



---

---

Time for a reformation  
of NHS management

---

---

Dr Christoph Lees

---

24<sup>th</sup> June 2013

---

## Dr Christoph Lees



Christoph is a NHS Consultant in Obstetrics and Fetal-Maternal Medicine. He has a longstanding interest in health policy and funding reform, having sat on the Civitas Health Policy Consensus Group (2002). He was one of the founding members of Doctors for Reform (2003), where notable campaigns included 1000 doctors writing to the then Prime Minister to rethink the UK's purely tax-based health funding and raising funds to support judicial review of the position of some Strategic Health Authorities on cancer co-payments. He has been involved in the funding debate with politicians from all parties in the UK and overseas. He is now a founding member of the new Doctors Policy Research Group, a medically-led health policy research unit attached to the independent Westminster think tank Civitas.

He is also a clinical researcher having published over 100 papers in Fetal-Maternal medicine and has a visiting Chair at The University of Leuven, Belgium. Christoph supervises higher degrees and directs a subspecialty training programme, having been the Royal College and Obstetricians first Ultrasound Training Officer (2009-2012).

---

The CQC, Mid Staffs, Morecombe Bay and other debacles will no doubt lead to a regime characterized by greater regulation and more frequent inspections, all tightly controlled and politically accountable on the basis that 'more regulation is better'. The Francis report promised no less.

We offer an alternative view. With the departure of David Nicholson as Chief Executive of the NHS in 2014, a unique opportunity will present itself. The last 15 years since the election of Tony Blair in 1997, continued under the stewardship of the current government, have seen incremental but very important changes which may to some extent explain how the NHS has found itself in its current conundrum.

Pre-1997, hospitals were inspected frequently and by and large, clinicians were responsible for their services. This included both doctors and nurses. Hospitals were regularly assessed by independent Royal College visits - and recommendations made. Where services were deemed to be below standard - particularly in relation to patient care and the training and supervision of junior doctors - swift action followed. These visits were stopped in 2004, following apparent irritation by the Department of Health that a decision to immediately suspend a service based on clinical concerns had in one celebrated case been made without reference to them. The cessation of these visits meant that doctors no longer had an independent role in quality assuring hospital services and training.

Over the same period, general management in the NHS, started under Roy Griffiths in the mid-1980s, became *de rigueur*. General management was not unequivocally bad, as service re-organization sometimes meant hard decisions being taken in the context of special pleading from

groups of clinicians. And where targets and waiting time directives are concerned - whether one regards these as good or bad - some form of central co-ordination was required across a hospital or group of hospitals. But the undoubted result of the method of its implementation was a weakening of the relationship between doctors and nurses and not only their patient, but also with the quality of care. This was a problem for patients because doctors are professionally accountable to their regulatory body and explicitly must not enact changes that could be seen to be detrimental to their patients' care, or else face potential de-registration and not working as a doctor again. No such stricture exists in the case of managers.

From 2002 onwards following Tony Blair's famous pledge to increase spending to European levels, the numbers of managers burgeoned. Their salaries and power increased disproportionately to other NHS workers. NHS management, previously something of a professional backwater, became a lucrative and enviable career with excellent pensions, benefits, cars and so on. And with Strategic Health Authorities, Primary Care Trusts and multiple quangos - all with Boards of Directors, PAs, communications offices and smart headquarters - a corps that previously was a few hundred strong suddenly numbered in the tens of thousands.

Greater political oversight was to be expected as so much of the country's wealth was now funding an unprecedented growth in the service. This meant that the pressure to be 'on message' was great: the NHS parlance for this was and is the word 'corporate'. To be corporate is good, not to be corporate is bad. Targets were political and organisational, not clinical. It is easy to see how decision making might be affected - and how a patient's interests might not be paramount. Managers dismissed or leaving one organization in a hurry would usually quickly find employment and often promotion in another. This was known jokingly as the 'souffle effect': the lighter you are, the higher you rise. Qualifications and degrees - required for progression in the clinical professions - were almost irrelevant in management. The pressure to be corporate, the benefits enjoyed and the power associated with these posts - especially at director level - led to a strong tendency to conform, not to rock the boat, and to profess loyalty to political utterances. Examples of this are too many to note but include the cancer drug co-payment guidance, which following public and professional pressure underwent an 180<sup>o</sup> change in the space of six months, and multiple mergers and closures. There were - and are - of course many good managers whose focus is patient care and excellence of services, but there were many who weren't.

So, what is now to be done - public inquiries promising more multi-point plans with recommendations? We doubt it. The answers may be relatively simple, and inexpensive. They may involve re-energizing professionals - who are, after all, accountable for what they do.

Our four point plan is:

1. The CQC tries to do too much. In its current form it is broken, so don't try to mend it and put it together as it was. Re-introduce inspections led by the relevant Royal Colleges with independent professionals whose day-job is providing service - these should also include representatives from patient groups and professional organisations. The CQC might remain as a purely regulatory but not inspecting organisation, collating reports and making recommendations to the Inspector General of the NHS.

2. Make clinicians - not managers - ultimately responsible for the services they provide. This will also empower them explicitly to whistle-blow if they believe that services are performing inadequately.
3. Introduce a requirement that in all clinical and non-clinical NHS management posts, applicants must undergo a 360<sup>0</sup> assessment from those they have worked with where specific questions on candour, honesty, trust and integrity are asked. Most people in an organisation know who they would trust to be honest and 'do the right thing'.
4. Stop appointing from within. Open up senior NHS appointments to all appropriately qualified - not just those that are existing managers in the NHS. That means that 'shop floor' doctors, nurses, physiotherapists, pharmacists and non-NHS professionals might have a chance - and bring a new perspective to the service.