Faculty of **Medical Leadership** and **Management**

FMLM response to NHS 10-Year Plan consultation

December 2024

What does your organisation want to see included in the 10-Year Health Plan and why?

The Faculty of Medical Leadership and Management (FMLM) was established in 2011 by all the UK medical Royal Colleges and faculties, and endorsed by the Academy of Medical Royal Colleges. A values-based charity, FMLM is the UK professional home for medical leadership. Built on evidence that shows effective leadership saves lives, FMLM's primary objective is to raise the standard of patient care by improving clinical leadership.

While there are many interventions that we would like to see, some of these are not necessarily within our scope as an organisation. Because of this FMLM's main focus is on the professionalisation of clinical leadership and management across healthcare.

Improved clinical leadership and management must be central to any reforms in the ten-year NHS plan for patients, teams, organisations, and systems, because:

- improved team performance and effective team working reduce medical errors, increase patient safety, and reduce mortality
- good leadership reduces staff stress, absenteeism, and turnover
- effective teams always outperform individuals, producing better financial control, a healthier workforce and higher-quality care
- with growing demand, increasing complexity and constrained resources, cooperation and collective clinical leadership and management across intra- and inter-organisational boundaries is vital to prioritise patient care at the system level.

We believe that the best way to level up the quality of managers and leaders – for the ultimate benefit of patients – is via the creation of a College of Clinical Leadership, which will act as a training body to ensure the workforce is equipped with the appropriate skills needed to meet agreed standards. Below we outline the current context, recommendations from recent key reports, and the main purpose of a College.

Current context

- In February 2024 there were 39,800 managers in the NHS representing 2.97% of the overall workforce.
- Between 2011 and 2024, the number of managers within the NHS has risen by 18% but this has been far outstripped by increases in clinicians (the number of doctors increased by 45%, and nurses by 26%).
- This is echoed by the 2024 Darzi report which found that the number of managers per clinician has declined markedly over time.
- Narratives about there being too many managers are false; the UK spends less on management compared to comparable international health systems.
- The 2024 Darzi report suggests that this is shortsighted, as the NHS may not be *"employing enough people whose primary responsibility is that its resources are used well, and the talents of its clinicians are focused on delivering high-quality care".*
- In 2023, the Care Quality Commission rated the leadership of over a fifth of NHS acute core services as either 'inadequate' or 'requires improvement', with maternity services (49%) and UEC (54%) scoring particularly poorly.
- Recent high-profile incidents, including the tragic events at the Countess of Chester Hospital, and the events that led to Martha's rule, have seen a greater spotlight on the management and leadership within the NHS.
- Concerns about patient safety and quality of care were subsequently key issues reported within the 2023 British Social Attitudes (BSA) survey, which recorded the lowest level of satisfaction with the NHS since the survey began in 1983, with only 24% of respondents expressing satisfaction.
- The Department of Health and Social Care spent £281 million on external management consultants in 2022/23.

- Leadership roles exist at many levels and in various forms across the NHS, and include managers and executives, as well as clinical and care leadership positions held by doctors, nurses, and other clinicians.
- However, there is no universal definition of what constitutes a leadership role, and as such, it is unclear exactly how many staff are in positions of leadership.
- It follows that without a clear definition or understanding, there can be no consistent standards to measure and value such roles.
- It is therefore inevitable that the quality of leadership and management within the UK's health services is variable and inconsistent.

Recommendations of reports on the Health Service

Published in 2024, the Lord Darzi led Independent Investigation of the National Health Service in England found that:

- *"good management has a vital role in healthcare: it exists to ensure that the maximum healthcare value is created with the resources that are available"*
- *"getting the best from people requires great leadership*" and that "*managers are there to ensure efficient organisation and process so that clinicians can deliver high-quality care to meet the needs of patients*"
- the NHS *"requires leadership at every level of the system and within and across all different staff groups"*
- *"the NHS has many strong and capable leaders. It needs more. Fortunately, leadership is not a quality that is simply endowed; it is a skill that can be learned."*
- likely due to staff shortages, many clinicians take on management responsibilities, but a skills and knowledge gap often results in them being "lauded in one capacity and demonised in another", which is counterproductive.

The report recommends investment in *"developing managerial talent and creating the conditions for success",* and reinforces the findings of both the Messenger Review of NHS Leadership and the Kark Review of the Fit and Proper Persons Test.

The Messenger Review found that:

- *"there has developed over time an institutional inadequacy in the way that leadership and management is trained, developed and valued"*
- the training landscape is messy and piecemeal, and not based on any consistent or agreed universal standards
- *"the interaction between the clinical community and the rest of the workforce is a key element in setting the right cultures and behaviours"*
- the NHS does not foster effective collaborative leadership, is geared towards the needs of the hierarchy rather than the patient, and leads to poor behavioural cultures.

Its recommendations, which received cross-party support, include:

- new measures to promote collaborative leadership and to set a unified set of values
- uniform standards for equal opportunities and fairness are set, with more training to ensure that the very best leadership approaches become ingrained
- a single set of unified leadership and management standards for NHS managers, delivered through accredited training
- a more simplified, standardised appraisal system for the NHS
- a new career and talent management function for managers at a regional level.

Similarly, the 2019 Kark review recommended developing competencies for directors, and a central database of their qualifications, training and appraisals.

Purpose of a College Clinical Leadership

To facilitate these recommendations, it has been proposed that a College of Executive and Clinical Leadership be created, possibly being developed out of the Faculty of Medical Leadership and Management. While proposed in the current government's 2024 manifesto, the initiative has cross-party support.

Via a model of 'collaboration not competition', a new College would act as a pan-NHS multidisciplinary professional body providing and assuring clinical leadership standards, curricula, and guidance frameworks, and enabling evidence-based leadership training and continuing professional development.

Without cutting across extant regulatory legislation and working with the existing Regulators and other Royal Colleges, Faculties and Specialist Associations, it could

define expected leadership behaviours and improve the culture of professionalised clinical leadership.

This would enable benchmarking of clinical leadership against agreed standards, and the recognition, celebration and sharing of best practice

It would also cohere a membership organisation of suitably qualified, experienced and patient safety-minded clinical leaders to support recruitment and promotion within NHS leadership roles.

A College of Executive and Clinical Leadership will:

- reduce variation in the quality of leaders by standardising clinical leadership training across healthcare, via accreditation
- work with an independent regulator to ensure standards of competence, education and skills are met, and enable more accountability, ultimately giving patients greater confidence
- support the continuous development of leadership skills among healthcare professionals at all levels, from frontline staff to senior executives
- facilitate leaders and managers with the skills to maximise efficacy, while working within a difficult operating environment, deliver transformation and enhance productivity
- help make leadership roles an appealing, exciting career choice across all healthcare specialities, and create a pipeline of high-quality leaders, providing support and guidance at every stage from university to retirement
- improve staff resilience and retention via upskilling opportunities, clearer career paths, and the increased job satisfaction associated with having good leaders
- promote cross-specialty and system collaboration, and bring clinical specialties together to work across silos when delivering change
- reduce the reliance on expensive management consultancies
- support the delivery of the wider recommendations of the Kark and Messenger reviews, to help foster an inclusive, values-based environment of support, collaboration and continuing professional development across healthcare.

What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

FMLM agrees with the ‘left shift’ of moving care away from being hospital-focused, towards increased delivery via primary, community and preventative care.

One of the biggest challenges is the workload pressures facing GPs. This is especially important through the patient’s lens, as in general practice, the patient-provider relationship is often closer than in Trusts.

General practice is the cornerstone of the NHS. It is the first point of contact for most patients seeking medical care and is responsible for delivering comprehensive primary health care to local communities (acute, chronic and preventative care), and ensuring access to more specialised secondary care services depending on clinical need.

Whilst facing unprecedented workforce and workload challenges and increasingly complex patient presentations, GPs continue to deliver more care than ever. In October 2024, general practice delivered a record 38.5 million appointments, over 1.6 million appointments each working weekday in England, with similarly high levels of workload being reported across the UK.

Yet the number of General Practitioners (GPs) has remained relatively stagnant since 2015, with a notable decline in GP partners during this period. This stagnation, coupled with an increasing patient population, has led to a significant rise in the average number of patients per GP. In October 2024, there were 63.66 million registered patients in England, resulting in each full-time equivalent GP being responsible for an average of 2,271 patients – a 17% increase since 2015.

In last year’s RCGP survey, 62% of GPs said that they do not have enough time to undertake training alongside their practice work. According to the General Medical Council's (GMC) 2024 workplace report, 48% of General Practitioners (GPs) reported struggling with their workload. This is higher than the 33% average across all doctors. So, whilst effective leadership in general practice is vital, it is also harder to deliver from overstretched staff.

It is clear that if a move away from hospital-based care is to be meaningfully achieved, more resources – and staff – must be found for primary care. GPs and their teams also need protected time for continued professional development, including training in leadership, supervision and mentoring skills, commensurate with their roles and responsibilities, if this transformation is to be enabled.

This is to say nothing of the wider community workforce, which has for years experienced chronic under-resourcing. As a result, the workforce that it does have may lack sufficient training or resources to handle some cases that would have been managed in hospitals, that are more complex. However, this can be mitigated through ongoing training, with ringfenced time dedicated to learning.

Question marks remain around the appropriateness of the infrastructure in community settings, and services appear fragmented. This will need to be remedied at ICS level, via integrated care pathways and partnerships across sectors – including social care. This will require strong leadership (both nationally and locally), wider partnership working, additional transformation funding, and an understanding from the centre that there may be some duplication of services during a transition period.

National and regional policies must promote financial and regulatory incentives to support the shift. ICS' should also seek to implement population health strategies, tailored to their communities, that prevent the need (or reduce demand) for hospital attendance, which are financially costly to the health service.

There are also opportunities to use digital health tools, services and solutions to reduce demand for hospital care, and empower patients to manage their own conditions where they want to be; at home, in their communities. See next question for more on tech/digital transformation.

What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

This is a question that other stakeholders will be better placed to answer, but in the view of FMLM key barriers include funding, time, complexity and staffing. However, getting it right would empower staff, boost productivity and increase patient satisfaction.

The NHS budget for capital spending lags behind that of comparable OECD nations, but the recent 12.8% real terms year-on-year uplift, announced in the Autumn 2024 budget, will take spending to £13.6bn in 2025-26.

A significant proportion of this has been allotted to specific projects, including new surgical hubs, scanners, beds and radiotherapy machines, as well as £2bn to invest in digital and technology (contingent on 2 per cent productivity next year).

However, history shows that when revenue budgets are squeezed, capital budgets are raided, at the expense of improvement and investment in tech. Efforts must be made to prevent this over the course of the next ten years.

There is a further financial challenge in that the current NHS estate is not fit for purpose. While some of the capital budget has been allocated for RAAC repairs, the overall maintenance backlog is estimated to stand at £13.8bn – much more than the 13.6 billion total cost of simply running the entire NHS estate. Put simply, the state of the NHS estate is now a hindrance to productivity and actually making the delivery of care harder.

The NHS Confederation has calculated that an annual rise in capital funding of £6.4 billion each year is required if the NHS is to meet its ambitions, particularly around productivity. It will be very difficult for leaders to facilitate technological transformation, when the very buildings these interventions will be housed in are falling apart.

Time and adequate staffing will also be a barrier to transformation. As of September 2024, there were 107,865 vacancies in secondary care alone in England.

This means that the staff we do have a severely overstretched and do not have the capacity to deliver the transformation needed or even learn how to use new technologies. Staff may resist change, be sceptical about the benefits and may worry about being replaced themselves.

Some of this may be remedied by a comprehensive, but light-touch training program to improve digital literacy and skills, but more staff are desperately needed. The objectives of the long-term workforce plan remain sound, but thought should be given as to how it interacts with digital transformation plans. A programme of regular and clear communications should be implemented at system level, alongside tailored campaigns and plans for local level. Leaders, staff and patients should be engaged and involved in change programmes.

There is a risk that new technology could widen health disparities, with only richer areas able to afford transformation, and operational adoption in poorer areas potentially creating barriers for less digital-savvy patients. Digital investment must be equitable and mindful of local population need.

Connecting disparate IT systems across health and care via the Federated Data Platform – if implemented well – will improve staff productivity, provide greater operational and public health insights, and make a huge difference to patients, who will find their journey across care much simpler and easier. However, concerns remain

around who the contract has been awarded to, privacy, security, legality, transparency, scope, and value for money. Again, these concerns may be abated via an improved programme of communication to build trust. Alongside that, cybersecurity measures should be strengthened.

AI presents a wealth of opportunities, but robust ethical guidelines and frameworks should be put in place before adoption, and any programmes for its adoption should start small in scale. Guidance on this must come from the centre.

Strong leadership will also be key in seeing these plans develop to fruition. Those in leadership positions must be equipped with change/financial management, communication and collaborative skills. Leaders are also uniquely placed to foster cultures of experimentation and innovation, and build staff buy-in. But, crucially, they must also be given time and space to deliver on clear objectives with such programmes taken into account when measuring wider short to mid-term performance. Preferred tech partners should also be determined by the centre, via a robust tendering process.

What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

This is a question that other stakeholders will be better placed to answer, but as mentioned in a previous question, the lack of integration across sections of the health service and social care, will hinder early detection of illnesses. The Federated Data Platform will help via the large-scale analysis of data to spot trends, along with AI, which should guide policy. Greater use of tech, such as wearables, will not only help at an individual level by monitoring the patient, but anonymised and aggregated data will provide insights at a local system level.

However, data can only do so much and will have limited impact if services remain disjointed. ICS leaders must be empowered to deliver on their purpose; integrating systems and creating clearer pathways. Community engagement and co-design with patients must be an embedded practice, to increase uptake and impact of any new services.

Shifting away from hospital care towards community will be a key enabler. Community care can facilitate better early intervention by helping patients better manage conditions, and preventing the need for treatment in expensive hospital settings. As

mentioned before, investment must shift away from acute care towards community, preventative care, and public health.

One example demonstrating the importance of the relationship and interconnectivity between health and care, is how children with ADHD and autism are treated and managed. Schools play a huge part in their care and development, yet education policy is not joined up with health and care.

As local authorities are responsible for a range of these services, good ICS leadership will be vital to foster partnerships and joined-up working, to make the best use of limited council budgets. An alternative may be to return public health to the remit of the health service. It is outside of the scope of this consultation, but tackling the causes of ill health properly will not be possible without investment in local authorities, alongside looking at the wider determinants of health (poverty, housing, education, food pricing etc) which requires cross-government collaboration. It is estimated that between 60-80% of our wellbeing is determined by social circumstances, the environment and lifestyle, so the government should consider wider policies such as smoking bans and air pollution measures. As a member of the UK Health Alliance for Climate Change, we agree that longer-term measures must be taken to reduce fossil fuel dependency, as climate change poses the greatest long-term risk to global health.

Strong leadership is required at all levels to prioritise prevention and early detection, particularly at ICS level, where a population health approach should be adopted to determine local at-risk groups. Leaders need to be equipped with the skills to advocate and implement systemic change, while fostering collaboration across boundaries, and promoting a culture of innovation and improvement.

Please use this box to share specific policy ideas for change. Please include how you would prioritise these and what timeframe you would expect to see this delivered in.

The number one priority must be expanding the workforce, followed by repairing the NHS's broken estate. However, these are long-term, necessary but expensive actions.

In the mid-term, we would encourage the government to fulfil its commitment to create a College of Executive and Clinical Leadership. This will help create a pipeline of future leaders by mandating leadership skills be taught from graduate up, and equip staff with the skills to better manage the limited resources they do have.