Good Governance in European Healthcare:
The NHS in England

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We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.
Good Governance in European Healthcare: The NHS in England

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Good Governance Institute

This report is part of a growing series of reports developed by the Good Governance Institute (GGI) that consider issues contributing to the better governance of healthcare organisations. GGI is an independent organisation working to improve governance through both direct work with individual boards and governing bodies, and by promoting better practice through broader, national programmes and studies. We run board development programmes, undertake governance reviews and support organisations develop towards authorisation.

Other recent GGI reports and board development tools have considered board assurance, patient safety, clinical audit, quality and safety of telehealth services for people with long-term conditions, diabetes services, better practice in treatment decision-making, productive diversity, the board assurance framework, integrated governance, governance between organisations and of course good governance.

GGI is committed to develop and promote the Good Governance Body of Knowledge

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Background to the piece of work

This short technical briefing paper is one of a series that GGI has produced, exploring good governance in European countries. Throughout these papers, we have been exploring:

- How healthcare organisations are governed
- What are the principles and national drivers of good governance?
- What are the pros and cons of the current governance structure?
- What are the future challenges for governance?
- How will governance adapt to the changing healthcare environment?

These essays have been produced based on GGI’s own experience working with healthcare organisations, a review of existing literature, and from our conversations with key contacts.

We have become aware that governance has been developed to varying degrees between different countries, and we feel that some countries have a lot of learning and experience to share, and we wish to support and facilitate this transfer of knowledge.

Next, we wish to further explore these complexities both in the countries already reviewed, as well as, potentially, a wider group of countries, including those in Eastern Europe and Scandinavia. We will be creating a ‘task and finish group’ in order to collaborate with representatives from each country and work together to create an in-depth, research led paper on good governance in European healthcare. We plan to launch this at the EHMA Annual Conference in 2018.
Introduction

Governance in England’s National Health Service (NHS) has been described as ‘the systems, processes and behaviours by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations.’

These aspects of the governance of healthcare in the UK are closely linked to the many reformations of the NHS that have taken place under different governments.

Background to the healthcare system

The Beveridge Model describes the British NHS whereby the state has oversight of and responsibility for the majority of healthcare provided in a country. Within the United Kingdom, each of the four constituent countries, England, Scotland, Wales and Northern Ireland, has its own NHS, whereby the majority of care is provided by and financed by the government, through borrowing and taxation. The English NHS covers 84% of the UK’s whole population and, therefore, will be the focus below.

Within the English health and social care system, the Department of Health (DH) led by the Secretary of State for Health, has responsibility for the strategic leadership and funding for both health and social care. A ministerial department, the DH is supported by 15 arm’s length bodies, and a number of other agencies and public bodies. These arm’s lengths bodies include NHS England, NHS Improvement, the Care Quality Commission (CQC), the National Institute for Health and Care Excellence (NICE), and Public Health England (PHE). Responsibility for regulation is now shared across a number of different bodies, including the CQC, which regulates all health and social care services in England, NHS Improvement, which oversees NHS foundation trusts, NHS trusts and independent providers, as well as a range of individual professional regulatory bodies such as the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC).

Following the reformation of the NHS under Margaret Thatcher’s government in the late eighties, there has been a clear divide between commissioners, organisations who purchase healthcare services for a given local population, and providers, the organisations who deliver these services. This split was maintained through the Labour reforms under Tony Blair, with the creation of Primary Care Trusts (PCTs), administrative bodies responsible for commissioning primary, community and secondary health services from providers, to fulfil the commissioner role, and a focus on the autonomy of, and competition between, hospital trusts.

Following Tony Blair’s reforms, which opened the door to competitive tendering, the Health and Social Care Act of 2012, led by the Secretary of State for Health Andrew Lansley, contained what has been described as the most far-reaching reforms in the history of the NHS. Strategic Health Authorities and PCTs were abolished, with PCTs being replaced by Clinical Commissioning Groups (CCGs), clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. CCGs are led by an elected governing body made up of GPs, other clinicians and lay members. The key themes of the act were increased competition between providers to be awarded contracts by CCGs, and clinicians being more involved in decision-making, and it is in this context of primary legislature that the NHS currently sits.

‘Modernisation and governance can be seen as part of a related discourse embracing such ideas as a shift from producer interests to client interests, from uniform standardised services to a demand led approach activated by the intelligent consumer.’


However, since this Act was passed, there has been a strong move throughout the UK towards the integration of health and social care services. In Scotland, the Public Bodies (Joint Working) (Scotland) Act 2014 requires NHS health boards and local authorities to integrate the planning and delivery of health and social care services, for example, through the creation of, and delegation of powers to, an Integration Joint Board (IJB). Wales have also been developing whole health economy type boards, in favour of the purchaser-provider split. In England meanwhile, NHS England has developed its Five Year Forward View (FYFV) which sets out a clear direction for the future of the NHS, a key aspect of which is the creation of Sustainability and Transformation Partnerships (STPs), in which health and social care organisations, local authorities, and social care organisations must work closely together to produce a plan for the integrated future of services in their area. New models of care, including Accountable Care Organisations, Multispecialty Community Providers, and Primary Acute Care Systems will be formed, which will require new governance structures and changes in organisational culture. All this is taking place despite no change in the legislative structure of the NHS, bringing about various governance challenges, for example relating to regulation, governance arrangements, and relationship building and decision-making. These future challenges will be discussed in more detail later in this paper.

**Current governance structure**

Both providers, including NHS trusts, NHS Foundation Trusts, and community and mental health providers, and commissioners (CCGs) use a corporate governance system borrowed from the city. Organisations use a committee structure, which is led by a ‘Board’, the ‘guiding mind’ of the organisation. The Boards of NHS Trusts consist of the executive directors of the organisation, in addition to non-executive directors (NEDs), members independent from the organisation, one of whom acts as the Chair. In many trusts, one of the NEDs will act as Senior Independent Director (SID). A role adapted from the corporate world, the SID was originally defined in the Cadbury report on corporate governance as the person to whom board members should look to in the case that the chairman is also the CEO, in order to address any concerns about this combined office, the FRC now defines the role of Senior Independent Director as ‘the sounding board for the chairman and… an intermediary for the other directors when necessary’. The SID may be the deputy chairperson, and as one of the independent directors must have, as stated by the Institute of Directors (IOD) ‘the necessary independence of character and judgement’ as well as not having any conflict of interests.

NHS trust boards are required by legislation to have no fewer than eight members, and no more than 11. Despite the different roles, NHS boards have a ‘unitary board’ model of governance, in which all directors have collective and corporate accountability for the performance of the organisation and across all areas, ensuring that the interests of patients remain central to what the organisation does. Both executive and non-executive directors make decisions as a single group.

The board of an NHS organisation has three primary responsibilities:

1. **Formulate strategy:**

   The board plays a leading role in formulating the organisation’s strategy, which should include a vision underpinned by clear strategic objectives, and a clear statement of the organisation’s purpose. Strategic decisions taken by the board should be closely aligned to the strategic direction that has been agreed upon.

2. **Be accountable:**

   It is the responsibility of the board to ensure that the NHS organisation operates in an open and transparent manner and applies duty of candour, whilst also holding the organisation to account for performance in delivering the strategy, and also to be assured on these matters.

3. **Shape the culture of the organisation:**

   The board has a key role in shaping an organisational culture that is caring, responsive and inclusive, with the patient at the centre of everything that the organisation does.

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2. Good Governance Institute, System Transformation Board Assurance Prompt, August 2017
4. FRC, UK Corporate Governance Code, FRC, 2014,
All NHS organisations will have a system of delegation and reservation, in which the board will decide which decisions it will ‘reserve’ to itself as a governance responsibility, and those it is comfortable to delegate elsewhere, for example to the management team or sub-committees. NHS organisations are obligated statutorily to have sub-committees responsible for audit and remuneration, while it is best practice to have a sub-committee responsible for quality and safety. Other common remits are finance and risk.

In recent years, many trusts have aspired to acquire foundation trust status. NHS foundation trusts (FTs) were established in 2006 as a part of the drive to create a more patient led NHS. FTs are more independent, not being subject to direction from the Secretary of State for Health, but are required by their constitutions to establish stronger connections with their local populations by encouraging them to become members of the trust. Therefore FTs have an additional branch of governance, a ‘council of governors’, to which FT members (members of the local population who choose to become members of the trust) are able to stand as, and vote to elect, representatives. Governors undertake a voluntary role and, although they are expected to undertake some statutory duties, largely related to oversight, it is still the board of directors with whom responsibility for the performance of the trust ultimately lies.

CCGs have a similar corporate structure, although on the boards of CCGs, known as ‘Governing Bodies’, in addition to executive directors from the CCG management team itself, there are lay members and GPs, selected from the local area that the CCG serves. Established by the Health and Social Care Act 2012, the reasoning behind this structure was that as GPs have a well-established knowledge and understanding of the particular healthcare needs of their local population, they are well positioned to take a leading role in making decisions on the commissioning of healthcare in the area. However, there are challenges to GP led governance, as will be discussed below.

In addition to the corporate governance role of boards, clinical governance is also a significant aspect of the governance of NHS trusts. The 1999 Health Act placed responsibility for clinical governance – used to describe the corporate responsibility of ‘the duty of quality’ – on the organisations responsible for local health systems: ‘clinical governance was to be the responsibility of a corporate body, accountable for the services it organised or provided for patients’. Clinical governance is the mechanisms and framework by which NHS organisations are responsible and accountable for ensuring the continuous improvement of the quality and safety of services delivered. This might be through, for example, the practice of clinical audit, staff education, or disseminating learning from complaints or serious incidents. However, its pervasiveness in UK healthcare has rather fluctuated, something that was exposed by the Francis Report into the failings at Mid-Staffordshire NHS Foundation Trust, which described a breakdown in clinical governance processes at the trust.

### Background to clinical governance

Around ten years ago, ‘there was a real concern at the lack of board attention on clinical matters… this was rectified by a robust approach to what was called clinical governance, but over time this was sidelined from corporate and audit agendas into subsidiary committees.’

The New Integrated Governance Handbook 2016, GGI

In recent years, NHS organisations have adopted a number of measures, originally outlined in the Integrated Governance Handbook, to help improve joined-up governance and the inclusion of clinical matters at the heart of governance. These have included reducing the number of committees, clarifying the annual cycle of business, senior and qualified board secretaries, audit committees that also review clinical systems, usable board assurance frameworks, board etiquette, information dashboards and annual board reviews.

At board level, the most senior clinical figure is the Medical Director, who will be supported by a team of Associate Medical Directors and Clinical Directors. However, as the board is a unitary board, oversight of clinical matters and ensuring that clinical governance is effective is the responsibility of the whole board.

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13. ibid
Perhaps due to the high level of effort that has been invested in healthcare governance in the UK, the principle of ownership is well-established and transparent. For example, ownership of CCGs lies with the government and the GP practices that are members of the CCG, who elect GP leaders to the CCG’s Governing Body. Meanwhile, ownership of FTs lies with the government and the Council of Governors, who are elected to their role by members of the public, a policy aimed at expanding public ownership and accountability of local services. Thus there has been a shift in focus to a system that delivers devolved accountability of greater ownership at public level, however there does still exist a tension from direct performance management from the centre.

Meanwhile, ‘entity’ is also a key principle. As an NHS organisation is a discrete entity and a legal personality, it thus, as a corporate body, owes duties of care and needs to observe responsibilities and compliances that are separate from those of the organisation’s owners or those controlling the organisation.14

**Regulation**

In terms of regulation, there is a range of national bodies responsible for the oversight and regulation of provider and commissioner organisations:

**Care Quality Commission (CQC):** the independent regulator for quality for health and social care in England, inspecting hospitals, care homes, GP practices, amongst other healthcare services. Whilst inspecting NHS acute hospitals, it focuses on five key domains: safe, caring, effective, responsive, and well-led, with the well-led component being defined as ensuring that ‘the leadership, management and governance of the organisation assures the delivery of high-quality person centred care, supports learning and innovation, and promotes an open and fair culture.’15 In addition,

**NHS Improvement (NHSI):** responsible for overseeing NHS trusts and foundation trusts, and has the power to place trusts who are not performing adequately into special measures. For CCGs, **NHS England (NHSE)** plays a similar role, whilst also setting the priorities and direction of the English NHS and working to improve health outcomes for the population of England. Meanwhile, the Healthwatch network, comprising the national body Healthwatch England and local Healthwatch, serving localities, acts as the ‘consumer champion’ for health and social care.

The NHS in England has a well-developed range of national drivers for good governance, with NHS organisations observing a variety of governance codes. In NHS trusts, these include the Financial Reporting Council (FRC)’s *UK Corporate Governance Code*, and a governance code specifically for NHS foundation trusts created by one of the predecessors of NHSI, Monitor. In commissioning, NHS England recommends that CCGs adhere to the *Good Governance Standard for Public Services 2004*.16 However, perhaps some of the most significant guiding principles are Nolan’s Principles of Public Life, ‘a key development for the governance of the UK public sector’.17 While originally intended to be guidelines for those employed in public affairs and public bodies, they now have much wider application across the public and voluntary sectors.18 The seven principles are as follows:

1. **Selflessness:** Holders of public office should act solely in terms of the public interest.
2. **Integrity:** Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
3. **Objectivity:** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
4. **Accountability:** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
5. **Openness:** Holders of public office must act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for doing so.
6. **Honesty:** Holders of public office should be truthful.
7. **Leadership:** Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

17. ibid
18. ibid.
Moving towards collaborative working

The development and implementation of STPs is currently being undertaken in England, aiming to deliver the goals of the 5YFV, integrating health and social care and achieving the ‘triple aim’ of improved population health, improved quality of care and financial savings. STPs are not new statutory bodies and are not intended to replace the existing accountabilities and governance structures of existing organisations. However, in order to succeed, NHS England have stated that all STPs will need a ‘basic governance and implementation “support chassis”’, in order to enable effective cross-organisational working. Therefore, in 2017 STPs became known as Sustainability and Transformation Partnerships rather than Sustainability and Transformation Plans. As outlined in the ‘Next Steps on the NHS Five Year Forward View, published by NHS England in March 2017, these partnerships will:

- form an STP board drawn from constituent organisations and including appropriate non-executive participation, and partners from general practice and local government. Formal CCG Committees in Common will be established, to enable strategic decision making between organisations
- where this has not already been done, appoint an STP chair/leader, using a fair process
- ensure the STP has the necessary programme management support by pooling expertise and people from across local organisations, while CCGs may align their management teams or governing bodies more closely with the STP geography^{19}

Footprints are currently working to clarify the governance arrangements for the coming together of different organisations, particularly with regard to acute trusts, a number of whom have begun the process of forming shared governance arrangements, including sharing a CEO while retaining their own board, and, in some cases, both boards having a common chair. Other trusts are looking to carry out full mergers or acquisitions^{20}

However, GGI’s experience of working with a number of organisations supporting the development of their STPs and subsequent governance arrangement has highlighted a range of governance challenges which will need to be negotiated as the STP process moves forward. These include:

- **capacity**: system leaders are being asked to engage with, and drive forward, their STPs whilst concurrently running large and often challenged organisations, which in many cases is resulting in a lack of progress being made
- **stakeholder engagement**: appropriate and early stakeholder engagement will be necessary to mitigate the risk of decisions taken being unpopular with the public, and to ensure that there is greater ownership of system challenges from wider stakeholders
- **relationship building and decision-making**: activity around the delivery of STPs is taking place in a system that was intended to support competition rather than integration, and which the STP footprints now have to work around. It has been difficult for commissioners and providers to bridge the cultural divide between organisations. Meanwhile, the level of engagement between NHS leaders and local authorities has varied widely across STP footprints
- **national bodies and regulation**: there is currently no regulatory framework for integration and new models of care, and organisations are inspected and held to account on an individual basis, rather than across the system. This is hindering the development of a truly collaborative working approach. Furthermore, there is a need for greater alignment between the national bodies, with a reportedly fragmented approach between NHSI and NHSE creating further complexities.
- **governance arrangements**: there are a number of governance challenges that will need to be addressed to ensure the success of system transformation. These include the need for organisations to develop shared risk arrangements, ensure appropriate organisational representation (and at the right levels), to consider funding and regulatory requirements and the need to work openly, transparently and collaboratively. Many local leaders have spoken of the challenge of being asked to work collectively on the STP while still being held to account as individual organisations, an issue which can only be negotiated through a change in culture reflecting a transition away from competition within the NHS^{21}

^{19} NHS England, Next Steps on the NHS Five Year Forward View, March 2017
^{20} Hempsons and NHS Providers, Governing for Transformation, 2016
^{21} The Good Governance Institute, System Transformation Board Assurance Prompt, August 2016
Pros and cons of the current system

The structure of healthcare governance in England generally has the potential to offer fit-for-purpose, effective governance, especially in NHS trusts where the governance structure is largely modelled upon a corporate governance structure, and so has efficient mechanisms in place. GGI’s experience is that in most cases, the mechanics of governance, including the systems and processes, of healthcare organisations in England, are usually robust and fit for purpose. When organisations are encountering problems in their governance, this is often due to a breakdown of the ‘dynamics’: the behaviours and etiquette of board members, for example, may not be conducive to effective governance, or there may be a culture of fear around reporting incidents or whistleblowing, which the board of directors would be ultimately accountable, and responsible for.

‘… if you don’t have them [behaviours] in place, all you’re left with is a structure. To make the structure come alive, you need the people, or the dynamics of governance.’

David Cockayne, Managing Director, GGI

For example, during the investigation into the failings at Mid-Staffordshire NHS Foundation Trust, it was reported that ‘significant gaps were found between the processes recorded on paper and the rigour with which they were applied.’

However, there has been some criticisms of the governance structure of foundation trusts, arguing that their complexities hinder, rather than facilitate, effective governance and decision making. In a March 2011 memorandum to Parliament, the Institute of Chartered Secretaries and Administrators (ICSA) delivered the following statement:

‘FTs still have to operate a governance framework unique within the UK economy and one that presents its own challenges and costs. The additional layer of governance inherent within the dynamic between the council of governors and the board of directors will impact on financial and non-financial resources. The dual nature of the decision-making process on specific areas of business development disadvantages FTs as their governance and accountability framework is more cumbersome operating an almost two-tier approach’

‘These reforms have changed the relationship between central government and the NHS and, in turn, new issues of accountability have arisen. For example, there is some concern that there are too many regulatory bodies, that there is a lack of clarity about their boundaries, that the lines of accountability are too complex and that, as a consequence, governance has become problematical.’


This reflects a wider problem within healthcare governance in the UK: its complexity, for example regarding the regulatory framework and range of reporting requirements that NHS organisations must negotiate. Furthermore, as the environment grows ever more complex with the development of STPs and cross-organisational working, the regulatory framework will at some point need to be refreshed so that it encourages collaborative working and collective decision making, facilitating the delivery of service transformation, as opposed to the current model where organisations are being asked to collaborate on STPs, and share risk, while still being held to account as individual organisations, in a regulatory environment which was designed to promote competitive behaviour.

A further potential governance challenge facing the NHS is that, although clinical governance should sit ‘within the envelope of corporate governance’\(^\text{24}\), there is often still a ‘silo’ between corporate and clinical governance, with clinical governance often being delegated to subordinate committees rather than being a key focus of the unitary board of directors. Although positive steps have been taken, GGI have recommended that further work needs to be done to ensure that clinical governance, and clinical quality, are central to governance, beginning at board level.

‘The audit committees must (re-) focus on clinical matters. Nowhere other than in UK health would you find the main business of the enterprise subordinated to a discrete (quality, governance, clinical) committee with often vague terms of reference and a lack of management and audit capacity to ensure safe delivery of the corporate services of the venture. We do not believe that the audit committee should do the often complex work of these committees, but it must have oversight that clinical audit, for example, is strategic, material and completed, leading to improvement.’

Governance in commissioning organisations is displaying similarly mixed results. Although the role of GPs on CCG Governing Bodies has clear benefits, helping to ensure that organisations are more in touch with the needs of their local population, whose views are known well by GPs, it has also brought difficulties in governance.

‘Governance in the new CCGs had a chequered start with GPs naturally assuming the rhetoric [from the government] actually meant they could be casual about accountabilities. This was not to be. It soon became clear that as statutory, albeit membership, bodies, CCGs would need authorisation, boards, audit committees and even a few lay members. CCGs were still a new organisational form. There was natural antipathy to avoid re-establishing PCT type vehicles and there was a clumsy understanding of conflicts of interest and accountability for public funds.’

When CCGs were established, there were concerns about how GPs would manage conflicts of interests as they took on their additional financial and contractual responsibilities as commissioners. As part of the logic in involving GPs in commissioning was that they had knowledge of, and involvement in, the local health economy, it was therefore feared that ‘the overall best interests of taxpayers and the local health population may not always be in the best interest of individual patients for whom GPs are required to advocate, or the companies and partnerships which they own, manage or work for.’\(^\text{25}\) These conflicts of interests could be direct or indirect financial interest, personal interests, or conflicts of loyalty, and there was concern that if these were not effectively managed, they ‘could undermined providers’ and regulators’ confidence in the probity and fairness of commissioners’ decisions, weaken patients’ confidence in the independence of healthcare professionals and, ultimately, destabilise public confidence in the system as a whole.\(^\text{26}\) To manage this potential issue, the General Practice Committee of the British Medical Association (BMA) produced guidance for GPs on how to ensure probity in their role as commissioners,\(^\text{27}\) whilst NHS England also produces statutory guidance for CCGs on managing conflicts of interest.\(^\text{28}\)

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25. The NHS Confederation and The Royal College of General Practitioners, Managing Conflicts of interest in clinical commissioning groups, September 2011
26. ibid
27. ibid
28. NHS England, Managing conflicts of interest: revised statutory guidance for CCGs 2017, June 2017
Even a few years on, as CCGs are now established organisations with clear governance structures and processes, there are governance challenges to be negotiated. Often, GPs can find it a challenge to take on a corporate role, being used to their day-to-day jobs of practicing medicine and running a small business, often referred to as ‘corner shop mentality’. This issue is often exacerbated by the fact that in many cases CCGs, given their awkward beginnings, often did not devote the necessary time and resource to providing induction and training for GP Governing Body members. That said, there are many CCGs whose GP Governing Body members have been successful in getting to grips with the corporate side of governance.

Finally, a significant challenge currently being faced by the NHS in the UK is extreme financial pressures, with many provider and commissioner organisations struggling to cope with considerable deficits, whilst there is an increasing demand for services. As research by the King’s Fund has pointed out, the NHS has faced a significant slowdown in funding growth: ‘between 2010/11 and 2014/15, health spending increased by an average of 1.2 per cent a year in real terms and increases are set to to continue at a similar rate until the end of this parliament. This is far below the historic annual growth rate of 3.7 per cent.’ Meanwhile, the ten years prior to 2015/16 saw a 22% increase in accident and emergency (A&E) attendances, a 40% increase in emergency admissions via A&E, and a 41% increase in elective admissions. This is creating substantial governance stresses as boards attempt to navigate these challenging circumstances whilst making difficult decisions. Furthermore, boards face the further pressure of maintaining the ‘grip’ of the day to day running of their organisation, while also allocating sufficient resource to the transformation work going on as part of their STPs.

Despite this, there has been a lot of investment in, and focus on, governance in healthcare in the UK in recent years and as a result, we believe that the UK has a lot of learning to share, particularly with regards to the principles of, and national driver for, good governance.

29. Ruth Robertson, Lillie Wenzel, James Thompson, Anna Charles, Understanding NHS financial pressures: How are they affecting patient care? The King’s Fund, March 2017
Conclusion: how future proof is the current system?

A key governance challenge facing the future of the NHS in England lies in the development and implementation of STPs. The headline issues that the STP plans must consider include improving quality and developing new models of care; improving health and wellbeing; and improving the efficiency and financial health of services. In order to achieve these primary aims, cross-organisational working and the integration of health and care services will be vital. However, there is no primary legislative driver for the implementation of STPs and collaborative working between NHS organisations, with England’s healthcare system still being built around the competition of the Health and Social Care Act 2012, which encouraged competition amongst NHS organisations, and introduced regulation to guard against anti-competitive behaviours. Organisational barriers, as well as the existing culture on many boards, which are used to a focus on competition and organisational sovereignty, may hinder the achievement of integration.

As organisations are still being regulated and inspected as individual organisations, not as part of the wider system, despite being asked to be accountable for the whole system, this may hinder the willingness of organisations to enter into agreements surrounding the management of joint risk and accountabilities, thus undermining the vision of integration.

‘Boards need to recognise that the answers to challenges are not within the walls of their organisation.’

Julian Hartley, CEO, Leeds Teaching Hospitals NHS Trust

Another aspect of STPs is that they will inevitably bring about mergers of healthcare organisations, or at least services being transferred from one hospital to another. However, Chief Executives of NHS Trusts and Foundation Trusts have raised concerns to GGI that this can create tensions within organisations, with clinicians not wanting to lose services from their own organisation. Boards must not ignore this, with the challenge described by one Chief Executive as a ‘fundamental reality of internal politics’. Instead, boards must involve staff in the design of plans in order to get whole organisations on board, and spread a change in culture towards collaboration throughout the organisation, and the system as a whole. Engagement of stakeholders will also need to be a key governance principle in the development of STPs, as the closure of certain services, particularly hospitals, which although may be best for the local health economy, are likely to be controversial moves that could cause significant opposition from the public. Appropriate and early engagement can help mitigate this risk, and ensure that there is greater ownership of system challenges from wider stakeholders.30

‘The overall architecture of governance which has understandably been designed around dispersed corporate boards for both provider and commissioning organisations has also unintentionally left some white spaces between organisations where patient care is at risk. The logic of concentrated focus on specified activity with its attended islands of accountability has resulted in a danger that no one takes ownership or responsibility for activity outside their own corporate boundaries.’


Therefore, in light of the challenges faced by organisations as they continue to advance through the STP process, the current governance structure of healthcare in England may not be completely future proof.

30. The Good Governance Institute, System Transformation Board Assurance Prompt, August 2016
That being said, there are examples of localities and their organisations moving towards collaborative working positively and successfully, and so, although the governance structures may require further development going forward, there are still opportunities. Boards should ensure that they are alive to the potential challenges, whilst ensuring that they uphold principles of good governance throughout the process and using governance as an enabler of transformation. Meanwhile, there must be a shared agreement around deliverables and accountability, and each organisation should have a responsibility for holding other organisations to account. Governance frameworks for STPs, including Memorandums of Understanding, Terms of Reference, and sharing and agreeing a common annual cycle of business will be good starting points for this.31

‘Accountability and good governance will accelerate the process and keep the system safe.’

Joe Rafferty, CEO, Mersey Care NHS Foundation Trust
