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Governance in the UK Health System

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Governance is important. It is how we hold ourselves to account and give confidence to the public, staff and partners that we have an organisation that is fit for purpose.

It is a tricky business though and a common question from non executive directors is 'how do I know what I don't know?'

UK Board System

In the UK hospitals are run with a unitary board system. This is a single board made up of executive directors who also manage departments, and non executives who are part time independent members recruited from the community, but usually nowadays with business acumen and experience.

All board members have the same responsibility to debate and to decide the strategic issues and risks facing the organisation, though executive directors often find it easier to remain in their departmental role.

The unitary board approach is not universal. In continental Europe and New Zealand for example, it is more common to find the dual board system with a board of part-time independent directors supported by the CEO and a separate

management board, the model also used by charitable trusts in the UK.

Again in England, Foundation Trusts are experimenting with an additional board of governors, the mutual model seeking to ensure stakeholder interests are well represented. Recent reports suggest this new model is getting a mixed response and more work is needed to develop its maturity.

Problems include the large size of these boards of governors (often with more than forty members), governors with single- issue interests and the failure of some appointed members to attend meetings.

The approach is not the same in the four UK devolved nations. Whereas in England the main focus recently has been on developing an NHS Constitution and the capacity and focus of Primary Care Trusts (PCTs) to commission healthcare; in Wales there has been a rejection of the internal market of commissioning and providing and new structures are being debated in an attempt to reduce the burden of governance.

Acute trusts across Wales have lately been merged into much larger and fewer Trusts and the likely model for Wales is the whole area board

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adopted in Scotland. Northern Ireland, which already has integrated health and social care providers, has recently (2007) merged the number of Trusts from 18 to just 5.

The role of the Health and Social Services Authority (HSSA), the single health authority which replaced the previous four boards, is being reconsidered.

In Scotland, the services are brigaded into one tier health boards which have responsibility for all non primary service

planning, enabling and delivery. In spite of this variation and experimentation there have been a number of consistent themes running through governance.

The UK Governance System

The UK system has been criticized for the following reasons:

- Boards are independent and should seek their own determination. Slavish response to central direction and targets is not good enough. The smarter orga nisations see compliance with central requirements as a first step to freedom to focus more locally
- Governance has become too divided with clinical, research, corporate, information governance operating in silos. New variants of partnership, quality or security governance are unhelpful in ensuring joined up working and accountability. The response in the UK over the last few years has been a programme of integrating governance, with a common ap proach to risks and incidents that are persistent, strategic and reputational. These are ad dres sed by the board whilst most other issues are recorded and analysed but managed as close as possible to the patient or service user.
- There is still some confusion between governance and management, and too many toolkits and guides really only address the management issues, the controls rather than the assurance that these controls are in place and working.
- There are a tricky set of issues which arise between organisations, We are seeing a consistent set of failures at the boundaries between teams and between organizations (ref ‘Learning from investigations’, Healthcare Commission 2008). These issues are: continuity of patient care, partnerships and mutual aid in event of pandemics, extremes of climate and terrorism. The debate on the simple rules and etiquette of governance between organisations(GBO) is in its infancy but the road maps to maturity are being developed (see GBO debate paper, IHM 2008)

Governance Recommendations

The 10 key points for integrated good governance are:

1. Clarity of purpose aligned to objectives and intent - the work of the board must be in tune with the strategy of the organization;

2. Strategic annual agenda cycle of business with all agendas integrated encompassing activity, resources and quality –

the board’s work programme is planned, and properly addresses the broad range of governance issues;

3. Integrated assurance system in place –the various assurance mechanisms, such as the board assurance framework, the risk register and adherence to external compliances are seen as a single, coherent framework;

4. Decision taking supported by intelligent information –board deliberations are based on robust and timely analysis and trends;

5. Streamlined committee structure; clear terms of reference and delegation; time limited – a cull of committees to focus NHS organizations along commercial lines with three principle committees (audit, remuneration and appointments) supported as and when needed by task and finish groups;

6. Audit committee strengthened to cover all governance issues –audit committees in the NHS are now required to move beyond finance and incorporate clinical and developmental issues into their work programmes. They are to scrutinise the governance systems: process rather than content;

7. Appoint board supports, e.g. company secretary AND senior independent director (SID) to support board, committees–the means by which an NHS board can be put on the same footing as commercial boards;

8. Selection, development and review of board members – proper appointment, induction and review for all board members with the Chair reviewing the contribution of executives as well as non execs to add value to the Board 9. Board etiquette agreed –the board agrees on the manner in which it will work, so that all mem bers of the board can constructively participate in the work of the board, and 10. Development of individual executive directors and nonexecutives by the Trust/Board to ensure board corporacy – with the aim of achieving a unitary board with equal and empowered contribution form both executives and non-executives.

Best practice suggests that ongoing personal development plans are in place for all directors.

Conclusion

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Governance in the UK is topical and evolving. The trick will be to demonstrate that whatever systems and behaviours we adopt will add value and confidence and begin to answer that tricky challenge of anticipating and reacting to what I do not yet know. As Lord Darzi makes clear in ‘High Quality Care for All’ (DH 2008) ‘What matters is that there should always be clarity and transparency about who takes what decisions on our behalf’. That is the assurance that the new NHS Constitution will seek to provide.

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