



Berkshire

davidoliver372@googlemail.com Follow

David on Twitter: @mancunianmedic

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ACUTE PERSPECTIVE

David Oliver: Covid-19 has shown the value of local and clinical NHS leadership

David Oliver *consultant in geriatrics and acute general medicine*

What does our initial response to the pandemic teach us about the balance, and future rebalancing, of central versus local healthcare leadership? Local clinicians and operational management have led most of the measures that have worked. Specialist medical societies, academic researchers, and journalists in mainstream and healthcare media have also had starring roles.

The government, and national arm's length organisations overseeing healthcare and public health, have lost any contest of competence or reputation. Indeed, many locally and clinically led successes have happened despite central failings. Those failings—from 10 Downing Street, the Cabinet, the Department of Health and Social Care, the now disbanded Public Health England, NHS England, and government communications teams—have been well documented. They include deficiencies in pandemic preparedness, a slow response by central agencies, failings on personal protective equipment (PPE) for frontline staff, inadequate testing capacity for patients and staff, and a chaotic approach to track and trace.¹⁻⁵

In my view, the pandemic has shown the value of skilled professional journalism in exposing much of this at a time of rather obsessional news management, with frontline staff and even communications directors silenced. Likewise, health policy think tanks such as the Nuffield Trust, the Health Foundation, and the King's Fund have done a sterling job with policy analysis and commentary. Professional organisations such as the British Thoracic Society, the British Geriatrics Society, and the Faculty of Intensive Care Medicine have put out numerous good practice resources and media responses. Academic groups and journals have published evidence reviews to guide clinical practice.

Most of all, the successes over the past six months have been local. The rapid reorganisation of primary care, with remote consulting and “hot hubs” for covid patients, was locally led. So was the doubling and tripling of intensive care capacity, the splitting of acute care streams and wards into “hot” and “cold” areas, the creation of additional outpatient care and step-down intermediate care capacity to ensure that more people were managed at home, and the reorganisation of roles and rotas to cope with the surge and the professionalism of frontline staff.

I don't want to overlook real concerns about excess mortality from non-covid-19 causes in people who didn't access acute or elective care during the pandemic—either through fear or because services had stopped—or the concerns about patient transfers

to care homes and subsequent outbreaks.^{6,7} Some of these decisions were also locally led. However, we already know from much of the literature on improvement and quality in healthcare that the key drivers are local organisational culture and clinical leadership, with effective local team working.^{8,9}

Of course, in a tax funded national system, central agencies have a legitimate and necessary role. However, for some time now I think that the NHS in England has been bedevilled by a top-down, sometimes bullying, culture of control over finances and performance against national targets, which threatens and constrains many local organisational leaders.

After the pandemic, we need to liberate local clinical leaders and managers and empower them to get on with solutions for their own organisations and local populations. I fear that what we'll see instead is ever greater central control, as the fallout from the pandemic becomes apparent and politicians get more anxious about NHS performance and reputation.

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