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A reorganisation you can see from space: The architecture of power in the new NHS

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Introduction

1. The April 2013 NHS reorganisation was big, even by the standards of the English NHS. NHS England Chief Executive David Nicholson famously said that the Cameron government reforms demanded "such a big change management, you could probably see it from space."[1]

2. As with previous NHS reorganisations big and small, the ideas were familiar: the idea that commissioning by GPs would improve care and efficiency; the idea that the central government, in the shape of the Department of Health, was too big and dictatorial; the idea that intermediate territorial levels of management such as Strategic Health Authorities were bureaucratic and superfluous; the idea that provider competition produces improved quality and efficiency; the idea that management expertise rather than politics improves health services; and the idea that it would be possible to invent, for all time, a structure for the NHS that would be immune to politics. These were all present in the 1988 reforms of the Thatcher government that implemented the internal market in the NHS, if not her 1983 introduction of general management into a system previously run by professionals. These ideas have shaped both government departments and the careers of everybody involved in managing the NHS for over thirty years.

3. One of the less visible components of the 2012 reorganization was the comprehensive reorganisation of the central policymaking apparatus in the NHS. The basic change was to spin off key parts of the old DH into new agencies, notably Public Health England (PHE) – an executive agency –and NHS England (NHSE), an executive non-departmental public body, one of the more tightly controlled kinds of quango in UK government.[2] Along with the more independent regulators, the Care Quality Commission (responsible for quality) and Monitor (responsible for overall market regulation, including setting the national tariff with NHS England), these four organizations now share the governance of the new NHS in England.

4. Following on from our previous articles on this subject, as well as earlier work by Patricia Day and Rudolf Klein, we examine, in this report, the organization of the DH and the centre of the NHS world.[3] It might seem bureaucratic and distant from the real business of health care, but the Department of Health is the only true tool of ministers, and the nodal point where the political system interacts with health. In addition, we look at the people who have been chosen to occupy this world. Organisation charts reflect the burden of work and preoccupations in organisations as well as personal power and politics and personnel decisions are, as any politician or manager knows, crucial to the success or failure of an initiative. One of the most important decisions that can be made is who shall have responsibility for an area or initiative.

5. What we find is an unstable world, where the tensions between policy, politics and management of the NHS in England are likely to mean further reorganisation in the future, but with a "thin" central Department of Health less able to steer the system than before. The separation of policy and management that the new DH and NHS England attempt is one that

has never been achieved before, despite concerted efforts from secretaries of state dating back to Kenneth Clarke.

6. In addition to the limited role and capacities of the DH, which history has shown to be unstable, the empowerment of quangos and regulators such as Monitor, NHSE, and the Care Quality Commission creates potential for incoherence, duplication, and turf wars at the centre.

7. Also, what is presented by Ministers as the de-centralisation of power away from the Department in effect amounts to a form of centralisation, partly through the powers of patronage and appointment which the Secretary of State has over key positions in a variety of organizations including Monitor and NHS England. In fact, we find that in most cases, the responsibility for the areas now covered by NHS England and Public Health England has gone to the people who worked in the same areas for the DH, so there is more continuity in these areas than change.

8. Monitor is the most notable case of this centralization unto an incoherent centre. Under the 2012 reforms, it is granted a market regulator role within the new NHS – enforcing competition law, setting prices for care and in effect determining the entry criteria to the new NHS market by issuing licenses to NHS and non-NHS providers. It is closer in function to the type of market regulator which might be found in the utility sector or a competition authority, and as such if it is to have the confidence of market entrants requires a level of formal autonomy from ministers which is distinctly new to the NHS. And, in undertaking this new role, it draws its top team from management consultancies and the private sector. This different set of cultures is also likely to create further tensions within the 4 central organizations about which values to give priority to when organising the delivery of NHS care. But perhaps playing the role of an outsider within the system is perhaps what current and also previous new-Labour ministers intended.

9. This report looks in the first instance at previous attempts to separate off policy and management within the NHS and situates the creation of NHS England and the new structure within this challenging history. It goes on to look at the size and make-up of the various organisations in the new NHS, including the backgrounds of the key personnel. It concludes with some observations about where next for the governance of the NHS given the tensions and instabilities identified. History suggests that the structure is unstable, and that governments will not be able to avoid blame or resist taking credit for actions taken by more distant organizations.

Separating policy and management within the NHS and back again – a recurring theme from Thatcher to Lansley

10. The creation of NHS England and Public Health England should not be seen as a radical departure from what went before but as yet another attempt to distance the management of the NHS from the Department of Health and political interference from Ministers, a policy which itself has a 30 year history.

11. Under the new system NHS England is responsible for planning and overseeing commissioning, including the proportion of commissioning that was designated as specialist in order to preserve its coherence after the reforms (e.g. cancer care and cardiac care).[4] Planning care networks on a large scale, coping with organizations that fall into difficulty, commissioning England-wide projects, and taking blame when things go wrong (as with the implementation of the 111 telephone advice service) - these are all tasks that the DH used to take on. In theory, NHS England will do much of what the Department of Health did, and in theory will be less affected by party political or public pressures.

12. Public Health England's role is much reconfigured because public health is much reconfigured, but it will carry out the England-wide public health activity that was also once the remit of the DH and the old Health Protection Agency.

13. In 1983, the Thatcher government commissioned a businessman, Sir Roy Griffiths, to review the organization of the NHS. The NHS had been run since 1974 on a system called "consensus management", which meant senior clinicians essentially ran its day-to-day operations - prima facie evidence of inefficiency and what we would now call "provider capture" in the eyes of Thatcher and her delegate. Griffiths responded with a thirty-page letter recommending the creation of a management corps that would replace professional self-management with businesslike, strategic, managerial competence.[5] The government implemented his recommendations, creating an NHS Management Board to focus on management, rather than policy, issues. More dramatically, it infused general management into every level of the NHS, and created a Management Executive to centralize managerial functions and skills.

14. Kenneth Clarke, when Health Secretary, moved the Management Executive to Leeds, helping to make the point that arms-length managerial expertise was different from, and fulfilled a different role than, policymaking. DH organizational charts from those years portrayed a rather thin organization, with communications, social care, finance, and the Chief Medical Officer keeping the Permanent Secretary company in London while everybody else to do with the NHS sat on the Management Executive side.[6]

15. The problem was that elected politicians, and voters, were very interested in the management and policies of the NHS, and neither the distance between London and Leeds nor the paper shield of a Management Board prevented political involvement in NHS decision making. Simple indicators such as the number of meetings between the Chief Executive of the NHS and the Secretary of State showed the problem; politicians who were largely accountable

for the NHS wanted to talk to the person whom they had appointed to run it.[7] Anecdotally, it was clear that people with ambition and power worked out ways to be based, or at least to squat, in London offices. The result was silly: an underemployed Permanent Secretary based in the Department was caught between ministers and the Chief Executive, with power in London and people in Leeds (or on the train in-between).

16. The formal end of the Management Executive came about during Alan Milburn's term as Secretary of State. In 2000, Milburn combined the Chief Executive and Permanent Secretary roles into one (occupied by Nigel Crisp) and his 'Shifting the Balance of Power' reforms formally merged the Management Executive back into the Department of Health. Milburn's perfectly sensible argument was that he did not see the Permanent Secretary as having a job to do; everything that interested him about the NHS reform agenda involved the Chief Executive and the Management Executive. So the experiment in arms-length management formally ended, having ended informally some time before.[8]

17. After the departure of Crisp in 2006, the division between the Chief Executive and Permanent Secretary was reinstated by Secretary of State Patricia Hewitt. The old problem immediately appeared: the DH had a set of interesting and important activities (research and development, social care, public health and legislation are all consequential) but most of what interested politicians lay in the purview of the Chief Executive. Andrew Lansley, by recreating the old Management Executive, solved that problem by leaving the DH as a smaller department and the NHS in the hands of a very large NHS management body (NHS England).

18. As **Table 1** shows the total headcount numbers in each of the new agencies which fall under the Department of Health reveal it to be a "very thin rim" around the NHS - a phrase used by a former Labour Secretary of State - with just 7% of the total staffing for ensuring health and social care delivery falling directly under its control.[9] Table 2 also shows that Public Health England and NHS England have between them over 4 times more Grade 6 and 7 level civil servants than the Department of Health, and 6 times more members of the Senior Civil Service at their disposal. In addition, as the Department of Health has experienced a 14% headcount reduction since 2010 it is difficult not to draw the conclusion that its capacity to direct the system has been "hollowed out".[10]

Table 1: Department of Health and its agencies – Full Time equivalents September 2013

Organisation name	Organisation type	Headcount	Full Time Equivalents
Department of Health	Ministerial Department	2,503	2,422
Care Quality Commission	Executive Non-Departmental Public Body	2,421	2,353
Health & Social Care Information Centre	Special Health Authority	2,263	2,153
Health Education England	Executive Non-Departmental Public Body	2,155	1,568
Health Research Authority	Special Health Authority	137	121
Human Fertilisation & Embryology Authority	Executive Non-Departmental Public Body	68	63
Human Tissue Authority	Executive Non-Departmental Public Body	46	45
Medicines & Healthcare Products Regulatory Agency	Executive Agency	1,270	1,211
Monitor	Executive Non-Departmental Public Body	354	340
National Institute for Health and Care Excellence	Special Health Authority	603	553
NHS Blood & Transplant	Special Health Authority	5,888	5,158
NHS Business Services Authority	Special Health Authority	2,758	2,516
NHS England	Executive Non-Departmental Public Body	5,942	5,423
NHS Litigation Authority	Special Health Authority	216	205
NHS Trust Development Authority	Special Health Authority	190	186
Public Health England	Executive Agency	5,510	5,092

(Source: DH workforce information: September 2013 1 November 2013)
https://www.gov.uk/government/publications/dh-workforce-information-september-2013

Table 2: Distribution of Civil Service Grades within the 4 organisational components of the new NHS – September 2013

Organisation	Civil Service Grade (Payroll, Full Time Equivalent)				
	Lower				Higher
	Administrative Officer /Administrative Assistant	Exec. Officer	Senior Executive Officer/Higher Executive Officer	Grade 6/7	Senior Civil Service
Department of Health	106.15	287.74	674.1	622.01	163.65
CQC	281.61	179.36	1381.27	248.29	72.21
Monitor	17	35.38	50.7	156.91	44
NHS England	1516.11	607.34	1075.18	1549.21	639.74
Public Health Eng-land	837.95	619.09	1650.64	1069.99	447.53

(Source: DH workforce information: September 2013 1 November 2013)
https://www.gov.uk/government/publications/dh-workforce-information-september-2013

19. The broad conclusion to be drawn from all of this is probably the one that Christopher Ham, Patricia Day and Rudolf Klein all drew long ago: separating policy and management is impossible in health services.[11] Policy objectives, such as greater private sector provision or improved cancer care, manifest themselves in concrete decisions about how to organize services. If politicians are to claim credit for the NHS, or at least escape blame, they will want to make policy. The response under Blair and Cameron has been to experiment with rigid legal structures, taking away the Secretary of State's direct levers with regard to, for example, Foundation Trusts, and instead entrust them to regulators. But that merely re-states the question: can regulators, or the giant new NHS England, avoid political attention from the people who appointed them and could abolish the organization by the end of the Parliament?

20. Indeed, as **Box 1** shows the first real winter crisis of the new system is starting to reveal how difficult is for Ministers to stay out of the day to day running of the system.

Box 1: The new system and the winter crisis – can Ministers really step out of the operational detail?

Concerns about the capacity of NHS providers to deal with a harsh winter in 2013/2014 is now seen as the main political challenge for the health service in England, with the Prime Minister and Number 10 'taking control' of the situation.

This is also being perceived as the first real test of the new accountability arrangements - thus far, the politicians seem unwilling to let the service get on and deal with the issues themselves as had been intended. The Chief Executives of the regulators (CQC, Monitor and the NHS Trust Development Authority) have been summoned to Downing Street, whilst the pressure on NHS England is also being ramped up.

According to the Health Service Journal one local area director within NHS England 'complained that the regularity and detail of returns required on winter plans and A&E performance by the organisation's headquarters was more intense than ever before'.

He said 'it was a result of the government demanding regular and detailed reports from NHS England nationally, even though 'it's an approach that's completely at odds with the spirit of the [government's] reforms', which were intended to separate day to day management of the service from politicians.'

As a further sign of political micro-management, the Health Secretary was recently reported to have personally phoned the Chief Executives of the 5 hospital trusts which had failed to meet the Accident and Emergency waiting times, seeking an explanation.

Thus the success or failure of the NHS to cope with the first winter of the new reforms could well determine the stability of the separation between DH and NHS England in the future.

(Sources: Ben Clover, 'Regulator chiefs summoned to Number 10 over winter pressures', Health Service Journal 30 October 2013; Ben Clover, Sophie Barnes 'Hunt demands explanations from A&E underperformers' HSJ 22 November 2013)

Liberating the NHS? Do the reforms truly mean de-centralisation of power within the new structures

"Of course the content of a White Paper is the opposite of the title"- DH civil servant, October 2011.

21. With the April 1 2013 implementation of the ideas in the 2010 White Paper Equity and Excellence: Liberating the NHS the Cameron government substantially advanced another long-standing trend in the English NHS.[12] In every reform since 1979, power has shifted from appointed territorial boards, such as regions, to regulators and agencies controlled from the centre. [13] It can look like decentralization: setting the "front line" free to deliver services and efficiency. But increasing the power of appointed regulators in London at the expense of the power of appointed boards in Yorkshire or the West Midlands often also means centralization. It tends to produce greater knowledge, legal power, and financial control at the centre and remove the buffers that regional boards once formed.

22. How are the boards appointed for the four key organizations, of Monitor, the CQC, NHS England and Public Health England? The answer is simple: they are appointed by the Secretary of State. Each board comprises a chair (appointed by the Secretary of State), non-executive directors appointed by the Secretary of State, and executive directors who are on the board *ex officio.* The board appoints the executive directors, including the Chief Executive. Non-executive directors outnumber the executive directors in order to guarantee political control- which is not the case with the largely ornamental boards of Whitehall departments, where the lines of authority run from ministers to civil servants rather than from the board to the department, and the non-executive directors are basically there to bring in outside perspectives.

Who sits in these new structures and what does this tell us about the new NHS structure?

23. The formal organization of the centre of the new NHS is, then, a classic structure that has never proved stable: a 'thin' Whitehall department as a rim around a very large NHS. But organization charts are never the entire story, even if they usually testify to the preoccupations and powers within a bureaucracy. People, especially people at the top, also matter. Governments make personnel decisions- and communicate preferences to their top officials- because they know that individuals, correctly chosen, have a big impact on the enthusiasm and efficacy of implementation.[14]

24. We compiled a database for 2012 and 2013 of the top (director-level and above) DH officials with information about their education, gender, and career history (most of which can be found in editions of Dod's). The data is posted online.[15]

The People running the Department of Health before April 1 2013

25. The Department of Health in 2012 was quite unlike any other civil service department. If the Whitehall of Sir Humphrey – the archetypal civil servant from the BBC series *Yes Minister* - was run by Oxbridge males who had been in the civil service for life, then the DH wasn't part of that Whitehall. The Treasury had 89% Oxbridge graduates; the DH had 8%. HMRC was ten percent female at the top; the DH was 40% female. Not even the Northern Ireland Civil Service, a formally separate body, stood out as much as the DH. This was no new development either; the DH was furthest of any department from the "Whitehall model", or caricature, of a male, Oxbridge, lifetime civil service unit in 2007 and before.[16] Only three people had experience in other Whitehall departments. By 2012 they all had roughly the same career trajectory: enter the DH from, usually, the NHS after a non-Oxbridge education, and then spend a long time in the department.

26. If the top echelons of the DH did not look much like the old mandarinate of *Yes Minister*, it is probably because so much of its hiring had come from outside the civil service- above all, from the NHS. Six of the top fifteen figures in the DH had more than seven years' experience in the medical professions, and four had more than seven years' experience in NHS management.

27. But compared to the turbulent department of 2005-2007, it is striking: the top staff of the DH were the survivors.[17] In 2006 the department came under some pressure in the media for having too much turnover and too many openings at the top; in 2006 the mean time in post was 4.05 years. In 2012, the turnover appeared to have slowed. The mean time in post was 4.43, the median time in post 2 years. The Whitehall median reported in 2006 was 4.1 (mean 2.9).[18],[19] More interesting, though, is that they had a mean of 13.2 years in the DH, and a median time in the department of ten. Given the fluidity of some posts (e.g. Richard Douglas, long standing Finance director, added portfolios over time), the time in department is strikingly high. What this tells us is that the DH was not part of an integrated "Whitehall". The "department of delivery" that Alan Milburn sought was created by hiring people from the NHS into a leadership cadre that, after the disruptions of around 2005, proved stable.

Table 3: Top Team by Time in Post

Year	Headcount	Years	Mean
2005	23	104	4.52
2006	23	98	4.26
2007	22	89	4.05
2008	17	75	4.41
2009	17	75	4.41
Total	41	137	

(source: Jarman and Greer, 2010)

The people running the Department of Health after April 1 2013

28. In 2010 we commented that the Department was in the "eye of the storm"- in the temporary calm found inside a hurricane. Behind it lay the disruptions of the Blair governments. Ahead of it lay the disruptions of the Cameron government.[20] The last relatively calm and clear weather ended on with the 2010 publication of the Liberating the NHS. As the reorganization passed into law and implementation, the storm hit the DH itself and left it scattered across a variety of executive agencies and non-departmental public bodies.

29. Who is left at the DH after the Lansley reforms? As noted above the DH is now smaller, having reduced the number of Directorates from 10 to 5 meaning there are now five Directors-General, a Chief Medical Officer (CMO), and a Permanent Secretary. The CMO, Permanent Secretary, and two Directors-General (for Public Health and Strategy and Finance) stayed in post; Richard Douglas' government biography notes that he is the longest-serving finance director in Whitehall.[21] The new Director-General for External Relations is a civil servant who moved from the Department for Work and Pensions, and the new Director-General for Social Care, Local Government and Care Partnerships entered in April 2013. He was previously Chief Executive of Croydon council.

30. The change in the size of the department might seem dramatic but compared to other Whitehall departments it is not; most of them have shrunk, and some for example, the Department for International Development also have half as many director-level positions as they did in 2007.

The people running the arms length bodies - NHS England, and Public Health England

31. The first, almost mathematical, implication of decentralization and a shift to multiple regulators is, of course, more executives. This means that the number of people in major decision-making roles outside of the Department of Health has increased since the 2012 reforms, even if a large number of other ‘quangos’ were eliminated in the reorganization – 170 in total.[22]

32. NHS England is an Executive Non-Departmental Public Body, an agency outside the formal structure of Whitehall, not bound by the Civil Service Code, appointed through the statutory public appointments system with ministers taking final decisions, and with specific constitutions and functions set out in the laws that create them, or left to their boards to determine. The first thing done by Ministers when these agencies were created was to appoint many of the same people to the agencies to do many of the same things they had been doing at the DH (**see Table 4**). Public Health England is an Executive Agency more tightly bound to the secretary of state than NHS England, and therefore easier to direct.

Table 4: Changing jobs in 2013

Job in 2012	Name	Job in summer 2013
DH Permanent Secretary	Una O'Brien	Permanent Secretary, DH
DH Chief Medical Officer	Sally Davies	Chief Medical Officer, DH
DH Director-General, Public Health	Felicity Harvey	Director-General, Public Health, DH
DH Director-General, Finance	Richard Douglas	Director-General, Finance, DH
DH Director, Families, Children and Inequalities	Fiona Goldhill	Director, Families, Children and Inequalities, DH
DH Chief Executive	David Nicholson	Chief Executive, NHSE
DH NHS Medical Director	Bruce Keogh	Medical Director, NHSE
DH Director-General NHS Operations	David Floyd	Deputy Chief Executive, NHSE
DH Chief Dental Officer	Barry Cockcroft	Chief Dental Officer, NHSE
DH Chief Pharmaceutical Officer	Keith Ridge	Chief Pharmaceutical Officer, NHSE
DH Chief Nursing Officer	Christine Beasley	retired; replaced by new Chief Nursing Officer, NHSE
Director of Nursing and Principal Advisor on Public Health to Government	Viv Bennett	Director of Nursing, PHE
DH Director Financial Planning and Allocations, Strategy Finance and NHS Directorate	Richard Murray	Chief Analyst, NHSE
DH Director-General, Social Care, Local Government and Care Partnerships Directorate	David Behan	Chief Executive, Care Quality Commission

(Sources: CQC, PHE, NHSE websites and authors' data set; websites accessed August 2013)

33. All the chief professional officers but the CMO moved to NHSE. In the civil service, each professional track has a chief officer somewhere. They are now in agencies, which is somewhat odd in terms of civil service theory (but of limited practical import); furthermore, the Chief Nursing Officers move into NHSE means that PHE has its own director of Nursing, as does the NHS Trust Development Authority.

34. The Chief Medical Officer is CMO not to the DH but to the government as a whole.[23] This divided loyalty - to the UK as well as to the DH, and to public health as well as to clinical medicine - was part of the reason why there was pressure to create an NHS medical director to deal with clinical medicine and NHS issues (of which there are enough) without the public health interests of the CMO and with more interest in working with and for NHS management. The CMO, therefore, remains in the DH, but with a far less clear role - NHS doctors have their own manager, and Public Health England is a powerful Executive Agency containing most of the old Health Protection Authority, with its own agenda and a close relationship to the Secretary of State. It appears that the CMO might suffer the fate of the Surgeon General in the US, who was shifted to an advisory and public-facing role as administrative responsibilities moved away to managers. It is not clear how this arrangement will work out or whether it is advisable.

35. In addition to these direct moves from the DH on April 1, we see recent DH alumni who had spent time in other areas of the NHS reappear in the quangos. Duncan Selbie was Director General of Programmes and Performance for the NHS and then the first Director General of Commissioning in the DH until leaving to spend five years as a hospital chief executive. He was appointed Chief Executive of Public Health England. Barbara Hakin was also a DH stalwart who worked in a Strategic Health Authority before moving to NHSE. It is unsurprising that Public Health England and NHS England have absorbed many of the people who worked in the DH; they absorbed many of the DH's functions, whereas the CQC and Monitor had been largely staffed before the April 2013 reorganization. Below this level, many people who had worked in the DH and moved to Strategic Health Authorities after about 2005 reappeared in NHS England, particularly in the areas dedicated to trust and commissioning support (which was much of SHAs' positive, as opposed to their fire-fighting, agenda).

The outsiders? Monitor as a challenger to the DH legacy.

36. While much of the DH seems to have moved to NHSE, the new structure has two other key organizations; Monitor and the CQC. These in effect act as regulators in the new market – one, Monitor, setting prices and issuing licenses to operate within the new NHS market, whilst also enforcing competition law – the other, the CQC, charged with guaranteeing a baseline of quality. Whilst the membership of the CQC board and top team has a similar lineage to those within the NHS England - including two new chief inspectors of primary care and hospitals recently moving from senior positions within NHS England – Monitor itself is an altogether different beast.[24] Although a comparatively small organisation, its remit and powers have been substantially extended under the 2012 reforms, and it is starting to challenge the DH and NHS England in terms of driving the policy agenda. As **Table 2** shows it is also more "top

heavy" than the other three organizations discussed here. Over two thirds of its staff are at Civil Service Grade 6 and over. This 'top heaviness' might reflect a need for the specialist technical skills required for Monitor to fulfill its regulatory role, but it also show its potential capacity to exercise policy leadership within the system.

Table 5: Monitor Executive Directors, December 2013

Name	Position	Previous private sector experience	Previous government/ NHS experience
David Bennett	Chief Executive	McKinsey	Prime Minister's Office*
Stephen Hay	Managing Director, Provider Regulation	KPMG	None
Adrian Masters	Managing Director, Sector Development	McKinsey, IBM, KPMG	Prime Minister's Office*
Miranda Carter	Executive Director of Assessment	Deloitte, PwC	None
Catherine Davies	Executive Director of Cooperation and Competition	"City law"	NHS Cooperation and Competition Panel; Competition Commission
Kate Moore	Executive Director of Legal Services	"City law", KPMG, Investors Compensation Scheme	None
Sue Meeson	Executive Director of Strategic Communications	Unilever	Legal Services Commission
Fiona Knight	Executive Director of Organisation Transformation	KPMG	None

(Source: Monitor website, accessed 29 November 2013)
http://www.monitor-nhsft.gov.uk/about-monitor/who-we-are/executive-team
*Prime Ministers' Office denotes various units within the PMO including the Prime Ministers' Delivery Unit.

37. And, bearing in mind that appointments to Monitor's board and its Chair and Chief Executive are made by the Secretary of State, it is clear that Monitor's new team, who came into office in 2012, were not appointed to preserve the legacy of the DH. Corporate consultancy and auditing firms are the dominant background (rather than the NHS, government, or other regulators, as might be imagined); any previous government experience tends to be very close to the Prime Minister. Monitor is in many ways an institutionalization of consultancy firms.

38. Indeed the 'schooling' of its new team, compared to those within NHS England is likely to lead to different points of view on the values which should dominate in the delivery of NHS care, as recent disagreements on the role of competition policy in the NHS reveal **(**see **Box 2).**

39. Moreover, Monitor has surprised some with its ambition. Using its broad powers under the Health and Social Care Act 'to make sure the whole sector works for patients' benefit', it commissioned a 350-slide management consultancy-style publication on options for addressing the growing shortfall in NHS funding or, as it puts it, 'sharing with decision makers in the sector the evidence they need to take sound decisions.'[25],[26] Published shortly before NHS England produced its own thought paper on the same subject, this perhaps suggests that Monitor, as the new entrant to the NHS 'policy market', is seeking to fill the gap left at the centre by Lansley's creative destruction, or at least to challenge NHS England's dominant position.[27]

Box 2: Competition policy– a bone of contention between NHS England and Monitor?

Under the Health and Social Care Act Monitor is given a specific duty to prevent any anti-competitive practices in the provision of health care services that are against the interest of patients. NHS England on the other hand must act to give patients a choice in their health care.

Because of these joint responsibilities both organisations are working together to produce a joint framework document on competition and choice for commissioners and providers.

But do they both agree on the benefits of competition and the circumstances when it is in the best interests of patients? According to recent reports, some differences of opinion seem to be emerging. At a recent NHS England Board meeting it was reported by the NHS England Policy Director that there was a "paucity of evidence" around the benefits of competition for patients, leading to a delay in the publication of the joint document.

Further, it is not clear that NHS England and Monitor see eye to eye on the application of competition law to NHS mergers. NHS England CEO David Nicholson has stated publicly that the application of competition law – a power held by Monitor - was getting in the way of driving up the quality of care.

Again, this is perhaps not a view shared by Monitor who have recently issued joint guidance with the Competition Commission and the Office of Fair Trading on the role that competition law should play in benefiting patient's interests.

(*Sources: David Williams, 'Competition guidance stalls amid lack of evidence of benefit to patients' Health Service Journal 16 September 2013; Dave West 'Competition rules hold back quality, says Nicholson' Health Service Journal 25 September 2013)*

Conclusion

Who runs the NHS in England and where next?

40. Organizationally, NHS England, PHE, Monitor and the CQC are the four key organisational structures of health policy, management and implementation, agencies and regulators accountable to the Secretary of State for personnel and policy with a thin Department of Health operating on the rim of this structure.

41. Following the 2012 reforms, the Department of Health itself is back to where it was in 1983: a ministerial office looking for a broader role. NHS England is in effect the successor to the DH and probably the NHS Management Executive. In terms of its broader role in the system, the DH seems to be reverting not to 1983 but to its pre-1948 version - focused on inducing local governments to do things in social care or public health in a predominantly market-based health system.

42. In personnel terms, the people who run the NHS are the same people who ran the DH under not just Cameron but also Brown (and in many cases even under Blair). The top cadre was remarkably undisturbed after 2012. The DH decanted most of its NHS expertise and responsibility into NHS England; with a few clear exceptions (e.g. David Behan, who left his job as head of social care in the DH for a position as Chief Executive of the CQC), people moved with their jobs to the NHSE.

43. Equally notable is how few people have moved from the top ranks of the DH to the CQC (one) or Monitor (zero). These organizations were already largely staffed before the 2013 reorganizations, so they did not have as many jobs to fill- and were staffed to behave differently from the DH. This is most notable in Monitor, which from its inception under Blair was focused on finance rather than care or management. Its DNA is more KPMG than DH. Its stability as an organisation – despite recent difficulties in appointing a chair - suggests that the Cameron government likes that as much as the Blair and Brown governments did.

44. The key question is whether the structure underpinned by these 4 organisations is stable. The DH, when not running the NHS, is a small entity, to the point where its cadre of senior civil servants amounts to just over 150. Its organization charts today look a good bit like its organization charts from 1988 or 2000: a few odd functions around a minister, balancing or failing to balance a large and complex organogram of NHS central management and a ministerial team that has not shrunk.

45. Yet such a "thin" department is unlikely to be sustainable in the longer term. The history of changes to the management of the NHS suggests that one of the key justifications for the introduction of the Lansley changes into the NHS- separating the NHS from the everyday politics of blame and partisanship - is flawed. It depends on the assumption that objections to events in the NHS will not be routed to a national politician who clearly has responsibility for health policy and who has a democratic opposition party to hold him or her to account, but rather to one of several poorly understood quangos.

46. In theory, this might lead to a great deal more political visibility for NHSE, Monitor, and the other agencies (somewhat in the manner that CQC is associated with failures in care quality), or a dissipation of public pressure into complex debates about responsibilities. In practice, it is far more likely that the Secretary of State for Health will keep the responsibility, at least for the short term, without the tools to do anything to solve any of the problems. Voters will continue to hold their elected representatives accountable for the health service. It is also hard to imagine that governments will cease to make promises to those voters about the NHS, and it would be surprising if the current structures satisfied politicians who want to make a difference in the NHS. And finally, there is a real risk of policy contradiction between different agencies, as we have detailed, and there is currently no authority that can definitively arbitrate.

47. Because of this, we contend that the question is not whether, but where, the new central co-ordination will grow.

48. Previously, the DH was the instrument ministers used to achieve some form of central co-ordination, taking the powers of the old Management Executive back into the Department as they tried to coordinate. Perhaps in the future they will leave an exiguous or 'hollowed out' DH, and focus on manipulating the people they have appointed to run the agencies. But the advantages of this are not entirely clear: instead of one clear central organizational focus, we would have ministers negotiating with a variety of ENDPBs that are less flexible and cut off from the political and media pressure which Ministers are required to endure.

49. Previous efforts to separate NHS management from policy have generally led to the re-integration of NHS management into the DH so that the Secretary of State can intervene and we foresee this happening again.

50. The outlier within this is Monitor. As more and more critical decisions within the new NHS are taken by Monitor on the tariffs paid to NHS providers, on competition policy and as well as on the standards of care provided by licensed operators, there is a possibility that the more contentious policy decisions and changes to provision will be driven by this non-majoritarian regulator with power accruing to it accordingly. As a new body, with a top team drawn from management consultancies and the private sector, the new power dynamic may instead be between Ministers and Monitor's Chair and Chief Executive. Unchartered waters, indeed, for NHS governance.

Broader lessons for Whitehall

51. The rest of Whitehall might also have an opportunity to learn from the experience of the DH. Discussions of civil service reform are still ongoing, with the government promoting a civil service reform plan and commissioning work on ways to increase ministerial control of the people around them[28][29]. From the vantage point of the DH, where there is one top person who looks like a classical Whitehall civil servant, these discussions seem strangely off target. The DH continues to be the kind of department ministers want: offering specialist expertise in delivery from a cadre of longstanding managers and profession-

als. Every Secretary of State since, at least, 1983 has taken measures to those ends[30]. But it is now a small department with an unclear role, flanked by giant quangos whose boards and chairs are appointed by ministers and which do most of the things that the public might expect a minister to do.

52. The Department of Health proved itself to be, indeed, a “Department of Delivery” (to use a term coined by Alan Milburn) in 2010-2013, delivering a reform that few policy analysts or implementers regarded as a good idea while attempting to carry out the “Nicholson challenge” of major savings on NHS activity- even if the activity itself showed the fatuity of dividing policy from management. The ideas came from elsewhere and the department delivered their implementation, concluding in its own partial self-liquidation into still more delivery-focused quangos whose coordination will be, essentially, done by the Secretary of State and his junior ministers. Few departments in Whitehall have made such a change so obediently. The DH is the future that politicians seek. If they do not like it, and the current organisation structure now in place remain unstable, then much of what we think about both the NHS and Whitehall is going to need some revision.

53. The Cameron government’s enormous reforms to the NHS have left observers incredulous for a number of reasons. Our study has focused on one: the historical implausibility of separating the management of the NHS from the financing and politics implicit in being a major part of government. Governments and DH officials have tried, for decades, to separate the NHS from the DH, in the service of greater or lesser autonomy, management, and market. The separation of NHSE from the DH is merely the latest, if probably the most determined effort to separate politics and the NHS. In each case, in the past, there has been an ultimate reversion of power to the DH. Eventually, though, it is governments and politicians, not civil servants or agency chiefs, who are held accountable for their health policies, and this ultimately ends up being reflected in how the overall system is configured.

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