level of disagreement from commissioners was similar to that of respondents from 'other' organisations).

Summary (6)

Knowledge, use and perceptions – NHS IQ

- Moving to **NHS IQ** data, with 40% actively disagreeing with this statement *I understand the purpose and aims of NHS IQ* there is clearly an issue around clarity of the purpose and aims of the organisation. Whilst the picture improves for the engaged group, 30% still did not agree that they understood the purpose and aims of NHS IQ.

- For those who had not engaged with NHS IQ, this level of disagreement jumped to 63%. This theme is strongly supported in the responses to open text questions with 18 messages to the review team, highlighting NHS IQ's unclear offer.

- In terms of whether NHS IQ supports quality improvement effectively across the system, there is a large proportion of neutral responses; 43% of the total sample neither agreed nor disagreed. This was even higher for the group that had not engaged, with 61% neither agreeing nor disagreeing. Even for the group that had engaged, only 39% actively agreed that NHS IQ effectively supports quality improvement across the system.

- Around a quarter of respondents in all groups actively disagreed that NHS IQ effectively supports quality improvement across the system. We don't know why this might be. The ambivalence could reflect an inability to comment at a system level, or a lack of demonstrable value. The sizeable minority that actively disagreed presumably feel that NHS IQ does not support quality improvement across the system, but this may just as easily be a comment about coverage as the value of support needed.

Summary (7)

- There were relatively low levels of agreement with the statements *'our organisation has been able to make use of NHSIQ'* and *'NHSIQ support has been valuable to us'* (35% and 31% respectively at total sample level).

- These findings are driven to some extent by the group that had not engaged disagreeing or being ambivalent towards these statements in relatively large numbers. However, even for the engaged group, only 48% agreed that they had been able to make use of NHSIQ and 42% agreed that NHSIQ support had been valuable. These findings are supported by comments in open text responses, where the value and ROI has been questioned.

- We explored ratings according to organisation type (provider, commissioner or other) and in view of the fact that there were low numbers for 'other' organisations (n=13), the findings need to be treated with caution.

- Across the board there appeared to be slightly higher levels of agreement from commissioners when compared to providers, except for the statement that quality improvement support should be provided nationally where over 50% of all organisations agreed (71% of providers, 62% of commissioners, 54% of others).

Summary (8)

Future support

- One of the themes to emerge from open responses was the importance that respondents placed on leadership development and quality improvement.

- 69% of the total sample agree it's important that leadership development support be provided nationally, this increases to 73% for those who have engaged with the NHS LA, dropping to 61% for those who have not engaged.

- In terms of quality improvement, the highest level of support (64% agreement) was given in relation to the statement *It is important that quality improvement is provided nationally*, with support reflected in messages to the review team where there was a clear theme around the need for regional and local focus with national co-ordination/guidance.

- Respondents were asked to rate four items in terms of their perceived importance (*essential, desirable, or not important*):

  1. Tailored programmes to support local priorities for leadership development/quality improvement
  2. Specific support to achieve Five Year Forward View outcomes improvement
  3. Consistent national approach to leadership development/quality improvement
  4. Support in working more closely with locally based bodies

Summary (9)

- The key findings are that the majority of respondents rate all four items as essential or desirable, so support is probably needed in all four areas.

- Local tailoring was rated as essential by the biggest proportion and is therefore clearly a priority in terms of future support. This is in line with comments made about both the NHS LA and NHS IQ. This is not to say that there is not strong support for a national approach alongside local work; respondents seem to generally want local tailoring within a national framework for consistency and transferability.

- 79% of those who had engaged with the **NHS LA** (63% in the total sample) would like to continue to work with the NHS LA in the future.

- 41% of all respondents would like to work with **NHS IQ** in future. This increases to 50% for the engaged group, but is just 19% for the group that had not engaged for whom levels of ambivalence were greater (57% compared to 32% for the engaged group).

Introduction and methods (1)

- A 20-item questionnaire was emailed to 371 stakeholders organisations (NHS Trusts and Foundation Trusts, Clinical Commissioning Groups, Academic Health Science Networks and Commissioning Support Units) by the NHS Confederation on 7 January 2015. The survey invite was directed at Chief Executive Officers, Medical Directors or accountable officers

- In an attempt to widen the sample, on the 13 January 2015, the Smith Review team send the survey link to a further 195 individuals representing national organisations (e.g. NHS England, Monitor, Public Health England), Royal Colleges and charitable organisations

- On the 26 January 2015, the Smith Review Steering group were invited to cascade the survey link to their stakeholders

- The survey was open between 7 January and 1 February 2015. In that time responses were received from 837 participants; 197 from the original target sample and 640 from wider stakeholders

Introduction and methods (2)

- An interim report, detailing findings from the initial 96 responses received by 13 January 2015 was produced for the Smith Review Steering Group meeting on 19 January 2015.

- The interim report was independently peer reviewed by Professor Ruth McDonald at the Manchester Business School in order to validate our approach to analysis and interpretations of emerging findings.

- As requested by the review team two reports have been produced. The first analysing data from the original NHS Confederation sample (197 responses) and the second report containing analysis of all the data including the first 197 (837 responses in total).
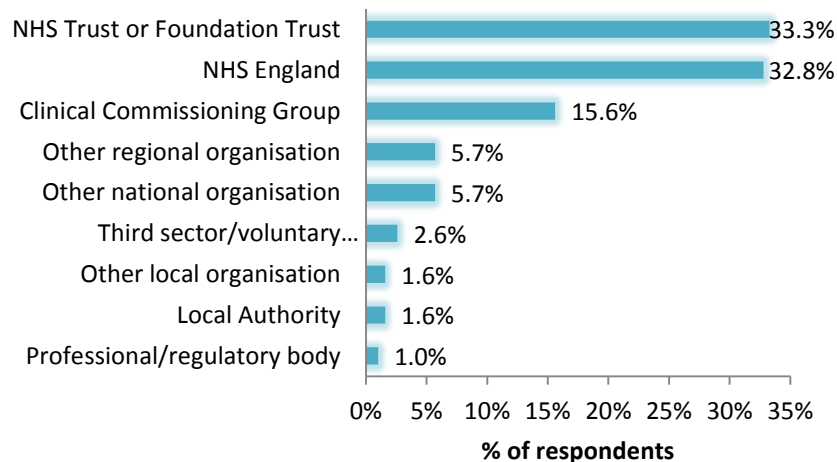
Study Limitations

There are a number of limitations to this survey and it is important to be mindful of these when considering the findings:

- Firstly as a result of using a mixed approach to sampling, it is not possible to calculate the response rate, or to comment on the representativeness of the sample at an individual, organisational, or regional level

- Secondly, as a result of the mixed approach to sampling, it is not possible to trace responses back to an individual so we cannot say with any certainly whether responses represent an organisation's experience or an individual's experience

- Finally, responses are dominated by individual NHS Trusts and NHS England. In addition, there is potential regional bias with 25% of responses from South Central
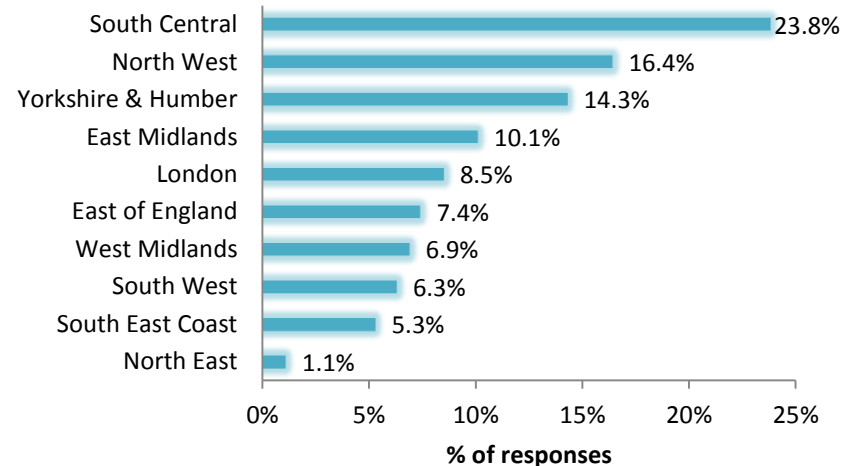
Respondents by region and organisation type

The online survey was sent to 371 stakeholders via NHS Confederation. In total there was 197 responses

Respondents by Organisation

Organisation	% of respondents
NHS Trust or Foundation Trust	33.3%
NHS England	32.8%
Clinical Commissioning Group	15.6%
Other regional organisation	5.7%
Other national organisation	5.7%
Third sector/voluntary…	2.6%
Other local organisation	1.6%
Local Authority	1.6%
Professional/regulatory body	1.0%

% of respondents

Respondents by region

Region	% of responses
South Central	23.8%
North West	16.4%
Yorkshire & Humber	14.3%
East Midlands	10.1%
London	8.5%
East of England	7.4%
West Midlands	6.9%
South West	6.3%
South East Coast	5.3%
North East	1.1%

% of responses

- Greatest representation from South Central (24%) followed by North West (16%) – potential bias from these regions
- Lowest response rate from North East (1.1%)
- A third of responses from NHS Trust or Foundation Trust (33%) while NHS England represent a further third of responses
- Lowest response from professional / regulatory bodies (1.0%) and Local Authorities (1.6%)
- 25% of all NHS England responses are from South Central in line with the proportion of responses from South Central in the total sample.

Section 1:

The NHS Leadership Academy

In the last 18 months, have you engaged with the NHS Leadership Academy?

Yes, 65 %

No, 35 %

Open response to nature of engagement:
- 50% of engaged had taken a course / programme/ training development through participation or had supported staff to do so. (31% of all respondents)
- General engagement (16% of engaged); attending event or masterclass (5% of engaged); developing course, tool and / or content or through coaching, mentoring or assessing (6% of engaged).

Open response to why not:
- 36% stated no requirement or that the offer was not relevant to their position (junior or senior)
- 20% stated that they were unaware or unclear of the offer from NHS Leadership Academy (7% of total sample)
- 6% reported too many other pressures on their time
- 9% said they had no contact or had not been approached by NHS Leadership Academy

78% of those who had engaged with the NHS Leadership Academy had also accessed leadership development support from elsewhere.

47% of those who had not engaged had accessed leadership development support from elsewhere

67% of all respondents have accessed leadership support from elsewhere while 33% have not.
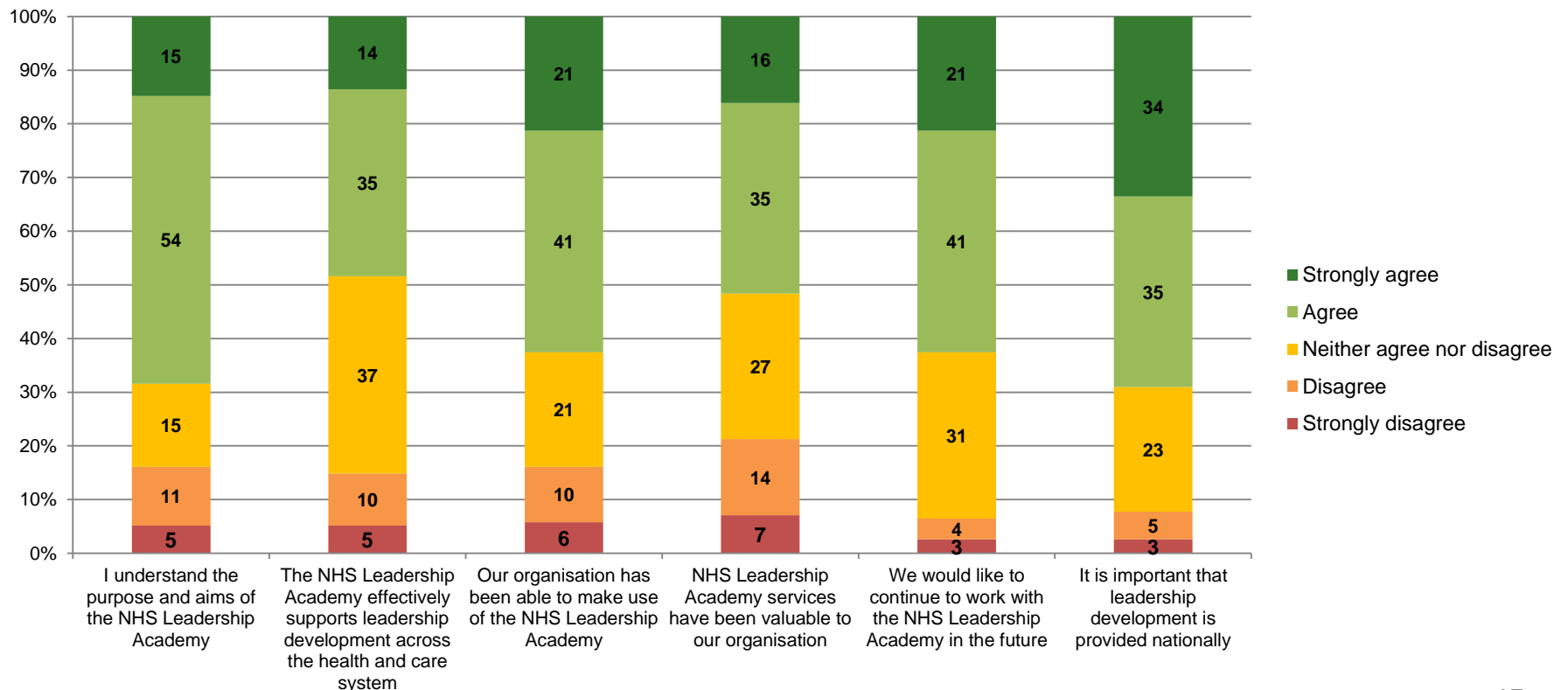
Where they accessed support:
Support from private sector, from independent consultants, coaches and subject experts; Internally or locally developed and bespoke programmes;
Formal training courses and seminars; Informal learning; partnering with other organisations; and specific mentioned organisations e.g. Kings Fund, NHS IQ, Health Foundation, UCL Partners, CSUs, Open University. Themes were similar whether respondents have engaged with LA or not, however, those who have not engaged have a higher proportion of mention of informal learning e.g. through self study, and internal or bespoke programmes.

Q8: Statements about NHS Leadership Academy

- Respondents were asked to state whether they *strongly agreed, agreed, neither agreed or disagreed, disagreed or strongly disagreed* to six statements.

- The first four statements reflect current or previous experience and understanding of the NHS Leadership Academy; the last two are about leadership support in the future.

- 155 respondents completed the question of which 106 (68%) had previously stated they had engaged with the NHS Leadership Academy and 46 (32%) had not.

Collector One Total sample n = 155

Legend:
- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

	I understand the purpose and aims of the NHS Leadership Academy	The NHS Leadership Academy effectively supports leadership development across the health and care system	Our organisation has been able to make use of the NHS Leadership Academy	NHS Leadership Academy services have been valuable to our organisation	We would like to continue to work with the NHS Leadership Academy in the future	It is important that leadership development is provided nationally
Strongly agree	15	14	21	16	21	34
Agree	54	35	41	35	41	35
Neither agree nor disagree	15	37	21	27	31	23
Disagree	11	10	10	14	4	5
Strongly disagree	5	5	6	7	3	3

Overall over two thirds stated total agreement for "*I understand the purpose and aims of the NHS Leadership Academy*" (68%)

✓ For those who had engaged with the NHS Leadership Academy understanding the purpose of the organisation increases to 84%

By removing those who had not engaged with the NHS Leadership Academy the ambivalence is decreased and the level of agreement increased for each of the statements

✓ With the exception of the statement "*The NHS Leadership Academy effectively supports leadership development across the health and care system*" the level of disagreement decreases when those who have not engaged are removed

✓ For this statement there was 16% total disagreement from those who had engaged – the highest level of disagreement from this group

Greatest ambivalence overall was found in response to "*The NHS Leadership Academy effectively supports leadership development across the health and care system*" (37%).

✓ However this is reduced to 23% among those who had engaged with the NHS Leadership Academy and increases to 67% among those who had not.

Of the 155 responses: 73 were from commissioning organisations, 57 from providers and 13 from 'others'.

✓ Commissioning organisations showed the least agreement and greatest ambivalence to all the statements

✓ Strongest agreement from 'other' organisations was consistent for all statements (note numbers are low)

# Q8: The NHS Leadership Academy now…

More people have been able to make use of the NHS Leadership Academy, than report that the NHS Leadership Academy has been of use to them:

✓ Overall 62% agreed / strongly agreed that their *"organisation had been able to make use of the NHS Leadership Academy"*

✓ 49% agreed / strongly agreed that *"NHS Leadership Academy services have been valuable to our organisation".*

✓ The difference remains for those who had engaged with NHS Leadership Academy these numbers increased to 80% (…*organisation has made use of*…) and 71% (…*has been valuable to*…)
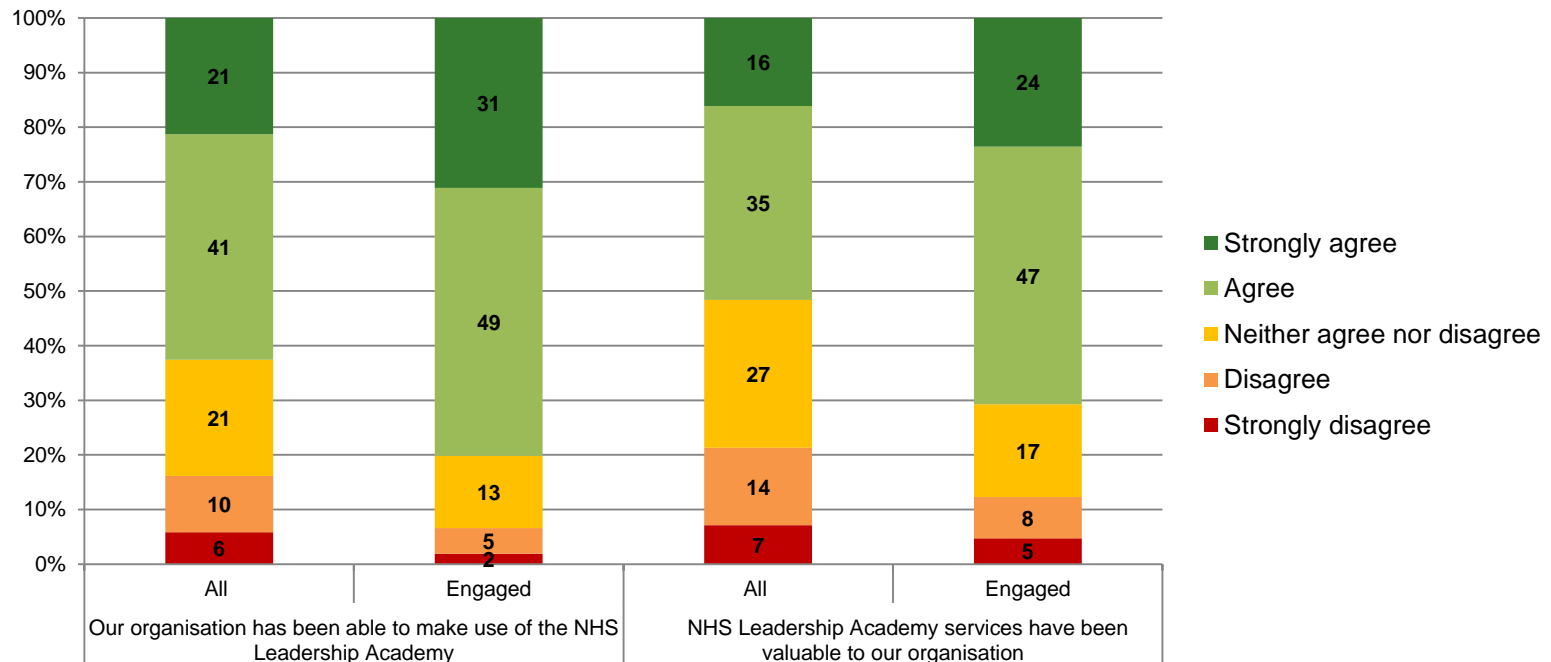
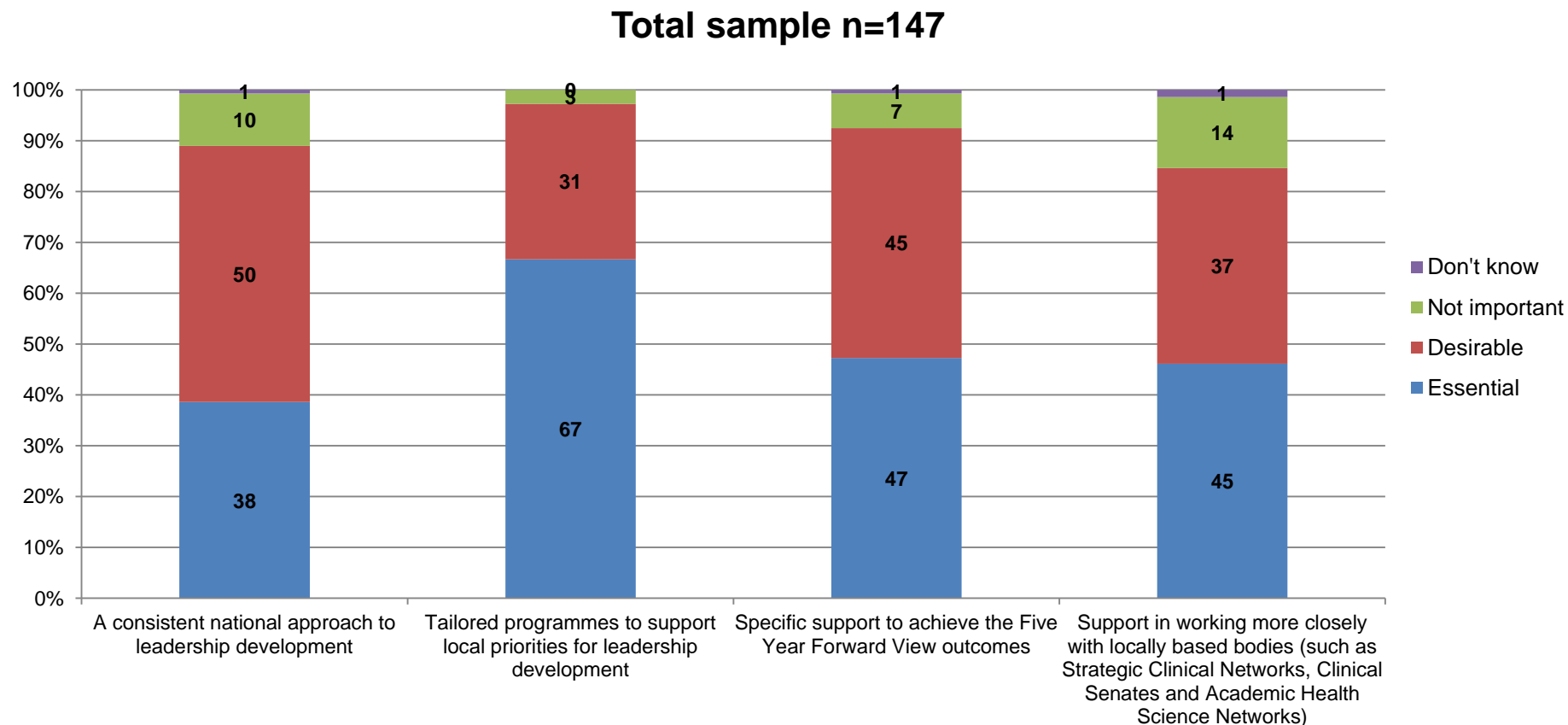# Q8: Leadership development support in future…

- **79% of those who engaged with the NHS Leadership Academy would like to work with them in the future (63% of the total sample)**

- **Overall there was 69% total agreement that leadership development should be provided nationally**
  - ✓ Statement received the lowest level of variation between those who had engaged and those who had not
  - ✓ 73% of those who had engaged with the NHS Leadership Academy
  - ✓ 61% of those who had not engaged
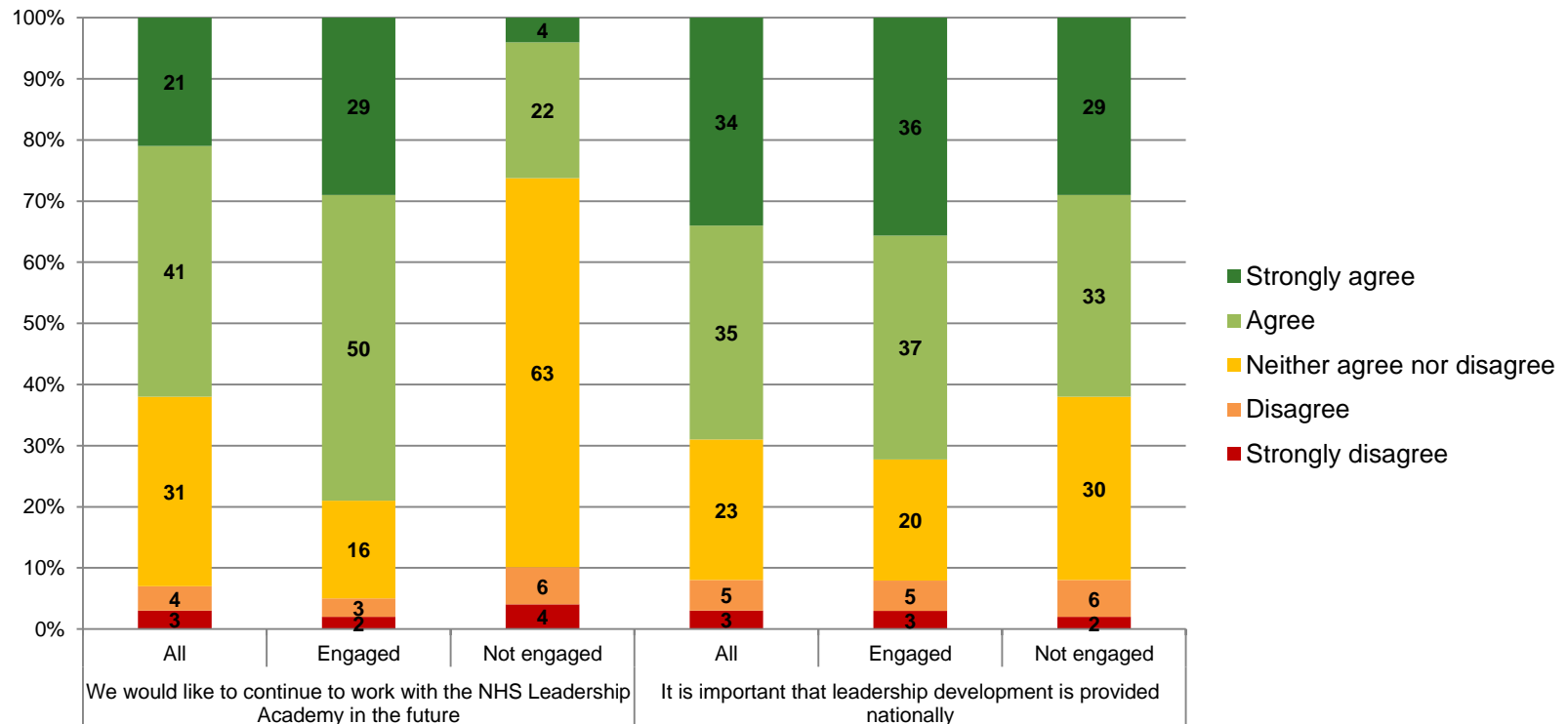
Respondents were asked to rate four statements in terms of *essential, desirable, not important or don't know* in relation to their organisation.

147 respondents completed the question

Total sample n=147

Q9: Leadership development support in the future…

All statements were highly rated from 82% either essential or desirable to 98%

Highest rating overall was for "*Tailored programmes to support local priorities for leadership development*"

- ✓ 67% essential and 31% desirable
- ✓ Only 3% rated this not important

Lowest rating overall was for "*Support in working more closely with locally based bodies*"

- ✓ 45% essential and 37% desirable
- ✓ 14% rated this not important

A consistent national approach was rated the least essential (38% essential, 50% desirable, 10% not important)

- ✓ Less variation between those who have engaged and those who have not compared to question 8 however only 29% of those who have not engaged rated a consistent national approach as essential
- ✓ Of the three organisation types provider organisations rated this the least important (38% essential and 13% not important

113 respondents completed this section
The most frequently mentioned topics/themes include:

- **System Leadership skills and competences** – e.g. whole systems leadership, leading staff to work as part of an integrated system, collaborative leadership, and how to create value across health systems.

- **Clinical leadership and development programmes** - to develop clinicians to lead and shape future services

- **Continual development of leaders and managers** at all levels including strategic board level, other senior managers, and middle managers

- **On going leadership development support** to local and national programmes as well as primary and social care, aligned with national strategic aims and regional requirements.

- **Support for emerging leaders, developing future leaders**, and succession planning, including leadership capability development targeted at high potential individuals

- **Quality Improvement methodology** and leading whole system transformational change, developing more leaders and maintaining those who lead change and transformation.

- **Team development** as opposed to individual development and creating high achieving teams

- **Coaching or mentoring** for staff at all levels

- **Leading in times of uncertainty and austerity** as well as resilience building.

- **Leadership programmes** that are practical, including need for a consistent definition of 'good leadership'.

- **Workforce developmen**t at all levels, as well as distributed leadership.

Messages to the review team…

The NHS Leadership Academy is currently being reviewed by NHS England. What message, if any, would you like to send to the review team about

a) **The NHS Leadership Academy and**
b) **Leadership development in the NHS more broadly?**

There were 112 responses to this question. Key themes to emerge include:

- **Comments on methodology and delivery mode**l- flexible portfolio of options, national leadership development strategy and systems, alignment with national and local priorities
- **Tailored to local priorities**
- **Value delivered** to individuals and organisations by the Leadership Academy
- **The importance of leadership development**, particularly in meeting current challenges, Five Year Forward View etc.
- **The need for improved engagement** by the Leadership Academy- with senior leaders, local organisations/client organisations, other organisations (e.g. LETBs, HEE), the voluntary sector, and with social care leadership and development.
- **The need for accessible and inclusive leadership development support-** including junior staff, diversity.
- **Improve visibility and understanding** of the Leadership Academy and its offer
- **The need for a national framework** to provide consistency and transferability
- **Culture of the wider NHS, and national bodies**, and its (negative) impact on realising the   value promised by leadership development programmes

Section 2:

The NHS Improving Quality

In the last 18 months, have you engaged with the NHS Improving Quality?

Yes, 68 %

No, 32 %

How they engaged:

- 41% of those who had engaged reported involvement with a specific programme (equate to 22% of all respondents)
- 16% stated involvement in events
- Other engagement = partnership working; supporting local initiatives; supporting national initiatives including audits; and general engagement

Why they hadn't engaged:

- 52% of those who said 'no' stated they were not
- aware of NHS Improving Quality or the offer
- (this equates to 13% of all respondents)
- 23% stated NHS IQ was not relevant to them (not clear if as an individual or organisation)
- 10% stated they worked with other organisations or within their own organisation; 8% reported no time

58% of those who had engaged with NHS Improving Quality had also accessed quality improvement support from elsewhere.

80% of those who had not engaged with NHS Improving Quality had accessed quality improvement support from elsewhere

65% of all respondents have accessed quality improvement support from elsewhere while 35% have not
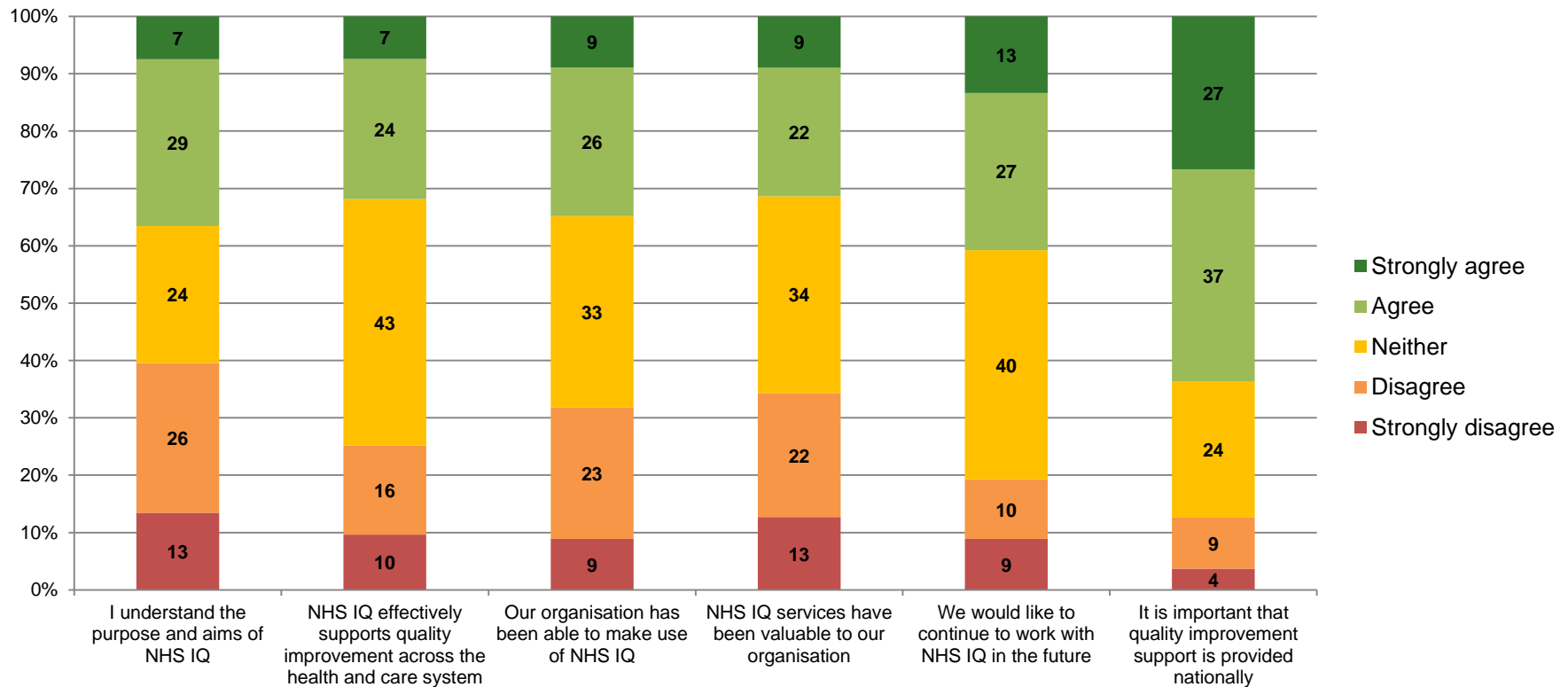
Where they accessed support:

Support from independent consultancies and subject experts; Internal reviews, local audits and benchmarking; Networks and Collaboratives; Internal/In-house developed programmes and support; buddying with other local organisations and specific mentioned organisations e.g. Strategic Clinical Networks ; AQuA; IHI, CSUs, AHSN, Health Foundation, ECIST, Improvement Academy, PwC, Foresight, Newton, Clinical senates, CLAHRC, universities, Virginia Mason Hospital, Nuffield, and Kings Fund. Themes were similar whether respondents have engaged with NHS IQ or not

Respondents were asked to state whether they *strongly agreed, agreed, neither agreed or disagreed, disagreed or strongly disagreed* to six statements. The first four statements reflect current or previous experience and understanding of NHS Improving Quality; the last two are about quality improvement support in the future.

135 respondents completed the question of which 97 (72%) had previously stated they had engaged with NHS Improving Quality and 38 (28%) had not.

Collector One Total sample n = 135

Legend:
- ■ Strongly agree
- ■ Agree
- ■ Neither
- ■ Disagree
- ■ Strongly disagree

Statement	Strongly disagree	Disagree	Neither	Agree	Strongly agree
I understand the purpose and aims of NHS IQ	13	26	24	29	7
NHS IQ effectively supports quality improvement across the health and care system	10	16	43	24	7
Our organisation has been able to make use of NHS IQ	9	23	33	26	9
NHS IQ services have been valuable to our organisation	13	22	34	22	9
We would like to continue to work with NHS IQ in the future	9	10	40	27	13
It is important that quality improvement support is provided nationally	4	9	24	37	27

Q17: NHS Improving Quality now…

There are high levels of ambivalence across all statements

✓ With similar proportions agreeing and disagreeing within each statement

Greatest ambiguity overall was found in response to "NHS Improving Quality effectively supports leadership development across the health and care system" (43% neither agreed nor disagreed).

✓ This is even higher for the group that had not engaged, with 61% neither agreeing nor disagreeing, compared to 36% for the engaged group

✓ Around a quarter of respondents in all groups actively disagreed with this statement

Highest level of disagreement for the statement for "I understand the purpose and aims of NHS Improving Quality " (39%)

✓ For those who had engaged with NHS Improving Quality, this dropped to 30%, but 63% of those who had not engaged did not understand the purpose and aims

Of the 135 responses to this question: 65 were from commissioning organisations, 45 from providers and 13 from 'others' (remainder unspecified)

✓ Provider organisations showed the greatest levels of disagreement across statements

✓ "Other" organisations slightly more likely to show agreement (but numbers are small for this group)

Q17: NHS Improving Quality now…

Around a third of respondents agreed or strongly agreed that their organisation has been able to make use of NHS Improving Quality, and has found its services valuable

✓ Overall 35% agreed / strongly agreed that their "*organisation had been able to make use of NHS Improving Quality*"

✓ 31% agreed / strongly agreed that "*NHS Improving Quality services have been valuable to our organisation*".

✓ Marginally more people have been able to make use of NHS Improving Quality than say that it had been valuable to them

✓ The difference remains for those who had engaged with NHS Improving Quality : 48% agreed/strongly agreed (…*organisation has made use of*…) and 42% agreed /strongly agreed (…*has been valuable to*…)

✓ Low levels contributed to by high levels of disagreement or ambivalence from the group that had not engaged with NHS Improving Quality

All n = 135, Engaged with NHS IQ n = 97
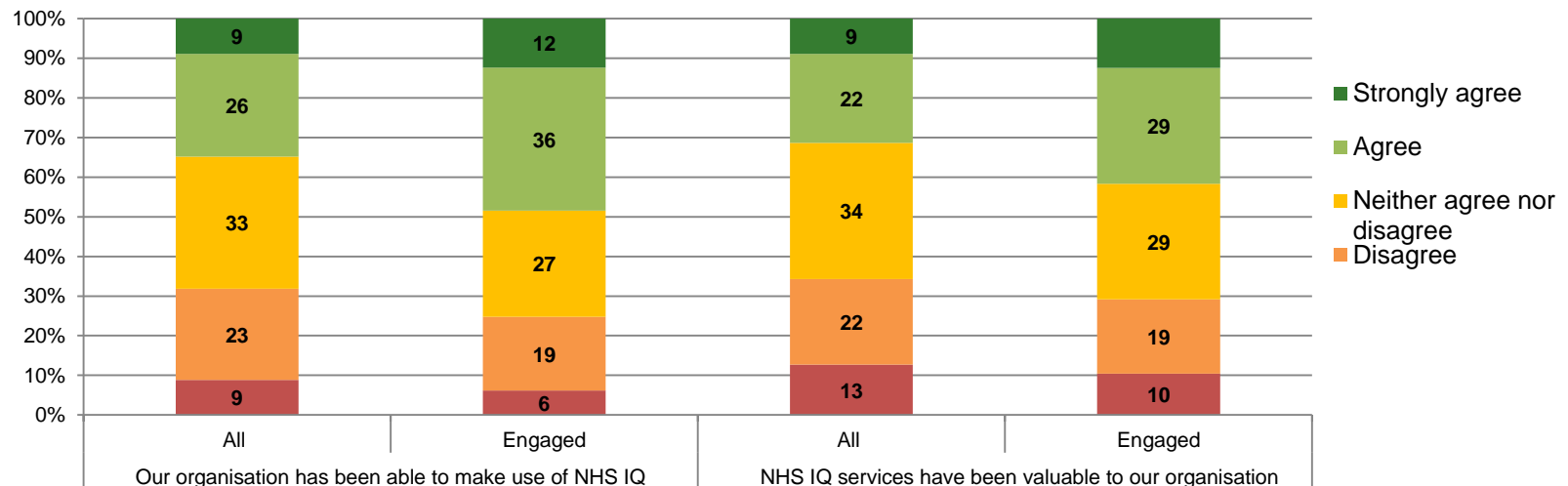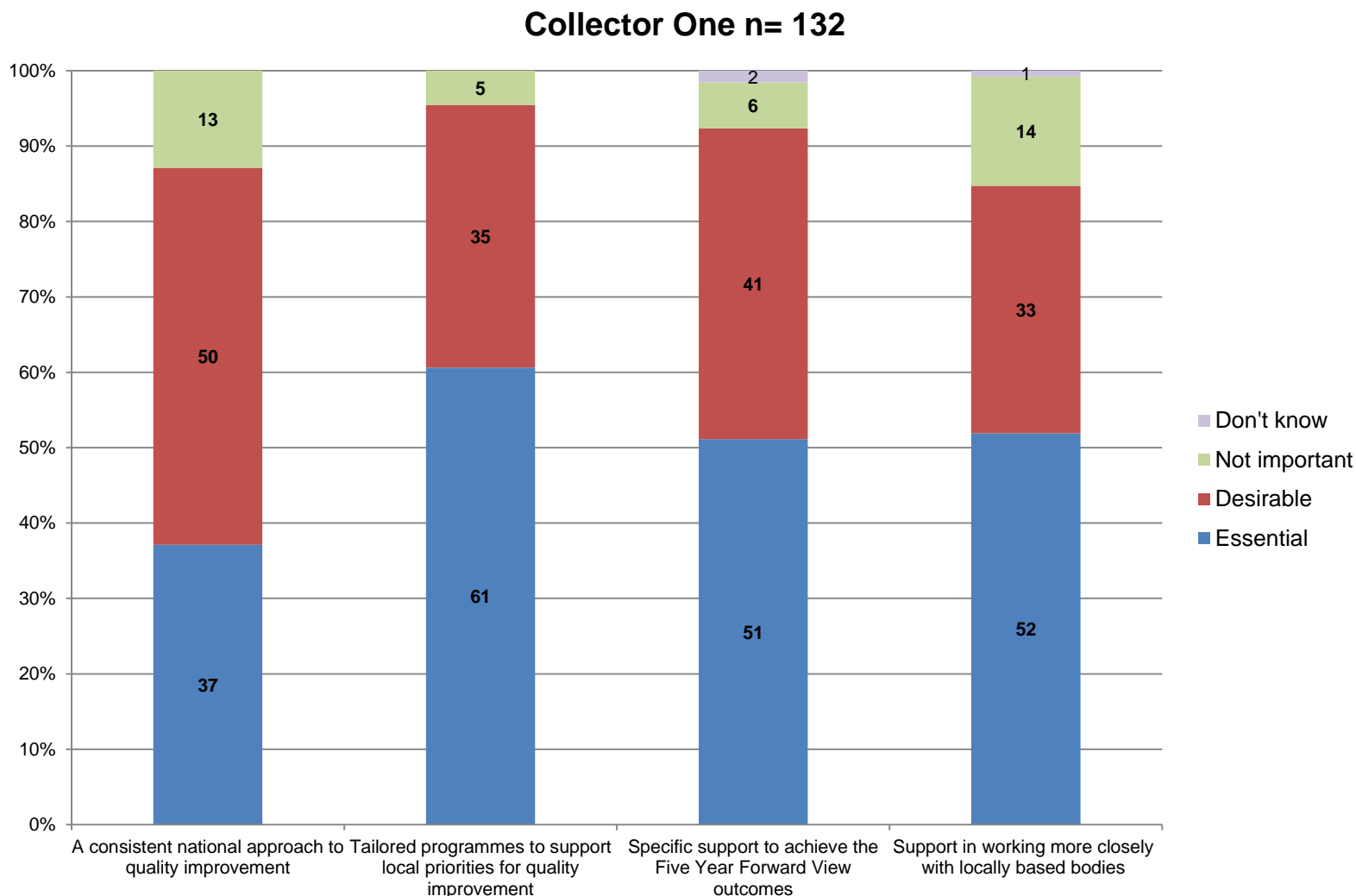
Q17: Quality Improvement support in future…

- 50% of those who engaged with NHS Improving Quality would like to work with them in the future (40% of the total sample) with a further third being ambivalent (40% of total sample)
- Overall there was 64% total agreement that quality improvement support should be provided nationally- the highest level of agreement across all statements. A further 24% were ambivalent

All n =135 / engaged n = 97/ not engaged n = 38
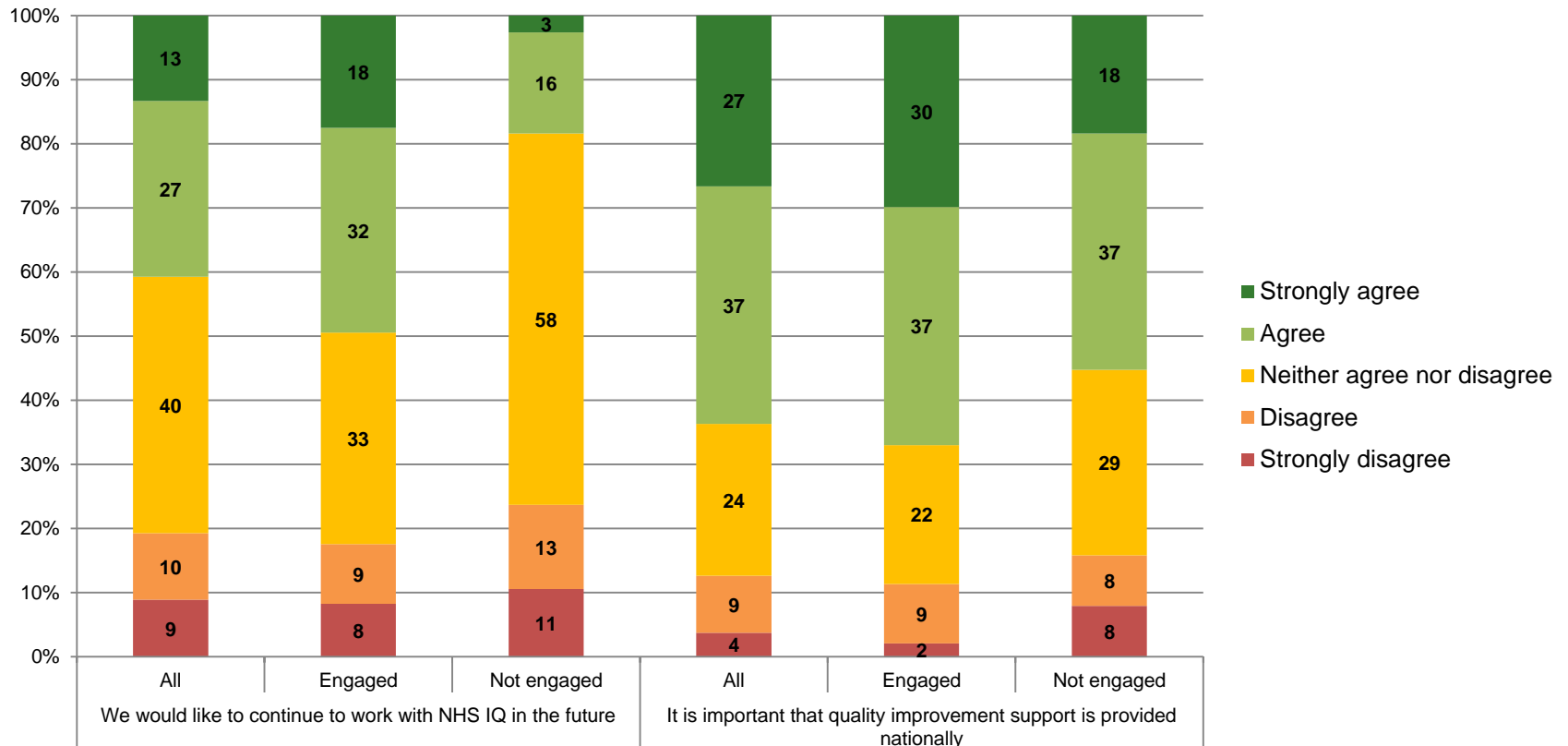
Respondents were asked to rate four statements in terms of *essential, desirable, not important or don't know* in relation to their organisation. respondents completed the question

Collector One n= 132

31

Q18: Quality improvement support in the future…

All statements were highly rated as essential or desirable to over 85% of respondents

Highest rating overall was for "Tailored programmes to support local priorities for quality improvement"

- ✓ 61% essential and 35% desirable
- ✓ Only 5% rated this not important

Similar proportions rated "Support in working more closely with locally based bodies" and "Support around Five year Forward View as essential:

- ✓ 52 % and 52% respectively
- ✓ Support around Five year Forward View received more 'desirable' ratings- 41% compared to 33% for support working more closely with locally based bodies

A consistent national approach was rated as essential by the smallest proportion (37% essential, 50% desirable, 15% not important)

There was little variation between those who had engaged and those who had not in terms of what they rated as essential, desirable or not important

- ✓ Numbers are small, but "other" organisations are more likely to rate each statement as essential.
- ✓ This is most marked for support in working with locally based bodies (84% compared to less than 50% for providers and commissioners

Q19. What quality improvement support, if any, might your organisation need in the future?

79 respondents completed this section
The most frequently mentioned topics/themes include:

- **Practical service improvement support** for local and regional systems, tailored to deliver change locally based on priorities, including support to implement service redesign and the Five Year Forward View

- **System Innovation and innovation diffusion**, enabling delivery, spread and testing of new ideas and models locally.

- **Evidence, evaluation and metrics knowledge and capability**, including robust evaluation of programmes, support in data collection and making better quality data available widely, and creating a knowledge hub.

- **Nationally facilitating opportunities for learning and sharing of best practice**, including support to disseminate evidence of what works elsewhere, to help build local expertise.

- **Developing a consistent and collective NHS wide approach to quality improvement**, including building quality improvement capability for all staff and making quality improvement expertise readily accessible locally.

- **Focus on outcomes for patients**

- **System integration**, including creating the conditions for integration and integrating work across health and social care.

- **Support better use of networks for quality improvement**, e.g. strategic support to Senates and Clinical Networks to help implement quality improvement.

Messages to the review team…

NHS Improving Quality is currently being reviewed by NHS England. What message, if any, would you like to send to the review team about:

(a) NHS Improving Quality and
(b) quality improvement in the NHS more broadly?

90 respondents completed this section and there was considerable overlap in responses broadly relating to NHS Improving Quality and quality improvement, so they have been combined these into key themes.

Eight overarching themes emerged:

- **Prioritisation of support** for quality Improvement across the NHS
- **Coordination and clarity** of remits and relationships of improvement bodies nationally
- **Regional and local focus** with national co-ordination and guidance
- **The focus** of national quality improvement support
- **Mandate, visibility and Unique Selling Point**
- **Funding, value and Return on Investment**
- **Positive perceptions** of a helpful, passionate team
- **Negative perceptions** of a over committed, remote and unresponsive team

Concluding messages

Please see the attached appendices for detail of the survey questions, tables of responses and verbatim responses to open questions

We wish to acknowledge:

- The NHS Confederation who disseminated the survey to their stakeholders
- The Smith Review Steering Group who disseminated and cascaded the survey link to their stakeholders
- Professor Ruth McDonald at the Manchester Business School who peer reviewed the interim report and provided helpful commentary
- The 837 respondents who completed the survey

National Review of NHS England-funded improvement and leadership bodies

Annex F

How the Review has engaged with stakeholders across health and care in England to shape outline recommendations

Introduction

In November 2015, NHS England launched a national review of those bodies, funded by NHS England, which are responsible for improvement and leadership development. Since then, the independent review team has engaged with a wide range of organisations, networks, bodies and individuals across the health and care system.

Our focus has been to consider the current leadership development and improvement architecture, including the NHS Leadership Academy, NHS Improving Quality (NHS IQ), Academic Health Science Networks (AHSNs), Strategic Clinical Networks and Clinical Senates, and what might need to be in place to provide effective support to commissioners and providers across health and care in meeting the national priorities and challenges over the next five years and beyond. Specifically, the review has focused on whether the right arrangements are currently in place to deliver the ambitions set out within NHS England's *Five Year Forward View (5YFV)*.

This report describes the work undertaken by the review team to ensure that the outline recommendations both reflect, and respond to the views and needs of health and care stakeholders. It also discusses the various themes and issues raised by participants, all of which have been considered by the review team.

Communications

A comprehensive stakeholder analysis identified the key groups and individuals across health and social care that were likely to have an interest in the review and its recommendations. Various communications were issued, through direct emails, website articles and posts, staff and stakeholder newsletters and social media, as well as via organisational and professional networks. These provided information about the review, shared the key questions being addressed by the review team, and encouraged feedback and participation.

An extensive number of networks supported the review team in conveying messages to key stakeholders. Here are just a few examples to provide a view of the type and variety of those involved, as well as the reach where known:

- NHS England
- NHS Providers
- NHS IQ newsletter (reach c. 3,000)
- NHS Networks (reach c. 50,000)
- AHSNs
- NHS Confederation
- NHS Employers
- Royal Colleges
- NHS Communications
- NHS Leadership Academy alumni and participants: (reach - over 31,000)

Communications leads used a variety of social media and on-line tools to convey related messages and to engage with key stakeholders. The potential reach of principal Twitter and on-line methods used is detailed below:

- Twitter activity (NHS IQ account *#SmithReviewNHS*): 168,727
- Twitter activity (NHS LA account): 305 click-throughs
- Article on NHS IQ website: 658 hits
- Information published on the NHS LA website: 811 unique views
- Information published on the NHS England website: 372 unique views

Reference Group

A Reference Group was established to ensure that all key stakeholders across the health and care system were represented as part of the Review's governance structure, and were able to both contribute to, and inform the outcome of the Review. Accountable to the Review's Steering Group, each member had responsibility for disseminating appropriate information across their respective networks, as well as for actively seeking, and feeding back relevant views to the Review team. A total of 71 reference group members represent stakeholders across the following areas:

- Commissioners (including CCGs)
- Providers
- Arm's Length Bodies including the regulators and NHS England
- NHS Leadership Academy
- NHS IQ
- National Clinical Directors
- Department of Health
- AHSNs, Clinical Senates and Strategic Clinical Networks
- NHS Confederation
- Social care
- Various other key agencies and external partners across the health and care system, including representatives from the independent and third sectors including the Health Foundation, The Kings Fund and the Nuffield Foundation
- Specialist improvement and leadership development agencies and special interest groups with existing links to health and care

Written submissions

An email address - england.smithreview@nhs.net - was established to enable people to contact the review team directly to submit their views, express an interest in attending events, to request further information, or to raise questions. The review team received 828 emails in total, excluding auto-responses. Of these, 75 were expressions of interest from people asking to be directly involved in an engagement event.

The review team received a total of 43 written submissions and comments for consideration. Seventeen of these were received from groups, networks and organisations to respond formally to the review following engagement with their members. Between them, these represent several thousands of clinicians and other health and care professionals, commissioners and providers, and include the NHS Confederation, the Royal College of Physicians, Health Education England, and Public Health England.

Face-to-face engagement events

Seventeen face-to-face events have been held at key locations across England: London, Birmingham, Nottingham and Manchester. These were attended by 126 individual participants, some of whom attended more than one event (156 attendances in total).

These engagement events have been iterative, from developing definitions and core purpose and assessing current arrangements against them, through to considering future arrangements and what they might deliver. An important feature of the review's approach has been to test, adapt and re-test emergent findings with a wide range of stakeholders. All activities have been led consistently by independent members of the review team both to promote impartiality, and to ensure that all views are considered fairly and equally.

Through these events, we have actively explored the views of existing 'customers' of NHS IQ and NHS Leadership Academy services to develop an impression of the effectiveness of current arrangements, as well as to identify what they might need in future to deliver both local and national priorities. These customers have included clinicians and staff from commissioner and provider organisations across primary, community, secondary and emergency care, and from mental health and partnership Trusts. Some participants have personally taken part in leadership development and improvement programmes, whereas others are responsible for commissioning or co-ordinating services on behalf of their organisation. To ensure a rounded view across health and care, we have also spoken to representatives from local government and social care, local and national partners, staff working within existing leadership development and improvement organisations, and key partners from related organisations, including charities and those with special interests.

Between them, participants have represented a wide range of professional groups at various levels, including medical, clinical and nursing, chief executives, chairs and board-level directors, senior managers, Human Resources (HR), Organisational Development (OD) and workforce planning, programme/improvement leads and specialists, and patient/lay representatives.

A further event is planned for 26th March 2015 to mark the end of the first phase of the review. It will bring together those individuals who have been active participants in the review to date, to appraise them of progress, to share the final outline recommendations as well as next steps, and to thank them for their involvement to date. The review team will demonstrate how their feedback has directly influenced the recommendations made, and encourage their participation in the next phase of the Review.

Webinar

A webinar was organised by NHS Clinical Commissioners, during which the lead independent reviewer shared details about the review, encouraged feedback, and invited questions. A total of seven members participated in the hour-long session.

Engagement geography

More than 200 individuals have engaged actively with the review by attending events or by submitting written comments. Between them, these participants represented 148 distinct organisations, all of which are marked on the map below. Please note that owing to the size of the map, some markers are obscured by others.

Of course, the views of many more individuals and organisations have been represented as part of formal feedback submitted by their professional representative bodies, or by membership networks. Only the central network or body is represented on this map, and the headquarters for many of these are based in London.

One of the objectives of the review was to seek views from organisations across England, and not to focus on any one particular location. As can be seen from the map, there is good representation from across most areas, and steps to strengthen this further in the next phase of the review are discussed in the following section.

Engagement statistics at-a-glance

The following table shows the number of participants engaging with the review, and how they represented various parts of, and professions within, the health and care system. It is important to note that these statistics include only those who provided their information, and that the Review engaged with many more people, including through professional networks and member organisations.

Overview	
• Total number of group engagement events held	17
• Total number of attendances at engagement events…	156
• …of which, total number of individual participants	126
• Webinar attendees	7
• Total number of individuals and representative organisations who have submitted written responses	43
• Total number of reference group members	73
Participants actively engaged with the review, e.g. attending engagement events	
• Total number of individuals	207
• Total number of distinct organisations represented by participants	148
• Of these organisations, the total number of bodies or networks responding formally on behalf of members or of staff	16
Professional groups represented	
• Clinical/medical, including nursing	51
• Chair/Chief Executive/Managing Director	60
• Other Board level leaders and senior managers	117
• Human Resources and Organisational Development	39
• Those in core programme management/improvement roles	12
Where participants work	
Healthcare Providers	
• Acute hospitals	54
• GPs & primary care	6
• Mental health	14
• Community	16
• Ambulance	1
• CSUs	4
• Care Homes	1
• Private healthcare providers	1
• National or regional representative bodies for NHS providers	8
Commissioners	
• National	20
• Regional	14
• Clinical Commissioning Groups	12
Social Care	
• Local Authorities/Local Government Associations/National Representatives	8
• Social Care Providers	2
Regulators	9
Unions/Representative Bodies	1
Wider health and care system	
• National	34
• SCNs/AHSNs	13
• Regional	13
Patient/carer representative organisations	4
Others (including charities and special interest)	21

Survey

A survey was also undertaken by the review team, which attracted more than 800 responses from clinicians and professionals across health and care. The findings are discussed within a separate report (Annex E), and these results are *not* considered within this particular report.

Review of AHSNs, Clinical Senates and Strategic Clinical Networks

A separate review was focusing on AHSNs, Clinical Senates and Strategic Clinical Networks, until it was brought into the overarching review of improvement and leadership development in December 2014. A significant amount of engagement was undertaken by this other review team, and this is discussed in a separate report (Annex G). However, further comments have been made about these particular bodies as part of the wider improvement and leadership development engagement process, and these *are* considered within this particular report.

Strengthening engagement in the next phase

The review team has captured many views from across a wide range of stakeholder groups in only a few weeks. Whilst this activity has been as extensive as possible, it is recognised that further engagement with key organisations, professions and groups will be essential in the next phase of the review, particularly when developing more detail relating to key priorities, roles and responsibilities, reviewing capabilities, and defining implementation plans.

Although all stakeholder groups will need to be involved, there needs to be particular emphasis on ensuring appropriate representation from the following groups:

- GPs (as providers) and primary care
- Care homes
- Ambulance services
- Healthwatch/patient representatives
- Social care
- Staff with protected characteristics, e.g. BME and those with disabilities
- Front-line staff and middle managers
- Junior doctors
- Royal Colleges, universities and academic networks

In addition, whilst most geographies across England have been represented, it is important in the next phase of the review to ensure discussion with areas that have unique health and care arrangements, for example, Manchester and the Isle of Wight; as well as ensuring a representative spread across the 'four corners' of England, including areas where there have been lower levels of involvement to date, e.g. East of England, far North of England, and Devon and Cornwall.

Where possible, an out-reach approach may prove the most effective way of ensuring engagement with organisations and individuals in particular locations, and careful planning

ahead will be essential to give *all* prospective participants the notice required to attend engagement activities.

Acknowledgements

The review team sincerely appreciates the time, resources and energy that have been invested by various organisations and individuals across health and social care to share views, attend events, and to communicate and engage further with their own members and colleagues. We have also been dependent on the kindness of a number of organisations and individuals in providing venues, supplying refreshments and making the appropriate administrative arrangements.

We would like to thank each and every participant for engaging with the review and its team members. This has enabled us to hear the views of so many groups and people in a relatively short space of time, and in so doing, has ensured that those working across health and care have been able to play an important part in shaping the review's recommendations.

What we have heard

The following sections summarise the views expressed in feedback submitted to the review, as well as during discussions at engagement events. All comments received have been grouped into themes as far as appropriate, and none is attributable to any particular party in accordance with *Chatham House Rules,* which was the approach adopted by the Review Team.

It is important to note that these themes capture views expressed for the purposes of informing recommendations. Whilst they have been considered in full and used to shape and test recommendations, they are not intended to be recommendations in their own right.

Themes relating to engagement feedback are split into three sections as follows:

1. Themes common to both improvement, and leadership development

2. Themes relating only to leadership development

3. Themes relating only to improvement

During the review, participants highlighted various initiatives, arrangements and activities as possible examples of best practice. The review team has welcomed and noted all of these, and may consider them when developing detailed implementation plans during the next phase. The review team has been careful to base outline recommendations on evidence and fact, and as no formal evaluation of these suggestions has been undertaken as yet, they have not been named within this report.

Common themes across improvement *and* leadership development

This section details the various themes and comments raised by participants that relate to both improvement and leadership development.

1. **Change *is* needed.** Participants were able to cite many positive examples of working with the NHS Leadership Academy and NHS IQ, whether involved directly or indirectly. However, there were many more examples of where improvements are needed, and there is strong appetite both for change, and for a more focused and consistent approach to be taken by all bodies. Some felt that the resources needed to deliver change had not been provided in sufficient quantities to ensure success.

2. **Alignment with national priorities.** There was strong consensus that leadership development and improvement strategies and related programmes should focus predominantly on enabling the delivery of ambitions set out within the 5YFV and on addressing the £30bn funding deficit. It is not felt that this is the case currently, and participants were clear that the present NHS does not have sufficient access to the capability and capacity required to deliver national priorities. Participants were clear that strategies for improvement and leadership development at national level should *not* be politically-driven.

3. **Leadership and improvement are linked and should not be viewed separately. All improvement and leadership development bodies should be joined up at local, regional and national level.** This sentiment applied not only to the delivery of improvement and leadership development programmes and activities, but also to the possible strategic arrangements for overseeing leadership development and improvement at a national level. It was felt that improvement should be a core component of leadership programmes, and *vice versa*. Participants stressed that without a balance of the two, neither improvement nor leadership will be fully effective, particularly in the current climate. One group discussed an example where certain organisations had experienced multiple Emergency Care Intensive Support Team (ECIST) visits, noting that these Trusts were failing to make improvements despite the remedial actions being clear. They suggested that failure in these instances was attributable to a lack of effective leadership, including a lack of understanding of how to deliver sustainable change.

   It was also noted that whilst improvement and leadership development should be considered together, methodologies and the approach to deliver each aspect will vary. There was strong desire to have clear, formalised arrangements that join up improvement and leadership development bodies from local and system levels, to regional and national levels. One participant noted that there are already objectives for bodies leading improvement and leadership development to work in collaboration, but that this does not happen in reality.

4. **The solution needs to promote and enable effective and inclusive system leadership and improvement.** There was an overwhelming consensus that any solution needs to focus on the system, rather than on organisations and individuals; and that this arrangement should include social care and local government. It is felt that, without this systems or 'place-based' approach, the achievement of ambitions set out within the 5YFV will be largely impossible.

Participants want to see leadership development programmes and activities that bring together teams and individuals from across health and social care, from across public, independent and third sectors, and from across the various clinical and non-clinical professions. This will help to build mutual understanding of respective cultures and challenges, help to forge collaborative relationships to address shared issues, develop capability across the system, and start to break down the 'them and us' culture.

Many participants advocated the need to involve partners (including patients and communities) at the beginning of each improvement programme so that a partnership approach was apparent from conception through to delivery and evaluation. This would help to ensure successful system change, through effective ownership, delivery and accountability from the outset, as well as avoiding the feeling of 'being done to'.

Similarly, this applies to organisational or, indeed, any change, whereby all those affected by the proposed change, whether directly or indirectly, should be part of assessing the problem and developing and implementing the solution.

Some participants also noted that, to meet the 5YFV, it will become increasingly important to engage local people (including patient and carer leaders) and support them in leading change within their own communities. They suggested that the most successful lifestyle changes are led by communities and so an 'in-reach' approach is key.

5. **Focus on bottom-up, not top-down.** Most participants stressed the importance of identifying and developing priorities and solutions from the 'bottom-up', i.e. starting with patients and front-line staff, to local organisations and through to local systems. Whilst participants recognised the need for national co-ordination and governance, participants did not want to see a nationally-prescribed approach beyond the introduction of outline frameworks and guiding principles where appropriate to do so.

6. **The importance of partnerships and collaboration.** Many participants stressed the importance of building, sustaining and strengthening key relationships with partners if the NHS is to deliver priorities at local and national levels over the next five years.

Some participants felt that bodies focusing on improvement and/or leadership should work better together, that they are not currently aligned and therefore send out inconsistent messages. This also gives rise to possible gaps as well as to duplication. They felt that there needed to be a 'place' where all related partners, leaders and experts can come together as equals, and where mainstream approaches can sit alongside the more radical and rebellious.

As for change leadership, participants felt that the Royal Colleges and Universities had an important role to play in developing improvement skills and capabilities as part of core clinical/medical training, including under- and post-graduate programmes. It was noted that the Academy of Medical Royal Colleges has a task and finish group relating to quality improvement in training.

There were a number of more specific suggestions and offers for partnership working, or where more alignment with NHS improvement and leadership development bodies might be helpful, including:

- UK Improvement Alliance

- Haelo
- AQuA
- Boehringer Ingelheim
- National Voices
- Faculty of Medical Leadership and Management (FMLM)
- Royal Colleges, including the Academy of Royal Colleges
- The King's Fund
- The Health Foundation
- British Medical Association
- Training/development/improvement consultancies
- *Skills for Health* and *Skills for Care* – a possible amalgamation

7. **Build on what works well, give things time to settle, and don't change everything.**
   There was a shared view that good work is being done in many areas, and that it is important not to lose this in any changes made to current arrangements. Whilst there was a common view that arrangements do need to change at a national level, there was strong encouragement to ensure the continuation of effective programmes and arrangements.

   Many participants stressed the need to allow time for recent changes to take full effect, noting that the NHS Leadership Academy and NHS IQ are still in their infancy. They felt that there would be significant risks to stopping or changing some aspects, and that changes should only be made to elements that are either not adding value, or will not deliver future ambitions.

   Conversely, there was a call from the few to be wholly radical and consider starting afresh. However, most agreed that an appropriate balance needed to be struck between making wholesale change, and building on what is in place and working well.

   Concerns were expressed about causing instability to the system as well as to key programmes underway. Similarly, it was noted that it takes time for improvement and leadership skills to bed in, and that recent training and learning will not yet have realised its full impact across NHS organisations. Some noted that relationships, particularly with the NHS Leadership Academy, are starting to become more effective but need more time to deliver.

8. **Don't underestimate how long it will take to embed the new arrangements.** During the various engagement events, many examples were shared of organisations and systems working to create an effective learning and improvement culture. It is clear that realising this ambition can take many years, and participants were concerned that, following this review, there would be an expectation that new arrangements would need to deliver 'overnight'; then, as a result of failure to achieve this, there would be a subsequent review resulting in further changes, and there would never be sufficient time allowed for any new arrangements to embed and deliver effectively.

   Some felt that there is evidence of 'gaming' at leadership level, with some leaders more focused on second-guessing the next wave of change and opportunities thereafter, rather than on delivering improvement. It was noted that this is a key risk of changing things too frequently.

   Participants felt that any new arrangements should be left alone to deliver for several years – some suggested at least ten. Some concerns were noted about the six-month

period proposed for the next phase of the review, feeling that this timescale is insufficient to develop *and* deliver an implementation plan.

9. **Don't invent something new.** There were strong feelings expressed that health and care in England already has the expertise to become the best improvement and leadership development system in the world. There was a shared view that those involved in the review should look both within the NHS, and to local government, the voluntary and not-for-profit sector, and to other partners in England to apply best practice that is already in place, and then to build on the expertise and capability that already exists. There were mixed views about looking at systems off-shore and whether they could realistically be adapted for use in England. There was also some reluctance to involve large consultancy firms, not least because of the need to build in-house skills, expertise and capability, as well as to ensure long-term ownership and organisational memory.

10. **There is a role for a national body/strategy, but with little or no remit for delivering improvement.** Some claimed that there was little evidence that national bodies had delivered to the scale intended, particularly the NHS IQ, e.g. seven-day service programme; and some felt that the resources needed to deliver change had not been provided in sufficient quantities to ensure success. There was a strong consensus that a central body was necessary, e.g. to co-ordinate improvement and leadership development across England and to promote best practice, frameworks etc. where appropriate to do so nationally. However, it was stressed that the role and remit for such arrangements should be absolutely clear and focused only on those aspects appropriate for consideration at national level. This would mean that the scope for any future organisation should be significantly narrower than it is presently.

11. **Arrangements should be driven, developed and delivered locally, with clear accountability.** Although there was consensus regarding the need for some national co-ordination, guidance and support, there was a clear message from nearly all participants that delivery should be owned and driven locally as far as possible, with limited or no national involvement. Participants wanted to see more resources made available closer to the front-line, including expertise and devolved funding, which would be easier to access. Many said that they would want to work together with partners to agree the priorities for this resource to deliver improvements (including leadership) across their local system. There was also an emphasis on the need to develop capacity and capability for leadership and quality improvement in front-line staff. Some felt it was important to see evidence of commitment at Chief Executive level across all organisations involved, and a membership model was suggested as one way of securing commitment. There was a clear consensus that the focus should *not* be aligned in any way with local political priorities, and that goals for delivery at local level should be realistic, practical and supported by appropriate levels of investment - or not done at all!

    Participants were also adamant that clear local accountability and delineation of responsibility is essential, particularly if local autonomy is granted; also, that governance arrangements through to national level should be both transparent and effective. However, such arrangements should not amount to 'approval processes', which have been proven to cause inertia and delay the implementation of local initiatives.

12. **Make sure that future arrangements are meaningful to 'jobbing' clinicians and other front-line staff.** At present, many feel detached from national or regional leadership bodies and are unaware of how they benefit, or impact on them in their day-to-day

roles. One clinician summed up their perception as: 'That management lot over there in London.'

13. **Current arrangements are fragmented, unclear and difficult to access.** Many participants described how their awareness of current arrangements was poor, particularly with regard to the existing architecture relating to improvement. For both improvement and leadership development, people felt that there needed to be better clarity of what is on offer and how to access it. Many said that the variety of leadership development and improvement programmes on offer is confusing, and that there needs to be a prospectus, or similar, to help navigate the various offerings at national, regional and local levels.

A significant number of participants claimed that they had never heard of NHS IQ, and many more were unfamiliar with the role that it plays. Similarly, the roles of AHSNs, Clinical Senates and Strategic Clinical Networks were unclear to most, and participants were often unsure how they fit together with each other, as well as with *Monitor* and the *Trust Development Agency*.

It is also important to help stakeholders understand how national bodies work together and what this means for them.

14. **Patients should be at the centre of any improvement strategy/programme.** Many participants felt that the patient or 'customer' is often lost in current arrangements. They felt that delivering benefit to patients and front-line working arrangements had to be the principle on which any improvement and/or leadership development strategy is based.

15. **Ensure value for money/ensure patient benefit is at the core.** It was noted by many that funding will remain a significant constraint. Participants stressed the need to ensure that future arrangements and programmes offered to the NHS and leaders respectively offer value for money, not just in terms of currency but also in terms of the time invested by the organisation and/or individual. At course level, it is important to ensure that similar or better programmes are not offered elsewhere for the same, or less cost. It was felt that, ultimately, patient care should benefit by more than the amount invested in future leadership development and improvement arrangements. There may be a role for partners to play in the delivery of future solutions.

16. **Appropriate governance and transparency in setting national priorities.** It was felt that any national body or bodies for leadership development and/or improvement should work across the six principal arm's length bodies: NHS England, the Department of Health, Trust Development Agency, Monitor, CQC and Public Health England. Some suggested that national priorities should be set by these bodies in collaboration, using clear criteria which focus on patient-led priorities and which ensure that there is no dominant voice or voices. Governance arrangements in terms of reporting and/or hosting should also reflect this.

17. **Greater support needed to develop primary care and other gaps.** It was noted by many that to deliver the 5YFV, significant improvements will be required across primary care. In turn, this will require GP/primary care change leadership and improvement capability, and this is considered to be a significant gap at present (although it is suggested that some relevant training may already be provided by the Royal College of GPs). Some feel that, at present, arrangements within primary care are neither sufficiently developed

nor mature enough to interface effectively with secondary care and other providers and commissioners to tackle the quality improvements that need to be made.

GPs, and many others participating within the review, felt that GPs *as providers* were often poorly catered for by existing improvement and leadership development arrangements. They feel this has been exacerbated by the fact that a significant amount of GP leadership talent has transferred over to commissioning-focused activities. Some participants suggest that current opportunities are more focused on GPs *as commissioners*, rather than tailored and promoted to general practice, and that there is an imbalance of support compared with that provided to secondary care. It was also noted that, with opportunities being communicated via clinical commissioning groups, those clinicians involved with commissioning are more likely to be earmarked for development.

It is evident from the review's discussions that there is, and will continue to be, significant tension in addressing the question of how much time and resources should appropriately be expended on developing GPs, given their self-employed status. However, participants also recognise that demand in general practice is increasing whilst funding is reducing; therefore, it will become ever-more challenging to support GPs and others within primary care to develop the skills and capabilities required to play the role expected of them in delivering system-wide improvements.

It is felt that future arrangements need to address this significant issue. As one participant put it: "GPs need the headspace, but you've got to find a way to get GPs out of the business without impacting on their business, because otherwise it directly affects patient care." Another asked of fellow participants: "remember that GPs need space to grow, and need to be supported too". A number of examples were shared with the review team, where local bodies have funded GP time to attend leadership development and quality improvement programmes, ultimately, to deliver benefit to patient care across the system. In one instance, the programme was significantly over-subscribed, demonstrating the sheer appetite of GPs to undergo leadership development.

Other possible gaps were highlighted, which a number of participants felt needed to be addressed to deliver the 5YFV. These include developing leadership and improvement skills and capability for:

- **Patient leaders** (including Healthwatch members, Foundation Trust patient governors, lay-members, expert patients etc.). Many organisations and programmes already look to patient representatives to add value, ensure a patient voice, and apply the appropriate level of scrutiny and challenge. Achieving the 5YFV will clearly require a strengthening of these arrangements. It is suggested that to maximise impact and play more of a role in identifying, delivering and supporting quality improvements, patient representatives will require the right leadership skills and capabilities.

- **Non-medical and non-nursing professions**, e.g. Allied Health Professionals. It is felt that these other clinical professions can often be overlooked.

- **General physicians in secondary care**. One submission shared that many physicians on one particular programme demonstrated they did not possess the quality improvement skills to deliver projects that they were already leading. Following training, there was a significant appetite shown for further development. The same

organisation suggested that they had demonstrated how leadership skills could be developed through supporting clinicians in leading quality improvement projects.

- **Middle managers** to manage the increasing pressures from above and from below, and to ensure that they receive the development that they need as leaders and as enablers for change.

- **Teams**, rather than individuals, to include team leadership skills and enabling improvement capability within teams. One participant expressed it simply: "Teams deliver change, not individuals or organisations."

- Staff within **care homes.** A number of participants noted that care homes were excluded from current leadership development and improvement activities. However, the NHS is responsible for commissioning thousands of residential places, and it is well known that significant improvements are needed within this particular care setting.

- **Commissioners.** Some felt that current leadership development approaches were more focused on providers, and that they should be developed to reach other parts of the system, including Clinical Commissioning Groups.

- **All staff band AfC band 6+.** There was a strong consensus that either all staff, or staff of band 6 and above should receive leadership development, even if they do not wish to progress their career further. This is because all staff at AfC 6 and above will be responsible for some leadership and management functions, as well as for improvement projects and activities. They should therefore be trained and developed accordingly. Similarly, those who are coming 'up through the ranks' should receive tailored training that will help to embed good leadership skills at an early stage (not after they have become leaders), and/or to help embed a helpful, reciprocal culture.

Some noted that they felt there was too much focus presently on identifying and developing the ambitious, career-focused leaders. They suggested that there needed to be more of a balanced approach taken to include those who wish to remain in their existing leadership role, and have no desire to progress their career further.

18. **The right culture needs to be nurtured if improvement and leadership development arrangements are to be successful.** Strengthening Organisational Development (OD) capability and approaches is felt to be critical in paving the way for good practice in leadership and improvement across health and care. Having the right culture, behaviours and attitudes in place are essential if the NHS is to deliver 'learning organisations'. Some felt that many organisations and leadership teams currently have a very poor understanding of OD, how it is applied, and how it can benefit both patient care and staff. It is felt that OD needs to have more gravitas and a possibly a place around the Board table, and that OD approaches need to underpin leadership development and improvement activities.

Many participants called for an environment in which it is safe to try out new ideas and learn from mistakes, without fear of reprisal. One clinician explained that they were 'terrified' of moving into a leadership role because of the way that they feel the NHS treats its leaders. Others supported the view that the culture was often punitive rather

than rewarding, and that leaders should not fear making acceptable mistakes whilst the organisation and its people are learning and developing.

Many participants stressed the importance of addressing more effectively poor leadership across the NHS, whether in provider, commissioner, monitoring or regulatory organisations. They shared examples of bullying cultures, of incongruent values and behaviours displayed by senior leaders, of the practice of transferring ineffective leaders from one NHS organisation to another, and of not addressing poor performance or inappropriate behaviour effectively or promptly. They wanted to feel they had the freedom to speak up about some of the 'wicked' issues so that they could be addressed.

They felt that the NHS is too tolerant of inconsistent or inappropriate behaviour, and that this problem needs to be tackled assertively and head-on if the NHS is to promote and exhibit the appropriate values, attitudes and behaviours throughout. This includes the removal of such leaders where appropriate. This in turn would send out the right message to all staff, and would support the development of a learning and improvement culture, which needs to start right at the top (including with monitoring and regulatory bodies). They added that by moving poor leaders out of senior roles, more opportunities would be created for prospective leaders with the appropriate values, behaviours and capabilities.

19. **Ensure that solutions can be monitored and evaluated.** This sentiment applied both to new arrangements delivered as a direct result of the review, as well as future leadership development and improvement programmes and activities. Participants were clear that role clarity, consistent standards, and a focus on outcomes and success factors are critical in ensuring that activities can be monitored and evaluated effectively. The ability to measure value for money and return on investment is essential, and participants felt these should be assessed predominantly in terms of the tangible benefit they have delivered to patients and to the front-line. It was suggested that all bodies should seek to ensure that benefits realised significantly outweigh their own operating costs. It is not felt that this is currently the case.

Some participants suggested that a monitoring body, such as the Care Quality Commission, might play a role in evaluating the effectiveness of change leadership and improvement within organisations.

20. **Develop shared definitions.** It is clear that the words 'system', 'improvement' and 'intervention' mean very different things across health and social care, and to professionals and groups within. Equally, people have different interpretations of the terms 'local' and 'regional'. Furthermore, people felt it was important to distinguish between 'acceptable variation', e.g. tailoring local arrangements to meet local needs, and 'inappropriate variation', e.g. inequalities in patient care or health outcomes. Participants felt that common definitions need to be developed across the system to ensure an alignment in understanding and focus.

Some noted that they particularly disliked the term 'service improvement' as they felt it encouraged focus on the wrong things; for example, some services should be replaced with other arrangements rather than improved, because they are wrong for patients in the first place.

21. **Equality matters.** A number of examples were shared of how those with disabilities or those from BME groups were able to add significant value to programmes seeking to

improve clinical services and patient access, because they had a better understanding of the clinical and other needs of patients and user groups. It was clear that such skills and knowledge cannot be learnt as effectively in a classroom environment; and indeed, some cannot be taught. These stories highlighted the importance of developing people with protected characteristics to become capable leaders with improvement capability.

A number of participants focused on the need to increase access to leadership development and training opportunities for specific groups, including BME, women, and those with disabilities, e.g. hearing, sight or mobility. Similarly, there needs to be more local encouragement to help individuals within these groups to come forward and feel that they have the support to reach their full potential. There are some examples of where this has worked very well, including through mentoring, and one-to-one development and support, but these are limited and largely based on exclusive local arrangements and relationships.

One participant also expressed their difficulties in accessing longer-term programmes, e.g. Mary Seacole, because of caring responsibilities at home, suggesting that training and other opportunities should be more flexible to suit individual circumstances. This is one example of how current arrangements can sometimes inadvertently exclude certain groups or individuals.

Conversely, feelings were also expressed by the minority that opportunities appear to be more targeted towards BME, senior and/or clinical staff, and that there should be better access for all.

It was felt that the NHS Leadership Academy (or whichever future lead body) should renew its focus on supporting the NHS in promoting and enabling diversity within the leadership community. However, it was noted that success would only be possible with a commitment to this agenda from all health and care partners across the system. One group called for an understanding that enabling a diverse 'choice' in leadership was a long-term aim and cannot possibly be delivered by the lead body alone.

22. **Excellent communications and engagement will be essential for success.** The need for excellent communications and engagement was stressed for any future arrangements, particularly in terms of:
   - Ensuring clarity and understanding of arrangements
   - Promoting membership
   - Raising awareness and enabling easy access
   - Encouraging active engagement and involvement of members and others
   - Enabling effective communication between systems, within systems, and with partners and members
   - Sharing best practice and achievements
   - Developing an evidence-base
   - Reputation management

23. **Other considerations.** A number of other comments were made which do not fall directly within the above themes. These are noted below:

   - These arrangements can only go so far in terms of healthcare working with social care, because the governance structures and cultures are so different

- Making time for clinicians and professional staff to reflect or to become involved in activities is an increasing problem, and developing leaders or delivering innovation will be virtually impossible unless this issue is addressed.

- Form should always follow function

- Capacity and capability to facilitate engagement for improvement purposes are limited

- The need to review developments in Manchester, and some questions about what this might mean for both other systems, and for the future of the NHS

- Some providers asked for clarity on how proposed changes would affect them, and how they will access resources and influence decisions within their local system

- Concerns over the delivery of review recommendations in the event of a change in Government

Themes: leadership development

This section describes the themes that relate exclusively to leadership development.

21 **Experiences and gaps.** Many participants cited various examples of positive personal experiences with leadership programmes they had undertaken, and it is clear that there is a lot of very good work being undertaken under the auspices of the NHS Leadership Academy. Nevertheless, all participants agreed that improvements or changes will be needed if the NHS and its partners are to address the challenges faced, and to achieve the vision set out within the 5YFV. Some of those from larger Trusts, e.g. within secondary care and mental health, said they felt that this national vision had not notably changed the leadership challenges faced by their organisations for some time.

Participants agreed that there was a distinct lack of existing and emergent leaders across the system with the capability, values and behaviours to deliver the ambitions set out within the 5YFV. One group of senior HR professionals described their difficulties when having to recruit to business-critical roles, e.g. Chief Executive, Medical Director, Finance Director, Director of Nursing etc. They explained that applicants were rarely of the calibre required, and that their ambition would be to have a choice of applicants, both in terms of capability, and to enable better representation of local population diversity at senior leadership level.

22 **Role and remit for a national body/centre of excellence.** The need for a national body or lead of some description was a belief shared by most participants. Suggestions for its role and remit were as follows:

- Identify and seek to embed a common set of leadership attitudes, values, behaviours and approaches across the entire NHS, where it is felt that local variation would be inappropriate

- Define what good leadership looks like

- Seek out leading edge practice in leadership development in other healthcare systems, industries and sectors, and facilitate their translation into the NHS

- Lead and share related research and evaluation

- Set and promote consistent standards of leadership development

- Ensure alignment with other leadership development organisations across the system at national and local levels

- Maintain a strong, national and independent voice

- Provide direction and co-ordinate leadership activities across the NHS and accelerate their development where possible

- Commission and accredit leadership programmes

- Develop strategies to build and enhance leadership capability

- Draw up a list of accredited and approved suppliers of leadership development

- Advise regional bodies in procuring support

One group noted that it is also important to consider the leadership challenge for 2030 onwards (and not just for 2020), as some of the challenges faced over the next five years

may simply be deferred through leadership and improvement approaches, rather than addressed in full.

23 **Hosting arrangements.** The issue of where to host any national leadership body or bodies was not a major focus within general discussions or feedback received. Rather, discussions centred more on the importance of a collaborative systems-approach to leadership development. It should be noted that the NHS Leadership Academy set out a number of options within their submission, which may be helpful to consider.

There were, however, some strong and opposing views relating to whether the NHS Leadership Academy should sit within Health Education England. At one end of the spectrum, people felt that there would be synergies in pulling together related resources, whilst on the other, there was concern that the important focus on leadership would be diluted or lost if hosted within a larger organisation. What was agreed is the need for a closer partnership between the two organisations, with clearer defining of roles and boundaries, as well as a review of the various programmes undertaken (including the Management Training Scheme) to ensure alignment.

24 **Leadership strategy, development and training should be multi-professional across different health and care sectors**. Participants called for more of a systems approach to leadership development strategies and programmes, as opposed to the more traditional organisational, or professional approaches. This approach should apply equally to the structure and positioning of any leadership development body or bodies, and to the make-up of participants on any given programme.

It was felt that it was imperative to involve a range of professions from diverse organisations and sectors in the same leadership and improvement programmes and activities. This approach should help to encourage peer relationships across partner organisations and professions, create mutual understanding and awareness, break down barriers, permit more effective collaboration, and enable partnership working to address the similar challenges faced by the health and care system.

This approach would also begin to tackle the 'them and us' culture, for example, where clinicians can understand and articulate financial issues, and Finance Directors are appropriately conversant with clinical considerations. Examples cited of professions or boundaries considered by some participants to be occasionally 'at odds' with each other are listed below. Please note that these are not in any way exhaustive.

- Clinical and Management
- Clinical and Financial
- Health and Social Care
- Public, Independent, Voluntary and Private Sectors
- Commissioners and Providers

25 **Embed and promote values-based leadership.** Another highly popular and important theme is the need to develop leadership with clear and consistent values. Whilst capability and competence are also essential, it is felt that too many NHS leaders lack the values, behaviours and attitudes that are considered to be essential. There were numerous mentions of culture being driven by the behaviour of very senior leaders within the NHS, and a call for all leaders from provision and commissioning, to policy-setting, monitoring and regulation to lead by example.

Participants wanted to see values-based leadership principles embedded in medical schools, universities and graduate programmes, to ensure that the NHS is developing future generations of leaders who will have the necessary capabilities and attributes to serve as role models throughout their NHS careers.

Many participants suggested that the NHS recruitment process needs to be refreshed so that it takes a values-based approach. This would help to improve the quality of leaders appointed, ensuring that they are more likely to serve as role models and therefore help to drive the desired culture.

Some felt that the turnaround and performance-driven skills of leaders recruited - often by regulators and monitoring bodies - to troubled organisations are not always balanced with the values, behaviours and attitudes appropriate for the NHS. They feel that this causes problems for the NHS and the organisation, is damaging to an organisation's culture in the short- and long-term, and conveys the wrong messages about 'what good leadership looks like'.

There were a number of discussions relating to tensions caused by competition within the system, and how it can sometimes lead to unhelpful behaviour. These participants felt that a values-based approach to leadership would help to ensure that it is possible for collaboration and compassion to exist within a competitive market.

26 **Strengthen regional arrangements and networks.** The need to focus on regional arrangements was a strong theme, and many expressed that academies at regional level should be supported and strengthened to address regional variation, with far less focus on delivery at a national level. A few go so far as to suggest local solutions aligned to individual organisations. Most ask for the freedom to deliver local arrangements tailored to system priorities, with funding aligned accordingly.

Many expressed that it was important to have more of a network of regional centres of excellence, expertise and learning in both quality improvement and leadership development. Encouraged and co-ordinated by a central body, these should be responsible for developing improvement and leadership capability at every level, and across entire systems. Furthermore, they should align with other regional leadership academies or bodies as well as local bodies responsible for improvement. It was generally felt that flexibility is essential, as there is not a 'one size fits all' solution, and that delivery of training should be based, delivered and tailored at a local level as far as possible.

There was some suggestion that the NHS Leadership Academy at national level had at times stifled regional creativity, and some participants expressed concerns over the handling of devolved funding and inertia caused by untimely approval processes.

27 **Deliver effective talent management, supported by ongoing career development and support.** This was another of the most popular topics raised within discussion groups, and views were largely consistent. It was suggested by many that one of the key focuses for the national body should be the effective management of talent at national level, as well as the co-ordination of activities at local level. This should include retention strategies and succession planning. Participants felt that talent management is currently poor across the NHS, and that it should start before entry into the NHS at University,

medical school and management trainee programmes. There is a need to work in partnership with the Royal Colleges and Universities to address this.

Linked to talent management is the need to ensure appropriate leadership development throughout the individual's career from entry right up until the point that they leave the NHS. A number of participants referred to the approach taken by the military, and suggested that there was much to be learnt from this. Many of those who had attended leadership development programmes said that they were worthwhile and helpful, but that there was often a feeling that they had been 'done' to. They felt that there needed to be continuous support, coaching and mentoring to support them throughout their careers, and many asked for more of a focus on experiential learning and vocational training, and not just to specialise in the delivery of distinct programmes.

Whilst it was felt that the national body should co-ordinate the top talent, there was a call for local systems to be able to manage their own talent, possibly in accordance with a national framework provided that it ensures the flexibility to tailor approaches according to local need. There were concerns that the selection process to talent pools was not appropriate or fair at times, for example, where a Board position in a large Trust automatically qualifies the post-holder for a place on the scheme. Some participants noted that there needed to be more focus on the fostering of talent within middle management and amongst NHS trainees. One group suggested that the NHS should foster larger talent pools, and should not be afraid of growing greater numbers of capable and ready leaders.

There was a suggestion that funding should be earmarked for the purpose of developing and delivering effective talent management, and that some or all of this may be secured as a result of reviewing and honing existing leadership programmes.

Whilst not always directly related to talent management per se, some felt that workforce planning was often inadequate. One example given was of a current programme to recruit nurses from overseas, because there were no nurses coming through the pipeline in England. Allegedly, this situation was as a direct result of earlier forecasts which suggested that there would be a decreasing need for nursing staff in the future, and so causing a slowing down in training new nursing staff.

There were a variety of comments relating to the NHS graduate programme. Some criticised the scheme, saying that it was not bringing through sufficient numbers and that local solutions had to be determined to ensure that young talent was being encouraged and nurtured. Others said they would rather have a higher calibre of graduate even if it meant fewer numbers. One suggested that, having spoken to those on the graduate scheme, around half had expressed no intention of staying in the NHS on completion of the programme. Lastly, it was felt that with decreasing numbers of graduates taking part in the scheme, it no longer offered value for money, and only a small number of Trusts were able to benefit from the programme.

28 **Develop the organisation and its culture, and not just the individual.** Many of those who had undertaken leadership programmes, e.g. Darzi fellows, spoke of issues when they returned to the organisation. Some said that their peers and others placed them under significant pressure on their return. They suggest that this arose, perhaps, from jealousy or a lack of understanding of what the programme entailed for the wider organisation, e.g. 'a lazy year out'. Many say that these challenges limited their capacity

to make change happen locally, as well as their own personal improvement and development.

It was strongly felt by many that leadership training for individuals is often disconnected from the organisation, and this needs to be addressed. This would help to ensure that opportunities to use newfound skills are available to those returning from training. It was suggested that there is a need to help develop the culture across healthcare organisations so that both organisations and individuals want to improve and to develop effective leaders, and that the wider benefit is widely communicated and understood.

29 **Ensure follow-up and ongoing support.** Many felt that there was a need to set goals (including competencies and behaviours) as part of any leadership development, e.g. 'what will I commit to changing as a result?'. They felt that there should be appropriate follow-up and review of how well leadership styles and capabilities have developed or changed following training and development.

It is suggested that, when clinicians and others are taken out of the 'real world' for a period of time to attend programmes, more help is needed with the practical application of what has been learnt in the 'classroom' when they return to their organisations. It was felt that ongoing programmes of coaching and support are essential. This approach would help individuals to address any hostile responses they may receive when returning to the organisation (see section 28), or for those working under more challenging circumstances, e.g. organisations in special measures.

Also suggested were peer reviews, and individual feedback and assessment to help evaluate the degree to which personal goals have been accomplished. Organisational coaching was also proposed as a means of developing the organisation and environment, as well as the individual. Some suggested that this should be developed and delivered locally, as existing national programmes do not meet all their needs.

It was claimed by some that there is insufficient preparation of individuals before going into the 'real world', and that more support is needed to help them deal with the pressures associated with more senior positions. One participant claims that this lack of support led to them making the decision to step down from a leadership post.

30 **Developing leadership programmes.** There was a strong consensus for developing leadership programmes to include, as core:

- Quality improvement and change leadership
- Communications training
- Engagement skills e.g. with staff, patients and whole communities
- Managing the Politics and the 'politics', and understanding the Political cycle to help facilitate change
- More focus on embedding values and positive behaviours and attitudes
- The importance of being inclusive, the benefits of harnessing a diverse workforce and understanding different cultures, backgrounds and characteristics
- Practical application, as well as theory

31 **General improvements suggested.** Individual participants shared a number of improvements that they felt were needed, and these are listed below:

- Training approaches need to be geared more towards the clinician mindset to appeal to clinicians and enable their buy-in, e.g. more evidence-based examples
- There needs to be more training needs analysis before and after sending someone on leadership development
- There needs to be a better selection process for those who go through leadership training, ensuring that they do not get lost in the system afterwards. There was more than one suggestion of tracking leaders using their national insurance numbers
- It would be helpful to have a personal contact at the Leadership Academy to help with problems such as issues with the 360 review process.
- There needs to be more strategic alignment across programmes, e.g. the leadership framework does not appear to fit with the *Nye Bevan* programme
- Opportunities need to be made to aspiring leaders, and not just to existing ones
- Equal opportunity and access for all clinicians (including AHPs) – not just medical and nursing
- Course leaders need to have experience of leading in senior positions. It is felt that, more commonly, trainers have little or no relevant experience
- The ratios of clinicians on programmes does not reflect the increasing numbers of clinicians in leadership positions
- A coaching and mentoring register would be welcomed
- Consider a more modular approach with options to select courses from different levels
- Certain components of leadership training should be mandatory, as these skills are as essential as other aspects, e.g. clinical care

32 **Evaluating leadership development.** Some participants discussed the need to measure the impact of leadership development, and suggested that this should be part of future arrangements. This should not be limited to the person who attended, but should also assess the resultant effect it has had on their peer group and organisation. It was noted that measuring the 'ripple effect' of individual development on organisations was very difficult, but that there needs to be some way of building up an evidence base. This would also help to sell the importance of participating in leadership programmes to more organisations, clinicians and others.

33 **Addressing barriers.** Many participants described perceived barriers, which, if addressed, may help both to improve the effectiveness of leadership development programmes, and to embed model behaviours, attitudes and values across organisations. These are as follows:

- The need to provide and/or protect clinical time for reflection and development
- A mismatch between the local view of who is appropriate for leadership development, and the national view
- Inconsistent quality/application/opportunities for leadership training across Trusts
- In some cases, no suitable promotions or opportunities have been available after attending training, so some individuals were unable to advance their careers, or were unable to apply their learning to benefit patients and their organisation

- Further funding is needed to improve access to discretionary programmes which are valued by local NHS organisations

- Many (senior) clinicians are not trained to be leaders

- A general lack of encouragement to develop good doctors and staff on the ground

- There is too much focus locally on mandatory training, and not enough on leadership development

- Inability to access the training needed from the NHS Leadership Academy, so the requirement to look externally, e.g. MBA

- There needs to be a way to encourage politicians to think beyond the four-year cycle if long-term changes are going to be possible, e.g. hospital closures

34 **Other considerations.** The following individual comments were received which, though not falling into any of the common themes listed above, may be helpful to consider further when developing recommendations.

- The appraisal/individual review process and performance should link directly to pay and reward. This will help to encourage positive behaviour and effective performance

- Look at the IHI Open School/MOOCs - online platform vehicle for development (develop social responsibility)

- Mary Seacole is a good programme, but is not really an effective way of developing leadership

- New, contemporary approaches are needed- the NHS is still stuck in its old ways

- Leadership is not a profession in itself – it is part of a role

Themes: improvement

This section describes the themes that relate exclusively to aspects of improvement.

35 **Commitment to national improvement talent.** It was clear that participants valued the quality improvement expertise presently available at national level, and there was strong support to retain valuable skills and experience in the event of any possible restructuring. It was felt that national arrangements tended to pull such resources away from local systems, and participants were keen to see a redistribution of national resources closer to the front-line.

36 **Role of a national body.** Participants shared strong views about needing to ensure that the focus of any national body is restricted to what might actually be achieved at a national level. There should be a limited number of priorities, and very clear, realistic goals with measures for their evaluation. The scope for a national body should therefore be narrower and far more focused at present.

Possible key objectives and activities suggested by participants include:

- Ensuring a common language of improvement across health and social care, and between different professions

- Horizon scanning and thought leadership, and helping to prepare the health and care sector for the future

- Providing national brokering services across health and care, and building and nurturing a network of regional improvement bodies. The *UK Improvement Alliance* was cited on several occasions as a possible partner and vehicle to enable this

- Supporting, encouraging and paving the way for local innovation, whilst being careful *not* to stifle it

- Bringing together and facilitating sector-led leadership programmes on key issues, including clinicians and managers

- Supporting shared learning and knowledge, including through partners, and enabling/facilitating comparisons and benchmarking

- Developing and/or enabling coaching, mentoring and support for staff leading change (whether undertaking a specific improvement role, or as part of the 'day job'). This might include supporting clinicians and other staff as change agents, and ensuring that they have opportunities when back in their organisations to apply the theory they have learnt in the 'classroom'. It is also considered important to train staff in understanding and using data properly

- Leading and promoting cultural change across the health and care sector

- Developing and promoting NHS improvement as a dedicated profession with standards and a clear career pathway. This may also help to safeguard change agents at organisational level, as well as help to embed improvement capability at local level

- Promoting national-level change programmes which are essential to achieving improvements across England, e.g. better access to, and use of primary care data; technology adoption; and health information, informatics and

measurement. One national body suggested a focus on cardiovascular diseases, as well as maximising the contribution to health improvement and disease prevention

- Developing a national framework/model/standards and tools for effective improvement, which is not prescriptive and which organisations can *choose* to adopt

- It was felt important to develop more practical, evidence-based approaches, rather than more conceptual, theoretical work or methodologies. A small number of participants discussed the importance of not believing in the *PR*, citing examples of locations and systems whose reputation was positive, yet which appeared to have more quality issues than elsewhere, for example the number of Trusts in special measures following the review by Sir Bruce Keogh

- Ensuring the delivery of evidence-based best practice and improvement support which directly supports delivery of national priorities, e.g. if addressing sepsis is a national priority, then ensure that toolkits are available on improving sepsis

- Investigating improvement claims, undertaking benchmarking and supporting peer-to-peer review, and identifying and promoting best/leading edge practice in quality improvement and transformation within England and other healthcare systems and sectors. Facilitating their translation, where applicable, into health and care, disseminating and supporting local adaptation and implementation

- Supporting (including through providing resources) and engaging time-constrained clinicians to develop and deliver innovations. Addressing clinical time pressures is a key issue

- Provide leadership and direction to local organisations on quality improvement, but only if matched with local freedoms

- Supporting and co-ordinating improvement in clinical communities and priority pathways and accelerating improvement in these areas

- Identifying minimum standards for successful change, e.g. the number of change agents for a certain size of organisation

- Helping to get organisations and people off the 'starting block' and then moving to local delivery

- Drawing up a list of accredited and approved suppliers of quality improvement

- Advising regional bodies in procuring support

In terms of scope, there was a feeling that improvement approaches currently cater more for hospital-based care and ambulance services. However, they also need to consider commissioning as well as GP practices, primary care and nursing homes, for example.

37 **Hosting arrangements.** Where the national arrangements might be hosted was not a subject for frequent discussion, but some strong - and sometimes opposing - views were expressed.

Concerns were noted by some about the function being based within NHS England, including that quality improvement might lose its influence and its brand, and importantly that it may not reflect the priorities and needs of social care and other partners across the health and care system. Nevertheless, the need for a formal link to

NHS England was recognised, for example, to gain access to primary and secondary care, and some actively promoted NHS England as the most appropriate host.

A small few were keen to see a regional or local hosting arrangement based within either an NHS commissioner, or a provider; and others suggested perhaps a University or the Health Foundation. There was one suggestion that the national team might sit under the National Quality Board.

38 **Restructuring considerations.** Some participants noted the importance of considering where NHS IQ staff and programmes should transfer, to ensure that key pieces of work were not compromised. There was a popular theme that staff and programmes should be devolved into regional structures to ensure momentum was not lost, and to ramp up regional and local expertise.

Some felt that the most cost-effective approach would be to consolidate programmes and realign them with the 5YFV, making adaptations to, and clarifications of roles and responsibilities rather than to introduce significant changes. Regardless of the approach, there was a consensus amongst those who commented that programmes should be reviewed and reshaped in accordance with priorities.

It was noted that some helpful aspects, including the National Clinical Advisory Team (NCAT) and ECIST appeared to be lost in the previous restructure. People valued the non-judgemental and supportive approach taken by these bodies, and would welcome their re-emergence. It is important to ensure continuation of the elements that work well if any future restructuring is to take place.

Some focused on the need to be brave, and let people 'go' where the alternative would be to put 'square pegs in round holes.' They added that inappropriately matching people to positions would push problems into local systems and cause unacceptable inertia in delivering the changes required.

39 **Supporting improvement specialists and teams.** It was felt that there needs to be significantly more support for change agents through access to, for example, coaching, mentoring, action learning sets and training. This will help to sustain improvement resource and to support individuals and teams in overcoming barriers faced. It will also ensure continuous learning and sharing.

Some participants felt that improvement within health and care should be recognised as a profession, with reward and recognition systems reflecting and encouraging improvement activities. Ultimately, all agreed that improvement should be a part of everyone's day job. It is felt that the Key Skills Framework should be adapted both to reflect this, and to support improvement as a dedicated profession.

40 **Recognising and celebrating achievement to incentivise, motivate and engage.**
Many noted that current arrangements within the NHS are often punitive, and that the current culture does not allow for mistakes to be made (including not meeting performance targets in full). Various suggestions were offered to counter this, which would also serve to encourage innovation and acceptable risk-taking for the purposes of improving patient services and outcomes.

It was felt important to celebrate any achievements across the system, particularly at local level and no matter how small. This would help to create enthusiasm for improvement work, as well as develop an evidence-base.

To incentivise partners to collaborate in improvement, one participant suggested that systems could be work towards the achievement of a prestigious system-based accolade, e.g. a star system, or an earned title, such as with the '*Investors in People'* scheme.

Some noted that it is important to recognise clinicians' involvement with titles, as kudos is important to many and can help to motivate them and encourage their involvement, e.g. such as with the patient safety arrangements, fellowships or a title such as 'national leader in…'.

41 **Radical thinking.** Where expressed, there was strong support for both *Health and Care Radicals* and *The Edge*. However, there was some concern that these were becoming increasingly abstract and perhaps moving too far away from the mainstream; also, that it was important to ensure a balance with the scientific and evidence-based mindset of many clinicians and others. Some felt there needed to be a place for these alongside more mainstream activities, to ensure that practical solutions might be developed.

42 **AHSNs.** Some participants suggested that AHSNs should be commissioned to provide improvement expertise and help to develop capability within providers. Explicit delivery targets for national improvement priorities should also be set for them. Participants wanted to see more alignment between AHSNs and local/regional arrangements and priorities.

43 **Support for Local Improvement Coalitions.** In later engagement events, the review team shared emergent thinking relating to the possible establishment of Local Improvement Coalitions (LICs). There was wide-spread support for both this suggestion, and for mirroring the geography of the existing AHSNs. Participants shared the following ideas as to what might be included within the role and remit, as follows:

- Responsibility for NHS Interim Management and Support (IMAS) and Intensive Support Teams (ISTs) should sit with the LICs

- Local Healthwatch organisations should play an active role, possibly as members of the LICs

- LICs should broker relationships across the system, especially where they already have good networks and arrangements in place

- The Health and Wellbeing Board and/or its partners should be a member of the LIC, particularly local authorities, public health and social care

- The LICs should link into local academia and CLAHRCs (Collaborations for Applied Health Research and Care). It was noted that academic networks are a very good, but seldom-used way of engaging with clinicians and GPs. One group suggested that academic institutions should be given a formal delivery remit

- Bringing together data and information from across the system

How the LICs might engage with GPs was considered to be a very important question for consideration, particularly given the challenges in engaging GPs *as providers* (see section 17 above). A number of other provider organisations noted that, to buy into the model,

the benefits to them would need to be clear, as would how they might participate in decision-making and access the resources available.

It was felt that a membership model would be helpful to ensure commitment to, and ownership of the LIC, and that involvement at Chief Executive level would be essential.

Whether through the LIC or an alternative model, it was suggested that local collaborations or networks should be responsible for sharing learning, embedding local improvement capability, and for developing a cadre of improvement leaders with advanced expertise.

Some felt that AHSNs would be well placed to co-ordinate arrangements for the LICs, and all fifteen AHSNs subscribed to a shared written response to express their support in principle for leading and co-ordinating such arrangements. They noted that creating local bodies elsewhere in the system, with which they would be required to collaborate, would fragment the work they are doing, drain their resources, and cause further confusion within the system. AHSNs were clear that they would not wish to become responsible for performance management of the system, and that it is important not to re-create Strategic Health Authority arrangements, or parts thereof. They also emphasised that they would wish to continue their work relating to innovation and wealth creation in conjunction with local industry.

However, there were concerns raised by many participants that not all AHSNs would be ready or capable of taking on this responsibility without further development, and that not all would necessarily choose to. It was suggested that arrangements for LICs should be determined locally, based on appetite, capability and, ultimately, what works for the local system. A full review of AHSN capability was felt to be essential in the next phase of the review, as was a consideration of how a national body might be able to co-ordinate the work across fifteen systems.

Some participants noted that the NHS Leadership Academy's Local Delivery Partner (LDP) geographies were different from the AHSNs (ten as opposed to fifteen). There were questions as to how this might work, and some concern over spreading LDP resources too thinly as a result. One particular LDP debated how yet another local membership model might co-exist with the membership approach they already have in place.

Some asked about the role, if any, that independent providers might play in LICs, and raised issues of conflict of interest given the competitive nature of the market. It was felt that there were also many other similar conflicts to consider within the health and care system, not least between providers and commissioners, and between provider organisations, and that whilst this may not be insurmountable, it certainly requires some careful consideration.

The need to manage expectations in terms of what could be delivered was raised, and some participants were concerned about the scope and scale, questioning where resources, capacity and investment might come from.

There was also a suggestion that there be a pool of quality improvement resources. Some said they would like to see the availability of consultancy skills to support Trusts in difficulty.

44 Concerns relating to the size of the national improvement team. As emergent proposals were shared with participants, a few noted that a 'small' national team of around 30 people was still too large.

45 Improvement in primary care, and challenges with data. It was noted that current improvement models are very hospital-centric and there needs to be more of a focus on tailoring approaches to suit primary care. It was suggested that primary care possibly has the some of the most technologically advanced systems in many respects, but there are significant challenges in accessing and analysing related data. As the data exists in many cases, it was questioned whether investment might be needed to increase analytical resource, as has previously been the case in secondary care, mental health and the ambulance service. This is a significant barrier to improvement, and needs to be addressed if primary care is to be developed to facilitate delivery of the 5YFV.

46 Barriers and cultural aspects. Participants shared a number of perceived barriers, which they felt needed to be addressed if an improvement culture and approach is to be nurtured across health and care. These are as follows:

- Achieving the 5YFV will require a wholesale change in mindset

- Culture is often a barrier, and the right culture and behaviours are needed at system, organisational, team and individual level to support, deliver and sustain change. A 'blue skies thinking' approach is needed, rather than being confined to perceived boundaries

- Clinical hierarchy and culture can be a barrier to change and innovation, and this needs to be addressed

- It is important to protect local improvement resource(s). There are examples of whole teams being axed to address financial pressures

- Political interference at local and national level is a big factor in both addressing and delivering changes needed. Mechanisms to address this are important, and central support may be needed at times

- There are many leaders and managers in post who do not have improvement skills and also may not have the leadership skills required to support change. It is important that this is addressed

- It is important for national bodies to understand and accept that locally-selected projects will not always hit the priority targets. However, they are meaningful locally, therefore more likely to succeed and will help to embed the required improvement culture, skills and capability. Compromise is needed - perhaps an agreed mix of national and local priorities

47 Improvement principles. There were many comments expressed about the core principles essential to any improvement strategy or approach. These are summarised below.

- Improvement needs to be everyone's business, and improvement capability should be developed at all levels. This also ensures that skills are not lost when experts move on

- Improvements and best practice advocated must be evidence-based to ensure clinical buy-in

- It is important to educate different professions about what is, and is not possible and how to achieve compromise, e.g. possibilities for financial savings within and outside of London are very different owing to different capital structures

- There is no one magic solution, and local solutions or pilots must be adapted for local implementation. It is important to recognise that some best practice may not be suitable for implementation elsewhere

- Change approaches need to happen more quickly. They are currently too slow with 3 to 5 year time-frames

- Peer challenge and learning from other sectors is an important factor

- There needs to be a consistent application of project approaches, not just picking and choosing what suits, otherwise important aspects are missed

- More focus is needed on the implementation of change, which is where projects often falter

- There should be more quality assurance in the project approaches used and applied

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Annex G

Review of Strategic Clinical Networks, Clinical Senate and Academic Health Science Networks: Final report

March 2015

Contents

Executive summary

The review began in September 2014, and has sought to answer four questions:

A. What purpose were SCNs / Senates / AHSNs originally designed to fulfil (for NHS England, for commissioners and for the wider system)?
B. What benefits are they providing **currently**?
C. What functions are needed in **future** to support a self-improving system and the delivery of transformational change, particularly in light of the priorities that will be identified through the 5 Year Forward View?
D. How should the architecture by arranged to provide these functions, to ensure maximum value for the £100m investment?

Having engaged widely with stakeholders, including those working in AHSNs, SCNs and Clinical Senates, and with those they serve, we have found that all of the bodies subject to this review are delivering benefits in some areas. Those working within them are committed to their objectives and to working to improve the quality of health services. The bodies have forged strong partnerships across their geographies and are working through these to spread evidence, best practice and innovation.

However, there is a lack of clarity as to the role, remit, responsibilities, governance and accountability, and expectations on the bodies. This has resulted in inconsistencies between bodies in terms of
- their oversight and accountability relationships, both with NHS England and their members;
- how well they are able to demonstrate impact systematically;
- the extent to which they are aligned with the priorities of the statutory parts of the system that they serve, both locally and nationally; and
- how far they are aligned with each other and can avoid duplication.

With this in mind, the recommendations from this review are centred on the conclusions that the three parts of the system play a key role in the system and should continue. However, that changes are needed to clarify their roles, to strengthen accountability and governance, to ensure relevance to local health economies' and national priorities, and to secure appropriate alignment between bodies.

In summary, we recommend that:
- Clinical Senates' role should be to support transformation through the provision of independent clinical advice on major service change. There should be one overarching senate governing body per region. They should be accountable to the Regional Medical Director and continue to have independent Chairs.
- SCNs should be known as 'Clinical Networks' recognising that they operate on a continuum between an operational and strategic focus. There should be robust business planning and assurance process put in place.
- Our ambition should be that AHSNs and Clinical Network are streamlined, and operate as a single support entity for their member commissioners, providers and professionals. We expect that there will be a small number of AHSNs where a streamlined approach could be achieved in 2015/16.
- Clinical Network boundaries should be aligned with AHSN boundaries, wherever possible. There should be a minimum expectation that AHSNs and Clinical Networks' business plans, including focus, priorities and delivery mechanisms are aligned. Strengthened governance and assurance processes should be implemented from 1 April 2015/16 to ensure value for money from the continued investment in this architecture.

Part one

Background

1. NHS England currently invests circa £100m p.a. in infrastructure at a sub-regional level which is designed to support improvement, innovation and change in the health system. Whilst this architecture is funded by NHS England, it provides support at three levels: to NHS England, to commissioners; and to the wider health system. The architecture includes:

    a. four Strategic Clinical Networks (SCNs), operating in 12 geographic areas;

    b. 12 Clinical Senates; and

    c. 15 Academic Health Science Networks (AHSNs).

2. This infrastructure plays a vital role in supporting the NHS to be a self-improving system, to harness the best practice and innovation available to improve patient care, and to maximise the NHS 's contribution to economic growth. However, the origins of the different elements are varied, and one year into its existence, there was a need to reflect and take stock of how it has been operating, and how the NHS could get best value from this resource.

3. NHS England has therefore been conducting a review of this architecture as part of the wider development of an operating model for NHS England, underneath the Organisational Alignment and Capability (OAC) Programme.

4. The OAC Programme overall aims to:

    a. ensure the organisation is clearer and focused on its core purpose and priority objectives

    b. build new capabilities for the organisation, which are critical for it to carry out its role as a commissioning organisation; and

    c. streamline and align the functions and structures which support the organisation to work more effectively across the national support centre, regions and area teams to minimise duplication and make more effective use of our resources.

5. In this context, the review has examined the role and function of SCNs, AHSNs and Clinical Senates currently, and sought to understand what functions are needed in the system and how these can best be provided in the future. It is taking in place in parallel with an interconnected review of the NHS Leadership Academy and NHS Improving Quality.

6. Given the wider context within which this review has taken place, the review has also sought to bring clarity to potential staff implications of any options going forward, and to align with the wider OAC Programme timetable.

Terms of Reference

7. The review's terms of reference are set out in the box below.

8. In parallel, a review of NHS Improving Quality and the Leadership Academy, is being conducted. A single Strategic Steering Group was established to bring the findings of both review together.

Review of SCNs, AHSNs and Clinical Senates – terms of reference:

a. To review the purpose, scope and alignment of Strategic Clinical Networks, Academic Health Science Networks and Senates, funded by NHS England, to identify where there is confusion, complexity or duplication of function, with a view to ensuring best value for the resources invested.

b. To provide early findings to the Strategic Steering Group in December, with input from key stakeholders and other arm's length bodies, and to understand and clarify potential staff implications

c. To inform and align with the review of NHSIQ and the NHS Leadership Academy, with a view to informing the NHS England programme budget and business plan decisions for 2015/16.

How the review has been conducted

Governance

9. This review of SCNs, AHSNs and Clinical Senates was commissioned by the Organisational Alignment and Capability Programme Board in September 2014. The SRO for this review has been Karen Wheeler on behalf of the NHS England Leadership Team. It has been guided by an Operational Steering Group, comprised of:

    -   Commissioning Operations Directorate: Richard Barker (Chair), David Levy, Nigel Acheson, Damian Riley, Andy Mitchell, Wendy Saviour
    -   Medical Directorate: John Stewart
    -   Nursing: Hilary Garratt
    -   Finance: Sam Higginson
    -   Patients and Information: Giles Wilmore
    -   NHSIQ: Steve Fairman
    -   Commissioning Strategy: Michael Macdonnell

10. The review has been conducted by a working group with resource from the National Support Centre and each regional clinical team, including:

    -   David Levy (Chair) – Regional Medical Director, Midlands and East
    -   Nigel Acheson – Regional Medical Director, South
    -   Simon Bennett – Director, Clinical Policy and Professional Standards, National Support Centre
    -   Lauren Hughes – Head of Quality Strategy, National Support Centre
    -   Genevieve Dalton – General Manager Revalidation, Networks & Senates, Midlands and East
    -   Jane Dunning – Deputy to Regional Medical Director, North
    -   Pat Haye – Deputy Director Clinical Senates and Clinical Networks, South
    -   Lucy Grothier – Associate Director, Strategic Clinical Networks, London

The Working Group reports into the Operational Steering Group, which in turn reports into a Strategic Steering Group which has overseen both the review of SCNs, Senates and AHSNs, and the parallel review of the NHS Leadership Academy and NHS Improving Quality.
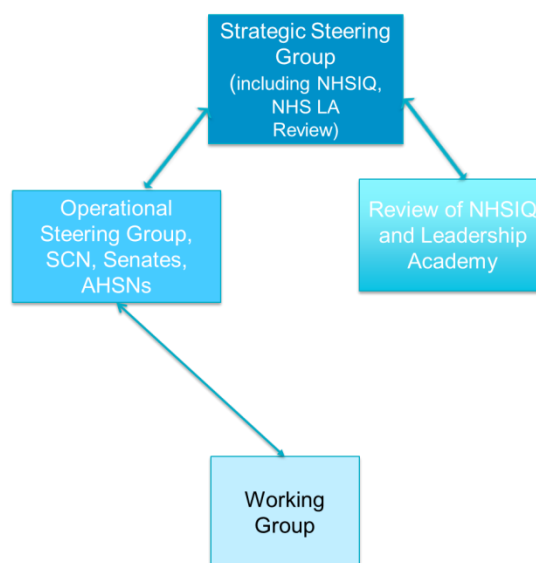
Key questions

11. The review has considered what improvement and innovation support is needed by a) NHS England, b) commissioners and c) the wider system. It has sought to answer a set of four key questions:

   A. What purpose were SCNs / Senates / AHSNs originally designed to fulfil (for NHS England, for commissioners and for the wider system)?

   B. What benefits are they providing **currently**?

   C. What functions are needed in **future** to support a self-improving system and the delivery of transformational change, particularly in light of the priorities that will be identified through the 5 Year Forward View?

   D. How should the architecture by arranged to provide these functions, to ensure maximum value for the £100m investment?

12. These questions have been considered in the context of wider improvement and collaborative roles and organisations in the health system such as Operational Delivery Networks, the National Clinical Directors, Commissioning Support Units, NHS Improving Quality, NHS RightCare, the NHS Leadership Academy, Intensive Support Teams and others.

Timetable

13. There have been four phases to the review:

Mid – end September 2014
1 Desk based work to gather and map information
Prepare for phase 2

Early – end October 2014
2 Engagement with stakeholders to test and build on information gathered in phase 1

Early – mid November 2014
3 Development of early findings for the Strategic Steering Group
Understanding and clarifying staff implications

November – December 2014
4 Testing options with stakeholders and informing / aligning with the review of NHSIQ and NHS Leadership Academy

Engagement with stakeholders

14. There are a range of key stakeholders which the review has sought to engage with and gather and test views, including:

- Leaders, staff and members of AHSNs, SCNs and Clinical Senates
- Networks working with and as part of the above
- NHS England directorates, and National Clinical Directors
- Patients and the Public, and representative bodies
- Voluntary sector organisations and representative bodies
- Clinical Commissioning Groups
- Providers
- Department of Health and other arm's length bodies, particularly CQC, Monitor, and NHS TDA

15. The working group have engaged with stakeholders in each region through a variety of engagement events and meetings, by seeking written views in response to the review's four key questions. We received over 290 written responses to the review, and engaged with stakeholders by attending over 40 meetings and events. We also held two national events bringing together over 100 stakeholders from across the health economy to consider the four questions. The views and ideas we heard have been incredibly informative and helpful and have informed this report.
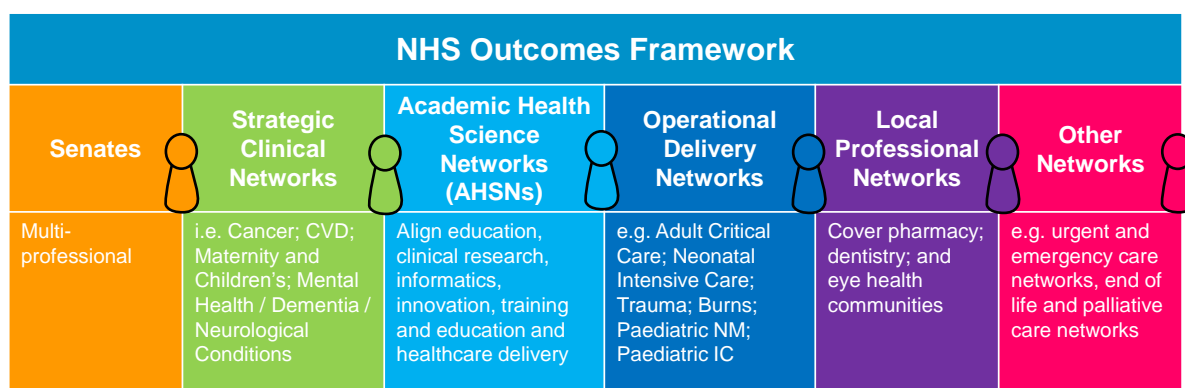
Dependencies

16. There are several dependencies identified for the review, which the working group and Operational Steering Group have been conscious of in conducting the review and producing the report:

a. **Forward view** – the Five Year Forward View was published while the review was being conducted. The review's findings need to be considered in the context of the vision the Forward View set out and what support the health and care system will need to get there;

b. **Running costs reductions** – the 15% running cost reductions which are being made across NHS England will apply to the admin funded elements of SCNs and Senates. This review will need to take account of the shape of the structures once the running costs have been reduced;

c. **Developing a new Operating Model for NHS England** – this review is one component of wider work to develop a coherent operating model for NHS England. This review will need to take place in the context of and respond to other elements of the operating model as they develop; and

d. **AHSN Licence** – AHSNs were created in 2013 and were given a five year licence from NHS England which is contractual. A contract is signed on an annual basis between NHS England and each AHSN to reflect their priorities for the coming year and their funding allocation.

Part two

What we have heard:

17. There are a range of networks in the health system, which have evolved historically from a number of different source, funding streams and with different purposes, as the figure below illustrates:

Different types of network

NHS Outcomes Framework					
Senates	**Strategic Clinical Networks**	**Academic Health Science Networks (AHSNs)**	**Operational Delivery Networks**	**Local Professional Networks**	**Other Networks**
Multi-professional	i.e. Cancer; CVD; Maternity and Children's; Mental Health / Dementia / Neurological Conditions	Align education, clinical research, informatics, innovation, training and education and healthcare delivery	e.g. Adult Critical Care; Neonatal Intensive Care; Trauma; Burns; Paediatric NM; Paediatric IC	Cover pharmacy; dentistry; and eye health communities	e.g. urgent and emergency care networks, end of life and palliative care networks

18. Whilst this review has focussed on SCNs, AHSNs and Clinical Senates it has had to consider the roles of other networks, relevant groups and organisations. In conducting the review, the team also heard views about the current role and future potential of the NHS Leadership Academy and NHS Improving Quality, which are being reviewed separately. This report does not touch on the roles of these groups, but what was heard has been fed into the Strategic Steering Group overseeing both reviews.

19. This chapter will now set out a summary of what the review has heard in response to the four key questions that it has asked:

    a. What purpose were SCNs / Senates / AHSNs originally designed to fulfil (for NHS England, for commissioners and for the wider system)?
    b. What benefits are they providing **currently**?
    c. What functions are needed in **future** to support a self-improving system and the delivery of transformational change, particularly in light of the priorities that will be identified through the 5 Year Forward View?
    d. How should the architecture by arranged to provide these functions, to ensure maximum value for the £100m investment?

A. What purpose were SCNs / Senates / AHSNs originally designed to fulfil (for NHS England, for commissioners and for the wider system)?

<u>Strategic Clinical Networks</u>

21. *The Way Forward – Strategic Clinical Networks (26 July 2012, NHS Commissioning Board Authority)*, set out the vision and direction for SCNs as follows:

> "We will introduce a new type of network called strategic clinical networks. They will be established in areas of major healthcare challenge where a whole system, integrated approach is needed to achieve a real change in quality and outcomes of care for patients. Strategic clinical networks will help commissioners reduce unwarranted variation in services and will encourage innovation. They will use the NHS single change model as the framework for their improvement activities."

> "A small number of strategic clinical networks will help drive improvements in key areas.

> - when a large scale change is required across very complex pathways of care involving many professional groups and organisations and is the best approach to planning and delivery of services; and

> - where a co-ordinated, combined improvement approach is needed to overcome certain healthcare challenges, which have not responded previously to other improvement efforts."

> "From 2013 SCNs will be established and supported in the following areas:

> - Cancer

> - Cardiovascular disease (incorporating cardiac, stroke, diabetes and renal disease)

> - Maternity and children;

> - Mental health, dementia and neurological conditions."

> "Strategic clinical networks will be established for up to five years, depending upon the amount of change that is needed in a specific area. As priorities change or when the work of one of the initial strategic clinical networks concludes the NHS CB will identify new conditions or patient groups that would benefit from a strategic clinical network approach."

22. Strategic Clinical Networks are accountable to NHS England through a line management relationship between the SCN Associate Director and Area Team Medical Director. The extent to which this operates as a typical line management relationship varies, with some SCNs being more closely aligned with Area Team priorities than others.

Clinical Senates

23. *The Way Forward – Strategic Clinical Networks (26 July 2012, NHS Commissioning Board Authority)* also set out a vision at a high level for Clinical Senates:

> "Clinical senates will provide evidence-based advice to help commissioners put the needs of patients above those of organisations or professions. They are likely to play a key role in providing a strategic overview of major service change – for example, on service redesign and reconfiguration."

24. Further detail on the role and purpose of Clinical Senates was then published six months later in *The Way Forward – Clinical Senates (25 January 2013, NHS Commissioning Board Authority):*

> "Clinical Senates will be established across the country from April 2013 to play a unique role in the commissioning system by providing strategic clinical advice and leadership across a broad geographical area to CCGs, HWBs and the NHS CB.

> Clinical Senates will not be focused on a particular condition. Instead they will take a broader, strategic view on the totality of healthcare within a particular geographical area, for example providing a strategic overview of major service change. They will be non-statutory advisory bodies with no executive authority or legal obligations and therefore they will need to work collaboratively with commissioning organisations**."**

> "The type of strategic advice and leadership Clinical Senates will be able to provide includes:

> * engaging with statutory commissioners, such as CCGs and the NHS CB to identify aspects of health care where there is potential to improve outcomes and value. Providing advice about the areas for inquiry or collaboration, and the areas for further analysis of current evidence and practice

> * promoting and supporting the sharing of innovation and good ideas

> * mediating for their population about the implementation of best practice, what is acceptable variation and the potential for improvement with AHSNs for a specific part of the country. Based on evidence and clinical expertise, they will be able to assist in providing the public profile on service changes

> * providing clinical leadership and credibility. Understanding the reasons why clinical services are achieving current clinical outcomes and advising when there is potential for improvement through significant reconfiguration of services

> * taking a proactive role in promoting and overseeing major service change, for example advising on the complex and challenging issues that may arise from service reconfiguration within their areas

> * linking clinical expertise with local knowledge such as advising on clinical pathways when there is lack of consensus in the local health system

> * engaging with clinical networks within a geographical area."

25. Clinical Senates are chaired by an independent Clinical Chair, who is appointed by NHS England. Management support to the Senate is provided by NHS England staff, reporting to the SCN Associate Director, who is accountable through a line management relationship between to the Area Team Medical Director.

Academic Health Science Networks

26. AHSNs were first described in *Innovation, Health and Wealth (5 December 2011, Department of Health)* as follows:

   "The AHSNs will present a unique opportunity to align education, clinical research, informatics, innovation, training & education and healthcare delivery. Their goal will be to improve patient and population health outcomes by translating research into practice and developing and implementing integrated health care services. Working with AHSCs, they will identify high impact innovations and spread their use at pace and scale throughout their networks."

   "Every local NHS organisation should aspire to be affiliated to its local AHSN, which would act as a high quality, high value gateway for any NHS organisation needing support or help with innovation, and provide industry with focused points of access to the NHS. Acting as a lead customer, the AHSN would work with industry to scope problems and jointly develop solutions to key health challenges. The AHSNs will strengthen the collaboration between clinicians and other practitioners and the medical technology industry on which innovative product development so often depends."

   "They would support knowledge exchange networks to build alliances across internal and external networks and actively share latest best practice, and provide for rapid evaluation and early adoption of new innovations under tight surveillance and monitoring."

27. After a period of development and negotiation, this role was translated into four objectives which are set out in AHSNs' 5 year licence with NHS England:

   • Focus on the needs of patients and local populations;
   • Speed up adoption of innovation into practice to improve clinical outcomes and patient experience;
   • Build a culture of partnership and collaboration; and,
   • Create wealth through co-development, testing, evaluation and early adoption and spread of new products and services

28. AHSNs are independent organisations, two thirds of which are set up as companies limited by guarantee. The others are hosted by NHS trusts and foundation trusts. They contract annually with NHS England, under the terms of a 5-year licence. NHS England holds AHSNs to account for their deliverables under their contract with NHS England, and their overall effectiveness and governance through a quarterly process, led by the National Medical Directorate and Regional Medical Directors. AHSNs are required to publish an annual report.

B. What benefits are they providing currently?

29. The information submitted to the review illustrated that all of the bodies subject to this review are delivering benefits in some areas. Those working within them are clearly committed to their objectives and to working to improve the quality of health services. The bodies have forged strong partnerships across their geographies and are working through these to spread evidence, best practice and innovation.

30. However, there are inconsistencies between bodies in terms of where they derive their priorities; how well they are able to demonstrate impact systematically; and the extent to which they are aligned with each other and with the priorities of the statutory parts of the system that they serve, both locally and nationally.

31. In this section, we will set out what we heard in terms of the benefits being provided by each part of the system subject to this review, and where there are areas of duplication and misalignment.

Strategic Clinical Networks

32. SCNs are acting in a range of roles along a continuum, from operational to strategic. The uniting factor is the focus on spreading evidence, best practice and clinical standards. Key to their success is the extent to which they are driven by their members' priorities, helping them to work collaboratively to solve problems faced locally.

33. SCNs are by definition the sum of the commissioners, providers and professionals who come together as part of the network; NHS England funding provides the support for that network to come together. However, this has got lost in some areas, and in the minds of some stakeholders, whose perception is that a SCN is a body that carries out improvement-type activity.

34. By pathway, SCNs approach and focus is determined to a large extent by whether networks were in place historically in that clinical area, and where the pathway is in its evolution:

    • Cancer and CVD networks have existed in some form in the system for some time and so tend to now be more operational.

    • Maternity networks are in many parts focussed on reconfiguration of services and pathways.

    • Mental health networks tend to be focussed on delivering national priorities, e.g. dementia and IAPT, and on making the case for investment in mental health.

    • Children's elements of networks also focussed on making the case for investment and improvement in services and pathways.

35. Not all regions' SCNs are organised around the four priority areas: in two regions, networks are organised around the domains of the NHS Outcomes Framework. This has led to confusion and a lack of consistency in approach, focus and expectation from NHS England and from customers of the networks.

36. Within regions, other networks have been established in other clinical areas to reflect local priorities, particularly for respiratory disease. In London during 2014/15, 15 networks have been funded from the central allocation of £2.08m.

Case Study 1: Northern England SCN work on Familial Hypercholesterolaemia, with the AHSN and CCGs

Although one of the commonest inherited conditions affecting around 1 in 500 people, FH is asymptomatic and therefore under diagnosed, with 85% of those affected remaining undiagnosed. The Northern Strategic Clinical Network supported a Lipids Specialist Advisory Group to agree a model of service delivery covering all 9 Acute Trusts in the region and prepared business cases to support funding bids. This has led to support from and partnership with a number of organisations including the AHSN, the BHF, the Northern CCG forum, pharma, an SME, the Genetics service and the provider organisations. Patients are now seen by a Lipids Specialist in their local lipids clinic, tested and once they have a definitive diagnosis they also see the genetics nurse who will gather the family tree and arrange cascade testing. The testing is part funded by an AHSN bid working with a company who are developing and establishing next generation sequencing assays. The network role has been to facilitate the continued partnership, To work with the Lipids Specialists to get the hub and spoke model of working in place and also currently to support the virtual FH MDT. The aim of this initiative is to raise the prevalence of confirmed diagnosis from the current 15% to 50% of those affected resulting in fewer premature cardiovascular deaths

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Case Study 2: South East Coast SCN, advice on maternity service configuration

The MCYP SCN was asked by two CCGs to provide advice within 3 weeks on the evidence base that would support (or otherwise) the development of a business case for a Standalone Midwifery Led Unit (FMU) in a particular town. The SCN established a small clinical working group to pull together the advice, based on consideration of a number of factors:
- choice provided by current maternity service provision in the area
- the evidence on the benefits of an MLU
- data on current and future population projections and birth rates (including home births, teenage and BME birth rates)
- future demands on existing consultant obstetric units in the area

The resulting advice was well received by the CCGs, who described it as an 'excellent piece of work providing a clear basis on which the CCGs can respond to any public or NHS system questions on this matter'. The advice was included as evidence in the CCG recommendations to the governing body and was cited in response to the significant media and public interest in the issue. This is a good example of the added value that an SCN can bring at short notice in harnessing expert clinical opinion on sensitive issues to support CCG decision making processes.

Case Study 3: Neurological SCN collective work on standards of care

SCNs have worked together with the National Clinical Director for neurological conditions, the Association of British Neurologists and the Neurological Alliance to develop a framework to improve the care of people with neurological conditions. The framework will provide a mechanism to support commissioners and healthcare professionals to improve the configuration and delivery of services using a set of national standards and measures which will improve access to and the quality of services across the country. The framework builds on the quality standards developed by the Association of British Neurologists translating a number of key standards into quality measures for unscheduled care: acute neurology and non-urgent care which can be used to measure improvements in care. The work has been developed on behalf of the 12 SCNs with significant input from the Greater Manchester, Lancashire & South Cumbria SCN and further work is under discussion to provide a similar framework for neurology services within primary care.

Clinical Senates

37. The stage of development of clinical senates is very varied. Their role is unclear to themselves and to stakeholders in many areas.

38. London has had a clinical senate for some time, and so its role and work programme is clear and established. East Midlands also has a well-established clinical senate which works in an integrated way with its SCNs and AHSN – the senate acts as a sense-checker for their work programmes.

39. Elsewhere, several senates are only just starting to come together, having their first meetings in September 2014. Others have been together for some time but are not yet focussed in work programme or remit.

40. It is important to note that Clinical Senates have assumed the NCAT role as part of the formal process to assure reconfiguration of clinical services. The lack of reconfiguration work at present is resulting in continued uncertainty about their purpose. Some senates as a result have sought to define their role more broadly, e.g. in focussing on improving population outcomes, however this has added to the confusion as to what their role is.

Case study 4: Greater Manchester, Lancashire and South Cumbria Senate, providing clinical advice on stroke services

The Senate provided a full independent clinical review of Greater Manchester's plans for future stroke services following the peer reviewed publication of the comparison between the London and Manchester systems and their outcomes in the BMJ. A team of clinical experts performed a review, including reviewing the information, interviews with key stakeholders and site visits. Aims of the review were to provide clinical advice with regard to optimising the working of the network model, maintaining a focus on the period after the 72 hour acute care bundle and clinical advice on how the model can be sustained in light of other potential reconfigurations. The review team found that excellent work has gone on in improving services for the hyper acute and acute phase of the stroke patient journey, but that the plans for care post 72 hours were less robust. The review team produced a comprehensive report and made 9 key recommendations to consider in future development of the stroke service across GM. This was well received by the sponsoring CCG commissioner on behalf of the Greater Manchester Integrated Stroke Service (GMISS) . The senate has been invited to review the action plans of GMISS wrt our recommendations in 3 months.

Case Study 5: Wessex Clinical Senate Council - Recommendation on Vascular Surgery in South East Hampshire

In September 2013 the Wessex Senate Council was asked by NHS England (Wessex) to consider four options for reconfiguration of vascular surgery in South East Hampshire. The Council was asked to review the four proposed options for vascular services against national and local guidance and to advise on the potential impact on patient outcomes, co-dependencies, co-location of services and standards for inter-organisational and inter-agency collaboration.

The Senate Council reviewed all of the options and found that the proposed options for the provision of vascular surgery in South East Hampshire did not identify a sustainable pathway and workforce, which would withstand shortages in key skills and keep up with rapid technological changes. There was a need for greater focus on the delivery of elective and emergency services with high quality pre and post discharge rehabilitation, re-enablement and psychological support close to where the patients live.

The Senate Council made a number of recommendations including that services should be provided by a single clinical service across the Portsmouth Hospitals and University Hospitals Southampton NHS Trusts, including all vascular surgeons, vascular radiologists, together with other staff as the service and commissioners determine. They also made recommendations around the staffing, accountability, training and development.

Case Study 6: South West Clinical Senate – recommendations on HIV care

The South West Clinical Senate was asked by the specialised commissioners, South West, to provide advice on the optimal model/s to deliver HIV care to children and adults with specific reference to 24/7 access to specialist opinion; late diagnosis; and people over 50 years of age.

The South West Senate Council meeting to consider the issues was held in two parts, hearing evidence about service provision from expert witnesses including a member of the National Clinical Reference Group for HIV, two senior consultants caring for adults and children respectively, PHE, a Bristol University expert in the distribution of HIV, and the Terrence Higgins Trust. Having heard the evidence, senate council members discussed options for services, including how to address the continued issue of stigma and the provision of HIV services for children.

The service specification for the specialised HIV pathway requires the availability 24/7 of expert consultant advice for patients who might be admitted to hospital with acute manifestations or complications. The prevalence of patients living with HIV, which is skewed towards the two large urban conurbations in the South West, Bristol and Plymouth, makes the provision of 24/7 services particularly challenging. Neither area is able to comply with the requirements of the specification. The South West Senate arrived at its decision in support of the establishment of a single South West HIV provider network for adults living with HIV, with two hubs each providing 24/7 specialist opinion.

AHSNs

41. The nature of their licence means that inevitably, AHSNs' focus varies across their four objectives. Some AHSNs are heavily focussed on innovation / wealth agenda, working closely with other parts of the economic growth infrastructure, e.g. Regional Growth Funds, Local Enterprise Partnerships, to connect industry with the NHS. Others are predominantly focused on health improvement, seeking to connect providers and commissioners with academia with a view to spreading evidence and best practice, and using the power of analysis to identify solutions to deep rooted problems. Some AHSNs are achieving a balance between these two areas of focus, and are succeeding in harnessing the opportunities offered in academia and from industry to the benefit of both the health system, and economic productivity of their region.

42. AHSNs' role and remit has not been well communicates, and so is not well understood amongst some sections of stakeholders. Providers tend to be well connected with their AHSNs, with Chief Executives sitting on AHSN boards and leading many of their programmes. However, commissioners tend to see AHSNs as 'provider clubs' which undermines the intention that they would network all providers and commissioners in a region. The extent of industry engagement varies – those SMEs and larger companies working directly with AHSNs tend to be positive about their contribution, however more widely their role is less well known.

43. Since their establishment in 2013, AHSNs have taken on responsibility in several national priority areas. Under their health improvement objective, each AHSN has now taken responsibility for hosting a patient safety collaborative following publication of Professor Don Berwick's report "A promise to learn – a commitment to act: improving the safety of patients in England". The collaboratives are expected to "support individuals, teams and organisations to build skills about safety improvement, create space and time to work on safety issues, and provide opportunities to continually learn from each other".

44. AHSNs have also taken on a role around medicines optimisation, under their objectives to spread innovation, and contribute to economic growth. This involves them supporting NHS England and the ABPI to spread learning and best practice around medicines safety and optimisation, as well as implementation of the Pharmaceutical Price Regulatory Scheme.

45. Where AHSNs are actively engaged in their health improvement workstreams, they tend to be working well in collaboration with their SCNs, identifying areas of potential overlap and avoiding duplication. However, in some areas, there is little evidence of AHSNs and SCNs engaging in dialogue as to how their respective activities and agendas might support each other.

AHSNs

Case Study 7: Wessex AHSN and the Bournemouth Orthopaedic Institute

Wessex AHSN has worked in partnership with Dorset Local Enterprise Partnership and Bournemouth University to develop a Bournemouth University Orthopaedic Institute (BUOI), and secure the first tranche of a three year Local Growth Fund bid totalling £700K to develop the institute's services and facilities. The aim over the next 5 years is to develop an orthopaedic cluster, generated from the activities and services of BUOI, to improve the health and quality of life of over 1000 patients, creating up to £100M in new funding for UK plc and generating up to 500 jobs. Although early days for the Institute it has already attracted multi-national company interest and has successfully secured projects that will generate several £000,000s of inward investment.

Case Study 8: East Midlands AHSN acting as the system facilitator in the region

East Midlands AHSN has developed strong partnerships to drive improvements in healthcare across its region. The AHSN has helped to secure a formal Partnership Agreement between the Collaboration for Leadership in Applied Health Research and Care, East Midlands (EM CLAHRC), Health Education East Midlands (HEEM), the East Midlands Leadership Academy (EMLA) and the East Midlands Clinical Senate and Strategic Clinical Networks (SCNs). The partnership approach is supporting commissioners and providers of NHS services to improve health and wellbeing for the local population, ensuring a joined-up approach is taken to addressing health priorities, avoiding duplication and improving efficiency, and has been particularly effective in offering a joined up support offer to Keogh trusts and those in special measures.

Case Study 9: South West Peninsula AHSN providing analytical and facilitation support to the urgent and emergency care systems in their region

South West AHSN has worked closely with the four CCGs in the region to analyse and understand current activity and demand in the NHS in their region by providing a comprehensive analysis of Emergency Admissions. Rather than using quarter on quarter comparisons which often results in misleading conclusions, the AHSN model provides analysis of activity information to understand underlying trends. Coupled with the AHSNs work identifying the region's demographical challenges - the region has a higher percentage of people aged 57 and above than the national average, and lower percentage of people aged 0-11 and 24-41 than any other region in the country - the analysis has enabled CCGs to see that a much more innovative and radical approach to the redesign of services is needed for the South West to meet its outcome and financial challenges. Their impartial analysis was recognised as accurate by both commissioners and providers and is facilitating dialogue as to how to transform services across the region.

C. What functions are needed in future to support a self-improving system and the delivery of transformational change, particularly in light of the priorities that will be identified through the 5 Year Forward View?

46. There are three areas of support which this review has identified as essential within the system. They are all relevant to the parts of the system subject to this review, although not exclusive to them. The parallel review of NHSIQ and the NHS Leadership Academy will wish to consider how they can contribute to each:

   a. <u>Support for the transformational changes necessary to make the NHS sustainable.</u> The Five Year Forward View has articulated a vision of how services will be delivered in the future, with more focus on prevention, empowered patients and engaged communities, where services are delivered in an integrated way according to individual needs, closer to home. *The Forward View into Action: Planning for 2015/16* published in December articulates the readiness of the system to meet these challenges: some health economies are on the cusp of being able to deliver the new care models envisaged and will be able to lead the way for the rest of the system; and some health economies have long standing challenges which mean they need targeted support and intervention to develop a sustainable approach for the future. However, the majority of health economies will fall within neither group.

   The parts of the system subject to this review can offer support to all three groups, although could perhaps offer most value to the majority in the middle. The support needs to take the shape of:

   • networking of professionals, commissioners and providers to facilitate the design of new pathways and care models across traditional boundaries
   • providing analysis, evidence and evaluation capacity and capability across the networked professionals, commissioners and providers to help them understand the opportunities for transformation and how they might be realised;
   • using the networks to spread innovation and best value pathways; and
   • offering clear governance and decision-making processes for the new pathways and care models to be introduced.

   b. <u>Support for the NHS to be a self-improving system.</u> The quality failings of the not too distant past must act as constant reminders of the need for a consistent and universal focus on maintaining and continuously improving the quality of care provided to patients. Considerable variation in the quality of care still exists and this must be addressed. It cannot be sustainable for quality problems to be identified after the event, and improvement projects and programmes to be introduced to provider and commissioner organisations in reaction. To safeguard our NHS and its patients, the system must become self-improving. Staff and leadership must see identifying opportunities for improvement and putting these into practice part of their business as usual. This requires system-wide recognition of the importance of quality improvement

and capability development. The parts of the architecture subject to this review could offer support in several ways:

- networking professionals, commissioners and providers to share experience and challenges, spreading innovation, learning and best practice;
- providing analysis (including baselining, variation and comparative analysis), evidence and evaluation capacity and capability across the networked professionals, commissioners and providers to help them identify, implement and evaluate opportunities for quality improvement,; and
- offering and signposting to education and training on quality improvement science and techniques.

Whilst these support offers should be universal, there is a need for additional targeted support to those providers who are having quality problems and/or who have received poor ratings from CQC. There is also an argument for explicit focus on particular elements of service provision which we know to be challenged, or less advanced in systematically adopting quality improvement approaches, for example primary care and specialised services.

c. Providing leadership for transformational change and continuous quality improvement: the pursuit of transformational change and a self-improving system are significant challenges, and require strong leadership at every level, and particularly within local health economies. Effective leadership creates the right conditions and environment for change and learning, bringing partners together across boundaries. The parts of the system subject to this review should have an explicit role in supporting and fostering that leadership, through the support outlined above.

47. The following section considers how the support outlined above might best be provided, and the next chapter then makes recommendations as to what changes could be made to the architecture to make this possible.

D. How should the architecture by arranged to provide these functions, to ensure maximum value for the £100m investment?

48. Commissioners and providers of healthcare services, as the statutory organisations with responsibility for securing the provision of services to patients, are the customers of the services on offer from the parts of the architecture subject to this review. Through our engagement with commissioners and providers, and discussion with stakeholders across the system, six key principles emerged which should guide how the future architecture should be arranged to provide the functions identified in section C:

   a. Organisation(s) with clear remit, purpose, and delivery mechanisms – over the last 18 months the health system has been in flux. New organisations have emerged, and historic organisations have closed down. Inevitably, there has been confusion as to who is responsible for what and how they should go about discharging their responsibilities. Overlaps, duplication and gaps have emerged. There needs to be absolute clarity as to the purpose of organisations set up to support commissioners and providers in the mind of the end user, and in the minds of those working within the organisations themselves.

   b. Single aligned geography wherever possible – it is a feature of our new health system that geographical lines on maps have be drawn and redrawn, and redrawn in different ways depending on the perspective. This has added to the overlap, duplication and gaps discussed earlier, as well as making the task of connecting with other players in the system even more challenging. AHSNs, SCNs, Senates and other stakeholders have told us that they would like geographies to be aligned wherever possible, not necessarily around the administrative jurisdictions that have been set out by NHS England, but around the patient flows.

   c. Clear, consistent expectations and accountability with freedom to respond to local needs and priorities – the emerging and evolving nature of the new health system has inevitably led to inconsistencies in understanding and expectations on the part of various stakeholders to the parts of the system subject to this review. In the previous chapter we set out the formal accountability relationships between AHSNs, SCNs, and Senates with NHS England. These relationships have been transacted in different ways in different parts of the country. Going forward, there needs to be clearly defined governance arrangements, including lines of accountability and assurance mechanisms. Business planning and assurance processes should be codified and formalised, with specific expectations of delivery for the year ahead being defined and agreed, and then monitored in year. Business plans need to reflect local priorities from 5 year strategic plans and national priorities where relevant.

   d. Real and shared ownership model by the providers and commissioner – we have heard that unless the parts of the system subject to this review are focussed on issues of priority to commissioners and providers, interacting with them is simply a drain on resources. If the taxpayer is to derive maximum benefit from its investment in this architecture, it must be hardwired into commissioners and providers. Inherent in the

establishment of AHSNs was that they should adopt a membership model where all commissioners and providers are members of their local AHSN. Some have taken this further, with members contributing financially, and therefore having a 'stake' in what is on offer to them. This model should be exploited more widely. If stakeholders feel ownership, they are more likely to invest time and resource in return for the support on offer, so contributing to sharing best practice, experience and expertise with others.

e. <u>Single front door to an aligned support offer</u> – commissioners and providers are stretched for resources, including the capacity to think through how to solve the strategic challenges they face, and to connect with all the other players in the system that they need to. They have told us strongly that the architecture designed to support them must connect with their priorities, and make it as straightforward as possible to interact with. They would ideally like a 'one-stop shop', although not necessarily in organisational form; rather a support offer which is interconnected, rationalised and targeted to their needs and the demands on them.

49. This chapter has summarised what we have heard from stakeholders and the parts of the system subject to this review, in response to the four questions we posed. The next chapter sets out the recommendations that emerge from what we have heard, and what some of the next steps might be to make these recommendations a reality.

Part three

Recommendations

50. The overriding message that the review has heard is that there is confusion in the system, and a lack of clear boundaries and expectations as to the support on offer, and against what the bodies providing that support will be held to account.   Within the organisations themselves, this has meant that they have not been able to focus consistently on specific goals, and have lacked well understood operating models. In turn, several areas have found it difficult to understand how and where best to work together –particularly prevalent between SCNs and AHSNs where there can be overlap in the health improvement aspects of their role.

51. However, the review has also heard of the unquestionable value in the act of networking commissioners, providers and professionals, within and between each other to share best practice, experience and expertise. Where there are established networks, focused around a shared interest or challenge, with people engaged in working together and sharing knowledge, it is the health services and patients who access those services that benefit. Going forward, we must nurture and support the power and potential of networking people and organisations for the greater good.

52. We have also heard strongly that the parts of the system subject to this review are on the whole still in their infancy, only 18 months (when the review began) into existence in their new form. Now more than ever, commissioners and providers need the help and support of such resource in taking forward the transformational change needed to make the NHS sustainable. There is consensus that it would not be helpful at this stage in the evolution of the system for the result of this review to be widespread change and upheaval. The benefit of stability is evidenced by the fact that nearly all of the individual bodies cited by stakeholders as being most effective are those that were in existence prior to April 2013: UCL Partners AHSN, East Midlands Clinical Senate, the Clinical Senate and 15+ clinical networks in London.

53. With all of this in mind, this review has made a series of recommendations:

   i. Defined purpose – drawing on the functions we identified as necessary in the system:

      o Clinical Senates: *To support health economies to improve the health outcomes of their local communities by providing evidence-based clinical advice to commissioners and providers on major service changes. They should bring together clinicians from a range of specialties and across a geography, with patients and the public, to put the needs of patients above those of organisations or professions.*

      o Clinical Networks (renamed from SCNs): *To support health economies to improve the health outcomes of their local communities by connecting commissioners, providers, professionals and patients and the public across a pathway of care / service area to share best practice and innovation, measure and benchmark quality and outcomes, and drive improvement.*

- o Academic Health Science Networks: *To support health economies to improve the health outcomes of their local communities, and maximise the NHS's contribution to economic growth by enabling and catalysing change through collaboration, and the spread of innovation and best practice*

ii. Codified and formalised governance arrangements –
- o defined business planning and signoff processes, which reflect a) a small number of national priorities as appropriate to the purpose of each part of the system; and b) local priorities as set out in 5 year strategic plans
- o timely budget allocation to support timely business planning and sign off,
- o robust assurance processes in-year and at end-year led by NHS England regional teams, supported by the National Support Centre
- o appropriate NHS England investment in the assurance function to be provided by regional teams
- o operating and assurance models to be refreshed to reflect recommendations of this review

iii. Consolidated Clinical Senates with additional support –
- o the importance of clinical engagement across the current Senate footprint is recognised and should be retained
- o there should be one overarching senate governing body per region. This body should be accountable to the Regional Medical Director. They should continue to have independent Chairs.
- o administrative and managerial support should be consolidated were possible and increased to ensure that they are equipped to fulfil their vital role consistently.

iv. Alignment between AHSNs and CNs –
- o ambition that AHSNs and Clinical Network are streamlined, and operate as a single support entity for their member commissioners, providers and professionals. AHSNs become a 'network of networks' harnessing the power and opportunities of the collaboration and partnerships that they have built to improve health and wealth.
- o minimum expectation that AHSNs and Clinical Networks' business plans, including focus, priorities and delivery mechanisms are aligned – to be assessed by Regional Medical Teams through business planning sign off and quarterly assurance processes, supported by the National Medical Directorate. Geographies should be coterminous wherever possible
- o likely that there will be a small number of AHSNs where a streamlined approach could be achieved in 2015/16.
- o extent of alignment / streamlining should be determined by Regional Medical Teams through the business planning process, supported by the National Medical Directorate.

WHAT DO THESE RECOMMENDATIONS MEAN FOR …

Clinical Senates

54. Clarity of purpose – the role of Clinical Senates should be clarified as per their original intention, set out in July 2012:

    To support health economies to improve the health outcomes of their local communities by providing objective clinical advice to commissioners and providers on service transformation, including the redesign of pathways and organisational reconfiguration. They should bring together clinicians from a range of specialties and across a geography, and patients and the public, to put the needs of patients above those of organisations or professions.

55. Operating model / delivery mechanism
    a. The importance of clinical engagement across the current Senate footprint is recognised and should be retained
    b. There should be one overarching senate governing body per region. This body should be accountable to the Regional Medical Director. They should continue to have independent Chairs. Administrative and managerial support should be consolidated were possible and increased to ensure that they are equipped to fulfil their vital role consistently.
    c. Their business schedule should be determined by the transformation agenda within their region, and priorities derived from five year strategic plans. For example, in 2015/16 there should be an explicit focus on urgent and emergency care.
    d. The Operating model for Clinical Senates should be refreshed, and individual operating procedures developed for each region. Their operations and effectiveness should be overseen by Regional Teams in NHS England.

56. Alignment
    a. Clinical Networks and AHSNs will be supporting commissioners and providers in understanding how services should be changed, based on the available evidence and analysis of data. Once a change proposal has been developed, the Clinical Senate will offer objective clinical advice on its merits and the case for change. As such, the Clinical Senate will need to work with the AHSNs and Clinical Networks in its region to ensure that its work programme is aligned, and the Clinical Networks and AHSNs will need to provide information to the Clinical Senate where required.

(Strategic) Clinical Networks

57. Clarity of purpose

    a. Should be renamed as 'Clinical Networks'. In practice, Clinical Networks are operating along a continuum from operational to strategic, with many in between. We should explicitly recognise this. The use of 'strategic' does not help in providing clarity as to their role.

    b. Clinical Networks' role should be:

    To support health economies to improve the health outcomes of their local communities by connecting commissioners, providers, professionals and patients and the public across a pathway of care / service area to share best practice and innovation, measure and benchmark quality and outcomes, and drive improvement.

    c. Within this broad role, each network (i.e. on each pathway within each geography) will need to clearly define and articulate what they are seeking to achieve and their delivery mechanisms.

58. Operating Model / delivery mechanism

    a. These will differ according to the needs of the pathway, for example, some may be focussed more on operational issues such as patient flow, others may be focussed on building the evidence and cost case for change and investment. As above, each network within each geography should clearly define their operating model and delivery mechanisms and make these public.

    b. There should continue to be Clinical Networks in each of the four current priority areas. However, these were only ever intended to be priority areas for up to five years from 2012. Therefore, the areas on which there are mandatory networks, supported by NHS England national network funding, should be reviewed and refreshed during 2016/17, with a view to a new set of priority areas for national priority areas being identified and in place from 2017/18. It may be that on review at that point, some networks are transitioned into 'business as usual', operating as Operational Delivery Networks.

    c. Clinical Networks on the four current priority areas should derive national strategic direction from the relevant National Clinical Directors. Business plans should reflect national priorities and reflect local challenges drawing on 5 year strategic plans.

    d. From the national network funding, health economies should also be able to identify local priority areas which would benefit from a Clinical Network. The number and pathways should be determined as part of business planning.

    e. Clinical Networks should continue to be supported by a support team from NHS England (the Clinical Network Support Team). The support teams should be accountable to a sub-regional Medical Director for the day to day operation of the network. The regional Medical Team should be responsible for signing off business plans, and assuring delivery of business plans in year, supported by the National Medical Directorate. NCD and other views should be taken into account as part of assurance.

59. Alignment

   a. Our ambition should be that AHSNs and Clinical Network are streamlined, and operate as a single support entity for their member commissioners, providers and professionals. AHSNs would become a 'network of networks' harnessing the power and opportunities of the collaboration and partnerships that the have built to improve health and wealth.

   b. There should be a minimum expectation that AHSNs and Clinical Networks' business plans, including focus, priorities and delivery mechanisms are aligned – this will be assessed by Regional Medical Teams through business planning sign off and quarterly assurance processes, supported by the National Medical Directorate. Geographies should be coterminous wherever possible.

   c. This streamlined model will require AHSNs to have the desire and capability to take on the responsibilities of supporting Clinical Networks in their region. It is likely that there will be a small number of AHSNs where a streamlined approach could be achieved in 2015/16.

   d. The extent of alignment / streamlining should be determined by Regional Medical Teams through the business planning process, supported by the national Medical Directorate.

Academic Health Science Networks

60. NB: in relation to AHSNs, this review has focussed on the health aspects of their objectives. The Cabinet Office recently conducted a deep dive study into the wealth aspects of their objectives, and made recommendations on strengthening their delivery in that respect. The recommendations set out below draw on and are consistent with their findings where relevant.

61. Clarity of purpose
    a. AHSNs' role is set out in their four licence objectives, however this has not been well explained and communicated, and their aims and delivery mechanisms have been confused. It should be widely communicated that their role is:

    To support health economies to improve the health outcomes of their local communities, and maximise the NHS's contribution to economic growth by enabling and catalysing change through collaboration, and the spread of innovation and best practice.

    b. In the last year, there have been national priorities assigned to AHSNs in line with their licence objectives: Patient Safety Collaboratives and medicines optimisation. This should be more explicitly recognised, and other national priorities considered for 2015/16, e.g. AHSNs' role in the new test bed sites announced in the 5YFV, and in supporting commissioners and providers to develop the transformational changes outlined in the 5YFV.

62. Operating model / delivery mechanism
    a. There should continue to be 15 AHSNs with their current geographies, where relationships are becoming established. However, AHSNs should not be discouraged from merging if they decide to do so.
    b. Awareness and understanding of the role of AHSNs needs to be increased if they are to be able to fulfil their role. Their role as outlined above, alongside case studies and evidence of delivery should be communicated widely and consistently.
    c. Their business plans should be developed around the clear parameters of this role, and should include a manageable number of deliverables with measurable metrics reflecting local priorities in 5 year strategic plans, and national priorities.
    d. NHS England should strengthen the business planning and assurance process so that it is:

        • more robust, using a consistent approach across all regions, capturing financial, risk and delivery information in a consistent and robust way;
        • useful to AHSNs by providing development support and expertise;
        • focussed on enabling AHSNs and NHSE to demonstrate their impact, e.g. through economic growth metrics, stakeholder survey and indicator criteria; and
        • relevant to national NHS England priorities, ensuring that AHSNs are able to contribute to these where they have a role to play.

63. Alignment
    a. Our ambition should be that AHSNs and Clinical Network are streamlined, and operate as a single support entity for their member commissioners, providers and professionals. AHSNs would become a 'network of networks' harnessing the power and opportunities of the collaboration and partnerships that the have built to improve health and wealth.
    b. There should be a minimum expectation that AHSNs and Clinical Networks' business plans, including focus, priorities and delivery mechanisms are aligned – this will be assessed by Regional Medical Teams through business planning sign off and quarterly assurance processes, supported by the National Medical Directorate. Geographies should be coterminous wherever possible.
    c. This streamlined model will require AHSNs to have the desire and capability to take on the responsibilities of supporting Clinical Networks in their region. It is likely that there will be a small number of AHSNs where a streamlined approach could be achieved in 2015/16.
    d. The extent of alignment / streamlining should be determined by Regional Medical Teams through the business planning process, supported by the national Medical Directorate.

Next steps

64. Implementation of these recommendations should be taken forward alongside the implementation of the recommendations from the parallel review into the NHS Leadership Academy and NHSIQ, as part of a single programme. It will be important that the groundwork is put in place at an early stage to ensure that there is clarity for staff affected, and that planning can take place on the basis of agreed financial allocations.

65. There are five broad workstreams, with several products each, for the implementation phase in respect of AHSNs, Clinical Networks and Clinical Senates:

66. **Finance:** ensuring that there is clarity as to financial allocations, consistent with the model proposed in this review, so that planning can take place as to priorities for 2015/16 and staff structures. In particular, the follow steps are needed:
    a. Agree proportion of Admin Funding required for regional and national assurance role.
    b. Agree admin funding allocations for Senates and Clinical Networks
    c. Agree overall Programme Funding allocations for both Clinical Networks and AHSNs
    d. Agree consistent programme funding formula to be applied to Clinical Networks and AHSNs

67. **Business planning and alignment:** ensuring the bodies that have been subject to this review can plan for 2015/16 in such a way that is consistent with the recommendations from this review, and in particular, that practicalities are worked through in respect of where greater alignment is needed. The following steps are needed:
    a. Agree Clinical Senate geographies
    b. Updating and aligning Clinical Networks and AHSN boundaries (co-terminus)
    c. Clinical Networks: Business Plan development and sign-off for 15/16
    d. Sign-off AHSN Business Plans for 2015/16

68. **Operating and assurance models:** these need to be developed, consistent with the recommendations from this review, for each of the bodies that have been subject to the review:
    a. A Single Operating and Assurance Model for Clinical Senates
    b. A Single Operating and Assurance Model for Clinical Networks
    c. AHSN Assurance Framework

69. **People and organisational development:** it is vital that a robust and fair process is put in place to ensure that the structures and staff needed to support the model proposed in this review are established and retained / recruited. In particular, this should involve as a priority:
    a. New structures to be designed and agreed
    b. Job design activities (incl. Job Descriptions and Person Specifications) to be developed
    c. Organisational Development Plans to be developed for Clinical Networks and Senates
    d. Recruitment to the new structures

70. **Communications and engagement:** the success of this model will hinge on stakeholders – both within the bodies subject to this review and those who rely on their services and support – understanding the new model, how it should operate and what they can expect. Therefore proactive and consistent communications and engagement is vital. This must include:
    a. Consistent narrative being developed (for use both internally and externally) clarifying role and purpose of each part of the architecture
    b. Communications plan for affected staff regarding the proposed changes must be put in place
    c. Communications plan for stakeholders regarding the proposed changes should be developed
    d. Provision and arrangements for ongoing communications support must be secured.

71. It will be important that the oversight of these workstreams is provided as part of the implementation programme for the Review of Improvement and Leadership. How each part of the system works with each other and with the resulting structures in respect of the NHS IQ and Leadership Academy functions will also need to be defined and communicated. One key part of the system that this review has not looked at is Operational Delivery Networks – a key next step should be to consider how these interact with Clinical Networks and AHSNs, and how they can best be aligned.

Annex H – Background and Financial summary

NHS Improving Quality

NHS Improving Quality (NHS IQ) was set up to help the NHS change in a sustainable way, so that high quality care can be a reality for everyone. NHS IQ brings together knowledge, expertise and experience to develop improvement skills across the entire health and care system.

NHS IQ was set up by the Department of Health and NHS England in April 2013 under the terms of a three year agreement. It was established by bringing together five legacy organisations:

- National Cancer Action Team
- National End of Life Care Programme
- NHS Diabetes and Kidney Care
- NHS Improvement
- NHS Institute for Innovation and Improvement

NHS IQ's work to date has focused on building capacity and capability in the system, and on improvement programmes looking at priority areas such as seven day services, patient safety, living longer lives, long term conditions and experience of care.

NHS Leadership Academy

The NHS Leadership Academy was established in 2012 in order to help transform healthcare culture and services by professionalising healthcare leadership and create a more strategic approach to the development of talent across the NHS.

The NHS Leadership Academy's purpose is to work with partners to deliver excellent leadership development across the NHS to have a direct impact on patient care.

The Academy offers a range of tools, models, programmes and expertise to support individuals, organisations and local academies to develop leaders, celebrating and sharing where outstanding leadership makes a real difference.

In 2013 the Academy launched the largest and most comprehensive approach to leadership development ever undertaken through their suite of professional leadership programmes – which, in two years have now seen over 31,000 health care staff being a part of.

The principles of equality and inclusion are at the heart of the Academy's work – the NHS is a universal service and it is an aim of the Academy to ensure the development of a leadership community is representative of the community it serves.

Strategic Clinical Networks
The Strategic Clinical Networks were set up in April 2013. They were established in areas of major healthcare challenge where a whole system, integrated approach was needed to achieve a real change in quality and outcomes of care for patients.

Strategic clinical networks seek to help commissioners reduce unwarranted variation in services and encourage innovation. SCNs have been established and are supporting in the following areas:

- Cancer
- Cardiovascular disease (incorporating cardiac, stroke, diabetes and renal disease)
- Maternity and children;
- Mental health, dementia and neurological conditions.

Clinical Senates

Clinical Senates were established from April 2013 to play a unique role in the commissioning system by providing strategic clinical advice and leadership across a broad geographical area to CCGs, HWBs and the NHS England.

Clinical Senates take a broader, strategic view on the totality of healthcare within a particular geographical area, for example providing a strategic overview of major service change. They work collaboratively with commissioning organisations.

They provide independent strategic clinical advice as part of the NHS England reconfiguration assurance process having taken on the role of the National Clinical Advisory Team.

Academic Health Science Networks- AHSNs

The 15 AHSN's functions are to align education, clinical research, informatics, innovation, training & education and healthcare delivery. They are either hosted by a trust or are Companies Limited by Guarantee. They do not have any NHS England staff.

In 2013 a five year licence agreed was agreed with NHS England. AHSNs have four objectives in this licence:

- Focus on the needs of patients and local populations;
- Speed up adoption of innovation into practice to improve clinical outcomes and patient experience;
- Build a culture of partnership and collaboration; and,
- Create wealth through co-development, testing, evaluation and early adoption and spread of new products and services

Each AHSN have developed annual business plans in line with their Prospectus and licence and receive some of their funding from NHSE. In 2014 AHSNs took on the Patient Safety Collaborative function and revised their business plans accordingly.

Current Health and Care Improvement & Leadership Development Architecture: Financial and Workforce Summary

	2014/15			2015/16		Year on Year Reduction	
	WTE (Plan)	WTE (As at Dec 2014)	£'000	WTE (Plan)	£'000	£'000	%
Organisation: NHS IQ:							
Admin	96.26	89.00	10,205	68.82	7,376	2,829	27.72%
Programme	151.70	123.72	34,225	170.00	24,439	9,786	28.59%
Grand Total (Admin + Programme)	247.96	212.72	44,430	238.82	31,815	12,615	28.39%
Organisation: AHSNs, Clincial Senates and Clinical Networks							
Admin Budget:			10,000		8,500	1,500	15.00%
(Please note that only Clinical Senates and Clinical Networks receive Admin Funding)							
Programme Budget:			85,700		73,530	12,170	14.20%
(Please note that no decisions have yet been taken in respect of the split of programme monies between AHSNs, Clinical Senates and Clinical Networks)							
Total (Admin + Programme)			95,700		82,030	13,670	14.28%
Organisation: Leadership Academy							
Admin Budgets:							
NHS LA							
Sub-Total	20.20	17.00	2,058	17.70	2,000	58.00	2.82%
Programme Budgets:							
NHS LA							
Leadership Programmes	54.90	48.40	70,642	52.60	50,800	19,842	28.09%
Sub-Total	54.90	48.40	70,642	52.60	50,800	19,842	28.09%
Programme Budgets Total	54.90	48.40	70,642	52.60	50,800	19,842	28.09%
Grand Total (Admin + Programme)	75.10	65.40	72,700	70.30	52,800	19,900	27.37%