

# Clinical advice and leadership

## A report from the NHS Future Forum

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## Foreword



Clinical advice and leadership are pivotal to bringing about the necessary improvement in health outcomes envisaged in the Government's proposals for modernising the NHS. The Clinical Advice and Leadership workstream of the NHS Future Forum focused on how, through listening to people, we could make recommendations and suggestions for improvement to the current proposals.

This report reflects our collective views as an independent group of professionals who listened to many people using a range of methods throughout April and May 2011. We have reached a consensus that this report reflects what we have heard. The proposals, we feel, are a genuine attempt to offer solutions to the real anxieties expressed.

The NHS has seen many significant improvements over the last decade, largely due to the hard work and commitment of its staff. Everyone recognises that the service must continue to adapt and change to face the challenges of the next decade so that the NHS can deliver efficient, high quality, personalised services which empower people and respect the dignity and individual needs of the most vulnerable in our society. However, we believe that the legislation as currently constituted will not deliver the hoped for improvement in outcomes within the resources available.

Despite the relatively short timeframe for listening, it quickly became clear that the views we heard followed consistent themes. Most commonly heard was a concern that the full range of skills and clinical advice available from many different professional groups would not be actively engaged in a meaningful and influential way in the design and commissioning of services for patients.

There were powerful expressions of the value to patients of integrated care based on their needs and involving the NHS and other sectors and agencies. But we heard eloquent explanations of how the proposals could lead to reduced collaboration between health and care professionals.

Reflecting on what we were hearing from passionate and committed people I came to the conclusion that at the heart of many of the concerns is an apparent lack of trust. This is a fundamental requirement if true collaboration is to bring maximum benefit to patients. One of the causes may be the relatively 'permissive' or open nature of the Health and Social Care Bill, which sets out minimum requirements for new organisations within the NHS. This approach left many wondering how things would work and what their role would be in the new system. As a consequence, when considering solutions we noted a tension between prescribing through legislation and freedom to allow innovation and local solutions to emerge.

Whilst much of the discussion has focused on commissioning at a local level there were also anxieties about clinical leadership at a strategic level, and in many cases, recognition that there would be a need for the capability to take clinically strategic decisions across broader geographical and functional areas.

Our guiding principle in making proposals has been to focus on what will benefit patients through fostering trust, strong relationships and collaborative working across the health and

social care system, involving and engaging patients and the public in the development of new ways of working.

We have made specific recommendations which we believe should lead to improvements in the Bill and broader policy, as well as a number of proposals which we think should be considered by the NHS itself as real opportunities to bring about improvements and assist with cultural change. Through the many listening events we held and the feedback we received, we recognise that much of the desired improvement, about which there was consensus, would follow from changes in culture and behaviour. Whilst we recognise that legislation will not in itself bring about the step-change in NHS culture that will be required, it needs to provide a framework for helpful behaviours and improved ways of working.

In response to the messages we heard through the NHS Listening Exercise our overarching recommendation is that multi-professional advice and leadership should be visibly strengthened at all levels in the system. We make a clear distinction between the accountability of the governing bodies responsible for commissioning and the advice and engagement they need to achieve the best outcomes for patients. We have followed the principle that it is preferable to ensure that the right skills, capacity and capability are in place at all levels than have a tokenistic approach to representation. We propose that clinical and professional networks should have a significant role in providing a forum for multi-professional advice and influence. Bringing together clinical leaders at appropriate levels in the system in 'clinical senates' will provide a vehicle for cross speciality collaboration, strategic advice and innovation.

Evidence-based commissioning and practice is an important part of effective clinical advice and leadership. Our recommendations for improved information systems and flows, better collection and use of data about clinical outcomes and support for research and innovation are intended to promote evidence-based practice and seamless, integrated care.

In our recommendations, we set out more specifically how changes in the proposed legislation and broader policy, and recognition that successful change takes time to complete, could allay fears and meet the expectations of the many people that we heard from.

I want to extend my personal thanks to the Forum members who gave their time and energy so tirelessly throughout the NHS Listening Exercise. As a group, we want to thank the thousands who engaged with us, providing such considered and eloquent contributions to our work. The commitment to this process was extraordinary and demonstrated how passionately people feel about the NHS. For example, we heard from one group of Allied Health Professionals who had paid for their own accommodation the night before meeting with us so that they could prepare and make the best use of time. It is clear that there are so many areas where care for patients is being improved through clinical leadership and innovation and this should be recognised. As a group, we were struck by the genuine enthusiasm from the public, patients and health and care professionals and we would like to thank them for sharing their experiences and suggestions for improving health and care services with us.



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**Medical Director, NHS East Midlands**

## NHS Future Forum Clinical Advice and Leadership workstream

Multi-professional clinical advice, leadership and involvement in commissioning high quality integrated care are crucial if the proposed NHS reforms are to be successful. We make 13 recommendations for improvement to the proposals, grouped around three key themes:

- **multi-professional involvement in commissioning;**
- **clinical leadership at all levels and leadership development; and,**
- **information and evidence to support high quality integrated care.**

### ***There should be multi-professional involvement in commissioning:***

1. The current duties in the Health and Social Care Bill on commissioning consortia and the NHS Commissioning Board to seek appropriate advice should be strengthened to ensure that both are more directly required to take relevant multi-professional advice when making commissioning decisions.
2. As part of the authorisation and annual assessment process, commissioning consortia must demonstrate that they have the appropriate skills, capacity and capability to undertake their duties and functions.
3. Clinical and professional networks should be embedded in the new system. There should be further work to define and review the function, effectiveness and range of different types of networks.
4. Commissioning consortia and the NHS Commissioning Board should establish multi-specialty clinical senates to provide ongoing advice and support for their respective commissioning functions.
5. Independent advice from public health professionals should be available at every level of the system.
6. Given the importance of multi-professional input to commissioning, the terms 'GP led commissioning' or 'GP Commissioning Consortia' should be abandoned.

### ***There should be clinical advice and leadership at all levels of the system and clinicians should be supported through leadership development:***

7. The NHS Commissioning Board should have substantial multi-professional clinical leadership embedded within it including visible leadership for key groups and conditions, for example children, women, older people, mental health and learning disabilities.
8. The National Quality Board should review the provision of continuing professional development across the NHS.
9. All NHS organisations, particularly new ones, should ensure that appropriate leadership development and support are in place.
10. The Department of Health and the NHS Commissioning Board should ensure responsible officers continue to be in place to support doctors in improving care and ensuring their fitness to practice through revalidation.

***Information and evidence should be used to support high quality integrated care:***

11. All parts of the system need to ensure that information systems are developed, commissioned and implemented to support integrated care across and within organisations.
12. Commissioners should require that data about quality and outcomes of care is collected, shared and used in a transparent way to support informed patient choice and continuous improvement. The role of Quality Observatories and Public Health Observatories should be reviewed in this context.
13. Commissioning consortia should have a duty to promote research and innovation and the use of research evidence in the NHS. Commissioners must fund the treatment costs of patients who are taking part in research, in line with current Department of Health guidance.

# 1 Background

- 1.1 Over the past decade there have been significant improvements in the NHS – including better outcomes and patient experience in many areas. This is a credit to staff in the NHS. The single biggest challenge facing healthcare in England today is how to deliver high quality, efficient services within the available resources.
- 1.2 To address this challenge the Government has proposed reforms which are intended to put patients at the heart of services and give clinicians freedom to develop cost effective services focused on improved outcomes rather than processes. The Health and Social Care Bill includes provisions to:
  - create a new independent NHS Commissioning Board to allocate resources; oversee the commissioning of NHS care and directly commission primary care and certain specified services;
  - create local commissioning consortia to commission the bulk of health services; and,
  - place duties to continually improve quality on all new bodies in the system.
- 1.3 The Bill's key provisions relating to clinical advice and leadership state that:
  - members of commissioning consortia will be providers of primary medical services (members of a GP practice);
  - commissioning consortia and the NHS Commissioning Board will have a duty to make arrangements with a view to securing advice from people with professional expertise relating to physical and mental health to enable them to discharge their functions;
  - the NHS Commissioning Board can only authorise commissioning consortia once it is satisfied that consortia will be able to discharge their functions; and,
  - the NHS Commissioning Board is required to carry out annual performance assessments of commissioning consortia.
- 1.4 During the NHS Listening Exercise we heard views about these proposals. There was broad support for the intent of the reforms; to improve the quality of care for patients by empowering them to make informed decisions about their care. The focus on outcomes and giving clinicians a central role in commissioning health services was also welcomed.
- 1.5 However, in almost every listening session we attended we heard heartfelt expressions of anxiety about the modernisation proposals. These included:
  - different views about whether change on the proposed scale is needed;
  - concerns about losing what works well in the NHS now;
  - mixed views about the pace of change;
  - support for piloting or modelling changes;
  - worries about the 'transition phase' as new organisations are established; and,
  - anxiety about 'upheaval' in the NHS at the same time as the service is trying to make savings and become more efficient.
- 1.6 We heard feedback relating to other themes for the NHS Listening Exercise and we passed these to relevant NHS Future Forum members.

1.7 We heard diverse views on the theme of clinical advice and leadership but we were rapidly able to group them into three broad themes, highlighting the need for:

- **multi-professional involvement in commissioning;**
- **clinical leadership at all levels and leadership development; and,**
- **information and evidence to support high quality integrated care.**

1.8 What we heard in relation to each of these themes is set out below, together with our reflections on their implications and our recommendations arising from them.

## 2 Multi-professional involvement in commissioning

### What we heard

- 2.1 There was universal agreement that people would be best served if care were designed around their needs and based on the input of the public, patients and carers, health and social care professionals, the third sector and specialist societies.
- 2.2 Almost every group we met expressed fears that the proposed legislation is insufficient to guarantee that all relevant professions will be involved in commissioning decisions. To a lesser, but still significant extent, a similar concern was heard about multi-professional input to the NHS Commissioning Board in relation to its role in commissioning some services.
- 2.3 Many people told us they worried that the focus on GPs leading commissioning decisions for local populations could mean that others with a contribution to make to designing better services for patients would be excluded. More than once we heard that if a single professional group made such decisions in isolation it was a risk because *'they don't know what they don't know'*.
- 2.4 Others were worried about the potential exclusion of providers of NHS services or other health and care professionals who are able to understand and contribute to the design of whole 'pathways' of care, from prevention and diagnosis through to rehabilitation and reablement.
- 2.5 We heard powerful arguments for the important role of professionals such as Allied Health Professionals (AHPs), healthcare scientists, pharmacists and midwives whose contribution is too often overlooked. Optometrists, dentists and other groups explained how they can help, not only with improving quality of services, but reducing costs. We heard from many clinicians about the value they placed on the skills which their colleagues in management brought to the table.
- 2.6 Many groups felt the solution was to secure places on the boards of commissioning consortia. Specific suggestions included that a nurse, consultant physician, surgeon or psychiatrist should be required and many AHPs argued strongly for representation of their professions on governing bodies.
- 2.7 Others had concerns that this would be a tokenistic approach rather than one which would achieve genuine multi-professional involvement. Some said that the focus on representation on boards was not right and that the process of commissioning should be separated out from formal accountability arrangements. They told us *'The board has to be structured around those responsible for spend, but the function needs to be multi-disciplinary'* and *'clinical advice should not be confused with governance'*.
- 2.8 GPs in particular told us that they should retain accountability as their practices will be the basis for commissioning consortia.
- 2.9 Many thought that multi-professional input would be achieved if commissioning consortia and the NHS Commissioning Board were obliged to get multi-professional advice for their commissioning decisions. At the same time some were wary of over-

prescription in ways of achieving this engagement and creating unnecessary bureaucratic structures. Instead, they wanted to see the principle of involvement established alongside a *'collective responsibility and sense of purpose'*.

- 2.10 We heard concerns about the future for clinical and professional networks. There was acknowledgement that whilst some networks are working well to improve outcomes in many areas there is unacceptable variation in their effectiveness and some confusion as to their role and purpose.
- 2.11 There was general support for the principle of networks and interest in their potential role in supporting commissioning at the most appropriate population level for different services. Some people were worried that the commissioning of services for vulnerable groups (such as children, those with learning disabilities or mental health conditions) would be disadvantaged in the new system. There was also concern about the future commissioning of services for less common conditions, such as Motor Neurone Disease, which require specialised support for a small number of patients. Stakeholders for maternity services were particularly supportive of maternity networks as a way of improving outcomes and standards of care. They were also keen to ensure that commissioning of maternity services is undertaken at the most appropriate population level. Similarly, those representing ambulance trusts told us that ambulance services need to be commissioned at local, regional and national levels, as *'a one-size-fits-all approach will not work'*.
- 2.12 Expressions of concern were heard about where strategic commissioning decisions affecting larger populations would be made, if they are not made by local commissioning consortia or by the national NHS Commissioning Board. Some referred to a *'strategic gap'* for decisions at this level.
- 2.13 The future role of public health was not a separate part of the NHS Listening Exercise but was raised in many forums. The issues raised included concerns that the perspective and skills of public health professionals may not be available to or used by commissioners.
- 2.14 There was some concern that while the Health and Social Care Bill gives commissioning consortia responsibility for commissioning services for people registered with practices within consortia, it does not give consortia responsibility for commissioning services for the whole population within consortia boundaries.
- 2.15 The issue of potential conflicts of interest was raised by a number of groups. People were worried about the conflict that GPs may have as commissioners *and* providers, the conflict which patients may perceive in the doctor patient relationship if GPs have responsibilities for the costs of care, and the conflict which clinicians employed by hospital care providers may have if they offer advice to consortia on the commissioning of hospital services.
- 2.16 The colloquial name adopted for commissioning groups of *'GP Commissioning Consortia'* was widely felt to be unhelpful as it was perceived as indicating that only GPs will be involved. There was some support for broader terms such as *'Clinical Commissioning Consortia'*, *'Commissioning Groups'* or simply *'Commissioning Consortia'*, which is the term actually used in the Bill.

## Reflections

2.17 In response to the views we heard about multi-professional involvement in commissioning decisions we believe there are ways of making improvements. Through these recommendations we want to embed multi-professional and cross-sector involvement and collaboration in these organisations.

### *Appropriate advice*

2.18 We consider that the Health and Social Care Bill should place a stronger requirement on commissioning consortia and the NHS Commissioning Board to take appropriate advice when making commissioning decisions. We propose that there should be a clear obligation on these bodies to involve all those who have a contribution to make in the design of services.

2.19 We think that commissioning consortia should be required to demonstrate that they have robust arrangements for multi-professional involvement in service development and design. This requirement should be assured through the NHS Commissioning Board's authorisation and annual assessment of consortia.

2.20 Whilst not strictly part of the theme of clinical advice and leadership, we heard on so many occasions about the importance of public and patient involvement in the development of services that we want to highlight and support this.

### *Skills, capacity and capability*

2.21 It became clear that if all those who legitimately feel they have a contribution to make to commissioning decisions were to be part of the governance bodies of commissioning consortia these would be too large to fulfil their prime duties. We therefore concluded it is neither desirable or practical for the governing bodies of consortia to be representative of every group.

2.22 We propose that a clear distinction is made between the executive and accountability functions of governing bodies and wider input to commissioning decisions.

2.23 Commissioning consortia must have the right skills, competencies and behaviours to enable them deliver their functions. These skills are likely to be provided by both clinical and non-clinical leaders and are not dependent on job title or background.

2.24 We recognise the unique role of GPs who are tied in through their practice contracts to commissioning consortia and who therefore will have overall accountability for the decisions made by commissioning consortia.

2.25 In distinguishing between the decision-making processes and involvement in service and pathway design, it is our view that the NHS Commissioning Board should require commissioning consortia, through the authorisation process, to demonstrate that they have in place the appropriate skills, capacity and capability to fulfil their role as commissioners. This requirement should also be a feature of the NHS Commissioning Board's annual assessment of consortia.

2.26 It is important to recognise that different commissioning consortia will be ready to take on responsibility for commissioning at different times. Commissioning consortia will develop the required skills, capability and capacity for their new roles at different speeds. Some may be ready quickly, while others will take longer to mature and develop. There should not be an arbitrary deadline for authorisation of commissioning consortia. We are, however, clear that there must be a comprehensive system of commissioning consortia. The NHS Commissioning Board should support local commissioning where commissioning consortia are not ready to take on full responsibility.

### *Networks*

2.27 One way to provide 'clinical' (and public, patient, social care, third sector) advice to commissioners is through networks. In many areas there are examples of clinical and professional networks working well to support multi-professional input to deliver improved outcomes for patients. But we know there is variability in their effectiveness. It is clear from what we have heard that the term 'network' has many different meanings, including formal, informal, professional, communication and clinical networks. They currently operate in different ways; some as managed networks for the delivery of clinical care, for example networks for critical care and neonatal care, and some support commissioning and provider organisations, for example networks for cancer and cardiovascular disease. Others have a function to bring groups of professionals together to share best practice, for example health scientists' networks.

2.28 We propose that networks are supported and embedded at all levels of the system.

2.29 In order for this to be effective we believe there is a need for significant work to be done to review and describe the functions and consequently the most effective forms of networks for the future. This should include their role in supporting both commissioners and providers of services to improve outcomes for patients. We support the concept of flexibility so that where a 'task-and-finish' approach needs to be taken this is encouraged. This could include groups of professionals forming 'communities of practice' at a local level.

### *Clinical senates or cabinets*

2.30 We see a benefit for multi-professional leaders being brought together in groups which provide advice and support for a range of bodies, including commissioning consortia, the NHS Commissioning Board and health and wellbeing boards.

2.31 These groups might include members of the public, patients, clinicians, network leads, social care professionals and third sector organisations. They would be the manifestation of the broad range of input that is needed at all levels of the system and could provide a link between local clinical leaders supporting commissioning consortia and national clinical leaders supporting the NHS Commissioning Board. Our intention is not to suggest a layer of bureaucracy but to provide a forum for cross specialty clinical expertise, collaboration and advice. These groups could be called clinical senates, although clinical cabinets were referred to during the NHS Listening Exercise. As with networks we propose that the detail for their role and function, including their role in potential service reconfigurations, should now be developed.

### *Public health*

2.32 There should be strong and visible public health leadership to support the commissioning of services. It is important that independent advice from public health professionals is available at every level of the system, including being available to support commissioning consortia and health and wellbeing boards. Public health professionals can offer valuable expertise and will have a particular role in working across boundaries to support local authorities and commissioning consortia.

### *Commissioning for populations*

2.33 The wider responsibility of commissioning consortia for improving population health outcomes is a common theme across the NHS Future Forum's reports. We want to highlight and support the importance of consortia having responsibility for commissioning services that cover their whole population, including those not registered with practices.

### *Conflicts of interest*

2.34 With respect to conflicts of interest, the NHS Future Forum's report on Patient Involvement and Public Accountability discusses these concerns and proposes a role for health and wellbeing boards relating to conflicts of interest. We also consider that our recommendations in relation to networks and clinical senates will be helpful in reducing the potential for there to be real or perceived conflicts of interest in the design and commissioning of services.

### *Describing commissioning consortia*

2.35 We note that while the Health and Social Care Bill refers to consortia as 'Commissioning Consortia', the terms 'GP Commissioning Consortia' or 'GP led commissioning' are widely used to describe the new organisations. The language used about the new system should reflect that commissioning will not just involve GPs. We propose that the use of these terms is abandoned.

## **Recommendations on the theme of multi-professional involvement in commissioning**

- 1) The current duties in the Health and Social Care Bill on commissioning consortia and the NHS Commissioning Board to seek appropriate advice should be strengthened to ensure that both are more directly required to take relevant multi-professional advice when making commissioning decisions.**
- 2) As part of the authorisation and annual assessment process, commissioning consortia must demonstrate that they have the appropriate skills, capacity and capability to undertake their duties and functions.**
- 3) Clinical and professional networks should be embedded in the new system. There should be further work to define and review the function, effectiveness and range of different types of networks.**

- 4) Commissioning consortia and the NHS Commissioning Board should establish multi-specialty clinical senates to provide ongoing advice and support for their respective commissioning functions.**
- 5) Independent advice from public health professionals should be available at every level of the system.**
- 6) Given the importance of multi-professional input to commissioning, the terms 'GP led commissioning' or 'GP Commissioning Consortia' should be abandoned.**

### 3 Leadership and leadership development

#### What we heard

- 3.1 Many expressed a view that clinical leadership should be present at all levels in the system, including the NHS Commissioning Board and commissioning consortia.
- 3.2 There were anxieties expressed about clinical leadership in the future for specific areas such as children, women's health, older people, mental health and learning disabilities. The importance of clinical leadership at all levels for less common conditions was also highlighted.
- 3.3 Those working with children expressed particular worries about how the processes for safeguarding children would remain and become more effective, unless the expertise of designated and named professionals is retained in the new system.
- 3.4 Royal Colleges and other professional bodies told us about the role they could have in the new system, including at a national level. Academics told us they have an important leadership contribution to make to the NHS through linking research and teaching to improving services.
- 3.5 There was a recognition of the value of a range of leaders, but a plea that prescription should be avoided in the type of leadership roles required.
- 3.6 We heard widespread recognition that experienced managers have an important contribution to make to leading improvement in health and care services.
- 3.7 Anxieties were frequently expressed about the future independence of public health leaders alongside their accountability to Public Health England. Many wanted to ensure that Directors of Public Health are professionally qualified and registered. They also wanted public health professionals to have access to development programmes to ensure that they have the skills they need to be effective in leadership roles.
- 3.8 We heard the view that the NHS has not taken continuing professional development (CPD) for its staff seriously. People told us that there is huge variation in the support for CPD within and between organisations and across the NHS. We heard that while some hospitals and practices have invested in CPD, many have not.
- 3.9 People also wanted to see NHS organisations supporting leadership development for staff, particularly for those taking on new roles and responsibilities. This was noted by nurses, scientists and staff and associate specialist doctors amongst others. GPs often told us that they wanted to have leadership development support to ensure they have the right skills for their new roles as part of commissioning consortia. There was support for the development of leadership academies where health and social care staff could learn together.
- 3.10 We heard some concerns about whether the diversity of clinical leaders reflects the makeup of the current and future clinical workforce. In particular we heard concerns about the underrepresentation of women in medical leadership roles, when women now make up around 60 per cent of medical school entrants and around 60 per cent of GP Registrars.

- 3.11 Concerns were raised about future arrangements for responsible officers in the new system. Responsible officers support doctors in improving their care and are required to make recommendations to the General Medical Council (GMC) about the fitness to practice of doctors as part of the revalidation process. Revalidation requires licensed doctors to demonstrate to the GMC that they are practising in accordance with standards of practice set by the GMC. Some responsible officers are based in Primary Care Trusts and report in turn to responsible officers based in Strategic Health Authorities. People wanted to have reassurance that appropriate arrangements would be in place for responsible officers when Primary Care Trusts and Strategic Health Authorities are abolished.
- 3.12 Medical Royal Colleges told us that some NHS organisations were reluctant to release their members to do work for the benefit of the NHS. Many wanted to see more support from NHS organisations to enable clinicians to make a wider contribution to improvements in the NHS.
- 3.13 We heard from many people that legislation and structural changes would not themselves bring about improvements in the NHS but should support changes in culture and behaviours. The right kind of leadership with a focus on developing an environment based on trust and collaboration would set the direction.

## Reflections

- 3.14 Strong and visible clinical and professional leadership at all levels, focused on increasing trust and encouraging positive behaviour, will be key to bring about better outcomes for patients.
- 3.15 The NHS Commissioning Board should have substantial multi-professional clinical leadership embedded within it.
- 3.16 The NHS Commissioning Board should include visible leadership at a national level for children and women's health separately, for mental health, learning disabilities and for older people. Further consideration should also be given to leadership for less common conditions. Multi-professional clinical leadership mirroring the national arrangements at sub-national levels should provide a 'line of sight' and potential for succession planning to national roles. This could be in part through clinical senates providing links through networks and local organisations.
- 3.17 There should be robust arrangements for designated and named professionals for safeguarding children in the new system as part of wider systems to maintain and improve safeguarding arrangements for children.
- 3.18 It is important that the NHS Commissioning Board draws on the expertise of a range of health and care professionals and has a close relationship with Royal Colleges and other professional bodies.
- 3.19 There should be recognition of the skills of many current managers and these should be valued within the new system, so that future organisations can benefit from clinical leaders working in partnership with managers.

- 3.20 There needs to be strong independent leadership for public health at all levels of the system – locally and nationally. Public health staff need to be professionally qualified, appropriately registered and supported through leadership development. Non-medically qualified public health specialists who are not eligible for specialist medical registration by the General Medical Council are admitted to a voluntary register. We recommend that registration by an appropriate national body should be compulsory for non-medically qualified public health staff. In response to the concerns that we heard about the independence of public health advice at a national level, we advise against establishing Public Health England fully within the Department of Health.
- 3.21 Supporting the development of staff in the NHS is essential if the service is to continually improve and meet new challenges. The variation in the current provision of continuing professional development (CPD) for NHS staff is unacceptable. The NHS Constitution<sup>1</sup> commits the NHS to provide staff with personal development and appropriate training. This commitment should be honoured and CPD should be prioritised and accessible to all staff in an appropriate and proportionate way. Development should be part of appraisals and linked to the outcomes that organisations are working to achieve. CPD is a crucial part of good management and effective clinical governance. The issues around provision of CPD are complex, including issues around funding and staffing cover. We recommend that the National Quality Board reviews the provision of CPD across the NHS.
- 3.22 Leadership development will also be important to support those staff who will be taking on new roles and responsibilities. All NHS organisations, particularly new ones, should ensure that appropriate leadership development and support are in place.
- 3.23 There needs to be acknowledgement that some groups are underrepresented in clinical leadership roles and appropriate development opportunities should be provided to support their leadership. Particular attention should be paid to women and those from black and minority ethnic backgrounds to support them to take up leadership roles.
- 3.24 Individuals must recognise the need to develop their professionalism, team-working, management and leadership skills to complement their technical skills. This needs to be reinforced by professional regulators and supported by the professional bodies.
- 3.25 Significant work is undertaken by NHS staff on behalf of Royal Colleges and other organisations which is of benefit to the wider NHS. NHS organisations should support and facilitate this work.
- 3.26 The Department of Health and the NHS Commissioning Board should ensure responsible officers are in place in the new system to support doctors in improving care and ensuring their fitness to practice through revalidation. It is crucial that there are clear arrangements for responsible officers' roles when Strategic Health Authorities and Primary Care Trusts are abolished.

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<sup>1</sup> The NHS Constitution for England, January 2009

## **Recommendations on the theme of leadership and leadership development**

- 7) The NHS Commissioning Board should have substantial multi-professional clinical leadership embedded within it including visible leadership for key groups and conditions for example children, women, older people, mental health and learning disabilities.**
- 8) The National Quality Board should review the provision of continuing professional development across the NHS.**
- 9) All NHS organisations, particularly new ones, should ensure that appropriate leadership development and support are in place.**
- 10) The Department of Health and the NHS Commissioning Board should ensure responsible officers continue to be in place to support doctors in improving care and ensuring their fitness to practice through revalidation.**

## 4 Information and evidence to support high quality integrated care

### What we heard

- 4.1 We listened to fears that the proposals around choice and competition would make it more difficult for clinicians to provide effective advice and leadership across primary and secondary care, to collaborate and work together to improve service quality and to provide integrated, coordinated services for patients.
- 4.2 Some were worried that the reforms '*could reinforce divisions between GPs and specialists*'. We heard that without better information sharing with patients, between professionals and across organisations in the new system, it will be more difficult to provide coordinated care.
- 4.3 Some had concerns that current tariff arrangements within Payment by Results was focussed on individual episodes of care and does not properly incentivise the commissioning of integrated pathways of care for patients.
- 4.4 Many highlighted inadequacies in the current system relating to the accessibility and use of data about health outcomes. Clinicians said they wanted to have better access to accurate data about health outcomes so that they could benchmark outcomes and improve services. They wanted to see data collected and used to support evidence-based practice and evidence-based commissioning. Many pointed out that this data also needs to be transparent and widely available, especially to enable patients to make informed choices about their care.
- 4.5 Support was expressed for maintenance of national schemes led by professional organisations to assure and improve quality and to inform commissioning of high quality services. There was also support for the role of Quality Observatories and Public Health Observatories in improving access to high quality outcomes data.
- 4.6 People wanted to see national evidence-based guidance and standards being available to inform commissioning of services. It was widely felt that clinical leaders should be focused on implementation of nationally agreed standards of care, based on evidence.
- 4.7 Clinicians told us that they were worried that research and innovation would not be promoted and supported in the new system. Academics in particular told us they were concerned that commissioning consortia would not be required to financially support the funding of treatments within research.
- 4.8 Whilst we heard support for the duty to promote effective innovation placed on the NHS Commissioning Board we heard that this should extend to support for a culture for innovation and that this should apply equally to commissioning consortia.

## Reflections

- 4.9 People want to have joined up health and care services which are based on their needs rather than having to adapt to the way services are organised. Integrated care should be supported through collaborative multi-professional clinical involvement and leadership as we have described above and through better information systems.
- 4.10 Information systems which enable information sharing and seamless, integrated care within and between organisations should be developed more rapidly and include all healthcare providers. We would expect the Government's response to the consultation on '*Liberating the NHS: An Information Revolution*'<sup>2</sup> to address these points.
- 4.11 There should be further work to ensure tariff arrangements support the commissioning of joined up care pathways and that payment arrangements provide the right incentives and rewards for high quality care.
- 4.12 Through contracts commissioners should require clinicians to collect and use data about quality and health outcomes in a transparent way to support patients to make informed choices about their care and to support continuous improvement of care. This data should be used to deliver evidence-based practice and evidence-based commissioning.
- 4.13 The work of Quality Observatories and Public Health Observatories should be reviewed and built on so that Observatories are able to support commissioning consortia and networks in access to and benchmarking of outcomes data in the future. National audits, databases, registries, service accreditation schemes and quality improvement networks should also be supported and used to enable and assure quality improvements.
- 4.14 We support the role of the National Institute of Health and Clinical Excellence (NICE) in developing a suite of national evidence-based Quality Standards. Commissioning organisations should use these Quality Standards in developing and assessing services.
- 4.15 Commissioning consortia should have a similar duty as the NHS Commissioning Board to promote innovation and support research. Commissioning consortia must fund the treatment costs of patients who are taking part in research, in line with current Department of Health guidance.

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<sup>2</sup> '*Liberating the NHS: An Information Revolution*' Department of Health, October 2010

## **Recommendations on the theme of information and evidence to support high quality integrated care**

- 11) All parts of the system need to ensure that information systems are developed, commissioned and implemented to support integrated care across and within organisations.**
- 12) Commissioners should require that data about quality and outcomes of care is collected, shared and used in a transparent way to support informed patient choice and continuous improvement. The role of Quality Observatories and Public Health Observatories should be reviewed in this context.**
- 13) Commissioning consortia should have a duty to promote research and innovation and the use of research evidence in the NHS. Commissioners must fund the treatment costs of patients who are taking part in research, in line with current Department of Health guidance.**

## 5 Conclusion

5.1 We have made 13 recommendations after reflecting on the views we heard around three key themes:

- **multi-professional involvement in commissioning;**
- **clinical leadership at all levels and leadership development; and,**
- **information and evidence to support high quality integrated care.**

5.2 Our recommendations are intended to ensure that there is multi-professional clinical advice and leadership at every level of the NHS and that those who have an important contribution to make to designing and commissioning health services are actively included. We suggest improvements to the Health and Social Care Bill and make proposals to support wider improvements in NHS care.

5.3 Our reflections and recommendations are based on listening to many committed and passionate people over the past eight weeks. The quality of engagement in our work demonstrates the value of proactive listening and we support this listening continuing as modernisation proposals are implemented.

