Just About Managing

The Role of Effective Management and Leadership in Improving NHS Performance and Productivity

John Power, Dr Sean Phillips, Stuart Carroll

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Endorsements

"I welcome this timely and authoritative report from Policy Exchange - a substantive contribution to the public policy debate on the future of the NHS. It is without doubt that effective management is a requirement if we want to deliver a high-performing and more productive NHS – something which was clear to me throughout my tenure as Health Secretary. The authors are right to draw our attention to the fact that we must look more closely at the skillsets and competencies we wish managers to develop and to encourage ICBs to take on a greater role in developing training and leadership capabilities, relevant to their population. I also welcome the focus on encouraging a greater number of clinicians to develop core management skills given the UK remains an outlier in the proportion of clinicians holding the most senior leadership roles. I commend the recommendations of this report."

The Rt Hon Jeremy Hunt MP, Secretary of State for Health, 2012-2018; Chancellor of the Exchequer, 2022-2024

"This is a fascinating piece of work drawing on deep engagement with people on the front line. I'm sure it will be closely studied by people on all sides of the debate."

Neil O'Brien MP, Parliamentary Under Secretary of State at the Department of Health and Social Care, 2022-2023

"I very much welcome this crucial Policy Exchange report. Effective management is intrinsically linked with good NHS performance, and it is evident that key changes to the shape of NHS management are urgently needed. As the son of a doctor and nurse, and with my own experiences working as a surgeon in the NHS, I commend the findings of this report."

Dr Neil Shastri-Hurst MP, Member of Parliament for Solihull West & Shirley

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Abbreviations

ACP	Advanced Clinical Practitioner
A&E	Accident and Emergency
AACE	Association of Ambulance Chief Executives
BMA	British Medical Association
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
FFT	Friends and Family Test
FMLM	The Faculty of Medical Leadership and Management
EDI	Equality, Diversity and Inclusion
GP	General Practitioner
GMTS	Graduate Management Training Scheme
HSSIB	Health Services Safety Investigations Body
HR	Human Resources
ICB	Integrated Care Board
ICS	Integrated Care System
MDT	Multi-Disciplinary Team
NHS	National Health Service
NHSE	NHS England
NIHR	National Institute for Health and Care Research
PALS	Patient Advice and Liaison Service
RCN	Royal College of Nursing
RCP	Royal College of Physicians

Executive Summary

The scale and volume of challenges facing the new ministerial team at the Department of Health and Social Care (DHSC) necessitates a significant turnaround operation to enhance NHS productivity and performance. Indeed, the Secretary of State for Health and Social Care used his first public statement to reflect that "the policy of this department is that the NHS is broken".[1] Amid operational pressures (including long waits for care), poor patient satisfaction (at its lowest levels since the early 1980s), high-profile cases of abuse and anaemic productivity growth since the pandemic, the way that the NHS is managed and led is back firmly in the spotlight.

The work of managers – particularly non-clinical, operational managers – working across the NHS is often invisible to the public, but touches almost every aspect of health and care delivery from the implementation of electronic patient records and upgrading the hospital estate to planning rotas for doctors and nurses. Yet the present debate concerning health and care management is often driven by a weak or anecdotal evidential basis.[2] In a recent interview, the Health Secretary reflected he was "unconvinced by the majority of research…which suggests the NHS is under-managed".[3] A recent study concludes that "there is little existing evidence to support either this narrative or counter-claims."[4] As the 2015 Smith Review noted, management capacity and capability is "under examined" in healthcare planning.[5]

Politicians (of all stripes) alongside commentators in the media have in recent years blamed poor performance on "NHS managers", whilst holding more positive opinions about "front line" staff.[6] A recent analysis from the Policy Unit at King's College London reveals half of the public believe there are "too many managers in the NHS".[7] Some healthcare professionals also reflect this view, perceiving non-clinical managers to be a challenge to professional autonomy and authority.[8]

In the public policy debate, too much emphasis is placed on discussion about the volume of managers working in the NHS: the narrative that either simply expanding the headline numbers of 'managers' or in scaling back a 'bloated bureaucracy' will deliver the necessary service improvement and efficiency gains.[9]

A greater focus on management capability is needed, as is a deeper understanding of the permissions and incentives which enable or inhibit improved performance and productivity. We also need to re-appraise where managers are positioned within the healthcare system. The central bureaucracy today is significant, with more than 19,000 people

1. 'The NHS is broken: Health and Social Care Secretary statement', *Department of Health and Social Care*, 5 July 2024 [link]
2. *By 'health and care services', we refer to services provided by NHS organisations, including acute, mental health and ambulance trusts, as well as primary care services as well as social care services.*
3. James Illman & Alastair McLellan, 'Streeting: We'll raise the share of funding for primary and community care within five years', *Health Service Journal*, 1 July 2024 [link]
4. Miqdad Asaria, Alistair McGuire and Andrew Street, 'The impact of management on hospital performance', *Fiscal Studies, Volume 43 Issue 1*, 9th December 2021, p79-95 [link]
5. NHS England, 'A review of centrally funded improvement and leadership development functions', *NHS Leadership Academy*, 27 March 2015 [link]
6. Matt Discombe, 'MP says NHS 'shambles' is fault of 'utterly useless managers'', *Health Service Journal, 9*, January 2023 [link]
7. 'Attitudes to pay and management in the NHS', *Ipsos/King's College London*, July 2024 [link]
8. Madeleine Kenrick and Kevin B. Kendrick et al., 'A qualitative study of hospital clinical staff perceptions of their interactions with healthcare middle managers', *Journal of Health Organisation and Management, Vol .36, No.4* , 20th December 2021, p428-447 [link]
9. Sorcha Bradley, 'Is the NHS no longer the UK's sacred cow?', *The Week*, 27 March 2024 [link]

are employed between NHS England (NHSE) and DHSC. In addition to this, the recently-published Independent Review of NHS Performance, authored by Lord Darzi, finds that "regulatory type organisations now employ some 7,000 staff, or 35 per provider trust, having doubled in size over the past 20 years".[10] The "right balance of management resources in different parts of the structure" is needed, he concludes.[11]

Such an assessment must not fix its attention solely upon the management of hospitals (as important as this is) but **must also consider the requirements of the healthcare system as a whole** – particularly primary and community healthcare services whose management and leadership requirements are less frequently discussed in policy debates, but where expectations for the transformation of services are great and there are unique challenges and circumstances to be addressed given these are far more devolved and dispersed care settings.

Moreover, we should not solely investigate roles, but must also consider the architecture and "organisational culture" which influences activity within the NHS as well as the NHS's interaction with Government departments and arms-length bodies.[12]

The focus and purpose of this report, therefore, is two-fold:

1. **Firstly, to present a more detailed portrait of the state of NHS management today to inform the discussion around about future reform.** How is management distributed across the country and across organisations? Would a greater volume of managers overall deliver improved performance? Are there particular skillsets we are lacking?
2. **Secondly, to set out the case for change and to make a series of recommendations for reform.**

To explore these questions, we conducted a desk-based review of the literature, conducted more than forty unstructured interviews and issued Freedom of Information (FOI) requests to every hospital trust and integrated care system in England (alongside every health board in Scotland and all NHS organisations in Wales and Northern Ireland). We then cross-referenced these FOI requests with the findings (in the case of English organisations) with recent Care Quality Commission (CQC) investigations and results from the NHS Staff Survey over the past five years. In addition, we also sought to draw lessons from case studies – both contemporary and historic where effective management and leadership turned around performance considerably.

Interviews that we conducted revealed:

- **The 'risk reward ratio' for operational managers – particularly those working within NHS Trusts – is misaligned.** Many feel they (and their peers) have limited autonomy to drive the change they

10. Lord Darzi of Denham, Independent Investigation of the National Health Service in England, *DHSC*, September 2024 [link], p. 10
11. Ibid, p. 13
12. Bryan Jones, Tim Horton and Joe Home, 'Strengthening NHS management and leadership', *The Health Foundation*, 26 February 2022 [link]

wish to see 'on the ground', owing to requests for information and assurance from NHSE, Regions or the relevant, local ICB.

- **Many NHS organisations lack key managerial capabilities** – with which to improve processes or analytical functions creating challenges for the delivery of transformation projects (e.g. robotic process automation to streamline back-office functions).
- At the senior and executive levels of management, there was a sense of a **diminishing attractiveness of taking on the most challenging roles**, such as becoming a Chief Operating Officer or Chief Executive of a trust with historic performance issues. "The juice", one interviewee put it, "isn't currently worth the squeeze".
- Almost all we spoke to reflected **concerns about the way that NHS organisations today were regulated**: that respect for the regulator and inspectorate (the Care Quality Commission, CQC) had reduced in recent years due to inconsistency of approach and the recruitment of a less experienced inspectorate overall.

The main findings of the FOIs are as follows:

- **The average percentage of staff who are employed with managerial responsibilities within the NHS organisations who responded was 6%.** This is higher, therefore, than the commonly cited figure of 2%. The NHS is, therefore, 'undermanaged' compared to other sectors (and international comparators), but not by as much as is often described.
- **The majority of 'managers' (53%) (working in acute NHS trusts) are ranked below Band 8A** according to the Agenda for Change (AfC) pay scale used by NHS Employers, indicating that the vast majority of those with the title 'manager' are not senior staff, or in positions of leadership.
- **There is a negligible correlation between the percentage of total staff who are managers and overall performance as rated by the regulator, the CQC**, revealing that a focus solely upon increasing the total volume of managers working across NHS organisations is unlikely to enhance performance.
- **81.1% of NHS hospital trusts and Integrated Care Boards (ICBs) surveyed for this report had not dismissed a single manager in the past twelve months, either for gross misconduct or poor performance.** This includes several NHS organisations in the 'Recovery Support Programme' (formerly known as 'special measures') for poor performance, and some of the hospitals which currently have some of the lowest patient satisfaction ratings and worst outcomes on the NHS Staff Survey. For instance:

    - **Nottingham University Hospital Trusts**, which employs 1,245 managers, managing over 19,000 staff had not dismissed a single manager for gross misconduct or poor performance in

the last year. In its latest CQC report, published in September 2023, Nottingham was rated as 'requiring improvement' on four of five main performance categories.

- **University Hospitals Plymouth**, which employs 1,058 managers, also had not dismissed a single manager in the previous twelve months. In November 2023, only 53% of patients were seen within four hours (missing the 95% national target by a considerable margin).

An appraisal of the current challenges facing the NHS suggests a wider set of reforms are also required to enhance the operating environment in which managers work. First and foremost, there is a pressing need to review the role and approach of the central bureaucracy.

- **There are too many structural tiers of management throughout the NHS which has created layers of complexity and reduced accountability.** Whilst many readers may baulk at the suggestion further structural reform is required, there is a strong case where carefully planned and managed over the course of a parliamentary term. The functions of NHS England (NHSE) should be (re)merged with the DHSC and an NHS Management Board (re)established within the DHSC in its place. The headcount and functions of the seven NHS Regions meanwhile should be reviewed and roles increasingly delegated either to Integrated Care Boards (ICBs) – or back to DHSC accordingly.
- **There are too few incentives for managers which encourage innovation, proportionate and calculated risk-taking and ultimately, a focus on improvement of the things which matter most to the patient and their families.** In other words, current targets and incentives for managers too often furnish the needs of the system, rather than the consumer. For instance, the way that quality across the NHS is currently assessed under-values the insights generated via patient feedback and complaint. We therefore recommend that greater weight is applied to patient perspectives in both individual and organisational performance appraisal.
- To utilise insights from patient feedback and complaint more effectively, the currently fragmented and inconsistently used patient feedback and complaint mechanisms, such as the Friends and Family Test should be reformed and **a new, unified system called "NHS Patient View" should be created, driven by increased use of the NHS App** with sentiment analysis used to generate swifter insights and analytical reports for use by clinical divisions and senior management, as well as external organisations for patient voice (Healthwatch England) or regulatory bodies (the CQC).
- **The consistency of training and development for staff in core**

management skills who are current or aspirant leaders (both clinical and non-clinical) is weak and sporadic across the NHS. Planning for operational management requirements is insufficient to meet the future needs of primary care (particularly general practice) and community health services.

- **Whilst a set of core competencies expected of managers (according to their seniority) should be clarified at a national level (with a clear emphasis on 'hard' skills, such as process improvement). We suggest the development of a new approach to training and development which is underpinned by greater levels of devolution**, to enable integrated care systems (ICSs) and Trusts to develop their own programmes and placements, tailored to meet the specific needs of their population and to stimulate greater competition amongst educational providers. **This is an approach which we believe should be pursued over progressing with the formal regulation of managers.**

Summary of Recommendations

NHS Governance and Provider Regulation

1. **The governance of the NHS should be simplified by reducing the tiers of structural management separating 'the centre' from the 'front line' from five to three over the course of the next Parliament.**
    a. NHS England should be abolished and its functions merged with the Department of Health and Social Care (DHSC) to reduce policy development duplication and to enhance ministerial oversight. A distinct NHS operational function should however continue to reside within DHSC, as it did prior to the Health and Social Care Act (2012) in the form of an NHS Management Board.
    b. The role of NHS Regions should be reviewed, with current responsibilities increasingly devolved to Integrated Care Boards (ICBs) or delivered nationally – by DHSC.

2. **DHSC should commission a review into bodies with a statutory responsibility for patient safety to clarify purpose and remits.**
    a. Within the scope of the review should be the Care Quality Commission (CQC), the Health Services Safety Investigations Body (HSSIB) and The Parliamentary and Health Service Ombudsman (PHSO).
    b. Reforms – building on the Dash Review – are required to the Care Quality Commission (CQC) so it delivers greater consistency in assessments and draws from an inspectorate with more direct experience of the settings they inspect.
    c. Salaries for inspectors must be commensurate with positions of similar seniority at NHSE in order to encourage applications from the best candidates.
    d. There is a need for clear definitions of what 'Good' and 'Outstanding' care looks like across the NHS to be defined to enhance the consistency of inspections.
    e. The CQC should ensure 'Insight' reports for the providers it inspects are developed as standard, with benchmarked performance data to enable improved peer learning.
    f. The CQC's 'Well-Led' category should incorporate findings

regarding leadership pipelines and training – and should emphasise 'hard' management skills.

g. GP practice inspections should allow greater discretion on details which do not impact care quality or patient safety.

3. Rather than pursuing the formal regulation of NHS managers, a disbarring regime – based upon the recommendations of the Kark Review – should instead be introduced

Organisational Incentives

4. A new framework of incentives (and freedoms), including a "Prevention Premium", tethered to quality improvement for providers should be developed. These should be set out in the Ten-Year Plan for Health, currently being developed by DHSC.

- Incentives should focus on outcomes, rather than activity alone. They must be focused on health-benefits (i.e. specific care outcomes) but should also give weighting to non-health benefits. For instance, findings relating to patient feedback from a new service suggested in this report, "NHS Patient View" (Recommendation 5), should be incorporated.
- A 'Prevention Premium' should be developed for primary and community health service providers, where (for example) the direct costs of reduced demand in inpatient settings due to improved vaccination uptake or falls prevention which can be quantified in-year, are ring-fenced as investment for primary and community care services. An ICB might seek to use these resources as a dedicated capital investment fund.
- For acute care providers, incentives for shifting resources (and staff) to support delivering upon system-wide outcomes ("System Support") should include greater freedoms to develop their own capital reserves and the ability to hire staff in key operational roles beyond the Agenda for Change banding system – building on the original vision for Foundation Trusts.

5. A unified patient feedback and complaints service called "NHS Patient View" should be developed to unify currently fragmented patient feedback and complaint services.

a. Patient Advice and Liaison Service (PALS) should be reviewed (given they have not been formally, since 2008) as should the current use of the Friends and Family Test (FTT) as a means of appraising the current approach to leveraging patient feedback and complaint for quality improvement.

b. Driven by enhanced participation via the NHS App and the NHS website, all existing channels of patient feedback used by NHS organisations should be brought together and streamlined

under a single banner we would call 'NHS Patient View'. To reduce reporting burdens on staff handling feedback, sentiment analysis should be used to enable swifter analysis of insights. Information should be shared in a consistent and structured manner with Healthwatch England and the Care Quality Commission (CQC).

c. Its overarching design should be planned on a national basis, but each ICS should have ownership and responsibility for implementation. Insights from NHS Patient View should be used by managers and leaders – including in organisational or individual performance assessment.

6. **Expert Turnaround Teams – aimed at board level and senior management positions– should be developed and deployed to providers which have struggled to recruit into the most challenging senior roles to enhance current approaches to 'turnaround'. Eligible leaders should be identified by more routine, and structured approaches to talent spotting and career progression across the NHS.**
    a. Building on the recommendations of the Kerr and Messenger Reviews, a more desirable package of incentives (and support) for leaders who take on the most 'difficult to recruit to' roles is needed.
    b. A group of 'Super CEOs' or 'Super COOs' should be given greater autonomy to hire individuals in key operational roles beyond Agenda for Change pay bandings and should be given greater financial reward(s) for improving operational performance – particularly if this has been achieved in an organisation that has historically struggled to attract the best talent and where performance has persistently required improvement.

Training and Development

7. **Future operational management requirements for the NHS should be forecast in greater detail in the next iteration of the NHS Long-Term Workforce Plan in Summer 2025. A core set of management competencies at each level of seniority should be outlined by DHSC/NHSE, whilst dedicated approaches for enhancing operational management capability across primary care and community health services should be outlined.**
    a. There should be a focus on enhancing "core management skills" across all providers, including primary and community care. It should also set out means by which expertise in 'process design' and 'data management' can be objectively tested to certify that managers in the system have the right skills.

8. **Dedicated education and professional development programmes for management and leadership should be developed and coordinated across each integrated care system (ICS) by 2027.**
    a. The Elizabeth Garrett Anderson (EGA) scheme, operating as part of the NHS Leadership Academy, should be overhauled, and in its place a list of approved educational providers should be made available to providers.
    b. Funding currently allocated to general management and HR functions (which constitute the bulk of graduates on the GMTS scheme) should be increasingly distributed to Systems, Trusts and Community Interest Companies (CICs) to tailor their own schemes.
    c. These should provide leaders with opportunities to work across the health and care sector as a whole, adding management capacity to primary, social and community care.

9. **A 'Teach First' style scheme for individuals who do not have a clinical background, but who seek to enter NHS operational management at 'mid-career' level should be developed.**
    a. This should be regarded as one of the strands for delivering the "national mid-career programme for managers across health and social care" envisaged by the Messenger Review.
    b. Those accepted onto the programme should be hired in organisations which are 'under-managed' at present, including community health services, or where the provider is currently under-performing
    c. Those who are admitted onto the scheme should be paid at Band 8A level from the outset.

10. **Greater use of the apprenticeship route (Level 3 or higher apprenticeships) should be encouraged (and expanded) to support the recruitment of future NHS managers - with a particular focus on GP Practice Managers.**

11. **Reforms to the NHS Graduate Management Training Scheme (GMTS) should be introduced to include a four-week mandatory placement in a primary, community or social care provider alongside more routine monitoring of graduate retention rates to ensure ongoing value for money.**

12. **The governance processes around specific transformation projects should be simplified with the empowerment of below board level managers. "Change Certificates" should be issued to project managers once outline business cases have been approved by the executive leadership team.**

Performance and Analysis

13. **The Electronic Staff Record (ESR) should be enhanced so every NHS organisation records the total volume, experience and specialised skillsets of every individual with management responsibilities within their organisation.**
    a. This is to develop system intelligence for future planning requirements and to encourage a clearer definition of management across the NHS today.

14. **Additions should be made to the NHS Staff Survey to improve our understanding of how the NHS is managed.**
    a. Additional questions should be included to focus on domains including the internal coherence of organisational structures and effectiveness of workflows. We suggest the following questions are added:
        ii. "If I need to resolve a problem affecting my workflow, I always know who to speak to."
        iii. "I think that those in more senior positions to me understand the specific workflow challenges and pressures my colleagues are under.
        iv. "A lack of physical space on the organisations estate can cause conflict between my team and other teams."
        v. "The tools required to perform my core functions (e.g. IT) are of a sufficient standard to perform my role effectively."

15. **All operational managers should be formally appraised through the introduction of a digital portfolio and mandatory reviews against established criteria (where it is not already commonplace).**
    a. The aim is to ensure competencies and experience and more effectively 'logged' for the purpose of appraisal and review. Individual organisations should be responsible for the effective appraisal of managers.

16. **More effective procedures to dismiss managers who persistently under-perform are required.**
    a. An eight-week target should be set by the DHSC between issuance of a notice of poor performance (as defined by the Employment Act 2002) and the issuing of an employee notice.[13] Local termination policies and procedures should be adjusted to facilitate swifter dismissal.

13. 'Employment Act 2002', *Legislation.gov.uk*, (last accessed 7th June 2024) [link]

Introduction

The improvement of health and care services is a matter of central importance to the public. The new Government will need to address a range of significant and deep-rooted challenges – both operational and cultural – in order to 'turnaround' current performance.[14] This comes at a time when public satisfaction with the NHS is at its lowest levels since the British Social Attitudes survey was introduced in 1981.[15] In his first public statement, the new Secretary of State for Health and Social Care declared that "the policy of this department is that the NHS is broken". In doing so, the new Health Secretary "effectively…put the whole of NHS England into special measures".[16]

This report considers the factors the new Government will need to consider to improve the performance and productivity of the NHS, proceeding on the basis that effective management and leadership represents one of the key ingredients which can influence the culture and performance of an organisation (See Table 1 for description of the difference between management and leadership).

For all the commentary on 'NHS managers', the public policy debate too often produces more heat than light, defined by an unhelpful binary: that the volume of managers across the NHS must simply increase for performance to improve ("the NHS is under-managed"), or that NHS managers are symptomatic of a "bloated bureaucracy" and that if only more focus and resource were allocated to the 'front line' (i.e. to clinicians) the service would be in better shape ("there are too many NHS managers").[2] A fundamental issue is that the subject of healthcare management remains "evidence light" in the UK.[17]

Table 1 – What is the Difference Between Management and Leadership?

- **Management** responsibilities are to plan, organise, and control resources to achieve defined goals within an organisation.
- **Leadership** is about motivating individuals within an organisation to achieve a common goal through effective relationship-building and empowering others to deliver.[18]

14. Genevieve Cameron, Luisa Buzelli, Kate Duxbury et al, 'The public's views on the future of the NHS in England', *The Health Foundation*, May 2024 [link]
15. 'Public attitudes to the NHS and social care ', *National Centre for Social Research*, [link]
16. Siva Anandaciva, 'Is the NHS broken and what does that mean?', *The King's Fund*, 9 July 2024 [link]
17. Peter Lees, 'Medical leadership: time to grow the evidence', *BMJ Leader*, Vol 1 No 1, 3rd April 2017 [link]
18. Jacob Flint, 'What is the key difference between a manager and a leader?' *University of Salford*, 16th March 2023 [link]

Methodology

To inform this report, we conducted unstructured interviews with a number current and former NHS managers (including general practice managers), Chief Executives at top-performing community and acute trusts alongside representatives of membership organisations and academics with experience and insight into management of healthcare systems.

We wanted to hear from those who had experienced both poor and effective management practices and to learn from those who has successfully 'turned around' an organisation where there had been a history of poor performance, or where they had sought to address challenges raised by the regulator (for example).

We sent an FOI request to every hospital trust and Integrated Care Board across England and to every Health Board in Wales, Scotland and Northern Ireland to understand more about the number of 'managers' working in each organisation and their level of seniority in order to create a more granular picture of the differences between different NHS organisations and to discern patterns from geographic variance, manager ratios and performance.

We should however caveat from the outset that we recognise these organisations do not encompass the totality of those in management roles working across all NHS organisations. For instance, this exercise does not encompass GP practice managers, nor those with management responsibilities for Community Interest Companies (CICs). It does not provide any detail on current management levels working across social care providers either.

Report Structure

The report is structured as follows:

- **Chapter 1 introduces the key challenges facing NHS leadership today** – which the new Government and NHS management must address.
- **Chapter 2 presents a portrait of NHS managers and leaders across the NHS today and examines how they are trained and developed.** Drawing upon literature review and insights from long-form interviews, it provides an overview, including current routes to roles, approaches training and perspectives from a range of managers working across the NHS today encompassing reflections upon culture, improvement and performance management.
- **Chapter 3 summarises evidence from interviews conducted with current and former NHS managers** – from chief executive level to those current on the GMTS scheme
- **Chapter 4 sets out the findings of FOI requests made by Policy Exchange** and presents an analysis of this data, mapped against other key indicators of performance, including CQC reviews and the findings of recent NHS Staff Surveys.
- **Chapter 5 considers the evidence linking management,**

performance and productivity and compares this against our findings from FOI requests.

- **Chapter 6 considers the future for management and leadership in the NHS**, including future training and leadership requirements, including across primary and community care settings.
- **Chapter 7 considers the organisational factors and 'operational environment' which can enable more effective management and leadership of NHS services.**

Chapter 1 – Managing the NHS: Six Interlocking Challenges

> *"From today, the policy of this department is that the NHS is broken. That is the experience of patients who are not receiving the care they deserve, and of the staff working in the NHS who can see that - despite giving their best - this is not good enough."*
>
> **Rt Hon Wes Streeting MP**, Secretary of State for Health and Social Care[19]
>
> *"To really deliver at scale requires tough conversations and decisions about governance and accountability. We need clarity on who is doing what (and who is not), single joint plans and most importantly, we must understand how decisions will be made and transacted."*
>
> **Richard Mitchell**, Chair, East Midlands Acute Providers Network[20]

Challenge 1: The Performance Problem

"Assessing the performance of a health system effectively is the first step to improve it."[21]

To that end, the recent publication of an Independent Review of NHS Performance by Lord Darzi which lays out many "hard truths" about NHS performance is welcome.[22] The performance of NHS organisations is largely determined (by the press and public, at least) by whether or not the organisation meets the targets set out in the NHS Constitution for England – including targets relating to elective care ("the waiting list") and the 'four hour' A&E target. Whilst less ambitious recovery milestones have recently been introduced, the constitutional targets have not been revised. Recent analysis from the Nuffield Trust shows that nine of the eleven waiting time targets set out in the NHS Constitution for England are not currently being met, including A&E waiting times.[23] A recent National Audit Office report reveals that "the timeliness of NHS treatment is generally poor". NHSE last met its official target for 95% of A&E patients to be admitted, transferred, or discharged within four hours in July 2015. While the number of people waiting to begin treatment for elective care has fallen from a September 2023 high, there were 7.6 million people on the waiting list in April 2024.[24]

But like all things to do with the NHS, there is substantial variation in performance, making such generalisations unhelpful at times. In January

19. The NHS is broken: Health and Social Care Secretary statement, *The Department of Health and Social Care*, 5 July 2024 [link]
20. Richard Mitchell, 'We need a tough conversation on the roles of ICSs and provider collaboratives', *Health Service Journal*, 10th January 2024 [link]
21. Dheepa Rajan, Irene Papanicolas, Marina Karanikolos et al., 'Health system performance assessment: A primer for policy-makers', *European Observatory on Health Systems and Policies*, 8th November 2022 [link]
22. Dominic Penna, 'Wes Streeting announces 'warts and all' NHS performance review', *Daily Telegraph*, 11 July 2024 [link]
23. 'A decade of failure to uphold NHS patients' rights to timely care', *Nuffield Trust*, 21 June 2024 [link]
24. NHS Financial Management and Sustainability, *National Audit Office*, July 2024 [link]

2024, the then Secretary of State for Health and Social Care revealed in a speech to the Nuffield Trust that just fifteen hospital trusts made up over half of the hours lost to ambulance handover delays.[25]

The Care Quality Commission (CQC) – the independent regulator – investigates NHS organisations and rates their performance based upon six key categories such as how 'well-led' they are, or how effectively they are utilising resources, according to criteria set out in its inspection framework. A final combined 'overall' ranking is then assigned to the provider.[26]

Yet, the DHSC recently launched a review, led by Dr Penny Dash, chair of the North West London Integrated Care Board, which identified "significant internal failings" at the CQC, leading to an ability to identify poor performance at hospitals, care homes and GP practices. Dr Dash's review found a lack of clinical expertise among inspectors, a lack of consistency in assessments and problems with CQC's IT systems. As a result, the Health Secretary has called into question the ability of the regulator to consistently and effectively judge the quality of health and care services.[27]

In addition to the role of the regulator, a variety of information sources are also used to develop NHS England's own 'National Oversight Framework' (explained in detail in Table 3) including core metrics on performance, as set out in the NHS Constitution. This is complemented by information from other sources such as the NHS Staff Survey. Based upon these metrics, each provider is assigned to a 'segment' between 1 (highest performing) and 4 (lowest performing, and will enter the 'Recovery Support Programme').

With respect to the newest statutory organisations, ICSs, the method by which their performance is assessed is yet to be fully determined. A recent King's Fund report suggests that "NHS England should focus on holding ICBs to account for their achievements in growing primary and community health and care services."[28]

Table 2 – NHS Oversight and Assessment Framework

The NHS Oversight and Assessment Framework serves four core purposes[29]:

1. To align priorities across the NHS and with wider system partners to drive shared ownership of improvement
2. to enable the sharing of good practices to support mutual improvement
3. to identify where ICBs and/or providers may benefit from or require support or intervention, and
4. to provide an objective basis for decisions about when and how NHS England intervenes using our regulatory powers should this be necessary

25. Rt Hon Victoria Atkins MP, 'Speech: The 2024 Budget and NHS productivity", Nuffield Trust Summit 2024, 7 March 2024 [link]
26. 'Inspection framework: NHS trusts and foundation trusts', *Care Quality Commission*, 2018 [link]
27. Government acts after report highlights failings at regulator, *DHSC*, 26 July 2024 [link]
28. Beccy Baird, Deborah Fenney, Danielle Jefferies, Dr Andy Brooks, 'Making care closer to home a reality: Refocusing the system to primary and community care', *The Kings Fund*, 13th February 2024 [link]
29. NHS Oversight Framework [link]

Segment	Description	How we will support	How we will drive improvement	How we will intervene
1	Consistently high-performing across domains, delivering against plans and operating in a high-functioning NHS system. Has a track record of successful delivery or effective recovery.	No specific support or intervention needs are identified. Expected to offer peer support to others or support the development of best practice tools.	Will work alongside us to develop best practices and improvement initiatives in areas in which the organisation excels. May be asked to work with us to provide an expert challenge to other organisations.	The use of our enforcement powers is not compatible with this segment. Where enforcement action is required, the organisation will be assigned a delivery segment of 2 or more.
2	Developing with confidence in the ability to improve further and operate in a high-functioning NHS system. Specific issues exist with plans in place that have the support of system partners.	The organisation can diagnose and clearly explain its support needs which will be predominantly supplied locally. Our support on specific issues is provided where appropriate.	Will work with us to support the development of best practices in areas of high performance. Targeted support aimed at improving specific pathways where issues have been diagnosed.	Due to the relatively high-performing nature of the organisation and its level of maturity, the use of enforcement powers will not be common but may be used where specific issues call for this approach.
3	ICB or provider and/or wider system are significantly off-track in a range of areas. We lack confidence in the capability to respond to challenges without support.	Support needs are diagnosed together and delivered through local support offers, defined national support programmes and bespoke regional interventions.	Receives enhanced scrutiny targeted at delivering improvement in the most challenged performance areas. Recovery KPIs and trajectories are agreed upon and proactively monitored.	We may apply interventions and/or direct an organisation to take specific actions related to diagnosed issues. Enforcement action may be taken where required.

4	There have been multiple serious failures of patient safety, quality, finance, leadership, or governance or the ICB or provider and NHS system face serious, long-standing and complex issues requiring an intensive co-ordinated response	The Recovery Support Programme (RSP) supports the ICB or provider in undertaking a full diagnostic to identify support needs and develop a full recovery plan in collaboration with system partners	We appoint an improvement director to intensively support the organisation to meet improvement goals. Increased scrutiny to ensure delivery of the agreed recovery plan and meet transition criteria to transition to segment 3.	Entry into the Recovery Support Programme (RSP) and subsequent enforcement action are agreed through relevant executive governance group. Transition out of RSP into segment 3 requires transition criteria to be met.

The Recovery Support Programme (RSP)

For ICBs and trusts who are placed in 'Segment 4' of the Oversight Framework, the national Recovery Support Programme (RSP) (which used to be called 'special measures' provides "focused and integrated support, working in a coordinated way with the ICB, regional and national NHS England teams".[30]

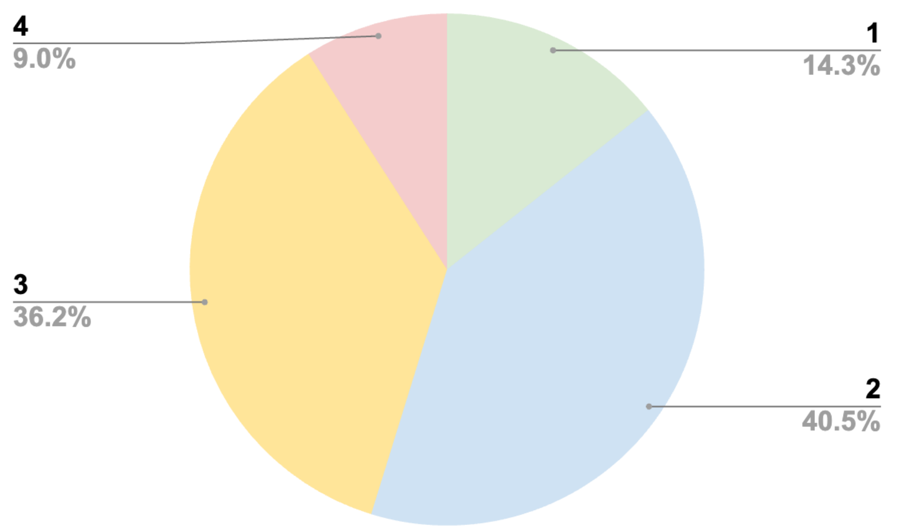
- An ICB or trust is eligible to be considered for mandated intensive support and entry to segment 4 if, in addition to the considerations for mandated support above, any of the following criteria are met:
  - Longstanding and/or complex issues that are preventing agreed levels of improvement for ICBs or trusts or;
  - A significant underlying deficit and/or a significant actual or forecast gap to the agreed financial plan or;
  - A catastrophic failure in leadership or governance that risks damaging the reputation of the NHS

- On entering the RSP, a diagnostic stocktake, involving all relevant trust, system, regional and national partners, will:
  - identify the root cause(s) of the problem(s) and the structural and strategic issues that must be addressed
  - recommend the criteria that must be met for the system or organisation to exit mandated intensive support (exit criteria)
  - review the capability of the ICB's or trust's leadership.

30. NHS Oversight Framework [link] p. 20

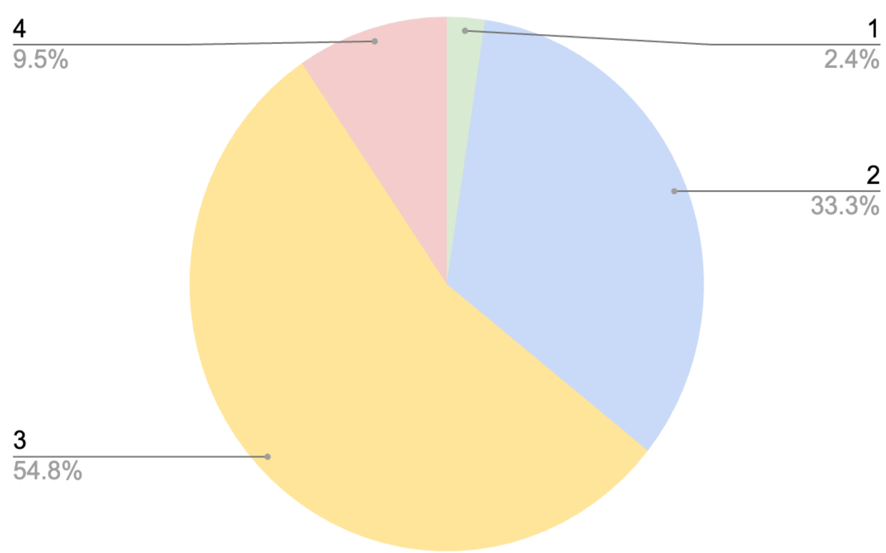
- NHS England has the option of using its statutory powers, including the power to issue directions where an ICB is failing or is at risk of failing to discharge any of its duties, conferred by section 14Z61 of the National Health Service Act 2006 (as amended). There was no recorded use of these powers during 2022/23.

Figure 1 – Proportion of Trusts Currently in Each 'Segment' of NHS Oversight Framework (December 2023/January 2024)



Source: NHS oversight framework segmentation [link]

Figure 2 – Proportion of Integrated Care Boards Currently in Each 'Segment' of NHS Oversight Framework (December 2023/January 2024)



Source: NHS Oversight Framework Segmentation [link]

- The vast majority of trusts (76.7%) in the NHS sit between segments 2-3 for performance according to the NHS Oversight Framework.
- Twenty-one trusts, and three integrated care boards, remain in the Recovery Support Programme, which applies to trusts in segment 4 of the National Oversight Framework and means they receive "mandated intensive support".[31]

There is a view amongst some NHS leaders that NHSE has sought to encourage ICBs to take on a greater performance management role of the providers on their 'patch', thus adding new responsibilities and a new layer of assessment, rather than delegating existing oversight. "This 'middle layer" of oversight has become "too crowded and too burdensome", one ICB leader has recently commented.[32] There is also an important debate to be had about whether these approaches accurately capture the ways we may wish to assess an NHS organisation overall, or whether we give each assessment element appropriate weighting.

The new Government have suggested the introduction of 'league tables' with which the public would be able to more easily appraise and compare NHS providers. We might – for instance – consider the weighting given to the volume (and quality) of clinical research activity an organisation undertakes, given this is often a key marker of improved care quality. There is also a strong case to give greater weighting to patient feedback and opinion as a marker of care quality – this is a subject to which we return in the final chapter of this report.

Challenge 2: The Productivity Problem

> *"It needs to be stressed that falling productivity doesn't reduce the workload for staff. Rather, it crushes their enjoyment of work. Instead of putting their time and talents into achieving better outcomes, clinicians' efforts are wasted on solving process problems, such as ringing around wards desperately trying to find available beds."*
>
> **The Rt Hon. Professor the Lord Darzi of Denham**, Independent Investigation of the National Health Service in England

As the economist Paul Krugman famously said of productivity: 'productivity isn't everything. But in the long run, it is almost everything.'[33] NHSE has recently revealed that acute hospital productivity is roughly 11% lower than outputs in 2019 (see Fig. 2).[34] Yet, the DHSC allocated NHSE a budget of £152.6 billion in 2022–23 (£28.4 billion more than its budget in 2016–17 at 2022–23 prices).[35] The number of doctors working in emergency medicine has nearly doubled over the past 13 years to 9,600 and ambulance staff numbers have increased by around 50% in the past

31. 'Recovery Support Programme, NHS Oversight Framework 2022/23', *NHS England*, (last accessed 12th June 2024) [link]
32. Kathy McLean, 'Making ICBs performance managers will slow integration', *Health Service Journal*, 8 August 2024 [link]
33. 'Productivity isn't everything, but in the long run, it's almost everything', *McKinsey*, February 16th 2021 [link]
34. Julian Kelly, 'NHS productivity', *NHS England*, 16th May 2024 [link]
35. 'Access to urgent and emergency care', *House of Commons Public Accounts Committee*, 16th October 2023, p8 [link]

the past 11 years (see analysis from the Institute for Fiscal Studies, depicted in Fig. 4 below).[36] Despite more funding and more staff than it had pre-pandemic, NHS productivity decreased by 23% over the two years 2019–20 and 2020–21.[37] Total inputs into the NHS (including labour and capital) grew by 24.2% in 2021, while hospital and community output fell by 19.9%.[38] This is not a uniform position across all NHS services, however. General practice, for instance, is delivering 20% more appointments per month than it was in August 2019.[39]

This is an issue across the four devolved nations of the United Kingdom and creates a highly challenging situation for sustainable delivery of services, for demand upon healthcare services across OECD countries rises on average by 4% a year. The NHS Long Term Workforce Plan, however, is predicated upon an assumption of 1.5-2% per annum growth in labour productivity over the next fifteen years.[40] Can we be sure that this productivity will materialise? The evidence of recent months suggests not.[41] The most recent Budget included £3.4 billion for the NHS tied to a commitment for the NHS to deliver 1.9% average productivity growth from 2025-26 to 2029-30, rising to 2% over the final two years.[42] It is not yet clear if the new Government will commit to these plans.

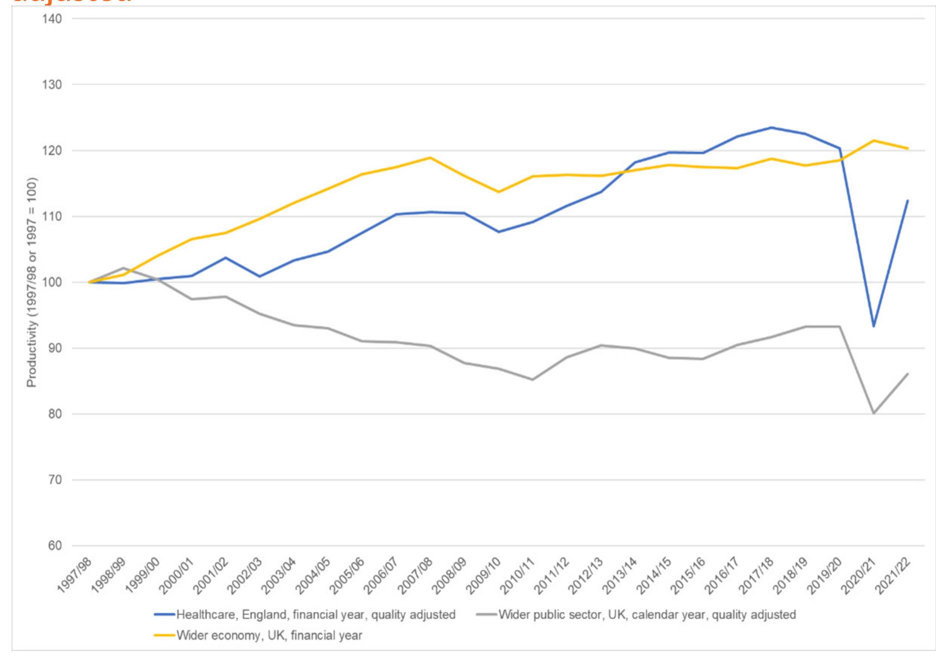
These findings have stimulated a wide-ranging debate in recent months.[43] Many factors have been postulated for this development, ranging from staff burnout, a lack of investment in key equipment and facilities to the changing skill-mix and experience of staff. According to the Nuffield Trust, the proportion of new nursing registrants (less than a year on register) nearly doubled from one in 27 in 2018 to one in 14 in 2023. Non-UK nurse joiners also doubled in proportion from 21% six years ago to 42%. Over a third (34%) of all nurses and midwives under 35, compared to 28% in 2015. [44]

Others have suggested that the result of a reduction in non-clinical managers has played a significant role. Yet, counterintuitively, between 2010 and 2018, productivity in the NHS grew faster than in the wider economy at a time the overall number of managers was reduced.[45]

This likely wasn't due to constraining management numbers, however, but due to limits to capital investment and running many services 'hot'. For instance, bed numbers fell over the period, leading to high – and ultimately, unsustainable – occupancy rates.

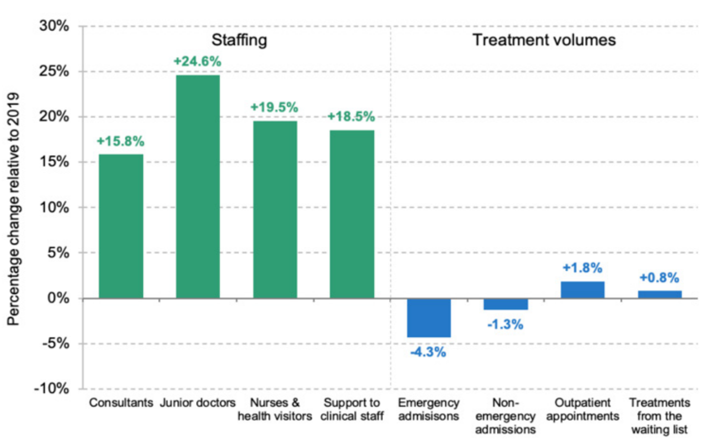
36. Max Warner, Ben Zaranko, 'Is there really an NHS productivity crisis?', *Institute for Fiscal Studies*, 17th November 2023 [link]
37. Matt Discombe, "MP says NHS 'shambles' if fault of 'utterly useless managers', *Health Service Journal*, 9th January 2023 [link]
38. Sara Zella, Ryan Powell, 'Public service productivity, healthcare, England: financial year ending 2021', *Office for National Statistics*, 29th March 2023 [link]
39. 'GPs have seen a 20% workload increase and appointments growing in complexity, says College Vice Chair', *Royal College of General Practitioners*, 2nd October 2023 [link]
40. 'NHS Long Term Workforce Plan', *NHS England*, 30th June 2023 [link]
41. James Lewis, 'Public service productivity, healthcare, England: financial year ending 2019', *Office For National Statistics*, 2nd February 2021 [link]
42. Letter from Rt Hon Jeremy Hunt to Lord Bridges of Headley, 'Long-run projections of public spending and public sector productivity', 16th April 2024 [link]
43. Sam Freedman, Rachel Wolf, 'The NHS productivity puzzle: Why has hospital activity not increased in line with funding and staffing?', *Institute for Government*, 13th June 2023 [link]
44. Lucina Rolewicz, 'The changing experience levels of NHS staff', *Nuffield Trust*, 7th March 2024 [link]
45. 'NHS Managers: Performance and Efficiency', *UK Parliament Hansard*, 1st March 2022 [link]

Figure 3 – Public sector healthcare productivity statistics published for 1997/98-2021/22 (financial year), England only, quality adjusted



Source: Julian Kelly, Report: 'NHS productivity', NHS England Board Meeting Papers, Agenda item: 6 (public session), 16 May 2024 [link]

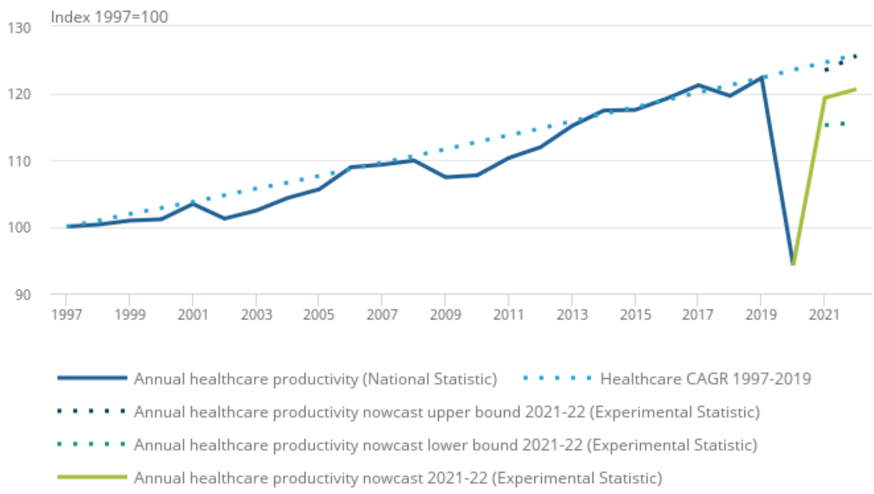
Figure 4 – Hospital staffing and treatment volumes in 2023 (compared with 2019 figures)



Note: Staffing is measured in full-time equivalents. Outpatient appointments only include attended appointments. Treatments from the waiting list are also included in outpatient appointments and non-emergency admissions. Hospital staffing refers to staffing in acute NHS trusts, and compares January–July 2023 with January–July 2019. Hospital treatment volumes compare January–September 2023 with January–September 2019.

Source: Max Warner & Ben Zaranko, 'Is there really an NHS productivity crisis?', Institute for Fiscal Studies, 17 November 2023 [link]

Figure 5 – Total public service productivity, "Annual healthcare productivity on a quality-adjusted basis is estimated to be 5.5% below pre-coronavirus (COVID-19) pandemic levels, using ONS lower bound estimate"



Source: Public service productivity from the Office for National Statistics

Source: 'Public service productivity, UK: 1997 to 2022', Office for National Statistics [link]

Challenge 3: Public Satisfaction

Public satisfaction with the NHS has fallen in recent months to the lowest recorded levels since the British Social Attitudes survey (the most significant and robust annual assessment of attitudes on the matter) was first published in 1981. According to the most recent survey, published in March 2024, less than a quarter of people are satisfied with the way the NHS is running overall – a fall of 5 percentage points from the previous year. The pandemic clearly had an impact on the public's overall impression of NHS services. Since 2020, satisfaction has fallen by 29 percentage points. Since 2019, satisfaction with GP services has fallen by 34 percentage points. The key priorities for the public, according to respondents include: making it easier to get a GP appointment (52%), increasing the number of staff in the NHS (51%), improving waiting times for planned operations / elective care (47%) and improving waiting times in A&E (45%).[46] As Policy Exchange research has previously shown, insufficient or inadequate patient communication, or an inability to accurately coordinate care between different settings across an 'interface', e.g. between general practice and hospital outpatients are also significant drivers of dissatisfaction and have been historically under-prioritised as areas for targeted reform and action by policymakers.

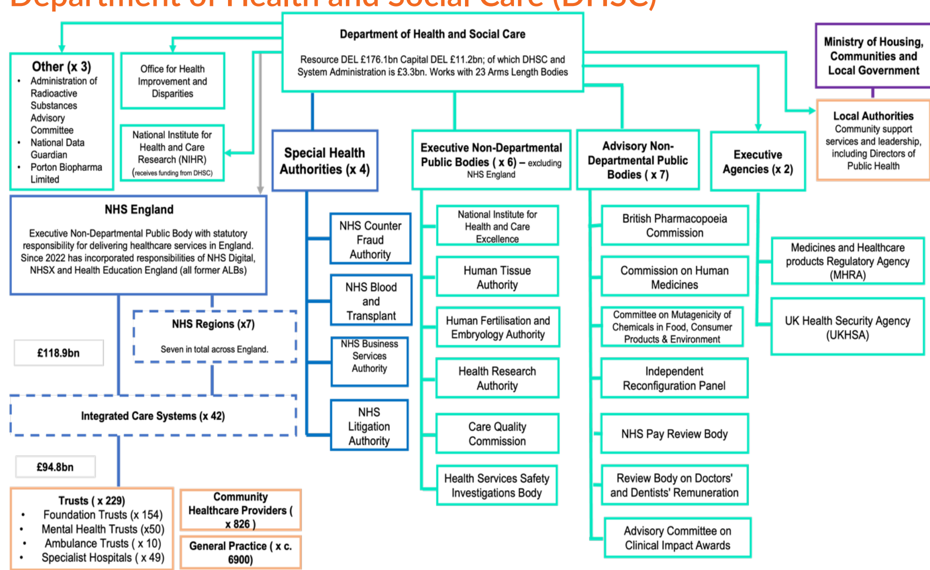
46. Public satisfaction with the NHS slumps to new record low, *The King's Fund*, 27 March 2024 [link]

Possible Driver 1: Politics & Providers

The Secretary of State for Health and Social Care is accountable for an immensely complex institutional ecosystem governing and regulating health and care services. Figure 6 below represents at attempt at visualising this complexity. As we have put it in a recent report, "rather than a slow-moving 'super-tanker' (as it is sometimes described), the NHS ought to be regarded as a large, unwieldy flotilla – often proving challenging for ministers to 'grip'".[47]

Nicholas Timmins once said that "organisation, re-organisation and re-disorganisation" might well be dubbed the NHS disease."[48] Since 1974, there have been over forty significant structural reforms to the NHS. Yet, the "organisational learning between them appears non-existent".[49] As recently as 2022, NHS England (NHSE), Health Education England and NHS Digital had a combined total of 24,300 posts.[50] But these posts have since been reduced by 30 per cent in all, with the three organisations merging into a 'new NHS England'. Over the next two years NHSE will transfer more further posts to integrated care boards (ICBs), for example as a result of the delegation of specialised commissioning and of vaccination and screening services.[51] As of 31 March 2023, NHSE directly employed 15,172 staff. [52]

Figure 6 – Institutional Architecture for the Governance and Regulation of Health and Care Services in England through the Department of Health and Social Care (DHSC)



Source: Based upon Department of Health and Social Care Annual Report and Accounts 2022-23 [link]

While there has been recent change at the 'centre', it is equally true of the 'intermediate tier'.

As of today, responsibilities, cooperation and accountabilities between

47. Sean Phillips, 'Mission Critical: The Secretary of State for Health and Social Care's First Hundred Days', *Policy Exchange (July 2024)* [link]
48. Nicholas Timmins, 'Never Again? The story of the Health and Social Care Act 2012', *The Kings Fund*, 11th July 2012, p.16 [link]
49. For a review of limited evaluation of quality improvement initiatives in maternity care between 2010 and 2023, see: James McGowan, Bothaina Attal and Isla Kuhn et al ., 'Quality and reporting of large-scale improvement programmes: a review of maternity initiatives in the English NHS, 2010-2023' *BMJ Quality & Safety*, 29 November 2023 [link]
50. Dave West, '6,000 plus jobs to be at 'new NHS England'', *Health Service Journal*, 7 July 2022 [link]
51. Dave West, 'NHSE declares rationalisation is over after cutting 7,000 posts', *Health Service Journal*, 16 May 2024 [link]
52. 'Annual Report and Accounts 2022-23', *NHS England*, 25th January 2024 [link]

ICBs and Foundation Trusts remain unclear and unsettled two years after the passage of the Health and Care Act (and eighteen months on from the Hewitt Review). Much like Michael Lambert has noted – with reference to the Morecambe Bay Inquiry – the "intermediate tier" lacks "a single regional policy architecture to manage relations across functional domains".[53]

Table 3 – NHS Foundation Trusts and Integrated Care Systems – Explained

Foundation Trust(s)	• Of the 229 hospital trusts across England, 154 are Foundation Trusts (FTs) • The first FTs emerged in 2004, developed as public benefit corporations – a form of socially owned institution similar to a cooperative society or mutual organisation. • They are subject to a governance regime that replaced accountability to Whitehall with accountability mechanisms to their local population through a board of governors and a management board, as well as regulators (when set up, the Commission of Healthcare Improvement' and 'Monitor' for finance and governance). • Whilst FTs follow national guidelines, targets, standards and principles as set out in the NHS Constitution, the model envisaged FTs to possess a significant degree of operational independence from central Government, including the free to determine their own pay, to retain surpluses and fewer restrictions on the disposal of assets with which to raise capital.
Integrated Care System(s)	• Placed on a statutory basis with the Health and Care Act 2022, 42 integrated care boards (ICBs) cover populations of between 500,000 and 3,000,000 people). • The ICB has a statutory responsibility for commissioning services in across a defined geography. • In addition to the ICB, each Integrated care system (ICS) has an integrated care partnership (ICP). The ICP operates as a forum to bring partners – local government, NHS and others – together across the relevant geographical footprint.

Perhaps the key conundrum facing policymakers today lies in whether to give Foundation Trusts greater power (or at least maintaining their current levels of autonomy), or providing ICBs with greater powers to determine how many is spent and services are delivered across all the

53. Michael Lambert, 'A history of the intermediate tier in the English NHS: Centre, region, periphery', *Social Policy & Administration*, 28th February 2024, pp. 1-14 [link]

relevant providers over the geography it serves.[54] Fig. 7 below shows that since 2017, no Foundation Trusts have been established, whilst Fig. 8 shows the proportion of providers within each ICB geography that have Foundation Trust status. In some ICBs, such as Bedfordshire Luton & Milton Keynes, every provider within its geography has Foundation Trust status, whilst in Herefordshire and Worcestershire, none currently do.

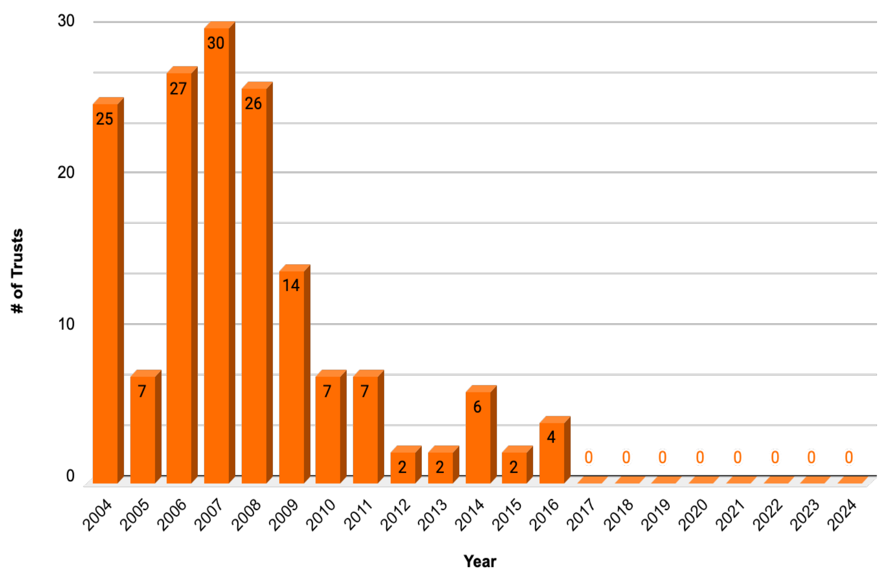
From 2010, "aspects of its health reform agenda – tariff, competition policy and devolution… helped Foundation Trusts become and remain much more independent." [55] But this has since unwound – particularly since the passing of the Health and Care Act (2022) which placed ICSs on a statutory footing. "Collaborative working" which systems seek to instil has been welcomed, but balancing system and individual responsibilities has proven a difficult balancing act.[56]

One study into ICSs across the English NHS notes that while "collaborative working was welcomed by system members", "the agreement of local governance arrangements was ongoing and challenging, with concerns that system priorities could run counter to organisational interests."[57] A senior leader in the NHS that we have spoken to for this report reflected that the ICS had 'almost nothing to do' with the day-to-day running of the Trust. The – at times – frustrated Provider-Commissioner dynamic which characterised the relationship between Trusts and Clinical Commissioning Groups (CCGs) a decade ago has lived on amidst recent structural changes.[58]

As such, some have suggested narrowing the focus and responsibilities of ICBs so their work targets primary and community care and the 'pivot to prevention', leaving secondary care to trusts and provider collaboratives, overseen by NHSE. Others are more firmly of the view that ICBs must provide the "continuum" in health services, from public health to specialist services.[59] Bill Shields, the chief financial officer and interim chief executive officer of the Devon ICS has stated: "I think the two models that we've got are going to become increasingly incompatible, it has to be one or the other, and then decide on that one…because at the moment, I think we've got this situation with two competing elements who could actually lead the system. I don't know that they're compatible with each other."[60] If they are to succeed, some have argued, ICSs must become "systems convenors and transformers", and not simply system regulators and inspectors (as Mike Farrar and Andy Cowper have put it).[61] These relationships and responsibilities remain unclear, however, with significant implications for the day-to-day running of the NHS.

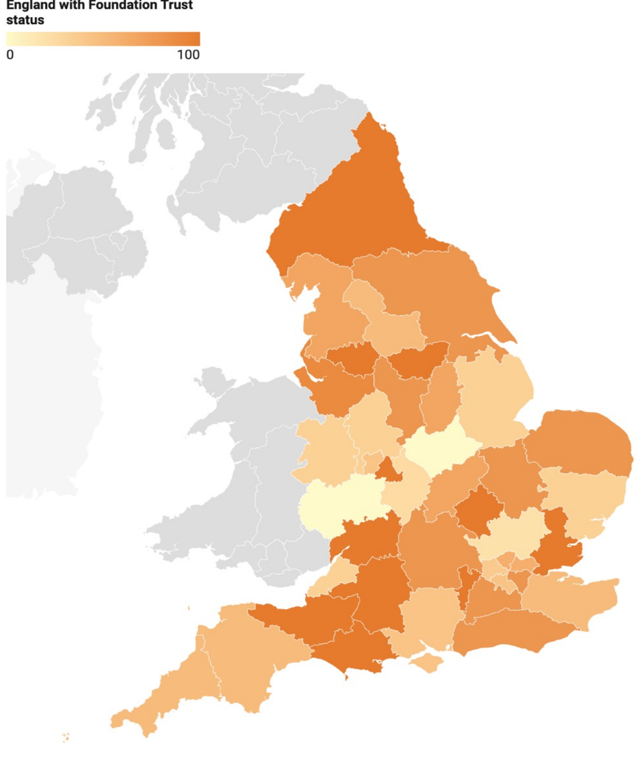
54. *Note: Foundation Trusts were placed on a statutory footing in 2003 and are regarded as one of the central reforms of the 'New Labour' years in the NHS. Their purpose was to provide greater freedoms to providers to seek additional income and capital for investment from a wider range of sources.*
55. Bill Moyes & Paul Corrigan, 'Future Foundations: Towards a new culture in the NHS', *Policy Exchange*, 18th March 2010 [link]
56. Mari Sanderson and Pauline Allen et al., 'Developing architecture of system management in the English NHS: evidence from a qualitative study of three Integrated Care Systems', *BMJ Open*, 8th February 2023 [link]
57. Ibid
58. Henry Anderson, "Hewitt's ICS using health inequality cash to 'offset deficit'", *Health Service Journal*, 31st May 2024 [link]
59. Dave West "'Keep the faith in ICBs' urges national leader', *Health Service Journal*, 30th May 2024 [link]
60. Henry Anderson, "Money 'leaching' from NHS due to patient choice policy, says ICS boss", *Health Service Journal*, 12th December 2023 [link]
61. Mike Farrar, Andy Cowper, 'Getting to the point of health systems', *Health Policy Insight*, 13th June 2023 [link]

Figure 7 – Number of NHS Organisations authorised as NHS Foundation Trusts for the First Time



Source: Lord Darzi of Denham, Independent Investigation of the National Health Service in England, DHSC, September 2024 [link]

Figure 8 – The Proportion of Providers (%) within each Integrated Care System (ICS) Footprint with Foundation Trust Status



Source: Policy Exchange analysis of the 'System directory', NHS England [link]

All the while, we have seen the emergence of groupings of trusts (such as provider collaboratives), as well as Chairs and CEOs in common, who may have a shared leadership team but have not undergone the formal process of a merger. For instance, Barts Health and Barking, Havering and Redbridge Trusts have said they will move to create a single executive team, while Hull University Teaching Hospitals and Northern Lincolnshire and Goole FT appointed a shared CEO in early 2024.[62] Another example can be found with the "Southern Ambulance Services Collaboration" which will jointly fund work to harmonise driver training (which is not currently recognised when staff move between trusts, meaning they have to retrain).[63]

Into this mix is the issue of complicated (and often, blurred) lines of accountability between NHS providers and elected politicians. It is worth remembering that operational independence for the NHS at a national level has a short history, dating back (legislatively) to the Health and Social Care Act 2012, and intellectually, to a white paper the Conservative Party produced in Opposition in 2007 called 'NHS Autonomy and Accountability'.[64] The creation of ICSs has however further devolved power from DHSC and ministers, as the recent Hewitt Review reflects: "The [DHSC] needs to accept that provider trusts and ICBs do not report to them".[65] This is by no means an entirely new phenomenon, however. "The dirty secret", as Paul Corrigan, recently appointed as Strategic Advisor at DHSC once noted, is that "the NHS command-and-control management style is that it is all command and no control."[66]

Possible Driver 2: Process Problems

> *"Think really hard about senior management structure…Big productivity has come through process change."*
>
> **Professor Diane Coyle[67]**

The major issues of the NHS have been described as "failures of process, coordination and communication."[68] 'Better organisation' – not necessarily 'more staff' alone – has been regarded as key to future improvement.[69] As one senior NHS England leader has recently remarked, systems must "get back [their] operational process muscle" and not expect problems just to be solved by further investment to boost capacity.[70]

Take the current NHSE target for an 85% day case and 85% theatre utilisation for elective care.[71] Getting it Right First Time (GIRFT) have a theatre productivity programme which trusts are recommended to use to meet the target, but there is significant variation in uptake and performance.[72] The following conclusion from a recent study is relevant: "the role of a theatre manager is all too often devolved to relatively junior staff unacquainted with the literature, because the role might be assumed to require only common sense. Hence, erroneous goals (starting on time, maximizing utilisation or booking to the mean) are applied.[73]

The pioneering work of Professor Anita Tucker in the United States

62. Nick Carding, 'City's two acutes to share CEO and chair', *Health Service Journal*, 6th December 2023 [link]
63. Alison Moore, 'Five trusts join forces on AI and procurement', *Health Service Journal*, 23rd May 2024 [link]
64. Anna Dixon, 'Freeing the NHS from politics', *The Kings Fund*, 26 May 2010 [link]
65. Rt Hon Patricia Hewitt, 'The Hewitt Review', *Gov.uk*, 4th April 2023 [link]
66. Paul Corrigan, 'The Mechanics and Morality of Change in the NHS', *Health Matters*, 8th January 2024 [link]
67. 'The Productivity Policy Agenda with Diane Coyle', *The Productivity Institute*, October 21st 2022 [link]
68. Steve Black, 'The mythbuster: Former BBC man's fall illustrates why the NHS wastes money', *Health Service Journal*, 6th November 2023 [link]
69. Paul Corrigan, 'Productivity in the operating theatre and the role of logistics', *Health Matters*, 30th May 2024 [link]
70. 'Daily Insight: Flex your muscles', *Health Service Journal*, 21st May 2024 [link]
71. '2024/25 priorities and operational planning guidance', *NHS England*, (last accessed 12th June 2024), p18 [link]
72. Theatre productivity', *NHS England*, (last accessed 12th June 2024) [link]
73. M. Charlesworth & J.J Pandit, 'Rational performance metrics for operating theatres, principles for efficiency and how to achieve it', *British Journal of Surgery, Vol. 107, No. 2* (5th January 2020), pp. 63-69 [link]. On the evidence base around the changing levels of experience of NHS staff, see Lucina Rolewicz, 'The changing experience levels of NHS staff', *Nuffield Trust*, 7 March 2024 [link]

has found that "frontline care clinicians and staff in hospitals spend at least 10% of their time working around operational failures: situations in which information, supplies, or equipment needed for patient care are insufficient."[74] Further research is needed in UK to understand the full extent of the challenge, but recent work from Professor Mary Dixon-Woods and colleagues at the THIS Institute has – for instance – identified operational failures as being "highly consequential for GPs' experiences of work".[75]

There are countless further (non-clinical) examples which 'slow the NHS down'. The "eternal need" for business cases has been described to us "as a decoy for delay and avoiding difficult decisions". It is not clear why business cases might be required to repair broken heating systems or decontamination machines, for instance.[76] This is reflective of a wider set of challenges with the capital regime and our ability to effectively spend the allocation. A recurring pattern in recent years has been for capital budgets to be spent to shore up revenue, whilst managers have struggled to sign-off on projects, or secure capital investment, owing to the 'in-year' approach, limiting the ability to plan over multiple years. As a result, both estates and equipment require significant upgrading over the coming years.[77] Many NHS staff are frequently working with outdated (or failing) equipment; computers that take minutes to boot up or which disconnect arbitrarily. This is regularly cited as a major source of workplace frustration – among the clinical and non-clinical workforce.[78] Constrained capital investment has been a long-standing issue however, with the Institute for Government finding that between 1970 and 2020 in only two years (2007 and 2009) did the UK exceed the OECD average for capital investment in health.[79] There is little doubt that the capital regime, including the current approach by HM Treasury ought to be appraised, but there is plenty that NHS organisations can do internally to streamline the way that projects develop, i.e. through streamlining business cases and sign-off processes.

In addition to these more localised examples, process issues can be driven from levels above in the structural hierarchy. Consider the issue of handling data requests from NHS England and NHS Regions. As one manager put to us, "if we receive ten requests from the Region, that's your whole bandwidth for the day". It is an approach, where the centre seeks "reassurance" but ultimately does not necessarily enhance performance or quality in the process. The Rt Hon Jeremy Hunt MP has recently stated that the NHS is being "micromanaged to death", instead advocating for hospitals to be given the same "freedom to innovate" as academy schools.[80]

The cumulative effect of these influences upon process design have meant that – as a recent survey from the Chartered Management Institute reveals – one in four NHS managers and leaders (27 per cent) say their senior leadership is "ineffective". Most report that management-related issues are now blocking them from effectively recruiting staff and are leading to poor organisational culture.[81] Organisational agility, driven by management and leadership behaviours are also important and can be

74. Anita Tucker, W. Scott Hensler & Laura D. Janisse, 'Designed for Workarounds: A Qualitative Study of the Causes of Operational Failures in Hospitals', *The Permanente Journal*, Vol. 18, No. 3 (2014), 33–41 [link]
75. Carol Sinnott, Jordan M Moxey and Sonja Marjanovic et al. 'Identifying how GPs spend their time and the obstacles they face: a mixed-methods study', *British Journal of General Practice*, Vol. 72, No. 715 (2022), e148-e160. [link]
76. Marcel Levi, 'A Dutchman in London: reflections of a hospital chief executive from the Netherlands in the NHS', *BMJ Leader*, *6*, June 29th 2021, p81-83 [link]
77. Policy Exchange & Nuffield Trust, 'NHS Capital and Infrastructure: Delivering the manifesto and unlocking potential', 4 November 2022 [link]
78. Sarah Johnson, 'NHS IT can't keep up with health service demands, survey of staff finds', *The Guardian*, 20th March 2018 [link]
79. Stuart Hoddinott et al., Fixing public services: Priorities for the new Labour government, *Institute for Government* [link]
80. Eleanor Hayward, Georgia Lambert, 'Jeremy Hunt: NHS is being micromanaged to death', *The Times*, December 6th 2023 [link]
81. Anthony Painter, "The NHS needs to give it's 'accidental managers' more support'", *Health Service Journal*, 27th November 2023 [link]

thought of as a missing driver of productivity.[82]

Possible Driver 3: The Cultural Problem

> *"There lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism... an institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern."*[83]
>
> **Sir Robert Francis**

Ultimately, it is not possible to propose future reforms to the development and function of NHS managers without an exploration of the culture of management. Within an organisation, culture can have significant impacts upon the development of shared values, goals and thereby overall efficiency: Are staff involved in shaping new proposals? Do they feel ownership of them? Do they feel able to highlight areas of concern? Are changes aligned with other strategic priorities and organisational values? Factors such as these will play a significant part in securing support for new ways of working.[84] Culture underpins the way in NHS management "sees itself and operates, is a critical factor in shaping what managers do, how others perceive them, and how they respond to pressure and challenge".[85]

There are many theories on culture, with the overwhelming majority stressing the importance of organisational values, beliefs and purpose. The organisational theorist Edgar Schein helpfully captured culture based upon three principles: 1) basic assumptions and underlying beliefs, 2) espoused values, and 3) artifacts.[86] In short, espoused values must be made real, otherwise a toxic culture will result. Too often, the culture within NHS organisations can prove invidious to its values with adverse consequences for performance and delivery.

One of the most important assessments of NHS management culture in modern times was made by the Bristol Inquiry which reported in 2001. That concluded that "the culture of the future must be a culture of safety and of quality; a culture of openness and of accountability", with the report critiquing an unhealthy "club culture" which had emerged.[87] Unfortunately, it seems clear that this culture still persists in too many parts of the NHS today even in the wake of a series of patient safety reviews over the past fifteen years which have reached similar conclusions.

Whilst many of those we have spoken to for this research indicated that the extant system for encouraging whistleblowing had benefitted from the introduction of Freedom to Speak Up, there remains a culture – evident and sadly widespread – in which individuals feel they cannot, or will not 'rock the boat' by raising concerns. This cultural problem doesn't just impact safety, but performance overall, where less senior managers feel unable to propose changes to processes that could involve difficult conversations with more senior leadership.

The results of the most recent NHS Staff Survey 2023 (published March 2024) show that at a national level, under two-thirds (62.31%)

82. Tim Horton, Anita Mehay & Will Warburton, Agility: the missing ingredient for NHS productivity, *The Health Foundation*, 13 October 2021 [link]
83. Sir Robert Francis KC, 'Report of the Mid Staffordshire NHS Foundation: Executive summary (2013) [link]
84. Tim Horton, Anita Mehay, Will Warburton, 'Agility: the missing ingredient for NHS productivity, *The Health Foundation*, 3rd October 2021 [link] On culture, see: Rowena Jacobs, Russell Mannion, Huw T. O. Davies et al., 'The relationship between organisational culture and performance in acute hospitals', *Social Science & Medicine Volume 76*, January 2012, p 115-125 [link]
85. Judith Smith & Naomi Chambers, 'The regulation and development of NHS managers: a discussion paper, In host publication www.midstaffspublicinquiry.com (2011) [link]
86. Edgar Schien, 'Organisation, Culture and Leadership', 9 December 2016 [link]
87. Judith Smith & Naomi Chambers, 'The regulation and development of NHS managers: a discussion paper, In host publication www.midstaffspublicinquiry.com (2011) [link]

of respondents felt "confident to speak up about anything that concerned them". Just half (50.07%) of respondents meanwhile were "confident that their organisation would address their concern". Just half (51.86%) of staff responding who had experienced harassment, bullying or abuse said that they or a colleague had reported it.[88]

The most recent Freedom to Speak Up Guardian survey found that almost two-thirds of respondents (66%) reflected that 'nothing will be done' as a barrier to speaking up within their organisation. As a review of this recent survey put it, "feelings of futility [are] on a par with the fear of detriment as the main barrier to speaking up".[89]

These findings have particular significance for certain parts of the NHS. The worm of community healthcare teams is highly devolved. "You cannot have command and control approach when people are working autonomously", as one interviewee put it to us. There is, therefore, something different required with respect to the leadership culture required, where the freedom to speak up, to be open about risks in a timely and effective way are equally – if not even more – important.

Organisations in some sectors (e.g. acute care) seemed better prepared to implement policies relating to openness than others (e.g. in mental health services and ambulance trusts). These challenges relate in part to the features of these different sectors (e.g. the more hierarchical cultures typically found in ambulance services).[90]

88. 'National Results', *NHS Staff Survey*, 2023 [link]. See the results of q25e, q25f for results quoted here.
89. 'Freedom to Speak Up Guardian Survey 2023', *National Guardian* [link]
90. Graham Martin, Sarah Chew, Mary Dixon-Woods, 'Senior stakeholder views on policies to foster a culture of openness in the English National health Service: a qualitative interview study', *Journal of the Royal Society of Medicine*, 3 December 2018 [link]. See also responses to this challenge, Siobhan Melia, Culture Review of Ambulance Trusts: Commissioned by NHS England, February 2024 [link]

Chapter 2 – A Portrait of NHS Management

"The key is to root out unnecessary administrative cost, and to spend money on the right thing – frontline care"

Labour Party General Election Manifesto (1997)[91]

"We've trained 7,000 more nurses, we've got 9,000 more nurses, we've got 9,000 more doctors, and we also managed to take out of the NHS 20,000 bureaucrats; because I want the money spent on patient care"

Rt Hon David Cameron MP during the 2015 General Election Campaign[92]

"We've got too little management, we're a £150bn organisation, and we've got less managers than most organisations half our size"

Dame Clare Gerada, Co-Chair, NHS Assembly (2023)[93]

What is an 'NHS Manager'?

The administration of healthcare services in Britain stretches back beyond the foundation of the NHS in 1948, but the importance of administrators, who have since become 'managers', has grown as the healthcare system has grown in size and complexity. The Appendix of this report contains a comprehensive overview and timeline of the policy interventions and developments regarding management and leadership since the foundation of the NHS.

Despite this, as a prescient King's Fund analysis puts it, "we know remarkably little about the NHS management workforce – how many managers there are and what they do; who they are and where they come from; what training or educational backgrounds they have and how much that prepares them for management; how they come to work in management roles and what place this has in their career; and how their management careers progress or develop over time."[94] As the authors of that report rightly identify, "while for clinical occupational groups in the NHS (such as doctors, nurses and therapists) substantial effort has been invested in workforce planning, with the intention of matching current and future workforce capacity (in terms of both numbers and skills) to the needs of the NHS and understanding current and future career patterns and trajectories, no similar work has been undertaken for NHS management."[95]

91. 'Labour Party Manifesto, 1997 General Election', *Archive of Labour Party Manifestos*, (last accessed 12th June 2024) [link]
92. 'Leaders' Debate- 'How Will You Protect Our NHS?', *YouTube, 2nd April 2015* [link]
93. Henry Anderson, 'Fewer managers calls are nonsense, says NHS England review author', *Health Service Journal*, 23rd June 2023 [link]
94. Kieran Walshe, Liz Smith 'The NHS management workforce', *Kings Fund and Manchester Business School*, 2011, p.5 [link]
95. Ibid

Today, there remains a significant information gap which has been reflected in public policy and public perceptions regarding NHS management. As outlined in the Executive Summary, the public generally hold 'front line staff' in higher regard than 'managers'. Indeed, a recent analysis from the Policy Unit at King's College London reveals that half of the public believe there are "too many managers in the NHS". Only 12% believe there are "not enough managers". 46% of people surveyed believed that they weren't "worth what they were paid". A significant majority (63%) felt that managers "create bureaucracy that is a burden on other staff".[96] Yet a comparison of with comparator healthcare systems in Europe and North America (See Fig. 10, below) reveals that the UK spends proportionately less than others on administration (just under 2%, similar to Sweden).

NHS management encompasses a wide range of functions. In the hospital setting, this can be broadly categorised into three related activities: management of staff, management of budgets and management of patients.[97] These can include the organisation of clinical activity, performance analysis (against national and local standards, overseeing financial matters and governance (of operational matters, professional standards etc)).[98] A useful survey on NHS management published showed that the 'NHS Careers' website then listed seventy-eight categories of manager (including clinical management, human resources management, IT and financial management). There was "no data available" on which category of management had seen the most growth in the preceding years.[99]

The Binley's Database of NHS Management, supplied by Wilmington Healthcare, which has been collected and published since 1991 (and updated every four months) defines a 'managerial' role to any individual with decision-making power, specifically in relation to budgeting, financial management and allocation of resources. Over one hundred such roles are listed.[100] An 'NHS Manager' can, therefore, be considered to be staff who have supervisory responsibilities, staff with 'manager' in the title or staff who have a position at director level. Yet, according to that definition, all of those who may have managerial responsibilities at not captured by what is currently the most complete data on the total volume of managers working in the NHS, the monthly NHS Hospital and Community Health Service (HCHS) data which records the total number of 'senior managers' and 'general managers' working in the NHS.

An analysis of the Binley's database by Professor Ian Kirkpatrick and Professor Becky Malby counted 25,119 managers in the NHS as a whole in 2018/19.[101] The figure meanwhile increased to 31,361 if roles such as clinical leads were included, i.e. 'hybrid professional managers'.[102] But these figures do not encompass GP practice managers for instance, nor those working at 'the centre'. In written evidence to the Senior Salaries Review Body last year, DHSC estimated that there were 2778 Very Senior Managers (VSMs) working in NHS Trusts and (then) Clinical Commissioning Groups (CCGs).[103] They estimated that there were a

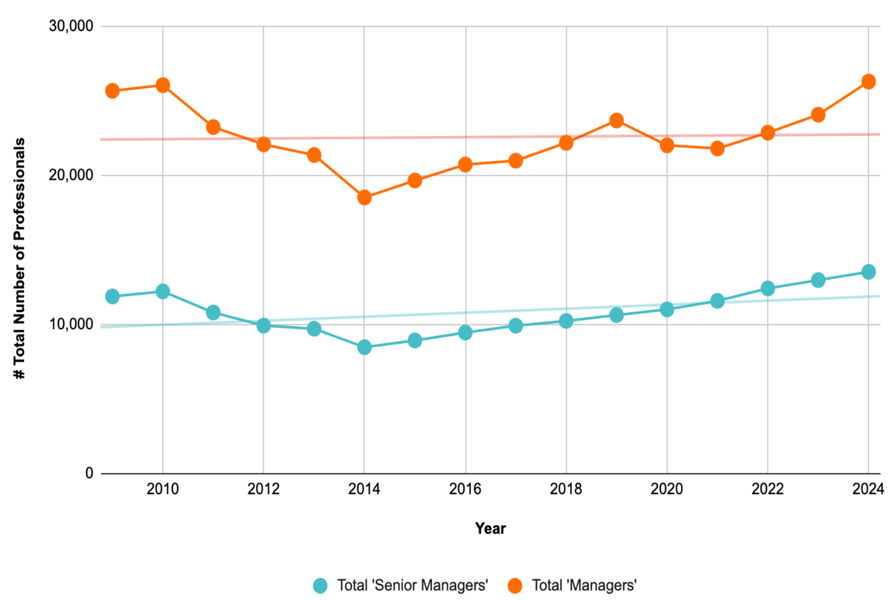
96. 'Attitudes to pay and management in the NHS', *Ipsos/King's College London*, July 2024 [link]
97. Miqdad Asaria, Alistair McGuire, Andrew Street, 'The impact of management on hospital performance', *Fiscal Studies*, 9th December 2021 [link]
98. Kirean Dingley, 'What is a NHS hospital manager (and what do they do)?', *Chronic Kidney Disease Explained*, 12th March 2024 [link]
99. 'General Election 2010', *The Kings Fund*, (last accessed 12th June 2024) [link]
100. 'Healthcare Customer Data', *Wilmington Healthcare*, (last accessed 12th June 2024) [link]
101. Ian Kirkpatrick and Becky Malby, 'Is the NHS overmanaged?', *NHS Confederation*, 24 January 2022 [link]
102. Ian Kirkpatrick, Ali Atanlar, Gianluca Veronesi, 'Hybrid professional managers in healthcare: an expanding or thwarted occupational interest?', *Public Management Review*, 25th October 2021 [link]
103. DHSC's written evidence to the Senior Salaries Review Body (SSRB) 2021 to 2022, *DHSC* [link]

further 470 Executive Senior Managers working in Arms-Length Bodies such as the CQC and Public Health England.[104]

The Database of NHS Management indicates that across the NHS as a whole, 3,829 management roles were held by doctors. This amounts to 15.2 per cent of all managers in the database and, in England only, to 3.2 per cent of the medical workforce. Such figures suggest a relatively low level of participation in management roles, although this increased slightly when more operational, clinical leadership roles, were included. In 2018, there were 2,721 clinical leads in the NHS (over 80 per cent operating in the English acute care hospital sector), the vast majority of whom were doctors.[105] Women made up a majority (ca. 57 per cent) of managers and just under 50 per cent of senior roles (including board membership).[106]

An important caveat to all commentary regarding NHS management at present is however, that – as a recent Health Foundation blog piece notes – "we don't…know for certain how many NHS staff have management responsibilities, let alone whether they have the training and support necessary to do their jobs effectively. The national statistics we have miss large numbers of clinicians who have management responsibilities, and there is a dearth of up-to-date evidence about the day-to-day experiences of NHS managers."[107]

Figure 9 – The Total Number of 'General Managers' or 'Senior Managers' Working in the NHS, 2009-2024



Source: NHS Workforce Statistics [link].

Data for earlier periods is also available. For data from 1995, see: https://hansard.parliament.uk/Commons/1996-12-03/debates/392a3a57-bae5-4656-a65b-d5dff35ee588/NhsManagers & https://files.digital.nhs.uk/publicationimport/pub00xxx/pub00716/nhs-staf-1995-2005-over-rep.pdf

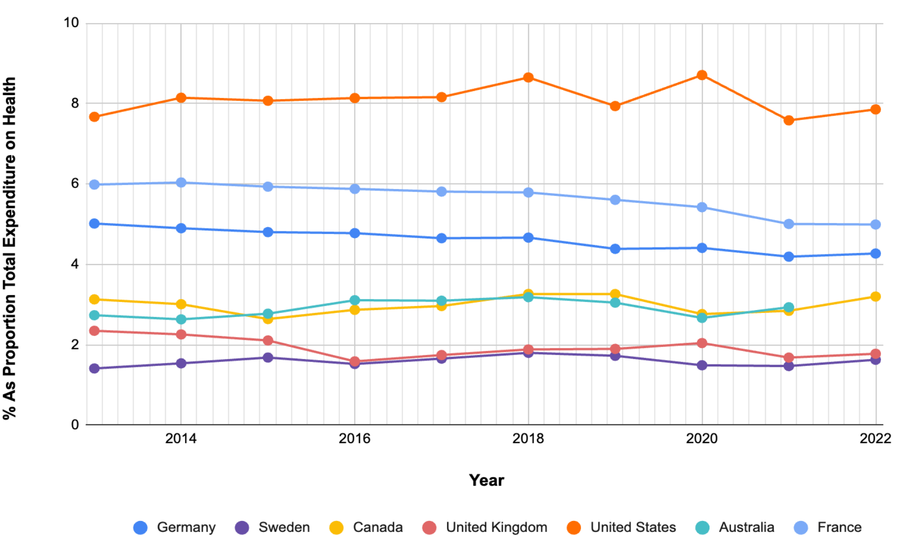
104. Ibid
105. Ibid
106. Brian Kirpatrick, Becky Malby, 'Is the NHS overmanaged?', *NHS Confederation*, 24th January 2022 [link]
107. Bryan Jones & Tim Horton, 'In defence of NHS managers: a response to the Conservative plan to cut 5,500 posts', *The Health Foundation*, 5 June 2024 [link]

Note: 1995 figures include 6,660 practice managers employed by general practitioners, and excludes managers who need to be qualified health care professionals to do their job. Later figures discount independent contractor services, such as general practice and community interest company providers.

Who is and who is not an 'NHS manager' has been subject to debate – a finding echoed in responses to the FOI requests we issued and discussed in later chapters. NHS organisations currently use a range of definitions. Several trusts in response to our FOIs pointed out that many of their employees with the word 'manager' in their title were, in fact, not managing anybody at all. There can also be a blurring of those in dedicated, non-clinical managerial roles and clinical professionals – particularly in acute hospital trusts – who undertake some part-time managerial responsibilities.[108]

Several trusts responded by telling us that their internal Electronic Staff Record (ESR) system did not have a function for summarising details on those in managerial roles. This confusion around definitions can make it difficult for the system to plan workforce effectively. One interviewee we spoke to told us that managers are often hired on an 'ad-hoc' basis according to immediate need, without a full perspective on how staffing levels could impact capacity.

Figure 10 – Proportion of Expenditure on 'Administration' as a Proportion (%) of Overall Healthcare Spending, International Comparison



Source: OECD Data Explorer [link]

108. Ibid

How Are Managers Trained and Leadership Developed?

NHS managers come from a variety of backgrounds – both clinical and non-clinical, the medical and healthcare professions, accountancy and law, estates, engineering, IT, human resources and other branches of both public and private sector. There is no single route to entry, nor any standard mandatory qualifications or training requirements.[109]

The majority of managers (82%) in the NHS begin either as clinical staff or administrative staff and progress to positions of management as they serve more time and gain experience.[110] They receive little in the way of formal training as their career progresses into mid-level positions, however, and have been described as 'managers by accident' as a result.[111] The NHS's formal educational programme for managers, the Elizabeth Garrett Anderson Programme, is mostly reserved for those seeking 'leadership' roles in the NHS.

There are also apprenticeship programmes such as the Edward Jenner Programme and other provider-specific schemes. These schemes are all delivered by the NHS Leadership Academy.[112]

The Elizabeth Garrett Anderson Programme provides management training for two different groups: those at mid-career level who want to move into leadership, and for trainees on the NHS's Graduate Management Training Scheme (GMTS). In 2021, 350 graduates took part in the GMTS.[113] Graduates on the GMTS often become senior leaders in the NHS. Indeed, all three Chief Executives of NHS England have been graduates of the Scheme.

Training programmes offered by the NHS are delivered through the NHS Leadership Academy which sits within the 'People Directorate' within NHS England.[114] It currently offers the following programmes:

Table 4 – Training development programmes currently offered by the NHS Leadership Academy (as of July 2024)[115]

Programme Name	Description / Comments
EDWARD JENNER PROGRAMME	A programme designed for aspirant leaders (looking to move into management role in 1-2 years).[116]
MARY SEACOLE PROGRAMME	A six-month leadership development programme offered to NHS workers who have a formal leadership role.[117]
ROSALIND FRANKLIN PROGRAMME	A nine-month course designed for clinicians and managers in the middle of their career who already have responsibility for a team, looking for the next step into a leadership role.[118]
ELIZABETH GARRETT ANDERSON PROGRAMME	Twenty-four-month master's degree programme to create the next generation of NHS managers.[119] This programme is the most popular on offer and is used by graduates entering the GMTS scheme.[120]

109. David Oliver, 'As a doctor I don't believe regulation of managers should be a priority', *Health Service Journal*, 28th September 2023 [link]
110. Anthony Painter, "The NHS needs to give its 'accidental managers' more support", *Health Service Journal*, 27th November 2023 [link]
111. Ibid
112. 'NHS Long Term Workforce Plan', *NHS England*, 30th June 2023, p. 50 [link]
113. 'The NHS Graduate Management Training Scheme Annual Report 2020/22', *NHS Leadership Academy*, (last accessed 12th June 2024) [link]
114. NHS Leadership Academy Homepage, *NHS Leadership Academy*, (last accessed 5th June 2024) [link]
115. 'Sustainability Leadership for Greener Health and Care Programme', *NHS Leadership Academy*, (last accessed 12th June 2024) [link]
116. 'Edward Jenner Programme v2.1, *NHS Leadership Academy* (last accessed 5th June 2024) [link]
117. 'Mary Seacole Programme... Eligibility', *NHS Leadership Academy*, [link]
118. Ibid
119. 'Elizabeth Garrett Anderson Programme', *NHS Leadership Academy*, [link]
120. 'Scheme', NHS Graduate Management Training Scheme, (last accessed 5th June 2024) [link]

	A leadership development programme designed for senior leaders who are looking to progress into executive roles at a board level within the next two years.

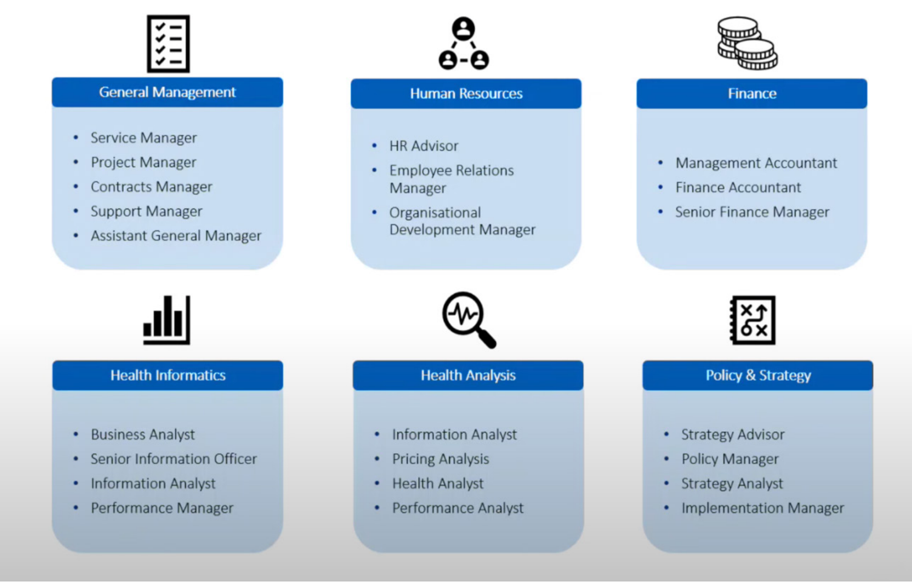
The NHS Graduate Management Training Scheme GMTS)

The GMTS is a two-year training course undertaken by graduates interested in a career in the NHS. The scheme is roughly analogous to the Fast Stream within the Civil Service and its graduates populate some of the most senior positions across the NHS. On average each year, 65% of those who enter the scheme remain employed by the NHS.[121]

There are many different specialisms in the scheme, the largest of which is the 'General Management' scheme, which comprised 55% of the 2021/22 intake.[122] In this specialism, graduates will usually have two placements, one 'operational' and one 'strategic'. Between these two placements, graduates will spend eight weeks on placement in an organisation external to the NHS.

Alongside these commitments, as it stands, all graduates of the scheme also take part in the Elizabeth Garrett Anderson (EGA) educational scheme. Trainees must complete at least one year of this scheme with the full course comprising seven models taught over a twenty-four-month period, with two written assignments per module and a final 10,000-word healthcare leadership case study.[123] The course is delivered by the NHS in partnership with the University of Birmingham.[124]

Figure 11 – Types of Roles Undertaken According to Relevant GMTS Stream



Source: NHS GMTS insight webinar: September 2024 entry [link] (21:31)

121. 'The NHS Graduate Management Training Scheme Annual Report 2020/22', *NHS Leadership Academy*, (last accessed 12th June 2024) [link]
122. Ibid
123. 'Elizabeth Garrett Anderson Programme', *NHS Leadership Academy*, (last accessed 5th June 2024) [] link]
124. Ibid

The steady expansion in the number of graduates passing through the scheme has also shaped the role of managers. As the quantity of entrants grew over the 1960s and 1970s, and confidence in the role of administrators grew, so did the balance of power between Managers and Clinicians. While 'administrators' had traditionally been expected to be subservient to clinical staff, there was increasingly a parity between clinicians and administrators.[125] This led to the system design theory of 'consensus management' - whereby administrators and clinicians would reach decisions through negotiation.[126] This compromise held until the findings of the 'Griffiths Review', an inquiry into the effective use and management of manpower and resources, led by Roy Griffiths, a Director at J Sainsbury's, which recommended the introduction of general management within NHS organisations.[127]

Figure 12 – NHS GMTS Trainee Annual Intake, 1996-2021

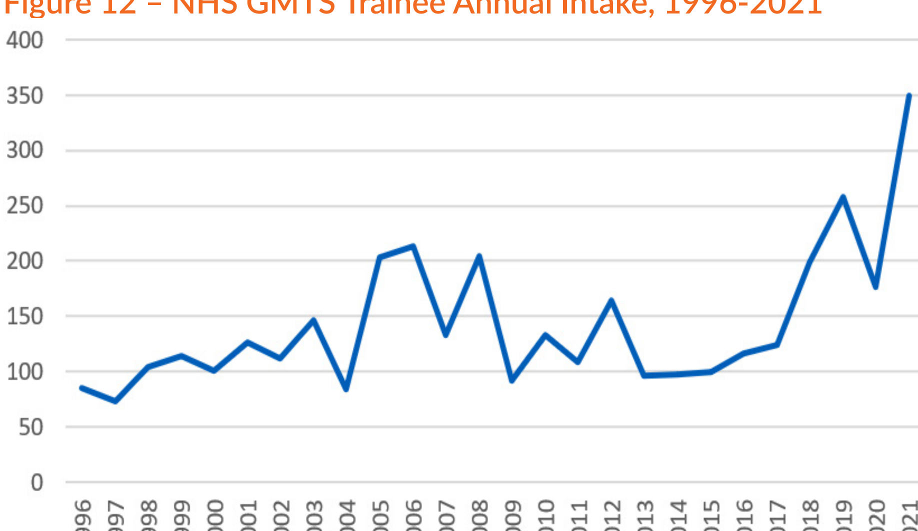


Table 5 – The Development of the GMTS Programme

Year	Development(s)
1945	Joint Committee puts forward the first proposed syllabus for NHS administrators, with exams covering public and social administration, economics, statistics, office practice, commercial law and book-keeping. Final exams have a similar focus on hard skills such as patient flow and legal issues impacting health.
1956	**National Administrative Training Scheme is launched.**[128] The first intake is of 14 trainees, with qualification managed by the independent Institute for Healthcare Management.[129]
1963	**Lycett Green Report** into the National Scheme is released, proposing the merging of the 'Regional' and 'National' schemes.[130] Scheme expands with a Finance specialism.[131]

125. Philip Begley, ''The type of person needed is one possessing a wide humanity': the development of the NHS national administrative training scheme', *Contemporary British History, Vol. 34 No.2* (2020), pp. 228-250 [link]
126. 'The changing role of managers in the NHS', *The King's Fund*, 14th October 2010 [link]
127. 'Griffiths report on management in the NHS', *The Health Foundation* [link]. Further details can be found in Table 17 in the Appendix
128. Philip Begley, ''The type of person needed is one possessing a wide humanity': the development of the NHS national administrative training scheme', *Contemporary British History, Vol. 34 No.2* (2020), pp. 228-250 [link]
129. Ibid
130. Ibid
131. 'The NHS Graduate Management Training Scheme Annual Report 2020/22', *NHS Leadership Academy*, (last accessed 12th June 2024) [link]

1986	**National Administrative Training Scheme rebranded as the "General Management Training Scheme" (GMTS)** in line with the new role for administrators as envisaged in the Griffiths Report.
2004	**Human Resources** stream added.[132]
2009	**Health Informatics** stream added.[133]
2015	**Rose Review** suggests expanding intake from 150 to 500. As of 2021, the scheme has been expanded to 350.
2016	**Policy and Strategy** stream added, running alongside a parallel scheme within DHSC.[134]
2017	**Health Analysis** as a specialism added.
2022	**Messenger Review** into leadership in the NHS, critical of management training. Also questions the 'elite' status given to graduates of the scheme.[135]

In addition to these programmes there are dedicated routes and resources for the development of leadership skills for clinicians:

- **The Faculty of Medical Leadership and Management (FMLM)** was established in 2011 and endorsed by the Academy of Medical Royal Colleges. The primary objective of the FMLM is to 'raise the standard of patient care by enhancing medical leadership.'[136] FMLM has developed Leadership and management standards for medical professionals which are derived from, and build upon, earlier work including the General Medical Council's (GMC) guidance, 'Leadership and Management for all doctors'.[137] The scheme is elite and only c. 50 individuals are selected for placements each year.
- **Royal Colleges** offer their own management and leadership courses and resources.[138] Many adapt their specialty curricula to emphasise competencies for clinical leadership.
- **Medical schools** are also required to incorporate leadership training under the GMCs Generic professional capabilities framework.[139]

A number of external organisations also provide leadership training, accessed by many NHS staff (these are illustrative examples, not a comprehensive list):

- **NHS Confederation** – provide a range of leadership programmes, including a number focused upon primary care.[140]
- **The Florence Nightingale Foundation** – Which works with nurses and midwives at every level of their career and across the NHS, military, social care, primary care and the charity and independent sectors, provide leadership development via range of programmes and scholarships.[141]
- **The King's Fund**, an independent think tank and health and

136. 'Professionalising medical leadership and management', *Faculty of Medical Leadership and Management*, (last accessed 5th June 2024), link
137. 'Leadership and Management standards for medical professionals', *Faculty of Medical Leadership and Management*, (last accessed 5th June 2024), link
138. 'Leadership and Management', *Royal College of General Practitioners* (last accessed 5th June 2024) [link]
139. Generic professional capabilities framework, *General Medical Council* [link]
140. Primary care leadership development, *NHS Confederation* [link]
141. *Florence Nightingale Foundation* [link]
132. Ibid
133. Ibid
134. Ibid
135. 'Leadership for a collaborative and inclusive future', *DHSC*, 8th June 2022 [] link]

care charity provides leadership development programmes encompassing strategic leadership, personal development of influence, negotiation and impact.

Beyond the Acutes: Managing General Practice

There are over 9,000 GP practice managers working across the UK, operating across both large multi-premise practices and small practices where there may be just one or two clinical staff employed.[142] Such is the case with many community pharmacy and optometry services also – some of which are owned and managed by a larger corporation, e.g. Boots, but many of whom remain small-scale and independently owned.

Many GP practice managers do not undertake responsibilities full time. Findings from Practice Index show (according to their 'Pay and Workload Survey for Practice Managers') that 28% of practice managers work less than 35 hours per week, whilst a further 9% work between 35 and 37 hours, 56% work either 37 or 37.5 hours per week, and the remaining 7% work up to 40 hours.[143] Many take on a role in general practice having developed experience in other sectors. The PMA State of Primary Care Summary Report 2022 revealed 28% of responders coming from retail, military, local authority, the care sector or other management roles. Yet we are reaching a concerning tipping point. That same report shows that 39% of non-clinical staff who responded to that year's survey would be retiring in the next year, with only 18% promoted over the previous twelve months.[144]

Few practice managers become partners. 26% of practice managers are paid £45,000 per annum or higher; 18% of practice managers are paid between £30,000 and £35,000 per annum. (In contrast, graduates from the GMTS often move into roles at acute trusts on Band 7 (c. £43k) or 8a roles according to the Agenda for Change pay scales and have opportunities to progress their salary fairly rapidly).

GP practice managers will often have a formal qualification, either the "Certificate/Diploma in Primary Care and Health Management (DPCHM)" which is awarded by the Association of Medical Secretaries, Practice Managers, Administrators and Receptionists (AMSPAR) or the "Vocational Training Scheme for General Practice Managers (VTSGPM)", awarded by the Institute of Healthcare Management (IHM).[145] Many are members of The Institute of General Practice Management, which supports the professional development of managers. Other organisations, such as Local Medical Committees (LMCs) offer learning programmes too, such as the Londonwide LMCs who offer a blended learning programme for general practice managers, which has been professionally accredited by the Royal College of General Practitioners and the CPD Standards Office.[146]

Alongside dedicated GP practice managers, many GPs themselves (most often GP partners) perform an important management (and leadership) role not only often of their own practice where they effectively "run the business" as independent contractors to the NHS, but also within new primary care networks (local groups of GP practices) which have

142. Robert Campbell, 'Being a Practice Manager: The Inside Story!', *Practice Index*, 12th February 2019 [link]
143. Ibid
144. A copy of this PMA report was kindly shared with Policy Exchange
145. 'Practice Manager', *NHS* (last accessed 5th June 2024) [link]
146. 'General Practice Management (GPM) Training Programme', *Londonwide LMCs*, (last accessed 5th June 2024) [link]

emerged since 2019. Some GP partners have undertaken part-time MBAs to enhance their understanding of finance and strategic management, but this is entirely voluntary.[147] Initiatives, such as 'Next Generation GP' have emerged in recent years, receiving funding from NHS England, but leadership development is not consistently offered.[148]

GP partners or GP practice managers will often undertake roles ranging from (but not limited to):

- Performing human resource functions
- Managing practice finances
- Having responsibility for regulation and compliance
- Having responsibility for premises/estates management
- Managing clinical governance and safeguarding
- Having responsibility for the management of training (such as for GP trainees or for Additional Roles)

As such, the make-up of each practice is unique and levels of autonomy are far greater than in acute settings. But despite the leadership role that many GPs perform (at both an individual practice level and across the local health economy), most receive little formal leadership training and there remains a "deficit of basic managerial skills" in some practices.[149] The lack of focus upon this deficit in national policymaking and in recent independent reviews – such as the Messenger Review – is a fair criticism.[150]

There is therefore a mismatch between the management (most often, non-clinical) needs and the fact that some of the most extensive reforms to the NHS are likely to occur across primary and community healthcare settings over the coming years, with primary care staff increasingly having to evolve how they work to deliver integrated services, meaning closer engagement with a wider range of professionals and providers and increasingly working within organisations of greater size (in terms of headcount) and scale (often working or cooperating over a far-wider geography).[151]

Some of those we spoke to for this research suggested that it was likely that the equivalent of a 'Chief Operations Officer' role would need to be created across primary care in the coming years as a result. Yet some of the resources which might help to enable this are currently being squeezed. For instance, the most recent GP contract proposes to roll the Clinical Director Payment and PCN Leadership and Management funding (£89m combined) into Core PCN funding, meaning this resource will likely be used for other purposes.[152] Others we spoke to reflected that there was more that NHSE (or larger providers) could offer to support practices, such as through the provision of template documents or streamlined services – such as payroll management.

Building on the relationship between secondary and primary care in the NHS is important for ensuring better collaboration within the system. One practical way that this relationship could be enhanced is to mandate trainees of GMTS to spend their eight week 'flexi-placement' in a primary

147. Sir John Oldham, 'Leading improvement on scale in healthcare: Sir John Oldham', *BMJ Leader Volume 6, Issue 2*, 18th May 2023, p79-80 [link]
148. Steve Gulati & Judith A. Smith, 'Evaluation of the first 5 years of the Next Generation GP leadership programme: balancing autonomy and accountability', *BMJ Leader* (2024) [link]
149. 'ROAN information sheet 24: Leadership in primary care', *NHS England*, January 2019 [link]
150. Becks Fisher & Judith Smith, 'The Messenger Review: a missed opportunity for primary care', *BMJ*, 9 June 2022 [link]
151. Richard Giordano, 'The leadership challenge for general practice in England', *The King's Fund*, 2011 [link] For a good example of the implications and impact of the introduction of the General Medical Services (GMS) contract upon GPs, see: Kath Checkland, 'Management in general practice: the challenge of the new General Medical Services contract', *British Journal of General Practice*, 1st October 2004, pp. 734-739 [link]
152. Sheinaz Stanfield, 'lots in contract worries me…', *X (formerly Twitter)*, 29th February 2024 [link]

or community healthcare provider setting. One interviewee suggested to us that multi-site primary care networks would likely prove the best-placed settings for this kind of arrangement.

The additional reason for the significance of this shift is that enhancing care across the 'interface' between providers has become increasingly important – both to ensure effective, high quality patient care but also be enhance patient experience. Policy Exchange has previously examined measures to improve working across the interface between primary and secondary care which may be instructive here.[153]

Government Policy and Reviews

There have been six major reviews pertaining to NHS management and leadership since 2015. These reviews have made a total of 147 recommendations. 117 (79.6%) of these have been accepted by the Government (the figure is however skewed by the Ockenden Review which made 84 recommendations, all of which were accepted by the Government). If Ockenden is not included, 33 of 63 recommendations – just over half (52%) have been accepted. Table 6 below gives further insight into the impact of recent reviews over the last ten years.

Table 6 – 'Scorecard' measuring the impact of policy interventions in the NHS across England, Scotland, Wales and Northern Ireland

Review	Recommendation(s)	Status
Rose (2015)	• Made 19 recommendations.[154] • Includes recommendation to expand Graduate Management Scheme (GMTS) from 150 to 500 places.[155]	• 9 implemented, 4 partially implemented and 6 not implemented at all. • Latest intake of GMTS (2024) recruited 250 graduates, falling from 350 in 2021.[156]
Smith (2015)	• Makes 16 recommendations. • Includes closing 'NHS IQ' and redistributing resources to localities.	• 9 recommendations implemented, 4 partially implemented, 3 not implemented at all.

153. Dr David Landau & Sean Phillips, 'Medical Evolution: Measures to improve the interface between primary and secondary care', *Policy Exchange*, 29 June 2023 [link]
154. Lord Rose, 'Better leadership for tomorrow: NHS Leadership Review', *Department of Health and Social Care*, 16th July 2015 [link]
155. Ibid
156. 'The NHS Graduate Management Training Scheme Annual Report 2020/22', *NHS Leadership Academy*, (last accessed 12th June 2024) [link] and 'About us', *NHS Graduate Management Training Scheme*, (accessed 5th June 2024) [link]

Kerr (2018)	• Makes 14 recommendations. • Includes reviewing assurance burden, empowering CQC to review systems and behavioural compacts to set expectations for standards amongst managers. • The review found that a top-down bullying culture persists in the NHS.[157]	• In total, 6 were implemented, with 2 partially implemented and 6 not implemented. • The NHS Long Term Workforce plan cites Kerr several times, including changing to the 'leadership pipeline'. • NHS Long Term Workforce plan also commits to 'considering' of a professional registration scheme.[158]
Kark (2019)	• Makes 77recommendations.[159] • Looks specifically at the Fit and Proper People's Test introduced in 2014, finding definitions of improper conduct too loose.[160]	• Secretary of State accepts 5 of the 7 recommendations.[161] • Recommendations not accepted include examining application of FPPT to Social Care and power to disbar for serious misconduct.[162] • Kark Implementation Steering group established in August 2019.[163] • New Fit and Proper People's test framework released by the NHS in August 2023.[164]
Ockenden (2022)	• Makes 84 recommendations for immediate implementation.[165]	• Secretary of State pledges to accept all 84 recommendations.[166] • Compliance by ICSs and Trusts was high as of May 2022.[167]

157. Ron Kerr, 'Empowering NHS leaders to lead', *Gov.UK*, 28th November 2018 [link]
158. 'Leadership and talent management' in 'Online version of the NHS long term plan', *NHS*, (accessed 5th June 2024) [link]
159. Tom Kark QC, Jane Russell, 'A Review of the Fit and Proper Person Test', *DHSC*, 6th February 2019 [link]
160. 'The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014', *UK Statutory Instruments*, (accessed 5th June 2024) [link]
161. 'Appendix 1: Recommendations from the Kark Review (2019)', *NHS England*, 2nd August 2023 [link]
162. Ibid
163. 'New Standards for NHS Board Members', *NHS England*, (accessed 5th June 2024) [link]
164. 'New Fit and Proper Persons Test Framework published', *NHS Providers*, 3rd August 2023 [link]
165. 'Findings, conclusions, and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust- the final Ockenden report', *NHS Providers*, 30th March 2022 [link]
166. The Rt Hon Sajid Javid MP, 'Ockenden report: statement by the Secretary of State for Health and Social Care', *Department of Health and Social Care*, 30th March 2022 [link]
167. 'Annex to Board paper: progress on interim Ockenden report by Region and Trust', *NHS England*, 19th May 2022 [link]

Kirkup (2022)	• Identifies 4 key areas for improvement in neonatal care and maternity services (based on review of services in East Kent): monitoring of safety, standards of clinical behaviour, teamworking and organisational behaviour.	• One section, 'The Future', discusses ongoing issues with performance management and patient safety which have not been addressed. For example, 6.22 'reasonable and proportionate sanctions are required for employers and professional regulators so that poor behaviour can be addressed before it becomes embedded and intractable'.[168] The NHS's latest framework for managing performer concerns (Feb 2022) is focused primarily on decisions around suspensions.[169] • A more responsive system of sanctions which corrects concerns around performance has not been introduced as yet.
Messenger (2022)	• Makes 7 recommendations. • Includes 'embedding' EDI across organisations and deploying talent to parts of the system that are challenged. [170]	• 4 of 7 recommendations implemented. • NHS actively reviewing implementation of two core recommendations, including accredited training and appraisals systems.

168. Dr Bill Kirkup CBE, 'Reading the signals. Maternity and neonatal services in East Kent- the Report of the Independent Investigation', *Gov.UK*, 19th October 2022 [link]
169. 'Framework for managing performer concerns', *NHS England*, 11th February 2022, p14 [link]
170. General Sir Gordon Messenger & Dame Linda Pollard, 'Health and social care review: leadership for a collaborative and inclusive future', *Department of Health and Social Care*, 8th June 2022 [link]

The Thirlwall Inquiry has also recently published its own review, collating recommendations from thirty inquiries over the course of the past thirty years that have taken place in England & Wales and which relate to events in hospitals and other healthcare settings, or safeguarding of vulnerable individuals.

This reveals an 'implementation gap' in responses to recommendations.[171] Reasons for this can be explained by the non-binding nature of recommendations; the priority given to recommendations by policymakers or other relevant bodies; challenges relating to their design, feasibility and cost; and the complexities of coordinating actions and responsibilities across multiple bodies.[172]

171. 'Review of previous recommendations published', *Thirlwall Inquiry*, 17th May 2024. The full document is available here [link].
172. 'Written evidence submitted by Graham Martin, Mary Dixon-Woods, and Jane O'Hara, The Healthcare Improvement Studies Institute (THIS Institute), University of Cambridge (NHL0031)', *UK Parliament*, February 2020 [link]

Chapter 3 – The Experience of Current NHS Managers

"In the present situation no one has the responsibility to bring things to a head, and matters therefore float around unresolved for far too long. Worse still, because every team member has a veto, some proposals are never aired because the proponents feel it will not be possible to get a consensus'"

Department of Health and Social Security Circular, 1984[173]

"The sense of constant demands from above, including from politicians, creates an institutional instinct, particularly in the healthcare sector, to look upwards to furnish the needs of the hierarchy rather than downwards to the needs of the service-user."

General Sir Gordon Messenger[174]

"In parts of the NHS, a mythology has grown up that it is too difficult to sack people. This must be reviewed and challenged".[175]

The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings

An Impossible Job?

In the vast majority of interviews we conducted, individuals – both those currently in senior leadership positions as well as those working in 'middle management' – reflected upon the significant challenges faced in the current NHS operating environment. Some reflected that they (or their colleagues) were to be judged on targets – such as for theatre utilisation – which due to their own skillsets or wider organisational circumstances could not be met. "I feel like we're set up for failure", said one. Many reflected that the current 'risk reward ratio' for operational managerial roles is misaligned, with many managers possessing limited autonomy to drive the change they wished to see 'on the ground'.

As it stands, and as a recent assessment from the LSE shows, NHS managers spend "considerable time performing administrative functions, ensuring regulatory standards, and meeting government requirements. Risk-taking by managers is largely discouraged with the managerial task being to ensure that things run smoothly".[176] "NHSE treats you like a mid-level manager at a bank", one of our interviewees reflected. Another stated that managers above all "craved freedom".

173. 'National Health Service Management in the 1980s', *Socialist Health Foundation*, 1994, [link]
174. 'Independent Report. Leadership for a collaborative and inclusive future', *Department of Health and Social Care*, 8th June 2022 [link]
175. The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings [link], p. 65
176. Miqdad Asaria, Alistair McGuire & Andrew Street, 'NHS hospital managers are constrained – hiring more won't improve performance', *LSE Business Review* [link]

Instead, many reflected a sense that they lacked the permission to innovate, to focus on improvement, or to take calculated risks: 'the juice wasn't worth the squeeze'. This was a particular challenge amongst more senior managers. One reflected that there were real issues in encouraging talented managers from taking on the toughest jobs, such as becoming a Chief Operating Officer – particularly at struggling hospital trusts. This finding has been reflected in the most recent report from the Review Body on Senior Salaries which states: "some do not see promotion to senior leadership as attractive, given the increased responsibility and loss of entitlements such as payments for overtime and being on-call."[177] That same report also suggests that almost half (46 per cent) of current NHS trust CEOs would become eligible to retire in the next 12 to 24 months.[178]

Many aspects of the current operating environment limit autonomy. Pay is set by the Agenda for Change system, alongside a framework for Very Senior Managers, with no space for discretionary bonuses. Assurance is sought 'from above', as are significant volumes of data requests – the purpose of which is not always clearly defined by the requesting organisation. One interviewee reflected that the proportion of time that managers now spent in handling such requests had increased significantly in recent years and that a re-balancing was required. A recent survey of ICB leaders across the NHS conducted by the Health Service Journal found the commonly chosen barrier to recovery was "too many national asks and objectives", with 89 per cent saying it was a significant or very significant barrier.[179] Therefore, we can confidently state that a number of the issues Sir Ron Kerr identified in his review of 2018 have not been addressed: "requests for information from national and regional bodies are not aligned, are frequently duplicative, and can end up entering the system at the wrong level".[180]

There is substantial evidence concerning the important role that 'middle managers' can play in creating an effective environment for adopting innovation – including ward managers and matrons.[181] 'Organisational intelligence' is particularly important.[182] Unlike their clinical counterparts, operational managers are expected to perform complex tasks that require a detailed understanding of NHS structures, regulations and processes – often – with limited support, structure and training. The NHS Leadership Academy Healthcare Leadership Model, presents desired leadership behaviours and explicitly states that leaders need to understand the culture and politics of their organisation, including the informal chain of command, with higher level leadership skills associated with expanding this understanding to the system level.[183]

In recent years, initiatives set up by operational managers themselves have emerged to try to improve peer learning and cooperation across the country. 'Proud2bOps' is a national network which seeks to connect Operational Managers and Leaders from across the healthcare sector in the UK which has also begun to work on developing a curriculum and set of competencies, according to seniority, to provide greater coherence and clearer routes for professional development for those undertaking

177. Quotation from the Forty-Sixth Annual Report on Senior Salaries Report No. 97 cited in Nick Kituno & Dave West, 'CEO 'exodus' threatens NHS, ministers told', *Health Service Journal*, 30 July 2024 [link]
178. Ibid
179. Dave West & Joe Talora, 'Radical rule changes would boost NHS recovery, say chiefs', *Health Service Journal*, 2 May 2024 [link]
180. Sir Ron Kerr, 'Empowering NHS leaders to lead', *DHSC*, 28 November 2018 [link]
181. D.A Buchanan, D.Denyer, J. Jaina, C. Kelliher et al, 'How do they manage? A qualitative study of the realities of middle and front-line management work in healthcare', *The National Center for Biotechnology Information*, June 2013 [link]
182. Alistair Beattie, Birju Bartoli, 'Organisational intelligence and successful change in NHS organisations', *British Journal of Healthcare Management*, 9th March 2020 [link]
183. Justin Waring, Simon Bishop, Jenelle Clarke et al, 'Acquiring and developing healthcare leaders' political skills: an interview study with healthcare leaders', *BMJ*, 23rd May 2022 [link]

operational roles.[184]

At the executive level of NHS organisations, turnover can be swift. Critical CQC reports often lead Chairs or Trust Chief Executives to resign.[185] An analysis conducted by the Health Service Journal in August 2023 found that almost a third of Chief Executives in NHS trusts had only been in post for eighteen months or less.[186] A study published prior to the COVID-19 pandemic found that Trust Chief Executives had a median tenure of just three years. The toughest jobs are the most difficult to fill: Trusts which had been rated 'inadequate' by the CQC had 14% of their posts vacant, compared to only 3% in Trusts that are rated as 'Outstanding'.[187]

Short tenures lead to a 'revolving door' approach to leadership and can lead to short-term decision-making.[188] A recent investigation in to Maternity and Neonatal Services in East Kent concluded that an "aggressive approach to reputational management" led failing organisations to simply rotate new staff in to positions, thus exacerbating structural problems.[189] It is therefore reasonable to suggest that the pace of turnover – particularly amongst senior NHS leadership responsible for providers is deleterious to performance.

Whilst this style of performance management is often seen at the executive or board level, it is much less strictly applied across 'middle management', however. The performance management strategy utilised most often by the NHS is the 360 Appraisal process, whereby confidential feedback is provided to individual employees from both their manager and those who report into them.[190] Some of those we interviewed suggested this system was ineffective, with one describing it as a 'tickbox' exercise that wasn't taken seriously. It was also suggested that in some cases managers were disinclined to provide negative reviews to minimise interpersonal tensions – a type of 'leniency bias'.[191]

The NHS's performance management technique has been described as a 'data-gathering exercise' simply because poor performance often does not carry real consequences.[192] The recent NHSE guidance, entitled 'Expectations of line managers' (published November 2023) is notably lacking in expectations with respect to performance management.[193] The 2022 NHS Staff Survey suggests that the current appraisal system is insufficient. 81.3% of staff surveyed stated that they had received an appraisal or review in the last 12 months, declining from 86.8% in 2018.[194] Only 21.9% of staff believe these appraisals had 'helped improve how they do their job'.[195]

One manager we interviewed explained that it remains too commonplace for ineffective – and sometimes even incompetent managers – to 'fail upwards' in the NHS. Because it can prove exceptionally difficult to dismiss an individual for poor performance, the easiest way to 'move on' members of staff can be to give them a glowing reference and help them apply for another job. A former senior manager in the NHS, writing anonymously in The Guardian in 2016 described the situation thus: 'in NHS management being fired means you continue working for more money'.[196] One interviewee we spoke to identified particular challenges

184. Proud2bOps [link]
185. Alison Moore, 'FT Chair steps down after critical CQC report', *Health Service Journal*, 30th December 2023 [link]
186. Nick Kituno, Dave West, 'Revealed: 60pc of trusts have a 'first time' CEO', *Health Service Journal*, 29th August 2023 [link]
187. Siva Anandaciva, Deborah Ward, Mandip Randhawa, Rihannon Edge, 'Leadership in today's NHS. Delivering the impossible', *The King's Fund*, 18th July 2018 [link]
188. Ibid
189. Dr Bill Kirkup CBE, 'Reading the signals. Maternity and neonatal services in East Kent- the Report of the Independent Investigation', *DHSC*, 19th October 2022, p.24 [link]
190. '360-degree feedback tool', *The NHS Leadership Academy*, (last accessed 6th June 2024) [link]
191. Linda Loberg, Stephan Nüesch, Johann Nils Foege, 'Forced distribution rating systems and team collaboration', *Journal of Economics Behaviour & Organisation, Vol. 188*, 1st June 2021 [link]
192. Paul Corrigan, 'One of the main problems with the current NHS "performance management regime" is that it doesn't manage NHS performance.', *Health Matters*, 11th December 2023 [link]
193. *NHS England*, 'The expectations of line managers in relation to people management', 16th January 2024 [link]
194. *NHS Staff Survey*, 'National Results', 2023, p. 37 [link]
195. Ibid
196. Anonymous, 'In NHS management, being fired means you continue working for more money', *The Guardian*, 14th November 2016 [link]

where such individuals assume positions of relative power, more likely to blame their junior colleagues and to try and take credit for their work, becoming 'defensive and paranoid'.

Ultimately, there is a need for a balance to be struck between managers considering their positions to be a 'job for life' and dismissing individuals for performance issues they do not have the qualities and competencies to discharge effectively. Responses to our FOI requests reveal that there is a quantitative basis to this assertion – it appears that only too infrequently are poor managers dismissed.

Some of those we spoke to said they could identify several individuals they knew of who had simply re-applied to other NHS organisations and did not declare their previous dismissal. This was a problem recognised in the Kark Review, which proposed implementing a disbarring mechanism which could be accessed by Human Resources departments to ensure those who have been dismissed are unable to find employment at other providers.[197] A version of Kark's recommendation was implemented in August 2023, with national guidance for a new 'standard reference' to be given for anybody leaving NHS provider board roles to be held on file until the individual turns seventy-five, with details of on ongoing complaints and disciplinary issues.

Clinicians v Managers and Clinicians as Managers

> *'Only 54% of the managers in our hospitals are clinicians – compared to 74% in Canada and the US, and 94% in Sweden. At the top, only a third of chief executives are clinicians…we should ask whether the NHS made a historic mistake in the 1980s by deliberately creating a manager class who were not clinicians, rather than making more effort to nurture and develop the management skills of those who are'.*
>
> **Rt Hon Jeremy Hunt MP**, Speech to the NHS Providers Annual Conference (2016).[198]

In contrast to many health systems in the world, many of those in NHS executive leadership positions do not have a clinical background. Indeed, only a third of NHS chief executives have a clinical background.[199] Compare this to other professions, such as headteachers or police chiefs where only a tiny fraction of leaders are not drawn from amongst the profession itself.

Whilst the significance of clashes between clinical and non-clinical staff can be over-played, cultural divides between professionals in NHS settings can be significant. This can be seen in the professional languages individuals use, e.g. most clinicians may dislike terms such as 'production' (the managerial term for dealing with sick patients), or 'business units' (their outpatient clinic or hospital ward).[200]

Some perceptions are long-standing. At the NHS's foundation, non-clinical managers were referred to as 'administrators'. Their job was to work for doctors. Ken Jarrold, who became a trainee administrator on a predecessor to the GMTS scheme in 1969 described the relationship as such:

197. Tom Kark QC, Jane Russell, 'A Review of the Fit and Proper Person Test', *Department of Health and Social Care*, 6th February 2019 [link]
198. The Rt Hon Jeremy Hunt MP, 'Speech. NHS Providers annual conference keynote speech', *Department of Health and Social Care*, 30th November 2016 [link]
199. 'Introduction' in 'Clinician to Chief Executive: Supporting Leaders of the Future' report, *NHS Providers, NHS Leadership Academy*, October 2018 [link]
200. Marcel Levi, 'A Dutchman in London: reflections of a hospital chief executive from the Netherlands in the NHS', *BMJ Leader*, 29th June 2021 [link]

> *"We were administrators. We were not expected to play any part in clinical work at all. Had I suggested to Mr Rowling, the consultant surgeon at the Royal that I wanted to know how many people he had on his waiting list, I would have been lucky to get out of the theatre alive."*[201]

This traditional relationship changed over the post-war period, with the administrator position transformed into that of the 'general manager' in the wake of the Griffiths reforms.[202] One academic, reflecting more recently on the development of New Public Management approaches, has reflected that "the creation of a non-clinical manager class brought with it a controlling leadership style not suited to the caring professions".[203] A series of policy documents, including a 2001 White Paper, 'Shifting the Balance' have made the case for less 'command and control' leadership from service managers. More recently, the philosophy of 'followership' instead of 'leadership' has sought to rekindle 'management by consensus'.[204]

Whilst it is clear that high-quality managers can be drawn from a wide range of both clinical non-clinical backgrounds, the improved involvement of clinicians in the management and leadership of NHS organisations would represent a positive development. There are strong foundations to build upon, with a clear appetite amongst younger clinicians to be educated and trained in the management side of healthcare provision.[205] Some of those we interviewed reflected that there was a real need to ensure that doctors-in-training or nursing staff (particularly those at Band 5 or Band 6) were able to access resources to support basic non-clinical management training to support their ability to recruit and to line manage.

One study, which considers evidence from Denmark, Australia and Switzerland found that when led by managers with high clinical expertise, hospital physicians were: more satisfied with their job, more satisfied with their supervisors' effectiveness and less likely to wish to quit their current job.[206] Another paper, published in 2013, investigating the presence and impact of clinicians on the boards of NHS acute Trusts over a three-year period (2006–2009) found the percentage of clinicians—and, more specifically, doctors—at the board level is positively associated to the rating achieved for the financial management of resources. Lending "support to the argument that increased clinical involvement in management decision-making will have benefits for the performance of hospital services".[207]

There is, therefore, an evidential basis for encouraging a greater number of clinicians to move into leadership roles within NHS organisations. So how might this be done?

The Labour Party included in their 2024 General Election manifesto a commitment to develop a 'College of Clinical Leadership'. But whilst it would be welcome to explore how a more consistent approach in encouraging clinicians to develop leadership skills (and to move into leadership roles) across the NHS, based on the present framing of the policy (and information available), it is not clear how the proposal differs from initiatives and oversight provided by existing Royal Colleges, nor is there clarity on how this organisation's role would differ from the existing Faculty of Medical Leadership and Management, other than expanding

201. Philip Begley, ''The type of person needed is one possessing a wide humanity': the development of the NHS national administrative training scheme', *Contemporary British History, Vol. 34 No.2* (2020), p. 229 [link]
202. Martin Gorsky, ''Searching for the People in Charge': Appraising the 1983 Griffiths NHS Management Inquiry', *The National Centre for Biotechnology Information*, January 2013 [link]
203. Melanie S. George, 'The effect of introducing new public management practices on compassion within the NHS', *Nursing Times*, April 2018 [link]
204. Clare Holt, Keith Grint, 'Followership in the NHS', *The King's Fund*, May 2011 [link]
205. Marcel Levi, 'A Dutchman in London: reflections of a hospital chief executive from the Netherlands in the NHS', *BMJ Leader*, 29th June 2021 [link]
206. Agnes Bäker, Amanda H Goodall, 'Do expert clinicians make the best managers? Evidence from hospitals in Denmark, Australia and Switzerland', *BMJ Leader*, 12th August 2021 [link]
207. Gianluca Veronesi,Ian Kirkpatrick &Francesco Vallascas, 'Does clinical management improve efficiency? Evidence from the English National Health Service', *Public Money & Management*, Vol. 34, No. 1 (2014), 35-42 [link]

placements, given the stated intention is for it to stand as an independent charitable institution.[208] Therefore, greater scrutiny of this proposal should take place before it is pursued and there may in fact be greater value in pursuing the notion of a 'College of Operational Leadership', given the limited convening mechanisms for these professionals, or a lack of agreed standards and competencies.

208. Nick Kituno, 'Some managers get no training or support, warns Pritchard', *Health Service Journal*, 16th November 2023 [link]

Chapter 4 – An Analysis of Freedom of Information Request Responses and National Surveys

> *"The purpose of a System is what it does, not what it claims to do…There is after all, no point in claiming that a system is to do what it constantly fails to do"*
>
> **Stafford Beer**[209]

In November 2023, Policy Exchange sent out Freedom of Information (FOI) Request to Acute Trusts, Community Healthcare Trusts, Integrated Care Boards across England, Alongside Health Boards in Wales, Scotland and Northern Ireland. These requests asked NHS organisations questions related to management under their employment. These questions included requests related to the total number of managers, their seniority and how often individuals had been dismissed for poor performance, amongst others. The request has been reproduced in full in the Appendix. Some responses (9) were not included in the data set.

	Requests Sent	% in Each Category Responding
Total Sent	218	100%
Responded	121	55%
No Response	102	45%
Acute Trust Reponses	55	45%
Community Trust Responses	35	13%
Integrated Care Board Responses	31	70%

The Relationship Between the Seniority of NHS Managers and Performance

A key concept for understanding the relative levels of seniority amongst staff employed in an NHS organisation is the pay 'banding system', known as 'Agenda for Change', summarised and explained in Table 7 below.

209.David Benjamin and David Komlos, 'The Purpose Of A System Is What It Does, Not What It Claims To Do', *Forbes*, 21 September 2021 [link]

Table 7 – 'Agenda for Change (AfC)' Explained

Agenda for Change (AfC) is a national banding system for payment that was introduced in 2004, setting salary 'bands' for staff with adjustments for years served.[210]

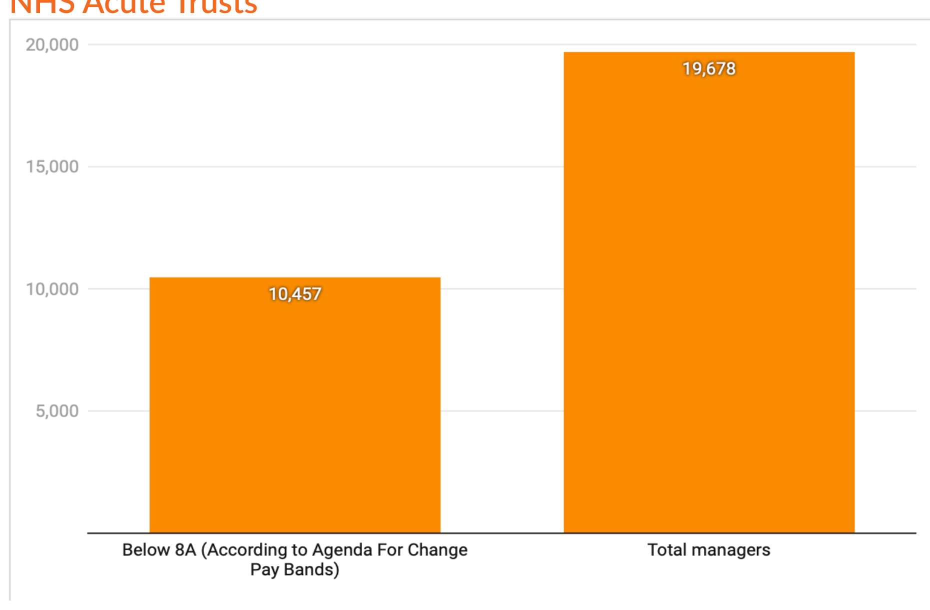
- It applies to the majority of staff directly employed by the NHS, with exceptions for doctors, dentists and very senior managers. Adjustments are made for staff living in areas like cities with higher costs of living. Salaries also increase within bandings depending on years of experience.
- Bandings range from 1 to 9. Band 8 is broken down in to four subdivisions – a,b,c,d. (A similar system is used within the Civil Service).[211]
- Banding levels and salaries are listed below with example occupations. These have not been adjusted for cost-of-living adjustments. These are based on the 2023/24 Pay Award.[212]
  - Band 1 – Cleaner | **£22,383**
  - Band 2 – Porter | **£22,816 up to £22,383**
  - Band 3 – Social Care Assistant | **£22,816 up to £24,336**
  - Band 4 – Occupational Therapy Assistant | **£25,147 up to £27,596**
  - Band 5 – Newly Qualified Midwife | **£28,407 up to £30,639**
  - Band 6 – Paramedic | **£35,392 up to £37,350**
  - Band 7 – Senior Radiographer | **£43,742 up to £45,996**
  - Band 8 (A, B, C, D) – Senior Operational Manager | **£50,952 up to £96,376**
- Band 9 – Chief Nursing Information Officer | **£99,891 up to £114,949**

Those who occupy Board/Executive roles are paid via a separate system: Very Senior Manager (VSM) pay framework.[213]

We wanted to get an understanding of what the proportion of NHS managers were ranked above and below Band 8A. This would inform us on the relative seniority of managers within the system, drawing on an important question around whether 'managers' have the authority to drive change, or if – in practice – they perform a more administrative function.

210. 'Agenda for Change', *The Health Foundation*, December 2004 [link]
211. 'Civil Service grades explained. How our roles are structured', *Department for Food, Environment and Rural Affairs*, (last accessed 5th June 2024) [][link]
212. 'Pay Scales for 2023/24', *NHS Employers*, 2nd May 2023 [link]
213. Very senior managers, *NHS Employers* [link]

Figure 13 – Number of Managers Above and Below Band 8a in NHS Acute Trusts



Source: Policy Exchange FOI Requests

Note: These figures have been calculated by adding all of the managers under 8A (according to AFC Pay Bands) and the total number of managers received from Acute Trusts. Entries where 8a was included in response were excluded from this calculation

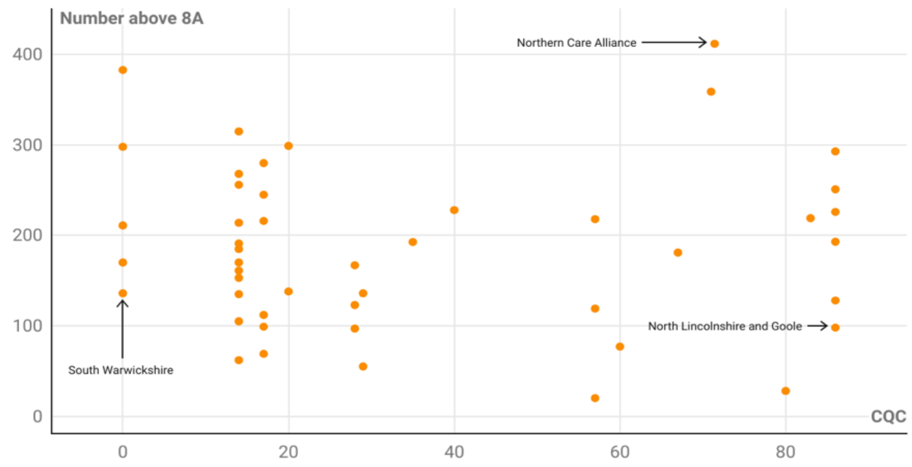
Below 8a	10,457
Total	19,678

As Figure 13 shows, a slim majority of managers in the NHS organisations we gathered information from are below band 8A (53%).

We wanted to see what impact that the seniority of management in a Trust would have on performance in an Acute setting. To determine performance, we went through different Acute Trusts and recorded their CQC ratings at the time of last inspection. The CQC (Care Quality Commission) assesses NHS providers against six core competencies: Safe, Effective, Caring, Responsive, Well-Led and good use of Resources.

We gave percentage ratings for each NHS organisation based on what proportion of competencies they were ranked 'Requires Improvement' or 'Inadequate' by the CQC, and then compared this number to the proportion of managers within the organisation which were band 8A or above.

Figure 14 – Correlation Between the Number of 'Senior Managers' (Band 8A and above) and Performance (CQC Rating of 'Requires Improvement' or 'Inadequate')



Average CQC	35%
Average Above 8A	193

This suggests that having proportionately more senior managers does not necessarily improve performance, but there are limits to what we can infer from these data points alone. Additional management capacity may have been added following poor CQC reports in order to turn things around, for instance. Ultimately, the factors that contribute to improved organisational performance are far wider than a focus upon specific roles alone.

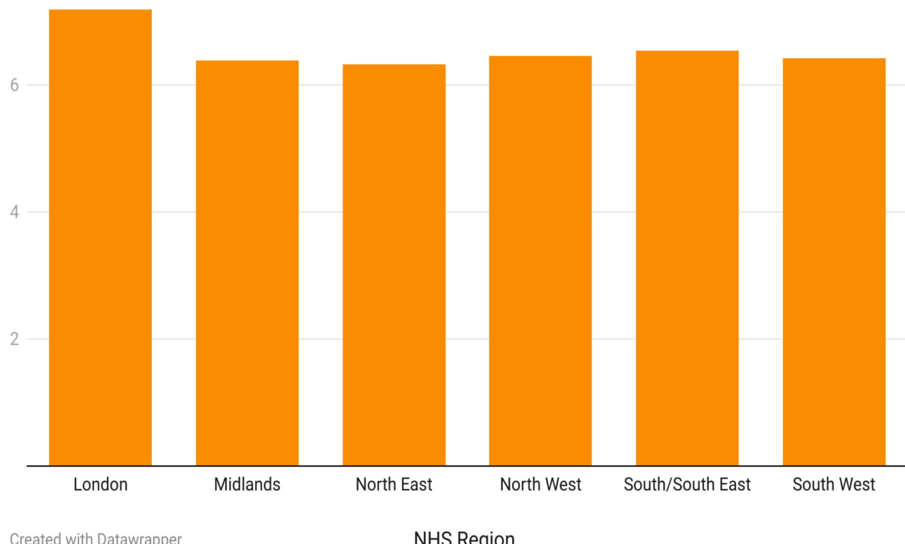
Staff to Manager Ratio in NHS Organisations

To provide further texture to our understanding of the role of managers within the system, we wanted to find out what proportion of total staff in NHS organisations were comprised of managers.

It is often said that the principal problem with performance in the NHS is that there are too few managers, and so we wanted to test whether there was a relationship between having a higher proportion of managers and improved performance.

For each NHS organisation, we compared the number of managers against the total number of staff employed to determine a 'staff-manager ratio'. Below is a breakdown of staff-manager ratios across all the Trusts within geography of each of the seven NHS Regions in England.

Figure 15 – Geographical variation in proportion of staff (%) that are managers (by NHS Region, based upon an analysis of acute trusts within the Region)



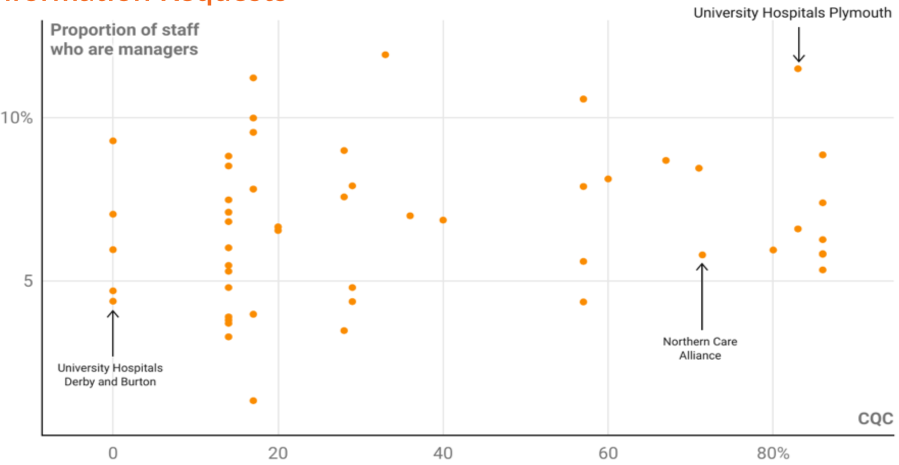
NHS Region	London	Midlands	North East	North West	South/ South East	South West
Staff to Manager Ratio	7.18%	6.38%	6.32%	6.45%	6.53%	6.41%

Note: The precise number of Staff in a Trust changes regularly due to new hires and positions opening up; the total staff number has been retrieved from a mixture of Trust documentation and staff websites.

As illustrated in Fig. 15, NHS organisations located in the London Region had the highest proportion of managers as a percentage of workforce, while the North East of England had the lowest.

But what difference does a difference in the 'staff-manager ratio' make to performance in NHS organisations?

Figure 16 – Correlation between Proportion of staff that are 'Manager's and Provider Performance according to Freedom of Information Requests



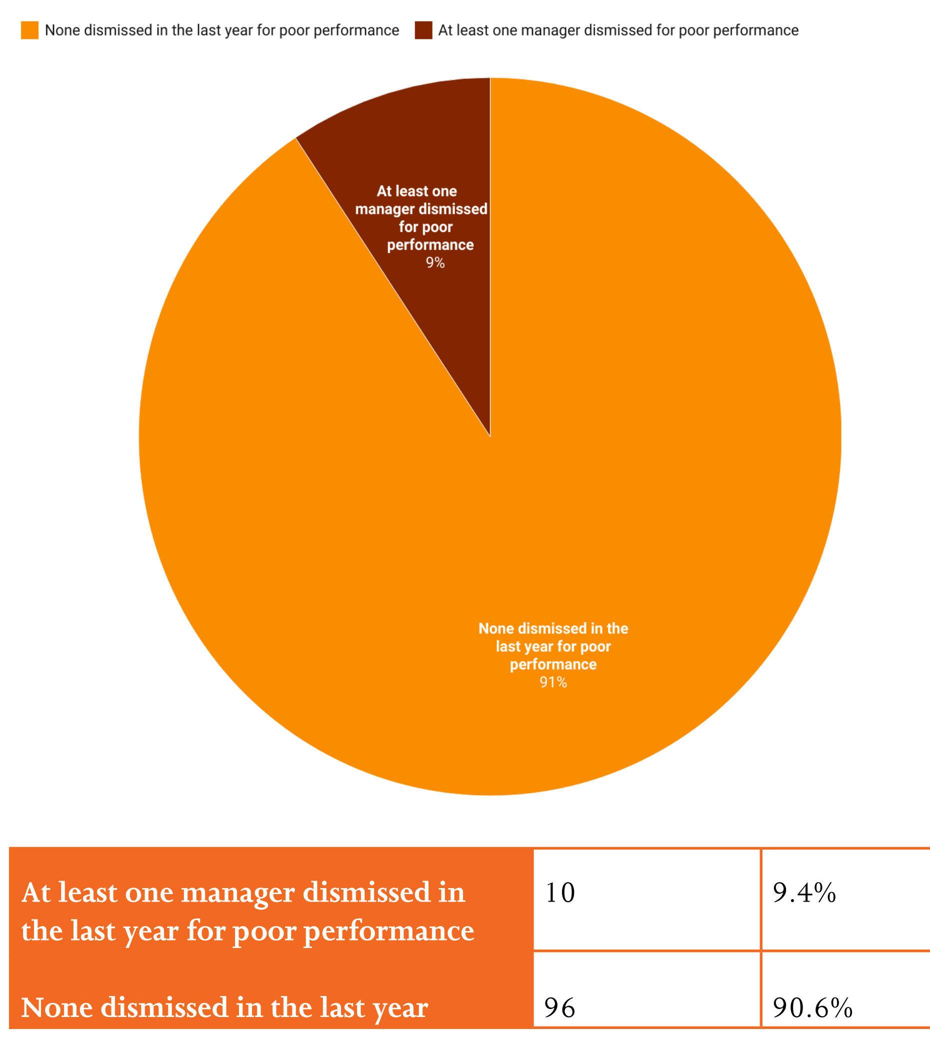
Average CQC Rating	36%
Average Staff-Manager Ratio	7%

As illustrated in Figure 16, we found a weak positive correlation between the proportion of staff that are managers and the percentage of areas rated as 'Require Improvement' by the CQC.[214] This evidence suggests that trusts with proportionally more managers do not necessarily perform better.

214.Haldun Akoglu, 'User's guide to correlation coefficients', *Turkish Journal of Emergency Medicine 18(3)*, August 7th 2018 [link]

Dismissals in NHS Organisations for Misconduct and Poor Performance

Figure 17 – Proportion of Trusts/ICBs (%) where managers have been dismissed for poor performance dismissed in the last year



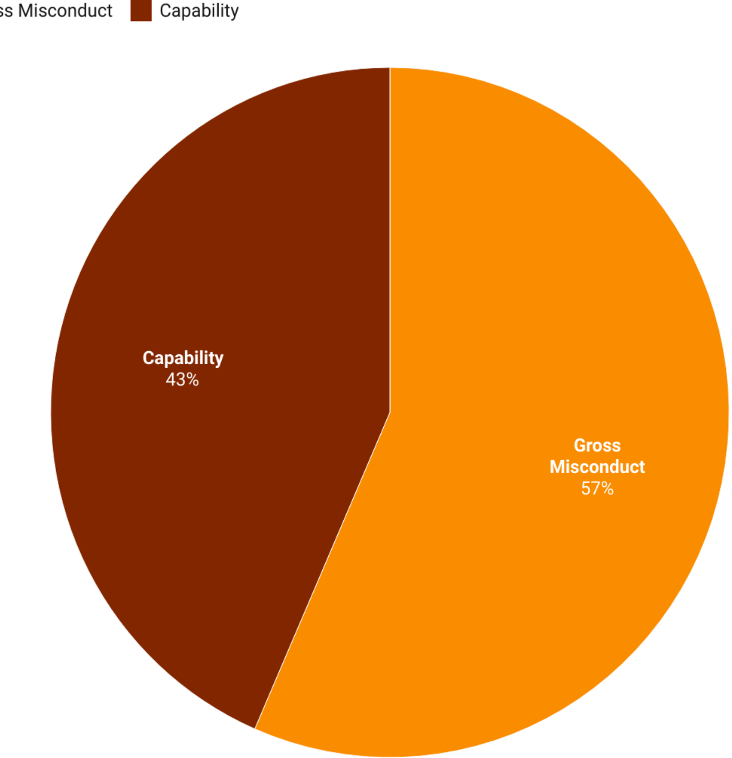
At least one manager dismissed in the last year for poor performance	10	9.4%
None dismissed in the last year	96	90.6%

90.6% of NHS organisations who responded to our FOI request(s) had not dismissed a single manager in the past year for poor performance. To protect individuals' privacy, most FOI teams told us that they could only tell us that 'less than 5' managers had been dismissed in the last year for either gross misconduct or poor performance. Not a single trust told us they had dismissed 5 or more managers in either category.

NHS providers are large organisations, many of which employ over ten thousand total staff, and thousands of managers. Of the acute NHS Trusts who responded to FOI requests not a single one had less than a hundred full time managers working in their service.

The average total number of managers in each acute Trust was 502. Of the trusts which told us they had not dismissed any managers, the average total number of managers working in their service was 431.

Figure 18 – Grounds for Dismissal, NHS Managers



Gross Misconduct	13	43%
Capability	10	57%

Our findings show that more managers (57%) are being dismissed for 'gross misconduct' (e.g. theft or physical violence) than for capability and poor performance (43%). The proportion of Trusts which have dismissed any manager for poor performance in the last year is 9.4% (across England).

To supplement these findings, we also examined results from the 2022 NHS Staff Survey and compared metrics related to leadership against the rate at which managers had been dismissed.

The NHS Staff Survey is a national survey that is conducted once a year by NHS England with the aim of providing a 'snapshot' of how staff experience their working lives at a given time.[174]. Combining evidence from the Staff Survey with CQC inspections and evidence from our FOIs reveals the following:

- **Nottingham University Hospitals NHS Trust**, which employs 1,245 managers, managing over 19,000 staff, told us that they had not fired a single person for gross misconduct or poor performance in the last year. In its latest CQC report, published in September of 2023, Nottingham was rated as 'requiring improvement' on four of five main performance categories.
- **University Hospitals Plymouth NHS Trust**, which employs

1,058 managers, has also not fired a single manager in the last year. In November 2023, it only managed to see 53% of patients in Accident and Emergency (A&E) within four hours (missing the 95% national target by a considerable margin).

After a recent CQC inspection, York and Scarborough Teaching Hospitals NHS Foundation Trust's maternity units were downgraded to the 'Requires Improvement' category. Sarah Dronsfield, deputy director of CQC operations in the North of England commented:

> *'We saw people using services being put at risk of harm from a lack of good processes, such as staff not completing risk assessments or keeping people's care plans up to date. We also saw infection control processes weren't effective in urgent and emergency care, with dirty equipment and premises, and clinical waste not being managed appropriately.'*[187]

York and Scarborough Teaching Hospitals NHS Foundation Trust had not dismissed any of their 476 managers for gross misconduct or poor performance in the last year.

If the CQC and the NHS Staff Survey are critical of management in a given NHS provider, and key quality indicators show that the Trust is not performing well, then one conclusion we might draw is that some managers across the organisation are not performing to the standard expected of them by the public, patients and taxpayer. The evidence collected by our FOI requests suggest that the mechanism by which NHS managers are held accountable is, therefore, not currently functioning effectively.

The NHS Staff Survey in More Detail

In 2022, 264 NHS organisations took part, including 215 trusts in England.[175] A total of 636,348 NHS staff responded; 16,773 of whom identified as 'general managers'.[176]

The questions that the NHS Staff Survey asks are aligned to the 'People Promise Summary Indicators' which were first introduced with the NHS 'People Plan' in 2021.[177] These indicators are listed below:

Indicators in the NHS Staff Survey

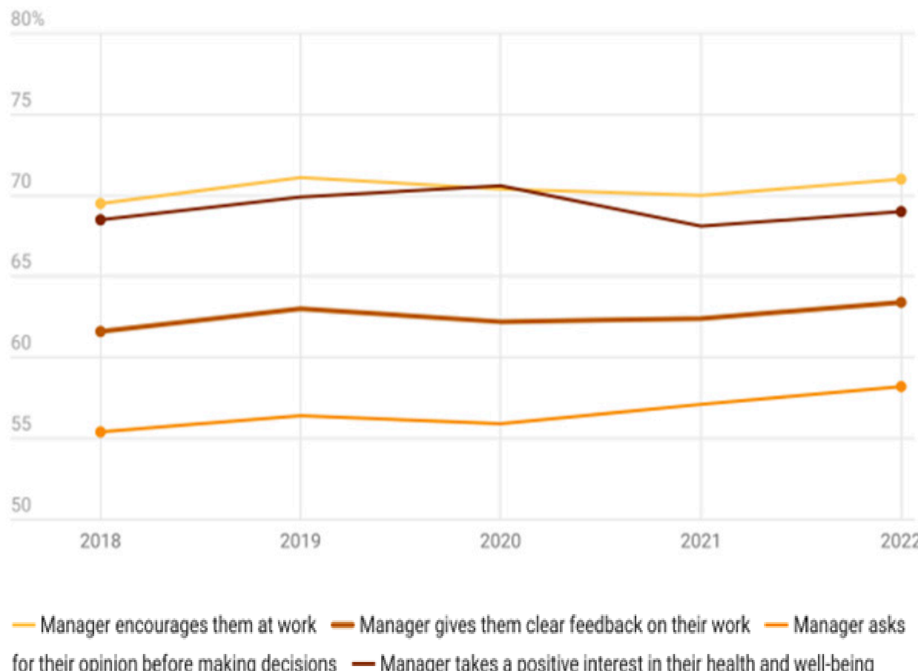
- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

One section of the report is dedicated entirely to line management and contains nine questions.[178]

Questions Directly Related to Management in the NHS Staff Survey

- Q9a – My immediate manager encourages me at work
- Q9b – My immediate manager gives me clear feedback on my work
- Q9c – My immediate manager asks for my opinion before making decisions that affect my work
- Q9d – My immediate manager takes a positive interest in my health and wellbeing
- Q9e – My immediate manager values my work.
- Q9f – My immediate manager works together with me to come to an understanding of problems
- Q9g – My immediate manager is interested in listening to me when I describe challenges I face
- Q9h – My immediate manager cares about my concerns
- Q9i – My immediate manager takes effective action to help me with any problems I face

Figure 19 – NHS Staff Survey Results with Questions Relating to Management (2018-2022)



As Fig. 19 shows, there has been little variation in scores nationally for the line management questions within the NHS Staff Survey over recent years. However, other questions and topics within the NHS Staff Survey itself provide indirect insight into the quality of management across the NHS.

Examining the responses specifically of general managers to the survey, one item stands out in particular:

- **8.2% of 'general managers' disagreed or strongly disagreed with the statement 'I always know what my work responsibilities are' (Q3a), the highest of any occupational group.**

Suggested Improvements to the NHS Staff Survey

The stated purpose of the NHS Staff Survey is to inform NHSE's national assessments of quality and safety, and at a local level, to inform the CQCs 'intelligent monitoring' of the performance of Trusts.[215] There is however scope to enhance the NHS Staff Survey so that we can improve out understand of how the NHS is managed today. Questions about management focus very specifically on the relationship between staff and their direct line managers, but this does not accurately reflect the relationship between staff and 'managers' more broadly.

The performance of managers who staff do not directly interact with, whether at a board level or in backroom functions – such as finance or estates – still impacts their workplace experience, and this should be reflected in questions also asked. More direct, challenging questions on management may provide a more substantive dataset for assessing the quality of management at a national level, and at a trust level. These questions would focus on specific indicators of 'effective' management as opposed to how supportive management is, on domains such as Digital Transformation, internal coherency of organisational structures and accountability, which have more practical application for delivering better outcomes for patients.

Suggested Additional Questions

(Q) **If I need to resolve a problem affecting my workflow, I always know who to speak to.**
(A) Strongly Agree / Agree / Not sure / Disagree / Strongly Disagree

(Q) **I think that those in more senior positions to me understand the specific workflow challenges and pressures my colleagues are under.**
(A) Strongly Agree / Agree / Not sure / Disagree / Strongly Disagree

(Q) **A lack of physical space on the organisations estate can cause conflict between my team and other teams.**
(A) Strongly Agree / Agree / Not sure / Disagree / Strongly Disagree

(Q) I think that financial resources in my organisation are distributed effectively and fairly by senior management.
(A) Strongly Agree / Agree / Not sure / Disagree / Strongly Disagree

(Q) The tools required to perform my core functions (e.g. IT) are of a sufficient standard to perform my role effectively.
(A) Strongly Agree / Agree / Not sure / Disagree / Strongly Disagree

215. 'NHS Staff Survey in England', *NHS England*, (last accessed 5th June 2024) [link]

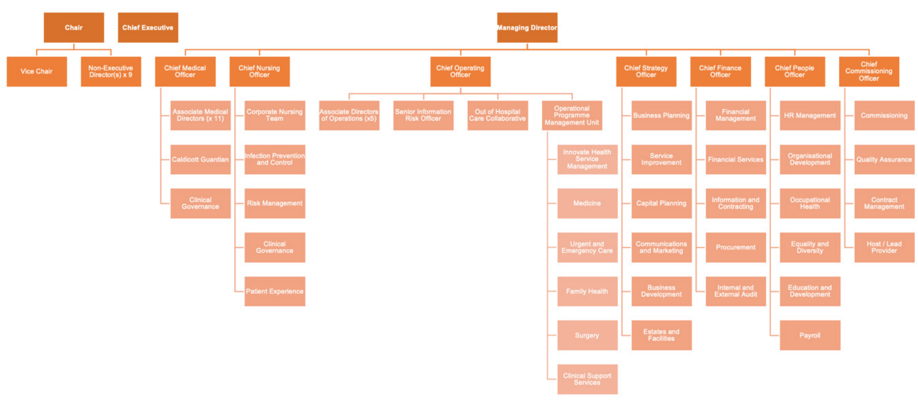
Chapter 5 – The Link Between NHS Management, Productivity and Performance

NHS organisations are complex. This can make it challenging to determine the criteria by which to effectively assess the impact that management and leadership has upon their performance overall. (See Fig. 20 below for an example of the leadership structure of a current NHS Foundation Trust, as of July 2024.)

Compare healthcare with another policy area such as secondary school education and the nature of this complexity is revealed. The headteacher of a school will usually sign-off on the appointment of each teacher that the school hires, meaning there is just one degree of separation between the head of the organisation and the 'front line'.

In a large trust employing over ten thousand staff with rapid turnover (averaging 12.5% in September 2022) it would be impossible for a CEO to scrutinise hiring decisions so closely.[216] A CEO of a Trust also is unlikely to have the same authority over clinicians as headteacher have over members of staff. Even a CEO with a clinical background could not have the requisite clinical knowledge to understand every single pathway. This can make performance management and driving change(s) within an organisation more technically challenging.

Figure 20 – Leadership Structure, based upon South Warwickshire University NHS Foundation Trust (2024)



Source: Leadership Structure, based upon South Warwickshire University NHS

216. Nihar Shembavnekar, Elaine Kelly, 'Retaining NHS nurses: what do trends in staff turnover tell us?', *The Health Foundation*, 3rd April 2023 [link]. Staff turnover averaged 12.5% in September 2022

Foundation Trust 2024 [link]

As such, NHS managers – including senior leadership at its largest organisations – are "more circumscribed in their role than private sector counterparts" and have to balance "multiple, perhaps conflicting, objectives".[217] Administrative tasks, meanwhile, can be regarded as "separate from and, on a day-to-day basis subordinate to, clinical activities". As one analysis puts it, therefore, in this context, the relationship between the degree of managerial input and performance is "likely to be tenuous at best, if evident at all".[218]

This finding can be arrived upon because previous studies have modelled hospital output as "a function of capital, physician and management input". Management input has been conceived either as "a distinct staff group in the hospital production function or as a way to influence total factor productivity". These two specific approaches have found little association between the degree of management input and hospital output(s). Table 8 below provides further analysis on the link between hospital management and performance, by the use of an indicative literature review.

217. Miqdad Asaria, Alistair McGuire, Andrew Street, 'The impact of management on hospital performance', *Institute for Fiscal Studies*, 9th December 2021 [link]
218. Ibid, note 8

Table 8– An Indicative Literature Review of the Impact of Hospital Management and Performance

Author(s)	Description	Outcome(s)
Zuchowski et al (2023)[219]	• Publicly available data on financial and structural parameters for 178 hospitals in Germany from the years 2015, 2016 and 2017 were collected and mean values were calculated for all variables. Nearest-neighbour matching was performed to allow comparisons to be made between hospitals with medical and non-medical leadership.	• "Hospital leadership structure is a crucial factor in organisational performance. The presence of a person with a medical background at the top level of hospital management can have a beneficial impact on the delivery of healthcare." • Nurse-to-patient and physician-to-patient ratios were significantly higher in hospitals with a medically-trained chief executive officer than in those without, as were the outpatient-to-inpatient case ratios. • Leadership type did not seem to have a significant impact on hospitals' financial performance.
Asaria et al. (2022)[220]	• Uses the electronic staff record (ESR), an integrated human resources and payroll system to determine total number of managers. • Considers five indicators, capturing financial performance and measures of timely and high-quality care.	• Finds no evidence of an association between quantity of management and various measures of hospital performance; some evidence that higher quality management is associated with better performance.

219. Matthias Zuchowski, Aydan Göller, Dennis Henzler, 'Is medical leadership associated with better hospital management? Evidence from a structural analysis of hospitals in Germany', *British Journal of Healthcare Management Vol. 29, No. 2*, 7th February 2023 [link]
220. Miqdad Asaria, Alistair McGuire, Andrew Street, 'The impact of management on hospital performance', *Institute for Fiscal Studies*, 9th December 2021 [link]

Janke et al (2020)[221]	• Examines the effectiveness of this approach in the context of English public hospitals, complex organizations with multi-million turnover	• Finds "little evidence that CEOs are able to change the performance of hospitals with respect to these key targets, or indeed with respect to almost any of wide range of measures of production which are easily observed by the government." • NHS CEOs may be in post for too short a time to have an effect, and also that certain CEOs may matter in certain conditions, i.e. that there are CEO-hospital match effects. These match effects, together with the short tenure of hospital CEOs in the English NHS system, may be the reason why we also find that certain CEOs are systematically paid more than others: when the average tenure period is short, the market cannot distinguish between a good match and good performance in all settings.

221. Katharina Janke, Carol Propper & Raffaella Sadun, 'The Impact of CEOs in the Public Sector: Evidence from the English NHS', *Harvard Business School*, 15th September 2020 [link]

Elkomy et al. (2018)[222]	• Studies individual leadership styles, namely, task-relations-, change- and integrity-oriented, and for different metrics of quality of healthcare provision, including staff and patient satisfaction survey measures and clinical performance indicators.	• "We find that task-oriented leadership has the strongest relationship with staff-rated hospital quality while change-oriented leadership relates most to patient satisfaction and the clinical measure. We also find some evidence that organizational autonomy and competition across hospitals moderates the effect of leadership quality on healthcare quality." • "Ideal healthcare leaders should behave as integrated leaders and that leadership matters at all levels of organizational hierarchy."
Kirkpatrick (2018)[223]	• Data from 160 hospital trusts in England from 2007 to 2012 analysed. "We wanted to know whether the proportion of managers in a hospital trust affected hospital efficiency, patient experience and the quality of clinical services."	• "Statistically significant correlation between the proportion of managers in a provider organisation and its performance has been observed. An increase in managers, from 2% to 3% of the workforce, has been associated with a 15% reduction in infection rates and a 5% improvement in hospital efficiency"

222. Shimaa Elkomy, Zahra Murad, Veronica Veleanu, 'Does Leadership Matter for Healthcare Service Quality? Evidence from NHS England', *International Public Management Journal, 26 (2)*, 2020, p147-174 [link]
223. Ian Kirpatrick, 'What the NHS needs is more managers', *Warwick Business School*, 17th December 2018 [link]

Birken (2018)[224]	• Explores middle managers' role in healthcare evidence-based practice implementation and its determinants.	• Middle managers "may play an important role in facilitating EBP implementation. Included studies offered little understanding regarding the relative importance of various roles, potential moderators of the relationship between middle managers' roles and EBP implementation, or determinants of middle managers' role in EBP implementation. Future studies should seek to understand determinants and moderators of middle managers' role. Clearer understanding may facilitate the translation of evidence into practice.
Tsai et al (2015)[225]	• Collection of data from surveys of nationally representative groups of hospitals in the United States and England to examine the relationships among hospital boards, management practices of front-line managers, and the quality of care delivered.	• "Hospitals with more effective management practices provided higher-quality care." • "Higher-rated hospital boards had superior performance by hospital management staff. Finally, we identified two signatures of high-performing hospital boards and management practice. Hospitals with boards that paid greater attention to clinical quality had management that better monitored quality performance."

224. Sarah Birken, Alecia Clary, Amir Alishahi Tabriz et al, 'Middle managers' role in implementing evidence-based practices in healthcare: a systematic review', *Implementation Science*, 12th December 2018 [link]
225. Thomas C. Tsai & Ashish K. Jha et al., 'Hospital Board and Management Practices Are Strongly Related To Hospital Performance On Clinical Quality Metrics', *Health Affairs*, Vol. 34, No. 8 (2015) [link]

Bloom et al. (2011)[226]	• Interview-based evaluation tool that defines and scores from one ("worst practice") to five ("best practice") 18 key management practices.	• "Publicly-owned organizations have consistently lower management scores in each sector, even after controlling for country and size" • "Promotion is based on time served, and persistent under-performers are not retrained or moved positions. One explanation for this is the strength of unions who place a great emphasis on equity, fairness and political criteria" • "Interviews with clinical practice leads in cardiology and orthopaedic departments in hospitals across several countries and found an association between higher-quality management and lower risk-adjusted hospital mortality from acute myocardial infraction (AMI)."

226. Nicholas Bloom, Christos Genakos, Raffaela Sadun & John Van Reenen, 'Management Practices Across Firms and Countries', *Harvard Business School*, 19th December 2011 [link]

Van Reenan et al. (2010)[227]	- Assesses adoption of management practices across c. 1,200 hospitals in Canada, France, Germany, Italy, Sweden, the UK, and the US. - Combines a calculation of hospital-level management score with hospital-level outcome data	- Strong relationship holds between hospital management and outcomes. - Better managed hospitals tend to have better clinical outcomes, higher levels of patient satisfaction and enhanced financial performance. - In UK, a one-point improvement in our assessed management practice scores is associated with a 6% fall in the rate of deaths from heart attacks. "While we cannot be sure that these are causal effects, the strength of the correlation suggests that management plays as much of an important role in healthcare as it does in industry." - Strongest findings: "competition stimulates better management and higher productivity". "Hospital size makes a difference: larger hospitals, especially those with more than 100 direct employees exhibit much higher levels of management than smaller hospitals."

227.John Van Reenen, Rebecca Homkes, Raffaella Sadun & Nicholas Bloom, 'Why good practices really matter in healthcare', *VOXEU The Centre for Economic Policy Research*, 17th December 2010 [link]

Söderlund (1999)[228]	• Study attempted to quantify the effect of management input on hospital productivity for the first three years of the NHS internal market (1991/2-1993/4). • Average cost function used to model the effect of management inputs on hospital costs	• No evidence found "that increasing management inputs was associated with improved productivity". • "On the contrary, spending more on top level managers appeared in fact to be associated with lower productivity levels. Results would thus appear to be in line with decisions to reduce the level of expenditure on management in NHS hospitals."

What an overview of the literature above reveals is an equivocal link between the volume of managers and provider performance, but does clearly demonstrate the importance of 'good management'.

'Well Led' Organisations

In addition to this literature review, we sought to overlay the findings of our FOI requests with other key indicators of trust performance to further investigate whether we might determine an association and/or causality between the volume of managers and enhanced performance.

The CQC sets out clear criteria for what they consider attributes of a 'Well-Led' organisation. Eight separate lines of inquiry on topics such as external engagement, risk management and clarity of responsibility for good governance are pursued during inspections.[229] These criteria are assessed through a wide range of evidence including staff surveys, interviews with board members and senior leaders and analysis of budgets and organisational performance against plans.[230] There is a reasonable balance between what might be described as 'hard' and 'soft' lines of inquiry; with insight in to performance management and process design being key criteria for a positive 'Well led' rating. However, there are some value judgements suggested on what 'good leadership' entails that could be questioned.

The seventh line of inquiry, W7, relates to the engagement of external stakeholders in the design of services; including staff, patients and partners.[231] Subsection 7.3 asks: 'Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture?[232] W1.3 asks whether or not there is evidence of collective leadership.[233]

Tables 9 and 10 below show a selection of high and low performing trusts according to the NHS Oversight Framework which responded to

229. 'Inspection Framework: NHS trusts and foundation trusts', *Care Quality Commission*, 2018 [link]
230. Ibid, p. 8
231. 'Inspection framework: NHS trusts and foundation trusts', *Care Quality Commission*, 2018 [link]
232. Ibid
233. Ibid
228. N. Soderlund, 'Do managers pay their way? The impact of management input on hospital productivity in the NHS internal market', *National Library of Medicine, National Center for Biotechnology Information*, January 1999 [link]

our FOI request.

Table 9 – High Performing Acute Trusts in NHS Oversight Framework

Trust	Northumbria Healthcare NHS Foundation Trust	South Warwickshire NHS Foundation Trust	Maidstone and Tunbridge Wells NHS Trust
CQC Combined Rating	Outstanding	Outstanding	Requires Improvement
CQC Well-Led Rating	Good	Outstanding	Good
Referral to Treatment waiting times RTT (December 2023) *National Average* – 56.6%	77.9	61.7	68.7
4-Hour A&E Target (January 2024 *National Average* – 70.3%	86.5	70.1	83.7
Cancer 62-day Referral *National Average* – 65.9%	79.9	60.1	85.3
Staff-Manager Ratio **Based Upon FOI**	4.7%	7.5%	4.4%

Table 10 – Lower Performing Acute Trusts in NHS Oversight Framework

Trust	Isle of Wight NHS Trust	University Hospitals Plymouth NHS Foundation Trust	Royal Devon University Healthcare NHS Foundation Trust
CQC Combined Rating	Requires Improvement	Requires Improvement	Good
CQC Well-Led Rating	Good	Good	Requires Improvement
Referral to Treatment waiting times RTT (December 2023) ***National Average – 56.6%***	51.92	54.9	53.3
4-Hour A&E Target (January 2024 ***National Average – 70.3%***	65.3	54.0	67.4
Cancer 62-day Referral ***National Average – 65.9%***	63.1	63.2	65.4
Staff-Manager Ratio **Based Upon FOI**	7.9%	10.58%	3.88%

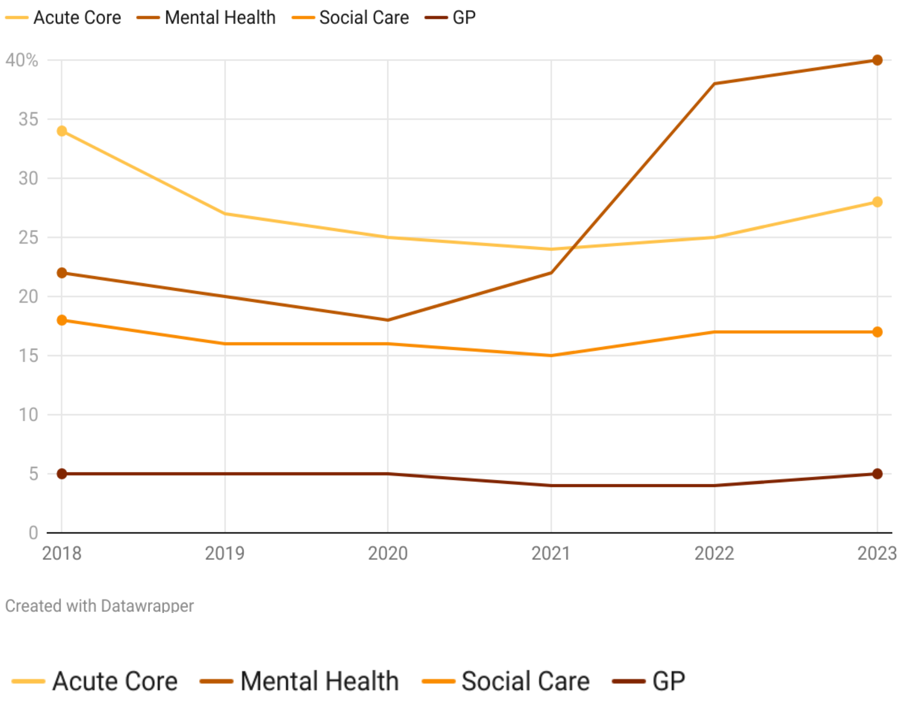
As Tables 9 and 10 indicate, the NHS Oversight Framework and CQC do broadly identify poor performance at the lower and higher ends of the spectrum. This is however at variance with a number of recent peer-reviewed publications which have suggested that performance indicators have proven a poor guide to subsequent inspection ratings, which "may call into question the validity of indicators, ratings or both".[234]

The CQC publishes an annual 'State of Care report' in October of each year. Fig. 21 below shows the proportion of NHS providers in each of the four main sectors which have been rated 'inadequate' or 'requires improvement'. The most notable trend in this dataset is the increase in

234. Thomas Allen, Kieran Walshe, Nathan Proudlove & Matt Sutton, 'Do performance indicators predict regulator ratings of healthcare providers? Cross-sectional study of acute hospitals in England', *International Journal for Quality in Health Care*, Vol. 32, No. 2 (2020), 113–119 [link]

poor performance among Mental Health Trusts, with an 122% increase in the number of services rated inadequate or requires improvement between 2020 and 2022. This can partly be attributed to the rapid increase in demand following the Covid-19 Pandemic. Referrals for Mental Health Services for Children (CAMHS) rose by 76.6% between February 2020 and February 2022.[235]

Figure 21 – Percentage of NHS Organisations rated 'Inadequate' or 'Requires Improvement' in the 'Well Led' category by the CQC between 2018-23, broken down by Provider Type



Looking specifically at the 'Well Led' category, we see that there has been a convergence of management quality between 2018 and 2023, with Acute, Mental Health and Social Care registering between 22-23% Inadequate or Requires Improvement in 2023. Overall, there is a fairly strong correlation (0.872) between 'well-led' and overall performance, indicating that poorer quality of management does correlate with worse performance in other categories.

GP services are much less likely to be rated as poorly performing or inadequate than other sectors, and there has been negligible change either for overall performance between 2018-2023. And yet, we know from the GP Patient Survey data that the number of patients describing their experience as 'good' has fallen from 83.8% in 2018 to 71.3% in 2023.[236]

The Role of the Regulators

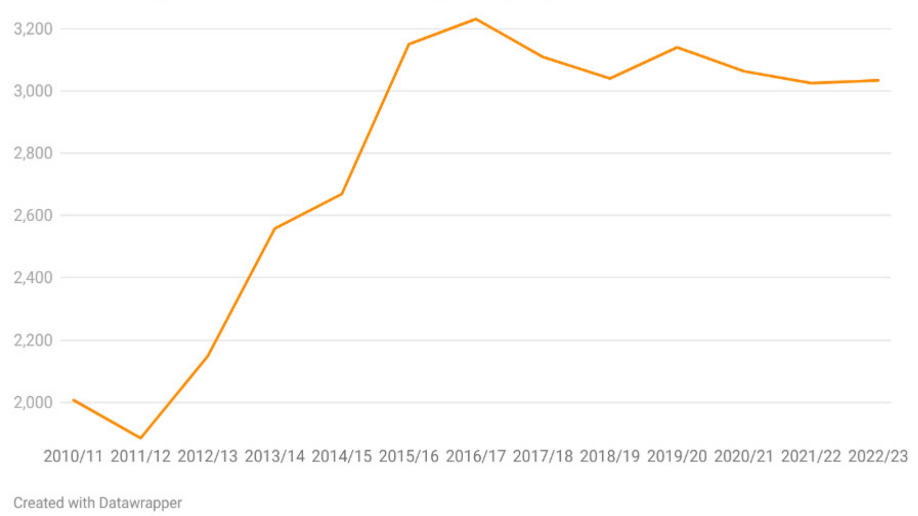
As health and social care are devolved matters, there are different regulators in England, Scotland and Wales. In recent years, confidence in the way that the regulator in England, the Care Quality Commission (CQC),

235. 'Analysis: the rise in mental health demand', *NHS Confederation*, 13th May 2022 [link]
236. 'National Report 2023 Survey', *GP Patient Survey*, 2023 [link]

assesses provider performance has declined. It has culminated in the recent proclamation from the Secretary of State for Health and Social Care, that the regulator is "not fit for purpose".[237] The basis of this judgment was the delivery of an interim report from Dr Penny Dash, chair of the North West London ICB, who has found inspection levels below where they were in 2019, as well as a lack of clinical expertise among inspectors, a lack of consistency in assessments and problems with the CQC's IT system(s).

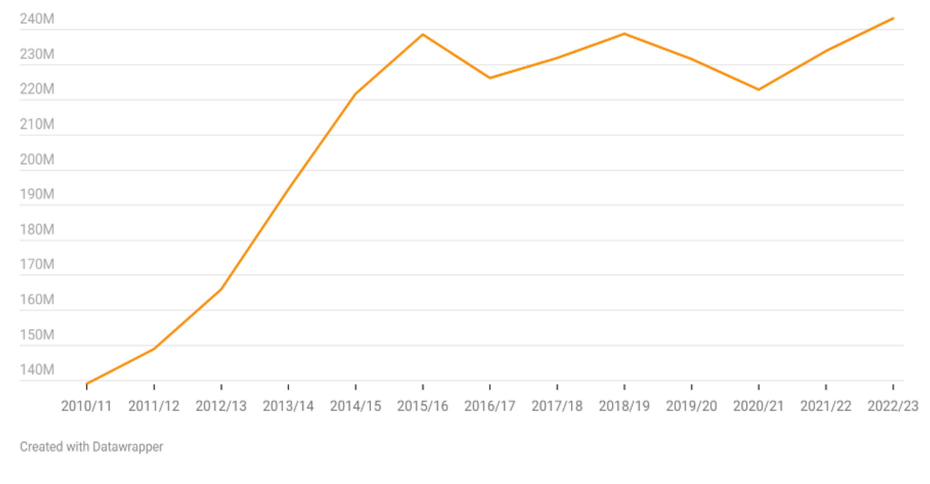
These findings are consistent with the perspectives of some of those we have spoken to as part of this research. Some interviewees reflected a noticeable reduction in the experience of inspectors in recent years, significant variations in the nature of investigations (including questions posed to senior leadership) despite a larger headcount and expenditure (see Fig. 22 and Fig. 23). This has reduced the confidence (and respect) which come with investigations. Others reflected more broadly on the approach to regulating complex services – is a single aggregate rating an effective way to determine overall quality and performance? Does it make sense, meanwhile to have NHS England effectively score its own providers – and to duplicate – to hold them to account? How effectively do they use evidence, such as that developed by local Healthwatch branches as a marker of quality despite their institutional proximity?

Figure 22 – Care Quality Commission, Directly Employed Staff Numbers, 2010-2023



237. Eleanor Hayward, 'Hospitals have gone unchecked for up to 10 years', *The Times*, 26 July 2024 [link]

Figure 23 – Care Quality Commission, Net Annual Expenditure (£)



A striking feature of the interim Dash Review is that whilst there is an "evidence category for outcomes data but surprisingly little evidence of assessments and inspections considering the outcomes of care". An example cited is that of the ninety-nine-quality statement and evidence categories considered, only two refer to outcomes of care.[238] Not only is there, therefore, a limited emphasis in outcomes, but it is not clear what Outstanding care should look like in objective terms.

CQC inspectors often require a substantial amount of data to conduct their investigations – as one GP practice manager pointed out to us, some of this information requested may often be held centrally by the NHS, creating additional bureaucracy. Others reflected that requests did not take an appropriate approach to risk. By way of example, some GP practice managers reflected the following based on recent inspections:

- "I've had inspectors berate us for using drawing pins on notice boards which could be "a hazard to patients" and advised to use velcro pads instead"
- "CQC would not take Friends and Family Test results as evidence of improvements in patient satisfaction – so why do we collect it every month?"
- "The inspector wanted to see our policy for young people working in the practice, they were particularly interested in 16 –18-year-olds. We don't have a policy for this as we have never employed anyone in this age bracket. We would of course have one if we needed one, but why should we have to write policy for policies sake? A colleague in a neighbouring practice didn't get asked about this at all and they have a 17-year-old apprentice…"

238. Penny Dash, Independent report: Review into the operational effectiveness of the Care Quality Commission: interim report, *DHSC*, 26 July 2024 [link]

The challenges associated with CQC inspections have in fact created an

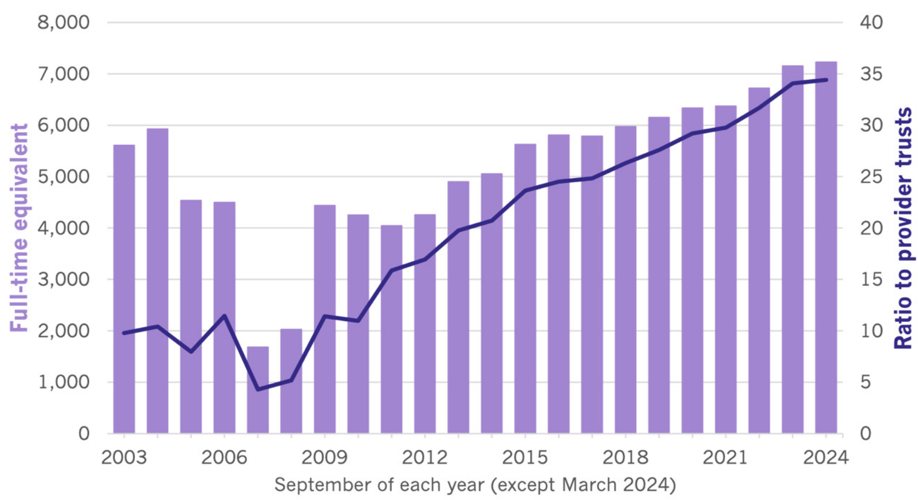
industry of consultancies who offer services to providers of both primary and social care. These consultancies advertise staff as 'ex-CQC' inspectors and offer support packages including mock inspections and guidance. A single inspector at a practice can charge fees upwards of £900 a day. A full package for a single practice can cost over £10,000.

The overall effect of these developments has culminated in the interim chief executive, Kate Terroni, reflecting that "our people are not able to effectively identify and manage risk and encourage improvement and innovation". "Our organisational structure, flow of decision making, roles, internal and external relationships do not promote a productive and credible way of working."[239] Dr Dash's recent review has found that of the locations the CQC has the power to inspect, it is estimated that around 1 in 5 have never received a rating.[240]

The cost of running the regulator meanwhile has risen significantly over the past decade (see Fig. 22 and Fig. 23 above).

As Lord Darzi's recently-published Independent Review has shown (see Fig. 24, below) the total headcount in 'regulatory type bodies' has increased from just over 2,000 in 2008 to more than 7,000 in 2024, and the number of people in regulatory roles for each provider trust has gone from 5 per provider to more than 35, as trusts have consolidated over the same period. He reflects that "this imposes a burden on Boards and management teams of care-providing organisations".[241]

Figure 24 – The full-time equivalent number of staff in NHS statutory bodies with 'regulatory' type functions, and the ratio of staff to provider Trusts



Source: Lord Darzi, Independent Investigation of the National Health Service in England: Technical Annex, DHSC, September 2024 [link] p. 325

Note: Statutory bodies in scope, include: NHS Resolution, National Institute for Health and Clinical Excellence, National Patient Safety Agency, NHS Counter Fraud

239. Emily Townsend, 'Exclusive: CQC admits it is failing to keep patients safe', *Health Service Journal*, 26 June 2024 [link]
240. Government acts after report highlights failings at regulator, *DHSC*, 26 July 2024 [link]
241. Lord Darzi of Denham, Independent Investigation of the National Health Service in England, *DHSC*, September 2024 [link], p. 123

Authority, Appointments Commission, Health Development Agency, NHS Information Authority, NHS Litigation Authority, National Treatment Agency, Prescription Pricing Authority, Family Health Services Appeal Authority, Dental Practice Board, Human Fertilisation and Embryology Authority, Health Research Authority, Human Tissue Authority, Care Quality Commission, the Medicines and Healthcare products Regulatory Agency and the Health Services Safety Investigations Body. The exact number of staff in each statutory organisation that have are involved in regulatory functions is unknown. Not all bodies listed are in scope across the whole time series. Some organisations were formed recently, some have been abolished, and some have changed names and/or function.

Some are of the view that the institutional landscape for ensuring patient safety overall has become far too fragmented with unclear responsibilities and overlapping remits. Indeed, some have questioned the logic of having an arms-length body responsible for independent investigations into patient safety concerns (the Health Services Safety Investigations Body, HSIB), set up in 2017) – when some would regard this to be part of the CQC's remit. Indeed, since 2022, some of the work of these bodies has merged. The HSIB maternity investigations programme is now hosted by the CQC (known as the Maternity and Newborn Safety Investigations programme).

There is a strong case for reform – to improve confidence both for NHS organisations and to ensure consumer confidence. To fix current issues it is vital that we ask some foundational questions. What is the right approach to regulation? Do we expect it to be an enabler of quality improvement as well as ensuring patient safety? Would we be advised to move closer-in-step with regulatory approaches being taken internationally, where accreditation is more commonplace? These are the questions that Ministers and senior leadership of NHS organisations and the regulator should consider first. A first, important step that should be taken is for the CQC to focus on the recruitment and retention of senior inspectors to improve confidence in the quality and consistency of its inspections. Pay packages for those working for regulators are far below what can be earned at NHS England or in individual providers. This must be equalised if the highest quality inspectors are to be recruited.

Approaches to 'Turning Around' Provider Performance

As part of our research, we interviewed a number of NHS trust Chief Executives who have sought to 'turnaround' the performance of their organisation (e.g. in the wake of a poor CQC inspection).

As part of this process, we sought to consider what the 'ingredients' which enable an effective turnaround may be.

Table 11 – Case Study – Imperial College Healthcare NHS Trust

Context

- Imperial College Healthcare NHS Trust in London is one of the largest trusts in the country, with more than 15,000 staff serving over a million people every year.[242]
- The Trust comprises five hospitals situated across Central and West London, including Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and The Western Eye, and is consistently rated alongst the leading NHS institutions for clinical research.
- When the current Chief Executive was appointed in 2018, the Trust was in Segment 3 of the NHS Oversight Framework, with a sizeable operating deficit and rated as 'requiring improvement' by the CQC in both the combined rating and the 'Well-Led' category (in 2014).
- The Trust is forecast to break-even financially this year, with the CQC upgrading the rating for 'Well-led' to 'Good' in 2019 and moving the Trust up to Segment 2 in the NHS Oversight Framework.

Approaches To 'Turnaround'

- The Trust launched a **"Improvement Through People Management"** course which now over 2,000 people have completed. The course considers approaches to effective inter-personal management, including how to have difficult conversations about performance, or dealing with unrealistic expectations about promotion.
- The Trust has also fostered **a direct and active role in managing the performance of General Managers** in the Trust and has taken steps to ensure that individuals with responsibility for performance of a service line have a good understanding its latest performance data.
- **A focus upon operational management:** Theatre efficiency at the Trust has risen from the bottom of the Shelford Group (a group of ten large teaching hospitals) to the top in recent years.
- **Reflections on organisational culture:** A framework of values has been developed via engagement with staff, resulting in so-called CAKE guidelines – Collaborative, Aspirational, Kind and Expert. Staff are held to account against these values.

242.'About us', *NHS Imperial College Healthcare*, (last accessed 6th June 2024) [link]

- The Trust has previously piloted a **Paired Learning Scheme** which linked those on the NHS Graduate Management Training Scheme with Foundation Year Two doctors. The Trust continues to pair managers and clinicians through its suite of leadership courses.[243]

Table 12 – Case Study – Sheffield Teaching Hospitals NHS Foundation Trust

Context

- Sheffield Teaching Hospitals NHS Foundation Trust is a combined Acute and Community Foundation Trust – one of the largest Trusts in the country, serving a population of almost 600,000 people with around 18,500 staff, operating on a budget exceeding £1.2bn a year.[244]
- A routine inspection in 2018 had rated the Trust 'Good' overall, with an 'Outstanding' ranking for 'Are Services Responsive?'.[245]
- In the Winter of 2021, however, the CQC issued the Trust with an 'Improvement Notice' detailing thirteen areas of concern and a ninety-three area action plan.
- The CQC's report found that in four of five categories for Quality, the Trust 'Required Improvement', with one category for safety rated 'Inadequate'.[246]

Responding to an Inspection

- Following a challenging CQC inspection, leaders will first need to assure the Board and Non-Executive Directors that the senior leadership team has the capabilities to effectively turnaround performance.
- At Sheffield, the leadership team was supported by the Board and NEDs and was given time to put the "house in order" whilst exercising significant oversight of the plans.
- **Grip from the top, but distributed responsibility:** At Sheffield, the Executive Team developed a streamlined action plan for improvement identifying key themes and a small number of impactful interventions, drawn up with the input of clinical staff. Trust leadership was clear that this would be more effective than drawing up a "Three-hundred-line spreadsheet of actions that everyone just switches off from".

243. Alice Roueché, Lizzie Smith, 'Re: Clinical Leadership and Management in the NHS', *Journal of the Royal Society of Medicine*, 3rd October 2011 [link]
244. 'About Us', *Sheffield Teaching Hospitals NHS*, (last accessed 6th June 2024) [link]
245. 'Sheffield Teaching Hospitals NHS Foundation Trust. Inspection Report', *Care Quality Commission*, 14th November 2018 [link]
246. 'Sheffield Teaching Hospitals NHS Foundation Trust. Inspection Report', *Care Quality Commission*, 5th April 2022 [link]

- **Effective oversight 'on the ground':** The Executive Team then ensured interventions to improve were carried out robustly. One such measure was to implement 'safety huddles'; regular multi-disciplinary meetings which focused clinical attention upon patients most at risk.[247]
    - Senior Managers ensured delivery on the plan by visiting clinical teams through "Quality Support Visits" in-person to observe huddles and see improvements in action.
    - Wards were given ratings for quality of care, with specific improvement support targeted for clinical teams in areas which were consistently rated as 'red'.
- **Results:** In the latest inspection report, conducted in 2022, the Trust had made significant progress, with two categories of five now rated 'Good', and none rated 'Inadequate'.[248]
- Wider leadership development approaches: The Trust also developed its own Leadership and Quality Improvement Training Programmes (LEAD), a standardised development offer for managers and leaders.[249]

247. Leading Change, Adding Value Team, 'The Atlas of Shared Learning Case Study', *NHS England*, 7th February 2019 [link]
248. 'Sheffield Teaching Hospitals NHS Foundation Trust. Inspection Report', *Care Quality Commission*, 22nd December 2022 [link]
249. 'Develop your leadership skills and improve services for patients. Leadership and Quality Improvement Training Programmes', *Sheffield Teaching Hospitals NHS Foundation Trust*, (last accessed 6th June 2024) [link]

Table 13 – Other Examples of Effective 'Turnaround'

Trust	Context	Commentary
Barking, Havering and Redbridge University Hospitals Trust (2020s)	Trust has been in and out of 'special measures' (and equivalent regimes) over the past decade: in care quality special measures for four years (2013 to 2017); several changes of senior leadership, including at CEO level during the 2010s.	• Trust leadership regarded promotion out of 'special measures' be in recognition of improvements in urgent and emergency care and in finances in particular. • **A Focus on Core Performance:** Significant improvement against four-hour A&E performance and reduced ambulance handover delays were seen over past two Winters (2022 and 2023). According to the NHS Confederation, BHRUHT "made the most improvement on waiting lists for emergency care than any other trust in England" during 2023.[250] • **Consolidated Leadership:** BHRT has consolidated its leadership, forming part of a "group" structure with neighbouring Barts Health Trust; they share a chair and "group CEO". • **Effective Capital Investment:** In 2019, BHRUHT's capital expenditure was c. £7m. In 2023, it was close to £50m.

250. Nick Kituno, 'Most improved' trust exits NHSE intensive support', *Health Service Journal*, 24th May 2024 [link]

Salford Royal NHS Foundation Trust (2010s)	In 2012, Salford Royal NHS Foundation Trust had one of the lowest mortality rates in the country; 92% of patients received harm-free care and 95% of patients stated they would recommend the hospital to friends and family. In both 2015 and 2018, Salford Hospital was rated by the CQC as outstanding.[251]	• **Importance of Shared Values:** Senior leadership emphasised the clarity of the values and behaviours they expected of all staff working at the trust. • **Visible leadership:** regarded as important for understanding what was happening 'on the ground' and as a means of targeting necessary changes. Senior leadership would often spend half days working alongside member of staff on wards to understand frustrations and impediments holding back performance. • **Spreading Best Practice and Leadership:** In 2016, Salford entered a part-merger with the neighbouring Pennine Acute Trust to become the 'Northern Care Alliance'. The Pennine Acute Trust, which was struggling with performance, saw a quick turnaround in standards of care.[252] The Chief Executive at that time, Sir David Dalton, was asked by Rt Hon Jeremy Hunt MP, then Secretary of State for Health, to write a report advising on how this could be in to practice in the NHS.[253] • We should note, however, that this improvement seen in the early 2010s has not sustained. In its most recent CQC inspection, the enlarged trust has been downgraded to 'Requires Improvement'.[254]

251. 'Salford Royal NHS Foundations Trust Salford Royal Hospital Quality Report', *Care Quality Commission*, 27th March 2015 [link] and; 'Salford Royal NHS Foundation Trust Inspection Report', *Care Quality Commission*, 24th August 2018 [link]
252. 'NHS heavyweight and trust boss Sir David Dalton announces retirement', *National Health Executive*, 20th November 2018 [link]
253. Candace Imison, 'Hospital chains: a recipe for success?', *The King's Fund*, 27th February 2014 [link]
254. Trust drops from 'outstanding' to 'requires improvement', *Health Service Journal*, 22 November 2022 [link]

Brighton and Sussex University Hospitals Trust (2000s)	Brighton and Sussex had a deficit of over £11m in 2005 & significant performance issues, such as with it's A&E department. In December 2005, Department of Health announced 'turnaround teams' would be sent to NHS bodies with the most significant financial issues. A review by KPMG had given Brighton the worst possible ratings for finance and management capability.	• **Clarity of Ownership and Effective Monitoring:** Savings Initiatives were developed, with discrete projects and accountabilities clearly assigned. Regular milestones had to be achieved and are then intensively monitored, on a weekly basis, by a specially established project management office (PMO).[255] • **Engagement of clinicians:** regarded a clear characteristic of successful turnaround. In Brighton, restructuring the organisation into three clinical divisions (emergency, elective and specialist), each headed by a divisional clinical director with a seat on the board. • **Effective use of incentives:** Payment by results provided "the right context for turnaround to be a success, forcing organisations to collect more detailed information about their costs and services, making decisions far more informed." [256]

Some of the Key Ingredients

- **Effective review of extant issues** – to ensure the remedy will be correct. High importance should be attached to understanding the nature of extent issues before solution(s) can be proposed.
- **Importance of creating common purpose and a 'theory of change'** – without buy-in from staff across organisation – particularly clinicians – little will happen. A clear articulation and agreement upon values and standards is needed.
- **Effective healthcare management requires a balance of quality, performance and finance** – these features are often reciprocal and reinforcing.

255.'Case studies in turnaround', HFMA Briefing: Contributing to the debate on NHS finance (September 2006) [link]

256.'Case studies in turnaround', HFMA Briefing: Contributing to the debate on NHS finance (September 2006) [link], p. 13

Recommendations

DHSC should commission a review into the patient safety organisations and healthcare regulators to clarify purpose and remits. Changes in particular are required at the Care Quality Commission (CQC) so it delivers greater consistency in assessments and draws from an inspectorate with more direct experience of the settings they inspect.

a. As the recently-published, interim Dash Review has found, there is no clear definition of what 'good' or 'outstanding' care looks like, resulting in a lack of consistency in how care is assessed.
b. CQC should seek to enhance its inspectorate with more individuals with greater direct experience of working in the settings they inspect to enhance the prestige of the organisation amongst NHS providers. Salaries for inspectors must be commensurate with positions of similar seniority at DHSC, NHSE in order to ensure encourage applications from the best candidates.
c. The "Well-Led" category should be expanded to include more detail about leadership pipelines and training and should focus on the development of 'hard' management skills.
d. The CQC should improve the consistency of GP practice inspections, and allow for more discretion on minor details which do not impact care quality or patient safety.

The Electronic Staff Record (ESR) should be enhanced so every NHS organisation records the total volume, experience and specialised skillsets of every individual with management responsibilities within their organisation. This is to develop system intelligence for future planning requirements and to encourage a clearer definition of management across the NHS today.

Additions should be made to the NHS Staff Survey to improve our understanding of how the NHS is managed. Additional questions should be included to focus on domains including the internal coherence of organisational structures and effectiveness of workflows. We suggest the following questions are added:

i. "If I need to resolve a problem affecting my workflow, I always know who to speak to."
ii. "I think that those in more senior positions to me understand the specific workflow challenges and pressures my colleagues are under.
iii. "A lack of physical space on the organisations estate can cause conflict between my team and other teams."

iv. "The tools required to perform my core functions (e.g. IT) are of a sufficient standard to perform my role effectively."

All operational managers should be formally appraised through the introduction of a digital portfolio and mandatory reviews against established criteria (where it is not already commonplace). The aim is to ensure competencies and experience and more effectively 'logged' for the purpose of appraisal and review. Individual organisations should be responsible for the effective appraisal of managers.

More effective procedures to dismiss managers who persistently under-perform are required. An eight-week target should be set by the DHSC between issuance of a notice of poor performance (as defined by the Employment Act 2002) and the issuing of an employee notice.[257] Local termination policies and procedures should be adjusted to facilitate swifter dismissal.

257. 'Employment Act 2002', *Legislation.gov.uk*, (last accessed 7th June 2024) [link]

Chapter 6 – Enhancing NHS Management and Leadership Training and Development

> *"Excellent talent remains invisible, career support remains opportunistic, talent-hoarding becomes the privileged domain of those that can, and the system struggles to deploy the best people to work where their skills are needed most."*
>
> **General Sir Gordon Messenger**[258]
>
> *"...If we are going to get the calibre of leaders that we need in the NHS, then that investment in their education, as well as the standard setting, as well as the accountability, is crucial"*
>
> **Amanda Pritchard**, Chief Executive, NHS England[259]
>
> *"We don't develop people here – as a consequence, many drift over time into consultancy"*
>
> **Anonymised reflection from an operational manager**

As the Chief Executive of NHSE, Amanda Pritchard, stated before the Health and Care Select Committee in the Autumn of 2023, the NHS must "bake in" the expectation of training and development if it is to attract and retain the best leaders.[260] The 2023 NHS Long Term Workforce Plan only mentions operational management in the abstract, regarding their roles in improving retainment of clinical staff.[261] This may have been due to the difficulties in securing the support of political stakeholders for increasing the number of non-clinical staff alongside doctors and nurses, but it may also be because of the difficulty in determining the quantity of managers that will be required in the future. Focus at NHSE has instead been upon implementing the findings of the Messenger Review of 2022 and in developing a 'roadmap' for a more consistent management and leadership development offer to employees.[262]

As our report has set out, enhancing NHS performance and productivity is not simply a question of increasing the overall number of managers.[263] As research from the National Institute for Health and Care Research (NIHR) states, "The obsession with management numbers and costs overlooks more significant issues concerning management capacity and the contributions that middle and front-line management make to clinical and organisation outcomes".[264] To instead judge this, we need to be far

258. General Sir Gordon Messenger, 'Independent report: Leadership for a collaborative and inclusive future', *DHSC*, 8 June 2022 [link]
259. Nick Kituno, 'Some managers get no training or support, warns Pritchard', *Health Service Journal*, 16th November 2023 [link]
260. Ibid
261. 'NHS Long Term Workforce Plan', *NHS England*, 30th June 2023 [link]
262. Simon Bottery, 'Time for a specific focus on adult social care leadership', *The King's Fund*, 9th March 2022 [link]
263. 'Using AI to improve back office efficiency in the NHS', *NHS England*, 11th February 2022 [link]
264. D.A. Buchanan, D. Denyer, J. Jaina, et al., 'How do they manage? A qualitative study of the realities of middle and front-line management work in healthcare', *National Institute for Health and Care Research* (June 2013) [link]

more clear-sighted about which functions managers should execute – both today and in the future. Moreover, we also need to be clearer about the balance between autonomy and accountability we expect them to possess. That requires better definition of roles.

Effective management is key to improving operational performance to ensuring the delivery of 'transformation' programmes – such as rolling out electronic patient records or upgrading an ageing hospital estate. Robotic process automation (RPA) has the potential to transform back-office functions and productivity, but a system that is poorly managed or which lacks the critical capabilities will not be able to effectively procure and implement these technologies. Financial management skills too are highly important, but one study notes that many managers are expected to learn budgeting 'on the job'.[265]

Prioritising Core Operational Management Skills

"Everything is Process"

Andrew Grove, Former Chief Executive of Intel [266]

One report has identified that the lack of a universal 'minimum quality' was responsible for much of the deficiency in management practices across the NHS.[267] Indeed, as it stands today there is no clear set of competencies expected of managers according to seniority. Policy Exchange understands that discussions have begun amongst a range of stakeholders, coordinated by NHSE, to determine what a curriculum, code of conduct and set of national standards might look like.

A number of those we have interviewed for this report pointed out that a priority for those in 'middle management' should be a focus on developing core functional skills such as process design and data analysis; whilst for executive leadership there was a far greater requirement for education in strategic thinking and politics and a greater understanding of how international systems of healthcare function.

The course curriculum of the Elizabeth Garrett Anderson (EGA) programme is reflective of the political philosophy of the NHS today. Collaboration between managers and clinicians is emphasised, contrasted favourably with 'command and control' methods. Trainees are encouraged to learn how to 'align stakeholder incentives' as a means for ensuring cohesion within the system, through careful negotiation of interpersonal relationships. There is a strong emphasis on Equality Diversity and Inclusion (EDI), described as one of three 'golden threads' of leadership which must be referred to in written assignments.[268] The EGA has been criticised by some for not adequately preparing graduates for the practical realities of management in NHS settings.[269] Some of those we have spoken to as part of this research also reflected this view, with one interviewee describing the course as 'overly theoretical'.

Graduates who are not on the General Management programme of the GMTS often receive education from outside the centrally-delivered EGA

265. Edward Granter, Paula Hyde, 'What have NHS managers ever done for us?', *London Journal of Primary Care*, December 2010 [link]
266. Ian Tien, 'Top Takeaways from Andy Grove's High Output Management' [link]
267. Richard Hyde, Niamh O Regan, 'A picture of health? Examining the state of leadership and management in healthcare', *Social Market Foundation*, July 2023 [link]
268. 'Welcome to the Elizabeth Garrett Anderson programme: Golden Threads', *NHS Leadership Academy*, (last accessed 6th June 2024) [link]
269. Nora Ann Colton, 'The NHS graduate management scheme is no longer fit for purpose', *Health Service Journal*, 7th November 2022 [link]

programme. For graduates on the Health Informatics scheme, the NHS funds graduates to study through University College London, for instance. One recent graduate was much more complimentary of their experience on this course, stating that its content was much more geared towards hard management skills with courses taught by leading academics. They stated that they use the lessons learned during this course 'every day' in their job.

A new balance between 'soft' and 'hard' needs to be found, with greater emphasis on core management skills, including process improvement. Too often there is a "disconnect between identifying an opportunity for productivity gains in principle and realising the benefits in practice."[270] There is a conflict between the desire to create an inclusive working environment and the need to create a more efficient system, and this is not reflected in what the NHS teaches as 'good management', and in how it evaluates the leadership of individual providers. The NHS Staff Survey moreover reveals clearly the frustration of staff relating to poor organisational processes and a poor culture of listening, yet most of the remedies explored by NHS organisations often centre on 'wellbeing' initiatives, separated from measures to improve the operational environment.

To meet these challenges, approaches to management and leadership training needs to be reformed, maintaining the most valuable elements of the current system, including the GMTS. Changing incentives for individuals is also required and should be reviewed by assessing how individuals progress through the 'Agenda for Change' banding system. Interview processes should prioritise selections based upon provable metrics. Some NHS staff have reflected that the approach could be substantially improved by requiring candidates to present hard evidence of their abilities and competencies (which could be demonstrated and supported via a digital portfolio).

International Comparisons

Given the unique nature of the NHS, it can be difficult to draw comparisons between the approach taken by the GMTS (for instance) and schemes that exist elsewhere. NHSE has recently set up a leadership observatory with the express purpose of commissioning research into management practices in other countries.[271] Countries with more centralised healthcare systems such as Spain do have national requirements for the training of managers, but our review of international evidence did not identify any other countries with a scheme that is directly equivalent to the GMTS.[272]

In most countries, healthcare management is taught as a specific degree, with practical placements offered alongside a three- or four-year course; differing to the structure of the GMTS which is a two-year job with an academic degree attached to it. While British universities do offer graduate and post graduate degrees in 'Healthcare Management', these are not always linked to NHS programmes itself, which is provider led.[273]

Some examples of approaches taken in leading healthcare systems internationally are provided in Fig. 25, below:

270. Tim Horton, Anita Mehay & Will Warburton, 'Agility: the missing ingredient for NHS productivity', *The Health Foundation*, 13th October 2021 [link]
271. 'Our Research- Leadership Observatory', *NHS Leadership Academy*, (last accessed 6th June 2024) [link]
272. Maria Luiza Silva Cunha, José-Manuel Freire, José Ramón Repullo & Virginia Alonso Hortale, 'Bureaucratic state and health management training from a historical perspective: similarities and differences between Brazil and Spain', *Saude Soc (Sao Paulo), Vol.28, No 2* (2019) [link]
273. 'BSc (Hons) Business and Healthcare Management', *Anglia Ruskin University*, (last accessed 7th June 2024) [link] and 'Health Management MSc. Postgraduate taught degree', *City, University of London*, (last accessed 7th June 2024) [link]

Figure 25 – Overview of Healthcare Management Approaches in Comparator Countries

United States	• An accreditation system called CAHME (Commission on Accreditation of Healthcare Management Education) has been set up to provide a 'gold standard' for professional healthcare managers, with multiple educational providers regulated by a central body.[274] • This system imposes a measure of directly quality control for academics; with a requirement that 'All professors will achieve at least 90% score on didactic core competency knowledge exam'.[275] • The CAHME criteria are also very prescriptive on 'hard' management skills. Core competencies include, but are not limited to: performance management, design of healthcare structures, operational improvement and information technology management.[276] • CAHME closely monitors where graduates work, including their salaries and positions. • One individual we spoke to assessed that measurement of the impact of leadership and management training in the UK is weak. As one Kings Fund paper has stated: 'overall, there is little robust evidence for the effectiveness of specific leadership development programmes.'[277]
France	• France has a highly-regulated entry to hospital management and requires individuals to complete the Hospital Director training programme at the Ecole des hautes études en santé publique (EHESP) in Rennes. This is a 27-month programme for people wishing to be hospital directors or assistant hospital directors with formal examination to gain entry.[278]

274. Commission on Accreditation of Healthcare [link]
275. 'Accreditation Standards and Self-Study Handbook. 2021 Standards', *Commission on Accreditation of Healthcare Management Education*, 10th November 2023 [link]
276. Ibid
277. Michael West, Kirsten Armit, Dr Lola Loewenthal et al, 'Leadership and leadership development in health care', *The King's Fund*, 25 February 2015 [link]
278. Judith Smith & Naomi Chambers, 'The regulation and development of NHS managers: a discussion paper, In host publication www.midstaffspublicinquiry.com (2011) [link]

Singapore	
	• Singapore's primary stream for teaching Healthcare Administration is through the national business administration school, Singapore Management University (SMU). Healthcare training is offered as a component of general Business Administration and is integrated with internships that take place at hospitals.[279] This draws in talented individuals who have an interest in business management at an undergraduate level but may only choose to specialise in health while at university. • SMU also offers a specific training course for Clinical management, the Graduate Diploma in Healthcare Management and Leadership.[280] The course content is broad, covering topics such as ethics and media crisis management that are not taught in the NHS's educational offerings.[281] • SMU also offers training for managers and executives who have business experience outside of healthcare looking to start in a healthcare setting.[282]

279. 'New undergraduate programme in healthcare administration launched', *HealthXchange.sg*, August 2018 [link]
280. 'SMU-SingHealth Graduate Diploma in Healthcare Management and Leadership (GDHM), *Singapore Management University*, (last accessed 7th June 2024) [link]
281. Ibid
282. 'Advanced Certificate in Healthcare Management and Leadership Module 1: The Healthcare Operating Environment', *Singapore Management University*, (last accessed 7th June 2024) [link]

Israel	• There are a variety of academic institutions offering clinical management training in Israel, including the Galilee International Management Institute. The offerings are different for different backgrounds, with courses on offer for those with medical experience.[283] • Bar-Ilan University also offers a full Masters in Healthcare administration.[284] Mandatory components on this scheme include quality and risk management, advanced management tools and epidemiology. • There is a long process for a doctor to becoming a clinical manager in Israel. This preparation period requires a degree in medicine, completion of residency training, a two-year business management or healthcare administration degree, followed by two years of supervised, practical training (including two oral examinations).[285] • Management is regarded as a speciality within Medicine in Israel (just like internal medicine or surgery, for instance), raising the esteem of clinical managers.[286]

'Managers by Accident'

As one trust chief executive put it to us, the NHS "does not consistently provide opportunities to develop [management and leadership skills]". Those who are self-driven and want to lead can get there, but identification and development of talent is not something systematically done. A recent review of current NHS trust chief executives found that "few, particularly from a medical or clinical background, described proactively seeking leadership opportunities early in their careers". Many received leadership training exclusively for senior healthcare leaders, often provided by The King's Fund or the NHS Leadership Academy.[287]

One interviewee we spoke to suggested that amongst nursing staff, a 'tap on the shoulder', rather than a 'book of opportunities' still felt like the norm when it came to opportunities to lead. Concerningly, the recent General Medical Council Training Survey has also found that since 2022, there has been a decline of six percentage points (69% to 63%) in the proportion of doctors in training agreeing that their posts gave them opportunities to develop their leadership skills.[288]

There has, therefore, been calls in recent years to enhance leadership opportunities. The development of the Faculty of Medical Leadership and Management (FMLM) has been a positive development over the past decade, notwithstanding the small number of clinicians who

287. Alex Till & Gerry McGivern, 'Routes to the Top: The Developmental Journeys of Medical, Clinical and Managerial NHS Executives', *The University of Warwick*, 30 June 2020 [link]
288. National training survey 2024, *General Medical Council* [link], p. 3
283. 'Health Systems Management', *Galilee International Management Institute*, (last accessed 7th June 2024) [link]
284. 'MHA in Health Systems Management', *Department of Management, Faculty of Social Sciences, Bar-Ilan University*, (last accessed 7th June 2024) [link]
285. 'Letters. Journals should select drug advertisements more carefully', *BMJ*, 31 May 2005 [link]
286. 'Doctors and managers: Healthcare management is treated as specialty in Israel, *BMJ*, 29 May 2003 [link]

undertake placements each year. One of the recommendations made by an interviewee was that over time the FMLM should focus on the ways it can spread best-practice more effectively by connecting those who have participating in leading leadership training and through the development of a resource library. As it was put to us, it "should have a bank of people and credibility".

What is missing however is a consistent offer to all clinical staff. All staff should be able to access training in the basics of management. Doctors in training or Band 6 nurses are unlikely to have had involvement in the recruitment of staff or to line manage, given the basis of their progression as a professional has been based upon the development of clinical competencies. A recent review suggests that the literature on the competences of the manager-clinician is "limited and partial, and provides no mutually agreed-upon definition of the role. Furthermore, current studies supply generic and partial indications regarding managerial competences without stating the specific competences necessary for a manager-clinician".[289]

It is also important to make greater opportunities are extended to 'managers by accident'.[290] These are individuals who have no formal training in management but have drifted upwards in to positions of responsibility and power as their career has naturally progressed with experience and time served. The NHS has previously sought to extend core educational offers, delivered by the centre, with mixed success. A number of schemes were launched in the early 2000s, including the 'NHS University' for those entering healthcare employment for the first time and those returning to work after a break, before being absorbed into a new NHS Institute for Learning, Skills and Innovation.[291] The NHS Staff College was an idea which had momentum behind it, owing to the leadership of Aidan Halligan, but only a small number of providers ever committed to developing the concept.[292]

Moreover, although Allied Health Professionals (AHPs) – which includes paramedics and physiotherapists for instance – are the third largest workforce in the NHS, strategic leadership positions for AHPs within the NHS have been relatively small in number. In England, NHS Trust executive boards are required to include a medical and a nurse director, but there is no obligation to include clinicians from other professions, meaning there is often a lack of visible leadership. [293]

The Hewitt Review, published in January 2023, identified opportunities for the development of distinct leadership development for individuals wishing to lead Integrated Care Systems.[294] We can see advantages to this approach and it in fact aligns to a proposal we have previously made with respect to enhancing opportunities for healthcare professionals to work between NHS settings (i.e. between primary and secondary care) through roles we have suggested are called "interface specialists".[295]

It is our contention that a key role for the NHS at a national level will be to determine the core competencies it wishes to see of its management – at each level of seniority. This should focus on core skills and must not

289. Simone Fanelli et al., 'Managerial competences in public organisations: the healthcare professionals' perspective', *BMC Health Services Research*, Vol. 20, No. 303 (2020) [link]
290. Anthony Painter, 'The NHS needs to give its 'accidental managers' more support', *Health Service Journal*, 27th November 2023 [link]
291. Donald MacLeod, 'NHS university axed', *The Guardian*, 30 November 2004 [link]
292. Aidan Halligan, 'The need for an NHS Staff College', *Journal of the Royal Society of Medicine*, Vol. 103, No. 10 [link]
293. Ibid
294. Rt Hon Patricia Hewitt, 'The Hewitt Review. An independent review of integrated care systems', *Department of Health and Social Care*, 4th April 2023 [link]
295. Dr David Landau, Dr Sean Phillips, 'Medical Evolution. Measures to improve the interface between primary and secondary care', *Policy Exchange*, 29th June 2023 [link]

constitute a 'wish list'. It must, moreover, build on work which has already been progressed by organisations, such as Proud2BeOps who have sought to develop the basis of a curriculum for NHS operational management. A values-based approach and an emphasis on culture may pose more challenges than it solves, given that individual trusts, in addition to the wide range of professional regulators already possess a set of standards and values by which they expect their workforce to abide by.

There are particular challenges meanwhile in ensuring an effective pipeline for non-clinical technical experts. Today, fewer than one in twenty NHS trust boards have a Chief Information Officer or Chief Digital Information Officer, as a voting executive director of the board, while just 10 per cent of ICBs had a long-term digital workforce plan in place. [296] One survey has suggested 86% of trusts currently find it "difficult or extremely difficult" to recruit Digital, Data and Technology (DDaT) professionals.[297] This is not just a challenge in relation to securing professionals with analytical capabilities, but also for medical engineering staff.

A draft NHS report, entitled "Building a Digital, Data and Technology, and Informatics Workforce in Health and Social Care: 2023 to 2028", reported upon by the Health Service Journal suggests creating additional flexibility at local level to enable enhanced pay (potentially beyond Agenda for Change) for professionals with required skillsets. To ensure market competitiveness and to develop talent inhouse, this is an option which ought to be taken forward.[298]

The Hewitt Review also reached similar conclusions, noting that "the health and care system urgently needs to develop, train and recruit more specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialized analytical and intelligence. Unfortunately, the Agenda for Change framework for NHS staff makes it impossible for systems to pay competitive salaries for these skilled professionals, with the result that too many ICBs and providers recruit the necessary staff on short-term contracts".[299]

One of our recommendations – building on the recent Messenger Review – is for a dedicated approach to be taken to recruit talent at the mid-career level from those who have a non-clinical background. Below, we set out a proposal for a 'Teach First' style scheme to be introduced.

296. Nick Kituno, 'Leaked national tech workforce plan proposes local pay rises', *Health Service Journal*, 18th March 2024 [link]
297. Ibid
298. Ibid
299. Rt Hon Patricia Hewitt, The Hewitt Review: An independent review of integrated care systems, *DHSC*, 4 April 2023 [link], p. 72

Developing a 'Teach First' Style Scheme for Mid-Career Entrants

One of the recommendations made in this report is for the development of a new scheme, aimed at individuals who do not have a clinical background, but who seek to enter NHS operational management at 'mid-career' level.

The scheme should be two years in length in total: those accepted onto the programme should be hired into organisations which are 'under-managed' at present or where the provider is currently under-performing. This is to provide those on the scheme with experience of working in a challenging operational context. But throughout the programme, each recruit would be 'buddied' with a member of the senior leadership within the trust and would be mandated to partake in management and leadership development training.

Those who are admitted onto the scheme should be paid at Band 8A level from the outset – a key reason for this is that for those on the GMTS who may be taking on their first job after undergraduate or graduate studies, the initial salary is unlikely to be an inhibiting factor, but it is likely to be a greater issue for those who have been in employment for a number of years and may have risen to positions of mid or even senior leadership within their field of expertise.

Benefits to be extended to those on the scheme (which should mirror many elements extended to graduates of the GMTS scheme)[300]:

- **Competitive salary:** A starting salary at Band 8a (according to Agenda for Change pay scales) on commencement, plus (where applicable) the NHS High Cost Area Supplement (HCAS).
- **Fully funded study package:** Ability to study for at least one professional qualification at no academic cost to trainees – with a focus upon development of required technical skills, e.g.
- **Pension:** Automatic enrolment onto the NHS Pension Scheme
- **Other benefits:** Access to Employee Assistance Programme (EAP) to Edenred and Cycle to work scheme.

300.Pay and Benefits, *NHS Graduate Management Training Scheme* [link]

The Case for Greater Devolution of Training and Development Programmes

> *"Whether or not the GMTS prepares you effectively is down to the placements you undertake. Some are high-quality, but I also know of people who spent entire year on placement working from home, never meeting a single member of their team in person."*
>
> **Anonymised reflection from a recent graduate of the GMTS**

The 2015 Smith Review identified increasing local 'ownership' of leadership development as important for improvement.[301] There is a strong case for stating that the Elizabeth Garrett Anderson programme – and the wider GMTS – should be reformed in this regard.

Taking a purely national approach enables standardisation and consistency of approach to talent management, but it may stifle innovation and the growth of a market for management and leadership skills development beyond those programmes which are offered nationally.

With 55,000 doctors-in-training throughout England (in instance) alone, this represents a significant cohort to ensure have access to the basics of management training, discussed above.

The opportunity should be taken, therefore, to find a greater balance between national and more localised approaches which enable standardisation where it is essential, but also to encourage greater innovation and focus on management and leadership development beyond 'the centre'. We also see opportunities to stimulate greater competition amongst providers of education to raise the bar management and leadership training overall as a result.

A number of trusts and ICBs have already begun or are looking to create their own bespoke management training schemes. Which begs the question: could this be a model for how we train graduates more widely? The two case studies below (Table 14 and Table 15) details how provider have sought to develop their own bespoke schemes.

301. 'Review of centrally funded improvement and leadership development functions', *Public Health England, NHS England, Monitor, Care Quality Commission*, 27th March 2015 [link]

Table 14 – Case Study – University Hospitals of Leicester NHS Trust / University of Leicester

Since 2017, University Hospitals of Leicester (in partnership with the University of Leicester) has run its own trust-level management training scheme, separate from the wider national programme, with the view of retaining management trainees 'in house'.[302] Interviews of graduates from this scheme suggested that Leicester's running of an 'in-house' scheme increased the extent to which trainees felt a local loyalty.[303]

The "pioneer scheme" was twenty months long and included a single placement hosted and funded by Clinical Management Groups (through reinvestment of vacancy monies).[304] The scheme was designed to run alongside and complement the NHS Graduate Management Training Scheme.

A notable difference between the local scheme and the National scheme is that there are only two placements on the local scheme. On the National Scheme, graduates are invited to take part in a two month 'flexi placement' after their first placement finishes.[305]

302. 'Experiences of the Internal UHL Graduate Management Trainee Programme', *University Hospitals of Leicester NHS Trust Board*, 1st November 2018 [link]
303. Ibid
304. Ibid
305. 'Flexi Placements', *NHS Graduate Management Training Scheme*, (last accessed 7th June 2024) [link]

Table 15 – Case Study: Guy's and St Thomas' NHS Foundation Trust

Guy's and St Thomas'
NHS Foundation Trust

Guy's and St Thomas' (GSTT) has run an internal Management Training Scheme since 2015 which runs alongside placements for graduates on the national MTS Scheme.[306]

How Does it Work & What is the Impact?

- GSTT has used this programme to enhance opportunities for those living in the local area, "to reflect the local community". The scheme serves to act as a pipeline for Service Managers at Band 7 and future General Managers.
- To achieve this, they have removed the requirement for a degree-level qualification. Instead, applicants must have a Level 2 in English and Maths (equivalent to a 'C' at GCSE).
- Candidates must sit a "cloud-based test" followed by panel interviews, representing an opportunity to meet other general managers on scheme, this differs from the GMTS scheme where there is no panel interview stage.
- The scheme had 1300 applications in January 2024, representing considerable growth in previous years (2022: 280 applicants; 2023-837 applicants).
- A longer first placement (than that organised by GMTS) allows trainees more time to settle into positions and to adapt to the extant culture and processes within the organisation.
- Over the two-year programme, trainees must work across clinical and corporate services with a focus on project management related roles.
- There is an accredited education component and monthly leadership development sessions (from individuals across GSTT organisations, finance and strategic leadership).
- This approach is reflected in retention rate – 76% of those who have been recruited via this route have remained working at GSTT.

Challenges

- As there is currently no central funding, it operates vias a system of "cross-charging". The current budget for the scheme is £6000 per year.

306.'Management Trainee. Guy's and St Thomas' NHS Foundation Trust', *NHS Jobs*, (last accessed 7th June 2024) [link]

- Those involved in running the scheme reflected that greater collaboration across the Integrated Care System would be advantageous, pointing to the fact that the development of a dedicated, local training scheme might not be appropriate for providers in all circumstances, for example, a small NHS Trust in a coastal region.
- Particularly successful local schemes could provide the blueprint for approach taken at other providers, with greater coordination of approach. As it was put it us: "why sit in different rooms trying to do the same thing?"

Conclusion

- Learning from the GSTT example, through larger organisations such as ICSs, is potential for improved administrative resourcing, and greater interest from candidates. There would also be a chance to share placements between Providers within the system to give trainees a broader range of experience.

How could a devolved model work?

Across an ICB footprint, providers could be empowered to commission professional development and academic or technical courses from a list of accredited educational institutions, creating competition on behalf of universities and colleges to provide the highest-quality offers. Trusts would be empowered to provide these educational programmes to managers within the system who wish to undertake formal leadership training to take the next step in their career.

One deficiency in any national scheme is its ability to respond to any specific local requirements. Although the national scheme does distribute trainees across the country, graduates are disproportionately drawn to London trusts. Distribution from the centre also means there is a variance in the quality of placements provided. One interviewee who had recently taken part of the scheme described it as the 'luck of the draw'. Empowering local trusts to create their own training schemes will have the further benefit of enabling improved 'buy-in' for graduates of the scheme. Having personal contacts within different parts of the hospital is often necessary to push transformation and change.

This won't work for all of elements of the scheme. For those in the 'Policy and Strategy' cohort it makes most sense for those graduates to work centrally. But this cohort only comprises 6% of the total graduates on the scheme.[307]

It is also questionable whether or not the 'graduate' requirement of GMTS requirement is necessary. With the exception of the 'Health Analysis' stream, which requires a degree with a numeracy element, the entry requirements for the GMTS (at present) are a 2:2 bachelor's degree in any subject from any university.[308] This is hardly a stringent requirement. In the year 2020/21, only 3% of students who acquired a

307. 'The NHS Graduate Management Training Scheme Annual Report 2020/2022', *NHS Leadership Academy*, (last accessed 7th June 2024) [link]
308. 'Entry Requirements', *NHS Graduate Management Training Scheme* (last accessed 9th June 2024) [link]

degree received a third.[309]

Whilst it is right that prospective trainee managers should have strong academic skills, this should be assessed at interview stage through the existing competency testing, to keep the scheme as open to people of different backgrounds and experiences as is possible. This has been the approach of the talent team at Guys and St Thomas's, who have designed their entry requirements so those without degree-level qualifications are not excluded (see Table 15 in this chapter above).

309. James Smurthwaite, 'Understanding the Undergraduate Grading System in the UK', *HotCoursesAbroad*, 28th April 2023 [link]

Recommendation(s)

Operational management requirements should be forecast in greater detail in next iteration of the NHS Long Term Workforce Plan in Summer 2025.

- NHSE has committed to updating the NHS Long-Term Workforce Plan at least every two years.[310] We suggest the next iteration includes: more detailed modelling of the current operational management requirements and leadership pipeline; an assessment of training needs and intake targets for different pathways into operational management roles (such as the GMTS).

Greater definition should be reflected in job titles and advertisements. The term 'manager' should be restricted to job descriptions which involve responsibility for staff and performance, as set out in the NHS Employers 'National Profiles for Professional Managers'.[311] This should aim to bring non-clinical management titles in line with clinical management positions such as 'Ward Manager'.

A 'Teach First' style scheme for individuals who do not have a clinical background, but who seek to enter NHS operational management at 'mid-career' level should be developed.

- Those accepted onto the programme should be hired in organisations which are 'under-managed' at present including within community health services, or where the provider is currently under-performing
- Those who are admitted onto the scheme should be paid at Band 8A level from the outset.

Reforms to the NHS Graduate Management Training Scheme (GMTS) should be introduced.

- The GMTS has historically (and will continue to) play an important role in raising the quality of management across the NHS.
- National retention rates after five years should be recorded and this information should be published annually. Data should also be collected on the retention of graduates, five and ten years after graduation for local schemes, to cross- compare with retention data recorded for the national programme.
- The link between the existing 'Policy and Strategy' scheme within the GMTS should be merged with DHSC's departmental policy graduate scheme.

310. 'NHS Long Term Workforce Plan', *NHS England*, June 2023 [link]
311. 'National profiles for professional managers', *NHS Employers*, (last accessed 24th June 2024) [link]

- The GMTS should include a new four-week mandatory placement in a primary, community or social care organisation.

Management and leadership training schemes, designed and coordinated at Integrated Care System (ICS) level should also be developed, with programmes in place across each of the 42 systems in England by 2027.

- Existing functions of GMTS, such as the Policy and Data streams should continue to be run centrally, but funding currently allocated to general management and HR functions (which constitute the bulk of graduates) should be increasingly distributed to Systems, Trusts and Community Interest Companies (CICs) to tailor their own schemes. These should provide leaders with opportunities to work across the health and care sector as a whole, adding management capacity to primary, social and community care.
- The Elizabeth Garrett Anderson (EGA) scheme, operated as part of the NHS Leadership Academy, currently used to train both graduates and prospective managers, should be overhauled, and in its place a list of approved educational providers should be made available to providers.

Operational managers should be performance managed and development measured through the introduction of a digital portfolio and mandatory annual appraisal (where this is not already commonplace).

To Regulate or Not to Regulate: Is That the Most Important Question?

The question of whether NHS managers should be subject to a set of agreed professional standards with national regulation governing their conduct, responsibilities and development has been a topic of regular conversation over the past twenty-five years.

When the report of the Bristol Royal Infirmary public inquiry was published in 2001, it recommended Government ought to consider statutory regulation of senior managers. Ken Jarrold, who had led work from the Institute of Health Services Management (IHSM) for a code of conduct, was asked to chair a Department of Health working group on the matter which resulted in a Code of Conduct for NHS Managers in October 2002.[312]

The subject has been at the forefront of a number of recent reviews – with the discussion particularly pronounced in the wake of the conviction of Lucy Letby. Last year, a GP from Nottinghamshire launched an online petition calling for professional regulations for NHS Managers, receiving

312.Judith Smith & Naomi Chambers, 'The regulation and development of NHS managers: a discussion paper, In host publication www.midstaffspublicinquiry.com (2011) [link]

25,544 signatures.[313] In their General Election manifesto, the new Government commit "implement professional standards and [to] regulate NHS managers, ensuring those who commit serious misconduct can never do so again".[314]

There is support for regulation of NHS managers as polled by Managers in Partnership – and many working across the NHS regard it as an inevitability.[315] As one manager said to us, "If it is good enough for board members, and good enough for other professions, then it is good enough for us".

But there are significant questions to be posed about how this diverse group of professionals would be regulated. Who would get to decide what professional standards should be in place – and indeed what should they be? Which activities should be regulated? What happens when an individual is covered by more than one regulator (where, for instance they operate in both a clinical and non-clinical role)?[316]

One interviewee, with years of experiencing managing acute settings, said that regulation might improve performance, but that putting "99% of the effort in to the 1% of managers who are problematic" would be an unproductive use of political capital and NHS resource.

Managers are after all drawn from a wide array of professional backgrounds, hold professional qualifications and memberships from a wide array of organisations (and regulators). A significant proportion of NHS managers are trained clinicians with ongoing clinical registration. Many working across finance or legal services will be registered with professional regulators.[317] How these regulatory regimes would 'overlap' is the subject of considerable debate. So is the question how any uniform 'Code of Practice' developed by NHSE would overlap with existing professional regulator codes of conduct and practice, or those which have developed at the individual organisational level.

It is unclear whether steps taken in this regard in fact meet the objective that most commentators are pursuing through regulation: enhancing patient safety and thwarting medical scandal. As the review in to the East Kent neo-natal services concluded - at least part of the responsibility for failings in care laid with clinical management.[318] As Jon Restell, the chief executive of Managers in Partnership, a union which represents health and social care managers puts it: "professional regulation is no silver bullet to solving problems of accountability around NHS managers."[319]

A further risk of regulation – depending upon how it is constituted – is that it erects barriers to entry for talent beyond the NHS – or health and care settings more broadly. Instead, in order to meet the growing challenges facing health and care – and for managers to implement new technologies which can enhance productivity will require the recruitment of experts with (often) non-clinical skillsets in fields such as data analytics or in implementing technologies such as robotic process automation (RPA).

313. 'Create a new regulatory body to hold NHS managers accountable', Petitions UK Government and Parliament [link]
314. *Change: Labour Party Manifesto 2024* [link]
315. Professional regulation won't improve NHS handling of concerns, managers warn, *Managers in Partnership*, 8 December 2023 [link]
316. Jon Restell, 'Regulating hospital managers is not the silver bullet to a safer NHS', *New Statesman, 6 September 2023* [link]
317. David Oliver, 'As a doctor I don't believe regulation of managers should be a priority', *Health Service Journal*, 28 September 2023 [link]
318. Government response to 'Reading the signals: maternity and neonatal services in East Kent - the report of the independent investigation', 3 August 2023 [link]
319. Jon Restell, 'Regulating hospital managers is not the silver bullet to a safer NHS', *New Statesman, 6 September 2023* [link]

Recommendation

Rather than pursuing the formal regulation of NHS managers, a disbarring regime – based upon the recommendations of the Kark Review – should instead be introduced

Chapter 7 – Enhancing The 'Operating Environment' Across the NHS

In this report so far, we have constructed a portrait of NHS management today, sought to diagnose some of the systemic challenges which are holding back improved performance and transformation and set out suggestions for how the pipeline for both clinical and non-clinical management may be enhanced.

In this chapter we comment on the current conditions and suggest measures to enhance the wider 'operating environment' to enable effective management, with a focus upon organisational structures, permissions and incentives.

Can the Centre Hold? Appraising the Central Bureaucracy

> *"As for the current split of NHS England as a statutorily independent commissioning board? Well it is bollocks…The idea therefore that the NHS is going to be this independent organisation, without political interference, and this, that and the other, is just rubbish and it has proved to be just rubbish. Every time anything crops up the Secretary of State intervenes and blames somebody else. Because this distancing has meant that he can blame somebody else but not accept any blame himself."*[320]
>
> **Rt Hon Frank Dobson**, Secretary of State for Health (1997-1999)

> *"Politics is the trap. And the only thing that can break it is politics. I'm afraid there is not a surfeit of politicians who think that their historical purpose, having got power, is somehow to give it away."* [321]
>
> **Rt Hon Alan Milburn**, Former Secretary of State for Health (1999-2001)

In his first week in post, the new Secretary of State for Health and Social Care instructed colleagues at DHSC and NHS England to work as "one team" and to air "competing views and interests". That such an instruction needs to be made speaks volumes.[322] A recent article from the Health Service Journal reveals that the two organisations "have had notoriously difficult and sometimes dysfunctional relationship, with tensions over

320. Glaziers and Window Breakers', *The Health Foundation*, p. 130
321. Ibid, p. 134
322. Zoe Tidman, 'Streeting tells NHSE and DHSC to 'work as one team' and air 'competing views'', *Health Service Journal*, 8 July 2024 [link]

policy development, funding, and sharing of information from the NHS to Government."[323] A recent opinion piece in the British Medical Journal reflects "a range of tensions, including those over territory, funding, responsibilities, and information sharing, have harmed the effectiveness of policy making across government and the upper echelons of the NHS".[324]

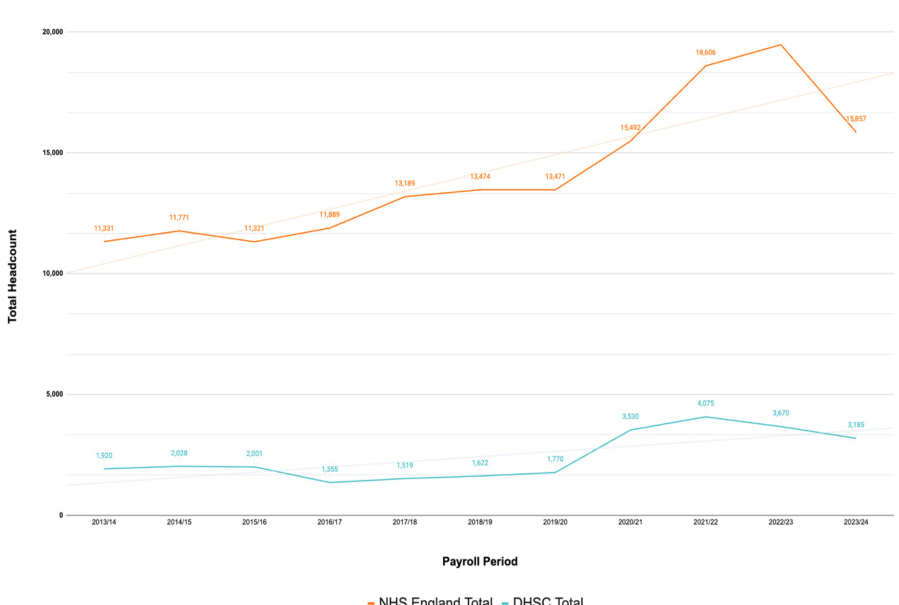
There is considerable disquiet amongst many about the prospects of further structural reform – indeed, as was stated in the Introduction to this report, it is regarded as some as the 'NHS disease'. The new Health Secretary has himself noted that there has been "too much chopping and changing" at NHSE and ICBs, as a result of "politicians who are keen to look tough and look busy by changing some letterheads and shipping people around organisations with different names and titles. I think [that's] utterly futile and wasteful."[325] But it has also been reported that he has reflected "the body responsible for delivering healthcare in England is part of the problem in performance. He wants all tiers of the NHS working together to deliver for patients".[326]

There has been a lively debate about the merits of an arms-length, non-departmental commissioning board for healthcare services, ever since the foundation of NHS England in 2013. In principle, the creating of a new body was to separate 'policy' from 'delivery'. Envisaged as a means of 'taking the politics out' of the delivery of healthcare, this assumption – however well-meaning – has not been realised. High levels of political control are desirable in a nationalised system – particularly where the public regard politicians to be responsible for the performance of the healthcare system. "Politics", as Alan Milburn once stated, "is the trap". Over time, NHSE has developed a considerable policy function. When first created, NHSE was envisaged by the then Secretary of State for Health to be a 'lean' organisation of a few hundred employees. The most recent annual report and accounts for NHSE and DHSC (both 2022-2023) reveal that there are five times the number of full-time equivalent staff working in NHSE (15,172) as DHSC (3,670).[327]

Even after considerable consolidation over the past two years – something which Policy Exchange encouraged – layers of management have increased overall in recent years (See Fig. 26, below).[328] As the Health Secretary has said himself, there are "far too many layers in NHS management structures…and lots of people holding other people to account".[329] An article which featured in Public Management Review characterises NHSE "as a meta-governor, insulating government whilst pursuing its own agenda, and raises crucial questions about governmental accountability".[330]

323. Ibid
324. Becks Fisher, 'Darzi 2.0: A full diagnostic assessment of the NHS may require uncomfortable investigations', *BMJ*, 24 July 2024 [link]
325. James Illman & Alastair McLellan, 'Streeting: We'll raise the share of funding for primary and community care within five years', *Health Service Journal*, 1 July 2024 [link]
326. Shaun Lintern, 'Labour says the NHS is broken. So what are the party's plans to fix it?', *The Times*, 7 July 2024 [link]
327. Annual Report and Accounts 2022-2023, *NHS England* [link], p. 88 & Annual Report and Accounts 2022-2023, *DHSC [link]*, p. 170
328. Robert Ede & Sean Phillips, 'Devolve to evolve? The future of specialised services within integrated care, *Policy Exchange*, 16 May 2022 [link]
329. James Illman & Alastair McLellan, 'Exclusive: Streeting has 'total confidence' in Amanda Pritchard', *Health Service Journal*, 1 July 2024 [link]
330. Jonathan Hammond et al. 'Autonomy, accountability, and ambiguity in arm's-length meta-governance: the case of NHS England', *Public Management Review*, Vol. 21, No. 8 (2019) [link]

Figure 26 – Total Headcount, NHS England & DHSC, 2013/14 - 2023/24



Source: NHS England, NHS Hospital & Community Health Service (HCHS) monthly workforce statistics: Staff in NHS Trusts and other core organisations [link]

In addition to the functions undertaken by NHSE, which entails setting the "national direction, allocat[ion of] resources, ensur[ing] accountability, defin[ing] the national strategy for supporting and developing people, mobilis[ing] expert networks, giv[ing] support to drive improvement, deliver[ing] essential services including national procurement and digital services, and lead the national agenda for transformation", it also works with third party organisations including NHS Business Services Authority (NHS BSA), NHS Shared Business Services, NHS Property Services Limited (NHS PS) and Primary Care Support England (PCSE), which are provided by Capita. Additionally, NHSE also hosts NHS Interim Management and Support and sponsors the Sustainability Unit. It also oversees commissioning support units (CSUs).[331]

This complexity and volume of activities undertaken by NHSE has made it increasingly difficult for the DHSC to be an effective sponsor (and scrutiniser) of its activities and its growth over time is symptomatic of a tendency to over-centralise public services over recent decades. We must, therefore, ask serious questions about whether present arrangements at national level (in particular) are maximising the effectiveness of the Government machinery and whether they represent good value for taxpayer.[332]

There are pros and cons to any structural reform – and too often this is a lever pulled before other routes at addressing issues are pursued. Nor does history show that attempts have been are routinely made at learning from previous reforms.[333] An attempt to seek structural neatness alone would

331. NHS England: Annual Report and Accounts 2022/23 [link]
332. 'Balancing the Books', *Policy Exchange*, October 2022 [link], p. 46
333. Nigel Edwards, The triumph of hope over experience: Lessons from the history of reorganisation, *NHS Confederation* [link]

be insufficient – and folly. The impacts of creating instability amongst institutions that have seen significant changes in recent years also cannot be discounted. Yet the case for change remains clear.

The current Minister for Health and Secondary Care has highlighted a "collapse" of public accountability as a reason for standing for election when working as an NHS manager herself: "When I started my NHS career as a planner in 1988, I was clear that Kenneth Clarke as Secretary of State was my boss. His intent was pretty evident." "But its collapse in the health service was a key factor in me seeking selection in 2012".[334] A number of years ago, the then Cabinet Secretary Sir Jeremy Heywood when attending a session of the Public Accounts Committee stated that accountability lay "somewhere between the Department of Health (as was then) and NHS England."[335] These challenges have persisted – many working in health policy today would give different answers when you ask them who is responsible for the delivery and performance of healthcare delivery.

In the short-term, the relationship between NHSE and DHSC should continue to be reset. Departmental Officials should continue to lead in giving advice to Ministers, whilst also enabling NHS officials to offer advice (but in the form of joint submissions). Greater co-location of teams who are working on the same policy and strategy issues in addition joining finance and communications functions more closely should be the direction of travel.

There is a need, for greater transparency between the two organisations and for more timely sharing of information and for more effective use of existing convening and cooperating mechanisms. During this Parliament, Ministers should review the functions currently carried out by NHSE overall to consider which can be transferred outright to DHSC to improve alignment, minimising the future prospect of overlapping or 'joint' teams. In a number of planned phases, NHSE should be abolished as an independent arms-length body. An NHS delivery function should remain within DHSC, however, in the form of an NHS Management Board. There is a clear, historic precedent for such an approach, as it would effectively re-instate the architecture which existed prior to the Health and Care Act of 2012.

Such a move should be regarded as part of a rebalancing; an attempt at putting powers and permissions in the right place. The reality is that some functions need to be overseen and held more tightly by ministers and others more loosely, where greater autonomy for managers and clinicians throughout the NHS will be beneficial and can begin to address a number of the challenges we have identified in this report.[336]

The centre must ultimately be focused on that which only it can do or where there is agreement that coordination at a national scale is beneficial. After all, the benefit of the NHS is that we can – in theory – make interventions at any optimal scale. A good example is work which has taken place in developing an 'NHS Staff Passport' which aims to reduce the need for NHS staff to duplicate information (such as when they make multiple job applications to different providers) and a training and qualification

334. Karin Smyth, 'The public needs to know where the buck stops', *Health Service Journal*, 16 May 2016 [link]
335. Ibid
336. Sean Phillips, Mission Critical: The New Secretary of State for Health and Social Care's First Hundred Days, *Policy Exchange*, July 2024 [link]

portal which has also been developed centrally.[337] Indeed, there are many examples where the effective implementation of an approach nationally can help to reduce unwarranted variation and waste. The work of Getting It Right First Time (GIRFT), a national programme of improvement and its specialty reports identify significant variation in procurement and litigation costs, huge variation in patient treatment options and poor-quality data with which to measure and compare interventions.[338] On procurement, over £30 billion is spent by providers each year and over 4,000 staff are employed to undertake this work. Recent work to create a spend comparison service is a helpful innovation and should be regarded as a means by which we can buy more intelligently. But, as a recent Public Accounts Committee report reflects that NHS Supply Chain has "failed to persuade trusts to use it, meaning trusts are missing out on opportunities for savings". As it stands, NHS Supply Chain is only achieving around 57% of market share.[339] There must be far greater oversight and focus on how this market share can be maximised. More can be done to ensure that providers (including GP practices) have improved access to administrative materials, such as a standardised templates for materials featuring national policy and patient information (currently, we still find NHS organisations writing their own version of policies).[340]

It has been estimated meanwhile that 30% of medical care is of low value or wastes resources, and 10% is harmful.[341] A recent review notes that a programme introduced to minimise and remove 'low value' care enabled 500,000 inappropriate or unnecessary interventions to be avoided in 2022/23. In one example provided, exercise electrocardiogram (ECG) for screening coronary heart disease was recommended as having no role in screening asymptomatic and low-risk patients.[342] The evidence-base interventions programme led by the Academy of Medical Royal Colleges in partnership with NHSE should continue to be supported and endorsed by Ministers. More routinely crowd-sourcing ideas from clinicians will be key in developing this approach. For instance, some have suggested abolishing the use of Anti-Embolism (TED) stockings, given limited evidence of their value. Doing so would save an estimated £38 million per year.[343] Others have pointed out limits to how truly 'national' approaches to workforce planning and preparation. Nursing skills are not – for instance – transferable between hospitals.[344]

337. Dave West, 'Labour commits to regulating NHS managers', *Health Service Journal*, 12th September 2023 [link]
338. Andrew N. Duncan & Rob Sayers, 'Getting it right first time: what have we learnt?', *Surgery, Vol. 41, No 8*, (August 2023), pp. 489-494 [link]
339. Public Accounts Committee, 'NHS Supply Chain and efficiencies in procurement', Twenty-Fourth Report of Session 2023–24 [link]
340. Beckie Livesey, 'This... Given the legal requirement to make all digital information...', *X*, 26th April 2024 [link]
341. Jeffrey Braithwaite, Paul Glasziou & Johanna Westbrook, 'The three numbers you need to know about healthcare: the 60-30-10 Challenge', *BMC Medicine*, 4th May 2020 [link]
342. Exercise electrocardiogram (ECG) for screening for coronary heart disease, Academy of Medical Royal Colleges [link]
343. 'Most patients undergoing planned surgery do not need compression stockings', *NIHR*, 14 July 2020 [link]
344. Tweet by *WearyMedic*, 8 July 2024 [link]

Recommendation

The governance of the NHS should be simplified by reducing the tiers of structural management separating 'the centre' from the 'front line' from five to three over the course of the next Parliament.

The Government should abolish NHS England as an independent commissioning body and should (re)merge key national functions within DHSC by re-establishing an 'NHS Management Board'.

- In the near term, DHSC should have full responsibility for developing the upcoming Ten-Year ear plan for Health and Care.
- NHS Regions should evolve, with individuals and responsibilities increasingly devolved to Integrated Care Boards (ICBs) or delivered nationally – within DHSC. For instance, ICBs increasingly host Local Professional Networks (LPNs) covering dentistry, pharmacy and eye health.

DHSC/NHSE should introduce a standardisation programme for key policy documents and templates, accessible to all NHS providers and should establish a joint working group which targets minimising bureaucracy associated with the ability for healthcare professionals to practice across NHS settings (e.g. for nursing staff to be able to seamlessly work across acute settings)

DHSC/NHSE should continue to tackle interventions of limited or no clinical value by furthering the work of the Academy of Medical Royal Colleges in partnership with NHS England.

All Systems Go?

> *"If we seriously want to improve the productivity of the NHS there is room for a rigorous curtailing of bureaucratic layers, useless meetings, and inconsequential get togethers. This would also be a very timely exercise as the largest risk of the announced (and promising) transformation of the NHS into the direction of integrated care systems is the creation of a bureaucratic monster with a myriad of inimitable and overlapping boards and meetings."*[345]
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> **Professor Marcel Levi**, former Chief Executive, University College London Hospitals NHS Foundation Trust

The establishment of a new layer in the 'intermediate tier' (ICSs) encourages us to rethink the future role the seven NHS Regions.[346] The Regional tier has historically joined-up NHS organisations and played a key role in emergency planning.[347] In addition, there are a number of other recent examples where larger-scale service organisation (beyond that which would be undertaken across an ICS footprint) is optimal. A good example is the development of trauma and stroke care across London as a whole, rather than independently commissioned via the five ICBs

345. Marcel Levi, 'A Dutchman in London: reflections of a hospital chief executive from the Netherlands in the NHS', *BMJ Leader*, Vol. 6, No 2 (2012) [link]
346. Dave West, 'The Integrator: Will NHS regions 'get out of the way'?', *Health Service Journal*, 24 February 2022 [link]
347. Nigel Edwards & Helen Buckingham, 'Strategic health authorities and regions: lessons from history', *Nuffield Trust*, 2 July 2020 [link]

across the city. Moreover, it remains the case that most ICBs are too small to commission many of the specialised services effectively – many require national leadership.

But whilst there may be a rationale, the remit and responsibilities which ought to sit at the 'intermediate tier' are far from clear as a greater range of services are either delegated to systems or there is a need for a clear, national approach. This suggests that the role of Regions is likely to become increasingly streamlined in the years ahead.

ICBs meanwhile are clearly still 'finding their feet'; managing high expectations, competing demands and diverse visions for their future role within the healthcare system. Many ICBs are already in significant financial deficit. Some of those we spoke to for this research suggested there was a risk of ICBs becoming an 'extra layer' in the NHS performance management hierarchy rather than becoming a nexus for the local system.[348] It is clear that effective convening mechanisms between Trusts and ICBs are still not in place uniformly across the NHS.

There are some core questions that still require answers:

- Should ICSs be able to choose their own priorities or should these be centrally set?
- To what extent should ICSs be performance managers of the providers on their patch?

Our response to these questions is that increasingly, where there is an appetite, systems should be able to set their own priorities in addition to delivery on a smaller set of 'non negotiable' national priorities. As long as clear convening mechanisms and arrangements between providers (e.g. the acute provider collaborative) are in place (which might look different, depending on the relevant geography and providers), they should be left to determine how best to meet the needs of their population. It may be the case that in a system with a high number of Foundation Trusts, there is a Trust-led approach to elective care, with the system taking a smaller role. In other instances, the system may have a far stronger role in encouraging the use of shared lists across providers, or in enhancing work at the 'interface' between primary and secondary care. Following the Hewitt Review, a 'lighter-touch' national accountability framework with regular reviews with NHS England in the form of 'High Accountability and Responsibility Partnerships (HARPS)' should be considered.[349]

Placing Trust in Trusts

Complex tiers of management – identified at the national and intermediate tiers of NHS organisation – are often found within individual NHS organisations themselves, including NHS Trusts. This presents a challenge because the literature on innovation suggests that flatter hierarchies can encourage greater levels of experimentation.[350] As such, there is a need for senior leadership to consider ways in which flows of information and decision-making can be optimised within their organisations.

348. Chris Naylor et al., 'Realising the potential of integrated care systems: Developing system-wide solutions to workforce challenges', *King's Fund* (July 2024), p. 39
349. *Hewitt Review*, p. 44 [link]
350. Sourobh Ghosh et al., The Effects of Hierarchy on Learning and Performance in Business Experimentation, *Harvard Business School*, Working Paper 20-081 [link]

An examination of the challenges in the delivery of key digital transformation programmes represents just one avenue to explore these extant challenges with current workflows and hierarchy – and how they might be addressed. The recently-published NHS Long Term Workforce Plan recognises these opportunities and makes the case for "taking full advantage of digital and technological innovations, such as speech recognition, robotic process automation, remote monitoring and AI."[351] In 2022, NHS England set out a vision for automation capability across all healthcare systems by 2023 and the leveraging of intelligent automation to transform service delivery by 2025.[352] That review shows that organisations using Robotic Process Automation (RPA) reported a 20–30% cost reduction and 30–50% return on investment, highlighting a large number of use cases.[353] The Long Term Workforce Plan foresees even greater changes across primary care, suggesting that "44% of all administrative work performed in general practice can be either mostly or completely automated, such as running payroll, sorting post, transcription work and printing letters", drawing upon a study conducted by the Oxford Internet Institute.[354] These developments necessitate the development of the management capacity with the right competencies across the NHS – but particularly across primary and community care services.

Some of the operational managers we spoke to suggested that "convoluted governance processes" slowed their organisation down and that there was an inefficient decision-making architecture. Part of this may be down to the particular skillsets contained within an organisation. For instance, some reflected challenges with those responsible for digital transformation where it sat within a large Finance or Business Intelligence function, not therefore being 'front and centre' of the department's priorities. Nor is there consistency in the types of governance processes which may be in place across different organisations. One manager spoke of his experience of completing clinical risk document which was ten times the length of a similar document used in the first Trust he worked in as part of the GMTS scheme.

Too often, "indecision is the decision [on digital innovation]," as the director of clinical innovation and strategic partnerships at Guy's and St Thomas' NHS Foundation Trust recently put it.[355] Then there are the challenging budgeting arrangements. Many – although not all – digital transformation programmes require effective spend of the capital budget, often determined in one-year cycles and non-recurring. This can make investment decisions more challenging and can also reduce appetite for long-term commitment and to upgrading systems over time. Moreover, even after the introduction of new tools, implementation can be challenging – and must be effectively managed. As one chief executive has recently put it, the trust may well have implemented a ""Rolls-Royce of an EPR", but "for lots of different reasons we're still driving it a little bit like it's a Ford Focus."[356]

These issues can be particularly acute in community health services, whose work has significant impacts upon wider system performance.

351. 'NHS Long Term Workforce Plan', *NHS England*, June 2023, p.18 [link]
352. 'RPA in the NHS. Guidance for designing, delivering and sustaining RPA within the NHS', *NHS England*, May 2022 [link]
353. Ibid
354. Matt Willis, 'Almost half of all administrative tasks in general practice could be automated, says new report', *Oxford Internet Institute*, 9th June 2020 [link]
355. Claire Read, 'Radical ideas to progress digitisation shared at Rewired 24', *Digital Health*, 20th March 2024 [link]
356. Nick Carding, ''Rolls-Royce' EPR still being driven 'like a 'Ford Focus' admits trust CEO', *Health Service Journal*, 21st May 2024 [link]

More effective analysis of staffing levels and ways of working across community services, so that the offer and care is more aligned and consistent would be hugely valuable – and ought to be led at the system level. Enhancing the Community Services Data Set (CSDS) will be a key part of this work. Recent analysis from Carnall Farrar has found that "information about contact activity is 60 to 85% complete, with the service referred to being a critically incomplete field". Clinical coding data also has limited completeness, "with less than 40% of contacts having a clinical coding showing the observation, procedure or finding, and less than 20% of patients having a primary diagnosis". Immunisation is only 23% complete, although childhood immunisation is 44% complete. (This tallies with previous work by Policy Exchange which has found poor data architecture within community health services).[357]

In addition to these 'internal' challenges, a number of externalities for trusts need to be clarified. Over recent years, the approach adopted through the Foundation Trust model which sought to enable greater freedoms to Trusts has been unwound. This is evident in the number of Trusts who have sought to adopt the Foundation Trust model. Fig. 7 in the Introduction showed that since 2017, no Trusts have attained Foundation Trust status. There are of course risks that organisations given too much autonomy with limited oversight can become behemoths, but the current approach risks constraining providers too far, with minimal incentives to experiment or to take calculated which risks demotivating and diminishing managers and senior leaders. As Lord Darzi has put it in his recently-published Independent Review, "the incentives for individual trust leaders are blunt. The only criteria by which trust chief executive pay is set is the turnover of the organisation. Neither the timeliness of access nor quality of care are routinely factored into pay. This encourages organisations to grow their revenue rather than to improve operational performance."[358]

Moreover, if we are serious about addressing productivity challenges, the reality is that motivation and capability – as a convincing report from The Health Foundation shows – will "determine the 'agility' of an organisation to grasp opportunities, and that this is critical for improving productivity". "Too often", the authors state, "policy is concerned with identifying opportunities and setting objectives for change, but not with providers' ability and readiness to respond effectively".[359]

We ought, therefore, to ensure there is clarity of vision and a theory of change set at a nation level, but we allow providers to target the areas they believe will enable them to leverage their particular expertise and deliver the strongest improvements in performance and productivity. The introduction of 'Global Digital Exemplars', or the recognition of centres of excellence in 'digital transformation' who could offer a model and support for others to 'follow' was a positive approach – and something that ought to be replicated more broadly, such as for clinical research activity.[360]

As has been recognised by many commentators on health policy, providers have had significant challenges with asset renewal – and with

357. Feargus Murphy, Kevin Atkin, Will Browne et al, 'How improved community data unlocks NHS efficiency', *Carnall Farrar*, 20th November 2023 [link]. See also: Robert Ede, Dr Sean Phillips. Yu Lin Chou, 'A Fresh Shot. The future for vaccines policy in England', *Policy Exchange*, 1st December 2022 [link]
358. Lord Darzi of Denham, Independent Investigation of the National Health Service in England, *DHSC*, September 2024 [link]
359. Tim Horton, Anita Mehay & Will Warburton, Agility: the missing ingredient for NHS productivity, *The Health Foundation*, 13 October 2021, [link]
360. Global Digital Exemplars, *NHS England* [link]

effectively utilising capital investment. Capital spend is often just 6-7% of a Trust's overall budget, compared to organisations in the private sector, whose investment may be around 15%. But this isn't simply a question of increasing the capital budget overall. There is a need to review credentialing arrangements so that fewer 'permission-seeking' steps are required, and to enable Trusts with a track-record of consistent improvement, good performance and prudent finances should be excused from reporting as often to 'the centre'.

Another approach we suggest ought to be pursued is the creation of 'Expert Turnaround Teams' – aimed at board level and senior management positions– should be developed and deployed to providers which have struggled to recruit into the most challenging senior roles. Such a model would build on the recommendations of the Kerr and Messenger Reviews, which call for a more desirable package of incentives (and support) for leaders who take on the most 'difficult to recruit to' roles. A key feature of these positions would be their ability to work with greater trust and autonomy (e.g. to hire individuals in key operational roles beyond Agenda for Change pay bandings). They should also be given greater financial reward(s) for delivering improved operational performance – particularly if this has been achieved in an organisation that has historically struggled to attract the best talent and where performance has persistently required improvement.

Recommendation(s)

Expert Turnaround Teams – aimed at board level and senior management positions– should be developed and deployed to providers which have struggled to recruit into the most challenging senior roles.

- Building on the recommendations of the Kerr and Messenger Reviews, a more desirable package of incentives (and support) for leaders who take on the most 'difficult to recruit to' roles is needed.
- These 'Super CEOs' or 'Super COOs' should be given greater autonomy to hire individuals in key operational roles beyond Agenda for Change pay bandings and should be given greater financial reward(s) for improving operational performance – particularly if this has been achieved in an organisation that has historically struggled to attract the best talent and where performance has persistently required improvement.

Senior Executive Leadership at Trusts and System-Level should audit current approaches to 'sign-off' to facilitate more effective and efficient delivery of key digital transformation or estates development programmes.

Operational managers should be empowered to take greater, calculated risks via the introduction of 'Change Certificates', issued to managers banded 8A and above who have been assigned to specific transformation projects.

- One of the key barriers to implementing changes to process and pathways is the need to acquire sign-off from multivarious 'stakeholders' within a clinical setting, including clinicians, finance teams, patient representative groups and others. Authority is too diffuse, and managers must attend multiple meetings over a number of months to make change happen.
- Change Certificates should be issued to project managers after presenting an evidenced business case to Executive Directors, including the Chief Executive, the Executive Director of operations and the Chief Clinical Officer.

The Case for New Incentives: The Role of a 'Prevention Premium'

A new framework of incentives (and freedoms) is required to encourage different management behaviours and to encourage a shift or to find an improved balance between hitting activity-related targets and delivering upon system-wide outcomes. This approach should be developed by DHSC (with consideration of all NHS organisations) and should be included in the Ten-Year Plan, currently being developed by DHSC. These incentives should be focused on health-benefits (i.e. specific care outcomes) but should also give greater weighting to non-health benefits. For instance, patient feedback should be more effectively drawn upon and should receive greater weighting in the assessment of services. The new service suggested in this report, NHS Patient View (see the next section) should be incorporated.

- **A 'Prevention Premium'** should be developed for primary and community health service providers, where (for example) the direct costs of reduced demand in inpatient settings due to enhanced vaccination uptake or fall management services in the community (which can be quantified in-year), are transferred to provide greater resource for primary and community care services. Each ICB should determine how the Premium ought to be utilised, e.g. calculated savings could be used as a means developing capital reserves for estates development across primary care.
- **For Trusts**, incentives for shifting resources (and staff) to support delivering upon system-wide outcomes should be developed. This incentive structure should be called '**System Support**' and might include encouraging the deployment of hospital staff to primary care settings to deliver clinics 'in the community', e.g. in paediatrics. Active participation, and demonstrable improvement in outcomes should include greater freedom(s) for the provider to develop capital reserves, to hire staff in key operational roles beyond the Agenda for Change banding system or to raise revenue – with a view to building on the original vision for Foundation Trusts.

Recommendation

A new framework of incentives (and freedoms) – including a Prevention Premium – should be developed by DHSC for all NHS providers which is tethered to quality improvement and the delivery of system-wide benefits. This should be included in the Ten-Year Plan, currently being developed by DHSC.

- Incentives should be a both financial and non-financial and should focus on outcomes, rather than activity delivered alone. They must be focused on health-benefits (i.e. specific care outcomes) but should also give greater weighting to non-health benefits.
- The findings relating to patient feedback from a new service suggested in this report, 'NHS Patient View' should be incorporated.
- A 'Prevention Premium' should be developed for primary and community health service providers, where (for example) the direct costs of reduced demand in inpatient settings due to enhanced vaccination uptake which can be quantified in-year, are directly transferred to primary care services.
- For acute care providers, incentives for shifting resources (and staff) to support delivering upon system-wide outcomes should include greater freedoms to develop capital reserves, to hire staff in key operational roles beyond the Agenda for Change banding system and to raise revenue – building on the original vision for Foundation Trusts.

A Source of Complaint? Maximising Patient Feedback for Quality Improvement: Developing 'NHS Patient View'

Enhancing patient experience matters beyond an individual's personal satisfaction with the care they receive. It can provide a focal point to motivate staff around a common purpose, can encourage patients to become more 'engaged' in supporting their own health and can help identify issues often invisible to the system which may hamper safety or productivity.[361]

A report published by the NHS Assembly in 2023 highlights for instance that effective communication matters just as much to patients as waiting times.[362] There are wider benefits from improved patient satisfaction too. A recent study finds that positive experiences of health services are associated with greater willingness to share health data.[363]

One opportunity to strengthen this link between patient experience and quality improvement is to improve the way we currently collect and interpret patient feedback and complaint – both as a means of more effectively acting upon patient safety concerns, but also as a means of more effectively responding to the things which matter most to the service user.

The total number of all reported written complaints in the NHS in 2022-23 was 229,458.[364] In Healthwatch England's most recent Annual Report, 373,000 individuals shared feedback with their local branch last year (and 11,615 with Healthwatch England directly).[365] Yet this data is rarely (or at least, inconsistently) used for quality improvement, despite it being what Sir Robert Francis once described as "gold dust".[366]

Current challenges

At present, routes for patient advocacy are incoherent. One study finds "muddled routes for raising formal complaints, investigative procedures structured to scrutinize the 'validity' of complaints, futile data collection systems, and adverse incentives and workarounds resulting from bureaucratic performance targets."[367]

This results in feedback gap. Recent findings from a campaign coordinated by the CQC and Healthwatch England found that 54% of people with long-term conditions said they are not being regularly asked by services to feed back about their care despite a significant majority being willing to do so.[368]

We ought to ask, therefore: does the average patient know the most effective route to provide feedback or to complain about the NHS service they have used? We would suggest more often than not, the answer is "no". There are too many channels for patients and service users to provide feedback; the system is complex to navigate.

Table 16 below sets out the many routes by which feedback and complaint upon NHS services can be provided.

Table 16 – Routes to Provide Feedback on NHS Services

361. 'Supporting people to manage their health', *The King's Fund*, 15 May 2014 [link]
362. 'The NHS in England at 75 (NHS@75)', *NHS Assembly*, (last accessed 7th June 2024) [link]
363. E. J. Kirkham, S. M. Lawrie, C. J. Crompton et al, 'Experience of clinical services shapes attitudes to mental health data sharing: findings from a UK-wide survey', *BMC Public Health*, 19th February 2022 [link]
364. Data on Written Complaints in the NHS, 2022-23 [link]
365. *Healthwatch England Annual Report 2022–23* [link]
366. Adam Brimelow, 'Treatment of whistleblowers a stain on NHS, says MPs', *BBC News*, 21st January 2015 [link]
367. J. van Dael, T.W. Reader & E.K. Mayer 'Do national policies for complaint handling in English hospitals support quality improvement? Lessons from a case study', *Journal of the Royal Society of Medicine*, May 31, 2022 [link]
368. *Healthwatch England*, Annual Report and Accounts 2022-2023 [link], p. 43

Method	Scale	Comment(s)
National Survey		
GP Patient Survey[369]	National – with findings at practice-level	• Annual, national survey of GP practice in England
NHS Patient Survey Programme[370] NHS England, Care Quality Commission & individual NHS trusts	National – all NHS trusts participate	• Conducted annually. Comprises six surveys: • Children and Young People's Patient Experience Survey • Adult Inpatient Survey, Maternity Survey • Urgent and Emergency Care Survey • Community Mental Health Survey • Cross Programme Development Work and Pilot Results
Nationally-Commissioned Services		
Friends and Family Test (FFT) NHS England	National programme, but commissioned locally	• Launched in 2013. Following treatment or discharge patient may be invited to complete the FFT, either on premises, or later. By post, text message, phone or website (provider-dependent) • A continuous improvement tool, intended to be quick and easy for all patients and service users to complete based on structured questionnaire • Results take time to collate and analyse - surveys usually report months after the contact with the patient has taken place • The FFT is "not designed to make comparisons across organisations, so this means we can allow local flexibility in how it can be applied to • maximise its usefulness for local improvement".[371]

369.GP Patient Survey [link]
370.NHS Patient Survey Programme [link]
371.Using the Friends and Family Test to improve patient experience, *NHS England and NHS Improvement guidance* [link]

The Patient Advice and Liaison Service (PALS) NHS trusts	Commissioned by individual providers	• Organised at trust-level • Provides confidential advice, support and information on health-related matters and acts as point of contact for patients, their families and their carers.
Provider Complaints Office NHS trusts	Local	• Dedicated complaints management functions within NHS organisations to handle written complaints or via hotline.
Care Opinion	National	• Non-profit organisation funded mainly through subscriptions from health and care organisations which provides the public with ability to submit written feedback on services online.
Statutory Bodies		
Healthwatch	National, with local branches	• A statutory committee of the independent regulator the Care Quality Commission (CQC). • Healthwatch established under the Health and Social Care Act 2012 to "understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf." • There are over 150 local Healthwatch branches across England
Care Quality Commission (CQC)	National	• The independent regulator of health and social care in England. • Appraise feedback either submitted directly via the public, or evidence shared via local Healthwatch branches (as well as other sources) to regulate providers.

The Health Services Safety Investigations Body (HHSIB)	National	• An executive non-departmental public body, sponsored by the Department of Health and Social Care, to replace the Healthcare Safety Investigation Branch (HSIB) which was part of NHS England and formed in 2017.[372] • Carries out multiple investigations each year by investigators from safety-critical industries and other professions including healthcare, military, aviation and law.
The Parliamentary and Health Service Ombudsman (PHSO)	National	• Makes final decisions on unresolved complaints about the NHS in England. This organisation is independent of the NHS.
Other Routes		
Member of Parliament	Local - National	Constituents will often raise issues and causes of concern relating to health and care with their MP if they are unable to receive prompt information relating to a query or concern, or if previous attempts at engagement have not progressed. This can represent a significant proportion of casework for an MPs office.
Website(s) / Social Media	N/A	Patients now routinely leave reviews on services on NHS.uk or via Google.
Patient Participation Groups (PPGs)	Local	Coordinated by individual GP practices to inform individual practice policy
Verbal Feedback	Local	Direct communication with staff by patients.

As it stands, patient perspectives are drawn upon from: national surveys, formal complaints and compliment services, services commissioned at the national as well as trust-level as well as drawing informally upon feedback provided online, such as via social media.

This includes large-scale surveys such as the national, Adult Inpatient Survey as well as the paper-based Friends and Family Test (FFT) which has been mandatory for providers to collect since 2014. Some providers have

372. Health Services Safety Investigations Body: Annual Report and Accounts 2023/24 [link], p. 4

set a target for 50% of people that leave to fill in the FFT, but this wealth of feedback is inconsistently used. As another study puts it, "patient feedback systems do not generally allow for learning across the organisation".[373] This isn't just an issue within organisations but beyond them too. These sources of insight are not analysed at a national level.[374] A 2017 study, published in the British Journal of General Practice, found that "although the FFT imposed little extra work on practices, it was judged to provide little additional insight over existing methods and to have had minimal impact on improving quality. Staff lacked confidence in the accuracy of the results given the lack of a representative sample and the risk of bias."[375]

Large numbers of staff on the 'front line' hear and handle patient feedback, including: Patient Advice and Liaison Service (PALS) teams, complaints handlers, patient engagement staff, Freedom to Speak Up Guardians and local Healthwatch teams. The Parliamentary and Health Service Ombudsman (PHSO) has recently commented that complaints managers "often receive limited access to training and are asked to address serious and complex issues with little assistance".[376] The NHS Leadership Academy meanwhile had no dedicated courses on patient experience until one was developed by the Patient Experience Library in January 2023.[377]

A review of the use of the Friends and Family Test (FTT) reveals concerns related to inefficiency in the flow of FFT data, challenges with interpreting the volume of data received, resulted in staff ambivalence towards FFT as a near real-time feedback initiative.[378] Indeed, only limited insights can be drawn from the way in which NHS England reports FFT data at a national level, which depicts volumes of "responses positive", and "responses negative". This is of limited utility for public debate on service improvement, because it leaves us only with a general impression of patient satisfaction. [379]

Whilst an ever-increasing amount (and diversity) of feedback is being collected, staff struggle to use it to make improvements to patient care. The CQC has recently reviewed its own whistleblowing complaints processing.[380] One of the key issues identified was the complexity of raising complaints, and the lack of a system to monitor progress on handling complaints. Some managers felt responsibility for patient experience feedback sat within the hospital hierarchy, demonstrating "that patient experience [is] a fractured domain, spread across several different disciplines." [381] In one trust, responsibility for complaints might be split across three different teams who have little crossover and therefore minimal capacity to consider this wealth of feedback from patients as a whole. The division between complaints and PALS— conceptually and practically is confusing and ought to be addressed.

All the while, ICSs have been delegated the responsibility for complaints handling. Until recently, NHSE would clinically review complaints to ensure standards were followed, but with delegation, it is not clear that each system is reviewing complaints consistently or with similar levels of rigour. A further risk is the creation of a further place to whom patients are referred for complaints where there is limited public understanding of

373. Ibid
374. Laura Sheard, Rosemary Peacock, Claire Marsh, Rebecca Lawton, 'What's the problem with patient experience feedback? A macro and micro understanding, based on findings from a three-site UK qualitative study', *Health Expectations*, 22nd September 2018 [link]
375. Tommaso Manacorda, Bob Erens, Nick Black and Nicholas Mays, 'The Friends and Family Test in general practice in England: a qualitative study of the views of staff and patients', *British Journal of General Practice*, Vol. 67, No. 658 (2017), e370-e376 [link]
376. 'Making Complaints Count: Supporting complaints handling in the NHS and UK Government Departments (Executive Summary) Introduction', *The Parliamentary and Health Service Ombudsman*, (last accessed 7th June 2024) [link]
377. 'Written evidence submitted by the Patient Experience Library (NHL0014)', *UK Parliament*, February 2024 [link]
378. M. Khanbai et al., 'Identifying factors that promote and limit the effective use of real-time patient experience feedback: a mixed-methods study in secondary care', *BMJ Open*, Vol. 11, No. 12 [link]
379. Friends and Family Test data, *NHS England*, April 2024 [link]
380. 'Listening, learning, responding to concerns', *CQC*, 29th March 2023 [link]
381. Laura Sheard, Rosemary Peacock, Claire Marsh, Rebecca Lawton, 'What's the problem with patient experience feedback? A macro and micro understanding, based on findings from a three-site UK qualitative study', *Health Expectations*, 22nd September 2018 [link]

the role that systems play.

Mirroring the current NHS staffing situation amongst the clinical workforce, some managers have reflected that they do not have enough staff or appropriate expertise (often stated as qualitative expertise) in their immediate teams to be able to work effectively to produce meaningful conclusions from the data they have received. Moreover, there is limited sharing of feedback amongst key organisations for patient safety and experience, including the CQC, the Health Services Safety Investigations Body (HHSIB) and Healthwatch. This is less about a willingness to share information – Healthwatch for example routinely share information to inform CQC inspections, but this is instead a structural issue, with impediments to effective collaboration owing to confusing and overlapping remits between organisations – a matter the Patient Safety Commissioner has recently commented upon.[382]

A recent review by the National Institute for Health and Care Research (NIHR) has found a lack of awareness of PALS among both clinicians and patients, missed opportunities for PALS services to learn from each other and different responsibilities in different trusts because of local funding, community needs and managers' priorities. That review suggests that PALS staff are provided with a more structured way of recording and grouping concerns and their resolution to make the service more efficient.[383]

The cumulative effect of these findings is that there is a strong case to review patient feedback and complaint provision overall. There has not been a major review of PALS since 2008. As it stands today, we have little sense of how much variation in there is in Trust expenditure on PALS, relative levels of satisfaction compared to other providers, nor a sense of how effectively PALS works with other feedback services, if they are split within an organisation.

Online feedback has been proposed as a way to drive transformative change in the health service through informing choice and improving quality.[384] Indeed, patients are increasingly using online platforms to provide feedback about their healthcare experiences. The NHS already commissions services including "IWantGreatCare" and "Care Opinion". Social media platforms increasingly offer patients a route to provide feedback. A recent analysis finds that the most frequently used formal review website for both reading and writing feedback was NHS Choices (used by 49% of 'readers' and 35% of 'writers'), followed by WebMD (15% and 5%, respectively) and Care Opinion, formerly Patient Opinion (6% and 9%, respectively).[385]

Patients actively use this feedback to inform their own care. A major study has found that many people (42% of internet users from across the general population) read online feedback from other patients. Fewer people (8%) write online feedback, but when they do one of their main reasons is to give praise. Most online feedback is positive in its tone and people describe caring about the NHS and wanting to help it ('caring for care'). They also want their feedback to elicit a response as part of a conversation.[386] Patients seek to find out about a drug, treatment or test

382. Dr Henrietta Hughes, "My plans for this year will benefit patients", *Patient Safety Commissioner* [link]
383. Patient Advice and Liaison Service: Are we making the most of PALS?, *NIHR*, 7 September 2022 [link]
384. Subject of growing interest internationally. A recent study from Brazil is instructive: Simone Burger, Ana Maria Saut, Fernando Tobal Berssaneti, 'Using patient feedback to drive quality improvement in hospitals: a qualitative study', *BMJ Open*, 23rd October 2020 [link]
385. John Powell, Helen Atherton, Veronika Williams et al, 'Using online patient feedback to improve NHS services: the INQUIRE multimethod study', *National Institute for Health Research: Health Services and Delivery Research, Volume 7 Issue 38* (October 2019), p.19 [link]
386. Ibid

(41%); choose where to have treatment (19%); or choose a health-care professional (17%). The most common reasons for providing reviews are to inform other patients (39%), praise a service (36%) or improve standards of NHS services (16%). Of the total sample, only 112 (6%) participants had been asked to write a review. Of those people who were asked to write a review, only 28 (25%) had written a review. [387]

Some clinicians are "sceptical about the reliability and validity of surveys, feeling they could not provide enough qualitative detail".[388] Other key issues include anonymity, confidentiality and ability to respond to feedback, representativeness and moderation/regulation of online feedback.[389] The representativeness and anonymous nature of online feedback have also been perceived as barriers to its usefulness. The latter is striking, as anonymity is often cited as one of the benefits to the consumer who may worry that identifiable feedback could affect their care. Doctors felt their right to respond to online patient feedback was limited by confidentiality and the anonymous nature of online comments.[390] Another analysis which explores the role of patient experience data for service improvement notes that the most commonly cited barrier to using patient experience data was a lack of staff time to examine the data (75%), followed by cost (35%), lack of staff interest/support (21%) and the volume of data for analysis (21%).[391]

There are however approaches already in use across the NHS which may enable more effective, less resource-intensive methods of analysis. In 2017, the Health Foundation supported Imperial College Healthcare NHS Trust and Imperial College London to develop a natural language processing (NLP) tool to analyse unstructured text comments from the FFT (and to summarise these results into reports.) The tool was able to analyse 6,000 comments in 15 minutes (this is to be compared with the four days it would take the same analysis if undertaken by a member of staff).[392]

There is a recognition that more work is needed to better understand how best to capture and use patient experience data for quality improvement, the contexts in which initiatives are successful and how to integrate patients and families in the ongoing implementation and evaluation processes.[393] To drive meaningful changes in care delivery, more standardised means of assessing feedback and implementation strategies is required. This case has been well made by Healthwatch England, whose 'What patients want' vision advocates for a single NHS complaints service that triages people to organisations like NHS trusts, regulators or safety bodies.[394] This is a welcome ambition and we believe that we should more effectively use service user insights to drive quality improvement and to move to a system of performance management which can in fact create greater freedoms for NHS organisations (and their leadership) as a result.

"NHS Patient View"

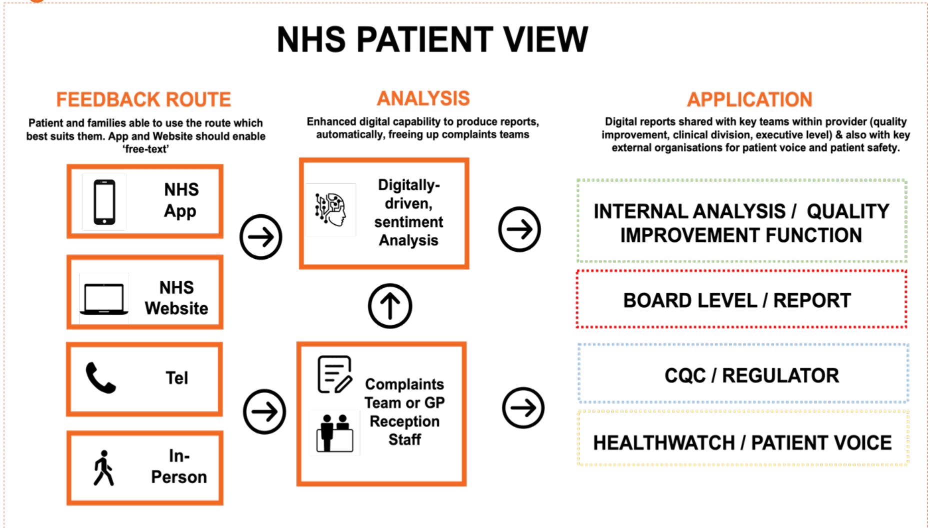
To that end, we have sought to conceptualise what such a service may look like – and be called. We suggest that it is called "NHS Patient View".

387. Ibid, p19
388. For a review of the literature, see Beccy Baird, Luca Tiratelli, Andy Brooks, Kristina Bergman, 'Levers for change in primary care: a review of the literature', *The King's Fund*, April 2022 [link]. For an analysis of the use of patient experience metrics and issues in delivering quality improvement at practice level, see: Jenni Burt, John Campbell, Gary Abel, 'Improving patient experience in primary care: a multimethod programme of research on the measurement and improvement of patient experience', *National Center for Biotechnology Information*, April 2017 [link]
389. Amadea Turk, Joanna Fleming, John Powell, Helen Atherton, 'Exploring UK doctor's attitudes towards online patient feedback: Thematic analysis of survey data', *Digital Health*, 5th March 2020 [link]
390. Ibid
391. Louise Locock, Chris Graham, Jenny King et al. 'Understanding how front-line staff use patient experience data for service improvement: an exploratory case study evaluation', *National Institute for Health Research. Health Services and Delivery Research, Volume 8, Issue 13*, March 2020 [link]
392. For further details, see Tim Horton, Anita Mehay & Will Warburton, Agility: the missing ingredient for NHS productivity, *The Health Foundation*, 13 October 2021 [link]
393. Lauren Cadel, Michelle Marcinow, Harprit Singh, Kerry Kuluski, 'The use of patient experience data for quality improvement in hospitals: A scoping review', *Patient Experience Journal, Vol. 9*, April 2022, pp. 174-188 [link]
394. 'What patients want: a vision for the NHS in 2030', *Healthwatch England* [link]

The NHS should leverage the opportunity for higher levels of participation via the NHS App, but all means of patient feedback (including verbal and written) should be brought together and streamlined under a single banner. Its overarching design should be planned on a national basis, but each ICS should have ownership and responsibility for its implementation. Sentiment analysis should be used to identify key themes and issues of concern.[395] Such an approach should be used to accelerate the means by which managers can analyse and plan interventions and to reduce workloads upon existing complain and feedback teams within Trusts. These analyses should be made available to CQC/Healthwatch on a routine basis to enable external analysis (and to inform inspections).

The findings from NHS Patient View should be used by managers and leaders – including in organisational or individual performance assessment and accountability processes. For a high-level overview of how such a system could be planned, see Fig. 27, below.

Figure 27 – "NHS Patient View"



In addition, a new, singular target across all NHS organisations should be announced setting clear expectations for when patients should receive a response to complaints – we believe that this should be within (and no longer than) four weeks. Patients support this position. Recent polling from Healthwatch England (in relation to the NHS Constitution for England) found that a majority of respondents were in favour of a system where complaints were resolved within 28 days.[396]

This approach should be regarded as a means to address the current disconnect between approaches to healthcare improvement, performance measurement and responsiveness to patient perspectives. These matters are often regarded as separate – even subordinate by some. This is wrong. The 2008 Darzi Review ("High Quality Care for All") noted that high-quality healthcare was built upon three equal pillars – clinical effectiveness, patient safety and patient experience.[397]

We are of the view that a new model of performance management

395. Felix Greaves & Daniel Ramirez-Cano et al., 'Use of Sentiment Analysis for Capturing Patient Experience From Free-Text Comments Posted Online', Journal of Medical Internet Research, Vol. 15, No. 11 (2013) [link]
396. Looking beyond the NHS Constitution to a meaningful Patient Promise, *Healthwatch England*, 17 May 2024 [link]
397. 'High quality care for all: NHS Next Stage Review final report', *DHSC*, 30th June 2008 [link]

which finds a new balance between health benefits (how effective was treatment) with non-health benefits (how was the person's experience) as well as an assessment of cost-effectiveness is needed to derive a more effective overall assessment of performance.[398]

A recent, novel study of mental health providers in England shows how this may be done. The study extends its evaluation to include provider responsiveness (such as continuity of care, clear communication) and access, in addition to measures of health benefit and production costs.[399] The model uses the Mental Health Minimum Data Set (MHMDS) which incorporates data on all adults using secondary mental health services funded by the NHS alongside provider-level information on patients' experience of Mental Health Trusts from the annual Community Mental Health Survey (CMHS). Fascinatingly, the study finds "only weak positive correlation between their measure and CQC ratings", suggesting "that the CQC criteria, or weightings placed on them by the CQC, differ considerably from those we derived from discrete choice experiments undertaken with members of the general population".[400]

Recommendation(s)

A unified patient feedback and complaints service called 'NHS Patient View' should be developed, overhauling current fragmentation and more effectively signposting the service user to where their feedback or complaint is best handled.

- Greater participation should be driven via the NHS App and NHS website, but all existing channels of patient feedback across the NHS should be brought together and streamlined under a single banner, 'NHS Patient View'.
- Its overarching design should be planned on a national basis, but each ICS should have ownership and responsibility for its implementation.
- The findings from NHS Patient View of patient feedback and complaint should used by managers and leaders – including in organisational or individual performance assessment and accountability processes.
- Current collection and analysis burdens upon complaints teams and other staff members should be reduced by the use of AI-driven sentiment analysis of submissions.
- Paper-based submissions (which should continue to be used) should be redesigned so that they can be easily scanned, and therefore analysed as if submitted digitally

In addition to these measures, a new, singular four-week target across all NHS organisations should be announced setting clear expectations for when patients should receive a response to complaints.

398. Justine Karpusheff, 'We should measure what matters, but it matters who chooses the measures', *The Health Foundation*, 25th March 2024 [link] ; Maria Jose Aragon, Hugh Gravelle, Adriana Castelli et al, 'Measuring the overall performance of mental healthcare providers', *Social Science and Medicine, Volume 344* (March 2024) [link]
399. Ibid
400. Ibid. See also: Donna Rowen, Philip. A. Powell, Arne Risa Hole, 'Valuing quality in mental healthcare: A discrete choice experiment eliciting preferences from mental healthcare service users, mental healthcare professionals and the general population', *Social Science and Medicine Volume, No. 301* (May 2022) [link]

Conclusion(s)

Today, the current complexion and capability of NHS management remains poorly understood. Data on this subject is of variable quality, meaning we do not have a complete picture of the quantum of management, nor detailed insight into its capabilities and competencies.

Approaches to enabling basic management training and in providing tailored leadership development are highly variable across the NHS – and in some cases absent entirely. For many working across the NHS, there is no clear means of accessing ongoing training and support for professional development of managerial and leadership skills.

For that reason, it is critical that **a clear set of competencies for those in management positions, according to seniority, is set by DHSC/ NHSE**, but to increase the capacity to enable all staff to be able to access training where relevant, **greater devolution must also take place – we suggest across a system footprint – to enable providers to tailor more readily tailor training and professional development requirements for their geography.**

Our research has also found significant variance in the functions that NHS managers discharge across the country (and in the volume of managers with specialised skillsets). For instance, too few trusts have dedicated analytical capabilities and data science teams, with many still fusing these functions into existing managerial teams, such as finance.

There is a need for the forthcoming, second iteration of the NHS Long Term Workforce Plan to more clearly outline operational management requirements for the health service. **A focus on requirements for primary and community health services is a must, for these are care settings that have too often remained an afterthought in the discussion about NHS management.**

Broader reforms are also required to the operating environment. Firstly, there are too many tiers of management and what we might call 'vertical programmes' throughout the NHS, creating confusion and complexity. Whilst there are many who will push back against the idea of further structural reform to the NHS, there is a strong case for reform,

when carefully planned and managed over the course of a parliamentary term. **We believe that the functions of NHSE should be (re)merged with the DHSC and an NHS Management Board established within DHSC, operating as a delivery arm for the service.** Personnel at NHS Regions meanwhile should be increasingly delegated to Integrated Care Boards – or to DHSC. In doing so, reducing tiers of management from five to three in the coming years.

The authority and freedom of clinical and non-clinical management to implement changes to process is too limited. If we expect managers to make quick improvements to productivity and to be accountable for failures to improve services, the architecture of decision making must be streamlined to facilitate improvement. Part of this is strengthening the autonomy of NHS organisations and their leadership – particularly where their work is delivering improved outcomes for the wider healthcare system. We encourage both systems and the providers within them to have greater 'earned autonomy' with improved operational performance.

There must be improved reward for effective management. Talent should be able to rise to positions of authority more swiftly and there should be greater reward for with who have taken on operational management roles in the most challenging contexts and delivered positive results. We have suggested the development of 'Expert Turnaround Teams' who are given the freedom to hire individuals to key positions beyond the Agenda for Change banding. We have also set out recommendations for systemic incentives in the form of a 'Prevention Premium' and 'System Support' to encourage a greater focus on partnership working to improve outcomes – and as a means of directing greater resource (personnel and money) toward primary and community care services.

Leadership matters, but management matters too. Much of the emphasis of training in the NHS pertains directly to developing an elite – the GMTS programme and FMLM are perhaps the best examples of this. Scrutiny for performance is rightly focused at the board and executive levels of organisations, but improving performance as a whole means a greater focus on management as a whole, not just those in executive leadership positions – particularly those in 'middle management', such as ward managers who can play a critical role in improving the efficiency and performance of service, if effective and when empowered.

Too often, there is ineffectual scrutiny (and jeopardy) associated with poor performance however – particularly amongst 'middle management'. Extant appraisal methods are insufficient at managing poor performance and it remains far too commonplace that poor performers are simply shuffled onto other teams. There must be a greater emphasis, therefore, on ongoing analysis, rather than an episodic approach to performance management, whilst the NHS as a whole must be more willing to move on those who do not meet the high-performance standards that

the public expect of the service.

Finally – we foresee a clearer and enhanced role for public engagement and for patient perspectives to be used as a means to improve services. We recommend that the complex, confusing and in many cases burdensome approaches to patient feedback are reformed by creating a single service entitled NHS Patient View. Driven by use via the NHS App and NHS website, all channels including verbal and written feedback should be 'fed in' and sentiment analysis used to provide swift insights for NHS managers that can also be used more routinely for performance management purposes and by regulatory bodies.

Appendix

Table 17 – History of management policy interventions since the foundation of the NHS

1945	**The National Health Service Act establishes a 'Central Health Services Council'** • An existing group of administrators – who had been trained in local community hospitals – begin working in the new NHS, with a patchwork of apprenticeships and courses offered.[401] • National efforts to improve quality of administrators with a national syllabus are drawn up alongside exams including subjects such as the laws impacting hospitals, governing bodies and catering. • Administrators seen as subordinate to clinicians; 'administrators - even senior ones – appeared to know their place was to be supportive technicians.'[402]
1948	**Foundation of the National Health Service** • Hospitals are led by 377 Hospital Management Committees which report into 14 regional Health Boards.[403] • Three-way professional hospital management between medicine, usually with a medical superintendent, a matron and a 'lay administrator' making decisions.[404] • Lay administrators are mostly expected to enable hospitals to function through background logistical support and not to question medical or nursing practice.[405]
1956	**National Administrative Training Scheme launched** • Precursor to the modern-day Graduate Management Programme (GMTS).[406] • Begins with fourteen trainees, run jointly by the King's Fund in London and the University of Manchester to 'provide the management cadre of the future'.[407]

401. Philip Begley, 'The type of person needed is one possessing a wide humanity': the development of the NHS national administrative training scheme', *Contemporary British History Volume 34, Issue 2*, 18th November 2019, p [link]
402. Ibid
403. Charles Webster, *The National Health Service: A Political History* (Oxford University Press, 1998), p. 21
404. Peter Greengross, Ken Grant, Elizabeth Collini, 'The History and Development of The UK National Health Service 1948-1999 Second Edition', *DFID Health Systems Resource Centre*, July 1999 [link]
405. Ibid
406. 'History 1948-2020. 72 years young', *NHS Graduate Management Training Scheme*, (last accessed 7th June 2024) [link]
407. Philip Begley, 'The type of person needed is one possessing a wide humanity': the development of the NHS national administrative training scheme', *Contemporary British History, Vol. 34, No. 2* (18th November 2019), p. 235 [link]

1966	**Brian Salmon chairs committee to deliver 'Salmon Report on Senior Nursing Staff Structure'** • Perception that there is confusion about the management of nurses within hospitals and that their profile should be raised.[408] • Recommends that Senior nurses be given management training for the first time.[409] • A clearly defined hierarchy to be introduced ranging from clinical nurses up to new Chief Nursing Officers, with the title of 'Matron' being abolished.[410]
1967	**George Godber chairs a committee to deliver 'Report of the Joint Working Party on the Organisation of Medical Work in Hospitals' – becomes known as the Cogwheel Report** • Aimed to improve input of clinicians in management by creating 'clinical divisions', each with their own chairman.[411] • 'The development of modern scientific medicine and the growth of the hospital medical team has not been accompanied by corresponding development of an appropriate administrative structure amongst clinicians.'[412] • Calls for more training in administration, both for clinicians but also for professional medical administrators.[413]
1972	**Sir Philip Rogers, chairs committee which writes a report called 'Management arrangements for the reorganised National Health Service' – becomes known as 'The Grey Book'** • Rejected the concept of "Chief Executives' in the NHS and called for multi-disciplinary management teams.[414] • Introduces the concept of Consensus Management to the NHS based on the work of a management scientist called Elliot Jacques, where teams would elect 'chairman' (often administrators) to co-ordinate collective decision making.[415] • NHS Managers were expected to have more prescriptive roles within hospitals with less flexibility in their responsibilities.[416]

408. H.A. Dewar, 'The hospital nurse after Salmon and Briggs', *Journal of the Royal Society of Medicine Volume 71*, June 1978 [link]
409. Adrian O'Dowd, 'A history of nursing in Britain: the 1960s', *Nursing Times*, 11th October 2021 [link]
410. H A Dewar, 'The hospital nurse after Salmon and Briggs', *Journal of the Royal Society of Medicine Volume 71*, June 1978 [link]
411. Philip Begley, 'The type of person needed is one possessing a wide humanity': the development of the NHS national administrative training scheme', *Contemporary British History Volume 34, Issue 2*, 18th November 2019, p240 [link]
412. 'Cogwheel Report', p.7
413. Ibid, p. 8
414. Brian Edwards, 'The National Health Service. A manager's tale. 1946-1992', *The Nuffield Provincial Hospitals Trust*, 1993, p.23 [link]
415. Ibid, p.24
416. Geoffrey Rivett, '1968-1977: Rethinking the National Health Service', *Nuffield Trust*, (last accessed 12th June 2024) [link]

1974	**NHS Reorganisation Act** • 207 Community Health Councils brought in to provide a patient voice after scandals in Ely Hospital in Cardiff amongst others.[417] • Principle of system collaboration introduced by Area Health Authorities which were intended to join up primary and secondary care to 'secure and advance the health and welfare of the people in England and Wales'.[418] • Health Ombudsman introduced with the power to investigate NHS bodies. • Consensus management introduced to resolve the issue of accountability between administrators and clinical professionals.[419]
October 1983	**NHS Management Inquiry: Griffiths Report published**[420] • Roy Griffiths, then a director of Sainsbury's, spends a year analysing NHS leadership. His final report identifies the 'consensus approach' as a key failing and concludes that "no one is in charge". • Recommends the creation of the 'General Manager' position to instil "a more thrusting and committed style of management".[421] • Proposed Chief Executives for Trusts which are later implemented.[422] • Recommended establishment of an NHS Management Board (NHSMB). Griffiths intended that the NHSMB would be multi-professional, drawing members from the private sector, NHS and civil service.[423] • These plans, which were eventually implemented in 1985, met fierce opposition from professional bodies such as the Royal College of Nursing (RCN) and the British Medical Association (BMA) (the trade union for doctors in the UK); with the BMA threatening not to co-operate with managerial decisions that threatened patients interests.[424]

417. Charles Webster, 'The National Health Service. A Political History', *Oxford University Press*, 1998, p.108 [link] For Ely Hospital Scandal; 'Ely Hospital, Cardiff', *Hansard 1803-2005*, 27th March 1969 [link]
418. 'NHS Reorganisation Act 1973', *The Health Foundation*, (last accessed 12th June 2024) [link]
419. Philip Begley, 'The type of person needed is one possessing a wide humanity': the development of the NHS national administrative training scheme', *Contemporary British History Volume 34, Issue 2*, 18th November 2019, p. 240 [link]
420. 'Griffiths Report on NHS October 1983', *The Socialist Health Foundation*, (last accessed 12th June 2024) [link]
421. Ibid
422. Martin Gorsky, 'Searching for the People in Charge': Appraising the 1983 Griffiths NHS Management Inquiry', *Medical History, Vol. 57, No. 1* (January 2013) [link]
423. 'Griffiths report on management in the NHS', *The Health Foundation*, (last accessed 12th June 2024) [link]
424. Martin Gorsky, 'Searching for the People in Charge': Appraising the 1983 Griffiths NHS Management Inquiry', *Medical History, Vol. 57, No. 1* (January 2013) [link]

2001	**'Shifting the Balance of Power' published, a white paper supporting New Labour's NHS modernisation strategy.[425]** • Emphasises the importance of devolving authority away from Whitehall and into the hands of front-line staff. • Plans to increase involvement of patients in their care, partly supported by increasing the amount of information they have available about services.[426] • NHS franchising introduced as a way of identifying top performing managers and deploy them where they are needed most in the NHS, especially inside newly developed Strategic Health Authorities.[427] • Incentives brought in to devolve to front-line teams.[428] • Establishment of a National Leadership centre to drive a national development programme to deliver 'management excellence'.[429]
July 2001	**'Bristol Royal Infirmary Inquiry' published investigating the care of children receiving complex cardiac surgical services between 1984-1995.[430]** • Inquires specifically in to the management of children's care and to identify failures to raise concerns about the quality of care promptly. • Inquiry concludes that 30-35 children treated in the BRI between 1991 and 1995 would have survived if they had been treated elsewhere.[431] • States that the Department of Health should 'establish an independent framework of regulation which will assure the quality of the care provided in and funded by the NHS'.[432]

425. 'Shifting the balance of power within the NHS' white paper', *The Health Foundation*, (last accessed 12th June 2024) [link]
426. 'Alan Milburn- 2001 Speech on Shifting the Balance of Power', *Political Speech Archive*, 14th February 2016 [link]
427. 'Shifting the Balance of Power within the NHS Securing Delivery', *Department of Health*, July 2001 [link]
428. Ibid
429. Ibid
430. 'Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995... Summary', *The Bristol Royal Infirmary Inquiry*, July 2001 [link]
431. Clare Dyer, 'Bristol inquiry', *The British Medical Journal*, 28th July 2001 [link]
432. 'Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995... A Health Service which is well led', *The Bristol Royal Infirmary Inquiry*, July 2001 [link]

<table>
<tr><td>2002</td><td>In response to the “Kennedy Report” in to Ian Paterson, a breast surgeon who deliberately harmed patients in his care, a ‘Code of Conduct for NHS Managers’ is produced by a Working Group chaired by Ken Jarrold CBE.[433]
Sets out key principles such as prioritising safety and care of patients, being honest and acting with integrity and respecting patient confidentiality.[434]
Also places a responsibility on managers for their own learning and development.[435]
Managers are given the ‘right’ to be judged fairly in appraisals, assistance with development and help to achieve a ‘reasonable’ work life balance.[436]
NHS employers are instructed to implement the code in to employment contracts, and to investigate breaches of the code as and when they occur.[437]</td></tr>
<tr><td>June 2008</td><td>‘High Quality Care for All’ published, a White Paper on the role of front-line staff in the system.[438]
Sets out principles for the NHS constitution, enshrining rights for patients and staff.
Funding for new hospitals to be conditional on responses of patients regarding the quality of delivered services.
Expansion of the concept of NHS Foundation Trusts explored to include community healthcare organisations.[439]
Set to introduce leadership training at an undergraduate stage for medical and nursing students.[440]</td></tr>
</table>

433. ‘Code of Conduct for NHS Managers’, *Department of Health*, October 2002 [link]
434. Ibid, p3
435. Ibid, p3
436. Ibid
437. Ibid, p9
438. ‘High Quality Care For All. NHS Next Stage Review Final Report’, *Department of Health*, June 2008 [link]
439. Ibid
440. Ibid

<table>
<tr><td>June 2008</td><td>'Developing the NHS performance regime' published by the Department of Health.[441]

Makes the case that 'increasingly pluralised' system for delivering healthcare cannot be administered by Whitehall, with local priorities driving decision making.[442]
'The philosophy underlying our approach is that individual organisations, and in most cases their Boards, are responsible for improving performance and addressing underperformance.'[443]
Performance dashboards to be made available at a trust level.[444]
NHS Chief Executive to be given discretionary powers to publicly designate PCTs and NHS Trusts as 'challenged' and subject to intervention at Board level.[445]
</td></tr>
<tr><td>2009</td><td>Care Quality Commission (CQC) established by an Act of Parliament to regulate and inspect health and social care providers in England.

A combination of three predecessor organisations; the Healthcare Commission the Commission for Social Care Inspection, the Mental Health Act Commission.[446]
Four-point scale established, from outstanding; good; requires improvement; and inadequate.[447]
No fixed time given for length between inspections, although the CQC aims to investigate providers who they judge to be at increased risk more regularly. A service which has been rated inadequate can expect another inspection within a year.[448]
</td></tr>
</table>

441. 'Developing the NHS Performance Regime', *Department for Health*, June 2008 [link]
442. Ibid
443. Ibid
444. Ibid
445. Ibid
446. 'Care Quality Commission (Registration) Regulations 2009', *National Health Service England, Social Care England, Public Health England*, 26th November 2009 [link]
447. 'Research Briefing. The Care Quality Commission', *UK Parliament, House of Commons Library*, 24th April 2020 [link]
448. Ibid

2010	**'Equity and Excellence: Liberating the NHS' published by incoming Conservative government.** • Emphasis on how clinicians can be 'liberated' and 'empowered' to innovate. • Goal for government to reduce management costs by 45% over four years to 'free up money for the frontline'.[449] • Performance to be focused on clinical outcomes instead of 'bureaucratic process'.[450] • Formal efforts to devolve power further to NHSE from DHSC, 'free from frequent and arbitrary political meddling.'[451] • Followed by revision to the 2010/11 NHS Operating Framework which proposes to reduce management costs by £850m (46 per cent) by 2013/14.[452]
February 2013	**'Francis Inquiry' into Mid Staffordshire scandal published.** • Investigated the Mid Staffordshire scandal, where up to 1200 patients were estimated to have died as a result of poor quality between January 2005 and March 2009.[453] • Constant reorganisations of the NHS were partly blamed, alongside the setting of national standards from the centre that were insensitive to local realities and clinical judgement.[454] • Toxic working culture identified, with elements including; 'a lack of openness to criticism', 'an acceptance of poor standards' and 'a failure to put the patient first in everything that is done'.[455] • Fit and proper persons test suggested for board directors to make sure they are suitable for positions of responsibility in the NHS.[456] • Suggests a uniform patient complaints process should be established as per the recommendations of the Patient's association.[457] • Calls for greater role of patients in the Care Quality Commission.[458]

449. 'Equity and excellence: Liberating the NHS', *Department of Health*, July 2010 [link]
450. Ibid
451. Ibid
452. 'Liberating the NHS white paper', *Gov.uk*, 12th July 2010 [link]
453. Denis Campbell, 'Mid Staffs hospital scandal: the essential guide', *The Guardian*, 6th February 2013 [link]
454. 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive Summary', *The Mid Staffordshire NHS Foundation Trust*, February 2013, p65 [link]
455. Ibid, p66
456. Ibid
457. Ibid
458. Ibid

2013	**'Cavendish Review' - An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings**[459] • Commissioned in the fallout of the Mid Staffordshire NHS Foundation Trust Public Inquiry, found healthcare support workers lacked oversight, standardised training, fair recognition, progression and were being deployed inappropriately by employers.
August 2013	**'Berwick Review' into patient safety published.**[460] • Points to a lack of accountability in the NHS as a result of the distribution of authority; 'When responsibility is diffused, it is not clearly owned.'[461] • Identifies that top-down targets have been gamed within the NHS in order for things to appear better than they are out of fear, partly because the system cannot improve its performance.[462] • Calls for modern methods of quality improvement, control and planning to employed in the NHS.[463]
2014	**'Dalton Review' of novel forms of organisational management in the NHS published.**[464] • Identifies the pace of transformational change as a major problem in the NHS, especially the 'early stages of planning and gaining consensus across the local health economy.'[465] • Suggests an increase in use of 'joint ventures' between trusts to pool clinical resources and deliver greater economies of scale.[466] • Made the case for leaders from high-performing trusts taking control of struggling organisations to turn them around.[467] • 'Credential' system proposed to identify organisations that are managed well.[468]

459. The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings [link]
460. 'Berwick review into patient safety', *DHSC*, 6th August 2013 [link]
461. 'A promise to learn- a commitment to act. Improving the Safety of Patients in England', *National Advisory Group on the Safety of Patients in England*, August 2013 [link]
462. Ibid
463. Ibid
464. 'Dalton review: options for providers of NHS care', *DHSC*, 5th December 2014 [link]
465. 'Examining new options and opportunities for providers of NHS care. The Dalton Review', *Care Quality Commission*, December 2014 [link]
466. Ibid
467. Ibid
468. Ibid

2015	**'Smith Review' into NHS leadership development published.**[469] • Describes 'the number of managers across the NHS and their technical skillset' to be 'significantly under examined'.[470] • States that the leadership development functions of the NHS are diffuse and poorly co-ordinated.[471] • 'There needs to be greater ownership of national programmes by local organisations and systems.'[472]
2017	**In a speech to the NHS Providers Annual Conference, the Rt Hon Jeremy Hunt MP calls for**[8]**:** • Faculty of Medical Leadership and Management to work with the GMC, NMC and HCPC (Health Care Professions Council) to ensure their policies, procedures and processes can encourage and enable more clinicians to transition into management roles. • New fast track development programme designed to support outstanding clinicians interested in moving into senior management positions. • GMC to work with HEE (Health Education England) to examine how clinical leadership can be incorporated as a core component of all specialty training and consider whether this should be established as a specialty or sub-specialty in its own right. • Expand the number of high calibre non-clinical graduates entering the NHS. So, from 2018, HEE to double the number of places available on the NHS graduate management training scheme to 200, as part of an intention to make the system truly sustainable by increasing the numbers to 1,000 places each year.
2018	**Kerr Review entitled Empowering NHS leaders to lead is published.**[473] • Recommends 360 reviews to manage performance, suggests that they should be submitted anonymously. • 'Administrative burden on leaders is too severe', beginning of Administrative Review Council (ARC). • National Talent Board to work with Leadership Academy to review leadership across the country.

469. 'Review of centrally funded improvement and leadership development functions', *Public Health England, Care Quality Commission, Monitor, NHS*, 27th March 2015 [link]
470. Ibid
471. Ibid
472. Ibid
473. Sir Ron Kerr, 'Empowering NHS leaders to lead', *Gov.uk*, 28th November 2018 [link]

March 2019	**Kark Review investigates systems for managing misconduct of senior staff.**[474] • Kark interrogated the existing 'Fit and Proper People's Test ', used to determine if managers at a director level were suitable for their positions, and concluded that it was not fit for purpose. • His key recommendation was for the government to introduce a national database for directors to monitor their training and appraisals, with a centralised council to control this register as with the GMC and practicing doctors. • While the government accepted this recommendation in principle, it was eventually shelved on the grounds of cost and complexity.[475]
July 2020	**'NHS People Plan' published on wellbeing of staff in the NHS.** • Brings forward 'flexibility by default', stating employers should be open to all non-clinical and clinical roles including an option to work flexibly.[476] • NHS employers told to work with staff representatives to agree diversity targets and put in new processes to address "systemic bias". Efforts also to increase BAME representation at a board level, and to reduce the 'disciplinary' gap.[477] • Launch of 'NHS Leadership Observatory' to examine best practice globally regarding leadership practice.[478]
November 2020	**'Busting Bureaucracy' published on empowering frontline staff by reducing excess bureaucratic burdens.**[479] • Points to rules around the sharing of data as inhibitive, with repetitive data requests clogging up the system. • CQC to move away from periodic inspections to reduce administrative burden and use data to proactively identify causes for concern. • Reviewing a reduction in the number of professional regulators (9) • A suggestive culture at a local level could be useful to point out excessive bureaucracy where it exists and make the case for change.

474. 'Kark review of the fit and proper persons test', *DHSC*, 6th February 2019 [link]
475. Laura Donnelly, 'Matt Hancock shelved plans to ban errant managers from the NHS', *Daily Telegraph*, 21st August 2023 [link]
476. 'We are the NHS: People Plan 2020/21- action for us all', *NHSE*, July 2020 [link]
477. Ibid
478. Ibid
479. 'Busting bureaucracy...', *DHSC*, 24th November 2020 [link]

November 2021	**'The Future of NHS Human Resources and development plan' published.**[480] • Sets out expectations for line managers in the NHS, and responsibilities with regard to EDI, recruitment, and employee wellbeing.[481] • Introduces curriculum of development tailored to needs of health and care sectors.[482] • Improve accountability on digital workforce by establishing boards for national organisations focused specifically on 'digital people strategic initiatives'.
April 2022	**'Ockenden Review' published regarding maternity services at Shrewsbury and Telford NHS Trust.**[483] • Calls for succession-planning programme to be put in place in order to identify potential future leaders and managers in maternity. • Stated that there should be minimum skills for those leading maternity governance teams including training in 'human factors, causal analysis and family engagement'.
June 2022	**Messenger Review into Leadership in the NHS published.**[484] • Focused on how leadership and the management of teams could be made more effective within both primary and secondary care settings. • Messenger identified that there was often a gap between 'accountability' and 'authority' with managers. • It also stated that there was a 'widespread acceptance' of 'discrimination, bullying and blame' that had become normalised in parts of the system.
April 2023	**The Hewitt Review into accountability and performance of Integrated Care Systems (ICSs) is published.**[485] • Recommends work should be done to "ensure that there is the flexibility to competitively recruit and train more specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialised analytical and intelligence."[486] • It also recommended that the NHS set up ICS leadership training specifically for 'system leaders'. • Government responds by stating that it is setting up an internal team to explore ICS leadership training.

480. 'The future of NHS human resources and organisational development report', *NHSE*, 22nd November 2021 [link]
481. 'The expectations of line managers in relation to people management', *NHSE*, 16th January 2024 [link]
482. 'Turning the vision into action', *NHS England*, 22nd November 2021 [link]
483. 'Final report of the Ockenden review', *DHSC*, 30th March 2022 [link]
484. 'Leadership for a collaborative and inclusive future', *DHSC*, 8th June 2022 [link]
485. 'Turning the vision into action', *NHSE*, 22nd November 2021 [link]
486. Rt Hon Patricia Hewitt, 'The Hewitt Review', *Gov.UK*, 4th April 2023 [link]

June 2023	**NHS Long Term Workforce Plan published**[487] • "Expanding apprenticeship routes can help address key workforce shortages and particularly benefit those professions that historically lack consistent route for training and career development, such as non-clinical professionals in corporate services, estates and facilities and general management."[488] • Makes the case for increased automation of administration through AI and speech recognition technologies.[489] • Commitment that all NHS managed and commissioned education will represent best practice in diversity and inclusion.[490]
August 2023	**New standards for NHS Board Governors to strengthen leadership and Governance**[71] • NHSE publishes a new framework on the appointment of senior board members. • Board managers to have standard reference written for them when they leave roles, with a record of any Gross Misconduct. • To be recorded in the nationwide Electronic Staff Record and checked during HR process.
September 2024	**'Darzi Review', An Independent Review of NHS Performance** • Notes "managerial capacity and capability have been degraded, and the trust and goodwill of many frontline staff has been lost." • The number of managers working in the service fell at an annual rate of 4 per cent in the first half of the 2010s, and from that lower base, it has since grown again, rising at 5.8 per cent a year in the past two years (to 2024). • "Capital approvals process is so byzantine that it is hard to find an NHS senior manager who understands it". • "Regulatory type organisations now employ some 7,000 staff, or 35 per provider trust, having doubled in size over the past 20 years. Taken together, there are nearly 80 people employed in regulatory and headquarters functions for each NHS provider trust."

487.'NHS Long Term Workforce Plan', NHSE, June 2023 [link]
488.Ibid
489.Ibid, p75
490.Ibid, p81

Figure 28– Freedom of Information Request issued by Policy Exchange

"Under the Freedom of Information Act 2000, I would like to request the following information.

In the questions below, 'Manager' or 'Managers' refers to any member of staff employed by the trust – on either a permanent, part-time (or other) contract which includes the term 'Manager', 'Director' or 'Executive' in their job title.

If providing any of the pieces of information would exceed the cost limit set out in the Act, I would like you to continue to respond to other pieces of information being asked.

1. How many Managers are currently employed in your Trust? In addition to the total number of Managers employed, please provide a breakdown of the number of Managers employed in each department, unit or ward. If you do not keep this information on record for every unit, or ward, please provide this information for as many as you can in a digital format.
2. How many managers were fired for gross misconduct in the year ending September 2023? Please redact any personal information.
3. How many managers were fired on grounds of capability in the year ending September 2023? By capability, I refer to poor performance, rather than ill-health, as set out in section 98(2) in the Employment Rights Act (1996). Please redact any personal information.
4. Of Managers that are currently employed by the trust:
    a. How many are below band 8A (according to current Agenda for Change pay rates)?
    b. How many are above band 8A (according to current Agenda for Change pay rates)?
    c. How many are currently on long-term sickness leave?
    d. How many are employed on part time contracts?

5. How many hours of overtime did 'on-call' Managers working in your Accident and Emergency department claim in each Week of July, August and September of 2023?"

An alternate version of this request was sent to FOI teams at Integrated Care Boards and Hospital boards in Wales, Northern Ireland and Scotland. Question 5 was changed to:

> 5. Of 'Managers' that are currently employed by your organisation, how many have responsibility for delivering your priorities for 'digital transformation'. By this, we refer to those who may be responsible for information governance, rolling out an Electronic Patient Record, or introducing innovative digital technologies.

For specialist hospitals and community trusts, we changed question 5 to:

> 5. How many hours of overtime did Managers working in your largest clinical department claim in each Week of July, August and September of 2023? The largest clinical department should be defined as the department with the most clinical staff working in it."

Table 18 – FOI Responses – Acute Trusts

Trust Name	Region	Q1 (Total Man)	Q2	Q3	Q4 (A)	Q4 (B)	Q4 (C)	Q4 (D)	Q5
Ashford and St Peter's Hospitals NHS Foundation Trust	South	241	0	0	114	62	3	35	Refusal
Bedfordshire Hospitals NHS Foundation Trust	East of England	599	0	2	343	256	<5	87	Not provided
Blackpool Teaching Hospitals NHS Foundation Trust	North West	577	0	0	284	293	14	108	Refusal
Calderdale and Huddersfield NHS Foundation Trust	North West	455	0	0	288 (AfC onl	167 (AfC onl	5	101	0
County Durham and Darlington NHS Foundation Trust	North East	271	0	0	101	170	4	49	0
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	North West	409	0	0	198	191	8	104	15 Jul Aug 43 Sep 49
East Cheshire NHS Trust	North West	198	0	0	143	55	5	75	Not provided
East Sussex Healthcare NHS Trust	South	263	1	0	110	153	17	49	Not provided
Essex Partnership University NHS Foundation Trust	South	596	0	0	248	348	33	135	
Gateshead Health NHS Foundation Trust	North East	371	0	0	176	135	7	88	Not provided
George Eliot Hospital NHS Trust	Midlands	119	1	0	64	28	2	12	18
Great Western Hospitals NHS Foundation Trust	South West	378	0	0	150	109	2	114	Not held
Hampshire Hospitals NHS Foundation Trust	South	323	<5	0	158	165 (inc 8A)	Not provided	64	0
Homerton Healthcare NHS Foundation Trust	London	191	0	0	108	28	Not Provided	29	Not held
Leeds Teaching Hospitals NHS Trust	North West	952	Not provided	Not provided	371	268	161	15	0
Maidstone and Tunbridge Wells NHS Trust	South	416	0	0	269	44	62	3	Not provided
Mid Cheshire Hospitals NHS Foundation Trust	North West	320	0	0	215	105	3	40	0
Milton Keynes University Hospital NHS Foundation Trust	South	215	0	0	65	136	2	38	Not held
North Bristol NHS Trust	South West	524	0	0	184	331 (Inc 8A)	5	121	0
Northern Care Alliance NHS Foundation Trust	North West	1159	<10	0	747	412	49	153	Not held
Northern Lincolnshire and Goole NHS Foundation Trust	Midlands	420	0	0	322 Inc 8a	98	Refusal	64	Refusal
Northumbria Healthcare NHS Foundation Trust	North East	565	1	0	354	211	9	98	235.77
Nottingham University Hospitals NHS Trust	Midlands	1245	0	0	916	299	28	304	0
Portsmouth Hospitals University NHS Trust	South	Not provided	1	0	180	287	3	103	0
Rotheram NHS Foundation Trust	North West	244	0	0	152	77 (inc 8a)	11	45	0
Royal Free London NHS Foundation Trust	London	1874	1	2	600	1272	36	316	0
Sandwell and West Birmingham Hospitals NHS Trust	Midlands	401	0	0	150	251	5	53	0
South Warwickshire NHS Foundation Trust	Midlands	282	0	0	148	136	4	45	0
Torbay and South Devon NHS Foundation Trust	South West	378	0	0	152	226 (inc b8A	36	71	Not held
University College London Hospitals NHS Foundation Trust	London	698	0	0	383	315	<5	40	0
University Hospital Southampton NHS Foundation Trust	South	947	2	0	588	359 (inc 8a)	13	303	0
University Hospitals Bristol and Weston NHS Foundation Trust	South West	628	0	<5	395	214	9	137	0
University Hospitals of Derby and Burton NHS Foundation Trust	Midlands	548	Not provided	Not provided	250	298	6	117	Refusal
University Hospitals of Morecambe Bay NHS Foundation Trust	North West	222	0	1	49	161 (inc 8a)	9	30	0
University Hospitals Plymouth NHS Trust	South West	1058	0	0	901	148 (inc 8a)	14	421	Not provided
West Suffolk NHS Foundation Trust	South	410	0	0	192	218 (inc 8a)	7	88	0
Whittington Health NHS Trust	London	265	<5	<5	80	185	3	32	
Worcestershire Acute Hospitals NHS Trust	Midlands	209	0	0	86	123	<5	24	23.5
Wrightington, Wigan and Leigh NHS Foundation Trust	North West	428	0	0	284	138	Not provided	Not provided	Not provided
Wye Valley NHS Trust	Midlands	223	0	0	95	128	<6	66	18 August, 19/5 Sep
York and Scarborough Teaching Hospitals NHS Foundation Trust	North East	476	0	0	346	116	3	96	0

Note: Some NHS Trusts provide both Acute and Community services. For the purposes of this dataset, we have categorised all Trusts providing both Acute and Community Services as Acute.

Table 19 – FOI Reponses – Community and Specialist Trusts

Trust Name	Region	Q1 (Total Man)	Q2	Q3	Q4 (A)	Q4 (B)	Q4 (C)	Q4 (D)	Q5
Alder Hey Children's Hospital Trust	North West	286	Not provided	0	159	127	6	63	16
Berkshire Healthcare NHS Foundation Trust	South West	298	<5	0	128	170	<5	55	0
Birmingham and Solihull Mental Health NHS Foundation Trust	Midlands	553	0	0	194	257	9	122	327
Birmingham Women's and Children's NHS Foundation Trust	Midlands	527	0	0	305	222	9	102	0
Cambridgeshire and Peterborough NHS Foundation Trust	East of England	179	0	0	110	69	4	43	832.42
Central London Community Healthcare NHS Trust	London	550	0	1	158	392	7	82	19
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	North West	886	0	0	424	295	15	222	259.01
Derbyshire Healthcare NHS Foundation Trust	Midlands	187	0	0	103	69	3	Not provid	0
East London NHS Foundation Trust	London	602	0	<5	219	383	8	113	0
Kent Community Health NHS Foundation Trust	South	332	0	0	203	64	9	91	0
Lancashire and South Cumbria NHS Foundation Trust	North West	806	0	0	360	219	25	120	Not held
Leeds and York Partnership NHS Foundation Trust	North West	337	0	0	211	112	0	69	0
Lincolnshire Community Health Services NHS Trust	North	106	0	0	76	20	5	22	0
Norfolk and Suffolk NHS Foundation Trust	East of England	391	0	0	146	245	8	85	Jul 31 Aug 13 Sep 61
North Cumbria Integrated Care NHS Foundation Trust	North West	427	0	0	240	85 (77,25)	9	114	N/A
North East Ambulance Service NHS Trust	North East	172	0	0	56	116	2	32	Not provided
North London Mental Health Partnership	London	195	0	0	86	105	2	29	0
North Staffordshire Combined Healthcare NHS Trust	Midlands	176	0	0	98	59	0	41	0
Northamptonshire Healthcare NHS Foundation Trust	Midlands	268	0	0	91	69	8	26	19.6
Notthinghamshire Healthcare NHS Foundation Trust	Midlands	576	<5	0	462	114	<5	77	N/A
Oxford Health NHS Foundation Trust	South	600	0	0	320	280	0	119	N/A
Queen Victoria NHS Foundation Trust	South	96	0	0	41	43	0	17	8.5
Sheffield Children's NHS Foundatoin Trust	North West	306	Not provided	Not provided	145	161	Not provided	111	Not provided
Shropshire Community Health NHS Trust	Midlands	99	0	0	49	50	2	19	0
South Central Ambulance Service	South	318	0	0	191	127	4	25	Not held
South London and Maudsley NHS Foundation Trust	London	478	Not provided	Not provided	262	216	9	48	Jul 13.3 Aug 0 Sep 14
Tavistock and Portman NHS Foundation Trust	London	125	0	0	57	66	2	37	0
Tees, Esk and Wear Valleys NHS Foundation Trust	North East	522	0	0	341	181	13	68	Jul 0 Aug 6.5 Sep 6
The Christie NHS Foundation Trust	North West	743	Refusal	Refusal	425	285	6	55	Refusal
The Clatterbridge Cancer Centre NHS Foundation Trust	North West	198	0	0	110	88	0	29	15 hours
The Royal Orthopaedic Hospital NHS Foundation Trust	Midlands	241	0	0	174	67	2	64	0
The Walton Centre NHS Foundation Trust	South	93	0	0	39	54	1	6	0
Worcestershire Acute Hospitals NHS Trust	Midlands	360	0	0	190	97	4	89	12

Table 20 – FOI Reponses – Integrated Care Systems and Boards

Name	Country	Q1	Q2	Q3	Q4 (A)	Q4 (B)	Q4 (C)	Q4 (D)	Q5
Birmingham and Solihull ICS	England	450	0	<5	238	112	7	132	Not provided
Black Country ICS	England	171	0	0	31-35	136-140	8	38	3
Bristol, North Somerset and South Gloucestershir	England	178	0	0	55	110	1	36	7
Cardiff and Vale University Health Board	Wales	264	0	0	0	264	2	47	14
Cheshire and Merseyside ICB	England	477	0	0	153	212	8	86	7
Coventry and Warwickshire ICS	England	360	0	0	190	97	4	89	12
Cwm Taf Morgannwg University Health Board	Wales	188	0	0	0	188	7	20	5
Dumfries and Galloway Health Board	Scotland	69	0	0	7	62	0	<5	5
Hertforshire and West Essex ICS	England	Not provided	Not provided	Not provided	147	106	Not provided	42	1
Hywel Da University Health Board	Wales	Not provided	Not provided	Not provided	Not provided	Not provided	Not provided	Not provided	5
Kent and Medway ICS	England	285	<5	<5	56	224	<5	36	12
Leicester, Leicestershire and Rutland ICS	England	133	0	0	21	112	1	19	1
NHS Ayshire & Arran	Scotland	448	0	0	206	242	10	97	17
NHS Devon ICB	England	Not provided	0	0	Not provided	Not provided	Not provided	Not provided	Not provided
NHS Dorset ICB	England	244	0	0	99	145	1	59	22
NHS Fife Board	Scotland	43	0	0	<5	42	0	<5	<5
NHS Frimley ICB	England	981	0	<5	495	361	9	172	All Managers
NHS Grampian Board	Scotland	21	0	0	N/A	N/A	0	3	2
NHS Lincolnshire ICS	England	92	0	0	Not held	Not held	Not held	Not held	1
NHS North West London ICS	England	526	0	0	301	193	6	64	Not provided
NHS Western Isles	Scotland	1024	0	0	696	328	30	102.00	23
North East and North Cumbria ICS	England	243	Not provided	Not provided	90	123	Not provided	52	6
North East London Health & Care Partnership	England	335	0	Not provided	40	295	5	38	Not provided
Northwest London ICS	England	564	0	0	113 b8a	451	6	90	4
Orkney NHS Board	Scotland	44	0	0	Not provided	Not provided	Not provided	9	2
South East London ICS	England	253	0	0	33	199	5	113	16
South West London ICS	England	235	0	0	63	172	2	24	14
South Yorkshire and Bassetlaw ICS	England	112	0	0	0	70	7	23	7
Suffolk and North East Essex ICB	England	110	0	0	49	61	1	25	Not provided
West Yorkshire ICB	England	Not provided	<5	0	83	128	10	Not provided	Not provided

Note: Trusts with aberrant responses (2SD outside of the mean data range) were not included in these datasets. Where Trusts included Band 8a with their responses to Q4(A) or Q4 (B) this has been noted.

Figure 29 – Clarification Requested by a Trust

- **Could you please confirm you are happy for us to include only those with 'Manager, Director or Executive' in their job title? Please note this would omit groups of Senior Managers based on their job title within ESR e.g. Head of Service/Clinical Service, Head of Operations and some of our board execs who do not have Executive in their title.**

Figure 30 – Clarification Requested by a Trust to the Definition of a Manager

At the beginning of your request you have stated "I am interested in the managers who oversee the operation of the board, not managers working in the hospitals." however within Q1 you are requesting the information to be provided for a breakdown of the number of Managers employed in each **department, unit or ward.**

Can you please specify which staff members you would like included within this response. Also to note staff members roles can be named for example project manager but they are not an actual acting manager.

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