NHS

"Inspiring leaders: leadership for quality"

Guidance for NHS talent and leadership plans

DH Department of Health

DH Information Reader Box

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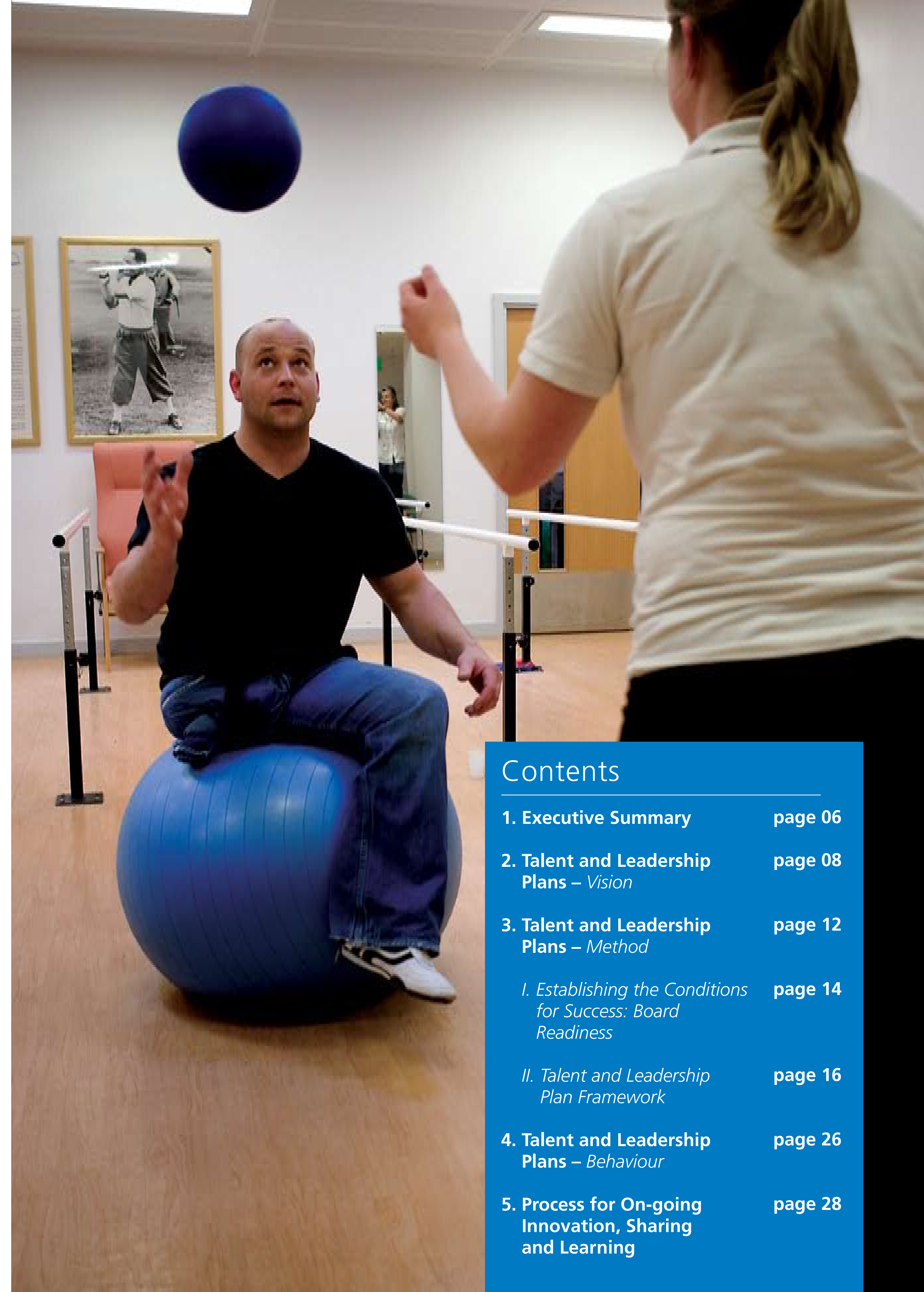

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Foreword

We are on a fantastic journey, as we move the NHS towards becoming a diverse, plural and responsive system which can wrap services around the needs of individual patients and communities.

The purpose of this guidance is to provide a best practice framework for the development of leaders across healthcare.

The Next Stage Review, led by Parliamentary Under Secretary of State for Health, Lord Darzi, sets out a compelling clinically-based vision to take us forward. Its final report, *High Quality Care For All*, makes quality the organising principle of the NHS as we strive significantly to improve healthcare services for patients.

No one underestimates the scale of this challenge. It is a huge cultural shift for the NHS.

We have looked at evidence from across the globe about large-scale change and what works and what does not. This shows that leadership which looks out to communities and to customers, in our case patients, is more likely to deliver the changes we are seeking than leadership that continually looks up to the bureaucracy and to the centre.

Leaders who are skilled at working across systems and boundaries are more likely to deliver the transformation we are seeking.

"It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose."

The NHS is only just beginning to grasp the importance of leadership. We have not systematically identified, nurtured and promoted talent and leadership. While we have fantastic and talented leaders in the NHS, to take us to the next stage, we need to embrace more people with different skills and backgrounds and support the development of healthcare staff in a sustained way.

This is critical for us to get right. We will really struggle to deliver locally-driven services that are responsive to the needs of individual patients if our leadership and workforce are not representative of the communities we serve.

The National Leadership Council, which I will chair, will be responsible for ensuring we have a systematic way of identifying and developing leaders to move to the next stage and beyond.

There are four principles which I believe the NHS needs to adhere to in taking this agenda forward - both to hold me to account and for me to be able to hold the service to account.

Those four principles are co-production, subsidiarity, clinical engagement, and system alignment.

Co-production means that all parts of the system need to work together on shaping and implementing change. This sounds like management jargon, but what it means in essence is engaging people across the system to work together to make change happen. This approach is what made the Next Stage Review process so successful, and it has informed the World Class Commissioning programme and the development of this guidance.

Subsidiarity means ensuring that decisions are taken at the right level of the system, which means as close to the patient as possible. It means an enabling role for the centre, with more power and responsibility residing with patients and clinicians. And it means looking 'out, not up' wherever possible.

While the National Leadership Council will have responsibility for championing and assuring leadership and talent stewardship, SHA boards need to foster collaboration, enabling investment and shared action where it is in the interests of developing leaders and leadership pipelines. Trust boards need to ensure that the conditions are in place for all those responsible to spot talent and develop leadership. It is also individuals themselves who need to take ownership of their own career development in the knowledge that they will be given access to the support they need to succeed.

Clinical ownership and leadership was crucial to the success of the Next Stage Review process, and this must be maintained during implementation. If we get it right, the quality agenda has great potential to mobilise and empower clinicians across the system. And, conversely, we will get nowhere without clinicians on board. So clinical leadership needs to be part of everything we do.

System alignment – achieving complex cultural changes, such as making quality our organising principle, requires all the different parts of the system to pull in the same direction and work with partners.

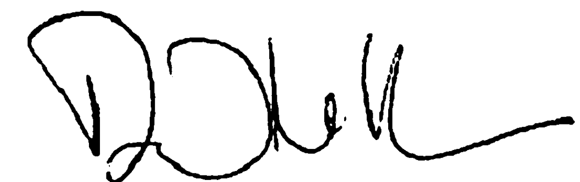
We have hundreds of organisations setting standards, measuring them and commenting on them. This makes it difficult to define what success looks like.

That is why the National Quality Board has come out of the Next Stage Review; to better align the regulators, the standard setters, the Royal Colleges and line management. If we could get into a position of being able to define success, it would be very powerful.

It is imperative that we align what we are doing on leadership with what we want to achieve on quality. This is what I call leadership with a purpose.

Over the past year, the Department of Health has worked extensively with the NHS and other stakeholders to determine how best to foster talent and leadership development, and it is clear that there is a great deal of enthusiasm for a more systematic approach.

Spotting and developing confident leaders is a priority for us all if improving quality is our shared purpose. This guidance represents our best collective thinking to date. I invite you to use it and contribute to its improvement as we learn how to bring leadership centre stage over the coming months.



David Nicholson
NHS Chief Executive

Executive Summary

The purpose of this document is to provide guidance for Strategic Health Authorities (SHAs) on talent and leadership planning.

The Operating Framework for the NHS in England 2008/09 set out the Department of Health's (DH's) commitment to introducing talent and leadership plans at the regional level to improve leadership capacity and capability. In addition, *High Quality Care For All* made clear the leadership challenge to make quality the organising principle of the NHS and to deliver the regional clinical visions.

During the design and testing of this guidance, users identified what is required of a talent and leadership plan. Users were also clear that change management is needed if talent and leadership are to contribute to improving quality and creating a shift in NHS culture.

For this year, then, SHAs' priorities are to facilitate talent and leadership improvement across their region. We anticipate that:

- SHA boards will take action to ensure that the conditions are right across their region for the development of a talent and leadership plan which results in quality improvements and contributes to a transformation in culture. This change management activity should be defined and agreed by March 2009 for all SHAs.
- SHA boards will ensure that a completed talent and leadership plan is in place by the end of July 2009.

In accordance with the principle of subsidiarity, the diagram below sets out the key roles and responsibilities for talent and leadership development at each level of the healthcare system.

Overview of the Talent and Leadership Framework

(Diagram: Co-production at all levels of the system; Subsidiarity; Leadership for quality)

Level	Key purposes	Sample products
National	- Ensure conditions and incentives enable leadership for quality - Set standards to ensure value for money - Lead on creating advocacy for improvement - Commission top leader programmes	- National Leadership Council – Annual Report - Commission leadership development for undergraduate and postgraduate curricula and NHS top leaders - Evidence gathering on current leadership capability and capacity
Regional	**- Facilitate regional collaboration to improve developing leadership capacity and capability for quality** **- Tailor regional standards** **- Commission senior development programmes**	**- Regional talent and leadership plan** **- Commission development programmes (eg for aspiring chief executives, executive directors, senior clinical leaders etc)**
Employer	- Create and foster conditions for talent and leadership development - Align career paths with patient pathways and service delivery - Ensure that the profile of leaders reflects the communities served - Participate in regional improvement	- Organisation diagnostic and improvement plans - Provision of assurance where funding has been made available - Commission and implement programmes (eg Trust Board Development, Leadership for Quality etc)
Individual	- Continuously learn and develop - Spot talent and support the development of others	- Personal development plan and career portfolio - Commitment to coaching, teaching and/or mentoring others

Talent and Leadership Plans – Vision

Key Elements of NHS Leadership

Engagement with hundreds of leaders over recent months has revealed an increasingly clear vision for talent and leadership. We have also been discussing the management methods and behaviour that can contribute to increased leadership for quality.

Leaders themselves are realising that they will need to work in different ways if they are to help create and foster a culture of continuous quality improvement, based on local patient and community needs. This involves working collaboratively with patients, staff, their partner organisations and their communities. It also requires courage to free people up so that everyone can act confidently in the interests of local people.

There was strong feedback during the engagement process that we should organise this best practice guidance around the core elements of leadership that were described in *High Quality Care For All*. This has been done in chapters 2 to 4 of this document.

The Vision for talent and leadership for quality is that we are:

Spoilt for choice	**...when we appoint leaders and in the opportunities available to aspiring leaders**

...where

Everyone counts	**...with the profile of leaders reflecting the workforce and the communities they serve** **...and more clinicians are encouraged and equipped to become leaders alongside manager colleagues**

...and we are

As focused on our leadership development as on our clinical outcomes and financial management	**...with accountability for talent and leadership planning starting with the board** **...with appropriate levels of investment in time and resources**

...so that we

Provide better patient outcomes and ever increasing public confidence	**...by demonstrating that leaders make quality the organising principle of all that they do. They work in partnership with patients, their carers and with communities and are freed up to deliver improvements in the safety and effectiveness of services and in patient experience**

While prime responsibility for improving talent and leadership capacity and capability clearly rests with local employers, SHAs have a role across their regions to foster investment, collaboration and conditions for improvement. In order to progress the delivery of the talent and leadership vision, SHAs' priorities are to facilitate talent and leadership improvement across their region. We anticipate that:

- SHA boards will take action to ensure the conditions are right across their region for the development of a talent and leadership plan which results in quality improvements and contributes to a transformation in culture. This change management activity should be defined and agreed by March 2009 for all SHAs.
- SHA boards will ensure that a completed talent and leadership plan is in place by the end of July 2009.

Talent and leadership plans will form part of the SHA assurance and dialogue process with the DH, which is currently being developed.

The NHS is a complex system, and the approach organisations take to talent and leadership improvement will need to reflect this. SHAs will be responsible for talent and leadership planning for their own staff, but will also have a role to facilitate improvement at a regional level to ensure leadership capacity and capability exist to support the delivery of the regional clinical visions. There is also a role to commission leadership development interventions where it is appropriate for them to do so.

In the longer term, we anticipate that the five-year outcomes for SHAs will be that:

- a systematic approach will be in place to improve leadership capacity and capability to meet the delivery of high quality care and world class commissioning. Robust processes will be in place to identify the demand and supply of leaders with development interventions in place to be spoilt for choice with significant evidence of improvement.
- there will be an increased leadership supply, including clinical leaders, with leaders reflecting the workforce and the communities they serve (particularly people from black and minority ethnic backgrounds, women and disabled people).

Talent and Leadership Plans – Method

As set out in *The Operating Framework for the NHS in England 2008/09*, we expect that SHAs will take responsibility for facilitating the improvement of leadership across the regional health economy. They will work with commissioners and providers of NHS services to co-produce a systematic approach to talent and leadership development.

Leadership development is a key enabler in delivering quality and improving workforce diversity. Healthcare organisations need to attract, retain and develop people from different backgrounds so that the workforce across the sector reflects the communities it serves at all levels, from the frontline to the boardroom.

We know that collaboration within and across organisations is essential. Developing talent is impossible to achieve in isolation, not least because the best leaders often move across organisational and regional boundaries to further their careers.

We anticipate that SHAs will foster collaboration and enable investment in talent development pathways for the most senior leaders in the region. A prime focus for improvement will be on aspiring directors for all functional roles and on aspiring chief executives.

Alongside this, PCTs are accountable for building capacity within their own talent and leadership pools to become world class and ensure that conditions are in place for talent spotting and development.

Providers have a key role to play in developing the leaders and leadership they need for the achievement of quality services. Providers and commissioners also have a responsibility for participating in the leadership improvement efforts across the region.

The role of the National Leadership Council will be to champion the improvement of talent and leadership development resulting in the healthcare sector being spoilt for choice in the talent available for key posts. Where it makes sense to do so, system-wide development will be commissioned via the National Leadership Council to support regional and local talent development pathways.

To meet the priorities set out in Chapter 2 the table on page 14 sets out the SHA talent and leadership planning actions.

What then follows is national guidance to set expectations and share learning.

It includes insight into how SHA boards can assess the state of readiness across their region to achieve a transformational culture change in talent and leadership.

The subsequent talent and leadership plan template outlines the issues SHAs may want to consider in the creation of regional talent and leadership plans. The content of both of these tools has been developed with four SHAs and a diverse range of employers.

SHA Talent and Leadership Plans Actions

We anticipate that SHA boards will take action to ensure the conditions are right across their region for the improvement of talent and leadership which results in quality improvement and contributes to a transformation of culture. We anticipate that plans to create these conditions will be defined and agreed before the end of March.	Work within the four SHA regions informed us that talent and leadership plans are more likely to be successful if certain prerequisites are in place across the region. These are outlined in the state of readiness learnings on page 15. We anticipate that SHA boards will have signed off that they have a robust plan to create the conditions for the improvement of talent and leadership development by March 2009.
Completed talent and leadership plans in place by the end of July.	The testing of this guidance confirmed that SHAs should be in a good position to produce a completed talent and leadership plan by July 2009.
Assurance of the talent and leadership plans from July onwards.	Talent and leadership plans will form part of the SHA assurance and dialogue process with the DH, which is currently being developed.

Establishing the conditions: state of readiness

When the four SHA health economies and local employers tested this guidance, they found that the conditions have to be right in the system to create meaningful talent and leadership plans. The learning from this is summarised on page 15 to allow SHA boards to consider the readiness and receptivity of commissioners and providers to co-produce what is needed for improvement.

As overall accountability sits with SHA boards, it is right for them to be able to assure themselves that the necessary conditions are being created to enable talent and leadership plans to be developed.

SHA Talent and Leadership Plans State of Readiness – Learnings

To ensure readiness for talent and leadership planning:

- The SHA chair and chief executive personally and demonstrably lead on the improvement of leadership capacity and capability both within the SHA and across the regional system to support the delivery of clinical visions. This is likely to be more than 20 per cent of the chief executive's time.
- There is a named SHA board director who leads on improvement of leadership and sufficient resources are allocated to support these plans. SHA board members are also likely to spend time teaching and mentoring.
- The SHA board can demonstrate that it is as focused on developing talent and leadership as on service delivery and financial management.
- There is sufficient shared ambition across organisations in the region to strengthen leadership capacity and capability for quality and on collaborating for improvement.
- Action plans are in place to establish the conditions for collaboration across the region to enable improvement and the preparation of talent and leadership plans. SHA plans are consistent with the principles of co-production, subsidiarity, clinical ownership and leadership, and system alignment. The plans will address the necessary infrastructure, culture and data for collaboratively delivering sustainable improvements.
- There is evidence of staff engagement and communication that will ensure transparency of talent and leadership processes for individuals trying to develop their skills and careers.
- The SHA board can demonstrate that it is satisfied with how they will improve the talent and leadership dashboard measures, particularly for clinicians, those from black and minority ethic backgrounds, women and disabled people.

To ensure on-going success in talent and leadership planning:

- SHA talent and leadership plans enable delivery of strategic and operational plans.
- The SHA board is satisfied that there is sufficient alignment between models of care, patient pathways and the existing and emerging talent development pathways. Plans are in place to close any gaps.
- The SHA board facilitates participation in improvement discussions with key partners at least bi-annually.
- There is transparency in how talent pools are created and used to add value to appointment processes.
- Robust evidence and data is available to enable informed discussion at a regional level so improvement can be assured and learning surfaced.

Talent and leadership planning

The guidance that follows has been shaped by four SHA health economies and a diverse range of local employers. The core content for the plan is laid out and can be built on so that it meets regional needs.

This core content will evolve as the processes, system needs and vision for talent and leadership mature. The DH is committed to refreshing this guidance based on future learning and emerging evidence.

DH is in the process of establishing the National Leadership Council which will enable improvement in leadership capacity and capability at a sector- wide level. Clear priorities are emerging including the need for a systematic analysis of the incentives and barriers to enable a diverse talent pool to progress in healthcare. The outcome of this work will inform future talent and leadership planning.

The table opposite summarises the content of the key chapters of the talent and leadership plan and the detail that follows reflects the learning from those involved in designing and testing the guidance.

SHA Talent and Leadership Planning

Key Content Areas	
Vision and behaviour required to transform leadership for quality	Identifies the SHA vision and summarises what will be different around talent and leadership capacity and capability in three/ five year's time and the accountabilities and behaviour that will underpin success.
Methods	
Diagnosis	Describes the current leadership capacity and capability: the demand, the supply, the diversity profile, the gaps between supply and demand, and how these need to change to deliver the regional clinical vision.
Plans to close the gaps	Describes the regional collaborative actions required to deliver improvement and to close the identified gaps between demand and supply and the required leadership for quality.
Pathways and investment	Describes the investment in leadership development to be made and how this aligns to models of care, patient pathways and regional priorities.
Links to system-wide initiatives	Describes regional and local talent and leadership activities on system-wide priorities such as quality and world class commissioning. Makes explicit how the talent and leadership plans support PCT world class commissioning organisational development plans.
Barriers and risks	Describes the challenges that can be addressed locally and regionally and what needs to be addressed at a national level.

Vision and Behaviour for Change

We anticipate that the start of the plan will set out the three to five year vision and ambitions for talent and leadership. The regional context for talent and leadership plans, including how the plans will enable the regional clinical vision to be achieved, should be made clear. Account also needs to be taken of changing models of care and the evolving expectations of leaders. Leaders need to be able to operate with increased freedom and be clear about the accompanying responsibilities. The obligations laid out in the NHS Constitution also need to be addressed, as do the changing aspirations and demographics of the current and future workforce.

To create the right conditions for improvement, we anticipate that SHAs will not only describe 'how' talent and leadership plans will be produced, but also the cultural change required to enable the necessary collaboration between organisations. The plans will be evidence-based, demonstrate openness and transparency, and ensure that leadership teams are confident in supporting talent and leadership processes and of their roles and accountabilities within them.

Examples of the behaviour changes needed to deliver effective talent and leadership plans were discussed in the four SHAs who tested this guidance, and are outlined in Chapter 4.

In developing their visions, SHAs may want to consider the following questions.

- What is the short-term (0-1 year), medium-term (1-3 year), and long-term (3-5 year) vision for talent and leadership in the region?
- How does this vision support PCT strategic, operational and organisational development plans?
- What are the main opportunities and challenges in developing talent and leadership?
- Does the vision consider the changing expectations of leaders and support clinicians broadening their roles into becoming partners and leaders as well as practitioners?
- Does the vision ensure that the leadership workforce profile reflects the wider workforce and local communities, in particular people from a black and minority ethnic background, women, people with disabilities and other diversity strands?

Diagnosis – Demand, Supply and Gaps

The first section of the SHA talent and leadership plan looks at the vision for improving talent and leadership, how this will be achieved and the behavioural changes needed to get there. To help inform the vision, it is important to be able to describe the current level of leadership capacity and capability. It is also important to articulate the current and emerging demand for leadership given the regional clinical vision.

By diagnosing the current demand and supply, a gap analysis can be conducted looking at the current, 0-1 year, 1-3 year and 3-5 year forecasts. This diagnosis will then inform the shape of the plan and where most effort is required.

The processes in place to diagnose the current state of talent and leadership, identifying the demand, supply, workforce profile and gaps, should be outlined in this section of the plan.

The work with the SHA health economies and further discussion with leaders across the system concluded that talent and leadership *assessment* processes (e.g. appraisals) and talent and leadership *development* processes (e.g. aspiring chief executive programmes) need to be aligned. Individuals need to be assessed and developed not only on their current performance, but also against their potential and ambition. Practice in the public and private sector also considers factors such as mobility and resilience.

You will find the talent and leadership dashboard that informed the plans in the four regional health economies on pages 24 and 25.

The dashboard was also tested with a diverse range of employers at nationally sponsored deliberative events. For SHAs to complete the dashboard as part of their talent and leadership plan, collaboration will be required across their regional health economy. It is the ambition in 2009 for the dashboard to be used as an input into the assurance dialogues between SHAs and the DH.

When considering the diversity profile, it is useful to seek evidence of the progression of different groups by level. This will help to identify where there might be systemic gaps or barriers. It is also useful to look at longitudinal data by group from the staff survey.

Plans to Close the Gaps

Once the gaps in leadership capacity and capability have been identified, we anticipate that the next section of the plan will deal with how gaps will be closed.

SHAs may want to consider the following questions.

- Are targeted development interventions in place to ensure that talent and leadership pools are reflective of regional communities?
- Are targeted development interventions in place to ensure that talent and leadership pools are reflective of the wider workforce, in particular people from a black and minority ethnic background, women and people with disabilities?
- Are targeted development interventions in place to meet the goal of increasing clinician representation in talent and leadership pools?
- Are talent pools in place to support talent and leadership planning for critical posts?
- Have the enablers that are designed to remove the barriers to progression been put in place?

Pathways and Investment

To close the gaps between demand and supply successfully, talent development pathways[1] aligned to models of care and patient pathways will need to be strengthened. We anticipate that this section of the plan will describe what the pathways are and where investments will be made at local, regional and national level.

High Quality Care For All made several leadership development commitments, which will complement the significant investment already made by the NHS in leadership development. These commitments include developing a new standard in healthcare leadership, the Leadership for Quality Certificate, which will operate at three levels (clinical and non-clinical managers, service line leaders, and senior directors). Development for the most senior levels in the NHS will also be enhanced.

NHS Interim Management and Support (IMAS), launched in March 2008, provides leaders with development opportunities by assigning them to a variety of projects within NHS organisations. These new regional development opportunities should be used to provide stretch and to develop skills and experience.

In outlining talent development pathways, it may be helpful to consider the following questions.

- Do the talent development pathways support closing the gaps between leadership demand and supply?
- Are the talent development pathways clearly articulated, documented and communicated across the region so that existing and potential leaders know how to access them?
- Are roles organised not just around the delivery of care but also to enable people to acquire the required experience to succeed in future leadership roles?
- Do national and regional leadership programmes align to progression along the pathway?
- Are the roles of SHAs, PCTs, FTs and other partners in talent and leadership development understood and agreed?
- Is sufficient resource and budget allocated recurrently to broader leadership development interventions to develop the skills and behaviour for the leadership of quality?

1 Talent development pathways are the career steps that are required to progress to more senior roles. It is acknowledged that there may be some variation in pathways between organisations depending on what is needed to meet models of care and patient pathways.

Links with System-Wide Initiatives

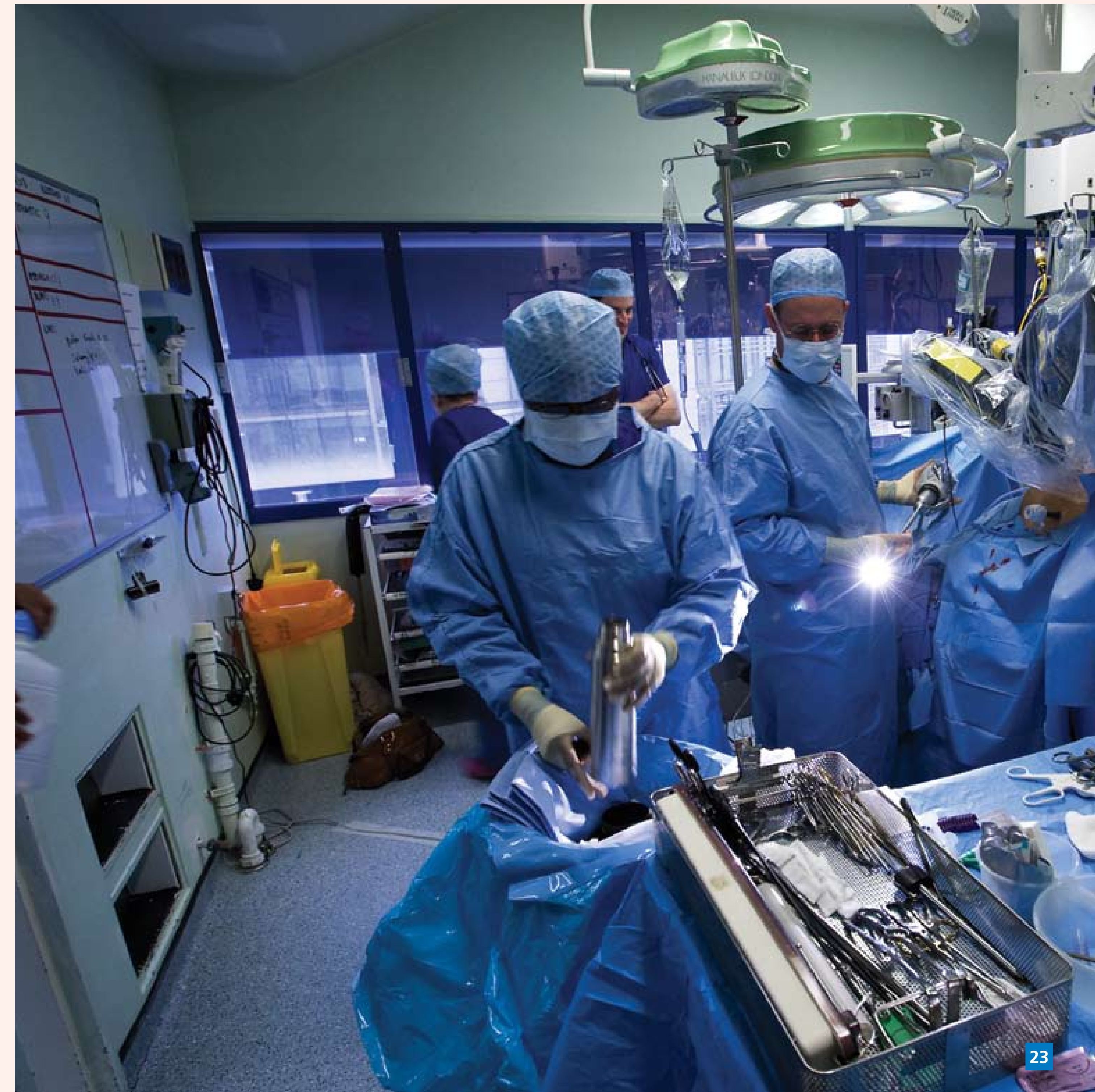
SHA talent and leadership planning is an enabler of wider system priorities. PCT organisational development plans underpin PCTs' five-year strategic plans. They set out how the PCT as an organisation is planning to develop to meet the needs of world class commissioning including the organisational culture, communications and information systems. SHA talent and leadership plans will support these organisational development plans by focusing on the development of individual talent and putting in place plans to accelerate and support leadership development. The purpose of this section of the plan is to describe the regional and local activities that will support these wider system priorities.

In making links with system-wide initiatives, SHAs may want to consider the following questions.

- Is the SHA board able to articulate how talent and leadership planning supports *High Quality Care For All* and the regional clinical visions?
- Is the SHA board able to articulate how talent and leadership planning supports world class commissioning? In particular, how do plans align with PCT organisational development plans to ensure that PCTs are planning for the development of individuals as well as the overall organisation?
- How do SHA talent and leadership plans draw upon the developmental feedback following the world class commissioning panel reviews, including the potential for improvement offered by the expert panel?
- Is there a clear line of sight between the SHA talent and leadership plan and improving patient care?
- Is the assurance process between DH and SHAs for talent and leadership clearly communicated across the region and owned by the SHA board?
- Are activities and initiatives underway or planned in the region to support this year's identified priorities?

Systems Barriers and Risks

This section of the talent and leadership plan serves as a summary of the risks and barriers that will have appeared in the plan. We anticipate that it will describe the barriers and risks that need to be addressed at national, regional and local level. Mitigating actions for those risks with the highest probability and impact will be outlined and, where needed, barriers and risks escalated to national level.



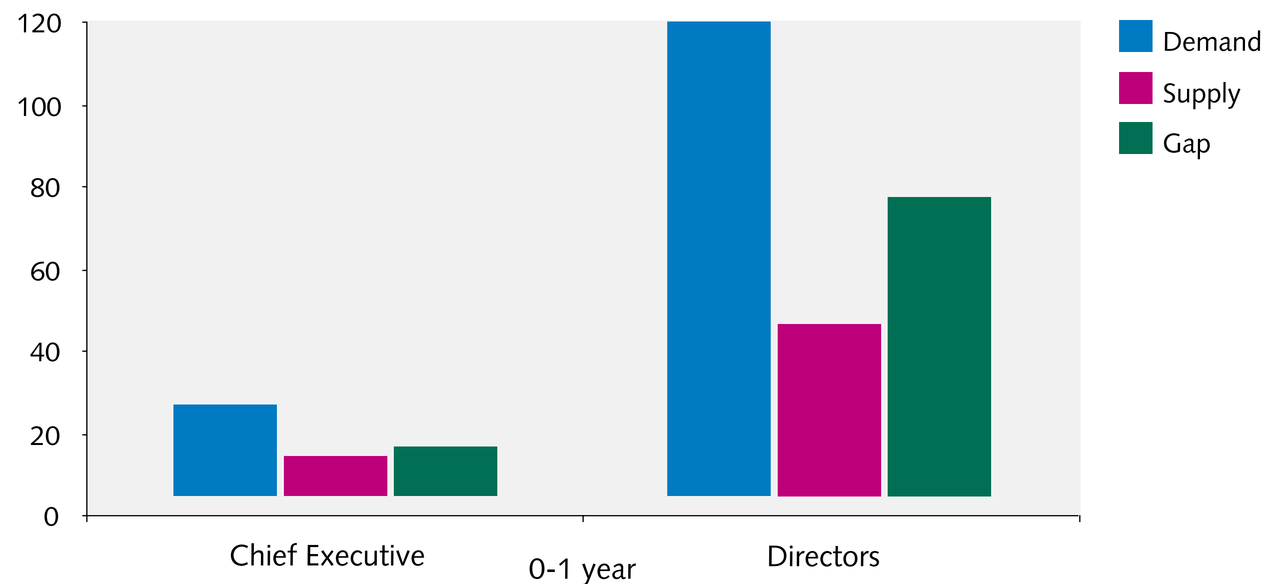
Assuring talent strength: SHA dashboard

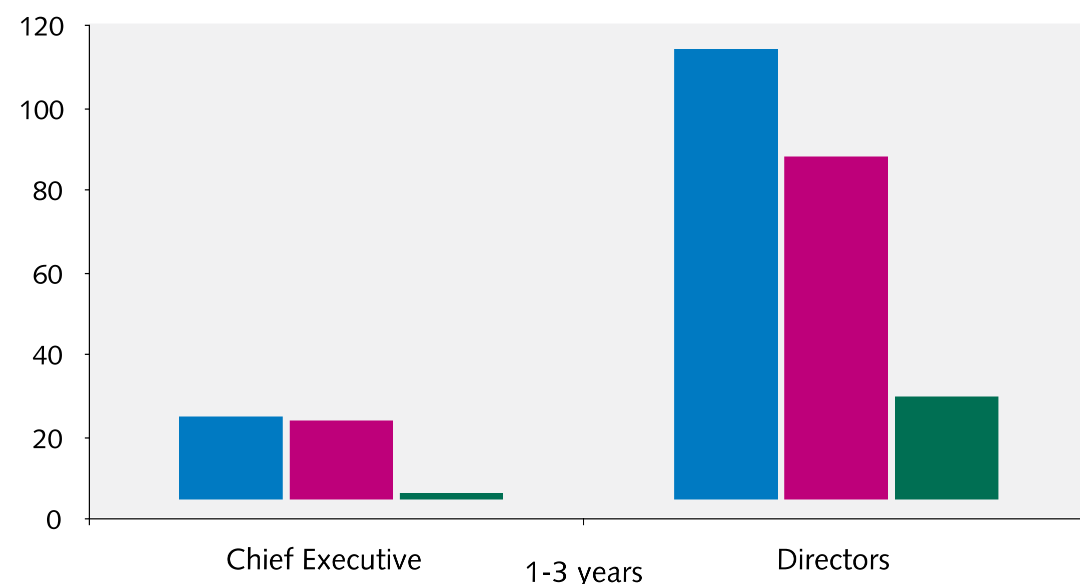
Spoilt for choice

RAG Status

ILLUSTRATIVE FIGURES ONLY

Demand, Supply and Gaps: ready now and growing talent

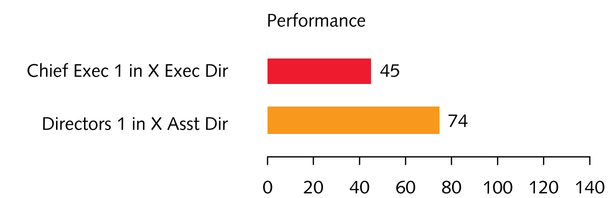




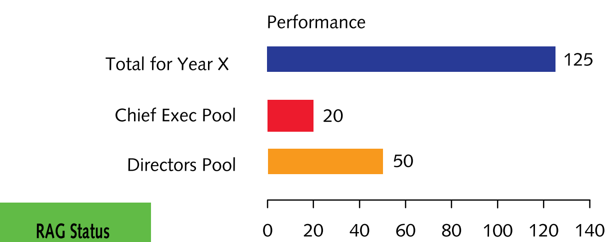
Level 1: Chief Executives, Level 2: Board Directors

Encouraging everyone to spot talent

Staff in talent pools for:



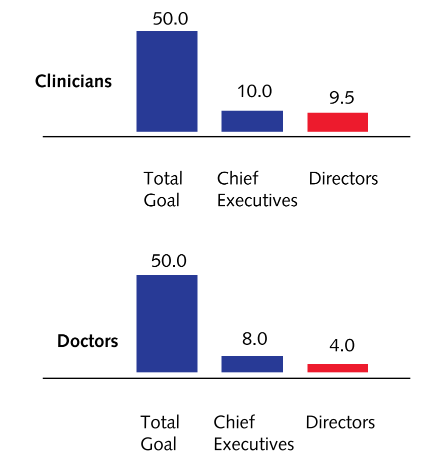
Number of staff added to regional pool for emerging talent last year:



RAG Status

Encouraging more clinicians to become leaders

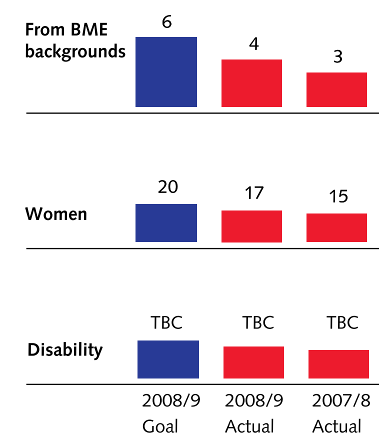
% ready now talent pool for Chief Execs who are:



RAG Status

Reflective of our communities

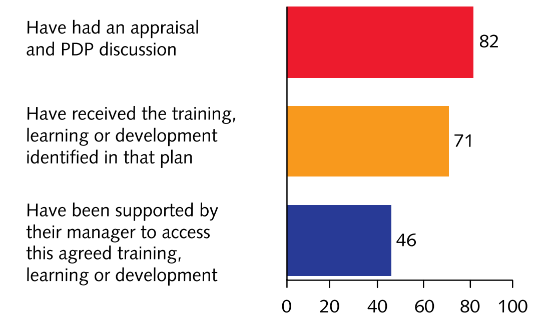
% ready now talent pool for Chief Execs who are:



RAG Status

Transparent about what is required to progress and supportive of staff to get there

Managers responding to staff survey saying they:



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Talent and Leadership – Behaviour

Behaviour change may be required to develop a culture which fosters leadership development for quality. Clear accountability for developing this culture and role-modelling the behaviour needed rests at all levels in the system but also at SHA board level. SHA board ownership can influence the tone, style and ways of working to achieve systematic organisational development and talent and leadership improvement.

One of the early tests of progress will be evidence that behaviour is changing in line with the NHS values. The SHA health economies who worked with this guidance identified five areas where behaviour change may be needed:

- **Taking succession seriously** at all levels. Chairs, chief executives and boards have a critical leadership role to foster a culture where the spotting and development of talent is built into the assessment of performance of managers at all levels.

- **Creating consistency and transparency of process** to make it easier for potential leaders to understand the development pathways available to them. This will require a clear understanding of emerging patient pathways and models of care. It will also require SHAs to work with each other to facilitate development and flexibility of opportunities available to leaders.

- **Demonstrating boldness and openness** by committing to using the NHS values and pledges to patients and staff in the NHS Constitution within talent and leadership plans and supporting processes. Creating the expectation that development discussions are conducted with respect and dignity, and that individuals are encouraged to challenge so that the value that 'Everyone Counts' is genuinely reflected in appointment and promotion decisions.

- **Willingness to steward talent** across the system to ensure that healthcare is spoilt for choice in its leaders, and individuals are spoilt for choice in the opportunities available to them. Behaviour may need to be challenged where there is evidence that organisations are hoarding talent rather than being stewards of it.

- **Valuing diversity across the system** to ensure that the leadership community reflects the diversity of the workforce delivering NHS services and the communities it serves. Also that there is evidence that sustainable and diverse talent and leadership pipelines are in place for future appointments.

On-going Innovation and Improvement

Innovation and learning

This guidance provides an SHA talent and leadership planning framework based on current experience from inside and outside of the health sector.

In the majority of places regional networks and coalitions are already in development to move talent and leadership plans forward. These networks are adding value and can continue to help move the healthcare sector further, faster by:

- sharing best practice.
- looking externally at where best practice and innovation exists which can be applied in the NHS.
- looking at cross-boundary issues and the innovations and coalitions necessary to resolve them.

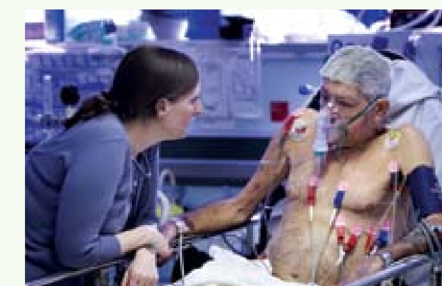
NHS Evidence will be used nationally to share proven learning about what works. This will also enable us continuously to improve this guidance.

There is a real opportunity to foster talent and leadership development in a way that fully supports end to end patient pathways and provides opportunities for career development across health and social care. The best organisations are already actively working on this with partners and case studies will be published as they become available.

Dialogue around the talent and leadership plans will also ensure learning is shared and inform action. It will also enable a more evidenced-based assessment of progress to be shared with the National Leadership Council when it is established early in 2009.

The dashboard outlined in Chapter 3 has been tested during the consultation and development of this guidance. The DH with SHAs will learn what is required for ongoing national and local metrics. Both the National Leadership Council and the National Quality Board will benefit from this learning.

The DH remains committed to updating the guidance as we learn from the talent and leadership plans, identify what works well and what actions should be taken at each level within the NHS.



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