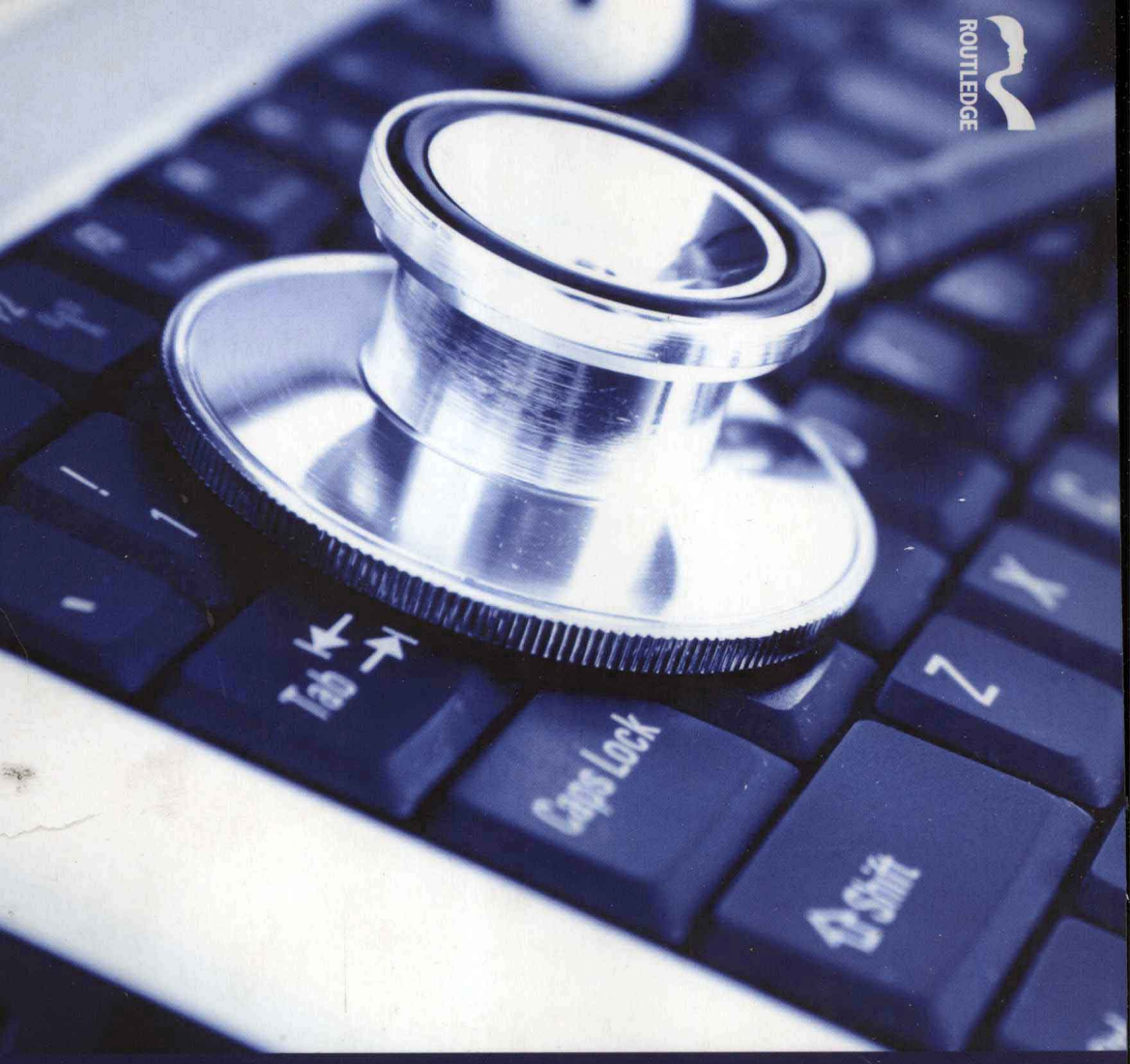

Governing the New NHS

Issues and tensions in health service management

John Storey, John Bullivant and Andrew Corbett-Nolan

First published 2011
by Routledge
2 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

Simultaneously published in the USA and Canada
by Routledge
270 Madison Avenue, New York, NY 10016

Routledge is an imprint of the Taylor & Francis Group,
an informa business

Typeset in Sabon by Glyph International
Printed and bound in Great Britain by
TJ International Ltd, Padstow, Cornwall

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging-in-Publication Data
Governing the new NHS: issues and tensions in health service management / edited by John Storey, John Bullivant and Andrew Corbett-Nolan.
p. cm.
Includes bibliographical references.
1. Great Britain. National Health Service—Administration. 2. National health services—Great Britain—Administration. I. Storey, John, 1947. II. Bullivant, John R. N. III. Corbett-Nolan, Andrew.
[DNLM: 1. Great Britain. National Health Service. 2. Clinical Governance—standards—Great Britain. 3. Clinical Governance—organisation & administration—Great Britain. 4. Health Policy—Great Britain. 5. State Medicine—Great Britain.
W 84.4 FA1 G721 2011]
RA412.5.G7G634 2011
362.1068—dc22 2010012494

ISBN13: 978-0-415-49275-1 (hbk)
ISBN13: 978-0-415-49276-8 (pbk)
ISBN13: 978-0-203-84246-1 (ebk)

Acknowledgements

List of expert witnesses

Wayne Bartlett, International Technical Assurance Director, Tribal HELM
Julie Bolus, Executive Director of Quality and Clinical Assurance, NHS Doncaster
John Bruce, Chairman of Southend University Hospital NHS Foundation Trust
Mark Butler, Director of The People Organisation and Non Executive Director of the NHS Cebtre for Involvement
John Deffenbaugh, Director, Frontline Consultants
Stuart Fallowfield, Assistant. Director of Audit, Durham & Tees Audit Consortium (DATAC)
David Goldberg, formerly Director of the Commissioning Institute, Humana Europe
Shane Gordon, Associate Medical Director, NHS East of England, National Co-lead PBC Federation
Martin Green, Chief Executive, English Community Care Association
Roger Hymas, Consultant, formerly Strategy Adviser Humana Europe and Director of Commissioning at Hampshire PCT
Ann Lloyd, Commissioner for London, Appointments Commission, formerly Chief Executive, NHS Wales
Peter Molyneux, Chairman of NHS Kensington and Chelsea
David Owens, Partner, Bevan Brittan LLP
Michael Parker, Chairman of Kings College London Hospitals NHS FT
Michael Ridgwell, Director, South East Coast PCT Alliance
Kerry Rogers, Company Secretary, Rotherham NHS FT
Tessa Shellens, Solicitor, Consultant in Health and Public Sector Law
Bryan Stoten, Chair NHS Warwickshire, and formerly Chairman of the NHS Confederation
Jasbir Sunner, VP, Strategic Partnerships, Nephrology and Support Services at Humber River Regional Hospital, formerly Executive Director, Corporate Development and Strategy at St Mary's NHS Trust
Julia Unwin, Chief Executive of the Rowntree Foundation

John Whitehouse, Director of Audit, Durham and Tees Audit Consortium (DATAC)

Mike Wistow, Associate Director of Performance & Planning, Lancashire Care NHS Foundation Trust

We are especially grateful to Andrew Harris who contributed so much to the early work on Chapter 3 'The Governance of Networks'. Andrew has a deep personal knowledge of the issues and tensions in health service networks.

A note on terminology

During the writing of this book, the Primary Care Trusts (PCTs) have been in transition. In line with the idea that PCTs should take the lead, they have been requested to refer to themselves as NHS [Place] rather than PCT. So for example there is NHS Buckinghamshire, NHS Salford, and so on. In the main, throughout the book for the sake of clarity we refer to these bodies as PCTs. Following the General Election of May 2010 the future of the PCTs has become uncertain. The White Paper of July 2010 indicates that the role of the PCTs is to be scaled back as GPs increasingly take more responsibility for commissioning health services before the final abolition of PCTs in 2013. This fluctuation between GP-led commissioning and health authority-led commissioning is of course not new and it is likely to swing back and forth for some time to come. The underlying tensions and issues remain essentially the same.

Foreword

The latest set of National Health Service (NHS) policy reforms is not the only clarion call for change in health care in the UK. Medicine progresses inexorably – as do the expectations and needs of aging patients and changing local communities. In parallel, the very concepts of how care is organised, 'hospital', 'clinic', 'doctor,' 'generalist' and the nature of being a 'patient' continue to evolve along with the language of how we lead, control and direct what are increasingly complex institutions.

This book is aimed at the thoughtful board member who is mindful of the nuance of this changing landscape and its impact on the way health care and social care organisations will be governed in the future. It has been produced with the practical application of good governance in mind. It explains why we are where we are and it highlights the key dilemmas and tensions – those that are novel and those that will return again and again wherever and however health care is offered.

The authors use their experience of working closely with boards to bring much needed clarity to the practical exercise of governing. Their insights are enhanced by drawing adroitly on current academic thinking about health-care governance. Many board colleagues have contributed their perspectives, thus bringing alive the day-to-day dilemmas that face those governing health-care systems and organisations.

Many people other than board members will find this book useful, in particular colleagues from local authorities reflecting on the heritage of our health-care boards as well as clinicians now being asked to balance the allocation of population resources while also meeting the clinical needs of individual patients.

Governance is a living discipline in health care. As the NHS embarks on the next controversial stage in its improvement odyssey, one thing is certain – the need to improve the clarity of accountabilities will not diminish and nor will the responsibilities of those governing the new NHS.

Dr Alasdair Honeyman
MBBS BSc MSc MRCGP

Preface

The furore, controversy and delays which greeted the proposals from the new Secretary of State, Andrew Lansley in July 2010 were highly indicative of the importance of governance in health care. His attempts to cut back on 'bureaucracy' by scaling-down or even abolishing the institutions of governance at regional and local levels and to hand more direct responsibility to General Practitioners (GPs) met with resistance not only from the opposition but also from senior Conservative and Liberal members of the committee designed to resolve issues for the coalition government. The Treasury was not satisfied that accountabilities were in place for the massive sums to be handed over to GPs. Doubts were expressed about the capability or even willingness of GPs to take responsibility of the additional commissioning duties. The many and varied proposals to establish new Health Authorities with 'accounting officer' status overseeing GP clusters or consortia would recreate, in a new form, the long-standing regional/local infrastructure of governance in the NHS which has been a feature of the NHS architecture for many decades. The names change but the core underlying issues, tensions and dilemmas remain essentially the same. These concern governance.

'Governance', at first sight, might appear a rather legalistic and even arcane subject. It may appear far less compelling and exciting than seemingly more appealing subjects such as 'leadership' or 'strategy'. We treat strategy and leadership as subsets of governance. Good governance is concerned with five main elements: apart from strategy and leadership it should also be engaged with vision, assurance and probity. In fact, governance of health services is concerned with some of the most crucial questions – ones which we will argue come prior to leadership and related concepts and practices. This is because it is concerned with fundamental questions about who should, and does, make decisions about the allocation of resources across the whole health system.

Ought more money to be spent on mental health and less on cancer? Ought your local accident and emergency service to be closed down in exchange for a possibly superior service some miles down the road? How should patterns of inequities, whereby, in the same city, life expectancy may differ by 15 years from east to west, be addressed? How do we balance the

desire for fertility treatment with the need for dementia services in others? When do we no longer fund cancer care for those who will most certainly die but might treasure an extra month with their family? How do we retain the confidence of the local population when much needed service changes mean one unit closes in order to build up another? These dilemmas are the stuff of health-care governance.

Each of the options will attract advocates and impassioned opponents. So who should decide and how? Are the kinds of questions listed in the previous paragraph ones which should be settled by instruction from the centre – with the chief executive of the NHS and the Department of Health determining the answer? Or should local people have a stronger voice through local representation mechanisms? What is good governance? Is it sufficient for a board to follow and apply the given rules meticulously or should a board use the rules in order to make local judgements – which would mean of course varied outcomes? Health governance is centrally concerned with these sorts of questions and they are the issues examined in this book.

There are lively debates about distinctions between leadership and governance and between management and governance. The boundaries are far from definitive. These are contested terms and we explore the different stances in this book. Even within corporate governance there are different models (for example one view is that governance should remain clearly distinct from management; another view is that too sharp a segmentation can prove dangerous – at least in the health-care domain). Our own stance is closer to the latter view. We argue that if executive and non-executive directors of boards are to do their jobs properly they need to be involved in the strategy and they need to be knowledgeable about certain aspects of health care.

We are not persuaded by the 'policy governance' view which seeks to keep governance separate from operational management. Indeed, we suggest that many of the failings in health-care governance in both provider and commissioning trusts in recent years have stemmed from directors failing to understand the nature of health care and failing to be appropriately engaged. Too many trusts make token attempts to involve the non-executive directors in strategy through ritualistic away days. We will argue that good governance goes well beyond such tokenistic measures.

A number of other books seek to attend to aspects of these kinds of issues and questions. Some are of a legalistic nature and seek to clarify and interpret the rules and regulations. They describe the system as it is 'intended' to work in official terms. Other works are of a critical nature. They review health policy and set out to critique the underlying principles. A third set of works on health governance is more prescriptive and designed to advise and instruct board members about how to conduct themselves.

The approach adopted by this book is different. It is an uncommon mixture of three elements. The first is a description of the 'official' position (a synopsis of Acts of Parliament, policy statements and other documents such

as the Operating Framework). These descriptions amount to an account of how governance is supposed to work. The second element is a commentary upon how the system actually works in practice – here we draw upon research reports and on our own research as well as insights drawn from insider engagement. Third, where appropriate, the book includes a number of practical guidance tools.

This unusual admix of approaches has been enabled by pooling the diverse experiences and expertise of the authors. Insights are derived from very active and close engagement in health service governance across scores of trusts. These practical insights are complemented by academic research – both primary and secondary in nature.

The book focuses on NHS England because of the extent of the reforms to governance but we do recognise the importance of developments in Wales, Scotland and Northern Ireland, and at appropriate points in the analysis cross references are made to these comparative practices.

The book is enhanced by the extensive use of insights from 'expert witnesses'. These are practitioners drawn from many levels and many parts of the NHS – most of them occupying key positions which allow unique insights into the real operation of NHS governance. We arranged to interview these expert witnesses and persuaded a number of them to submit written statements in the manner familiar to Parliamentary select committees. Extracts from these expert witness statements are used through the book so that readers can gain access to the thinking about the issues from a very wide range of influential players – the people who help to make the system work. A list of the expert witnesses can be found in the Acknowledgements section of this book.

List of abbreviations

(Note: This list contains some institutions which are now defunct but are included here as part of the historical context described at times in the book.)

ABC	Activity Based Costing
AHP	Allied Health Professional
AHSC	Academic Health Science Centre
BAF	Board Assurance Framework
BAP	Board Assurance Prompt
BMA	British Medical Association
CMA	Case Management Approach
C&AG	Comptroller and Auditor General
CCG	Collaborative Commissioning Groups
CfPS	Centre for Public Scrutiny
CHAI	Commission for Healthcare Audit and Inspection
CHD	Coronary Heart Disease
CHI	Commission for Health Improvement
CHPs	Community Health Partnerships
CHRE	Council for Healthcare Regulatory Excellence
CIPFA	Chartered Institute of Public Finance and Accountancy
CMS	Centres for Medicare and Medicaid Services
COHSASA	Council for Health Services Accreditation of Southern Africa
COP	Community of Practice
CPA	Clinical Pathology Accreditation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DGH	District General Hospital
DH	Department of Health (England)
DHA	District Health Authority
EFQM	European Foundation for Quality Management
EHR	Electronic Health Record

FESC	Framework for External Support for Commissioning
FT	Foundation Trust
GBO	Governance Between Organisations
GMS	General Medical Service
GGI	Good Governance Institute
HAP	Hospital Accreditation Programme
HAS	Health Advisory Service
HCC	Healthcare Commission
HIW	Healthcare Inspectorate Wales
HPC	Health Professions Council
HQS	Health Quality Service
HQIP	Healthcare Quality Improvement Partnership
HSA	Health Services Accreditation
HSCB	Health and Social Care Board
IBE	Institute of Business Ethics
ICSA	Institute of Chartered Secretaries and Administrators
IHI	Institute for Healthcare Improvement
IHM	Institute of Healthcare Management
ISQua	International Society for Quality in Healthcare
JSNA	Joint Strategic Needs Assessment
LAA	Local Area Agreement
LCGs	Local Commissioning Groups
LDP	Local Delivery Plan
LHB	Local Health Boards (Wales)
LMC	Local Medical Committee
LIFT	Local Improvement Finance Trust
LIT	Local Implementation Team
LPCTCEG	London PCT Chief Executives Group
MOUs	Memorandum of Understanding
NAO	National Audit Office
NCAS	National Clinical Assessment Service
NCGST	NHS Clinical Governance Support Team
NETS	North East Transformation System
NICE	National Institute for Clinical Excellence
NIII	National Institute for Innovation and Improvement
NLC	National Leadership Council
NMC	Nursing and Midwifery Council
NPSA	National Patient Safety Agency
NRES	National Research Ethics Service
NSD	National Services Division
NSF	National Service Framework
OPM	Office for Public Management

PBC	Practice-based Commissioning
PCG	Primary Care Group
PCT	Primary Care Trust
PEC	Professional Executive Committee
PFI	Private Finance Initiative
PPI	Patient and Public Involvement
PSNI	Pharmaceutical Society of Northern Ireland
QALY or QuALY	Quality-adjusted life-year, a system which allocates each treatment a score for the benefit it gives in quality and length of life and is then compared to cost.
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
RCN	Royal College of Nursing
RPSGB	Royal Pharmaceutical Society of Great Britain
SAFF	Service and Financial Framework
SCG	Specialised Commissioning Groups
SfBH	Standards for Better Health
SHA	Strategic Health Authority
SIC	Statements on Internal Control
SID	Strategic Intention and Direction
SLA	Service Level Agreement
SMR	Standardised Mortality Ratio (standardised mortality ratio is the ratio of observed deaths to expected deaths)
SpHA	Special Health Authority
SPG	Specialised Commissioning Group
TCS	Transforming Community Services
WCC	World Class Commissioning
VFM	Value for Money

Contents

List of illustrations

1 The architecture of NHS governance

Issues and tensions

Introduction

Two decades of government reforms to the health service in the UK have wrought huge changes to the way these services are organised and governed. At the top-tier level, health governance has been devolved from London to Wales, Scotland and Northern Ireland. Within England, accountabilities for primary, secondary and tertiary care, and mental health services have been redistributed and in a broad sense devolved extensively away from Whitehall outwards and downwards into individual, independent organisations each governed by a board comprising non-executive directors as well as executive directors. There are approximately 5,000 individuals occupying seats on these boards. Achieving 'foundation trust' (FT) status frees organisations from control and monitoring by the centre, and from their regional agents, the strategic health authorities (SHAs). In their stead, the trust directors are accountable to 'boards of governors' elected by local 'members' – patients and citizens of the local communities served by these hospital trusts. The roles and interrelationships between the boards of directors and the governors remain uncertain and unresolved. With the new coalition government in 2010, this process of reform has if anything accelerated with stronger roles for GPs and local authorities. Directors sitting on these trust boards have to negotiate their roles not only with regard to each other but also in relation to the shifting and multiple principles and institutions which form the macrosystem of governance. With the reforms announced in the 2010 White Paper this challenge has reached new heights of complexity. Despite a pre-election pledge to avoid structural change the new Secretary of State went on to trigger one of the most radical upheavals since 1948. One immediate consequence of centre-led intervention was the resignation of the Chair of NHS London along with a number of the other Non-Executive Directors leading to concerns about whether the Board was viable. Examination and clarification of roles in the crossfire of these multiple forces is one of the central rationales of this book.

'Governance' has become a defining narrative in analyses not only of health services but of public policy more generally (see for example Rhodes 1997;

Newman 2001; Kooiman 2003). Although widely used, the concept has been hard to define. Rhodes lists a number of different and indeed diverse usages – for example from the political studies and public administration domain, the idea of a shift from a central and providing state to an enabling state, which devolves accountability to distributed governing agencies; from the corporate governance domain, the idea of good governance based on procedures and defined roles; and from the policy domain, the idea of self-organising networks. He also lists other usages but his own interest in the concept seems to rest mainly with the self-organising networks idea.

More widely still, in his theory of transaction costs Williamson (1975) posited markets and hierarchies as alternative ways of governing economic exchanges and thus of economic life. These types of 'transactions' and their associated costs are also fundamental, alternative, governance mechanisms. Markets rely on prices, competition and contracts to help allocate resources. Economic exchange is guided by an invisible hand. Hierarchies, on the other hand, bring actors involved in an economic exchange under the control of a clear governing authority. This authority establishes rules and roles and reserves the right to resolve conflict by declaration. Subsequently, to these two 'pure types' of governance of economic exchanges have been added hybrid forms which are neither markets nor hierarchies – most notably alliances, interorganisational networks, joint ventures and other forms of interorganisational arrangements. Together, these forms represent the wider perspective on governance when viewed from a macroeconomic and political economy perspective.

When viewed from the narrower and more focused perspective of board governance, the NHS has been able to offer an increasing amount of practical guidance as it learns from the experiences of boards from within and from outside the NHS. Key documents of this kind include *The Healthy NHS Board* (National Leadership Council 2010) *The Intelligent Board* (Appointments Commission 2006) and *Governing the NHS* (Department of Health 2003). The documents offer useful practical descriptions and advice about the various roles of the board as a collective entity, and the individual roles for members of these boards. Much of this advice stems from similar guidance found in commercial settings – as found for example in the Walker review of corporate governance in banking and finance (Walker 2009) and the *Combined Code on Corporate Governance* (Combined Code 2008, now the UK Corporate Governance Code 2010). Hence, purposes of NHS boards are clarified – to formulate strategy, to ensure accountability and to shape culture. Likewise, the factors which need to be taken into account when pursuing these purposes are also helpfully clarified (such as understanding of context, seeking out appropriate information and engaging with key stakeholders).

In this book, we conceive of health-care governance as an interlocking, *multilevel phenomenon*. Thus, while most certainly of focal concern is the behaviour of boards that are explicitly charged with governing their

organisations, we also argue that these behaviours and the dilemmas with which they try to grapple can only be properly understood in the wider context of the market, hierarchy and network forms that they have to interpret, and within which they have to operate. This point can in part be illustrated by the fact that, following the publication of the report from the extensive corporate level inquiry into the Mid Staffordshire NHS Foundation Trust (Francis 2010), the head of the inquiry recommended a further inquiry into the *wider system of regulation* which allowed the massive failures of governance at trust level to persist and seemingly go unnoticed. The recommendation from that inquiry which touches most directly on this point is worth quoting in full:

> The Department of Health should consider instigating an independent examination of the operation of commissioning, supervisory and regulatory bodies in relation to their monitoring role at Stafford hospital with the objective of learning lessons about how failing hospitals are identified.
>
> (Francis 2010: 28)

Governance in health is about the oversight and balancing of financial, clinical and patient satisfaction objectives. This process takes place between interlocking tiers. This book is about the interplay between these tiers of governance and that is why we have chapters covering governance of and in the provider organisations, the commissioning organisations, networks and the regulators.

But, before we go any further, the question to be asked is: does governance matter and if so, in what ways and to what extent? Some senior managers – and senior clinicians – schooled in the arts of planning, leadership and strategy or schooled in the tenets of professional autonomy, are at times ambivalent about the contribution of governance. Perhaps not fully sure about, nor practised in, the arts of governance, too used to controlling directly or simply lacking in confidence to be transparent and to listen to additional voices, some chief executives are tempted to try to 'manage' the board itself. And some senior clinicians are tempted to stand aloof from board engagement. Where the management ploy succeeds it turns the tables: instead of management being steered by governance, governance is steered by management. In such instances governance is neutered and it is, on the surface at least, made not to matter. But where governance is made ineffectual, or is ineffectual to start with, the impact can be catastrophic. In financial or delivery of care terms, or both, trusts with poor governance have repeatedly run into very deep trouble. The Chief Executive of the Mid Staffordshire NHS trust, Martin Yeates, who resigned when the Healthcare Commission (HCC) first made its critical report, said he had been appointed to a failing organisation 'lacking in any governance arrangements' (Francis, 2010).