Better leadership for tomorrow

NHS Leadership Review

Lord Rose

June 2015

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Foreword

Early in 2014 the Secretary of State for Health, the Rt Hon Jeremy Hunt MP, asked me to review what might be done to attract and develop talent from inside and outside the health sector into leading positions in the NHS; and to recommend how strong leadership in hospital Trusts might help transform the way things get done and to report my findings by the end of the calendar year, which I duly did. Early in 2015 the Secretary of State requested that I extend this report to consider how best to equip Clinical Commissioning Groups to deliver the *Five Year Forward View*, which had been published late 2014[1].

I started this Review in March 2014. I have met and listened to a wide range of stakeholders at meetings, briefings, visits and roundtables (details of this are contained at the end of this report). I have also read a significant amount of literature. I focused my attention on acute and secondary care (both NHS Trusts and Foundation Trusts, referred to together in this document as Trusts) as well as commissioning: there is no specific coverage here of primary care. There are specific recommendations for those in leadership positions within commissioning and provider organisations but in reality many of the recommendations are for the whole of the NHS.

I would make the following observations:

[1] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

- First, the NHS consistently delivers great service through a committed and passionate workforce of 1.38m staff in England[2]. During my Review I heard many great stories (only a few not so great). Mostly I found staff motivated and focused, often running on goodwill in a tough environment; some places felt more positive than others.
- Second, I saw and heard for myself the massive change that the NHS is embracing post 2012. This change needs to be allowed to settle down. There is genuine concern within the service that further restructuring will be imposed upon the system, which would be unhelpful. This is despite the current Government making no indication of wishing to do so. Through no fault of their own, people are often ill-prepared or ill-equipped to implement the changes asked of them.
- Third, the NHS performs an extraordinary service and is staffed by some extraordinary *people*, but the whole organisation could and should be made more effective by the application of some common-sense tactical and strategic thinking.

What I discovered and the evidence presented to me, would come as no surprise to anyone in any large organisation operating on the same scale. The NHS is not alone in facing the challenges highlighted in this Review.

There must be a shared vision; attention must be paid to its people, and those people must be helped, guided and assessed in their performance and delivery.

[2] NHS Choices, www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx

The recommendations of this Review are made in the areas of training, performance management, bureaucracy and management support.

In making them, I acknowledge that readers may feel review-fatigue; so I have kept this as succinct as possible. I also recognise that the NHS is immensely complex, and that one apparently straightforward recommendation will have many implications and perhaps unintended consequences; but because we are intimidated by complexity and scale there is equally a danger of doing nothing. The way to handle complex matters is to simplify them wherever possible. It is a risk we should take.

This Review is deliberately practical in its enquiry and recommendations. It builds on themes uncovered in the 2013 Mid-Staffordshire NHS Foundation Trust Inquiry[3] (Francis Report) and on other more recent reviews (Dalton 2014[4], King's Fund 2014 and 2015)[5] and the *Five Year Forward View* (NHS 2015); Simply put, this Review aims to make people better qualified to manage and to lead.

It is striking that the NHS has a central resource for quality but not for people, and these recommendations set out to address the fact that the people of the NHS are its main asset. What emerges is a range of recommendations (listed in

[3] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, Volume 3, Chapter 24- Leadership, page 1545, (6 February 2013), www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf
[4] *Dalton Review: options for providers of NHS care* (5 December 2014), www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care
[5] *System Leadership: Lessons and learning from AQuA's Integrated care discovery communities* (14 October 2014), The Kings Fund, www.kingsfund.org.uk/publications/system-leadership and http://www.kingsfund.org.uk/publications/leadership-and-leadership-development-health-care

the Executive Summary and in Recommendations), from the promotion of *one vision of the NHS* to an initiative to *cut bureaucracy*: simple enough ideas, tough to implement well on the scale required, and perhaps all the more important because of that.

Everyone should know what great leadership looks like; and even though not every job will require leadership qualities, some parts of every job will. We should not try to prescribe from any particular discipline. We should aim to develop, recognise and reward appropriately leadership qualities across the whole NHS workforce. Leadership qualities should be celebrated across all disciplines and job grades.

We should also recognise that we must work with what we have. A few simple things would make a huge difference: some centralised effort on training; or helping middle managers keep their confidence and focus; or knowing that the top leaders of tomorrow may be doctors, nurses or administrators. At the start of their NHS career, everyone should have adequate training; in mid-career they should have adequate support and clear pathways to progression as managers; and top leaders should have the appropriate support and experience to enable them to make correct decisions.

From my perspective of a manager from the private sector, these recommendations are simple remedies that could make the NHS more effective,

recognising that it is neither private sector nor centralised. Clearly, a patient is not a customer in the same sense, yet any organisation with the scope and reach of the NHS requires strong leadership and management *at all levels and in all parts of the system*. Everything comes down to its people, both right now and in the future: so we must pay attention now if we are to expect results in 10, 15, 20 years. People are long-term.

The recommendations apply to the whole NHS, but they will not and cannot find universal support or answer all issues. However, a way needs to be found to implement them in what is essentially a federation. The development of people and sharing of best practice should not be left to chance. There is much good practice and good leadership out there. I urge the means to share it and to join it up so that best practice may be spread more rapidly.

The NHS is one of our society's proudest achievements, but the challenges it faces could hardly be more daunting. The NHS remains a comprehensive service, free at the point of delivery, regardless of the ability to pay, and funded from general taxation. However, rising demand and treatment costs; the need for improvement in certain kinds of care; and the state of the public finances means that "Simply doing things in the same way will no longer be affordable in the future."[6]

[6] *Government response to the NHS Future Forum report* (20 June 2011), Department of Health, www.gov.uk/government/publications/government-response-to-the-nhs-future-forum-report

The *Five Year Forward View* has a clear vision of what the future should look like; but not enough focus on leadership and skills that will be needed to implement it. I leave you with three questions related to my central themes:

- Leadership is the key to making changes stick. How is great leadership recognised across the NHS?
- How do we find and nurture the people that are needed to lead the NHS over the next 10 years?
- How do we help all NHS staff become the best versions of themselves at work?

This Review offers some answers to these questions.

Lord Rose

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Executive Summary and Recommendations

The NHS has most of the resources it needs to deal effectively with the issues identified in this review. The key strengths that the Review found include: the commitment of staff at all levels and in all parts of the NHS; the profound goodwill of its stakeholders, and the strong support of its funder, the Department of Health.

The quality of NHS clinical care, which is highly regarded, is not always matched by its ability to identify, assess, and manage its staff consistently. Some of the systems and procedures necessary for this do not exist, or where they do exist are only partially effective.

The level and pace of change in the NHS remains unsustainably high: this places significant, often competing demands on all levels of its leadership and management. The administrative, bureaucratic and regulatory burden is fast becoming insupportable. There are three areas of particular concern:

1. Vision: There is a lack of One NHS Vision and of a common ethos.
2. People: The NHS has committed to a vast range of changes however; there is insufficient management and leadership capability to deal effectively with the scale of challenges associated with these.
3. Performance: There is a need for proper overall direction of careers in management across the medical, administrative and nursing cadres.

Many of these problems are chronic and have been unaddressed over an extended period and by different Governments. Clearly, some of these recommendations are of a strategic nature; others tactical and operational. Several are interrelated and overlapping, as one would expect them to be in a complex organisation.

Recommendations:

There are two pre-conditions that must be met before any of these recommendations can be effected: These are simple and profound:

R1: Form a single service-wide communication strategy within the NHS to cascade and broadcast good (and sometimes less good) news and information as well as best practice to NHS staff, Trusts and Clinical Commissioning Groups.

and

R2: Create a short NHS handbook/ passport/ map summarising in short and/ or visual form the NHS core values, to be published, broadcast and implemented throughout the NHS.

Training:

R3: Charge Health Education England (HEE) to coordinate the content, progress and quality of all NHS training including responsibility for the

coordination and measurement of all management training in the NHS. At the core of this is a 90-day action cycle. HEE must promote cross-functional training in all disciplines and at all levels, coordinating the teaching of management basics such as appraisal, motivation, negotiation and leadership

R4: Move sponsorship of the NHS Leadership Academy from NHS England into HEE

R5: Include accredited/ nominated training establishments as part of a diverse training effort.

R6: Review, refresh and extend (x10) the NHS graduate scheme; establish career pathways, a greater variety of placements and a guaranteed job after three years' training (quality and assessment permitting).

R7: Refresh middle management by training and a more porous approach both from within the NHS and externally (recruitment from, and secondment to, other sectors).

R8: Require senior managers to attend accredited courses for a qualification to show that consistent levels of experience and training have been reached across the NHS. On completion of this course they will enter a senior management talent pool open to all Trusts.

Performance Management

R9: Set, teach and embed core management competencies and associated expected behaviours at each management level.

R10: Establish a mechanism for providing on-going career support for all those in a management role allowing individuals to increasingly take charge and identify their own development needs.

R11: Establish and embed an NHS system of simple, rational appraisal (a balanced scorecard for individuals) supported by a regular course in giving and receiving appraisals as part of the core provision of the single training body. At a senior level, these appraisals should be standardised across the NHS.

Bureaucracy

R12: Review the data demands of regulators and oversight bodies; these can then be rationalised and harmonised in order to produce consistent, clear and simple reporting that does not distract staff from patient care.

R13: Merge the oversight bodies, the Trust Development Agency (TDA) and Monitor.

R14: Spend time, on a regular basis, at all levels of the NHS to review the need for each data returns being requested and to feed any findings to the Executive and Non-Executive Teams to review.

R15: Establish and maintain a clearer system of simple rational appraisal (balanced scorecard for the organisation).

R16: Health and Social Care Information Centre (HSCIC) should develop an easily accessible Burden Impact Assessment template and protocol.

Management Support

R17: Create NHS wide comment boards. Website and supporting technology to be designed and implemented to share best practice.

R18: Set minimum term, centrally held, contracts for some very senior managers subject to assessment and appraisal.

R19: Formally review Non-Executive Director (NED) and CCG lay member activity (including, competence and remuneration); and establish a system of volunteer NEDs from other sectors.

Background to the Review

The NHS has recently undergone one of the largest and most radical changes in its 66-year history in the form of the 2012 Health and Social Care Act ("the 2012 Act")[7] and (two years earlier) *Liberating the NHS*[8]. The 2006 Act as amended by the 2012 Act is the legislation in force at the time of this Review.

This wave of change was designed in part to remove day-to-day management of the NHS from the centre of Government. GPs would commission services and the National Commissioning Board (now NHS England) would be given a mandate from Government that sets out the strategic direction in the form of objectives it must achieve; this would limit micromanagement of the NHS by the Department of Health and distance management of the NHS from Government.

The 2012 Act changed the landscape of the NHS fundamentally. Previously the Secretary of State for Health oversaw the NHS through 10 Strategic Health Authorities (SHAs) that in turn oversaw 151 Primary Care Trusts (PCTs). These PCTs commissioned services from hospitals, GPs and all others providing front-line NHS care. The 2012 Act increased the level of oversight by replacing SHAs and PCTs with a number of new bodies including NHS England which includes four regional commissioning offices, a number of Commissioning Support Units and 27 NHS England Area Teams which oversee Clinical Commissioning Groups (CCGs). Money flows from NHS

[7] Health and Social Care Act (2012), www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[8] *Equity and Excellence: Liberating the NHS*, (12 July 2010), www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

England directly to the CCGs which then purchase care in hospitals, Mental Health and Community Services. Specialist services and primary care services are commissioned directly by NHS England, though this too is changing. Local Authorities can also commission some public health services. New levels of accountability were also created. Devolution of accountability away from the centre of government will take time to work.

Clinical Commissioning Groups (CCGs) are autonomous statutory bodies accountable to their members through a governing body. They work closely with other organisations such as local Health and Wellbeing Boards and NHS England. While CCGs are independent, there are a number of duties that they must fulfil which are set out in the [NHS Act 2006, as amended by the] Health and Social Care Act 2012. In late November 2014 some restructuring of NHS England took place with the 24 area teams outside London being replaced by 12 sub regions[9].

Background to the General Themes:

This is a time of extraordinary and rapid change, and this above all else shapes the evidence gathered here. A clear picture emerges of an organisation with many strengths and opportunities both to control the present and to plan for the future. But the picture also includes significant

[9] www.england.nhs.uk/2014/11/28/director-appointments/

shortcomings in the management of staff, and of a lack of local strategic oversight indicative of broader issues in the NHS.

This ought to be a time for great transformation *without structural reorganisation*: the NHS is facing both urgent and important issues. There is an urgent need for more efficiency savings, increased pressure on services from an aging population with multiple needs, and there are the unintended consequences of medical progress such as people living longer with multiple conditions. There are both risks and opportunities.

In funding, for example, the NHS has been rated by the US Commonwealth Fund as the most efficient health care system in the developed world: the NHS scores highest on quality, access and efficiency; it spends the second-lowest amount on healthcare among the 11 nations surveyed (£2,008 per head).[10] Yet the NHS is now being asked to make further massive savings of the order of those that Sir David Nicholson set out for 2011-2015[11]. There is estimated to be a potential deficit of £30bn by 2020-2021.[12] This is placing NHS staff under greater pressure.

The *Five Year Forward View*[13] is welcome and commonsense. It focuses on three things: *managing demand*, *improving efficiency* and *additional funding*. This thinking has helped to shape the context in which this Review made its

[10] *Mirror, Mirror on the wall, 2014 update: How the US health system compares internationally* (16 June 2014), The Commonwealth Fund, www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror
[11] www.stockport.nhs.uk/websitedocs/2010_11_25_Item_6.PDF page 2: *Department of Health Business plan 2011-2015*, (8 November 2010)
[12] *The NHS belongs to the people: A call to action*, (July 2013), NHS England, www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf
[13] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

findings. The *Five Year Forward View* brings a long overdue emphasis on prevention and a continuing and renewed commitment to patients being given more control of their own care. As many have pointed out, it is an "adapt or die" message.

The *Five Year Forward View*[14] recognises that there is a funding gap, a need to join up primary care, social care and acute care and show a practical route to making things more efficient. The vision set out will likely cost an extra £8bn, on top of the £22bn efficiency savings the NHS may be able to make on its own, to implement:

> "If the NHS achieves all the efficiencies identified in the plan – an extremely tall order in itself – leaders say that an extra £1.5bn a year above inflation will be needed, or around £8bn in total, to eradicate a £30bn deficit"[15].

The *Five Year Forward View* sets out the need to move away from the short-term answers into longer term more radical solutions. However, it does not dwell on the most important resource alongside money: people.

The story is the same in the 2012 Act. This put clinicians at the centre of commissioning, freed up providers, continued to empower patients, and brought the NHS, public health and adult social care together for the first time in Health

[14] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/
[15] British Medical Journal (1 Nov 2014)

and Wellbeing Boards. The 2012 legislation created a number new structures, including CCGs, and enhanced roles for the Care Quality Commission; and removed others, including SHAs. The 2012 Act presaged radical change, and it is still too early to say if or how those changes will be successful. Yet wherever structures change, people need to be equipped to run them. Equally, the *Five Year Forward View* says little of the challenges for NHS staff from either the provider or commissioning side. A report from The King's Fund (December 2014) makes clear where some of these challenges currently sit:

> Talent management is key. The responsibility for developing future leaders needs to be taken seriously… It is important that a culture of development and support should pervade – one that allows senior leaders the time and space to try new things… one where they are free from the weight of scrutiny and blame that dominates today.[16]

It lists the well-established need to fill gaps in leadership training, to establish an NHS leadership strategy and development plan, and to remove the disincentives to innovate and take risks. The King's Fund report touches on many things noted in this Review: structural uncertainty, the regulatory burden, career development, talent management, and CEO tenure, all issues which have shaped the recommendations here.

[16] *Leadership Vacancies in the NHS: What can be done about them?* (2014), Ayesha Janjua, The Kings Fund,

Findings & Interpretations

There are seven **General Themes** that emerged; the Review grouped the general themes under the following headings:

1. **NHS vision & ethos (*one vision of the NHS*)**
2. **Leading constant change (*one vision of the NHS, its People*)**
3. **Training (*one vision of the NHS, its People*)**
4. **The management environment (*its People*)**
5. **Performance management (*its Performance*)**
6. **Bureaucracy (*its Performance*)**
7. **Trusts (*its Performance*)**

1 NHS Vision & Ethos

There is a huge opportunity here. The NHS has a great story to tell; but there is no focused vision given to the NHS workforce as a whole. The full-time workforce (1.38m) has grown by 160,000 since 2000[17]. There is an opportunity and need to instill an NHS-wide vision along the lines of "shared values – locally delivered".

[17] *Health and Social Care Information Centre, Annual Workforce Census, (2013*), www.hscic.gov.uk/catalogue/PUB13724/nhs-staf-2003-2013-over-rep.pdf

There have been many initiatives announced by successive Governments, most recently the *Five Year Forward View* (2014)[18] and the Dalton Review (2014). It is the aim of this Review to complement their work and to set out the necessary skills needed across the whole NHS workforce in order to make their visions a reality.

An agreed, shared, vision would give the NHS a united ethos and a consistent approach to getting things done. This would have a direct impact on what good leadership looks like, and on how it is recognised and felt. The NHS needs to focus all the more intently on a single ethos and vision to counteract its increasingly devolved structure. This is because the NHS is essentially a federation made up of individual organisations. Each varies by size and geography; and each has an identity shaped by practice and culture. However though there may be different organisations in the system, the leadership skills needed throughout are the same.

Unfortunately at no point has the time been taken to consider the skills and talent needed to drive the NHS system forward together.

The NHS, as a whole, lacks a clear, consistent, view of what 'good' or 'best' leadership look like. In 2013, Sir Robert Francis QC set out in his public inquiry report some of the criteria for what good leadership in healthcare might be, including visibility, listening, understanding, cross-boundary thinking, challenging, probity, openness and courage. Principal among these is "the

[18] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

ability to create and communicate vision and strategy."[19] This is a set of values that need to be broadcast more effectively within the NHS.

The lack of leadership based on values throughout the NHS has led to some of the most negative comments given to the Review, including; *there is a culture of fear*; *it's all too difficult*; *there is an obsession with targets* and *it is impossible to operate in the current climate of suspicion and change*. Or *What is its plan? What is its vision?*

A lack of good, clear, leadership in some areas is concerning. Some see the NHS, both internally and externally, as full of people making excuses for poor care, passing the buck and shrugging off responsibility. Some people remain afraid to raise concerns fearing that either nothing will happen or that if something does there will be a negative consequence to it. There is a lack of basic training for leaders and managers on how to listen to people and an increased feeling of unconscious pressure being brought to bear to achieve targets at the expense of staff who are willing to raise issues. Greater emphasis is needed now on the skills and development needed to support change and to assist in the delivery of the vision set out in the *Five Year Forward View*.

However, it is not just the lack of leadership that is creating problems. While individual hospitals and Trusts can usually (and rightly) articulate their own vision, for the NHS this seems to be lacking. When people were asked: *what*

[19] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, Volume 3, Chapter 24- Leadership, page 1545, (6 February 2013),www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf

does a good NHS look like, what would success be? shockingly there was no single answer. Despite what was set out in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, many had no answer at all.

Innovative care models depend on people to run them, on porters, receptionists, nurses, consultants, specialists, technicians, therapists, GPs, service commissioners and many others. These care models will never become a consistent and well-understood reality across the UK unless there is a single NHS vision effectively communicated and understood by all NHS staff.

This review also found that there was no consistant clear picture for CCGs of what 'good' commissioning performance looks like. CCGs are new bodies, understandably trying to find their feet; but without such a vision their leaders will find it difficult to secure services of a high standard and, over time, to recruit and retain high quality individuals.

2 Leading Constant Change

The *Five Year Forward View* rightly says: "we detect no appetite for a wholesale structural reorganisation.[20]" This puts it too mildly: there is widespread change fatigue and an irritation that new changes are not given sufficient time to bed in.

[20] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

A lack of stability is felt across the NHS, with a deep-rooted concern over the many and varied messages sent from the centre of Government. For a number of years there have been a range of initiatives and changes of emphasis: Patient safety and quality of care (Lord Darzi's *High Quality Care for All*[21]); Financial performance (derived from the Foundation Trusts reforms); and Performance efficiency (in light of current financial constraints). In other areas of the system we have seen shifts of emphasis between Local Authority commissioning, centralized commissioning through PCTs and more recently clinical commissioning, with a strong emphasis on a lead role for GPs.

None of these changes have been supported by the deliberate development of the skills needed to deliver them. That needs to be put right, with a greater focus on the whole NHS workforce and on developing the talent and skills of its future leaders: they need to be better prepared for the daily challenges of leading a Trust, a team, a ward, a clinical or specialist group or a CCG [over the long term].

This has implications for leadership (which provides the motivation and inspiration) and management (which provides the implementation). As the Dalton Review (2014) points out, "leadership is key to change" [22]. Strong and capable leadership is key to driving transformational change and often involves taking bold decisions. More support is needed for leaders to develop large-scale

[21] *High Quality Care for all: NHS Next Stage Review Final Report,* (June 2008), Department of Health
[22] *Dalton Review: options for providers of NHS care* (5 December 2014), Theme 5, www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care

change management, strategic and commercial skills and the ability to lead in a networked or group structure are becoming more important.

This is important throughout the NHS, and especially for the relatively new CCG Chairs and leaders, so they can fully implement the vision set out in the *Five Year Forward View*. The current level of support given to CCG Chairs and other senior individuals such as Accountable Officers and Chief Clinical Officers is woefully inadequate. There is no 'step up' for these individuals: either they have the necessary leadership skills or they don't. A systematic way to identify and develop this group is needed. Some CCGs do well planning for the future but instances of this are the exception rather than the rule.

Centrally and throughout the NHS there is concern that more structural change means a greater risk to services being delivered below standard. More generally, some argue that the time to take risks was when the NHS had money, and not now. However, this Review argues that the greater risk now lies in doing nothing.

It is widely accepted that the NHS requires transformation in places: most large scale organisations do. To make changes stick, more stable management is required. There will always be those that accept change in any organisation, and those who do not. The former are invariably in the minority. Leaders must ensure that the organisation understands the

necessity to change, and must find ways to bring their staff along with them. However, to do this, time and head-room are essential.

There are signs of growing frustration amongst those in CCG leadership roles at their inability to 'make a difference': some commented that with the publication of the *Five Year Forward View* they are looking to move from commissioning to provider roles. This frustration needs addressing. The models of care set out in the *Five Year Forward View* require strong leadership throughout the system to implement the vision and change needed.

3 Training

NHS management careers depend too much on chance. Training and development are often sporadic. There is limited investment in systematic leadership training for staff and as a consequence capability suffers which is ultimately poor for the patient.

There are several training institutions responsible for training NHS staff,[23] and no mandatory requirement to use them. A significant number of Trusts therefore develop their own training programmes with the help of external consultants. Many of these are of a high calibre but this plurality of provision results in a lack of consistency in the level of training and development received; both depend on the organisation, the area in which it is located and

[23] For instance the NHS Leadership Academy, Health Education England, the NHS Staff College

the individual ward or part of the hospital itself. This Review has found that all forms of initial training tend to lack a consistent, cross-disciplinary approach.

The NHS recruits high calibre graduate trainees, but the numbers are far too low (approx. 100 per year). Although these trainees receive excellent initial training, they are not subsequently managed, monitored and developed. While they are successfully retained, their potential could be better optimized. Some examples of how this could be achieved could be to develop specific roles for those recently graduated, or for there to be greater encouragement for secondments to a variety of NHS posts such as in a commissioning organisation or role. There does not appear to be the level of communication required between those who may have a need for a first year graduate, the graduates themselves and the NHS leadership academy. A number of organisations commented that they would welcome a first year graduate, particularly in the commissioning sector, but were unable to secure one.

Clinical students are not taught either early enough or in sufficient detail during their training about how the NHS works. Many reported that it took them a considerable amount of time to ascertain how the NHS worked as a whole. Neither is there a clear career development structure for clinicians wanting to take on management or leadership positions. The role of Clinical Director is a key role in a successful Trust and development for those clinicians who wish to take on this challenge must be supported and encouraged. While not all will wish to take on management responsibility, there is still a need for all to be able to show leadership skills.

The key leadership relationships within a Trust are between the Chief Executive, the Clinical Director and Chief Nurse, and between the Chief Executive and the Chair. A crucial relationship also exists between the Executive and the Non-Executive Team. There is a need for each group to undergo cross functional training (that is, training not specific to one area or organisation within the NHS) together to build their capability and resilience as well as their combined ability to lead.

The CCG Chair is the lynchpin of the system. Relationships between CCG Chairs in a geographical area, and between Chairs and their provider organisations, are key relationships. Cross-functional training for local Chairs, their top teams and local providers will build better communication between them.

The level of service integration envisaged in the *Five Year Forward View* highlights an opportunity to take joint training one step further. The creation of training programmes, open to all across the health and care sector would have a significant impact on leadership, in particular on the promotion of good practice and of positive collaboration throughout the system.

The NHS Leadership Academy (NHSLA) provides extensive training for large numbers of provider staff at all levels, but does not enjoy the following or

status necessary to make it the key provider for people development in the NHS. If it is to enjoy that status it needs to be bulked up and given the appropriate credibility and status to deliver. This might best be done under the aegis of another organisation such as Health Education England (HEE): at present the NHSLA is too light for heavy work and too heavy for light work. The NHS Staff College delivers similar leadership training to a diverse group of people including executive and ward teams. It too does not currently have the status or scale necessary for it to become the key provider for people development in the NHS.

Together the NHS Leadership Academy and the NHS Staff College working with other key leadership organisations (the NHS Staff College in particular already works with the British Military) should be able to develop and accredit a number of tailored courses, offered in a variety of lengths to suit the needs of the individual (such as a number of courses the NHS Leadership Academy currently provides) and/or organisation. All must be of a recognised and uniform standard.

Training across the NHS should be more mobile, flexible and agile. A variety of locations are needed with oversight from a single organisation. Training could be provided from other public facilities (eg military, education) already known to provide high quality leadership training.

Senior management development needs to be better served – both for the development of those from within the NHS and those recruited externally. Just

as graduate trainees need to be taught about how the NHS works early in their career, so too should those coming in at a more senior level so that they become effective quickly.

Whilst there should be more, and more consistent, promotion from within, there often appear to be barriers to recruiting externally. Reasons given to the Review were that the NHS is too complicated, the pay too low, or the media perception too negative. The current "fast track" scheme appears an expensive – and as yet unproven - way to develop/attract future top talent in sufficient numbers.

The NHS needs to be more porous, encouraging managers to join from other sectors, or leave to rejoin the NHS later; yet its main effort should be in developing its own. Retaining and developing existing staff will always be more cost effective than filling from outside. The Review found no systematic approach to developing managers and leaders (as there is for instance in the Department of Health or Civil Service more broadly)[24].

There is a lack of permeability or interchange of managers between providers and commissioners, yet the *Five Year Forward View* advocates greater integration. Moreover, CCG staff with a wider demographic view of health rather than an organisational one would be advantageous. Equally, a Trust employee moving to a commissioning organisation would provide the commissioner with a better understanding of the services it procures.

[24] *Civil Service high Potential Stream; A talent strategy for the Civil Service 2013/14 – 2016/17, https://civilservicelearning.civilservice.gov.uk/sites/default/files/corporate_talent_strategy_v0f.pdf*

Much more can be done to encourage those working in CCGs to take part in courses offered by the NHSLA and the NHS Staff College. This provision needs to be supplemented by a new training programme for the specific needs of those working in commissioning.

4 The Management Environment

There is a widespread and deep-rooted perception that management is "the dark side". Doctors and nurses can be seen and often position themselves in opposition to management. This is unhelpful.

Management itself is often far too tactical in its behaviour; there is not enough strategic thinking. Great commercial organisations tend to spend more time thinking about the future.[25] The short-termism of NHS management thinking derives from two things: the need for constant regulatory data, and the fear of not being able to change fast enough.

The management structures are various and complex. What became clear is that no one model fits all circumstances.[26] In a plural management environment, two things tend to happen: first, those leaders who are best able to read the rules and interpret the system will prosper (and this may be entirely serendipitous).

[25] *Tapping the strategic potential of boards,* (2014), Bhagat, Hirt & Kehoe, McKinsey and Company www.mckinsey.com/insights/strategy/tapping_the_strategic_potential_of_boards

[26] For example: service-level chain; multi-site trust; federation, joint venture; franchise; multi-service chain; integrated care organisation.

Second, in an uncertain environment, the quality of outcome depends all the more heavily on the quality of the people.

For example, many of the best leaders are successful despite the system; or they had found a way to work it to achieve what they needed. They knew there was no single or mandated way to get things done. For the better leaders, this presents an opportunity to solve or work around a problem; but for weaker and/or newer leaders in less well-resourced areas, this presents a real problem and erodes morale.

Risk taking within acceptable clinical and commercial parameters is not encouraged, recognised or rewarded. An avoidance of failure is often noticed more than drive for innovative success.

At executive level, Chief Executives in particular need a strong team around them for support. Once a solid executive team is formed in a Trust it will often move with them; this practice should be encouraged where appropriate and viable.

Discussions during the Review highlighted the churn of Trust Chief Executives and the unsettling effect this has on Trusts. 7% of all CEO positions were reported as unfilled[27]; and the average tenure was 700 days. There is little clarity on the accuracy of tenure; but these statistics paint a picture of frequent arrivals and departures of senior leadership, of unsettled leadership teams

[27] *Leadership vacancies in the NHS* (December 2014), The Kings Fund. The report states that 7% of all trusts were without a substantive CEO which increased to 17% for trusts in special measures

and of initiative fatigue as yet another Chief Executive brings in yet another fresh approach.

Trusts in special measures or which are poorly performing often have an experienced and well respected Chief Executive brought in to turn around the Trust. However, the reality is that the centre of government does not always give enough time for a new, experienced leader to analyze what is happening, to identify any issues and subsequently to bring in a new team to stabilise any problems found before being overrun with numerous, often unnecessary and, on occasion, heavy handed inspections. These inspections often come with the expectation of *immediate* improvement and when, unsurprisingly, an immediate, service-wide improvement has not been delivered, leaders and their teams are placed at fault. To identify, analyze, rectify and implement all take time; they are not a linear process, especially as poor practice comes to light. Changing embedded culture and increasing staff morale through mutual understanding and respect takes time to deliver. Whilst there are reasons behind the increasing number of inspections, balance is still lacking. Further work needs to be conducted on reflecting the need for the Care Quality Commission (CQC) in particular to continue to respond to concerns raised to them whilst recognising the time a new CEO may need to identify problems and issues and to begin turning round a failing Trust.

By treating leaders in this position impatiently, the NHS is missing a pool of experienced leaders who could be unwilling to put themselves and their careers under scrutiny without the assurance that they will receive the time

and space to consider and effect any necessary transformation. The addition of leadership as part of the CQC inspection under its "well-led" domain, while welcome has added additional pressure/scrutiny on staff.

In essence, since the beginnings of the professionalisation of general management in the 1980s as a result of the Griffiths Report[28], authority was given to the administrators whilst delivery remained with clinicians. An atmosphere of mutual distrust persists between clinicians and managers. It is particularly noticeable in Trusts which are not performing well rather than those that are; the latter tend to be a more cohesive team. There is no unifying ethos across all disciplines. Little has been done to rectify this. There is not enough management by walking about and listening. The NHS remains stubbornly tribal.

A number of CCG Chairs reported difficulties in balancing their role as Chair and their responsibilities as practicing GPs. More should be done to support these clinical leaders. Continuing in practice should be welcomed as it strengthens the authority and credibility of the individual. Without the necessary support and headroom a similar problem emerges where Chairs are managing rather than leading their CCG.

There remains tension between CCGs and provider organisations. In part this is due to the fragmented nature of commissioning (a single hospital for example will have multiple commissioners of the same service). More should

[28] The Griffiths Report, (October 1983), http://www.sochealth.co.uk/resources/national-health-service/griffiths-report-october-1983/

be done to encourage greater collaboration and integration of working between CCGs and providers. A good example of this is in East London where a strategic programme brings together providers of acute and mental health care with the local authorities, the three local CCGs, NHS England and the TDA. The publication of the *Five Year Forward* View creates an opportunity to rethink management structures and back office services. Co-location of different area management teams would be one way to achieve this, although for reasons of geography or historic credibility it may not be possible for all.

5 Performance Management

There is little differentiation between the good, the bad and the ugly. All Trust Chief Executives are paid similarly, although those in Foundation Trusts are likely to be paid more than those in NHS Trusts (executive salary tends to increase in larger NHS organisations). The NHS is unable to clearly state and identify in specific areas what they do well and what they could do even better; and this it seems makes the job of leaders even harder. For CCGs the differentiation is even harder to see.

In terms of remuneration CCG Chairs were able to negotiate their own salaries. Without the means to understand what areas are doing well and not so well there is no way to help share best practice, to drive up performance, or to understand if a salary is appropriate for an individual in a specific area.

The Review heard that a CCG scorecard is currently under development and this is to be welcomed.

Performance management of individuals is haphazard and weak. It is too often a form-filling exercise; staff are not held to account, praised and developed in equal measure. Done well, this is a good way to improve organisational performance or quality. There is work ongoing but it does not go far enough and is not embedded throughout the NHS. The 2013 NHS staff survey results stated that 84% of staff had received an appraisal while only 38% said that their appraisal had been well structured. This resonates with what this Review heard.

Performance management means thinking about how best to train, equip and assign the right people to the right roles; it should help managers and others plan their own careers and acquire the necessary professional skills. However, throughout the NHS the phrase 'performance management' when applied to individuals is synonymous with something negative; when it should mean a communication process that occurs throughout the year between manager and employee to support both the employee's and the organisation's objectives, it can equally be considered as a regular conversation on an individual's career development.

As a whole the performance management culture within the NHS is lacking: objective setting, reviewing, and clear lines of responsibility and accountability are absent. Agenda for Change should have addressed this but more work is

still required to embed this within local management structures. Moreover, due to the infancy of a thorough performance management system in the NHS there appears to be a lack of a transparent 360 degree feedback system.

There is suspicion throughout the NHS, quite understandably, that as performance management is not consistently applied, it becomes a case of *why to me and not to them*? How often individual managers, units, wards request feedback for their staff from patients is unclear.

Closely related to performance management is talent management. There is no central talent pool or NHS-wide structured talent management scheme in place. This is the case for general management, for clinicians and for both Trusts and CCGs. The creation of a talent pool on a national scale has been attempted by the NHS on a number of occasions; clearly one size cannot fit all NHS organisations; but there must be a rational attempt to improve what there is now. While there is currently greater emphasis being placed on developing and 'spotting' talent in Trusts this report has less concern in this area than in the commissioning sector where there is not such a large pool of individuals to draw upon. There is no lack of talent here, rather there is no longer a joined up approach to both talent and succession planning. Encouraging greater flow of individuals between provider and commissioner organisations would utilise this untapped talent.

Talent cannot be managed without a single competency framework for all NHS staff. There isn't one. This absence, combined with the lack of a systematic appraisal, makes development and deployment of key talent almost impossible. Consistent use of competency frameworks and appraisals help set standards. Throughout the NHS there appears to be a marked lack of holding people to account for their performance. The NHS is still seen to routinely move staff upwards or sideways, not out, even when they're not performing. This must stop.

Clinicians contributing to this Review felt they were treated differently from general managers in that they find themselves under greater and more stringent scrutiny. Moving a poorly performing manager essentially rewards incompetence or semi-competence; although it is extremely difficult to sanction or remove a clinician, the stakes are high for that individual (he or she can be struck off the medical register). There is a need here to level the playing field.

At Board level, performance management is also vital. The quality of Non-Executive Directors (NEDs) on Trust boards appears highly variable as do lay members of CCGs. NHS Trust NEDs receive comparatively poor pay and are required to commit significant time to the role particularly in comparison to those working in a Foundation Trust. For NHS Trusts the current rate for NEDs is £6,157 and for Chairs between £18,621 and £23,600 depending on turnover. These rates can be increased by the Secretary of State for Health on an exceptional basis. Foundation Trusts are able to set their own levels of

remuneration necessary to successfully fill their posts. This means that though many NEDs are of a high calibre and are dedicated to their role, the NHS is mostly limiting itself to those with time to devote to the task; these people are often retired and sometimes lack currency in day-to-day management. This is particularly pronounced in NHS Trusts and CCGs, where there is a real need to make these roles more attractive.

There is a lack of clarity about the value NEDs bring. The key question is: *are they holding Trusts to account*? Many seem diligent; but how can their expertise be better shared across the system? How can it be amplified? NEDs need to see beyond their own institutions. This is difficult given the commitment to an individual institution and the fragmented structure of the NHS. The story is similar for lay members in CCGs.

The lack of performance management and talent management has three severe consequences for the NHS.

- First, management cannot improve without the means to do so. Yet there appears to be an embedded reluctance in asking for help; support is viewed as a weakness. There are instances of bullying in this area. There are few role models (particularly in medical management) and not enough shared leadership practices (for example, some of the best leaders leave around 30% of their time

unscheduled so that they can walk around, listen and know and understand what they are driving).

- Second, there is a chronic shortage of good leaders in the NHS. Leadership can be taught and learned. Bringing into the NHS people at higher levels is not the whole answer. Rather the NHS needs greater *diversity* by bringing people into leadership at all levels.

- Third, management standards are not recognised or applied across the organisation. For example, there are obvious inconsistencies in simple practices, systems and communication across wards and hospitals. For instance, there is a wide difference in the quality of notice, patient and ward communication boards, patient documentation, IT systems and nurse staff uniform colours.

Performance management should relate to an organisation's values. But for the NHS, there are many competing values: the NHS is stuck in a circle of *finance - quality - safety - efficiency* as operational priorities. All should be classed as an NHS priority equally. Performance must be managed throughout by means of a more balanced scorecard.

6 Bureaucracy

In 2013 *The regulation and oversight of NHS Trusts and NHS Foundation*

Trusts promised:

> "In [the] future, this division of roles will be simpler and clearer: the Care Quality Commission will focus on assessing and reporting on quality and Monitor and the NHS Trust Development Authority will be responsible for using their enforcement power to address quality problems[29]".

However, the NHS is drowning in bureaucracy. This is evident at all levels. There are two reasons for this: first, the NHS is too vertically structured; and second there are too many regulatory organisations making too many reporting requests.

The number of oversight bodies has grown as the NHS has become more fragmented and more distant from Government. Each of the bodies responsible for monitoring and compliance (eg CQC / Monitor / TDA) has its own mandate; each issues its own demands for data as well as requests directly from CCGs. This has spawned an industry of data collecting. Requests for data are often made regardless of whether the data has been collected in a different format elsewhere and irrespective of the impact on daily business. Regulators appear to be in overdrive and whilst some of this is understandable there needs to be a renewed focus on the sharing of information between regulators and for their perspective to change to consider outcomes rather than inputs.

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[29] *The regulation and oversight of NHS Trusts and NHS Foundation Trusts (May 2013), www.gov.uk/government/uploads/system/uploads/attachment_data/file/200446/regulation-oversight-NHS-trusts.pdf*

Requests to Trusts from CCGs are often the product of a central (DH/NHS England) demand. Requests made in this manner put needless strain on all areas of the system from Trusts, CCGs and indeed NHS England area teams.

It is a commonly held belief that there are one too many oversight bodies and the findings of this Review support that view. This was also the view of the Francis Report and the thrust of one of its recommendations. Since then CQC, Monitor and NHS TDA have built closer working relationships, but there is still some way to go[30].

Monitor's role as a health service oversight body is to ensure NHS Foundation Trusts are well-led and that essential services are provided should a Foundation Trust get into difficulties, it also has a wider remit as the sector regulator. The NHS Trust Development Authority provides a similar role to NHS Trusts, overseeing their performance and governance, as well as progress toward NHS Foundation Trust status. These two bodies operating as a single oversight body would significantly clarify the NHS regulatory and accountability structure.

The Review notes that the influence of targets, regulators and inspectors is seen as ubiquitous and wearing. Bureaucratic reporting has made both individual Trusts' and the NHS' views short-term. And if short-termism also

[30] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, (6 February 2013), www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf Recommendation 19 – There should be a single regulator dealing with both corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts

means the lack of a long view, it is an unintended consequence of the lack of a strategic intermediary; the disappearance of the Strategic Health Authorities means there is no one to lead any region in a collaborative reconfiguration over the longer term.

Although it has been suggested that CCGs should undertake this important role, it would be unreasonable to expect that most of these relatively new organisations have capacity or authority to do so – at least for now. This means that a significant gap in regional leadership remains; many continue to mourn the loss of SHAs.

Too much is being done by numbers. Within the NHS, everyone is managing upwards by means of complying with data requests; for good leadership to flourish, they should be delegating downwards. People need to be and to feel trusted beyond compliance.

7 Balkanization of Trusts & Silo Working

There are currently 211 CCGs, 158 Acute Trusts, 10 Ambulance Trusts, 51 Mental Health Trusts and 31 Health and Care Trusts as part of the NHS federation as well as a myriad of other providers of care. The landscape of this federation has become fragmented in terms of both the numbers and activities of Trusts; within many Trusts silo working is endemic. This means that any activity within a Trust is horizontally separated from the same activity in other Trusts and vertically separated from other activities in its home Trust.

The same is true for CCGs, where there is a need for greater local and regional collaboration. Yet collaboration is more difficult in an environment that has been designed to create competition. Better communication between Trusts and CCGs would help reduce fragmentation of the landscape. There are too many "city-states" and not enough cooperation between them.

The current Trust system is inimical to collaboration; it is not a proper open market as Trusts cannot share with each other commercial information such as price with their suppliers. While their suppliers have a complete picture of the commercial territory. All recent reforms have been about devolving the system. Now there is no one system leader; so all are vying for territory. The loss of the Strategic Health Authorities, for example, means there is no mandate for system leadership, and no eye on what is happening across the system.

The Review heard that the system is creaking and that competition is causing harm, even that there has been too much competition. It is notably absent from the *Five Year Forward View*. Foundation Trusts have been a good development, but left to their own devices and without a framework for competition and cooperation, they are part of a system that is dangerously centrifugal. There is a need for a new balance between competition and cooperation to be considered for the good of the patient and for good practice to be more widely shared.

There are two classes of Trust. The rich have got richer and the poor poorer.

Big has become beautiful and bigger Trusts are becoming richer and therefore more successful with few exceptions. There is no predisposition to close that gap.

Given that Trusts tend to work in isolation from each other, Chief Executives reported the difficulty in being given the room to make decisions that benefit their *regional* health economy but are against the Foundation Trusts' (in particular) best interest. In some cases, the best decision in local health terms has exposed the Foundation Trust to scrutiny from Monitor.

Trusts are resolutely separatist, silo organisations; often they think tactically rather than strategically. They are therefore not keen to lend out staff, and consequently both the individual and the organisation feel unable to grow (this is a particular problem at middle management level). Chief Executives expressed concern over the challenge of taking on the more difficult Trusts: they saw them as isolated outposts with no central protection.

There are a number of notable collaborations[31] within the commissioning landscape in particular in and around London. The NHS must consider these, and other, areas of best practice and look to share and disseminate lessons learnt. There is no place in the vision outlined by the *Five Year Forward View* for individualistic, separatist Trusts and CCGs.

[31] For instance http://www.swlccgs.nhs.uk/ and http://integration.healthiernorthwestlondon.nhs.uk/,

In summary

First, change in the NHS is constant, at times radical, unwelcome and uncertain. Second, over time the NHS has become more devolved, more market-like, more local, more distant from the Department of Health, and hence more fragmented. Third, patients have a greater voice, as do regulators like the CQC and Monitor; each with their own priorities and demands.

These three clear observations place huge demands on NHS staff, on doctors, nurses and administrators alike. None are fully trained or equipped for the extra uncertainty brought about by constant change, the extra complexity brought about by the proliferation of NHS Foundation Trusts, the introduction of CCGs and the increased demands for data and performance metrics brought about by a regulated approach.

This has produced a critical leadership tipping point in the NHS. This point has coincided with a set of internal and external challenges. The answer is not more management but better leadership; not more attention to resources but more focus on how to handle change and uncertainty. The NHS is operating with unprecedented levels of demand, and with limited funding, and its people are under pressure not previously felt. There is an undeniable and urgent need for all NHS leaders to be more visible and to be seen as embodying the culture and values of the NHS. A value-based leadership culture is noticeably absent.

There is a feeling of too many undoable jobs; of over-stretching targets given the available resources; of no time or space ("bandwidth") to think; of limited available mentoring and support; and of the intense scrutiny (top-down command and control, even comments of bullying) that is stopping staff (all types: nurses, general managers, doctors, specialists) wanting to take on extra responsibility and leadership roles.

Managing and leading in the NHS is now harder than ever; the capacity for managers to think through strategic changes and embed them is limited. There is constant fire-fighting in a data-hungry environment closely governed by targets set and monitored by regulators and inspectors. This has led to a high degree of bureaucracy and upward management which is time-consuming and often distracts leaders from focusing on patients.

The complexity and requirement for continuous reporting has caused distraction from delivering the big picture. There is a preoccupation with targets. Data collection in acute Trusts is not always appropriately managed, and there is little Board oversight. Furthermore the NHS has moved from a space of too much 'underlap' pre-Francis where one regulator assumes another is dealing with the data, to a place where there is too much overlap and duplication.

Unfortunately this is compounded by the three prominent staff groups "the triumvirate" of disciplines (Nurses, Doctors and General Managers) who often

do not understand each other's priorities. Despite the importance of clinical leadership a gulf remains between clinicians and managers; it can be hard to get clinicians to sit around a table and be accountable for the organisation as a whole.

Imagine an organisation where everyone understands and values the role of others, however seemingly small; where the main effort is clear; where local variations can apply without bureaucratic censure; where people trust each other and seek to be trusted; where delegation, training and personal and professional growth are seen as aspects of the same thing. This is what an organisation with effective leadership looks like. It is an organisation equipped both for long-term planning and also for the immediate uncertainties and complexities required of any group of people (especially a large one) that seeks to provide the full range of health care to a large and changing population.

A lack of cohesive leadership will produce an organisation where relations between staff and patients are merely transactional, doggedly contractual, obsessed with data and lacking in innovation and inspiration.

There is no less capability or capacity in the NHS than in the private sector; this Review addresses the question of how to harness them so people can give their best. The NHS has all that is needed to be an extraordinary organisation in which values produce the leadership qualities and behaviours necessary for it to thrive in the future.

Recommendations

The Review's findings shaped its seven main themes. These strategic elements are common to any organisation that seeks to achieve anything remarkable; there must be a shared vision; attention must be paid to people, and those people must be helped, guided and assessed in their performance. These themes flow through everything that is recommended here, and have a bearing on the success of all the recommendations. Most importantly, two conditions (R1 and R2) are a necessary prelude to all the recommendations. These are simple yet profound, and they set the scene for success.

1. First, *the NHS needs a collective vision.* A federation as large and plural as the NHS cannot afford to be disjointed. It must think collectively and act locally. The NHS is full of very good people, but it must do more to communicate and share good practice, celebrate success and foster a united ethos. There should be a concentrated effort to create a communications strategy in order to do this. Focusing on the positives within the NHS will bring up and drive out the negatives (it tends to be counter-productive to focus too much on negative behaviour). A collective effort depends on a collective understanding.

R1: Form a single service-wide communication strategy within the NHS to cascade and broadcast good (and sometimes less good) news and information as well as best practice to NHS staff, Trusts and CCGs.

2. *The second prerequisite condition is cultural. The NHS needs to create a values-based culture*. A large and complex organisation can be made more effective if all of its people behave in ways that are ethically consistent, and in ways that show they share the same values and base what they do on those values. There is already the ground work for this: the NHS Constitution includes a Staff Handbook, and Trusts communicate the NHS values contained within it in a variety of ways. But there needs to be a consistency in approach. Values must be easily and quickly understood across the NHS. Great leadership must be understood and fostered in staff at every level; the three military services are good examples of how this can be achieved across an organisation. A new and more visual format will promote this.

R2: Create a short NHS handbook/ passport/ map summarising in short and/ or visual form the NHS core values to be published, broadcast and implemented throughout the NHS.

The Review's further recommendations fall into four practical areas. **Training (R3-R8), Performance Management (R9-R11), Bureaucracy (R12-R16), and Management Support (R17-R19)**. In practical terms, the Review recommends what can and must be done. These areas are inter-related: the first two focus on providing what is not yet there, and the last two on removing barriers to great performance and effective, satisfying work.

Every one of these recommendations is aimed at supporting staff and patients of the NHS. They are practical, realistic and sometimes pragmatic: in a word,

commonsense. They have to work for all concerned, and are designed to make people's jobs easier, to release potential, and to optimize performance.

There is some overlap between them but this is only in terms of impact; something to be expected in a complex organisation such as the NHS. Some of these recommendations are strategic, others are tactical and operational. There is no recommendation to do nothing: in fact, the risks of inaction (although this can be a proper decision in some circumstances) are considerable. The Review urges that 2015 must not be yet another year when these much needed changes are left undone.

Training (R3–R8)

3. *The NHS needs a central body to coordinate its training effort and resources*. The NHS is a federal organisation. The performance of its management depends on its capacity and ability to set and maintain standards in management, to set and support the right kinds of behaviour, and to share across the organisation those things that it does best. Performance management of individuals must link to core competencies, values and objectives with time set aside to discuss and central oversight of this. Support and training needs to be given at all levels to do this. There are a number of places that these universal competencies could be taken from including the CQC 'well led' competencies or the NHS Leadership Academy's Clinical Leadership Competency Framework. Other organisations that achieve this do so by concerted training overseen by a centre that can

coordinate what things are taught, why they are taught, and where and how they are taught. Without such a body and the clarity it must be charged with bringing, the NHS is at extreme risk of wasting management effort and resources. In order to make training consistent, replicable and responsive across the organisation, such a body would be responsible for a consistent training regime across clinical, administrative and nursing / ancillary disciplines. Moreover, such a training body should be set up to be alert and sensitive to changing needs, and should have at its core a 90-day cycle of training requirement set by a body of more junior or middle-ranking staff: their body informs the core what their staff training needs are, and in 90 days the core reports back; in a further 90 days, the training must be in place.

R3: Charge HEE to coordinate the content, progress and quality of all NHS training including responsibility for the coordination and measurement of all management training in the NHS. At the core of this is a 90-day action cycle. HEE must promote cross-functional training in all disciplines and at all levels, coordinating the teaching of management basics such as appraisal, motivation, negotiation and leadership.

4 *People must be equipped for the changes the NHS has asked them to make.* There has been enormous change in the NHS in the last two years. This has come at a time when catalytic change has been the only constant. Yet little has been done to equip people either personally or professionally to manage change and to make themselves properly able to do what is asked of them. The NHS must help its people manage their performance by moving

towards a single competency framework – with one locus (not necessarily a central establishment) of delivery. There needs to be a single training hub to co-ordinate all aspects of training for all individuals across the NHS. There are valuable examples across the military (much could be learned from the Joint Services Command & Staff College, for example). Training must take the form of competencies across all disciplines: leadership, project management, finance, negotiation, motivation, and HR etc. To work, it must be consistent. There must therefore be a single body responsible for the coordination of all training levels, including management training in the NHS.

R4: Move sponsorship of the NHS Leadership Academy from NHS England into HEE.

5. *It is important to maintain quality, pluralism and innovation in training courses,* These should be available in various locations across the country. Training courses should have status, appeal and impact for those staff taking them; they should also be substantial enough to allow people time to reflect on what they have learned, and to form cohorts with their peers. For the NHS these courses should be diverse, accredited, and flexible. This form of collective and action learning is invaluable in developing both individual and organisational competence.

There should be greater diversity of training programmes, some directed at specific organisational needs, such as those working in the acute sector or in the commissioning sector. Others should be directed at increasing collaboration across the sectors bringing together leaders from a variety of

sectors such as local government, Public Health, acute, commissioning and primary care.

R5: Include accredited/ nominated training establishments as part of a diverse training effort.

6. *The graduate scheme is woefully small and under-powered.* The scheme needs to be reviewed, refreshed and extended tenfold with larger numbers of individuals joining each year. To produce managers who see the bigger picture across the NHS, a wider range of postings should be undertaken (NHS acute, mental health, ALBs, CCGs) with an assessment necessary at the end of the tenure to ensure consistency of standards; this approach might better support a flexible and innovative programme of graduate recruitment.

R6: Review, refresh and extend (x10) the NHS graduate scheme; establish career pathways, a greater variety of placements and a guaranteed job after three years' training (quality and assessment permitting).

7. *As managers progress, they must be supported by being exposed to the learning they need in order to do their job*; this learning must of course be current, but equally it should be maintained, such that there is little "skill fade" or stagnation. Exposure to other forms of management and leadership, in other sectors, would be of great benefit.

R7: Refresh middle management by training and a more porous approach both from within the NHS and externally (recruitment from, and secondment to, other sectors).

8. As management is identified and nurtured from within the NHS, and encouraged from outside the NHS, *standards must be maintained and benchmarked against internal and external data*. This is not a call for new measurement or burdensome reporting, but an answer to the need for consistency in performance across all Trusts. One way of achieving this is by an accredited qualification. This has two benefits: external talent can measure itself by qualifying for entry into the NHS management cadre; internal talent can, by registering for and passing this checkpoint, begin to form a *talent pool* on which the entire organisation can draw.

R8: Require senior managers to attend accredited courses for a qualification to show consistent levels of experience and training have been reached across the NHS. On completion of this course they enter a senior management talent pool open to all Trusts.

Performance Management (R9-R11)

9. *It is crucial for the future of the NHS that it creates and supports a cadre of capable, trained and current managers from all disciplines and increases its level of cultural diversity to better reflect its staff.* In order that its training effort can be rational and effective, the NHS must identify and

broadcast core management skills and competencies across the organisation and expectations for delivery at clearly structured management levels. The NHS must begin cross-disciplinary (doctor, nurse and administrative) leadership and management training earlier in individuals careers.

R9: Set, teach and embed core management competencies and associated expected behaviours at each management level.

10. As a consequence of a more highly trained and self-aware management cadre in the NHS, with recognised and developed competencies, *there will be a need for some form of through-career support* to guide individuals as they progress. Individuals should be encouraged to increase their personal accountability for their training needs. Existing talent must therefore be identified and nurtured: More resource should be applied to the development of all management careers in the NHS. Training gates / experience points should be established as part of career progression. A widespread HR programme of talent-spotting, mentoring, networking and inside/outside secondment should be established.

R10: Establish a mechanism for providing on-going career support for all those in a management role allowing individuals to increasingly take charge and identify their own developmental needs.

11. In step with a more rational training programme, better career handling, and recognised leadership and management competencies, *the ways in which people give and receive praise or encouragement or advice need to be codified and made more uniform*. The Review noted that there is little

consistency in how appraisals are conducted, and this must be addressed urgently; this is in part to support the one vision of the NHS (inculcating NHS values into the training and appraisal environment), and in part so that everyone can reasonably expect the same from their appraisal, process wherever they work[32]. The best leaders give *feedback that is both constructive and thought- provoking*. Both positive and negative feedback should be descriptive – given with openness, transparency and candour. This should be built into any new framework.

R11: Establish and embed an NHS system of simple, rational appraisal (a balanced scorecard for individuals) supported by a regular course in giving and receiving appraisals as part of the core provision of the single training body. At a senior level, these appraisals should be standardised across the NHS.

Bureaucracy (R12-R16)

12. *There is an unnecessary burden of bureaucracy*: the NHS is justified in its complaints that there are too many organisations asking for similar returns of data for compliance and monitoring purposes. Reviews have looked into this before (the latest by HSCIC) but they need to go further. There is a need to move from a system where information is *pushed to the centre* to a system where information is *pulled from the centre.*

[32] *NHS Staff Management and Health Service Quality* , Michael West and Jeremy Dawson www.gov.uk/government/uploads/system/uploads/attachment_data/file/215454/dh_129658.pdf , Shows that a good appraisal correlates to lower levels of patient mortality and increases staff engagement

R12: Review the data demands of regulators and oversight bodies; these can then be rationalised and harmonised in order to produce consistent, clear and simple reporting that does not distract staff from patient care.

13. *Clarity is needed within the NHS's accountability and regulatory structure*: bringing together the two current oversight bodies the NHS TDA and Monitor would significantly contribute to this. While any further structural reform needs to be fully justified, the publication of the *Five Year Forward View* provides a stimulus to consider the future oversight model for the NHS. Furthermore, a review of the TDA is now due, as when originally established it was agreed that there would be a review into its continued existence within three years[33]. In the past there may have been good reasons for viewing Foundation Trusts and NHS Trusts differently. However, given that both sets of organisations now display a wide range of performance, it makes sense if support is provided by a single body which has the necessary breadth of experience, staff and contacts.

R13: Merge oversight bodies, the NHS Trust Development Authority and Monitor.

14. *There is an urgent need to improve the management environment by cutting bureaucracy*. As part of an initiative to make the NHS less bureaucratic, and to clean out its attic, the whole organisation needs to undertake an effectiveness review to simplify, standardise and share best

[33] http://www.legislation.gov.uk/uksi/2012/901/memorandum/contents

practice. Further, there is a need for a 'good housekeeping' review of necessary / unnecessary data returns to be taken periodically and an effectiveness review to take place to simplify, standardise and share best practice in data management. Committee work and administrative burden must be lessened. Non-Executive Directors in Acute Trusts would be well placed to consider the level of reporting requested and to communicate concerns around feasibility of requests to the organisation concerned. They could also be instrumental in considering the level of data needed to discharge their duty in holding the Trust to account**.**

R14: Spend time on a regular basis at all levels of the NHS to review the need for each data return being requested and to feed any findings to the Executive and Non-Executive Teams to review.

15. *The NHS must know how to recognise the good, the bad and the ugly*: this can be achieved by annual appraisals and merit awards, all matched against a single vision and ethos. The NHS requires a *consistent balanced scorecard* in which each critical area is given equal prominence. Through enhanced performance management at all levels and in all disciplines, the NHS should be able to identify both the good and poor performers and be able to seek new ways of working together to accomplish strategic goals.

R15: Establish and maintain a clearer system of simple rational appraisal (balanced scorecard for the organisation).

16. This Review has commented on the specific level of data burden felt by Trusts from data requests from CCGs. Many of these requests are driven

directly by NHS England and the Department of Health (DH). A greater level of independence and power should be given to CCGs by means of an accountable SRO (at either Director of Commissioning, Chief Information Officer or Caldicott Guardian level) for ensuring that data requests are not creating additional burden on the system and are necessary and proportionate. It would be their responsibility to ensure that for each data request a Burden Impact Assessment had been produced by the initial requestor (NHS England or DH) and to share it on demand from a Trust Board when discharging their duty to review all requests.

R16: Health and Social Care Information Centre (HSCIC) to develop an easily accessible Burden Impact Assessment template and protocol.

Management Support (R17-R19)

17. *The NHS must simplify, standardise, and share best practice*. The NHS can and must make use of its diversity and scale by sharing experience and best practice. People must be able to talk between Trusts, organisations and across distance. This will break down barriers between organisations, inform managers, doctors and nurses, and above all benefit patients by bringing the collected wisdom of the organisation to bear on their treatment. This will make the spread of best practice more consistent, more urgent, and more speedy. Individual NHS organisational identities should not shirk sharing

between one another, and between sites; nor should they be a barrier to asking for help.

R17: Create NHS wide comment boards. Websites and supporting technology to be designed and implemented to share best practice.

18. Some senior managers and senior leaders will be attracted to turning around poor Trusts. *The NHS needs a team of turnaround specialists ready to apply their expertise to failing Trusts – an elite cadre of known and trusted individuals* implicitly trusted by the regulators, and paid centrally. In order to do so, they need time to assess the situation, assemble their team, and execute their strategy. In order to give good leaders the headroom and protection needed to take on the more challenging Trusts the TDA and Monitor should consider creating a shared resource of individuals willing to be on two year fixed term contracts able to work in an agile manner, deployed to a variety of Trusts.

R18: Set minimum term centrally held contracts for some very senior managers subject to assessment and appraisal.

19. *Trust boards, their Non-Executive Directors and CCG lay members must be better trained.* Research by McKinsey & Co across 770 companies in commercial and not-for-profit sectors showed that better performing boards spent over twice the amount of time than poorly performing boards when it came to talent management, performance management and strategy[34].Trust Executive and Non-Executive Teams require a training programme to allow

[34]McKinsey Quarterly (2014, Number 2), McKinsey and Company, www.mckinsey.com/~/media/mckinsey/dotcom/insights/sustainability/mckinsey%20quarterly%202014%20number%202%20issue%20overview/mckinsey%20quarterly_2014_number%202.ashx.Page 14

them to develop as a cohesive group of leaders. Consideration must be given to increasing the base level of remuneration as standard across NHS Trusts in order to increase the number of potential candidates. This is the same for CCG lay members. The time commitment of Non-Executive Directors and lay members can be extensive, and there is a need to review the expectations of a NED, or the way in which they are brought into the organisation. For instance a single NED job could be shared between two people, shorter terms of employment could be examined or a system of volunteer NEDs from other parts of the health service or other sectors could be considered. There is a role for Boards in Leadership Development and this should be fully explored. A talent pool of potential NEDs and lay members should be considered for the future.

R19: Formally review NED and CCG lay member activity (including, competence and remuneration) in line with the CQC Well Led initiative; and establish a system of volunteer NEDs from other sectors.

Acknowledgements / References

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The questions asked of me by the Rt Hon Jeremy Hunt MP

- What more could be done to attract top talent from within and outside the health sector into leading positions in NHS hospital Trusts, and;
- How strong leadership in hospital Trusts can be used as a force for good to transform organisational culture

were by necessity wide ranging and focused on acute Trusts. However during the course of my review I found that leadership challenges in the NHS are not confined to these areas alone. I therefore welcomed the request to consider the whole system, following the publication of the NHS's Five Year Forward View.

I hope that my recommendations can be taken as a blueprint going forward for the NHS as a whole, whatever part of the system.

Over the course of the Review, I have had the opportunity of visiting many health care organisations across the length and breadth of the country, including Foundation Trusts, NHS Trusts, Mental Health Trusts and CCGs.

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