Paper 3

NQB role in the context of the Improvement and Leadership Review

Purpose

1. To set out how the NQB's role will sit alongside the emerging governance for the improvement architecture, coming out of the Improvement and Leadership Review (Smith Review).

Background

2. The Improvement and Leadership Review was established 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 review has completed and the report is ready for publication, following ministerial consideration. A summary of recommendations is attached at Annex A. Included in the recommendations is that governing boards should be established for leadership and for improvement. The governance arrangements are intended:

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

4. The NQB is keen to ensure that both governing bodies are connected with its work, and that there is clarity as to respective and distinct roles and responsibilities. The improvement governing board in particular will need to operate alongside the NQB, with the concepts of 'improvement' and 'quality improvement' being similar in the minds of most people.

5. The NQB asked that the Secretariat work with the Department of Health and the Improvement and Leadership Review Implementation Team, led by John Wilderspin, to develop a proposal for how roles and responsibilities might be aligned.

Respective Roles and Responsibilities

6. Given the current context in which the system is operating, and the Five Year Forward View, the NQB is clear that quality must be seen within the context of value. The NQB's focus as set out in its terms of reference, is focussing on quality in the context of maximising value for the patient and taxpayer. This therefore this brings the concepts of 'Quality Improvement' and 'Improvement' together, and should guide how we consider the respective roles of the NQB and the new Improvement Governing Board.

7. With this in mind, the following division of responsibilities between the NQB and the new Improvement Governing Board are proposed:

    a. The NQB sets the strategy and direction in respect of quality, including quality improvement (in the context of value). This means that it is likely to redefine quality in the current context of the system, set out the system-wide framework through which it can be pursued by organisations nationally and locally, and identify the priorities for quality improvement, both in the short and longer term. This would all be with a view to 'closing' the quality and care gap identified in the 5YFV, whilst also impacting on the other two gaps: health and wellbeing, and finance and efficiency. The NQB would not have a role in the governance or overseeing delivery of the improvement architecture – which should be the role of the Improvement Governance Board.

    b. The Improvement Governance Board is responsible for overseeing the roll out of the new improvement architecture nationally and locally, in such a way as is consistent with the strategic direction (definition, framework, priorities) set out by the NQB. On an ongoing basis, it could retain a role around the governance and delivery of the improvement architecture which would sit alongside and be connected to the NQB, and the individual responsibilities of ALBs.

8. Many of the same people will be involved in the discussions and support of both groups work and so ensuring alignment and avoiding duplication should be possible. The above description is consistent with the NQB's Terms of Reference as they have been agreed. The new Improvement Governing Board does not yet have terms of reference, and so this description will be used to guide their development. The NQB will also wish to consider how it can work with the Leadership Governing Board once it is established.

The NQB is asked to confirm that it is content with this high level description of roles and responsibilities.

Annex A

Recommendations from the Review of Centrally Funded Improvement and Leadership Development Functions (the Smith Review)

(These recommendations are taken from the Executive Summary of the final Review Report)

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): The resources and expertise currently within NHS Interim Management and Support (IMAS), which includes the Intensive Support Teams (ISTs), currently managed by NHS England, should be governed jointly by Monitor, NHS TDA and NHS England, and consideration should be given to where these arrangements are best hosted.

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.