WRITTEN EVIDENCE SUBMITTED BY THE NATIONAL LEAD GOVERNORS ASSOCIATION (NLGA)

To the House of Commons Public Bill Committee on the Health Bill [Bill 009 2026-27]

Date of Submission: 3 June 2026

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1 Executive Summary.

1.1 The National Lead Governors Association (NLGA) strongly objects to the provisions within the Health Bill that seek to abolish the statutory requirement for Councils of Governors (CoGs) in NHS foundation trusts, dismantle local membership constituencies, and centralise non-executive appointments under the Secretary of State.

1.2 Removing the local democratic tier replaces transparent, community-led local accountability with an over-centralised, state-directed command structure, flatly contradicting the stated objective to empower the frontline workforce.

1.3 Combined with the proposed abolition of Healthwatch, these structural changes create a critical public accountability deficit across the NHS, stripping patients and communities of independent, statutory mechanisms to challenge failing trust boards.

1.4 Core Recommendation: The Committee must subject the centralising provisions of this Bill to rigorous scrutiny. Removing the statutory framework for Councils of Governors and independent patient representation would significantly weaken local autonomy, undermine transparent governance, and erode the mechanisms through which communities hold providers to account. Failure to amend the legislation accordingly risks collapsing public trust, inflating administrative costs, and creating an accountability vacuum that could directly compromise patient safety

2 About the NLGA

2.1 The NLGA represents the collective voice of Lead Governors and Councils of Governors across NHS Foundation Trusts in England.

2.2 Our members represent over one million NHS public, patient, and staff members, spanning an average of 10,000 to 15,000 active members per individual trust constituency. We provide independent, unpaid, and rigorous non-executive oversight to ensure that trusts remain responsive to the communities they serve

3 The Loss of a Professional, Specialist, and Democratic Asset Base

3.1 **3.1** The Government's claim that removing Councils of Governors will "reduce excessive oversight" represents a fundamental misunderstanding of the professional calibre of modern Councils of Governors.

3.2 Far from being an administrative layer, modern Councils of Governors comprise highly accomplished public and patient professionals—including retired clinicians, senior legal experts, financial directors, and community leaders. **Crucially, this body also includes democratically elected staff governors, including frontline doctors, nurses, and allied health professionals.** This composition ensures clinical frontline insight is hardwired directly into trust governance.

3.3 Governors are democratically elected by thousands of local trust members specifically to represent the patient, public, and staff interest, creating an unparalleled system of checks and balances.

3.4 **The Primacy of Statutory Protection:** The role of the Council of Governors is established in primary statute as a deliberate legislative safeguard to protect the public from executive overreach. Reducing public accountability to a discretionary, non-statutory option—or removing it entirely—leaves the NHS exposed. Statutory protection must remain enshrined in law.

3.5 Stripping away the Council of Governors discards this massive intellectual asset base. The proposed alternative—relying solely on a trust presenting its annual accounts at a single public meeting—is a passive exercise that fails to replace proactive, continuous governance

4 The Statutory Role and Quantifiable Contribution of Governors

4.1 Governors do not interfere in daily operational management; rather, they fulfil distinct statutory duties under primary legislation that protect public money and patients.

4.2 Holding Non-Executive Directors (NEDs) to Account:

4.3 Pursuant to **Section 151 of the Health and Social Care Act 2012**, governors hold a statutory duty to scrutinise the performance of the Board of Directors via rigorous quarterly accountability sessions.

4.4 Representing the Member and Public Voice: Governors act as a bidirectional conduit, holding regular community constituency surgeries, patient focus groups, and staff forums to feed qualitative data directly back to the Board.

4.5 Statutory Appointments and Remuneration: Under Schedule 7 of the National Health Service Act 2006, governors are responsible for appointing high-calibre Trust Chairs and NEDs, ensuring that recruitment panels remain independent of executive influence.

4.6 Approving Significant Transactions: Under **Section 84 of the Care Act 2014**, governors hold the statutory power to approve or veto "significant transactions," mergers, or increases in private patient income, protecting trusts from high-risk commercial joint ventures without public consent.

4.7 Net Economic **Value to the Taxpayer:** Critics of local governance cite the minor administrative overheads required to maintain a Council of Governors, including independent statutory election services, local travel expenses, and meeting venue hires. Across an average trust, these combined administrative costs total approximately **£25,000 to £35,000 per annum**. However, based on a conservative estimate of 200 hours of voluntary service per governor annually, a Council provides over **300,000 hours of senior executive-level scrutiny nationwide, valued at over £15 million completely free of charge**. Even when subtracting all local recruitment, election, and travel expenses, Councils of Governors deliver a massive **85% net-positive financial return on investment** to the NHS, entirely outperforming any paid state bureaucracy.

5 The Danger of Over-Centralisation and Executive Capture

5.1 Under the current legislative framework, Governors hold the critical statutory power to appoint, suspend, and determine the remuneration of the Trust Chair and NEDs, ensuring that non-executives remain accountable to the public rather than to the executive directors they scrutinise.

5.2 The Health Bill proposes to transfer these appointment and dismissal powers entirely to the Secretary of State, creating a severe risk of political patronage, executive capture, and the erosion of board independence.

5.3 Without a locally elected Council of Governors to anchor a trust to its geographic population, powerful trust Chief Executives will operate in a local vacuum, leaving residents powerless to challenge closures, service reconfigurations, or poor clinical performance.

6 The Compounding Impact of Abolishing Healthwatch and the Whitehall Alternative

6.1 The threat to public accountability is severely compounded by the Bill's provisions to abolish Healthwatch England and the 150 local Healthwatch branches.

6.2 The Government proposes to transfer these functions to Integrated Care Boards (ICBs) for health services, and to local authorities for social care. This introduces an irreconcilable conflict of interest, as ICBs cannot independently gather patient feedback on the very system they plan and fund.

6.3 The proposed mitigation—creating a centralized civil service post of **Director of Patient Experience** based in Whitehall—is structurally flawed and operationally untenable, moving the patient voice out of local communities and into a London government department.

6.4 A Whitehall-based director cannot possibly monitor or advocate for the diverse and highly localised needs of patients across diverse regions, from rural coastal communities to major industrial conurbations.

6.5 Furthermore, creating a highly paid, centralized civil service apparatus at a time when the Department of Health and Social Care claims to be cutting administrative overheads is deeply contradictory. A single Senior Civil Service (SCS) Director post in Whitehall commands a base salary between £75,000 and £120,000. When multiplied by the support infrastructure required to monitor hundreds of trusts—alongside pensions and London-weighted overheads—the cost to the taxpayer is immense. Replacing an unpaid network of dedicated local volunteers with a costly, insulated Whitehall executive represents an unjustifiable burden on public funds.

6.6 By simultaneously eliminating the internal public anchor (Councils of Governors), the external patient watchdog (Healthwatch), and introducing a compromised, distant civil service role, the Bill systematically dismantles the entire patient-voice architecture established over the past two decades.

7 Structural and Financial Impact Analysis

7.1 To assist the Committee in evaluating the efficiency claims made in the Government's fact sheets, the NLGA provides the following direct comparison of the competing governance models:

Evaluation Metric	Current Statutory Framework (Councils of Governors)	Proposed Whitehall Model (Director of Patient Experience)
Annual Financial Cost	**Minimal Operational Overhead** (£25k–£35k per trust for local travel claims, independent election management, and meeting spaces).	**High Centralised Cost** (Multi-million pound Whitehall budget covering Senior Civil Service base salaries of £75k–£120k per director, plus pensions and London-weighted support staff).
Net Return on Investment	**Overwhelmingly Positive:** Generates **£15 million** in free, expert oversight, eclipsing minor local costs.	**Wholly Negative:** Consumes heavy frontline NHS funding to establish an insulated, non-productive bureaucratic layer.
Total Oversight Capacity	**Over 300,000 hours** of localized, trust-specific statutory scrutiny per year.	**Severely limited** hours divided across hundreds of distant NHS trusts.
Primary Legislation Mandate	Established under **Primary Statute** (NHS Act 2006 / Health & Social Care Act 2012).	**Discretionary civil service post** vulnerable to shifting political patronage.
Workforce Integration	**Directly hardwired** via democratically elected frontline staff governors.	**Completely silenced** and replaced by distant bureaucratic reporting lines.

8. Lessons from Patient Safety Failures.

8.1 History demonstrates that major systemic failures in the NHS—such as those exposed by the Francis Inquiry into Mid Staffordshire—occur precisely when executive boards become insulated from local public feedback and independent challenge.

8.2 Active, well-supported Councils of Governors act as an early-warning system. Removing them and relying on a distant Whitehall department silences the frontline insights of patients, carers, and staff at the exact moment the NHS is attempting a massive structural transformation.

9. Proposed Amendments to the Bill

9.1 The NLGA urges the Public Bill Committee to adopt the following amendments to prevent a total collapse in local public trust:

Amendment 1: Total Retention of Local Democratic Statutory Framework

9.2 The Committee must delete Clause 12 and Clause 13 in their entirety. The statutory requirement under Schedule 7 of the National Health Service Act 2006 for NHS foundation trusts to maintain an elected Council of Governors and a distinct public/staff membership constituency must be preserved as a non-negotiable safeguard of local democracy.

Amendment 2: Rejection of Ministerial Patronage and Executive Capture

9.3 The Committee must strike out Clause 14 transferring provider non-executive appointment and dismissal powers to the Secretary of State. The power to appoint and remove Trust Chairs and Non-Executive Directors must remain exclusively with locally elected Councils of Governors.

Amendment 3: Absolute Protection of Independent Patient Advocacy

9.4 The Committee must veto the dissolution of Healthwatch under Clause 15. The proposal to transfer patient voice functions to Integrated Care Boards (ICBs) or an insulated, costly Whitehall directorate is entirely untenable. Local Healthwatch functions must remain legally independent, completely isolated from commissioning budgets, and free from civil service protocols.

10.. Evidence on the Effectiveness of the Role of the Council of Governors

10.1 Research was referenced in the impact assessment on Reform to the foundation trust model - (IA number: DHSCIA9715). The research cited involves four case studies from 2019, two papers from 2012, and a study from 2016. Although the impact statement referenced some findings of research in relation to the value of Governors, it highlighted criticism about their effectiveness and ability to represent diverse communities. We find it incomprehensible that such outdated and narrowly scoped research should be put forward evidence to justify these significant proposals to remove the requirement for Councils of Governors and FT membership.

10.2 The NLGA conducted a recent survey of Lead Governor members during April and May 2026. The results of the responses (a summary report of these can be supplied as further evidence) indicate how FT Cog's have been successful in:

- improving the diversity of their Councils and attracting Governors with a wide range of backgrounds
- the appointment of young Governors
- innovating different types of engagement
- supporting Governors in enhancing their skills
- successfully appointing high quality Chairs and NEDs
- developing effective systems to evidence how of Governors being assured that NEDs are effectively challenging the Board
- influencing decisions on patients, buildings and process issues, enabling expeditious transactions
- working closely with Healthwatch at a local level

10.3 The NLGA supports the principle of applying this good practice across all Foundation Trusts as part of a continuous improvement system and to make local democracy in local health provision of consistent high quality.

Closing Statement. The evidence in this submission demonstrates that the current statutory framework for local accountability is functioning effectively and delivering clear value for patients, communities, and NHS organisations. Parliament now has the opportunity to enhance and strengthen the mechanisms that already work, ensuring that transparent governance, local autonomy, and public accountability remain central to NHS decision-making. Centralising these functions would remove essential safeguards and distance decision-making from the communities most affected by it.

Removing a functioning statutory safeguard without a demonstrably superior alternative would represent a step backwards in public accountability, not an improvement.

Respectfully submitted on behalf of the National Lead Governors Association (NLGA),DAUGHNE TAYLOR. National Lead, NLGA / Chair of the Executive Board
National Lead Governors Association