Developing People – Improving Care

A national framework for action on improvement and leadership development in NHS-funded services

National Improvement and Leadership Development Board

Contents

Summary

What is this framework? It's the first version of a national framework to guide local, regional and national action on developing NHS-funded staff. Its sponsors are the main national organisations with NHS responsibilities.[1] The framework applies to everyone in NHS-funded roles in all professions and skill areas, clinical and otherwise. Future updates are expected to cover people in social care as well.

What is the framework's purpose? To equip and encourage people in NHS-funded roles to deliver continuous improvement in local health and care systems and gain pride and joy from their work. To that end, the framework aims to guide team leaders at every level of the NHS to develop a critical set of improvement and leadership capabilities among their staff and themselves.

Who is this document for? This document is directed primarily at the senior management teams of all organisations and partnerships responsible for NHS-funded activity. The idea is to release regular updates, improved by feedback from teams using the framework.

Why? Evidence and experience from high performing health and care systems shows that having these capabilities enables teams to continuously improve population health, patient care, and value for money. Developing these capabilities and giving people the time and support required to see them bear fruit is a reliable strategy for closing the three gaps identified in the NHS Five Year Forward View.

What are the critical capabilities to develop?

- **Systems leadership skills** for leaders improving local health and care systems, whether through sustainability and transformation plans, vanguards, or other new care models. These skills help leaders to build trusting relationships, agree shared system goals and collaborate across organisational and professional boundaries.
- **Improvement skills** for staff at all levels. Chief executives of the majority of provider trusts rated 'outstanding' by the Care Quality Commission credit established quality improvement (QI) methods[2] for improvement in their operational performance, staff satisfaction and quality outcomes.
- **Compassionate, inclusive leadership skills** for leaders at all levels. Compassionate leadership means paying close attention to all the people you lead, understanding the situations they face, responding empathetically and taking thoughtful and appropriate action to help. Inclusive leadership means progressing equality, valuing diversity and challenging power imbalances. These leadership behaviours create just,

1 Department of Health, NHS Improvement, Health Education England, NHS England, NHS Leadership Academy, National Institute for Health and Care Excellence, Public Health England and the Care Quality Commission, with input from the Local Government Association, Skills for Care, NHS Providers, NHS Clinical Commissioners and NHS Confederation.

2 Established QI approaches include Total Quality Management (TQM), Model for Improvement, Statistical Process Control, Six Sigma, Lean, Experienced-based Co-design, Theory of Constraints, and Business Process Re-engineering. www.health.org.uk/sites/health/files/QualityImprovementMadeSimple.pdf

learning cultures where improvement methods can engage colleagues, patients and carers, deliver cumulative performance improvements, and make health and care organisations great places to work.

- **Talent management** to fill current senior vacancies and future leadership pipelines with the right numbers of diverse, appropriately developed people.

What's the next step? All leadership teams (boards of national organisations included) to review their people development strategies and revise priorities and budgets to target building these capabilities for their staff and themselves.

Is there any new money? In today's climate, there won't be much new funding for this. But a lot of money is currently invested in people development across the NHS. The challenge is to maximise the impact of that investment on care for individuals, population health and value for money.

Where will the support come from? A lot can be done in-house if leadership teams can devote more of their time and attention to people development, working with existing organisational development teams and networks. In addition, NHS functions that provide such support are extending their offer to support action in line with the framework. See Section 3 for details.

Will regulators and inspectors back the framework? Yes. We're changing the rules and how we oversee them to back it up (see Section 3, Condition 5 for details). But we understand there may be scepticism about our ability to demonstrate the compassionate leadership called for by the framework. To show our conviction, we're making three pledges. Please hold us to account for keeping them:

- We will model in all our dealings with the service and in our own organisations the inclusive, compassionate leadership and attention to people development that establish continuous improvement cultures.
- We will support local decision-makers through collectively reshaping the regulatory and oversight environment. In particular, we owe local organisations and systems time and space to establish continuous improvement cultures.
- We will use the framework as a guide when we do anything at a national level concerning leadership, improvement and talent management so we engage across the service with one voice.

Views from the service

Perspectives from across the service on the importance of leadership and improvement

Shahnaz Aziz

Patient and Public Leadership Lead

East Midlands Academic Health Science Network

An inclusive NHS requires strong and sustained commitment from the top and throughout our NHS systems. It must go beyond paying lip service to adopting positive action approaches which embrace, develop and empower diverse views and ideas. It must unlock talent and innovations from staff at all levels and involve patients and citizens.

Dr Rebecca Hewitson

Paediatric Registrar

North Middlesex University Hospital NHS Trust

Leadership doesn't come from a job title, it comes from a frame of mind. Giving support to patients, families and staff members who want to lead positive changes within healthcare can have inspiring results. For me, continual improvement is about being open-minded, having humility and not forgetting to celebrate and learn from excellence.

Valerie Freestone

Specialist Clinical Dementia Nurse

Cambridge University Hospitals NHS Foundation Trust

I have worked with some incredible leaders in my time with the NHS, from ward managers and team leaders during my training, who taught me that leadership was less about hierarchy and more about team work, to more recent leaders who taught me to believe that I can be more than I think I can.

Rebecca McGheehan

Matron, Inpatient Cancer Services

Sheffield Teaching Hospitals NHS Foundation Trust

Leadership and improvement ensure we constantly provide the best quality care and treatment to our patients. Change one small thing every day and in a week you will have made a bigger change: imagine what you could change in a year.

Dr Gilbert Ozuzu

Lead Clinician and Consultant Eye Surgeon

University Hospitals of Morecambe Bay NHS Foundation Trust

I am passionate about good leadership because it leads to safe and good quality care for patients. Here in Morecambe Bay we have seen how good leadership can transform an organisation from low to high performance. We have witnessed a change in culture resulting from a leadership style that is inclusive, humble, open and engaging. Inclusive leadership is not just about fairness and equity. It is about getting the best out of ALL our staff for the benefit of ALL our patients.

Ruth Speare

Speciality Trainee in Public Health

Yorkshire and Humber

I view leadership as an enabling role, giving others the confidence and permission to innovate and develop. Individual, small-scale changes to improve the health of the public can add up to have a significant impact across a city or region. Effective leadership has to be collaborative and inclusive, not organisationally partisan, to focus on population need across the whole health and social care system.

Perspectives from across the service on the importance of leadership and improvement

Ian Perry

Leadership and Management Development Lead

The Orders of St John Care Trust

We're encouraging and supporting our leaders at all levels to have a different kind of dialogue with teams and colleagues, to have more appreciative and coaching conversations, to raise their awareness of their own leadership style and increase their confidence to challenge and innovate. Leadership, whether as a carer, an autonomous nurse, care leader, home manager, or in a support or senior management role, is vitally important to making the trust a great place to live and work.

Dr Jeremy Rushmer

Consultant in ICM and Medical Director

Northumbria Healthcare NHS Foundation Trust

Looking back now, 16 years after I nervously stuck my head over the parapet as a young consultant and aspiring Clinical Director who wanted to make a difference, I feel lucky to have done that in an organisation that wanted to develop me, challenge me and take me places I'd never been before (literally and metaphorically) with a cohort of like-minded colleagues who currently make a very effective team. I'm now enjoying talent spotting and developing my replacements.

Hein Scheffer

Director of Workforce

Herts Valleys CCG

Leadership is about inspiring others to be the best they can be. This is not achieved through fear, but through support, learning and clarity of direction.

Keeley Sheldon

General Manager for Adults

Nottinghamshire Healthcare NHS Foundation Trust

Learning about service improvement techniques has given me the confidence to transform the way we deliver our services. The techniques have had a positive impact on patient care and experience, and on the productivity and efficiency of the service models.

Dr Yuvraj Pattni

GP Registrar

London Deanery

Leadership and improvement is already part and parcel of being a clinician in the NHS today and, increasingly, the NHS of tomorrow. To drive improvement we need good leadership at every level within our organisations, not just at the top. If we refuse to accept leadership as our responsibility too, then we risk failing to do what is right not just for our patients but for the wider community.

Mark Rogers

Chief Executive and STP Lead

Birmingham City Council and Birmingham and Solihull STP

Great leadership has four facets: exhibiting empathy or being willing and able to see things from others' perspectives; building a common purpose, and developing teams and teamwork accordingly; encouraging "followship" or empowering others to rise to opportunities and challenges and to share in the leadership; but above all, the best leaders in class show humility and courage. When all these facets coalesce, improvement will be secured and sustained.

1. Explaining the framework

Overview

This document presents the first version of an evidence-based national framework to guide action on improvement skill-building, leadership development and talent management in NHS-funded services. The purpose of the framework is to equip and encourage people in NHS-funded roles to deliver continuous improvement in local health and care systems and gain pride and joy from their work. The framework applies to everyone in NHS-funded roles in all professions and skill areas, clinical and otherwise. The document is directed primarily at the senior management teams of all organisations and systems that do NHS-funded work – from the smallest GP partnerships to the largest national organisations – to inform their decisions on developing people. It will be updated regularly, using feedback from people testing the framework.

1.1 Background to the framework

Across England, people in local health and care organisations are working in partnership to dissolve barriers between primary care services and hospitals, between physical and mental health, and between health and social care.[1] Currently through sustainability and transformation plans (STPs), they are striving to build local health and care systems where people put the shared aims of improving care for individuals, improving population health and well-being, and improving value for money before organisational interests.

These complex tasks place new demands on the leadership, skills and morale of the 1.5 million people[2] who do NHS-funded work in already demanding circumstances. On top of mounting patient need and continued funding constraints, they are being asked to take on big changes in the way they work. 'Here and now' pressures on leaders leave little time for them to reflect on their leadership and how best to lead change. Partly for these reasons, the number of senior health service vacancies remains high and candidates scarce.[3]

As representatives of national health and care organisations, we have been listening to people across local health and care systems to understand these new demands and the changes in development and support that people need. We are learning from examples of inspiring people development in health and care around the United Kingdom and from extensive existing research and expertise in developing high quality health and care systems.[4]

This document presents the result: a framework for action on skill-building in improvement, leadership development and

1 *Five Year Forward View* www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

2 Source: NHS choices

3 An estimated 10% for NHS providers and 2% for CCGs. Source: NHS snapshot surveys of provider trusts (January 2016) and CCGs (March 2016)

4 To avoid overloading this document with references, key evidence and research informing the framework is referenced in the bibliography.

talent management at local, regional and national levels.[5] The purpose of the framework is to equip and encourage people in NHS-funded roles to deliver continuous improvement in local health and care systems and gain pride and joy from their work. The framework and initial actions proposed here are designed to be adapted and improved, in the spirit of continuous learning and quality improvement methods.[6] We intend to iterate the framework and actions in short cycles, reflecting the feedback, measurements and suggestions we receive, for as long as it takes to build cultures of continuous improvement in all NHS-funded services.

The framework applies to everyone doing NHS-funded work in all professions or skill areas, clinical and otherwise, and wherever they work in the service. It covers people working in public health, primary care, mental health, community, ambulance and acute services, as well as in clinical commissioning groups (CCGs), other commissioners, and regulatory and oversight groups. For the moment, proposed actions involving NHS resources necessarily focus on NHS staff. But we recognise that NHS and social care colleagues work increasingly closely and fruitfully in partnership, with each other and with their patients and service users. The NHS has much to learn from local authorities' and care organisations' experience of developing leaders and improving services under financial pressure.

We expect future iterations of the framework to be able to address health and social care staff jointly and reflect more of this experience.

1.2 Why this framework is a priority

The framework emphasises compassionate and inclusive leadership. This means paying close attention to all the people you lead, understanding in detail the situations they face, responding empathetically and taking thoughtful and appropriate action to help. It means progressing equality, valuing diversity and challenging existing power imbalances. This may sound a curiously 'soft' and timeless leadership approach to prioritise when health and care services face unprecedented, urgent pressures. But compassionate and inclusive leadership is embedded in high quality, high performing systems because it is the right way to behave evidence shows it is also the right way to unleash people's full potential to improve care working with patients and service users, improve population health and well-being, and improve value for money.

Taking action in line with the framework is therefore a reliable strategy for closing the three gaps identified in the NHS Five Year Forward View. This makes action in line with the framework a priority for all health and care system decision-makers. It may be a long, tough journey for some, given limited resources and competing demands for investment. But there are many examples to learn from

5 Developing strategies on these issues was recommended by the 2015 Smith review of centrally-funded improvement and leadership development functions www.england.nhs.uk/wp-content/uploads/2015/09/improv-ldrshp-dev-rev-sept15.pdf. Lord Rose's 2015 review *Better Leadership for Tomorrow* also made recommendations on NHS leadership covered in this framework www.england.nhs.uk/wp-content/uploads/2015/09/improv-ldrshp-dev-rev-sept15.pdf

6 Explained in *'Quality Improvement Made Simple'* from the Health Foundation. Established quality improvement approaches include Total Quality Management (TQM), Model for Improvement (including Plan Do Study Act or PDSA), Statistical Process Control, Six Sigma, Lean, Experienced-based Co-design, Theory of Constraints, and Business Process Re-engineering. See www.health.org.uk/sites/health/files/QualityImprovementMadeSimple.pdf

where people are making rapid progress in difficult circumstances. Moreover, returns to investment in line with the framework will be cumulative and measurable in terms of better outcomes for patients, improving health and well-being in the local community, more productive use of resources and greater staff engagement and satisfaction.

Acting in line with the framework is a priority for all of us in the national organisations. We have tried to model compassionate leadership in developing the framework but we know we have much further to go. Effective quality management requires a balance between quality planning, improvement and control.[7] We recognise the national organisations could do more to support improvement. Many of the support systems for leaders that used to exist are no longer there. We are committed to rebalancing our approach to give more support to health and care leaders planning and improving their local systems.

1.3 Changing demands create people development needs

As well as collaborating with local partners to develop local health and care systems, health organisations are again making greater use of quality improvement methods introduced to the NHS from other sectors. They are also carrying out recommendations made in recent reviews of NHS leadership,[8] organisational form[9] and productivity and efficiency.[10] All these initiatives are creating specific people development needs.

Leaders of organisations need system leadership skills to build the local health and care systems of tomorrow. They need to build trusting relationships with peers to work on STPs, lead collaborative change management and manage the inevitable conflicts between organisations competing for public resources, both money and people.

Much is expected of CCGs and primary care providers in building future systems. Primary care, community and voluntary service leadership is central to the joined up local health and care systems of tomorrow. Radical innovation with entrepreneurial leadership in primary care in particular has immense potential to improve value for patients and taxpayers. New primary care structures provide an opportunity to develop leaders with the skills to influence and change system thinking beyond the constraints of organisational boundaries. Yet implementing wide-ranging changes to care, teams and organisations presents an unprecedented leadership challenge for commissioners and primary care providers. There has never been a greater need to develop improvement and leadership capabilities in these areas.

Successful reshaping of local health systems depends heavily on the leadership of clinicians, working with partners in social care.

7 See the Juran Triangle http://www.juran.com/elifeline/elifefiles/2009/09/Juran-Trilogy-Model.doc
8 The Rose Review www.gov.uk/government/uploads/system/uploads/attachment_data/file/445738/Lord_Rose_NHS_Report_acc.pdf
9 The Dalton Review www.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf
10 The Carter Review www.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

But clinicians are rarely trained in the major change management skills they need for the task. Moreover, they get little career support for challenging perceived boundaries between clinical and management roles. Consequently the systems leadership roles where clinicians can make such a big difference may not appear to them as attractive or feasible career opportunities.

Many more people working in health and care services want to learn improvement methods and how to use them in partnership with patients, families and carers. Not only do these methods deliver results in terms of quality and value for money, they also have tremendous power to engage, energise and motivate staff by recognising their individual and collective strengths and trusting them to work with patients and communities to make health and care systems better. However, these methods only deliver results from teams led by people skilled in compassionate and inclusive leadership, one reason this framework addresses leadership development and improvement together. More leaders with these qualities are needed at every level of health and care. Compassionate and inclusive behaviours are the key to creating cultures that engage and support all staff and teams, so that continuous improvement in performance becomes the norm.

Meeting these large-scale development needs is a huge new challenge for those responsible for system and organisation development (OD) in health and care services. For all the reasons above, people equipped with system leadership strengths, compassionate and inclusive leadership qualities and improvement leadership skills are at a premium in the NHS today. However, those suitably equipped are not always deployed to best effect. Altogether there is little systematic management of talent – that is, procedures for attracting, identifying, developing, appointing and supporting potential and existing leaders – across NHS-funded organisations and between local, regional and national levels.

Developing the leadership capabilities needed to achieve greater equality, diversity and inclusion at all levels is a further urgent need across NHS-funded activities. The talents of many staff who differ from the majority of leaders in race, gender, or other characteristics are frequently overlooked. As a result, the pool of people equipped to lead continuously improving teams, organisations and systems is neither big enough nor diverse enough to fill critical leadership roles. As noted above, inclusive leadership is not only right but essential to making the most of resources available to local health and care systems.

1.4 An adaptive framework for action

This situation calls for thoughtful action to build skills, develop current and future leaders and manage talent. The framework we propose for guiding such action is based on evidence and experience from high quality health and care systems. It identifies five conditions common to high quality systems that interact to produce a culture of continuous learning and improvement. We then propose actions to drive these five conditions in local, regional and national health and care systems across England. The actions will help to meet today's pressing people development needs.

The five conditions are:

1. **Leaders equipped to develop high quality local health and care systems in partnership.** Leaders of organisations in local health and care systems are able to collaborate with partners including patient leaders across organisational, professional and geographical boundaries in trusting relationships to achieve the same clear, shared system goals for their communities.

2. **Compassionate, inclusive and effective leaders at all levels.** Leaders demonstrate inclusion and compassion in all their interactions. They develop their own and their staff's skills and capacity to improve health services. They also have the specific management skills they need to meet today's challenges. Leadership is collective, in the sense that everyone feels responsible for making their bit of the system work better. Leadership development and talent management systems are sufficiently inclusive and organised to make the pool of people equipped to lead continuously improving teams big enough and diverse enough to fill critical leadership roles. Leadership at every level of the system truly reflects the talents and diversity of people working in the system and the communities they serve.

3. **Knowledge of improvement methods and how to use them at all levels.** Individuals and teams at every level know established improvement methods and are using them in partnership with patients, communities and citizens to improve their work processes and systems. There are enough people able to lead improvement project teams to release the full benefits of this knowledge.[11]

4. **Support systems for learning at local, regional and national levels.** There is sufficient training, coaching and organisation development capacity to meet development needs and support learning and improvement. Data and knowledge-sharing systems to support improvement and leadership development are in place and there are networks for sharing improvement knowledge and experience locally, regionally and nationally.

5. **Enabling, supportive and aligned regulation and oversight.** The regulation and oversight system gives local organisations and systems control of driving learning and improvement. At the same time, national organisations help local systems find the support and resources they need. The constituent parts of the regulation and oversight system behave consistently and 'speak with one voice'.

1.5 Actions and resources

Action is needed at every level of health and care systems in England to develop the leaders and skills that will protect and improve services in the short term and for the next 20 years. Resources are tight, but building continuous improvement capability is a priority.

11 For case studies showing how five NHS foundation trusts built quality improvement capability at scale within their organisations, see the Health Foundation's *Building the foundations for improvement* at www.health.org.uk/publication/building-foundations-improvement

1.5.1 Actions

To create conditions 1, 2 and 3 of the framework, all of us in teams directing NHS-funded work – from partners in the smallest general practice to boards of the largest national organisation – need to review our people development strategies and revise priorities, systems and budgets to target:

- **building improvement skills** among all our people
- **developing current and future leaders** with the compassionate, inclusive leadership qualities, improvement leadership skills and system leadership strengths as well as the specific management skills they need to meet today's challenges.
- **managing talent** to fill future leadership pipelines with the right numbers of diverse, appropriately developed people.

In short, the framework is a call to leadership teams to prioritise building the capacity and capability for organisational development in organisations and systems. We can do a lot of this ourselves by devoting more time and attention to developing people, working with our existing organisational development teams and networks. For instance, senior managers report having gained 70% of their development from experience on the job in different roles. So future leaders can be substantially developed by expressly managing the variety and content of their roles as their careers progress.

That said, many organisations and systems will be looking for support in reshaping their people development activities. The nationally funded NHS functions that provide such support have been closely involved in the work behind this framework. They are tailoring and extending their offer to meet the support needs of local organisations and systems (Condition 4). The national organisations shaping the oversight and regulatory environment are also taking action to align this environment with the conditions that drive continuous improvement (Condition 5). Section 3 gives more detail on the five conditions and actions proposed to help achieve them, including who is proposing to do what by when.

1.5.2 Resources

Given the current constraints on resources, new funding to support these actions will be hard to find. However, across NHS-funded organisations a considerable amount is currently invested in people development. The challenge is to maximise the impact of that investment on creating continuous improvement capability.

For the national organisations involved, this means revisiting and reallocating some current spending as well as finding new resources wherever we can. For local organisations, we know prioritising investment in people will be hard in this period of extreme financial pressure. On the other hand, engaging people and developing their capability for continuous improvement is the surest way to meet today's pressures and sustain success. And where people development is concerned, time, senior attention and imagination are often the critical resources. Across the country we need to share ideas and experience and learn from each other how to maximise the return on our investment in people.

1.6 What's new?

Many will remember the push to disseminate improvement skills across the NHS in the early 2000s. It helped to achieve some great results but didn't gain sufficient national momentum and many considered it overly centralised. There have been earlier central initiatives to promote leadership development too.

This framework aims to be different, in response to what people working in the service are asking for. It depends on local decision-makers taking local actions, supported by national and other NHS-funded organisations. The STP team members and the boards, management teams and accountable officers of local NHS providers and commissioners will take the decisions that really make it happen. Sharing ideas for improvement, leadership development and talent management with each other will drive progress. The job of the national organisations is to help, not to direct.

The framework's ultimate potential rests on the extraordinary commitment of individuals working in health and care to caring for patients and service users – the reason most people join the NHS and social care services. Its impact will come from equipping, empowering and trusting people to fulfil that mission and celebrating their success.

We know that everyone in health and care services must be able to count on people in the national organisations to act consistently in line with the framework. To this end, we make three pledges:

1. We will model in all our dealings with the service and in our own organisations the inclusive, compassionate leadership and attention to people development that establish continuous improvement cultures.
2. We will support local decision-makers through collectively reshaping the regulatory and oversight environment. In particular, we owe local organisations and systems time and space to establish continuous improvement cultures.
3. We will use the framework as a guide when we do anything at a national level concerning leadership, improvement and talent management so we engage across the service with one voice.

We recognise that honouring these pledges means big changes in how we behave. We understand the biggest risk facing the framework is scepticism about the gap between the compassionate leadership it advocates and the experience of many of you in your interactions with us. We know some of these changes will take time. But we ask you to hold us to account for getting better. Please let us know how we are doing and where we could improve.

We understand the scale of the challenge that significant system redesign and service reconfiguration will present to local leaders for the next few years. We are committed to helping every part of England create productive coalitions for change in health and care systems, and supporting rapid service redesign in primary care.

1.7 Tracking and evaluating progress

People responsible for actions in line with the National Improvement and Leadership Development (NILD) framework at local, regional or national levels will need to track the impact of those actions, evaluate them and adjust them accordingly.

The first part of the framework's purpose is to build across the service the capability 'to deliver continuous improvement in local health and care systems'. Performance data already collected and reported will help track the impact of framework actions against this goal. Local organisations and systems can expect the impact of actions to show up in, for example, changes in A&E waiting times and referral to treatment times, in their financial performance against organisation and system control totals, and in their metrics monitoring health outcomes and care redesign.[12] The impact of local actions will show up in changes in aggregate system performance data.

The second part of the framework's purpose is 'to equip and encourage people in NHS-funded roles to consistently gain pride and joy from their work'. The results of existing patient experience and staff engagement surveys, measures of discrimination and inclusion and other barometers of morale that are already in place will largely track the progress of action in line with the framework against this critical goal. Therefore tracking the impact of actions in line with the framework should not add to the service's current burden of data collection and reporting.

The national organisations are committed to tracking implementation of the actions we have taken responsibility for in this first version of the framework. The NILD board will hold us to account for carrying them out.

Evaluating actions and adjusting them will require more reflection, in particular to understand the extent to which any improvements in quantitative and qualitative performance data from organisations and systems result from actions in line with the framework. We are asking for advice on how to do this from specialists in this area and will share it across the service. Even more important to building this understanding will be rapidly sharing learning within and between organisations and systems about what is and isn't working. We will incorporate this learning in future iterations of the framework (another reason for making the framework iterative) so the actions that people experience as having the biggest impact on the ground can be more easily spread across the sector.

12 Source: core baseline STP metrics listed in NHS Planning Guidance 2016/17.

2. The framework in graphics

The three diagrams that follow illustrate how the elements of high performing health and care systems fit together to make them capable of continuous improvement. The diagrams aim to help teams and organisations to identify how their particular initiatives contribute to achieving that aim. The information in the diagrams is drawn from evidence and experience of high performing health and care systems.

Diagram 1 (The framework) is a driver diagram of the kind used in improvement projects. It shows the five conditions as the primary drivers of the framework's aim – continuous improvement in care for people, population health and value for money. The secondary drivers are the main components of each condition.

Diagram 2 (Proposed actions – driver diagram view) and Diagram 3 (Proposed actions – circular view) summarise the actions proposed in this first iteration of the framework that together will strengthen and further develop the secondary drivers of the five conditions.

Diagram 1: The framework

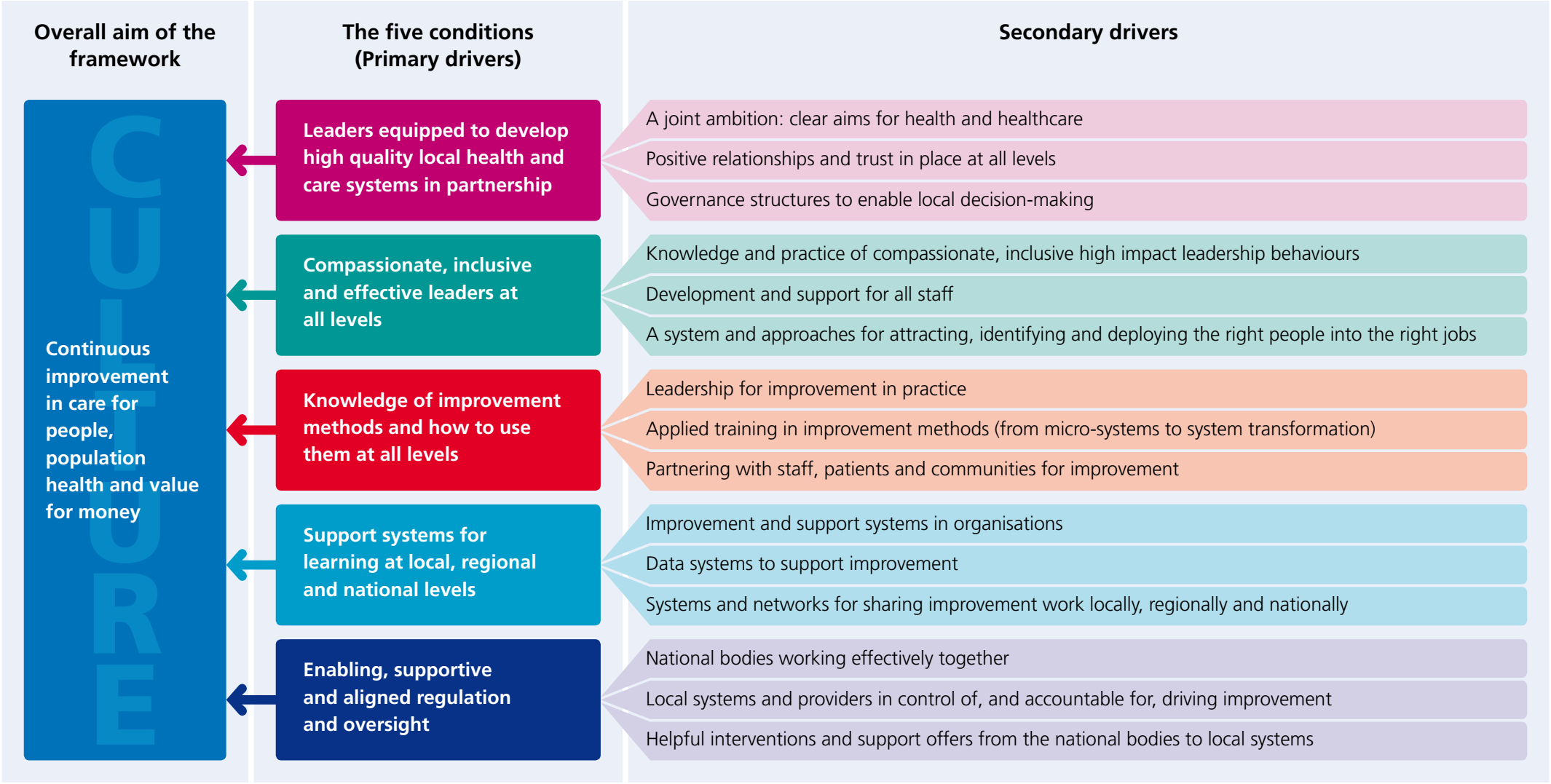


Diagram 2: Proposed actions – driver diagram view

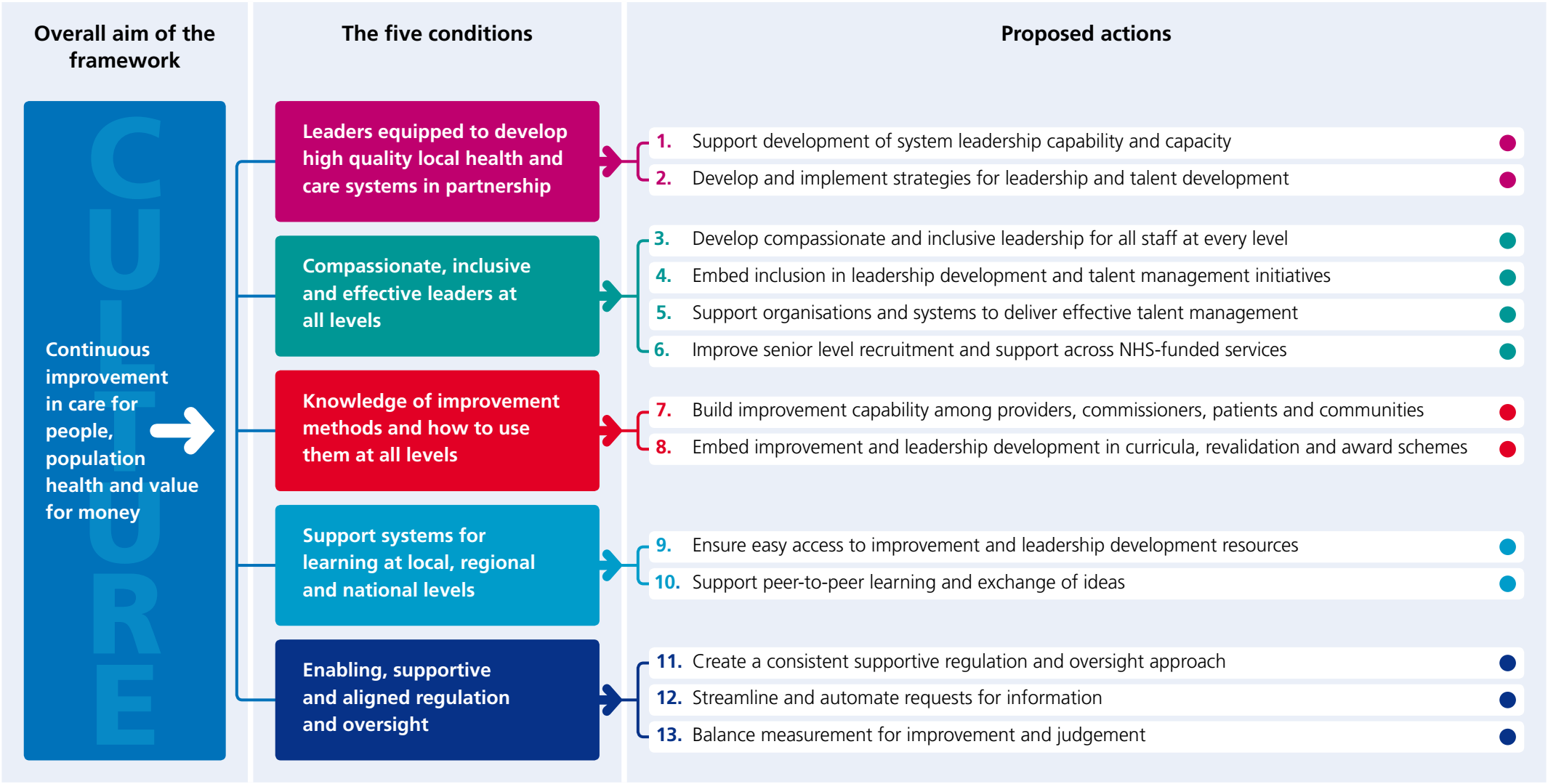
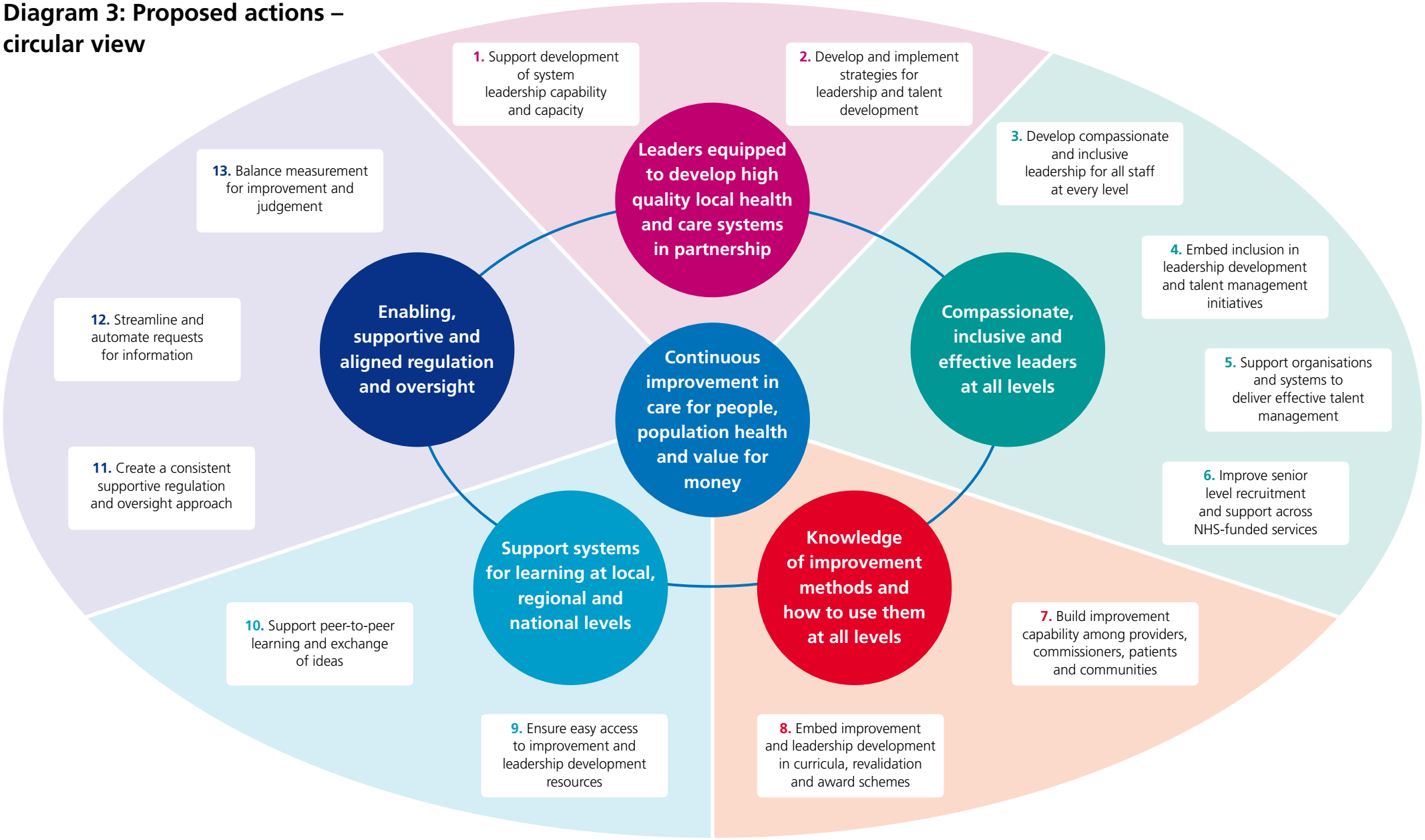


Diagram 3: Proposed actions – circular view



3. Conditions and proposed actions

This section explains the conditions in more detail and lists actions proposed at this stage to achieve each condition across the NHS-funded workforce. As this is the first version of the document, the list of actions is not yet complete. We know from engagement across health and care services that there is more to be done in certain areas and much to clarify in the next iteration, for example, on clinical leadership, time for leaders to reflect, learning relevant to improvement,[13] and how patients' and service users' knowledge and experience drive system improvement. Feedback from and discussion with people across the service as they adopt the framework will shape the content of future iterations (see Section 3, proposed action 11).

Condition 1:
Leaders equipped to develop high quality local health and care systems in partnership

The task of improving local health and care systems requires senior system leaders to bring together a wide range of stakeholders, including patient leaders, to agree aims and plan changes. Skills that equip them for the task include communication, collaboration, staff engagement, conflict management, holding challenging conversations about complex issues, and improvement methods including measurement for improvement.

Another skill critical to making joint decisions is the ability to pull together and interpret information from a health and care system, including the information on outcomes that shows the impact of changes. This information requirement puts a premium on knowing how to measure outcomes. Systems leaders are also looking for advice on how to integrate governance for this new collective responsibility and shared leadership.

To help them develop these skills and build trusting and stable relationships, system leaders need opportunities to train with leaders from different professions, sectors, levels and places. Local and national providers of leadership development need to tailor their support to meet the critical development needs system leaders face in a coherent and co-ordinated, 'place-based' approach. To speed the improvement of local health and care systems there is also an urgent need to support and champion existing OD teams across primary and secondary health and social care and to develop their capacity and capability.

Proposed actions

The NHS Leadership Academy, as part of Heath Education England (HEE), is already working with NHS Improvement, Public Health England, NHS England and other partners to make specific systems leadership development support available to each STP footprint. In addition, the following actions are proposed.

13 As described in W. Edwards Deming's system of profound knowledge www.qihub.scot.nhs.uk/quality-and-efficiency/2020-framework-for-quality-efficiency-and-value/improve/deming%E2%80%99s-system-of-profound-knowledge.aspx

Proposed action	Intended outcomes		Detailed actions	Responsible
1: Support development of system leadership capability and capacity	**Next 12 months**	System leaders and leadership teams know about and can access coherent and co-ordinated place-based support for developing their system leadership skills. STP teams will have discussed this issue and include their own systems leadership development in their planning	Local leadership academies will **advise on the support available** to individual system leaders and to sustainability and transformation leadership teams	HEE (NHS Leadership Academy)
	In 1–3 years	All organisations across primary and secondary health and care have good enough OD capability to enable effective team and inter-team working within and between organisations across health and care systems	Local leadership academies will **help senior teams to build OD capacity and capability** within their organisations and systems, working with current OD networks. Where such networks do not yet exist, local leadership academies will help to build them and develop the colleagues that the networks connect	HEE (NHS Leadership Academy) with all NHS funded organisations
			Local leadership academies will work with NHS England partners to map **OD capacity and capability across primary care** and agree a development plan and process	NHS England
		Colleagues across primary and secondary care and commissioning are building trusting relationships that progress changes planned in their respective STPs	Local leadership academies will **facilitate forums for leaders in each STP area** to help progress implementing their STPs, including implementing the OD plans for their local system	HEE (NHS Leadership Academy), with NHS England and NHS Improvement
2: Develop and implement strategies for leadership and talent development	**Next 12 months**	Leadership and talent development and planning become core strategic activities for all organisations and local health and care systems	All NHS-funded organisations, including national organisations, **develop their own leadership and talent development strategies** to create cultures of continuous improvement, with inclusive, compassionate leadership, delivering high quality care	All NHS funded organisations
	In 1–3 years	All organisations understand why they should make leadership and talent development and planning core strategic activities, and are supported in developing high quality strategies	Support organisations and systems to **develop and implement leadership and talent development strategies**. This entails extending and linking relevant communities of practice, and particularly encouraging clinicians and other professions to be integral to developing the strategies	HEE with NHS Improvement and NHS England

Condition 2:
Compassionate, inclusive and effective leaders at all levels

A healthcare organisation's culture – 'the way we do things around here' – shapes the behaviour of everyone in the organisation and directly affects the quality of care they provide. Research shows the most powerful factor influencing culture is leadership. Leaders who model compassion, inclusion and dedication to improvement in all their interactions are the key to creating cultures of continuous improvement in health and care.

Compassionate and inclusive leadership creates an environment where there is no bullying, and where learning and quality improvement become the norm. Continuous improvement depends on staff feeling safe and empowered to apply improvement methods in partnership with patients, families and communities. Where leaders act with compassion, staff feel valued, engaged and enabled to show compassion themselves. They feel obliged to speak up when something is wrong and empowered to continuously improve.

It is widely acknowledged that what happened in Mid-Staffordshire NHS Foundation Trust was caused by a range of factors, not least allowing a culture of fear and poor style of leadership to take hold. Among the recommendations of the Francis report and subsequent Berwick and Rose reports, the need for improved leadership, leadership behaviours, values and competencies was repeatedly highlighted. Compassionate and inclusive leadership is embedded in high quality, high performing systems and drives improvement in their overall performance – better outcomes for patients, better population health and better value for money.

Achieving this condition rests on three factors:

Developing a common understanding of the knowledge and practice of good leadership

A variety of frameworks are used across the NHS to develop, assess, select, promote and regulate leaders and leadership, and they are often incongruent. People across the system need to agree on 'what good leadership looks like' at different levels and develop consistent descriptions, using language common to all organisations and systems.

Ensuring lifelong learning for all staff

The leaders of health organisations are responsible for ensuring that the individuals and teams they lead receive appropriate skills and career development at the right time to fulfil their potential. According to research, senior executives report their sources of key development as learning from experience in role and on the job (70%), learning from others, especially mentors, coaches and learning sets (20%), and formal coursework and training (10%). At present, there are examples of excellent leadership and career development in different areas of NHS-funded activity, but evidence shows the offer is not consistent across the service or throughout people's careers. All staff need to receive regular high quality appraisal conversations and career development opportunities. Health organisations would benefit from greater sharing of existing good practice. Everyone in the service, regardless of where they work in NHS-funded care, would benefit from more consistent access to affordable and high quality development offers, predominantly on-the-job learning, combined with other learning support.

Developing inclusive systems for managing talent

High quality health and care systems are able to attract, identify and develop people with the potential for good leadership and to match them to opportunities as they arise, fitting the right talent to operational needs. Systems for matching people to roles where they can have the most impact are essential, both within and across health and care organisations. Such systems rest on strategic planning to make sure the supply of appropriately developed people matches trends in demand for senior leaders and other critical roles across the system. Planning needs to include creating the conditions in which equality, diversity and inclusion thrive in all teams and organisations across health and care services to speed progress towards a truly inclusive health and care leadership. Evidence shows that organisations with a diverse leadership perform better, with higher levels of staff morale.

We have heard clearly that people in leadership roles often feel isolated and insufficiently supported and valued. The ambition is to create an inclusive system of managed talent pipelines which can effectively and cost-efficiently identify, develop, and supply suitable candidates for vacant roles as well as support potential leaders as their careers progress and when they are in senior posts. Such a system will increase the diversity of background and skill sets among candidates for each role; make it easier for people to move around health and social care; and support the development of leaders who can work across sectors.

Proposed actions

Proposed action	Intended outcomes		Detailed actions	Responsible
3: Develop compassionate and inclusive leadership for all staff at every level	**Next 12 months**	All health and care organisations have a common understanding of 'what good leadership looks like', and are using it to guide the identification, development, assessment, appointment and support of leaders internally and across the system More strong candidates are ready and willing to put themselves forward for challenging NHS leadership roles, as national bodies make sure the regulatory regime consistently encourages improvement and compassionate, inclusive leadership (proposed action 11) and potential leaders in NHS-funded roles are better developed	Work with organisations at all levels to co-design a **guide for health and care leadership** for use across the system. The guide will include what good leadership looks like (knowledge, skills, attitudes and behaviours at different levels), how to identify talent and how to help individuals and organisations assess and meet their leadership development needs. Alongside this develop a consistent approach to senior level appraisals that reinforces the values, behaviours and practices of compassionate and inclusive leadership. This work will be reflected in the next update of the Well-Led Framework, due in April 2017	HEE (NHS Leadership Academy), with CQC, NHS Improvement, NHS England and Skills for Care
			Develop the **role of local leadership academies (LLAs) to enable, promote and improve leadership development** delivered locally (in-organisations). LLAs will support local organisations in co-designing and delivering high quality leadership development, signpost them to assured development providers, and kite-mark in-organisation leadership development activities. Local leadership development support will focus on **teams, leaders of teams** and **emerging clinical leaders**	HEE (NHS Leadership Academy)

Proposed action	Intended outcomes		Detailed actions	Responsible
3: Develop compassionate and inclusive leadership for all staff at every level	**In 1–3 years**	Greater national consistency and quality in leadership development, as well as better local support for leadership development and talent management, results in: • a bigger pool of current and future leaders with the knowledge, skills, attitudes and behaviours to create cultures of continuous improvement • improved staff engagement and reduced levels of discrimination and bullying (evidenced in staff survey results) • a bigger pool of aspiring senior leaders including clinical leaders, a higher number of qualified candidates per leadership vacancy, and fewer such vacancies	In collaboration with local and national partners, review and revise the design and delivery of development for **senior and mid-level leaders** across the system, especially in primary care. Ensure national consistency and quality in leadership development for aspiring directors and above, in line with enhanced talent management. Development for senior leaders to be designed and delivered nationally; development for mid-level leaders aspiring to senior roles to be designed nationally and delivered regionally	HEE (NHS Leadership Academy)
			Ensure **digital access** to open source resources and tools on compassionate and inclusive leadership across health and care	HEE (NHS Leadership Academy) with NHS Improvement and NHS England
		• A bigger pool of high potential leaders with the knowledge, skills, attitudes and habits to be compassionate, inclusive leaders and the skills and experience to work across health and care, and who receive improved career support	Work with health and social care colleagues to develop **a joint graduate management training scheme**, in addition to the NHS graduate management training scheme, that is appropriate to the future landscape of health and care	HEE (NHS Leadership Academy)/Skills for Care
			Double the size of the NHS graduate management training scheme by 2020 and provide more continuing career support for all trainees and training scheme alumni. Evaluate training schemes tailored to specific entrants as a model for attracting and rapidly developing high potential managers at later stages of their careers	HEE (NHS Leadership Academy)

Proposed action	Intended outcomes		Detailed actions	Responsible
4: Embed inclusion in leadership development and talent management initiatives	**Next 12 months**	Improved leadership capabilities are driving greater levels of equality, diversity and inclusion at all levels There is equal access to opportunities for career progression and people have the development support they need to pursue them. Line managers identify, encourage and support those from under-represented groups	Working closely with the NHS Equality and Diversity Council (EDC), launch a system-wide intervention to address discrimination against those with protected characteristics. The intervention will equip future leaders to accelerate inclusion and create just cultures that ensure inclusion is sustained. It will use action research to identify, design and implement the leadership development and leadership practices that are achieving inclusion. This work will itself be a programme of action that engages leaders across health and care	HEE (NHS Leadership Academy)
	In 1–3 years	All organisations cultivate the knowledge, skills and capabilities that create the conditions where equality, diversity and inclusion thrive. There is measurable progress towards a senior leadership group that represents the health and care workforce and wider population it serves. Evidence shows such representative leadership leads to more patient-centred care and better staff morale	Publicise ambitious targets to **improve diversity** at every level of NHS organisations and publish the impact of organisations' action on diversity. Encourage stakeholder forums and recruitment and exchange schemes to improve the diversity of future leaders, meaning diversity in skills, thinking, experience and background as well as in protected characteristics	NHS Equality and Diversity Council (EDC) and NHS national organisations

Proposed action	Intended outcomes		Detailed actions	Responsible
5: Support organisations and systems to deliver effective talent management	**Next 12 months**	All NHS-funded organisations know how to deliver effective, inclusive talent management	Building on existing evidence and materials, co-produce a clear statement of what 'good' and inclusive talent management looks like across the NHS system. All members of the NILD Board will publicly commit to putting good talent management in place in their own organisations. The impact and quality of these initiatives will be measured and results published annually	HEE (NHS Leadership Academy), with all members of the NILD Board
		Organisations and line managers have easy access to guidance and advice on how to implement better talent management	Co-design a programme **supporting organisations to do talent management better** at all levels. This entails building on existing regional talent management networks, which increase access to training and resources, and developing learning collaboratives which share best practice and support peer-to-peer learning	HEE (NHS Leadership Academy) with all members of the NILD Board
	In 1–3 years	All staff at all levels are provided with meaningful feedback and the support they need to fulfil their potential, making them feel more valued. Effective talent pipelines are in place, ensuring that the highest performing individuals across NHS-funded services are identified and adequately supported to become future leaders	Support local organisation leaders to **establish pilot talent management forums at regional and local system levels**. Such forums can take a partnership approach to strategically identifying and developing diverse talent across all the organisations they represent. The aim is for the pilots collectively to drive local talent development strategies and sustainable succession planning	HEE (NHS Leadership Academy)

Proposed action	Intended outcomes		Detailed actions	Responsible
6: Improve senior level recruitment and support across NHS-funded services	**Next 12 months**	Senior leaders in NHS-funded services feel more valued and continually supported to reach their full potential There is progress towards strategic and coherent talent management at the national level, ensuring effective succession-planning for the most senior roles across the health system	Continue work to **align and make better use of all existing NHS resource** involved in senior level development and recruitment. This work is aimed at offering more coherent national talent management support, covering executive, non-executive and interim board posts. The offer will include monitoring national talent pools; providing career management advice to rising talent; and supporting employers in targeting and appointing appropriately developed senior leaders	HEE (NHS Leadership Academy)
			Establish a national **senior leaders support function (SLSF)** with representatives from the health and care system. This team will inform and oversee senior talent management initiatives at national level. The SLSF will systematically source and use talent management data relevant to board level posts to inform national planning and investment decisions concerning the senior leadership pipelines for all professions. This will include regularly collecting new supply and demand data from across the NHS system along with analytical modelling	HEE (NHS Leadership Academy)
			Commission a **senior systems leaders scheme** as part of a nationally coordinated talent management programme to support leaders currently in the most senior roles, to attract and retain future senior leaders, and ensure effective succession planning for the most senior roles across the health system	HEE (NHS Leadership Academy)
			Continue to deliver or commission a set of development programmes for aspiring senior leaders across NHS-funded services and those already in post, particularly for future clinical leaders (for example, running another cohort through an executive fast track programme that prepares clinicians to take up chief executive posts) and for future leaders in primary care and commissioning	HEE (NHS Leadership Academy) with NHS England

Proposed action	Intended outcomes		Detailed actions	Responsible
6: **Improve senior level recruitment and support across NHS-funded services**	**In 1–3 years**	There is a sustainable and diverse pipeline of senior leaders for NHS-funded services and vacancies are filled quickly with leaders who have the right skills. Improved recruitment support and processes reduce reliance on commercial recruitment firms and deliver better value for money	Expand NHS recruitment support to board-level roles and establish a **national framework of preferred executive search agencies** that secures better value for money for NHS organisations	HEE (NHS Leadership Academy)

Condition 3:
Knowledge of improvement methods and how to use them at all levels

Chief executives of the majority of provider trusts rated 'outstanding' by the Care Quality Commission (CQC) have stated their commitment to quality improvement methods and continuous learning, which they credit with achieving improvements in operational performance, staff satisfaction and quality outcomes. Leaders of CCGs and primary care providers have given similar endorsements. The ambition inspired by this condition is for all NHS-funded organisations across England, with regional and national partners, to invest in building skills in quality improvement and continual learning among all their teams. The aim is for continuous improvement to be core to everyday work for everyone working in NHS-funded services. Extending this capability into primary, community and social care is vital to performance improvement across health and care systems.

There are several approaches to improvement methods[14] but all share the same basic principles. As the Berwick review identified, not everyone needs to be expert in an approach, but all staff and teams should understand the principles and all organisations should have enough staff with the leadership and expert analytical skills to lead and sustain improvement work through coaching teams. All teams should have the opportunity and time to apply improvement skills in their daily work, as well as access to on-going support and shared knowledge. Achieving this condition rests on senior leadership teams committing their organisations and systems to developing staff in improvement methods; making the substantial and sustained commitment of time and resources that success requires; and embedding training in improvement methods, alongside training in related managerial, team-working and leadership skills, in the training curricula and re-validation processes of all health and care staff.

Research into the factors driving high quality health systems shows that board and executive teams' understanding of leading for improvement is crucial. Leading for improvement includes allocating adequate resources, giving teams time for improvement activities (reducing less value-adding activities where possible), role-modelling improvement principles in leaders' own behaviour and celebrating successes.

There are a number of regional networks that support provider and commissioning organisations in building improvement capability very well. However, the extent, quality and availability of training and support vary across the country. A more coherent and co-ordinated offer at regional and local level is needed. Some NHS-funded organisations that have embedded improvement approaches already support peers: the national organisations involved in this framework are committed to supporting the development of improvement capability and peer-to-peer learning across England.

Patients, service users, families and communities should always be involved as equal partners with professionals in re-designing and improving processes and systems. Many healthcare organisations across England do this systematically, with impressive results. To extend this level of involvement across NHS-funded care depends on communicating its benefits to health and care teams, including patients, carers and other partners, and equipping them with the skills to do it well.

14 Established quality improvement approaches include Total Quality Management (TQM), Model for Improvement (including Plan Do Study Act or PDSA), Statistical Process Control, Six Sigma, Lean, Experienced-based Co-design, Theory of Constraints, and Business Process Re-engineering. See www.health.org.uk/sites/health/files/QualityImprovementMadeSimple.pdf

Proposed actions

Proposed action	Intended outcomes		Detailed actions	Responsible
7: Build improvement capability among providers, commissioners, patients and communities	**Next 12 months**	All leaders of healthcare organisations and systems, across primary, secondary and community care as well as commissioning and national bodies, have access to the knowledge and skills they need to lead quality improvement	Develop programmes for boards and executive teams of provider and commissioning organisations on **leading for improvement**, designed in collaboration with regional, national and international organisations experienced in this area	NHS Improvement with NHS England
			Co-design with primary care practitioners a **training offer for primary care** building on current good practice and aligned with the 'leading for improvement' programme, which is co-ordinated by NHS Improvement	NHS England (Primary Care Team)
			Embed leading for improvement in all core **leadership development programmes**	HEE (NHS Leadership Academy)
			Issue guidance for providers indicating the **scale of training required to embed quality improvement capability** in their organisations, ie what proportion of staff need training in improvement methods at each level, over what period, and the particular improvement skills they need to learn	NHS Improvement
		Regional and national improvement organisations have a better understanding of the type and level of improvement training and support available to local organisations and systems. They can clearly signpost such support, and address gaps in the existing training and support infrastructure	Identify the current **training and support infrastructure in relation to improvement**, in close co-operation with regional improvement organisations and networks	NHS Improvement and NHS England, with academic health science networks and other regional improvement organisations

Proposed action	Intended outcomes		Detailed actions	Responsible
7: Build improvement capability among providers, commissioners, patients and communities	**Next 12 months**	Patients and communities are involved as equal partners in the re-design of processes and systems	All members of the NILD Board will develop their organisations' approaches to involving **patients and/or carers** in their work and governance processes, working with existing advisory groups (eg Five Year Forward View People and communities Board) and sharing their experiences	All NILD Board members
	In 1–3 years	All providers and commissioners are supported in building improvement capability by a coherent and co-ordinated support offer at regional and local level, ensuring good value for money	Develop a **procurement framework** for specialist providers of improvement training and support	NHS Improvement
			Provide **guidance** to organisations on how to build organisational and systems improvement capability and work with improvement organisations to offer **regional support**	NHS Improvement, with NHS England
		All senior leaders are embedding an improvement mind-set in their organisations and model this. By 2020, all candidates appointed as chief executives to trusts and CCGs will need to demonstrate knowledge of, and experience in, applying improvement approaches, as well as compassionate, inclusive leadership	Support **boards and executive teams' access to relevant improvement training** through the 'leading for improvement' programmes, using local and regional partners. The programme's aim is to reach 25% of trust/CCG boards and executive teams by 2018, and 75% of this target group by 2020	NHS Improvement, with NHS England

Proposed action	Intended outcomes		Detailed actions	Responsible
8: Embed improvement and leadership development in curricula, revalidation and award schemes	**Next 12 months**	Training in quality improvement (QI) science and methods, as well as in managerial and leadership skills, are systematically and comprehensively embedded in training curricula for all health staff, clinical and non-clinical.	With the Medical Royal Colleges, the Academy of Medical Royal Colleges and other relevant professional groups, develop a strategy for **implementing the recommendations of *Quality Improvement – Training for Better Outcomes*** (Academy of Medical Royal Colleges 2016), in close co-operation with universities and training regulators	HEE
		Individuals and teams are strongly incentivised to improve health and care and rewarded for their contributions	Establish a working group to **review Clinical Excellence Awards**, with a view to designing an incentive and reward scheme focused on quality improvement and leadership development	Department of Health
	In 1–3 years	A substantial and increasing share of the NHS-funded workforce is skilled in QI methodology and sees continuous improvement as a normal component of everyday work, rather than an add on. Include knowledge of QI in revalidation processes and appraiser training for all health staff	Continue work with the Medical Royal Colleges, professional regulators and other professional groups **to implement new curricula and re-validation processes** that include core improvement, team working and leadership development skills	HEE

Condition 4:
Support systems for learning at local, regional and national levels

Getting full benefit from investments in improvement skills, leadership and talent management made in line with the framework depends on the underpinning support systems for these three areas. Several actions to extend infrastructure and learning systems to support all three appear under conditions 1, 2 and 3. Actions proposed under this condition promote essential resource and knowledge sharing.

To illustrate, thousands of people have already been trained in improvement methods across the health and care system in England. But not all of them have the support they need to apply their skills, such as help with data analysis. Having access to support and coaching from improvement experts, who help with the set-up and management of improvement projects and in sharing learning, has been shown to help embed improvement skills. There are also good examples of smaller commissioning or provider organisations sharing expert resources and infrastructure to support improvement teams working across their local system. Expert support is often crucial in ensuring the involvement of patients, carers and the wider community in improvement projects.

Sharing resources, knowledge and learning depends on building systems and networks locally, regionally and nationally. Being able to connect with teams working on similar projects offers much-needed support and peer-to-peer learning and also avoids wasting scarce resources on problems that others have already solved. Support for networks will help teams working on improvement skill-building, leadership development and talent management in England to connect with peers and experts in the rest of the UK and beyond.

Improvement and leadership development practitioners and teams across health and care often find pertinent evidence-based resources hard to locate. Action is also needed to make guidance and information on both leadership development and improvement easier to find and use.

Proposed actions

As a result of the Smith review of nationally funded improvement and leadership development functions (2015), several changes have already been made to the nationally funded improvement and leadership development functions, including moving the Leadership Academy under HEE and integrating NHS Improving Quality functions into NHS England. The actions proposed below build on the changes already made.

Proposed action	Intended outcomes		Detailed actions	Responsible
9: Ensure easy access to improvement and leadership development resources	**Next 12 months**	All staff in health and care organisations have easy access to improvement, leadership development and talent management resources, guidance, tools and best practice methods	Develop a **shared approach to knowledge spread and adoption** encouraging local organisations and systems to develop communities of practice, share case studies and make evidence from local, national and international research easily available through digital channels	HEE, NHS Improvement, NHS England
	In 1–3 years	All staff in health organisations have easy access to cost-efficient, online improvement technology to aid them in the set-up, management and sharing of improvement projects	With partners across the system, build on existing online improvement platforms to create a **national platform** that helps people to plan, manage and share learning from their improvement projects	NHS Improvement, with NHS England
10: Support peer-to-peer learning and exchange of ideas	**Next 12 months**	Organisations better understand what support patient leaders and NHS-funded staff need to share experience	**Build networks** of practitioners in patient and public involvement to raise awareness and share knowledge	NHS England (Public and Patient Engagement Directorate) and NHS Improvement (Faculty of Improvement)
		Individuals involved in improvement work (from policy to practice in every part of the health and care system) belong to improvement communities	Continue to develop the **Q Initiative** with the Health Foundation and other partners as a pan-UK network for individuals involved in improvement, which supports and advances their work	NHS Improvement
	In 1–3 years	Effective networks thrive across the health and care system, enabling the flow of improvement ideas, advice, tools and peer support across England, and proactive connections with the rest of the UK and beyond	Identify and align suitable **development support for a wider range of existing and emerging networks** supporting improvement, leadership development and talent management	NHS England, NHS Improvement, HEE (NHS Leadership Academy)

Condition 5:
Enabling, supportive and aligned regulation and oversight

Targeted investment in skill-building, leadership development and talent management at all levels will only have the desired impact if local organisations and systems are in control of driving their learning and improvement to suit the needs of their local communities. The regulatory and oversight bodies that set the national priorities for local organisations and systems must allow them that control and give them the space and support they need to succeed.

The purpose of regulating and overseeing local organisations is to make sure patients and other service-users receive the best care possible. Regulatory and oversight bodies do this by ensuring core standards are met, and making appropriate interventions when serious problems are identified. There is increasing recognition that the national bodies' and commissioners' general response to a worsening operational environment has been to increase their grip on local organisations and focus on short-term performance management interventions. Those subject to the various regimes sometimes regard the different bodies' individual responses as inconsistent and unco-ordinated. Although any inconsistencies are unintended, they can divert local management attention to responding to regulators and local oversight bodies at the expense of focusing on operations.

The regulatory and oversight bodies take these views seriously. We are working on more supportive approaches that focus on building the capability of people across the health and care system. For example:

- an aligned regulation and oversight approach between NHS Improvement, CQC and NHS England for accountable care organisations and new care models
- joint work between CQC and NHS Improvement on updating and fully aligning the Well-Led Framework, based on a single shared view of quality that draws on the same sources of evidence
- the *Shared Commitment to Quality* developed by the National Quality Board (NQB), which re-affirms and signals the commitment of the FYFV national leadership to quality and makes clear the collective commitment of the national bodies to safeguarding and driving improvements in quality
- implementing NHS Improvement's Single Oversight Framework, which directs support for improvement to trusts.

As a priority, we seek to ensure that the regulatory and oversight system does not stand in the way but encourages professionals, organisations, teams and local systems to improve patient care and outcomes. The national organisations, our regional presences and local oversight bodies must remove any unnecessary hurdles and burden, and make sure we all work closely together. Local organisations should not be asked to submit information more than once. Staff submitting data should understand why it is collected and be able to access it in a meaningful format for improving performance. Regional and national bodies should work together with local organisations and systems to share data and information, minimise data requests and explain such requests clearly.

Putting local systems and providers in control of driving improvement and making them accountable for it necessitates delegating priority-setting and decision-making to the local level. New models of local system leaders jointly planning and delivering services for local populations are already emerging. Some of these challenge existing regulatory and oversight structures and practice. Leaders at all levels need to collaborate to remove barriers to innovation and beneficial change. Local organisations and systems should be confident that they can have open discussions with national bodies on how to overcome such barriers.

Our aim is for regulation and oversight to be more consistent, supportive and fully aligned in the way it looks at and intervenes in performance and improvement across providers, commissioners and local health and care systems. As national bodies, this means we need to improve our understanding of the often complex factors driving outcomes, so we can offer support to commissioners and providers that adds real value and assess the extent of its impact. The support we provide should also help build capability for the long term across local health and care systems, beyond meeting short-term operational objectives. This change in horizon needs to be demonstrated in the actions the different regulation and oversight bodies take to prioritise and support leadership development and improvement.

Proposed action

We intend to use this framework as our collective guide in a process that will require many of us to question the 'way things are done'. Working through the process will take time and some outcomes will only be measurable in the medium term. However, work in many areas is already underway.

Proposed action	Intended outcomes		Detailed actions	Responsible
11: Create a consistent supportive regulatory approach	**Next 12 months**	All national bodies share a clear understanding of the changes in their approaches needed to make sure the regulatory regime consistently encourages improvement and compassionate, inclusive leadership	Continue and strengthen **inclusive dialogue across the system** to explore how regulatory and oversight approaches used in the NHS can be aligned to the strategic framework over time. A critical topic is the metrics used to measure progress. All national regulatory and oversight bodies will commit to act on insights generated by use of this and future iterations of the framework	CQC, NHS England, NHS Improvement
			Work with partners in the system to establish **mechanisms for organisations to feed back constructively** experiences in their dealings with national bodies that are not in keeping with the framework's expectations, and to make sure this information is regularly reviewed and acted upon. This action will build on existing processes in national organisations and evidence on what works best	NHS Improvement, with all National Board members
	In 1–3 years	Progress has been made towards a fully aligned regulatory approach, with all stakeholders from the system involved. Provider and commissioning organisations find interactions with national regulation and oversight organisations (and their local and regional teams) increasingly supportive and in line with the framework's ambitions	**Update each organisation's regulatory or oversight approaches** to prioritise the strategic framework's ambitions. For example, the CQC and NHS Improvement are doing this for their next release of the Well-Led Framework, due in April 2017	CQC, NHS Improvement, NHS England
			All national regulatory and oversight bodies ensure that their organisational development approach supports and enables **all their staff to behave in line with the principles of the National Improvement and Leadership Development framework**, including development in holding supportive conversations and understanding improvement methods	CQC, NHS England, NHS Improvement

Proposed action	Intended outcomes		Detailed actions	Responsible
12: Streamline and automate requests for information	**Next 12 months**	All national organisations own a cross-sector plan to minimise the burden associated with their information requests, with measurable targets	Develop a **joint initiative to assess current measurement activity** (including performance targets and associated metrics) and a strategy for 'measuring what matters'. This will include understanding local commissioner behaviour and how this may be influenced to reduce the data burden arising from local information requests for commissioning purposes. This action will be aligned with the work of the Burden Reduction Challenge Panel (DH), on-going work by NHS Digital, the initiative 'Paperless by 2020' (NIB) and the NQB's 'Measuring Quality' working group	National Quality Board, NILD Board and National Information Board (NIB)
	In 1–3 years	Provider organisations experience a measurable reduction in the data burden associated with the collection and submission of data for regulatory and commissioning purposes	**Implement the cross-sector strategy** to 'measure what matters' and associated actions to minimise the data burden, with regular assessment of the impact on providers	NQB, NILD Board and NIB

Proposed action	Intended outcomes		Detailed actions	Responsible
13: Balance measurement for improvement and judgement	**Next 12 months**	All provider and commissioning organisations have easy access to guidance and support on understanding measurement for improvement and how to implement it	In partnership with local organisations **develop guidance on good practice** in combining measurement for judgement and measurement for improvement, based on national and international good practice	NHS Improvement, NHS England
		All provider and commissioning organisations, as well as regional and national regulation and oversight bodies, are putting suitable systems in place to measure for improvement	Select a **pilot priority area** (eg cancer service delivery) to design and implement a comprehensive measurement strategy for the area across all levels (national regulation and oversight bodies and their regional teams; providers and CCGs), working with local partners in development and implementation	NHS England, NHS Improvement, CQC
		All provider, commissioning and regulation and oversight organisations plan/ start to develop sufficient analytical capability to design, analyse and interpret relevant measures to support improvement	Include **analytical skill building** as an explicit element of the 'Leading for Improvement' training offers. This will link with relevant work being done by the NIB (such as the Building a Digital-Ready Workforce programme), and work by NHS Digital relating to NHS England's personalised health and care 2020 strategy, as well as planned and new capability building offers for primary care and commissioners (such as NHS England's Right Care programme)	NHS Improvement, NHS England
	In 1–3 years	Provider and commissioning organisations, as well as regional and national regulation and oversight bodies, have suitable systems to measure for improvement	All members of the NILD Board **review their internal board reporting** to check that measures used give an adequate understanding of the organisation's trajectory of performance, and whether changes believed to be leading to improvements are having the intended impact NHS Improvement and NHS England will ensure that providers and commissioners are supported in adopting good practice on measuring for improvement, and signpost them to other support	NHS Improvement, NHS England

Annex 1: Bibliography

Introduction

The programme team consisted of three sub-teams focussing on different elements of the strategy. The team consulted a wide range of subject experts and research documents and resources. This bibliography represents some of the resources the teams drew on for this first version of the framework.

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Annex 2: Stakeholders

Our thanks go to all the people who kindly gave their time and expertise to develop this first version of the framework.

- NHS Provider and CCG leaders, specialists, and staff members
- Patient/user representative organisations
- Professional bodies
- Professional networks
- Royal colleges
- National NHS organisations
- Arms-length government bodies
- Research and academic organisations
- Think tanks
- Local delivery partners
- Academic health science networks
- Improvement organisations
- Private sector talent management specialists
- Public sector bodies including MoD and civil service talent support
- Networks/associations
- Our colleagues at NHS Scotland, NHS Wales, and Department of Health Northern Ireland who arranged informative visits for us to learn about their experience
- The NILD board, ALB working group, and all those on the Programme Team

Events/Surveys

- Those who attended the TM workshops and Lets Talk Talent national engagement events (7 July and 7 September)
- People who responded to the Let's Talk Talent online survey and took time to have one to one conversations with the team
- Those who attended the workshops to support the development of the national improvement and leadership development strategy (15th April in Gothenburg and 29th April at the Health Foundation)
- Those who attended the National LDI Strategy Events (14th June in Manchester and 21st June in London)

Annex 3: Glossary of terms

Continuous learning: constantly expanding skills through learning and increasing knowledge. For organisations, directing people's continuous learning towards relevant skills equips individuals and the organisation as a whole to adapt to a changing environment quickly, flexibly and successfully.

Cultures of continuous improvement: in health organisations, these exist where people 'have a rational understanding of how small improvements compound to make big differences; they love improving – both because they are passionate about the importance of their work and because it feels so good to move to a new level of performance; and they have enough confidence in their colleagues to believe the organization is capable of making progress.' (from George C. Halvorson, Chairman and CEO of Kaiser Permanente, the largest U.S. nonprofit health plan and hospital system, at https://hbr.org/2013/07/the-culture-to-cultivate)

Framework: a structure of interlinked items that guides action to achieve a particular purpose. A framework can be improved to reflect experience of using it by adding, deleting or adapting items.

Improvement: designing and redesigning work processes and systems that deliver healthcare with better outcomes and lower cost, wherever this can be achieved. Established improvement methods can be used to improve single processes and systems within organisations and also multiple processes and systems that may cross organisational boundaries, as in transformational change programmes and service reconfigurations across local health systems.

Leadership development: developing individuals for positions of responsibility and authority, supporting them in these roles, and developing the capacity of groups and organisations for leadership as a shared, collective process.

Measurement for improvement: shows whether work to improve a process or system is achieving its intended results. Measurement for improvement comprises measures that demonstrate current (baseline) performance in terms of quality and cost, performance goals for the process or system and the impact of improvement work on progress towards those goals. In health care, measurements are often used for reporting aggregate quality and cost results to oversight and regulatory bodies that "judge" the data against specific standards or rules. Measurements for judgement generally differ from measurements for improvement, although both types of measurement are important.

Organisational culture: the 'way we do things around here', influenced in particular by how leaders do six things: communicate the organisation's vision; translate the vision into practical objectives; manage people; make sure the organisation is just and fair; work in teams; and express core human values. (From the work of Professor Michael West, Head of Thought Leadership at the King's Fund see https://www.kingsfund.org.uk/blog/2016/01/if-it%E2%80%99s-about-culture-it%E2%80%99s-about-leadership).

Organisation development: enabling people to transform systems. OD applies behavioural science to organisational and systems issues to align their strategy with their capability. It enhances the effectiveness of systems by providing interventions that build people's collective capacity and capability to achieve shared goals. (For more information, see: http://nhsemployers.org/campaigns/organisational-development/what-is-organisational-development)

Quality: what matters most to service users concerning quality is that services are safe, effective, caring and responsive (good experience) and person-centred. Providers and commissioners that deliver such high quality services are well-led, use resources sustainably and are equitable. (Source: *A Shared Commitment to Quality* developed by the National Quality Board)

Sustainability and transformation plans: plans that show how local services will evolve and become sustainable over the next five years. The NHS Shared Planning Guidance 16/17–20/21 issued in December 2015 called for every health and care system in England to produce a five-year sustainability and transformation plan (STP). The health and care organisations within 44 defined geographic 'footprints', covering all areas of NHS spending in England, are collaborating on these plans, led by a named leader in each footprint. The plans cover improving quality and developing new models of care, improving health and wellbeing, and improving efficiency of services. While the guidance focuses mainly on NHS-funded services, STPs will also cover better integration with local authority services.

Talent management: the systematic attraction, identification, development, engagement and retention of talent in an organisation or system. Talent refers to individuals who can make a particular difference to organisational performance, either because of their high potential or because they are fulfilling their potential in critical roles (Source: the Chartered Institute of Personnel Development).

Talent pipelines: these provide the pools of candidates able to fill posts at each level of an organisation's staffing when those posts fall vacant or the organisation expands. Posts at different levels will require candidates with different competencies, knowledge and experience. Organisations need to equip their talent with the skills and experience to fill higher level roles while these individuals are in the talent pipelines leading to those roles.

The National Improvement and Leadership Development Board: the NILD board was formed by six arms-length government bodies and the Department of Health to oversee the work set out by the Smith review of centrally funded improvement and leadership development functions in 2015.[15] The board reports to the NHS Five Year Forward View Board consisting of the chief executives from the main leadership bodies involved in healthcare. The original NILD board was soon expanded to include other relevant organisations, such as the Local Government Association. Organisations currently represented on the NILD board and sending advisors to it are listed below.

Members of the NILD board comprise:

- Care Quality Commission
- Department of Health
- Health Education England
- National Institute for Health and Care Excellence
- NHS England
- NHS Improvement
- Public Health England

Organisations attending the NILD board:

- Local Government Association
- NHS Clinical Commissioners
- NHS Confederation
- NHS Leadership Academy
- NHS Providers
- Skills for Care

15 www.england.nhs.uk/wp-content/uploads/2015/09/improv-ldrshp-dev-rev-sept15.pdf