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Independent report

Leadership for a collaborative and inclusive future

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Contents

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Foreword from General Sir Gordon Messenger

In October 2021, the Secretary of State asked me, alongside my now good friend Dame Linda Pollard, to examine the state of leadership and management in the health and social care sector. A daunting remit, but one which recognised the impact that good leadership at every level can make in a workforce which has been under incredible pressure in recent years and where the demands on its commitment and goodwill show no sign of slacking.

As an outsider with limited sectoral experience, it was with some trepidation that I set off on our listening and learning phase; a perhaps unwelcome interloper at a time when everyone was understandably focused on the pandemic and its consequences. Yet, throughout, I have encountered nothing but friendliness, candour, self-reflection, pragmatism and support from the impressive array of experts, front-line staff, academics, service users and leaders who willingly gave us their time to share their views. I have always held our health and social care workforce in the highest regard, yet my respect and admiration has deepened through witnessing their selflessness, professionalism and resilience first-hand. My thanks go to all those we spoke to, and my apologies to those we unwittingly missed.

Of the many telling observations we have heard, 2 stand out as almost universal; firstly, the very real difference that first-rate leadership can make in health and social care, with many outstanding examples contributing directly to better service, yet; secondly, that the development of quality leadership and management is not adequately embedded or institutionalised in our health and care communities. We have consequently focused our findings on areas which improve awareness of the impact that good leadership can have, and which instil it as an instinctive characteristic in everyone, not just those with the word in their job title.

Huge variety exists in the way primary, secondary and social care is structured and governed, so it has proved difficult to identify sensible interventions that have consistent relevance and impact across the board. The NHS is itself far from a homogenous unified organisation but rather a federated ecosystem where complex tribal and status dynamics continue to exist. Given the clear benefits of cross-boundary teamwork and collaborative behaviours, everything should be done to encourage greater parity of esteem, conditions and influence between sectors and, within secondary care, a re-balancing of the focus on acute trusts to the benefit of their community, mental health and ambulance trust counterparts. The vast majority of health and care delivery never touches the acute sector, and it is in the interests of all to keep it that way, so more

equitable representation and empowerment must be a key enabler to enhanced collaboration. Equally, the more that can be done to instil locally a culture of teamwork, understanding and shared objectives across the primary, secondary and social care communities, the better will be the nation's public health outcomes.

To those of our recommendations which require time and resource to implement, I predict a partially understandable reaction that the current pressures on the system preclude investment beyond the urgent. My response is that a well-led, motivated, valued, collaborative, inclusive, resilient workforce is 'the' key to better patient and health and care outcomes, and that investment in people must sit alongside other operational and political priorities. To do anything else risks inexorable decline.

I would like to thank the review team who have supported me so energetically and ably. Without their insight, industry and support, I would still be lost in the foothills of the challenge set me and will be forever grateful for their patience and commitment over the last few months. A special mention must go to my co-lead, Linda Pollard, who has contributed so much despite also holding down a crunchy day-job. Her wisdom, decency and forthrightness have shone through every day and, if this review achieves what it sets out to, the plaudits are hers.

Sir Gordon Messenger
8 June 2022

Executive summary

For a report like this to have the impact intended, it needs to speak to the community it affects. It must be supportive but honest. It must recognise the challenges and the context faced, but it cannot duck the difficult or uncomfortable. It should respect the everyday commitment, determination and goodwill of leaders and staff at every level to improve outcomes and experience for patients and service users yet also, through well-intentioned, constructive criticism, aim to provide a framework for improvement.

In that vein, we must confront the fact that there has developed over time an institutional inadequacy in the way that leadership and management is trained, developed and valued. Collaborative behaviours, which are the bedrock of effective system outcomes, are not always encouraged or rewarded in a system which still relies heavily on siloed personal and organisational accountability. Very public external and internal pressures combine to generate stress in the

workplace. The sense of constant demands from above, including from politicians, creates an institutional instinct, particularly in the healthcare sector, to look upwards to furnish the needs of the hierarchy rather than downwards to the needs of the service-user. These pressures inevitably have an impact on behaviours in the workplace, and we have encountered too many reports to ignore of poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance. We experienced very little dissent on this characterisation; indeed, most have encouraged us to call it out for what it is.

These symptoms are not, we would observe, necessarily the fault of historical or existing leadership teams or their staff. They are the result of a combination of factors over many years; some structural, some cultural, some emanating from behaviours at the top, including politicians, some born of complex inter-professional and status issues in the workplace. The important conclusion, however, is that they should not be tolerated as they directly affect care of the service-user as well as the staff, and that they can be tackled but only through determined cultural change from the top of the system to the front-line.

The recommendations of a one-off review cannot provide all the necessary ingredients for such a shift, but we do attempt to identify key interventions which we hope will deliver momentum and scale. We identify the point of entry as a critical opportunity to set cultural and behavioural expectations, and to emphasise that how one behaves is as much a component of professional acumen as what one does. We propose a locally delivered mid-career development event, designed to bring together professionals from all parts of health and social care around the triple lens of collaborative leadership, broader cross-sector awareness and understanding, and behavioural expectations. We encourage the medical profession to examine honestly their role in setting cultures, given their unique influence in the workplace dynamic. Most critically, we advocate a step-change in the way the principles of equality, diversity and inclusion (EDI) are embedded as the personal responsibility of every leader and every member of staff. Although good practice is by no means rare, there is widespread evidence of considerable inequity in experience and opportunity for those with protected characteristics, of which we would call out race and disability as the most starkly disadvantaged. The only way to tackle this effectively is to mainstream it as the responsibility of all, to demand from everyone awareness of its realities, and to sanction those that don’t meet expectations. EDI should become a universal indicator of how the system respects and values its workforce, and the provision of an inclusive and fair culture should become a key metric by which leadership at all levels is judged.

Beyond cultures and behaviours, we chose to focus on the current absence of accepted standards and structures for the managerial cohort within the NHS.

With known exceptions, it has long been a profession that compares unfavourably to the clinical careers in the way it is trained, structured and perceived, and we received strong feedback from managers at all levels that greater professional status and more consistent, accredited training and development are required. This training must be aligned to professional skills required in the future, including digital and transformation, as well as core managerial delivery. We make recommendations to that end.

This approach to career management spills over into how individuals' particular skills and talents are encouraged and developed, and we heard frequently that managers do not always feel institutionally supported in their career choices. We did not find much evidence of a systemised career management function which exists to grow the right experience and talent and to place it where it is needed most. While there are many examples of world-class leadership in the NHS, we would observe that it often exists through the endeavours of an individual rather than as a consequence of proper talent management. The flip side of this opportunistic approach to succession planning is that it lacks equity and does not guarantee that the most deserving leaders reach the top. We would include non-executive director (NED) appointing in the same bracket. Despite the pivotal governance role of boards, the selection and development of NEDs is currently too localised and arbitrary to assure the right balance of skills, experience and background around the table.

It is clear that effective leadership can be an important, but by no means the only, component in addressing the thorny issue of geographical variation in the quality of care. We welcome the ongoing efforts by the current leadership to tackle this, and provide recommendations which seek to provide effective incentives for the right talent and teams to commit to these challenges, along with a package of support to give them the best chance of success.

The last section of the report is devoted to implementation, recognising that anyone can have great ideas but, if they don't lead to action, they are for nought.

Summary of recommendations

1. Targeted interventions on collaborative leadership and

organisational values.

A new, national entry-level induction for all who join health and social care.

A new, national mid-career programme for managers across health and social care.

2. Positive equality, diversity and inclusion (EDI) action

Embed inclusive leadership practice as the responsibility of all leaders.

Commit to promoting equal opportunity and fairness standards.

More stringently enforce existing measures to improve equal opportunities and fairness.

Enhance CQC role in ensuring improvement in EDI outcomes.

3. Consistent management standards delivered through accredited training

A single set of unified, core leadership and management standards for managers.

Training and development bundles to meet these standards.

4. A simplified, standard appraisal system for the NHS

A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system.

5. A new career and talent management function for managers

Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers.

6. More effective recruitment and development of non-executive directors

Establishment of an expanded, specialist non-executive talent and appointments team.

7. Encouraging top talent into challenged parts of the system

Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles.

1. Introduction

Effective leadership creates successful teams, and successful teams drive better outcomes. The best organisations are those which invest in their people to unlock their potential, and which build strong teams around a unifying purpose. The most successful are those which also foster leadership and accountability at every level, and where everyone is encouraged to become an agent for something bigger than themselves. This should be our goal.

There are many examples of inspirational leadership within the health and social care sector, delivered in the face of enormous pressure. From ward to board, from the manager in a care home to the receptionist in a GP surgery,

great leadership and personal example are being exercised daily in pursuit of the best possible outcomes for patients and public health. But such qualities are not universal and nor are leadership and management skills engrained as the basic building blocks of organisational success, as they perhaps are in other sectors.

We need to recognise that the context for change is highly challenging. External pressures such as manifold performance metrics, stringent regulatory requirements, and short-term political demands, combine with internal pressures such as staff shortages, budget issues, sectoral disparity and pandemic-induced backlogs to create a very difficult backdrop for compassionate leadership and collaborative, inclusive behaviour to thrive. These pressures can lead to 3 unwelcome outcomes:

- they drive a singular fixation on the task in hand, often to the detriment of nurturing the team and supporting its individuals. Over time this has certainly contributed to poorer experiences in the workplace and worsening outcomes; manifested by higher absence rates, deteriorating staff engagement and performance downturns
- they create an organisational instinct to prioritise the needs of the system and its hierarchy over a focus on the better patient and public health outcomes
- they can feed a sense of futility and helplessness in the workforce because individuals perceive they lack the tools or ability to rectify what they know is wrong

To reverse these trends requires a re-calibration towards building stronger teams and a renewed sense of respect and value amongst an empowered workforce, delivered through committed, compassionate leadership from bottom to top. The hard fact is that this must be prioritised alongside the pressing operational needs, and we should be ready to deploy the justification that spending time and resource on looking after the workforce will quickly repay the investment through improved support to patient and service users. Equally, the best way to root out inefficiency and waste is to encourage a collective accountability to tackle it, through empowerment and teamwork at all levels. In every way, investing in leadership and team-building makes economic sense.

Every opportunity must therefore be taken to embed such behaviours so that they become institutionally valued and instinctive to all. And right now we suggest a number of powerful factors combine to provide a generational opportunity to make the necessary cultural shift, owned and driven by the leadership at all levels of healthcare, social care and government:

- structurally, the introduction of the Health and Care Bill and the advent of integrated care systems (ICSs) provide greater opportunity to promote cross-sector collaborative and inclusive behaviours to deliver better system outcomes. The integration white paper (https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations) further reinforces the value of close, inter-professional working at local level
- organisationally, the rationalisation over the coming months into a unitary NHS England (NHSE) provides the opportunity to align behind a core set of values and a common leadership culture, with the potential for spill-over benefits into both primary and social care. Also, the emerging NHS operating model should provide the framework to align responsibilities, accountabilities and authorities
- internally, the NHS People Plan (https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/), People Promise (https://www.england.nhs.uk/ournhspeople/online-version/lfaop/our-nhs-people-promise/) and Our Leadership Way (https://www.leadershipacademy.nhs.uk/our-leadership-way-html/) provide the manifesto for change in the health sector; they deserve time to bed in and, if owned at every level and not perceived as merely more guidance from the top, have all the right components to motivate change
- culturally, a positive legacy of the pandemic is that it has changed the workplace dynamic across health and social care; driving accountability downwards, encouraging innovation, magnifying the value of teamwork including across sectoral boundaries, and strengthening a workforce sense of community through common experience and shared hardship. This sentiment should be capitalised upon

This introduction sets out both the opportunities and challenges which face our health and social care community. A one-off review like ours is unlikely to drive the deep cultural change needed – that must be the responsibility of existing leaders at all levels – but our hope is that our recommendations can provide the necessary frameworks and momentum to take the plunge.

Methodology

We kept our approach simple; form an inclusive and diverse team, consult as widely as possible, remain transparent throughout. Our excellent team, brought together at short notice, included representatives from the Department of Health and Social Care (DHSC), NHS England, Health Education England, NHSX and social care leaders, as well as clinicians, managers and academics – all bringing their own lived experience and personal knowledge of the health and care system. An early decision to ensure very strong EDI expertise in the core team proved consistently valuable.

Our ‘listen and learn’ phase was extensive, engaging with more than 1,000 stakeholders on over 400 different occasions, plus welcoming contribution from all via an open email address. We heard from all parts of the system and across the breadth of primary care, secondary care, local government, public health, social care, charity sector, patients and people who draw on care and support. We sought to avoid speaking only to the well-performing, better-known parts of the system, and actively encouraged constructive challenge and dissent throughout, including the establishment of a challenge board which proved highly effective. COVID measures prevented us from visiting many places personally, yet the generosity of people at every level to give up their time was highly encouraging and indicative of their desire to drive positive change.

We have attempted to limit the number of recommendations to a digestible number, recognising that implementation on too broad a front can quickly dilute impact. Instead, we have invested in working closely with those who will need to own the recommendations if they are to take root. Where appropriate, we have tried to align with existing initiatives and to support the conclusions of previous reviews. This includes Tom Kark’s recommendations (https://www.gov.uk/government/publications/kark-review-of-the-fit-and-proper-persons-test) regarding the fit and proper persons test for directors, which we feel are necessary alongside ours to ensure poor leadership is dealt with effectively. We have tried to avoid being over-specific in framing our findings, in the knowledge that subsequent co-creation is the best way both to ensure buy-in from the communities they affect and to minimise unforeseen disruption during inception.

Scope

Our terms of reference encouraged us to examine the nature of leadership across the entirety of health and adult social care, and from the top to the bottom of both. With a remit of this scale, we have necessarily focused in on a

few key themes which we hope will yield the largest impact. One challenge we faced was the very different structures, governance and accountabilities that co-exist across sectors, and it quickly became clear that the more hierarchical secondary care sector has more identifiable levers of change than the flatter, dispersed, multi-provider structures of the wider health and care landscape, particularly in primary care and social care. This can have the effect of making it harder to enact universal change in the latter sectors, and can also heighten the risk that individuals find opportunities for development more difficult to access.

We have attempted, with some success, to avoid a disproportionate focus on secondary care in our thinking and many of our recommendations are of relevance across all sectors, particularly those which address cultural and behavioural development. But we reluctantly conclude that we have not done them full justice and would advise further work to identify how the impact of better leadership and management can be applied most effectively in our primary and social care communities. Specifically, we commend the focus on developing primary care leadership in the work that Dr Claire Fuller is leading on a stocktake of primary care within ICSs. This will provide specific and practical advice to the ICS chief executives on how they can accelerate implementation of integrated primary care and prevention ambitions in the NHS Long Term Plan, which will include focusing on the importance of nurturing primary care leadership in their own systems. On social care, we have sensed a strong appetite amongst both local government and independent providers for collective, pan-sector leadership and management development, and strongly support the need for greater parity of investment in social care leadership.

2. Findings

This section sets out the key findings from our review which ranged both widely and deeply in health and social care. We encountered many examples of outstanding practice, including the difference that good, mature, collaborative working can make. Yet we also found areas where change and improvement are necessary to ensure leaders and managers are supported to deliver the best possible care. In that respect, while some of our observations may be perceived as critical or negative, they are by no means universal. But we heard them often enough to call them out.

Cultures and behaviours

In this area of cultures and behaviours, 2 broad themes emerged: the culture of collaboration and the culture of respect. Both themes emanate from and determine how people treat each other and service users; both affect the quality of care and outcomes for service users.

The culture of collaboration

We found that the current cultural environment tends to be unfriendly to the collaborative leadership needed to deliver health and social care in a changing and diverse environment. The system is undergoing a fundamental change from a competitive to a collaborative ethic, and behaviours need to reflect this. Decision-making too often relates to a narrow and limited set of accountabilities that do not allow, encourage or reward collaboration. We recognise that this is a direct result of how performance is currently measured, but strongly believe that a re-balancing towards collaborative, cross-boundary accountability is a pre-requisite to better outcomes.

We saw that the urgent tends to eclipse the important. Staff habitually respond to pressures inherent in the workplace by prioritising the task in hand rather than the team and individuals who together complete that task. This is unsustainable. Principal among the many agents that cause reactive rather than constructive behaviours are those pressures from above that force upward-looking rather than outward-looking responses. Some staff, for example, are presented with the responsibility to meet an external metric while lacking the ability or resource to meet it, while others operate freely without oversight in isolated areas. We saw accountability without authority, and vice versa.

Finally, we saw that leadership itself is undervalued as a way of setting the context for collaboration. Leadership is viewed as the responsibility only of those in specific line manager or senior leadership positions, rather than as a quality that runs instinctively through the entirety of the workforce. We found no consistent view of principles for collaborative or systems leadership; current models extol the virtue of certain behaviours but lack a structured framework.

The culture of respect

We heard too frequently that poor inter-personal behaviours and attitudes were experienced in the workplace. Although by no means everywhere, acceptance of discrimination, bullying, blame cultures and responsibility avoidance has almost become normalised in certain parts of the system, as evidenced by staff surveys and several publicised examples of poor practice. This exists at the micro-level, in individual workplaces, and across sectors, where the enduring lack of parity of esteem, conditions and status between healthcare and social care remains a blight on effective collaborative working.

How an organisation performs and behaves in relation to EDI is a clear indicator of its maturity and openness. Further, it will be a clear determinant of how an organisation fares in a rapidly changing social and work context. In this regard, we found that EDI, which is about respectful relationships and underpins a wider culture of respect, is partial, inconsistent and elective. In some places it is tokenistic.

Improving EDI is also a way of reframing career progression. The latter frequently depends on chance, contacts, regional variation, available time and budget. By training leaders to identify where such unfairness exists, access to opportunities will become allocated more fairly, and career progression will be determined more equitably.

In the NHS, we sensed a lack of psychological safety to speak up and listen, despite the excellent progress made since the Francis Report (https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry). We would observe that the Freedom to Speak Up initiative can be narrowly perceived through the lens of whistleblowing rather than also organisational improvement, and we would encourage a broader perspective.

The improvement of organisational learning within health and social care deserves a deeper examination. Too often we encountered limits on the freedom to try without fear of failure, and a willingness to tolerate poor practice while expending energy on workarounds.

Implications of our findings

First, on collaboration. The NHS is a complex ecosystem where personal, professional and organisational accountabilities flow vertically through distinct silos. Similarly, social care is a complex landscape of overlapping public, private, and charity provision. The system needs mechanisms to build and reinforce horizontal, collaborative decision-making; within and between individual organisations, and across the full health and social care sector [see recommendations 1, 2, 3, and 4]. To deliver this, we identify 2 critical points of intervention in careers to embed the necessary behaviours and to align expectations: set culture and improve knowledge [see recommendation 1].

Second, shared greater awareness of the entirety of health and social care would lead to greater empathy and understanding. The system must improve mutual awareness and provide opportunities for staff to engage beyond their professional environment, to appreciate the totality of system, and to value diverse professional approaches. ICSs and integration at place provide excellent opportunities to test and prove the value of collaborative and inclusive leadership.

Third, we think that EDI must be embedded and mainstreamed as the responsibility of all regardless of role, and especially leaders and managers from front line to board. This must include the practice of zero tolerance of discrimination, but also greater awareness of the realities in the workplace for those with protected characteristics. Health and social care must work harder at EDI, recognising it is important in its own right, and key to how seriously an organisation treats the lived experience in the workforce and upholds practices that deliver equitable outcomes for all. Beyond mainstreaming, we also recognise the need for positive action [see recommendations 1, 2, 3, 4, 5, and 6]. We are not advocating for additional EDI professionals; indeed we would anticipate a reduction in numbers over time as leaders demonstrate that they are equipped with the right skills to address inequality and create inclusive working cultures for all.

Standards and structures

The practice of management relies on both standards and structures; it emerged through our engagement that these are currently either insufficient or absent. Our observations cover the NHS specifically, but we recognise that many of these issues are equally relevant in wider health and social care. We recommend further work to investigate the levers to address common challenges, to ensure shared learning across health and social care can be applied with the most impact.

We found that management tends not to be perceived – formally or informally – as a professional activity. Management lacks the status enjoyed by the established professions in health and social care. We heard that this derives from the absence of acknowledged, universally applied standards to achieve agreed levels of behaviour and competence; and from inadequate, unstructured career support. Management can therefore appear as an under-valued career, rather than one at the very heart of great care.

We found inequity in how different managers are perceived; for example, the NHS Graduate Management Training Scheme (GMTS) is highly regarded, but it is unfair that participants are frequently treated as elite purely by virtue of having undertaken the scheme. Managers who do not join via GMTS, often equally talented, do not benefit from the same profile or opportunities. Lateral entrants are often inadequately inducted into leading and managing in context; and skills gained outside the sector, including those who have trained overseas, are not always fully valued. Clinicians who choose to take on leadership roles in addition to their clinical work told us they had little to no specific training to

prepare them.

Management and leadership training, although excellent in some instances, is not based on any consistent or agreed universal standards, is an unhelpful mix of accredited and unaccredited courses and opportunities to access training are inequitably applied. Too much management and leadership training and development, and associated cultural transformation work, is piecemeal, partial and isolated. This whole landscape needs tidying.

There are excellent examples of talent management within organisations, but they are too widely scattered and are rarely completely inclusive. We consistently heard from managers that the lack of structure means career opportunities can appear to be linked more to who one knows and the network one is able to create, than to one's skills and experience. We saw that career management does not start early enough, and this leads to narrowing career paths to the detriment of wider experience. Career management needs to support those in their first role as much as those at mid and later career; too often individuals are recruited to jobs, rather than recruited to careers.

We found a lack of consistency with appraisals – and in some areas, these were absent altogether. Appraisals can range from a performance review and a development conversation to a simple tick-box of tasks completed. Development needs are either focused on individual wants with no relationship to organisational goals, or are neglected in favour of immediate pressures. It was rare to hear of appraisal linking individual, team, organisational and system goals effectively.

Finally, workforce data. Currently, data is not collated and exploited to the benefit of the individuals, teams, organisations, systems or regions as a whole. The result is that excellent talent remains invisible, career support remains opportunistic, talent-hoarding becomes the privileged domain of those that can, and the system struggles to deploy the best people to work where their skills are needed most.

Implications of our findings

There is a need for universal standards, covering practical, procedural and behavioural elements with the aim of ensuring a clearer set of expectations, and in turn equitable recognition and parity. Proper standards require consolidation and coordination; both are lacking in the current preference for multiple competency frameworks and lists of competencies of variable quality. These standards need to apply to and work for all, including those working part time or flexibly.

Consequently, there is a need to develop a formal training curriculum for

managers, to deliver against these standards [see recommendation 3]. This requires larger-scale delivery of training to a pre-determined community, as opposed to the current system which is based on availability and opportunity. Completion of this training should be a pre-requisite to advancement to more senior roles, as current gateways can be arbitrary and inconsistently applied. The modules within this curriculum must allow for different career paths and preferences, but also be accredited to ensure high-quality consistency which is currently lacking. New accreditation could provide alternatives to master's-level expectations stipulated in many Agenda for Change job descriptions currently and will need to take account of prior learning within the bench marking required for the NHS.

We heard that more can be done to support and guide individuals in how they make their career choices. While career and talent management should remain the responsibility of all line managers, organisations and systems, we can see real value in greater oversight at regional level. This new, regional function should have direct responsibilities as well as strategic oversight of managerial careers, working in close partnership with all parts of the system including the system chief people officers or equivalent and organisations' human resource directors [see recommendation 5]. This function becomes the focal point for the NHS human capital in the region with vital responsibility for the collection of data.

To be truly effective as a talent management function requires a more consistent and effective approach to appraisals, including better training for line managers in their delivery [see recommendation 4]. There is currently too much variability in the quality, effectiveness and outcomes [see recommendation 2].

Wider observations

As well as the findings outlined above, we have a number of other observations.

Regulation and oversight

We found that there is a positive view that the CQC can influence collaboration across the whole of health and social care through its inspections, and welcome its increasing focus on teams and systems. The well-led domain of CQC reports can develop its focus on culture and values rather than on managerial processes, and thereby reflect collaborative, compassionate and inclusive leadership in organisations. A judicious use of metrics and data can be a uniting and enabling agent, particularly if they are the basis for open and honest discussions; however, we also heard that over-emphasis on metrics can be

burdensome and counter-productive. Where quality of care falls below what is required, the tone and outcome of regulatory visits can leave leaders feeling isolated and unsupported. With this in mind, we welcome the shift in emphasis from a punitive model to a remedial one.

Open, honest organisational learning here is priceless. We heard that good organisations have a positive relationship with regulators, while those performing less well often wait to be told what to improve. Transparency, and the ability to learn from mistakes and respond without blame, are all necessary for quality improvement; regulators can influence and promote both professional and organisational behavioural changes necessary. Readiness to seek help is a vital first step towards improvement and the route to external support must be clear, timely and stigma-free [see recommendation 7].

The role of the professional regulators (General Medical Council, Nursing and Midwifery Council and others) relates primarily to individuals but is increasingly important in assuring organisational quality. To ensure better read-across to professional standards, we would promote collaboration across all regulators in developing the management standards and the training materials for managers.

Clinical leadership

We found that the interaction between the clinical community and the rest of the workforce is a key element in setting the right cultures and behaviours. The authority and influence that doctors have both in society and within the NHS, means that the medical profession does have a unique responsibility for leading behavioural change where necessary and supporting a positive culture within their sector where all staff flourish.

Clinicians bring a perspective that spans patient interaction and wider population health needs. Done well, their knowledge and innate understanding of their ‘clinical tribes’ can be a huge force for good, but we have equally seen evidence that it can lead to entrenchment and loss of team ethos overall. We encountered the flawed assumption that simply acquiring seniority in a particular profession translates into leadership skills and knowledge; this both reduces the quality of leadership overall and can drive a sense of frustration for those individuals. Doctors are often co-opted for management roles, particularly early in their consultant career, for which they often feel inadequately prepared in comparison with their clinical training. An associated lack of fulfilment can set the tone for their approach to management later in careers.

We heard from allied health professionals that the lack of visibility of leaders from their professions on boards created a sense that careers in management would be limited. Senior nurses talked about ‘going to the dark side’ as a comment often made when they moved into senior management roles, although

nurse postgraduate training does provide elements of management learning. Again, the approach was felt to be ad-hoc and inconsistent.

Overall, even the most successful of clinical leaders reported that their career trajectories had been serendipitous, and that their knowledge was acquired in unstructured opportunities in comparison to their professional training.

We know the system will benefit from well trained, enthusiastic, supported clinical managers and leaders. Alongside the provision of national standards for NHS managers [see recommendation 3], education providers from undergraduate through to postgraduate education, working with professional regulators, have the opportunity to embed and align learning to prepare the clinical professions as future leaders.

The consistency of learning management and behavioural skills is often subsumed by clinical pressures. Extending access to the proposed management training bundles [see recommendation 3] provides an opportunity for a more structured and collective approach to management training for all clinicians. For the medical profession, this must include the trained medical workforce (that is, GPs, consultants and doctors in the staff and associate (SAS) grades). There are different challenges in primary care where we heard there is significant variation in leadership structures within and between GP practices, in their networks. We were told that it is unclear to a newly qualified GP which route provides the best leadership experience in comparison to the traditional clinical director to medical director pathway in hospitals. The new place partnership boards and integrated care boards should provide the outlets that are currently lacking for primary care and public health leaders. The same should be true for local social care leaders.

Leadership delivery in the future

We believe the current climate, including the move towards health and care integration and the work currently underway to merge the arms-length bodies and create a new NHSE, generates opportunity for a fresh approach to preparing leaders and managers in the future.

With regard to leadership development, it is entirely right that it is the role of the centre to demonstrate and drive the appropriate cultures and behaviours, around a set of unified values and purposes. We would observe that this is easier to achieve in the more unified structures of the NHS than in social care, and would encourage investment in setting common cultures and purposes across health and social care as a whole [see recommendation 1]. Further, as knowledge content changes with the impact of digital health and other innovations, future leaders need access to a very different curriculum.

In the context of the NHS and social care, we heard that leadership development is currently uncoordinated and inconsistent, with a crowded landscape of different guidance, agencies and oversight. We believe that rationalisation and accreditation of training opportunities is required, at a greater scale that serves the entire system [see recommendation 3]. There are some excellent leadership development offers available, but they are offered on a 'pull' basis (that is, available but not expected), rather than a 'push' basis where there is expectation that prescribed cohorts will participate. We advocate a shift to the latter.

Collaborative action from the centre, the regions and at local level in healthcare will move the system from being an opportunistic, 'pull' model described above to one that sets broad, core curricula and manages accredited delivery, recognising that a strong local flavour needs to exist in the detail. The existing leadership delivery models, particularly in the NHS, require change to reflect this. Greater alignment of leadership training and development across health and social care sectors would yield immediate benefit.

3. Recommendations

We think some of the changes we recommend are gradual, subtle, and precise; we think others are immediate, radical, and wide-ranging; we think all are necessary. By driving improvement in leadership and management, we are confident that their implementation will have a positive outcome on both public health outcomes, productivity and efficiency.

1. Targeted interventions on collaborative leadership and organisational values

A new, national entry-level induction for all who join health and social care.

A new, national mid-career programme for managers across health and social care.

As the delivery of care transforms, a move to greater integration, different skills, and more collaborative behaviours is required. This includes a need for

improved, standardised training on equality, diversity and inclusion [see recommendation 2] as part of a new approach to the production of skilled managers. There are 2 critical waypoints where a significant impact can be made with new training interventions:

- at entry into a career in health and social care, by whatever route
- at mid-career where individuals often refine their ambitions and career trajectories

What is needed here does not currently exist: this is not about scaling any existing training programmes.

Entry level

The scope here is intentionally broad, capturing the breadth of those who enter a role in healthcare, social care, local government, and relevant voluntary and private sector organisations. In the NHS, around 196,000 (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2021) staff joined or took up new roles between September 2020 and September 2021; in social care approximately 490,000 (https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx) staff joined or took up new roles in the financial year (FY) 2020 to 2021. The potential for impact is significant, the requirement for scale imperative.

The aim of this programme is to introduce new starters to the culture and values that are expected within services and to foster a sense of belonging wider than the immediate organisation. The content of this programme should therefore be co-created by partners across health and social care, including NHS England, DHSC, Local Government Association, Skills for Care, staff networks and patient representatives. This programme should be for all new entrants including those entering formal programmes (such as the Graduate Management Training Scheme or the Assessed and Supported Year in Employment programme) and be used in combination with local inductions. The framework should be nationally set, with certain allowance for local variation, and made universally available to ensure consistency. There is scope to build on the Care Certificate standards, which already set out the introductory knowledge and skills that are important for those in non-regulated roles.

Mid-career

This programme is targeted at middle managers working in healthcare, social care, local government, and relevant voluntary and private sector organisations.

We believe this needs to be 3 to 5 days and in person to get the full benefit, including ideally the creation of local alumni networks. It should work in harmony with the new national leadership programme outlined in the integration white paper. On implementation, the sectors should work together to identify the cohort for this programme which could include, but is not limited to, GPs, mid-career clinicians, NHS middle managers, principal social workers, registered managers and so on. It is vital that the content is co-created if we are to realise the level of collaboration, system awareness and local delivery needed for the future. Again, the framework content should be nationally set to ensure consistency, with flexible and local delivery, either within ICSs or at place level across regions.

2. Positive equality, diversity and inclusion (EDI) action

Embed inclusive leadership practice as the responsibility of all leaders.

Commit to promoting equal opportunity and fairness standards.

More stringently enforce existing measures to improve equal opportunities and fairness.

Enhance CQC role in ensuring improvement in EDI outcomes.

It is the task of leaders at every level to cultivate the conditions for individuals to overcome entrenched and often unacknowledged disadvantage, by ensuring staff recognise and remove subtle exclusionary practices, and by working to remove the set of unspoken assumptions that favour certain groups in terms of career advancement [see recommendation 5]. Dedicated EDI professionals exist to enable this transition. We would anticipate the numbers of dedicated experts to reduce as they successfully instil such awareness in leadership at all levels.

If implemented effectively, we are hopeful that every one of our recommendations will improve equality opportunity. In addition, we believe the following specific measures are urgently needed to enable the necessary improvements on EDI outcomes across health and social care:

- educate leaders to ensure they understand their role in demonstrating and improving inclusive leadership. This must include a more central role for EDI in leadership training and development which, in turn, requires greater skills

and understanding of the topic from those delivering the training. We would encourage the use of the Everyday Discrimination Scale as a useful, objective tool which supports leaders and teams to address this issue in the workplace

- agree and set uniform standards for equal opportunities and fairness across health and social care at entry-level and mid-career level [see recommendations 1 and 3]. Use accredited training modules to set and maintain these standards [see recommendation 3]. Ensure organisational and individual accountability for delivery against these standards, including through appraisals [see recommendation 4]. Uniform standards should help leaders learn how to address discrimination at individual, team and systemic levels
- more stringently enforce existing measures to improve equal opportunities and fairness across all NHS functions. We would encourage similar universal targets in social care. Teams and organisations should set year-on-year goals for improvement, for example by increasing the representation of under-represented groups in training, in development opportunities, and in senior roles [see recommendation 5]
- to support such accountability, the CQC needs to reinforce the behavioural and cultural change necessary, as recommended in the Inclusive Britain (https://www.gov.uk/government/publications/inclusive-britain-action-plan-government-response-to-the-commission-on-race-and-ethnic-disparities) policy paper. This includes ensuring that regulators take account of EDI data as part of their organisational assessments, and particularly the seriousness with which it is viewed by leaders

3. Consistent management standards delivered through accredited training

A single set of unified, core leadership and management standards for managers.

Training and development bundles to meet these standards.

While these recommendations are NHS specific, there is scope for the standards and core content of training and development bundles to be used more widely across health and social care, which should be explored in further detail. There is also good practice within social care from which the NHS can learn, such as principal social worker and registered manager standards.

The implementation next steps are as follows:

- development of the standards – the standards should be co-created, with input from across healthcare, including patient representatives, accounting for good practice that already exists, such as in the NHS People Plan. They should cover operational, strategic management and most importantly, the behavioural components and responsibilities for managers for inclusive leadership, as underpinned by all parts of this review. Once developed collaboratively, they should be nationally led and accessible to all
- development of the training bundles to meet the standards – single, standalone training intervention is unlikely to deliver the depth and breadth required, so we propose the co-creation of training and development bundles. These bundles should include a number of consistent training modules, on areas such as inclusive leadership [see recommendation 2] and core management skills and tools (such as how to conduct an effective appraisal [see recommendation 4]). This should build on existing good practice, such as the work of Proud2BOps in this area. We believe these bundles need a single accreditation process within the NHS to ensure consistency, high quality and portability. The bundles should also offer choice and flexibility to accommodate profession-specific requirements, local needs and individual career aspirations. Flexible components could include experiential learning, job shadowing, e-learning and skills-based projects
- roll out – in the first instance, the bundles should be made available to non-clinical NHS managers at entry and at a prescribed mid-career point. This will underpin a more established career pathway and professional status for non-clinical managers; we believe that the qualification needs to be transferable, recognised across the NHS, and a pre-requisite for further advancement. Some flexibility will be required for lateral entry. Over time, this should be a mandatory requirement for NHS managers [see recommendation 5]
- expansion – following roll out, there is opportunity to expand these bundles to all NHS clinical and non-clinical managers alike. This necessitates further work with educators, commissioners and regulators to develop the read-across to postgraduate clinical curricula where leadership and management skills are required

4. A simplified, standard appraisal system for the NHS

A more effective, consistent and behaviour-based appraisal system, of value to both the individual and the system.

While appraisals were paused during COVID, all staff in the NHS should have an annual appraisal. However, some express cynicism about effectiveness, as shown in the latest NHS Staff Survey (https://www.nhsstaffsurveys.com/). Improvement is needed to the process and quality of appraisal, irrespective of whether individuals wish to progress to higher roles or not. The new system should be based on improvement methodology in 2 parts:

- performance in role including both technical and behavioural elements
- a career conversation around ambition and aspiration

This should enable individuals, organisations, and the system to clearly identify talented individuals and their development needs; and then link them to the wider system [see recommendation 5].

Commitment to a unified, simplified appraisal process demonstrates a move away from siloed processes, short-termism and the whims or biases of individual leaders and managers. It requires a shift from the current unwarranted variation in how performance and career aspirations are managed, to a process that is equitable and supportive for all – working at the pace of individual aspiration.

All NHS employees should be within scope for this recommendation, but this should start with a focus on non-clinical managers in the 2022 to 2023 financial year to ensure those most in need of structured career management are supported as a first priority.

The new process should assess the extent to which the individual has upheld the core values of the service and the extent to which they demonstrate a commitment to EDI and fair treatment, not just technical skill [see recommendation 2]. It should focus on how the individual has behaved, not just what they have done.

Appraisals will continue to be an annual performance and career conversation, with in-year follow up, based on a single set of documentation, which should be co-created, agreed nationally and made available to all organisations. It should be designed to sit alongside and complement documentation needed for professional revalidation. The new system should have latitude for team input, including more extensive use of 360 feedback where appropriate.

As the effectiveness of appraisal is as much to do with the appraiser as with process, the management bundles [see recommendation 3] include compulsory training for effective, fair and inclusive appraisal. It is necessary that the new appraisal system considers the appraisee's experience of their manager, in relation to their commitment to EDI and their inclusive practices [see

recommendation 2]. Appraisal data, including completion, satisfaction and outcomes, should then form part of the evidence of a well-led organisation within CQC assessments.

5. A new career and talent management function for managers

> Creation of a new career and talent management function at regional level, which oversees and provides structure to NHS management careers.

There is a need to create a more aggregated career management function to address 3 problems:

- the lack of clarity for career progression in management
- the failure of the system to utilise and encourage the diverse talent available [see recommendation 2]
- the shortage of people wanting to be managers in challenged parts of the system [see recommendation 7]

An effective career and talent management function could overcome these challenges, providing a compact between NHS managers and their organisations – both in support of the individual and to the benefit of the organisation and the system. The function should sit predominantly with NHS England at regional level; but forming part of a coordinated structure at organisation, place, system and where necessary national level. It should initially support and provide structure for non-clinical NHS management careers, with the potential to expand the remit rapidly to also cover clinical managers once established.

This needs to be inclusive, with sufficient scope, scale, and authority to perform the following functions:

- plan – give structure to succession planning wider than can be achieved in individual organisations or systems; including moving people with the right skills and experience to where they are needed most [see recommendation 7]

- support – provide individuals with career advice and support; encourage and signpost training and development opportunities; and provide clear routes to promotion for every individual, encouraging breadth of experience [see recommendation 2].
- hold and analyse data – responsibility for data collection and storage of data on all managers, categorised by profession, in each region. Such regional databases would supplement the national database of board level appointments which was recommended in Kark's Review
- manage talent – encourage and manage the talent within a geography to ensure better visibility, effective succession planning, and matching skills to role and need. Discourage talent-hoarding, where it exists
- oversee – oversee compliance with mandated managerial standards, associated training, and appraisals [see recommendations 1, 3 and 4]

6. Effective recruitment and development of non-executive directors (NEDs)

Establishment of an expanded, specialist non-executive talent and appointments team.

All boards have 3 roles: formulating strategy, ensuring accountability and shaping culture. NEDs and board chairs achieve this through bringing independent, external perspectives, skills and challenge. They make up over half of NHS board roles, yet their importance can be undervalued.

In the absence of sufficient central support, NHS organisations and latterly systems repeatedly fund private sector executive search firms at significant cost. Despite this, appointments lack the diversity and wider experience needed for this vital assurance role, sometimes presenting people already known in the system. We must improve this.

The current non-executive talent and appointments team within NHS England is highly regarded, yet too small to achieve the depth and reach needed. An expanded team could undertake a range of new and scaled up activities to support provider and system boards in close partnership with wider NHS

England regional teams. These activities could include maximising attraction, setting standards and consistency in role descriptions, role preparation, induction and onboarding, management of talent pipelines and talent pools, central and regional databases and creating networks.

The team should have clear outcome measures and be accountable for evidencing a tangible shift year-on-year in diverse appointments [see recommendation 2]. A report by NHS Confederation (https://www.nhsconfed.org/publications/chairs-and-non-executives-nhs) shows the gains made in the early 2000s towards board diversity in the NHS have not been sustained, particularly in relation to women, people from black and minority ethnic communities and especially chairs and NEDs with disabilities. From the current position, we must break the mould and ensure a wider cross section of society see themself fulfilling this vital role. In short, the NHS must achieve greater diversity so that NED and chair roles more closely reflect the communities they serve and the staff they govern.

Without greater penetration into other sectors, investment will not result in the change needed nor deliver the pipeline of diverse NEDs that can provide the skills and oversight needed. An intervention based on the roles of the individual, team, organisation and system will best shape the NED contribution in the future. Therefore, forging greater links within systems, with other governmental departments, other public sector organisations and commercial providers is vital.

7. Encouraging top talent into challenged parts of the system

> Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles.

There are currently little or no incentives for leaders and managers to move into leadership roles in organisations in challenging circumstances. This section builds on previous recommendations in Sir Ron Kerr's Review (https://www.gov.uk/government/publications/sir-ron-kerr-review-empowering-nhs-leaders-to-lead) around a 'new deal' for leaders to make improvements through the creation of "an agreed package of incentives and support for leaders that take on 'difficult to recruit to' roles".

While there is good work already in train through NHS Intensive Support

Teams, an improved and more widespread offer is needed as leaders have reflected to us that the reputational risk of failure remains too high. The package of support offered to leaders and managers should consist of the following functions:

- build team capability – strategically place talented managers and clinicians into organisations and reward them with upward career progression, as being selected should be role modelled and celebrated [see recommendation 5]. Support new recruits and executive teams with a regional taskforce, which includes experienced clinicians and managers, to co-produce a sustainable improvement plan
- provide holistic support and diversity – provide support networks for executives, clinicians and managers, such as peer mentoring, coaching, training and development, and positive action programmes [see recommendation 5]
- allow time and space for improvement – NHS England, CQC and others to reduce reputational risk and target pressures by bolstering support for leaders, championing progress, and accepting that failure is a normal component of service improvement and transformation, thus allowing leaders the psychological ‘freedom to fail’
- ensure pragmatism – develop realistic improvement plans with appropriate structural support. These should be explicit and set out the expectations of the team, resource and support available - including funding to improve the quality of digital, estates, and equipment (as identified in Kerr’s Review). The plan should be peer reviewed by provider chief executives to ensure it is pragmatic
- attract top talent – use flexibility in available terms and conditions to attract and deploy talented individuals at Very Senior Manager level, including relocation support where available and appropriate for staff moving to rural and coastal areas where unwarranted variation tends to be greatest

4. Implementation

We strongly believe our recommendations should transform health and social care leadership and management and drive the cultural and structural changes necessary to future-proof it. But we also recognise that previous reviews have reached equally sensible conclusions but failed to have the impact they deserve. To avoid a similar fate, we would highlight the following key components of successful implementation:

- Review Implementation Office (RIO): this group, comprised of multi NHS, social care and local government members, and with the highest agency, is essential to provide and drive the pace and scale of the implementation of this review. Its task is to deliver beyond anything that we have in the system at the moment; and to foster sector-wide co-creation to set achievable deadlines and apportion appropriate responsibility. This group should have direct mandate from the Secretary of State and support from the leadership in NHS and local government to deliver the review's recommendations
- ownership and accountability by example from all leaders: for any recommendation to have a chance of making an impact, the leadership must buy into its provenance and live by its virtues. Indeed, the NHS Leadership Compact – 'Our Leadership Way' could easily be used: it has resulted from deep and wide consultation and aligns with the NHS People Plan and People Promise. We get a strong impression from the new leadership at the top of the NHS and from local government that this is an agenda they are prepared to own, incentivise and live by. But buy-in and co-creation from those most affected is also key, and we would encourage a collaborative approach to implementation, drawing on experience and insight from all leaders and the workforces they lead. There should be a strong local, frontline representation, and service users must be incorporated
- allocated time and resource: while we recognise the continuous pressure that the system will remain under, we strongly recommend a re-balancing of time and resource towards supporting and developing the workforce and argue that this will quickly repay the investment in the form of greater productivity, efficiency and quality
- data to support decision-making: workforce data is not yet sufficiently mature to support rapid implementation of some of our findings. While service-user data initiatives are clearly the priority for the time being, we would encourage

resource being available to deliver the data necessary to facilitate workforce planning and support

- firm policy on participation: we believe our recommended training and development elements should be mandatory for selected cohorts. Making participation optional will effectively de-prioritise it and, while sensible flexibility will be necessary especially in the primary care and social care arenas, we would advise a firm policy on participation
- associated rationalisation: a common symptom of change in hard-pressed organisations is that new initiatives are bolted on to, rather than merged into, existing frameworks. This only adds to complexity and inefficiency and inevitably lessens impact. There is certainly scope for rationalisation in the current approach, and we would encourage a root and branch re-alignment of leadership and management development as part of the ongoing re-organisation, with as much integration between health and social care as is organisationally feasible

We recognise that change cannot happen overnight, and that resources and staff effort are necessary pre-requisites to reform programmes. To that end, we have offered the Department and NHSE a number of recommendations for a resourced FY 2022 to 2023 programme to set the conditions for a fully-funded and supported programme of leadership and management investment programme in FY 2023 to 2024. This includes the formation of multi-disciplinary implementation teams and a number of proposals for early wins.

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