

Empowering NHS leaders to lead

Sir Ron Kerr

28 November 2018

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Letter to the Secretary of State for Health and Social Care

Dear Secretary of State,

It was a privilege to be asked by your Department to lead this short review which explored three of the key challenges faced by executive leaders across the NHS, namely:

- the expectations and support available for leaders - particularly in some of our most challenged organisations;
- the alignment of performance expectations at the organisational and system level; and
- the level of administrative burden placed upon executive leaders.

As you know, these issues have been looked at in the past and the findings will not be surprising to those working in the NHS. However, given the upcoming publication of the NHS's long-term plan, now seems like an appropriate time for these issues to be revisited and I have worked with colleagues across the Department's Arms-Length Bodies (ALBs) to ensure my proposed solutions align with the future vision for the NHS.

My overall aim has been to ensure that the NHS can be the best healthcare system in the world and continues to deliver high quality care for patients and their families. As you know executive level leaders in the NHS have increasingly demanding and complex roles. At the national level they are responsible for tracking progress and delivering on a wide range of issues, particularly safety, finance and performance, while also supporting transformational change and managing increasing demand for healthcare services locally. A complex array of levers and incentives exist to effect change and drive improvement in the health and care system which can impact in a confusing way on the front line and lead to misalignment of expectations. While the introduction of Care Quality Commission (CQC) ratings has been a powerful tool in driving improvements in quality of care and organisational leadership, it has not tackled the three specific issues looked at in this review.

My review team and I conducted an extensive literature review to evaluate the relative success of previous initiatives, and completed a consultation exercise with leaders across the NHS to gather further evidence and suggestions on what we can do to address the major challenges they face.

I have made a number of recommendations which I believe will begin to address the three challenges in the scope of this review. What has become clear to me through the course of

this work, is that real change will require collective action from the Department of Health and Social Care (DHSC) and its ALBs to deliver the recommendations in this review with gusto and rigour. I therefore ask that we review the implementation of these recommendations in a year's time and that your Department publishes an update on what progress has been made.

I would like to thank you personally for your support during the course of this review, my review team and steering group for their work on the report itself, NHS Providers and NHS Clinical Commissioners for the evidence they provided from the surveys they issued to their members, and the executive and non-executive leaders across the health and social care system for engaging so constructively and enthusiastically in the evidence gathering exercise.

Yours sincerely

Sir Ron Kerr

Non-Executive Director, Department of Health and Social Care

November 2018

Context and methodology

Sir Ron Kerr was commissioned by the Department of Health and Social Care (DHSC) to conduct a review into how the executive leadership¹ of the NHS could be better supported and empowered to ensure the best possible service is delivered for patients.

The review was asked to focus on three issues in particular:

- the expectations and support available for leaders - particularly those in challenging organisations and systems;
- the scope for further alignment of performance management expectations at the organisational and system level; and
- the options for reducing the administrative burden placed on executive leaders.

The scale of the challenge in addressing these concerns is great: the issues are historic and deep rooted. To obtain fresh insight into these areas, and to determine what has and has not worked in the past, there were two strands of evidence gathering.

- The first was a critical analysis of past reviews, reports and initiatives to understand why previous recommendations were not implemented as expected to identify key learning points.
- The second was a comprehensive programme of engagement with executive and non-executive leadership of NHS trusts, Clinical Commissioning Groups (CCGs) and Sustainability and Transformation Partnerships (STP) / Integrated Care Systems (ICS) leaders. A summary of this engagement programme can be found in **Box 1**.

This evidence has been used to formulate the findings set out in this review, and inform the recommendations in the pages that follow.

¹ In this report executive leadership refers to all executive level leaders in provider and commissioners in the NHS

The review was guided throughout by a steering group² with a breadth of expertise and experience.

Box 1: Summary of review engagement with executive leaders across the health and social care system

NHS Providers and NHS Clinical Commissioners surveyed their member organisations to gather views on the three themes in scope for the review. NHS Providers received 114 responses from Chief Executives of NHS trusts and NHS Clinical Commissioners received 26 responses from Accounting Officers of Clinical Commissioning Groups. NHS Providers and NHS Clinical Commissioners analysed the survey responses and produced an anonymised report for the review team.

STP and ICS leaders were also issued a survey directly by the review team, which received two responses.

The review team held 26 qualitative interviews with a range of executive leaders from across the health and care system. The type of organisation, the level of experience of the leader, the geographical location of the organisation (to ensure a spread across the country) and performance were all considered when selecting the sample of leaders to interview. This comprised 15 executives, Chief Executives and Non-Executive Directors of NHS trusts and 11 executives and Accounting Officers from CCGs.

² The Steering Group comprised of a number of CEOs from NHS trusts, CCGs and Sustainability and Transformation Partnerships/Integrated Care Systems, and representatives from NHS England, NHS Improvement, Health Education England, the Care Quality Commission, NHS Providers, NHS Clinical Commissioners and the Shelford Group

Support, leadership and a "new deal"

The NHS must empower leaders to lead, encouraging them to celebrate their successes and learn from their mistakes. In reality, a culture of blame and negativity continues to pervade the NHS. Despite best efforts, it is a fact of life that mistakes are made and error is unavoidable. The NHS needs to get much better at learning from both successes and failures, moving to a more open learning culture which encourages transparency and honesty. There is much more that can be done to nurture and support NHS leaders to thrive, so that they in turn can support their staff to deliver high quality care for patients.

Leadership positions within NHS trusts and CCGs are increasingly demanding and complex roles. Over time, a range of levers and incentives have been put in place to effect change and drive improvement in these organisations.

The review examined perceptions of the support provided to NHS leaders by the national bodies (DHSC and its ALBs). As part of this theme, the review also explored the current leadership development offer available to leaders and future leaders, and sought to understand how the NHS incentivises individuals with the requisite skills and capabilities to take on leadership roles in its most challenged organisations and systems.

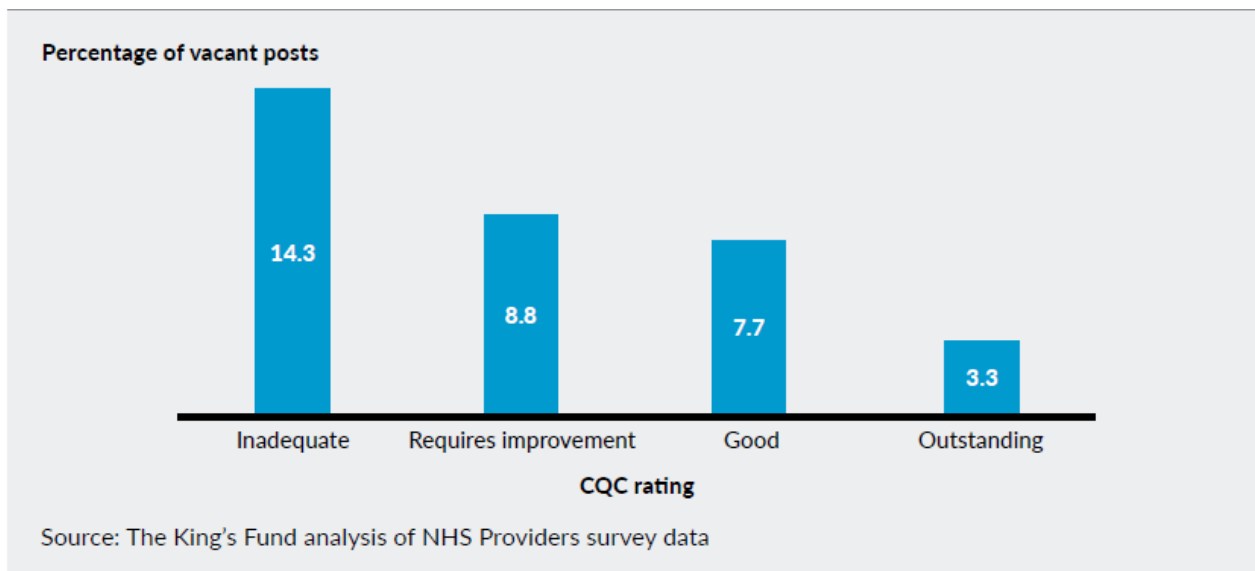
Summary of review findings and evidence

The NHS struggles to recruit to leadership positions in its most challenged organisations. The Kings Fund³ analysed NHS Providers survey data and found that trusts rated "outstanding" by the CQC had only 3% of executive posts with vacancies and 20% of executives who were appointed in the last two years. Trusts rated "inadequate" had a 14% vacancy rate and 72% of executives who were appointed in 2017.

Fieldwork indicated that executives (including chief executives) of trusts in special measures for quality are likely to be more inexperienced than those of high performing trusts. The King's Fund analysis also indicated a link between the proportion of vacant posts and the CQC rating, see **Chart 1**.

³Leadership in today's NHS, The King's Fund, 2018

Chart 1: Percentage of vacant posts by CQC rating 2015-17



Evidence from interviews suggested that leaders often feel that they are seen as the solution “in and of itself”, as opposed to the leader of an executive team and organisation, responsible for delivering an improvement plan. The level of professional risk served as a disincentive to individuals in taking up such positions.

“[to take on a challenged organisation there needs to be a] support package for the organisation. Agreement from the local system that things need to change. Support and buy in from the local system.” – NHS Clinical Commissioners survey

NHS leaders from providers and commissioners reported a "new deal" would be key to encouraging a greater number of leaders to take on these posts, with greater emphasis on organisations, STPs/ICSs and the ALBs generating a shared view of the problem alongside a realistic shared plan and trajectory for improvement. This should include a tailored support package for executive teams, reinforced by the right balance of 'space' to achieve their objectives and firm public backing from ALBs when the organisation pursues difficult but appropriate decisions.

Concerns were raised in some interviews that there did not seem to be a clear pipeline of the next generation of leaders, and suggested that more could be done to invest in local talent management. Several respondents gave the view that clinicians need to be given more training in management and systems to prepare and encourage greater numbers to move into leadership positions.

“[There are] very few incentives [to take on a leadership role at a challenged trust], but the system remains quite good at exploiting the passions and commitments of those brave enough to try because they are driven by the desire to do something/the right thing” – NHS Providers survey

Some interviewees told us that support from the national bodies often felt like additional monitoring. Many leaders reported that more needs to be done to support the current and next generation of leaders to develop their leadership skills, with a particular focus on system leadership, including greater political acumen and relationship management skills. This was backed up by the results of the NHS Providers survey which indicated varying levels of support from national bodies around system working. Respondents to the NHS Clinical Commissioners survey said that support around system working often focused on acute, urgent care.

“The culture of seeing CEOs as wholly dispensable is damaging to individuals, to organisations and the reputation of the wider NHS” – NHS Providers survey

Work underway

There are a number of changes due to take place, which will impact the way in which the NHS manages leadership and talent, in line with the messages from Developing People, Improving Care⁴ including a strengthened role for NHS Improvement (NHSI).

NHSI has created a new Chief People Officer position within the organisation’s senior leadership team. The Chief People Officer will work closely with NHS England (NHSE) as part of the alignment of the two organisations.

These changes provide a welcome opportunity for a renewed and strengthened approach - including the opportunity to work in closer partnership between national bodies and individual organisations - to how the NHS supports and develops its current and future cadre of leaders.

⁴ Developing People, Improving Care, NHS Improvement, 2016

Theme 1 recommendations: support and leadership

Recommendations 1.1 to 1.5 to be the responsibility of the incoming NHSI Chief People Officer. Owners for each recommendation are in brackets.

1.1. To endorse NHSI's plans to overhaul talent management and improve the development of leadership pipelines, including specific actions:

- a) The National Talent Board should work with ALBs including the Leadership Academy to annually review leadership across the country and hold the regions to account for developing their leadership pipelines and ensure consistency nationally. (NHSI)
- b) Regional Directors will be given responsibility for developing local leadership pipelines through Regional Talent Boards and within STP/ICS footprints, with support from the leaders of those systems. There should be kitemarks for championing diversity/ensuring the diversity of the cohort of leaders is proportional to the local population. (NHSI, NHSE)
- c) Organisations that have formed into a Group model, particularly those with standard operating models, should be supported to develop a future cadre of leaders who are able to sustainably apply these ways of working. Groups should have a responsibility to work with the Regional Talent Board and the Leadership Academy to support the development of talent pipelines for executive and non-executive positions within the regions in which they operate. (NHSI, NHSE)

1.2. NHS executive leadership development programmes (e.g. the aspiring chief executive programme) to include a stronger focus on the capabilities and behaviours associated with effective systems working and systems leadership, including; collaboration, negotiation, building and maintaining networks, clinical engagement and embedding governance, working with risk, and digital technology. Leadership development programmes should also place greater emphasis on the skills of operational management to prevent unnecessary escalation to executive level. They should also include enhanced modules to support leaders to develop the skills and capabilities required to lead the most challenged NHS organisations, including working as part of a system, and driving substantial and sustainable improvements in clinical care and patient outcomes. (NHSI)

1.3. Recognising the work that has been done already in this area and the work of the Faculty of Medical Leadership and Management, NHSI, HEE and professional regulatory bodies, working with Higher Education Institutions (HEIs), to ensure that there is appropriate undergraduate and postgraduate education of clinicians of all professions, allied health professionals and social workers. This should include more on systems and management, including governance, finance and use of resources, to raise awareness of and better prepare clinicians for leadership roles. (NHSI, HEE, professional regulatory bodies and HEIs)

1.4. Develop a recruitment strategy in partnership with NHS leaders to attract experienced and talented individuals with the requisite management and leadership capabilities from other sectors to take up executive leadership positions in the NHS, accompanied by an appropriate support package. (NHSI)

1.5. Formal buddying and mentoring schemes to be established as part of regional talent management (to increase the support offer to the cohorts of talent referenced in 1.1 to 1.4), with a particular focus on ensuring this supports leaders from a diverse range of backgrounds. (NHSI)

Theme 1 recommendations: a "new deal"

Recommendations 1.6 to 1.8 to be the responsibility of the Chief Improvement Officer, working with Regional Directors.

1.6. A new deal should be introduced by which the national bodies, STP/ICS lead, incoming Chief Executive, Chair and Non-Executive Directors agree to a "starting package", as referenced in paragraph 2.7 (above), including:

- a) A shared view (between local system players and regulators) of the problem and shared agreement on the plan, including system solutions to help address performance issues, realistic expectations of what success looks like and realistic timescales to deliver expected outcomes (and exit strategy).
- b) An agreed support package over a specified timescale and dedicated organisational development will be put in place for an agreed period of time. The support package should include practical improvement support and capital to address areas such as digital, data and technology, estates, and equipment should be prioritised.
- c) The right balance of 'space' to achieve their objectives and firm back from ALBs when the organisation pursues difficult but appropriate decisions. The new deal would be championed in a few high-profile cases to demonstrate a commitment to supporting leaders who take on challenging roles. (NHSE, NHSI)

1.7. Chief People Officer/National Talent Board/Regional Talent Boards should work with the Royal Colleges to identify the experience that clinical trainees could gain by working in the most challenged organisations to improve the flow of clinical trainees to such organisations. (NHSI)

1.8. The NHS long-term plan should establish a leadership workstream to give a national focus to:

- a) Understand how incentivise leaders to ensure that challenged organisations are seen as desirable places to work, to encourage talented and experienced leaders with the requisite skills to take up such positions.
- b) Improve how the NHS recognises improvements in performance to acknowledge success within NHS leadership.
- c) Consider further professionalisation of NHS management, including career planning and appraisals for NHS managers linked to the expected behaviours set out as part of recommendation 2.5. (NHSE and NHSI)

Alignment and expectations

NHS leaders are exposed to a range of unique pressures. The difference these leaders make is not just between success and failure, it's the difference between life and death. The conditions in which leaders operate are stressful and difficult, with great responsibility and the highest stakes. Over time, this has led to a negative working culture in which both bullying and discrimination are prevalent and accepted. This must change and should be led from the top, with NHS leaders ensuring they model the highest standards of behaviour. The review recommends a number of actions to build a modern working culture in which all staff feel supported, valued and respected for what they do and can challenge without fear.

As part of this theme, the review explored whether NHS leaders were clear on what was expected of them by the national bodies and how well aligned these expectations are in practice. The recommendations seek to address these issues in the context of the alignment of NHSE and NHSI.

“What is expected [of me] is not humanly deliverable” – NHS Providers survey

Summary of evidence and findings

The importance of good systems working and alignment was a key finding of the review. The research team found that trusts which sustained improvements upon exit from special measures for quality were more likely to operate in systems with strong relationships than those which did not.

Half of trust leaders who responded to the NHS Providers survey felt that messages from national bodies aligned with wider expectations of them as a leader, however they felt that there was lack of alignment in the messaging from national bodies about individual trust performance and the need to work across local systems. Some respondents cited examples of conflicting messages from national and regional parts of the same ALB and contradictory messaging on the same issue from different ALBs.

“I have a clear understanding of what I expect of myself. I have a clear understanding that different parts of NHSI have different expectations of what I am expected to deliver”
– NHS Providers survey

The review found that there is a tension for leaders in balancing organisational goals with system goals, although respondents to the NHS Providers survey generally reported that their local system supports them to deliver their leadership goals and that many have developed supportive, trusting relationships across their local systems. Respondents to the NHS Clinical Commissioners survey similarly reported that they understand what is required at the organisational level, and the majority reported that while there is a platform to support the development of aligned goals within their local system, expectations around system working are not clear at a national level.

As part of this theme, the review also found strong evidence of a culture of “negative behaviours” - which often stemmed from the different relative priorities and pressures between regulators and organisations. The behaviours described fall below the standards of what is expected in a professional setting. Some leaders told us that they did not feel confident that speaking out about these behaviours would make a difference.

“We have brought a number of challenges directly and by using [NHS Clinical Commissioners] too. Some of the challenges have been accepted and changed as a result. However, there have been too many instances where excessive controlling style, bordering on outright bullying or coercive control has been exhibited. As a Chair, I am not as exposed as officers to that sort of behaviour and I am very cognisant of challenging too hard when officers then bear the brunt of any challenge back. The original meetings of appropriate two-way challenge between NHSE and the CCG did not last very long.” - CCG leader

NHS leaders explained that they were striving to balance both organisational and system goals within the existing framework. However, the absence of formal legal, governance and system leadership arrangements meant that effective system working was often fuelled by collaboration grounded in pre-existing strong working relationships and goodwill. Some leaders told us that greater clarity of the expectations around organisations working as part of a system would be welcome.

Respondents to both the NHS Providers and NHS Clinical Commissioners surveys reported that where expectations of leaders were clear, they were not always deliverable. This message also emerged during interviews with NHS leaders, who explained that targets were inhibitive in general, but more so over winter where expectations felt unachievable.

Work underway

NHSE and NHSI are due to align their working arrangements at both the national and regional levels. The forthcoming new operating model should ensure that the issue of misalignment between the two organisations is improved. Both NHSE and NHSI must also seek to address the issue that conflicting messages can be sent to the rest of the system from within their respective organisations. The appointment of a joint Chief People Officer for NHSE and NHSI provides opportunity for a renewed focus on addressing the issue of “negative behaviours”, many of which stem from this misalignment.

The long-term plan for the NHS is due to be published shortly. This must set clear direction on systems working and the role respective organisations are expected to play.

The Care Quality Commission (CQC) bases their regulation of providers across health and social care on five key questions, one of which is “are they well-led”. This reviews the leadership, management and governance of an organisation, including an assessment of whether there are “positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs”⁵. In 2017, the Secretaries of State for Health and for Communities and Local Government asked the CQC to carry out targeted system reviews looking specifically at how services work together to support and care for people aged over 65.

Theme 2 recommendations: alignment and expectations

2.1. The alignment of NHSE/I should ensure a clear and aligned strategic direction for the NHS. DHSC ALBs should reflect this strategic direction within their business objectives (e.g. set through mandate/planning guidance), to counteract the risk of inconsistent, misaligned, and/or contradictory expectations being placed upon organisations by the ALBs. (DHSC, NHSE, NHSI)

2.2. As part of the long-term plan for the NHS, a road map to outline key milestones associated with development of local systems, such as the move to system control totals, should be introduced with clear expectations and associated incentives attached, to encourage its uptake. (NHSE)

2.3. Regional Directors to work with local leaders to set clear system goals which reflect local priorities, to which local leaders are held to account. There should be incentives in place to serve as a driver for providers and CCGs to work collaboratively with STPs to

⁵ Care Quality Commission, Inspection Framework: NHS trusts and foundation trusts. Taken from: https://www.cqc.org.uk/sites/default/files/20180921_9001100_trust-wide_well-led_inspection_framework_v5.pdf

deliver system change, e.g. devolved transformation budgets could be held and administered at STP/ICS level to be released to individual organisations to enable them to meet their system goals. (NHSE, NHSI)

2.4. CQC to be commissioned by DHSC to use powers afforded by Section 48 of the Health and Social Care Act 2008, to continue to undertake local system reviews to include the full range of health and care needs, to assess how well system partners are working together. (DHSC, CQC)

2.5. Through the alignment of NHSE and NHSI, there should be a number of actions taken to deal with the issue of negative behaviours and set clear expectations on the behaviours displayed by individuals working across the NHS, to be launched as part of the new NHSE/NHSI business model as a responsibility of the Chief People Officer.

a) A behavioural compact to be developed with a statement of expected behaviours, co-designed between NHS leaders, led by the Chief People Officer, modelled on best practice examples. This should provide an objective framework to serve as guidance on how negative behaviours should be handled and when they should be escalated.

b) A Memorandum of Understanding (MoU) to be agreed between Regional Directors, STP/ICS leads, CCG Accounting Officers and Trust Chief Executives as a formal agreement of these behaviours.

c) 360-degree feedback, with the option for the person feeding back to remain anonymous, should become common practice as part of the performance appraisal process to give greater scrutiny over the behaviours of individuals. There should be assurances that behavioural issues will be handled as part of the appraisal process.

d) Where there are instances of negative behaviours which persistently or gravely contradict the MoU, these should be subject to board level scrutiny of the respective ALB to ensure they are properly addressed. This should be led by a named non-executive director, in line with best practice governance principles. (NHSI)

The burden of information requests

Another pressure for NHS leaders is the heavy burden of bureaucracy. While there must be assurances that certain standards are met, the sheer volume of requests, many of which are duplicative, can distract from much of the good work leaders can do. Leaders should be fulfilling their vision to transform cultures and improve working practices for their staff and the care delivered to patients by clinical teams, rather than signing off information requests. This can result in leaders feeling disempowered and less able to lead their organisations with autonomy.

The review explored in detail the burden of requests for information placed upon NHS leaders and the alignment of requests for performance and assurance information to understand what practical changes can be made to alleviate the current situation.

Summary of evidence and findings

NHS leaders consistently reported that requests for information from national and regional bodies are not aligned, are frequently duplicative, and can end up entering the system at the wrong level. We also heard, particularly from the provider sector, that the current approach to requesting information from organisations and the associated deadlines, which are often short, can undermine the governance structures in place in these organisations as there is not time for the returns to go to the Board for scrutiny.

“It’s aligned in that they’re asking for the same thing. It’s not aligned in that they’re all asking for the same thing separately” – Trust Chief Executive

Respondents to both the NHS Clinical Commissioners and NHS Providers surveys felt largely unable to challenge requests from the centre that they viewed as inappropriate, or that the challenge would not be accepted. Trust leaders reported that there is a widespread negative view of pushing back and that those who do so are seen as at fault or inadequate. There was also a view from providers that it is harder for smaller organisations to challenge than it is for larger organisations.

“It’s not [aligned]. Certain elements flow but a lot of it is still random. The infrastructure and information governance gets in the way and causes a lot of problems. People tend not to know why they’re asking for the information.” – CCG Chair

There is evidence that leaders of trusts rated “outstanding” or “good” by the CQC or those with a rating of 1 or 2 on NHSI’s Single Oversight Framework⁶ (SOF), or those leaders who has been in post longer or with more experience, felt more able to challenge such requests. Some leaders from both providers and commissioners reported that they felt able to engage in a “mature debate”⁷ with the national bodies, with some regional teams open to such dialogue.

“Impossible to challenge national bodies or government as [there is] no vehicle to do so...there is little or no forum's now that recognise leadership in the NHS....More positively regional and area regulators are largely supportive and open to challenge, but often limited in their ability to act on the challenge.” – NHS Clinical Commissioners survey

Trust leaders also highlighted in interviews that the rationale for information requests is often unclear, as is the purpose for which the data will be used. There were concerns that this could lead to variation in how different areas responded to requests. Interviewees also reported that their organisations rarely received feedback on their requests, and some of the respondents to both the NHS Providers survey and NHS Clinical Commissioners survey felt that assurance can be a “box ticking” exercise.

Interviewees also suggested that meetings on performance and assurance matters were often duplicative, and gave examples where requests for joined up meetings on performance had been declined by the ALBs.

⁶ The Single Oversight framework is used by NHSI to determine how the organisation oversees NHS trusts and NHS foundation trusts. The framework is used to identify NHS providers' support needs across five themes: quality of care; finance and use of resources; operational performance; strategic change; leadership and improvement capability. Individual trusts are segmented into four categories according to the level of support needed, summarised as follows: 1) Providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; 2) Providers offered targeted support: there are concerns in relation to one or more of the themes; 3) Providers receiving mandated support for significant concerns; 4) Providers in special measures.

Taken from:

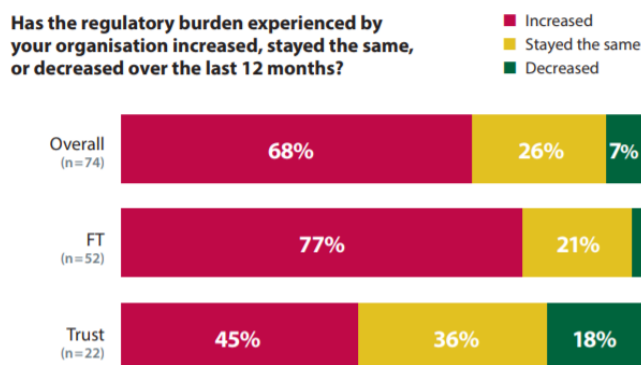
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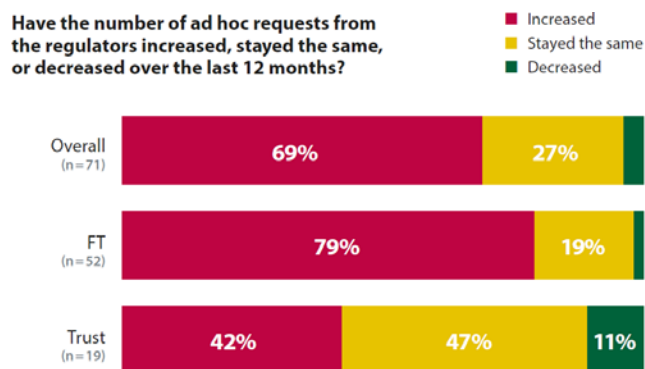
⁷ NHS Providers Survey, September 2018

“We do respectfully push back at irrelevant, overly burdensome requests without rationale – however [it] makes no difference” – NHS Providers survey

The graph below, taken from NHS Providers, Regulation Survey Report (2017)⁸, shows 68% of respondents said the number of requests had increased over the last 12 months.



The graph below, taken from NHS Providers, Regulation Survey Report (2017), shows 69% of respondents said the number of ad hoc requests had increased over the last 12 months.



⁸ Regulation Survey Report, NHS Providers (2017), Chapter three: regulatory burden and impact

Work underway

Under the new NHSE/I operating model, the expectation is that oversight of performance and assurance will be rebalanced, with a greater proportion of this taking place at the regional level than occurs currently. The new Regional Directors attending the boards-in-common meeting will help to ensure a consistent approach across the regions. This offers the opportunity to introduce a new framework for managing requests for information on performance and assurance.

Theme 3 recommendations: reducing the burden

3.1. A new leaner, risk adjusted approach to performance management and assurance, including greater transparency over requests agreed through a memorandum of understanding at NHSE and NHSI national level, regional teams and STP/ICS leads.

a) DHSC and ALBs to follow best practice in issuing and servicing requests, in line with:

(i) greater clinical input into decisions around the issuing of requests;

(ii) requests should clearly articulate the purpose of each collection;

(iii) adequate feedback should be provided on the returns; and

(iv) each request should estimate the time the ALBs expect it to take to complete, with each return indicating whether the estimate is accurate.

b) Managing assurance requests at a regional level:

(i) regions to be given greater autonomy to manage performance, overseen by each Regional Director to ensure national coherence as part of the national senior leadership team. The national bodies to agree a set of standard performance data, to be reviewed annually. Any requests issued outside of this to be signed off by the relevant board member; (NHSE, NHSI)

(ii) regions to be clear about what information they are expecting from each STP/ICS area on a quarterly basis. Any additional/ad hoc requests to be subject to sign off from the Regional Director, so that teams are empowered to push back on inappropriate requests; (NHSE, NHSI)

(iii) Regional Directors to ensure there are single integrated assurance meetings around key performance areas for example, urgent and emergency care, referral to treatment, winter, cancer, mental health and primary care for each STP/ICS area; (NHSE, NHSI) and

(iv) increasing ability for mature systems to manage performance across their organisations with less routine interference into individual trusts. (NHSE, NHSI)

c) Reviewing the assurance burden:

(i) the joint NHSE and NHSI board meetings-in-common should review annually the number and type of requests made into the healthcare system by all ALBs to ensure assurance requests are appropriate and aligned; (NHSE, NHSI)

(ii) ALBs should report requests made against their licence to DHSC (DHSC and ALBs); and

(iii) DHSC should work with ALBs to review the burden of information requests to assess how well the new ways of working are addressing this issue as part of the review of progress against all recommendations. (DHSC)

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