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BOARD PAPER - NHS ENGLAND

Title: Review of Improvement and Leadership Development Capability
From: Karen Wheeler, National Director Transformation and Corporate Operations
Purpose of paper: • To set out the Review findings and provisional recommendations. The current position has broad consensus from the Steering Group which is overseeing this work, chaired by Ed Smith. • This paper is being discussed in the Private Board meeting, because the recommendations, which affect staff and other organisations, are subject to cross system and DH confirmation before they are ready to be communicated.
The Board is invited to: • Review and approve the provisional findings and recommendations, subject to Steering Group consideration and approval on 20 March 2015.

Review of Improvement and Leadership Development Capability

Introduction

1. A review of the health and care system's current improvement and leadership development capability was initiated in November following the publication of the Five Year Forward View. The organisations considered as part of the review include NHS Improving Quality, the NHS Leadership Academy, Academic Health Science Networks (AHSNs), Strategic Clinical Networks (SCNs) and Clinical Senates.

2. This paper is intended to provide the Board with an overview of progress to date and the emergent findings and recommendations.

Scope and Purpose of the Review

3. The detailed scope and purpose of the Review is set out in the Terms of Reference provided at Appendix A, together with comments from the Steering Group. The Review's final report will address all of the specific questions posed in the Terms of Reference.

4. The Review's governance and decision making arrangements are also set out in the attached Terms of Reference. The Review is overseen by a Health and Care Steering Group, the membership of which is drawn from the senior leadership of the key national bodies with a shared interest in the system including NHS England, Department of Health (DH), NHS TDA, Monitor, Health Education England (HEE), Public Health England (PHE) and Care Quality Commission (CQC). The Steering Group is chaired by Ed Smith, in his role of leading the Review.

Progress to date

5. To date the review has focussed on:
    a) System wide engagement to capture views on the adequacy of current arrangements and on future requirements. The processes of engagement have included a system wide survey (co-ordinated by the NHS Confederation) and a series of engagement events across the country;
    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, presented to the Steering Group at its meeting on 19 January 2015;
    c) The development of provisional findings and recommendations, presented to the Review Steering Group at its meeting on 16 February 2015; and
    d) The review of correspondence from senior leaders indicating areas of agreement and disagreement by Ed Smith, Karen Wheeler and Tim Rideout (the independent reviewer) to establish a near final set of recommendations and next steps.

6. The final recommendations and next steps will be considered and approved by the Health and Care Steering Group at its final meeting on 20 March 2015, and are subject to confirmation from DH and other parties.

7. In the meantime the Board is asked to discuss the provisional findings and recommendations from an NHS England perspective and confirm their agreement or highlight other areas for consideration.

Background

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

9. Both organisations are hosted and funded through NHS England, though they provide support to the wider NHS (and in some instances the wide health and care system). 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.

10. It is now nearly two years since the reforms, 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, and considering how well the resource allocated to these two organisations is delivering expected outcomes for the wider healthcare system¸ and that we collectively get good value from money from their resources.

11. As part of the wider improvement review, NHS England also specifically included a review of AHSNs, clinical senates, and networks to 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.

12. We have ensured both aspects of the review are fully integrated, and, given the context of the Five Year Forward View, that they specifically address how we ensure our leadership and improvement activity is aligned with and focused on supporting the Five Year Forward View vision.

Timing

13. The Review started in November 2014 and will complete by March 2015. This has enabled it to pick up and address both the work of the Five Year Forward View and findings from the Stuart Rose review of leadership, the Robert Francis review of whistle blowing and taken account of other reviews in similar territory.

14. The Review's recommendations will almost inevitably have an impact on the staff who

currently work in the organisations currently delivering Improvement and Leadership Development. We have aimed to provide as much clarity as possible to enable staff who are potentially impacted by the Review to access redeployment opportunities. We have therefore signposted next steps required for detailed implementation and phasing the recommendations to minimise disruption to the areas of good work which are currently being delivered.

Description of the Current Arrangements

15. The current arrangements are summarised at Appendix B. This provides information on the respective organisations covered by the Review including headcount, costs and basic roles.

Provisional Findings

16. In relation to the current **improvement architecture** the headline findings can be summarised as follows:

    a) Delivery of safe, quality operational services in the here and now as well as the implementation of the Five Year Forward View requires strong improvement capability across the health and care system. Don Berwick's report[1] advised that there is a need for the NHS 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";
    b) The current architecture is remote, fragmented and unclear. The roles of NHS IQ, AHSNs, strategic clinical networks 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 and in many cases improvement support has been sought from other sources;
    c) The current architecture is not sufficiently connected to, and aligned with, the national strategic priorities (as currently articulated in the Five Year Forward View) and the focus of national system leadership;
    d) Service intervention arrangements are insufficiently coordinated and planned, and are not predicated upon a sustainable model, with intervention being repeatedly required by the same organisations and systems;
    e) There is widespread support for clear national coordination and guidance, but combined with a much greater emphasis than presently on local and regional improvement action.

    NHSIQ:

    f) While a number of NHS IQ's specific improvement programmes have been effective and have had impact, in overall terms insufficient impact has been made in terms of either service improvement or service transformation. The knowledge by the system of what has been available has also been poor, no doubt impacting on take-up. As a consequence the system's needs have not

[1] A promise to learn – a commitment to act. Improving the Safety of Patients in England (August 2013)

been met despite the considerable resources currently invested in the improvement architecture.

g) NHS IQ is not sufficiently connected to and aligned with local priorities and deliverables and the focus of local organisations and systems. This includes 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);

Clinical Senates:

h) The stage of development of clinical senates is very varied. For example, London and the East Midlands have developed clinical senates whose role and work programmes are clear and established. In other areas, their role is unclear to themselves and to stakeholders, with several senates only just starting to come together, having had their first meetings in autumn 2014.

Strategic Clinical Networks (SCNs):

i) 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. SCNs are by definition the sum of the commissioners, providers and professionals who come together as part of the network; however, this has got lost in some areas, and in the minds of some stakeholders, whose perception is that an SCN is a body that carries out improvement activity.

Academic Health Science Networks (AHSNs):

j) The nature of their licence means that inevitably AHSNs' focus varies across their four objectives. Some AHSNs tend to focus on innovation/wealth agenda, working closely with other parts of the economic growth infrastructure; others are more focused on health improvement, seeking to act as an honest broker between providers and commissioners with a view to spreading evidence and best practice;

k) AHSNs' role and remit has not been widely and consistently communicated, and so is not well understood amongst 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 that others;

l) 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. However, in some areas, there is still duplication and a lack of alignment in approach and focus.

17. The headline findings in relation to the current leadership development architecture can be summarised as follows:

a) Implementation of the Five Year Forward View requires the development of strong leadership capability and capacity at all levels across the health and care system. It therefore requires the leadership development capability to ensure that this is in place;

b) Leadership development must be integrated, system based, and fully informed by the needs of local organisations and systems as well as the overarching needs of the national system. This requires systemic collaboration, cooperation and coordination;
c) 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;
d) 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;
e) There is broad support for many of the national leadership development programmes, although it is too early to determine 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;
f) There is a reasonable level of awareness and understanding of the role of the NHS Leadership Academy and its Local Delivery Partners (LDPs);
g) There should be a greater focus on:
    i. 'Within organisation and system' leadership development;
    ii. The development of improvement skills for leaders and managers at all levels of the system;
    iii. The development of clinical leaders at organisational and system level;
    iv. The development of existing and future leaders who can operate effectively across health and care systems and organisational boundaries;
    v. Active succession planning and building a structured talent management approach within and across the commissioner, provider and wider system leadership communities.
h) Leadership development needs to be better connected and aligned to the delivery of the Five Year Forward View;
i) There needs to be greater ownership of national programmes by local organisations and systems and there is the potential for the programmes to be more targeted and focussed on areas of priority as determined by the system as a whole and aligned to the Five Year Forward View as well as on organisational improvement;
j) There is widespread support for clear national coordination, programme 'brokerage' and guidance, 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.

Provisional Recommendations

18. In light of the above findings a number of provisional recommendations have been developed with the Steering Group.

19. The following headline recommendations are made in relation to ***improvement and leadership development from an overarching system leadership perspective:***

a) A single national strategy for both improvement and leadership development (including talent management) should be created for the health and care system. This should set out the priorities for both commissioners and providers and it should assure and direct the resources needed to support delivery of these priorities, aligned to delivery of the Five Year Forward View;
b) Every NHS organisation should develop an improvement and leadership development and talent management strategy and development plan with clear milestones aligned to the delivery of the Five Year Forward View;
c) The new arrangements for improvement and leadership development (and the deployment of the associated resources) should be governed collectively by the six national organisations (NHS England, NHS TDA, Monitor, HEE, PHE and CQC) in a way that reflects and is aligned to the governance arrangements being established to support the Five Year Forward View; and
d) The resources and expertise of the Intensive Support Teams (ISTs), which currently are managed by NHS Interim Management Support (IMAS) and hosted by NHS England, should be governed jointly by Monitor, NHS TDA and NHS England and consideration given to independent hosting.

20. In relation specifically to the ***system's improvement architecture***, 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) Standard operating models (setting out the required improvement activity) should be developed for the system as a whole for all aspects of improvement (service improvement, service transformation and service intervention) informed by the learning from this Review. The operating models should be sufficiently flexible to respond to the variable needs across the system (in terms of variation in performance, readiness for change, scale of change required and so on) and recognise the importance of developing good leadership and operational management skills to lead and deliver the required improvement activities;

NHSIQ:

b) NHS IQ's resources and expertise should be retained, but integrated into the core system architecture rather than as a separate stand-alone national organisation;
c) A small national and high powered team should be established within NHS England (this will include people drawn from the current NHS IQ teams that have expertise in transformation techniques) to coordinate the national elements of improvement (with an explicit focus on strategy in line with the Five Year Forward View, monitoring, challenging and facilitating progress where it is faltering);
d) Wherever appropriate the remaining NHS IQ functions, programmes and resources (i.e. the majority of NHS IQ's current delivery capability) should be embedded in sub-regional structures, resulting in clearer points of access for improvement support for local organisations and systems, to ensure that the resources deployed achieve a much greater impact. It is therefore proposed that

fifteen Local Improvement Coalitions are established based upon the current AHSN geographical footprint. AHSNs have a potentially powerful role in improvement, and a good geography and local connections to make them a good vehicle for hosting local IQ type capability. However, their current role is not primarily of improvement, so a significant change would require a change of license and accountability arrangements. In the next stage we need to explore the option of extending AHSN role to take on improvement, though with accompanying change to license and accountability, and work with those AHSNs most ready to consider this change;

e) The Local Improvement Coalitions would account to the national system and to local providers and commissioners. The Coalitions would bring together all relevant local parties (including AHSNs, Clinical Networks, HEE's LETBs, the NHS Leadership Academy's LDPs, voluntary agencies, Health and Wellbeing Boards) and would be lead by a locally agreed lead agency (for example this could be the local AHSN);

f) A substantial programme of QI skills development (commissioned by the NHS Leadership Academy) should be initiated to ensure that sufficient capability is established at each level and in each part of the health and care system;

Clinical Senates:

g) Clinical Senates should continue, but it should be clarified that their role is to provide clinical advice rather than to manage improvement activity. Their role should be:
To support health economies to improve health outcomes of their local communities by providing evidence-based independent clinical advice to commissioners and providers on major service changes

h) They should be consolidated from 12 to four (1 in each region), have an independent chair, sufficient and administrative managerial support and clinical expertise to ensure that they are equipped to fulfil their vital role consistently;

i) 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.

AHSNs and SCNs:

j) AHSNs and Clinical Network should be streamlined and business plans aligned, operating as a single support entity for their member commissioners, providers and professionals;

k) 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.

l) SCNs should be renamed Clinical Networks and their improvement role clarified as :
To support health economies 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

m) There should continue to be Clinical Networks in each of the four current priority areas, Cancer, Cardiovascular, Maternity and Children, Neurological conditions. These networks 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. Local priorities could be supported by new Clinical Networks.

n) The 15 AHSNs should continue, though they should not be discouraged from merging if they decide to do so. Their role should be to:
*To support health economies to **i**mprove **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**.*

o) 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.

21. In specific relation to the system's ***leadership development architecture*** the intention is to establish a self-sustaining system where organisations and local economies build their own capabilities, but are held to account for progress:

a) The NHS Leadership Academy should continue to operate as a separate stand-alone national body, although its work needs to be refocused to incorporate:
   i. 'Within organisation and system' leadership development;
   ii. The development of existing and future leaders (clinical and managerial) who can operate effectively across health and care systems and organisational boundaries;
   iii. Active succession planning and building a structured talent management system within and across the commissioner and provider leadership communities.

b) The NHS Leadership Academy should coordinate the national elements of leadership development (with an explicit focus on national talent management, the development of standards and frameworks, the commissioning (but not the provision) of national programmes and resources, and strategic alignment);

c) The Local Delivery Partner (LDP) structures should be reformed to address the variation in performance and strategic alignment and should focus on regional talent management;

d) The NHS Leadership Academy's governance arrangements should be reformed to ensure a greater oversight by the whole system leadership responsible for the Five Year Forward View and with local organisations and systems;

e) Alternative funding models for the NHS Leadership Academy should be explored, including membership and subscription models, in order to increase local ownership and cost/benefit accountability to strengthen the Academy's financial resilience;

f) The partnership between the NHS Leadership Academy and Health Education England should be explicitly strengthened, including the development of a partnership agreement setting out the reciprocal relationship between the two organisations (including NHS Leadership Academy support to the leadership elements of professional curricula, the management of transition from

professional to leadership roles and so on). In addition the distribution of specific development programmes between the NHS Leadership Academy and Health Education England should be reviewed and revised;

g) The NHS Leadership Academy's name should be changed to reflect more accurately its refocused role and the pan-system importance of leadership development.

Implications and Benefits

22. The provisional recommendations are intended to address the questions and issues set out in the Review Terms of Reference (Appendix A). They do not necessarily represent an end state but a step towards much better alignment across the health and care system. The arrangements will inevitably develop as the improvement and leadership development architecture further matures.

Next Steps

23. The next steps can be summarised as follows:
    a) The findings and recommendations are being refined in light of the collective and individual responses from Steering Group members and wider key stakeholders to the broad direction of travel outlined in this paper. While there is broad support for the majority of recommendations there will be some areas where further work is required to secure a consensus and to identify the detailed next steps towards implementation;
    b) Develop the full Review report reflecting:
        i. The core purpose work, revised to reflect the views of the Steering Group and stakeholders;
        ii. A clear articulation of the current arrangements (including deployment of resources, particularly money and staff) and the evidence upon which the findings and recommendations above are based;
        iii. A clear articulation of the proposed arrangements (in line with the above direction of travel) including the proposed deployment of resources;
        iv. Full responses to each of the specific requirements set out in the Review's Terms of Reference.
    c) Continue stakeholder engagement via the Review's Reference Group, roundtable discussions and so on; and
    d) Develop a standard brief for general communications purposes; and
    e) Develop implementation plans and capacity to ensure, inter alia, that we retain expertise and skills, minimise any potential redundancy costs, secure a minimum saving of 15% across the improvement architecture and £2m from the Academy, and continue to support delivery of the Five Year Forward View.

24. The full and final report will be considered by the Steering Group at its meeting on 20 March 2015. In preparation for the Steering Group the final report will be sent for consideration by the Academy and NHS IQ's own governance bodies. Following the Steering Group's approval we would prefer to publish the report as soon as possible, before the pre-election period. However, we will need to agree formal approval and handling with DH (given the status of the Rose Review's report), who have indicated this may not be feasible. So we will work up an alternative handling plan.

Please note – sections 23 & 24 plus risks will change as handling during purdah has not yet been agreed, and may need an alternative approach for implementation.

Risks to be managed

25. There remain a number of risks to be managed as follows:
    a) Consensus has yet to be fully reached on all recommendations, although good progress has been made in this respect and there is broad alignment on the key findings and recommendations;
    b) The proposed model is predicated on a significant shift 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;
    c) The proposed changes will inevitably result in some disruption with a potential impact on delivery and progress in the short term. Effective transition processes will be critical;
    d) The proposed changes may result in some loss from the system of expertise, capability and resources. There will also be a transition cost associated with the proposed realignment of headcount;
    e) There may be a loss of confidence in the current bodies as the changes impact in the short term.

26. The risks need to be mitigated and managed with a robust implementation process that, inter alia, includes:
    a) A focus on maintaining effective capability and resources, albeit integrated into the new system and thereby minimising redundancy costs;
    b) The changes will not happen immediately on 1 April 2015, and may not land until but will be implemented over a six month period to end of September 2015 *(or once decisions have been made post the election).* Appropriate change programme governance will be established imminently with the six national bodies represented and using current resources as far as possible;
    c) While the relevant parts of the system are aware of the potential changes, a formal programme of communication now needs to be established; and
    d) In the meantime the NHS Leadership Academy and NHS IQ will continue to be managed via current arrangements.

Recommendations

27. The Board is invited to review and approve the provisional findings and recommendations, subject to Steering Group consideration and approval on 20 March 2015.

Karen Wheeler
March 2015