A proposal for better governance of the NHS at a national level

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ABSTRACT

The NHS is now widely regarded to be in crisis. Campaigners and politicians usually see more funding as the key to rescuing the NHS from its current straits. However, while money is an important part of any solution, it is not the key issue. Simply pouring money into the existing structure provides inefficient, short-term and piecemeal solutions. A key issue is that there is little effective national governance and no mechanism for reaching a consensus on the many bitter controversies and critical problems afflicting the NHS. Addressing these issues is an essential first step, and a matter of urgency.

KEYWORDS: Governance, governing board, leadership, medical royal colleges, NHS

Introduction

It is hard to imagine any large, complex organisation without a leader in overall charge, and without an effective governing board. And yet, these are precisely the conditions of national governance in the NHS. The *de facto* chief executive of the NHS is the Secretary of State for Health, a politician with no clinical background. The nominal chief executive, Simon Stevens, is a senior manager with long experience in health service management – but he lacks the authority to take in hand important problems facing the NHS, as the junior doctors' dispute clearly demonstrated. The board of NHS England is not structured as a governing board, or even as an advisory board, with only 3 of 16 board members having a clinical background.[1]

The Standing Medical Advisory Committee (SMAC) and the Standing Nursing and Midwifery Advisory Committee (SNMAC) were established by legislation in 1949 as sources of relatively independent clinical advice for governments. In 2003, for example, the SMAC consisted of 15 members, all of them doctors, with *ex officio* members including the presidents of medical royal colleges. Members were appointed by the Secretary of State following consultation with representative professional bodies. The remit of these committees was 'to advise the Secretary of State upon such matters relating to the services with which the committee are concerned as they think fit, and upon any questions referred to them by the Secretary of State'. Both the SMAC and the SNMAC were abolished by the then Labour government on 2 May 2005.[2,3]

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For many years, the NHS has been operating under centralised, almost purely political leadership of one colour or another, with marginal clinical input.

The current situation

The NHS is beset by diverse problems[4–8] and morale throughout the service is steadily declining.[9–11]

There is a cacophony of claim and counter-claim from different perspectives and interests on many critically important issues, never reaching a consensus. We debate the case for a particular issue and the case against, and we move on – the very antithesis of quality governance and effective leadership. We are like a fibrillating ventricle, generating a great deal of desperate activity, but achieving nothing.

The NHS needs, as a matter of urgency, a clinically knowledgeable governing board to take stock of the entirety of the NHS. The board's most urgent task would be to establish a clinically informed consensus on the numerous controversies and problems currently afflicting the NHS. Such a consensus would provide the NHS with a clear direction at national level, and go a long way towards re-establishing composure and staff morale. Without a consensus, effective leadership of the NHS is impossible.

The government needs to recognise that neither the Secretary of State, nor any other individual in the UK, has the knowledge and authority to govern the NHS essentially single-handed. The most frequent model for effective governance (whether it be a business, a charity or anything else) is a clear leader supported by an experienced and knowledgeable board.

It is an extraordinary reflection on the organisational weakness of the NHS at national level that some 10% of hospital beds in England are currently blocked because patients cannot be discharged for lack of the necessary social and nursing care in the community.[12] This bizarre situation is hugely wasteful of precious NHS finances, facilities and staff, and yet it has been allowed to persist for many years. It has seriously compromised the efficiency and viability of hospital services, staff morale and quality of patient care.[13]

A proposal for better governance

One simple approach to providing authoritative and representative clinical leadership at national level is for each of the 11 medical royal colleges in England (anaesthetists, emergency medicine, GPs, obstetricians and gynaecologists,

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ophthalmologists, paediatrics and child health, pathologists, physicians, psychiatrists, radiologists and surgeons) to nominate one of their members and for the Royal College of Nursing to nominate two of its members to join the existing board of NHS England. Two nominees from the allied health professions and one nominee from the Faculty of Public Health should also be included to provide important additional perspectives. Those nominated would join the board for a fixed term of perhaps 4 years, and would need to allocate perhaps 1 day per week to this role. Nominees would not require any particular skills or qualifications, but ideal individuals would be senior practising clinicians with a track record of high-quality leadership. It is likely that every college will have several such individuals willing to put themselves forward to their college for such a prestigious and important role. This structure is in fact more independent of government than the former SMAC and SNMAC. It could easily be implemented over a period of a few months, at essentially no cost.

It is crucial to note that those chosen for this role would not be representing their college or the interests of their particular specialty. They would have the backing of their college, but they would be on the board purely in their own right, with the sole objective of contributing to the national governance of the NHS. This would be done in combination with the other clinical and non-clinical members of the board, who would provide legal, financial and managerial advice. This role simplifies the relationship between the colleges and their nominees, and clearly distinguishes the role of the reconstituted NHS England Board from that of the Academy of Medical Royal Colleges.

This proposal places a particular responsibility on doctors and nurses to provide a clinical perspective to national governance in the NHS. This is not to undervalue the allied health professions (physiotherapists, paramedics in the ambulance service, scientists, radiographers, psychologists, occupational therapists, speech therapists, podiatrists and many others) upon each of which the NHS and high-quality patient care are absolutely dependent. The optimal functioning of the allied health professions will undoubtedly be a major subject of deliberation of the new board, and representatives of individual allied professions could be co-opted as appropriate. However, the number of individuals on a board cannot be unlimited if it is to function effectively, and the 16 members already proposed in this paper push at the limits of what is desirable. Doctors are the most senior members of the clinical service and they are backed by the large and prestigious medical royal colleges – a fact that is likely to be politically important, especially in the early years. There is also widespread support among the public for doctors and nurses to play a larger role in managing the health service.[14] Finally, there are 11 medical royal colleges in England in addition to the Royal College of Nursing. The colleges provide a simple, effective and uncontroversial approach to providing high calibre clinical nominees. These arrangements are not set in stone and would probably evolve with time and experience.

There would need to be an agreement in principle between the government, the medical royal colleges and the Royal College of Nursing for this initiative to proceed. It is likely that the college nominees would be most effective if they were formally attached to or formed a part of an existing group within the current governance structure. This is also likely to be more politically acceptable, especially in the first instance. In this regard, the NHS England Board would seem an obvious choice. The college nominees would need to discuss with the chairman and board members how they would best fit into the board structure; as their remit would be broadly strategic, this would likely be as non-executive directors. It would be best if the college nominees formed a distinct group within the board, perhaps called the Clinical Advisory Group. This group would elect one of their number as chairperson and ideally meet every 2 weeks in the first instance (rather than every 2 months, as for the main board). It is important that the recommendations of the Clinical Advisory Group be freely available.

This approach guarantees a breadth of clinical expertise among board members, and it provides the board with able people who carry the authority that would come from being chosen by their college for this important role. If the colleges undertook a college-wide consultation for the nomination, those nominated would also have a measure of democratic legitimacy.

The government holds the purse strings, and therefore will always have control of the NHS. It need have no concerns in that regard. However, the NHS can flourish only as a genuine partnership between politicians and clinicians. The board of NHS England, constructed as suggested, could represent the clinical arm of such a partnership. The government could then legitimately share the praises and blame for the successes and failures of the NHS; something it is likely to be especially keen to do at the moment.

There is a pervasive attitude that the current state of the NHS has been inevitable, a consequence of a rise in life expectancy, or the prevalence of dementia or type 2 diabetes, or a number of other things. It is, however, a usual consequence of ineffective leadership. Nothing happens suddenly in the NHS, apart from the imposition of political initiatives. Disease trends develop over a number of years, whether they be upwards (eg the rise in type 2 diabetes) or downwards (eg the major decline in deaths from heart disease). Disease patterns over winter and summer are also highly predictable. Those responsible have time to note these things and to plan for them.

It is an interesting irony that in 1948 it was idealistic politicians who had to drag doctors into the NHS. Today, doctors are among the most enthusiastic supporters of the NHS. It is their voice that must now be heard in order to ensure that the NHS survives into its second 70 years in a healthy state. ■

Conflicts of interest

The author has no conflicts of interest to declare.

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