

AN INDEPENDENT NHS: A REVIEW OF THE OPTIONS

by Brian Edwards



The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

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Published by
The Nuffield Trust
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London W1G 7LP

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Email: info@nuffieldtrust.org.uk
Website: www.nuffieldtrust.org.uk

Charity number 209201

© The Nuffield Trust 2007
ISBN-13: 978-1-905030-23-1

Typeset by Liquid Design and Communications Ltd
Telephone: 01452 840986

Printed by Q3 Digital/Litho, Loughborough, Leics.

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About the Author

Brian Edwards is Emeritus Professor of Healthcare Development at the University of Sheffield, where he was Dean of the School for Health and Related Research. He has extensive management experience in the health sector, having served as chair and chief executive of a number of NHS field authorities. He was a member of the NHS Executive, led many national groups, and was involved in the implementation of the Patient's Charter.

Acknowledgements

I am very grateful to Patricia Day, Senior Research Fellow at Bath University, and Scott Greer, Assistant Professor at the University of Michigan, for their assistance with the research for this project. This work is based on reviews of current literature and interviews and discussions with ministers, civil servants, health managers and clinicians, as well as some of the leading players in other public sector corporations, agencies and non-departmental public bodies (NDPBs). While all of these people generously gave their help in shaping the ideas in this paper, the responsibility for the conclusions lies entirely with me.

Preface

Discussion around the possibility of an independent NHS has frequently been mooted but often has been limited between two schools of thought: on the one hand that the sheer size of the budget for the NHS demands direct political accountability and control; on the other, that the electoral cycle has the effect of making the NHS a political football. The Nuffield Trust commissioned this project to help move the debate to a different level and more neutral territory, to explore governance models from different angles, and to review the special position of the NHS.

Brian Edwards, Emeritus Professor of Healthcare Development at the University of Sheffield, reviews the various arguments and the history of this issue and asks the question, if we do want an independent health service, what are the reasonable options and their costs and benefits? His observations and analysis of comparable structures will be required reading for policy-makers and politicians at this important stage in the history of the NHS.

We hope that this will be considered as an exploratory report, flagging the issues which will be encountered if these options are taken forward. If changes in governance are to be considered, an in depth examination of the current structure and impact of the options will need to be more fully explored before implementation of change.

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Chief Operating Officer
The Nuffield Trust*

INTRODUCTION

The Nuffield Trust commissioned an examination of the options for independent management of the NHS as a contribution to the current debate about the future of the NHS.

The starting point for the project was the question of whether independent management is necessary and desirable for the NHS. Highlighted by Tony Blair's recent statement¹, the current discussion revolves around this issue. However, this report goes beyond the initial question and explores the options for an independent body. It describes the various arguments for changing the management and delivery structure of the NHS. Through interviews and discussions with a wide variety of sectoral interests, both within and outside the NHS, a myriad options for future management have been explored. After considering more than 17 different options, the report discusses in detail the seven most likely models of governance.

Following the implementation of the 2006 Act², the changes to the status of foundation trusts and the role of commissioners have already affected the responsibilities of ministers in relation to the NHS. Fundamental change is under way, which will lead to a very different structure from the one that exists today. These changes will create an even sharper distinction between commissioners and providers. Providers will look to their own financial and strategic interests as they compete with each other and new providers from outside the NHS. This will probably lead to mergers and consolidation in the hospital sector, and perhaps also in primary care. It is not possible to manage the NHS as a total system while foundation trusts retain their independence. If this is a fixed point of policy, the independence debate has to focus on commissioning.

Thus some NHS specialists claim that with certain aspects of NHS management in flux, the status quo is not sustainable. However, during a series of interviews and discussions with a wide variety of sectoral interests, most of the participants were uncertain or ambivalent about the idea of 'independence' for NHS management. Their first instincts were to recommend a

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consolidation of the current investment in the NHS and the delivery of existing service gain targets. They felt that there should be no further organisational change. Those who did have strong views presented one of two arguments:

1. that it was unthinkable that the political process would allow an organisation the size of the NHS, spending huge sums of public money, to become independent, or
2. that the way to improve the NHS was to stop politicians meddling in its management.

This report aims to go beyond these two positions and to examine the case and options for change in some detail, and in the context of a wider public sector.

The study focuses on the NHS in England, but has some relevance to the rest of the UK.

EXECUTIVE SUMMARY

Ideas about creating an NHS authority that is independent of national political processes have been around for some years, but have never been developed into a full proposal. All of the political parties are looking at this option in the run-up to the next election, but so far, despite a growing political consensus, no detailed organisational shape or form has emerged. All of the ideas in this paper are cast in the context of the founding principles of the NHS – a service available to all citizens according to their need, and paid for predominantly out of national taxation.

Advantages

One advantage of an independent NHS Authority (NHSA) is thought to be the ability to create distance from the heat of political battle, which is considered to be damaging to the NHS. However, the NHS can never be totally removed from political debate and challenge, as the iconic status of the NHS in our society will generate its own problems for any organisation that seeks to change it radically.

An independent body with a stable, visible and respected leadership might find it easier to open up to public and professional debate, challenging questions about future patterns of delivery. It would be expected to conduct much of its business in public and to develop a managerial rather than a political culture. For the change to be worthwhile, an NHSA would have to offer more than a political screen. It would have to provide a credible and powerful platform for the modernisation of the NHS.

This different cultural environment would enhance the opportunity for remodelling clinical processes and improving the efficiency of the whole system.

Disadvantages

The principal objections to the idea of independence have centred on:

- the perceived need for tight national and political control over a sizeable slice of public expenditure
- the potential diminution of parliamentary accountability, and
- the need for ministers to drive change in what would otherwise be a professionally dominated organisation.

A 'professional' management team could not be guaranteed to manage the NHS better than ministers, but the setting and environment in which a professional team worked would be very different. The change needed at the top of the NHS is one of environment and culture, rather than of individuals. Improving the quality of service delivery and securing a full return on recent investment should be the main engines for change.

The view from other sectors

Generating more operational independence for public services has been a major plank of government policy for some years. This policy has been applied in health and other sectors of the economy, including broadcasting, telecommunications, postal and rail services. The results are mixed but relevant.

How independent is the NHS now?

The NHS of today is no longer a single, centrally managed monolith. Foundation trusts are genuinely independent and not subject to ministerial direction. There are various models for independence, which depend on whether the new organisation had a role as commissioner of health care, provider of health care, or both. If an NHSA had a significant role in providing services, the status of foundation trusts would need to be reappraised.

Alternative governance models

It is not the purpose of this study to grade each model according to its fitness for purpose – that would be a much larger work. Here the models are represented in a loose continuum from direct ministerial control to a position in which the government retains responsibility for funding and major priorities, but little else. The models are reasonably discrete, in order to aid discussion, but in practice they overlap and the features of one may well fit into another.

Seven potential models for an NHSA are described:

- a modernised NHS Executive within the Department of Health
- an NHS Commissioning Authority

- an NHS Corporation – a fully managed national service
- an NHS Corporation – a planning and commissioning organisation
- a regionalised NHS
- an NHS commissioned by local government
- an NHS as a public insurance company.

All of these organisations would need one independent regulator focused primarily on health providers. Commissioners should undertake their own inspections, and the balance of power between a regulator and any NHSA needs to be carefully balanced.

What are the implications of change?

Setting up a new NHSA will demand answers to a series of challenging practical questions, including the following.

- How would the organisation relate to ministers?
- How would it be appointed?
- What democratic engagement would there be?
- What express powers would the organisation have?

Funding questions would loom large, as would the organisation's use of existing or new economic levers. These questions need to be addressed before final decisions are made.

Any NHSA must be able to decide its own internal structures. This would be complicated if its subordinate organisations had a statutory base that they did not need. They would also require significant discretion over the economic levers and incentives they put in place to generate efficiency and conformance with commissioners' contracts.

Any new organisation must be able to reduce overhead costs for redeployment. An NHSA would mean a smaller Department of Health, with a crucial role in the wider field of public health. The new department would have to determine the policy framework within which any NHSA would operate. Ministers would retain ultimate accountability for system integrity (the NHS could be replaced in time, but it could never be allowed to collapse).

Distance from the political process cannot be the only criterion referred to when selecting a specific management model. Issues such as democratic engagement, the generation and sustaining of integrated care pathways for patients and other fundamental changes to service delivery are all crucial outcomes for an independent NHS. The change needed in the NHS is in the environment and culture at the top of the organisation. Improving the quality of service delivery and securing a return on investment must be the prime movers of change.

1. WHY NOW?

History

The idea of creating an independent NHS is not new. It has been suggested on a number of occasions in the past, and was considered in some detail by the Royal Commission on the NHS, which reported in 1979.³ It was, they stated, ‘one of the solutions most frequently advocated in evidence.’

Although they found the arguments in favour of setting up an independent authority attractive, they were not persuaded that improvements could not be made within the existing framework. It was, they concluded, ‘an idea that Ministers should keep under review.’

The Royal Commission’s analysis of the advantages and disadvantages of having an independent NHS can be summarised as follows.

Advantages

1. It would provide permanent and easily identifiable leadership for the NHS.
2. An NHS view would be presented publicly by a body that represented the whole of the NHS, and only the NHS.
3. Planning and decisions on the use of resources would be seen to be carried out by an independent body.

Disadvantages

1. Departments would lose their direct involvement in the management of the NHS.
2. MPs would have to raise their concerns about local issues with the authority or health authorities, rather than with the minister.
3. The large sums of money invested in the NHS would make some continued parliamentary

supervision inevitable. Parliament would be involved in legislation, the provision of funds and the securing of financial accountability.

4. Ministers would continue to have major functions (e.g. in appointing the chair and members, negotiating the appropriate level of funding and setting priorities and objectives).

An independent [authority] might act as a buffer between the NHS and Parliament, but the NHS would remain dependent on the willingness of Parliament to vote funds.³

The idea was resurrected briefly in 1986 during Norman Fowler's time as Secretary of State, when Sir Kenneth Stowe, the Permanent Secretary, presented it in private as one of the options for change following the implementation of the Griffiths Report.⁴ In practice, it would have involved converting the NHS Management Board into a Special Health Authority. Victor Paige, the first Chief Executive, strongly opposed the plan in the following terms:

To contemplate such prospects – even when the present Board is still incomplete and has been operating for just a few weeks in a diminished form – reveals a much lesser commitment to the sanctity of the earlier conclusions [based upon the Griffiths Report] than I had ever envisaged.⁴

His problem was with the timing rather than with the concept, which he would almost certainly have endorsed.

The idea was then dropped, although some years later Fowler expressed the following view:

Here you had the Health Service and here the Department of Health which was full of advisors. The Health Service was being managed out there and it seems to me that the sensible way of actually doing this ... was that we should have set up a Health Service Commission, a separate entity, financed from public funds. Under this model, the final accountability of the Secretary of State would remain, but the Commission would manage the NHS on his behalf.⁵

He reinforced this view in his memoirs:

By the end of my stay in health, I had become convinced that it would be possible to create a Health Commission with its own Chief Executive and Chairman.⁶

The idea bubbled up again in the Thatcher review of the NHS, and again during the debate in 1992 about the future of the Regional Health Authorities and a new intermediate tier. The then Secretary of State, Virginia Bottomley, was not enthusiastic. All that would happen, she claimed, was that yet another body would be created to spend its time knocking on the government's door for cash.⁴

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It was Fiona Godlee, Editor of the *British Medical Journal* (BMJ), who reopened the debate in April 2006:⁷

If the NHS – the 33rd largest economy in the world – is to stop being a political football kicked from one party's version of an internal market to another's, it needs to be protected from party politics. An independent NHS Authority ... could do this. Gordon Brown's first act as Chancellor was to give the Bank of England independence to set interest rates. His first act as Prime Minister should be to give independence to the NHS.

The *BMJ* letter columns were broadly supportive, although some readers pointed out that without the vigorous involvement of politicians the NHS would never have been created.

Common ground was that it was not the end of political engagement with the health agenda that was under discussion, but how much more operating independence could be given to those who deliver health care. The Labour Government started the ball rolling with foundation trusts, but how much further could independence go?

In their health policy groups, the three major political parties in England are developing ideas about the management of the NHS and its place in the political arena.

Tony Blair once talked about 'abandoning the old monolithic NHS and replacing it with one devolved and decentralised with far greater power in the hands of the patient.'⁸

Alan Milburn put it rather more graphically when he was Health Secretary, claiming that the NHS was 'the last great nationalised industry in need of modernisation.'⁴

Gordon Brown asked about personalised service for patients and 'the double devolution of power from Whitehall to Town Hall and Town Hall to citizen.'⁹

David Cameron has argued the case for 'advancing civic responsibility, transferring power and control to people and institutions at a local level.' He also claims to be committed to 'independence for the NHS, to take politics out of day-to-day management.'¹⁰

The Liberal Democrats want to 'free doctors and nurses from Whitehall meddling' and 'focus the Department of Health on making strategic decisions to improve the health of the nation, not micromanaging the NHS.'¹¹

So far this broad political consensus has little detailed form.

Tony Blair, in what was probably his last major speech on health,¹ warned against the idea of an independent NHS, on the grounds that it might be a means of avoiding tough decisions. (However, this is exactly the charge that was laid against the politicians by many of those who argued for the creation of an independent NHS authority, and it is explored later in this report.)

None of the major parties appear to want to challenge the founding principles of the NHS – that is, a comprehensive service paid for out of taxation and free to all on the basis of need. Therefore any new organisation needs to be able to deliver services within this policy framework

What problems would an independent NHS solve?

Many of the participants who were interviewed for this project were frankly sceptical about the benefits of yet another organisational change at the top of the NHS. Too often in the past, reorganisations have generated the illusion of change, but in reality deep-seated problems have remained. What problems will the creation of an independent NHS authority (NHSA) solve? What benefits are predicted and how will they be measured? What are the chances of delivering them? How much will it all cost? What might be lost? All of these questions need to be addressed before final decisions are made. The NHS is weary of constant reorganisation.

Even if one adopts a more positive approach to change, by arguing that the NHS needs a new organisational platform for growth and renewal, the same questions arise.

Once the big questions have been addressed, there is still a series of tough practical issues that need to be resolved. These are outlined in a later section (see page 61).

What is the NHS?

The public has a clear vision of the NHS as the organisation that provides both primary and secondary services to all UK citizens, when they need it and without charge. It is regarded as a single monolithic organisation with many component parts, but this is now a false perception.

The reality in 2007 is different, due to the creation of wholly independent foundation trusts (65 in May 2007, predicted to rise to 100 by April 2008),¹² the increasing use of independent and third-sector providers, and an expanding private sector that is offering care to NHS patients.

Some see the NHS as moving inexorably down a road towards eventually becoming a public insurance company that accesses care for citizens, still free at the point of need, from a wide network of providers, none of whom it manages. There is no reason in principle why the commissioning role also has to remain managed in the public sector. The founding principles of the NHS could remain intact with private-sector commissioning and provision models.

If this was to happen, the NHS would become an industry that needed to be regulated, rather than an organisation that needed to be managed.

This report tries to reflect these current and potential changes in our modelling.

A political football

One of the commonest justifications for an NHSA is to allow the NHS to escape from its position as a political football. It is argued that the NHS will never be able to modernise and change while it is operating in a highly charged political environment where every change can be labelled as a 'cut.' Every operational fault can be blamed on ministers even when, as was the case with the new GP contract, they left the negotiations to an NHS-based organisation. In British politics, any service that is led by politicians is a legitimate target for attack by opposition parties who want to demonstrate a government's incompetence.

When the NHS does well (e.g. in reducing waiting times), the evidence is often misbelieved by a public and media that are sceptical about political spin. Even the momentous decision to sharply increase NHS funding is being steadily devalued in the public and professional media on the grounds that the money has not been well spent. No doubt some of it might have been better spent, but the sheer scale of the increase must have done some good. This is particularly true in primary care, which has seen substantial expansion in recent years. The NHS is getting better, but it is looking and feeling worse. A review of health stories in the *Daily Mail* showed how persistent the attack was, with 200 negative articles published over a 12-month period. This rate is bound to increase in the run-up to an election.

The government's communications strategy of responding immediately to critical comment, and the demands that this makes on NHS organisations for immediate answers, reinforces the view of many that the NHS is hard-wired into the political process. A call from Downing Street about a critical story in the media is now a regular event for NHS Chief Executives. The search for good news stories is demanding and insistent. The recent example of civil servants being asked to identify reconfiguration hot spots for a ministerial discussion with the chairman of the Labour Party might have been intelligent politics, but it reinforced the strong political dimension to policy making inside the Department of Health.

The NHS is now much closer to the centre of national politics than it has ever been in the past, except perhaps for the period leading up to its inception in 1948. The NHS today is seen as being led and micromanaged by ministers from their offices in Whitehall. The Prime Minister makes no secret of his detailed engagement with the plans to modernise the NHS, and his regular meetings with ministers and the NHS Chief Executive to check on progress.

The reality is slightly different from the public perception. Whereas ministers are undoubtedly involved in operational detail, the delivery of NHS services on the ground is in the hands of hundreds of separate statutory bodies. Strategic health authorities, primary care trusts, NHS trusts, NHS foundation trusts and special health authorities all have their own views about priorities, and often resent the imposition of hundreds of ministerial targets at the expense of what they judge to be important for their local communities. Command and control can

deliver results, but in the NHS it generates little reciprocal loyalty, and the politicians shoulder all the blame when targets are missed. These were, after all, their targets.

Allegations about political bias in NHS policy making have been around for many years, regardless of the party that has been in power. A BBC Panorama programme that was broadcast in 1997 demonstrated that a significant number of service changes in marginal constituencies had been blocked on what were judged locally to be party political grounds. The scale of partisan bias in the UK is probably marginal, but suspicions remain deep-rooted when it comes to resource allocation and hospital reconfigurations.

It was the Labour Government who realised the dangers of a perception of bias and, as a consequence, created the NHS Appointments Commission to remove questions of political bias in the appointment of paid non-executive directors to NHS organisations.

Political damage

The political battles in recent years have undoubtedly played their part in tarnishing the reputation of the NHS. Ironically, this has occurred during a period when the philosophical gap between the parties with regard to NHS reform has been at its narrowest for years. The reputation of the NHS has been adversely affected by images of financial cuts (during a period of record growth), over-bureaucratisation, dirty and infection-ridden hospitals, rationing of new life-saving drugs, and general practice services that are difficult to access (despite a big increase in pay).

It would be unreasonable to blame the politicians for all of these perceived problems – except, of course, that they are ultimately in charge and have to take the pain that this responsibility imposes.

Creating distance between the NHS and party politics might not solve the problem. Rudolf Klein has written about the iconic status of the NHS, with its almost religious status in our society, ‘worshipped’ by the people.¹³ An NHA would find itself under attack from all quarters if it were identified in the public mind as damaging the service. In order to survive and be successful, it would need to identify itself firmly with the founding principles, and demonstrate improvement. The public loves the idea of an NHS. However, it is becoming increasingly dissatisfied with poor delivery.

But does the fact that the NHS is a political football matter to anyone other than the politicians and the media? Does it affect the day-to-day practice of clinical teams and their relationship with patients? Does it affect staff morale? The answer must be that it does, at least in the longer term. It impacts directly on the decision-making processes of the NHS, many of which have to include a political impact assessment. It will affect staff morale if the

community recognition of the value and competence of the NHS is in decline. It may already be impacting on a number of young people who are applying to train as health professionals. It will directly affect clinician–patient relationships if the competence or integrity of clinical staff is constantly being questioned and undermined. If the political process becomes tainted, this will rub off to some extent on the organisations that are being managed by this process.

Some of the models that we shall explore in this report will create more distance between the NHS and national politics, but so long as the NHS is funded from national taxation, the politics will never be far away. However, even a modest gap would be largely beneficial.

The gap might also ease the pre-election purdah rules about controversial decisions, which now seem to apply many months earlier than used to be the case. You cannot freeze an organisation for extended periods and expect it to thrive.

A major downside to political distance might be the removal of day-to-day pressure on ministers for increased investment. The decision by the Blair Government to radically increase NHS funding was an overtly political decision.

Postcode decisions

The tension surrounding local decision making about a national entitlement is very real. The political process goes into high gear when a patient in one part of England is denied access to drugs that are available to patients in another part of the country. What has never been settled is whether the value of local decision making is greater than that of universal equity. Those who argue for devolved decision making in health will have to confront this issue.

Leaving what amount to rationing decisions in the hands of trusted local professionals can work, but the only sure way through this problem is either to democratise local decision making in some way, or to have a clearly defined basket of national entitlements which are offered to all patients. Any NHSA would have to go some way down this path.

Openness and transparency

The current NHS headquarters are a closed part of central government. Ministers and their officials meet in private, as do the Chief Executive and his top team, and minutes of their meetings are not available for public inspection. Contact with the public is via press releases and the broadcast media, and is controlled. This is in stark contrast with NHS field authorities, which conduct the vast majority of their business in public. This is a significant gap that could be filled by an NHSA, which might be expected to operate more like an NHS field authority than a part of central government.

Would an NHSA be less of a political football than the NHS of today?

Managerial or political process?

The Department of Health has at its core a political machine that sees its role as changing or developing the NHS to meet political objectives and targets. This is entirely legitimate in a democracy.

However, it does skew internal processes so that greater weight is often given to ideas that will present the government in a favourable light or grab the headlines. Action to deal with deep-rooted problems has to fit the political cycle. Long-standing financial problems have been evident in some communities for years, but remain unresolved because the actions needed to deal with them have been judged to be politically impossible. Only under the current Secretary of State, with a change in government accounting rules, has financial balance become so important that unpalatable decisions have had to be made, whatever the level of political noise.

Ministers and their civil servants thrive on new and usually very well intentioned policy rather than the long hard slog of implementing yesterday's decisions. The good news is secured with the intent rather than the delivery. In the public sector, badly shaped or implemented policy does not lead to consequences as clear as a drop in sales or profit. It usually leads instead to a new policy. An NHTA might feel under less pressure to chase positive headlines and might weight their decisions differently, giving less weight to political and media impact and more to clinical gain and cost. The National Institute for Clinical Excellence (NICE) has set a good example by sticking to the science and the facts, regardless of the political and sometimes professional pressures. Their decisions and advice may not always be popular, but they are listened to with respect.

An NHTA will almost certainly find it easier to open up for public debate challenging proposals for change in the organisation of clinical care. Ministers will also be freer to listen to any public debate before taking a view of their own.

Reserve powers for ministers

This leads us to the question of reserve powers for ministers if an NHTA was to be created. All of the models in this paper assume a significant degree of continued ministerial involvement with and oversight of at least some parts the NHS. Ministers would retain responsibility for the wider public health policy, which in turn might produce another Health of the Nation plan. They would be the guardians of the founding principles of the NHS, and only they would be able to change those principles. Ministers would almost certainly lead the negotiations with the Treasury about levels of funding.

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Ministers would continue to play their part in deciding the priorities of the NHS and incorporating their requirements in the annual or biannual memorandum of agreement between the Department of Health and any NHSA. In practice this would be a powerful lever, as it would no doubt be tied to the release of additional funds. Ministers would regularly review the performance of any NHSA and hold them to account publicly in either a positive or a negative sense. If performance was judged to be unsatisfactory, ministers would have the power to change the chairman and non-executive members. At the end of the day, the responsibility for overall system integrity would have to remain with ministers.

Ministers and day-to-day management

Ministers have different styles of working with the NHS. Some prefer to engage with the big picture, while others like to work with the detail. Some judge that they have to handle the detail, whether they like it or not, because they are in charge. Thus ministers not only set national waiting-list targets, but also wade through the detailed policies that define them operationally. Their formal responsibilities range from major service policies to hospital catering.

Table 1Distribution of ministerial responsibility within the Department of Health in 2007¹⁴

TITLE	RESPONSIBILITIES	LINKS TO SHA AREA
Secretary of State	Overall responsibility for NHS and social care delivery and system reforms; finance and resources; strategic communications	
Minister of State for Health Services	International and EU business, preparation for emergencies, cancer services, cardiac services, diabetes services, mental health, prison health care, dentistry, patient and public involvement, renal services, equality and diversity issues	North West and North East strategic health authorities
Minister of State for Public Health	Public health White Paper and Bill, health inequalities, developing wider communications and social marketing for the Department's 'Small change, big difference' campaign, drugs (including drug treatment), tobacco and smoking, alcohol, physical activity, diet and nutrition, Health Protection Agency, communicable disease, immunisation and sexual health, Human Fertilisation and Embryology Authority, Food Standards Agency, fluoridation, sustainable development	Strategic health authorities on the South- East coast and in the West Midlands
Minister of State for Delivery and Reform	Finance, including financial recovery, allocations and comprehensive spending review. Capital development, including Private Finance Initiative, NHS Lift and community hospitals. NHS efficiency and productivity. Income generation and cost recovery. Delivery of targets, including 'access' and '18 weeks' and 'winter'. System reform, including reconfigurations, commissioning, choice, plurality, Independent Treatment Centres, contestability, payment by results and system management, including wider review of regulation. White Paper and primary care, including implementation of <i>Our Health, Our Care, Our Say</i> . Foundation trusts and unscheduled and emergency care, ID cards, statistics	East Midlands and East of England strategic health authorities

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TITLE	RESPONSIBILITIES	LINKS TO SHA AREA
Parliamentary Under-Secretary of State for Care Services	Social care finance, performance and workforce issues, Commission for Social Work Inspection, children's health, maternity services, child and adolescent mental health. Older people's services and dignity in care campaign, carers, continuing care, physical and learning disabilities, long-term conditions, services provided by allied health professionals, third-sector providers and the voluntary sector	Yorkshire and Humber and South West strategic health authorities
Minister of State for Quality	Safety and quality, including MRSA, patient safety and the National Patient Safety Agency (NPSA). Professional regulation, clinical negligence, redress and investigations, and inquiries. Research, pharmacy and healthcare products, including Medicines and Healthcare products Regulatory Agency (MHRA) and NICE, pharmaceutical industry, research and development, Genetics & Biotech information network. Healthcare Industries Taskforce (HIFT) and innovation, including National Institute for Innovation and Improvement, NHS/IT and Connecting for Health. NHS workforce issues, including numbers, planning and education, training, pay and pensions	South Central and London strategic health authorities

Few ministers on appointment have any experience of health policy or of managing large organisations. Yet they are involved in every aspect of the work of the Department of Health and the NHS. They are responsible for their policy area. Each minister has a private office and a team of civil servants in support, none of whom are in any way experts on the subjects included in their brief. They access specialist advice when the minister needs it. The policy advice to ministers does not routinely go through the office of the NHS Chief Executive.

Should ministers stick to priorities and avoid making decisions about clinical process?

In today's organisation it would be entirely appropriate for ministers to decide that cancer treatment needed a higher degree of priority, but should they go on to make decisions about the way in which cancer services are delivered? Is this the point where politics moves inappropriately into clinical management? Would clinical networks such as those for cancer or cardiac care have made more progress in a service managed by an NHS that was not hidebound by the statutory foundation of the various parts of the current NHS?

Ministers deal with media questions within their policy areas, even though an expert in the subject area might have produced a more effective response. Ministers handle the detail because they feel they have to because they are in charge. No health minister has ever resigned because of a failure in one of their own designated policy areas, so it is a responsibility without serious bite or risk.

But what evidence is there that a 'professional' management team could manage the NHS better than politicians? The answer lies not so much in the skill base of the individuals, which should be higher and more appropriate among professionals, but in the settings and environment in which they operated. A professional team would almost certainly be focused on a more limited number of deliverable targets and be able to spend more time on delivery. Targets would not be set to meet political cycles. They would still have to deal with a hostile media when things went wrong, but the pressure would lose its political intensity. They would also be able to innovate with a view to learning, without worrying so much about political blame when things did not go as expected. The pace of change would almost certainly be more measured. Selecting non-executive directors from outside the NHS to serve on any national Board would help to reduce institutional thinking and challenge traditional attitudes – a role that in the past has sometimes been left for ministers.

Ten years of the Blair Government have seen a swing from tight control and hands-on management, with hundreds of targets, to a position in 2007 where the possibility of an independent NHS is up for discussion. Current ministers have since acknowledged that having too many targets does not work, but it is doubtful whether this lesson will be remembered. Every new Secretary of State generates change, sometimes reversing decisions taken by their predecessor within the same government. Change equals progress in the political world, whereas consolidation does not produce headlines.

In recent years, ministers have been heavily engaged in the operational detail of the NHS. Would they be better sticking to policies about the big picture – many of which are in the public health arena – that only they can directly influence? Medicine today is such a complex and sophisticated science that one is forced to speculate whether it has outgrown its ability to be managed by political processes. This is a challenging issue in a society where the relationship between the state, civil society and the citizen is being redrawn.

Ministers and controversial issues

Plans to reconfigure health services are often very controversial, and lead to local and national protests, marches, petitions and, in one memorable case, a successful single-issue parliamentary election campaign.

In recent months, the Secretary of State has referred controversial proposals to reshape maternity services (to make them better and safer) in Greater Manchester to the NHS Independent Reconfiguration Panel for review before she makes a final decision that is bound to be unpopular with one side of the argument. This is a good example of a minister using the power of independent expert advice to underpin and legitimise difficult decisions. NICE is another example of the ability of an independent and expert body to deal with technical but nevertheless controversial issues. Independence can be a powerful political tool, as Gordon Brown showed with his decision to allow the Bank of England to determine interest rates. That ground-breaking but narrow decision has little relevance to any decision making about the management of the health sector, except in a philosophical and political sense.

What do ministers do when their constituents object strongly to the local impact of a national policy for which they are responsible, as happened recently with maternity services policy? The Chairman of the Labour Party argued¹⁵ that it was entirely legitimate for a minister, in their constituency role, to object to national policies (even if they created them) when their constituents were worried about their local application.

***Would an
NHS find it
easier to make
reconfiguration
decisions?***

Riding two horses does not fit well with notions about determined leadership. Some might argue that a minister's first duty in any case is to his constituents rather than to his ministry. Sometimes the right decisions are politically impossible, which sits uncomfortably with the responsibility for managing a vital public service. It has been extremely difficult to modernise London's NHS because of the strength of national and local politics – including strong trade union activity – despite a number of influential independent reports. The status quo is rarely a good option for a service that is coping with rapidly changing technology and rising public expectations.

One of the options in this report would place the responsibility for disputed reconfiguration decisions at arm's length from the political process. The decisions could be made by an NHS subject only to an appeal on process grounds to the Independent Regulator. Alternatively, local authorities and others who wished to dispute planned changes in their area could be granted the right to appeal directly to the Independent Regulator, with only a judicial review to follow on process grounds. Sometimes difficult decisions have to be made. However, in order to stick they have to be made properly and after appropriate consultation.

Provider networks

It would of course be possible to build within an NHSA a network of wholly owned but semi-autonomous organisations (both hospitals and primary care organisations) that sat alongside private and third-sector providers. In contractual terms the position of all the parties could be the same. This would redefine foundation trust status somewhat, without necessarily losing all of the benefits, but would have the advantage of permitting any NHSA to directly restructure the core of the provider sector in a planned manner if it judged such a step to be necessary. It might make it easier to develop clinical pathways which involve a number of providers, and to allow vertical integration between primary and secondary care.

Another way forward would be to create an independent provider network (a Hospital and Healthcare Federation) within or outside an NHSA with members from public and private sectors, all of whom would be eligible to treat NHS patients. They would regulate their own affairs subject to the disciplines imposed by their Regulator. Although this may appear to be an unlikely option, the prospect of provider chains is very real in the private and not-for-profit sectors in both primary and secondary care. In the longer term there are the possibilities of public-private partnerships as well as entirely new ownership models involving universities and teaching hospitals.

Who leads the NHS?

Leadership of the NHS has been an issue since its inception. It has never had a dominant non-political leader. Secretaries of State and ministerial teams come and go, leaving a mix of impressions about their strength and vision. Policy sometimes changes more with a change of minister than with a change of government. However, all ministers are transient. Managers have a leader in the NHS Chief Executive, but his leadership span has rarely extended to clinicians, who look instead to their professional organisations and local peers. At least one NHS Chief Executive saw his role not as leading the service in a traditional way, but as dealing with ministers and creating space for local leaders on the ground.⁴

At a national level the NHS Chief Executive has had to be an adviser to ministers and to retain political neutrality as a senior civil servant. When a former NHS Chief Executive intervened in a political row about the future of the NHS, by denying that it was about to be privatised, he nearly lost his job. He came under attack from both opposition politicians and senior civil servants who were worried about the politicisation of the top of the civil service.⁴ Powerful leaders have emerged in some trusts, but they have to operate in a complex environment in which clinical freedom is still highly prized. Managing health organisations is a highly skilled business.

An NHSA would create for the first time a role for a powerful non-political leader of the NHS.

An NHS in transition

The NHS appears to be in a constant state of change from one organisational form to another. For some this has been a healthy process of constant renewal and modernisation, while others regard the constant change as debilitating and dangerous. Tony Blair said recently:

The NHS is an important British institution. But it will not be preserved by neglect. It will survive and prosper if it changes as the population it serves changes. We have reached a crunch point, where the process of transition from one system to another is taking place. The NHS is moving from a 'get what you are given service' to a 'get what you want service' moulded around the decisions of the patient.⁸

The commissioner/provider split

Two policy themes in particular have been central to thinking about the NHS for nearly two decades. The first theme involved creating a clear distinction between those who commissioned health care for local communities and those who provided secondary care. This policy produced GP fundholding, which evolved into GP commissioning, operating within primary care trusts. The second theme concerned the creation of independent hospitals and community service providers who would have the self-belief and discipline to stand on their own. This led to self-governing NHS trusts, which evolved under a Labour government into foundation trusts that were even more distant from ministers and the rest of the NHS.

Most of the models that we describe in this report assume that the purchaser/provider split will continue, and that the independent status of foundation trusts will remain. Their contribution to the NHS will be shaped and controlled by the terms of their license from Monitor, their local members, and legal contracts with their commissioners defining the service that they will provide for NHS-funded patients. However, both of these policies come under challenge with some of the independence models.

Some now question the sharp separation of commissioner/provider roles and argue the case for integrated Health Boards along the lines of those developed in Scotland and New Zealand. Evidence from organisations such as Kaiser Permanente and the Veterans Administration in the USA would seem to support this view.¹⁶ Recent thinking within the Treasury about the need to integrate front-line service delivery (and thus remove, for example, the need for an individual citizen to contact the government 44 times in the event of a bereavement) may also be relevant.¹⁷

The danger of provider domination and economic capture is always a risk in any models that include a provider arm. Organisations with a significant provider arm will think twice before putting them at significant risk and thereby generating pressure on the rest of the organisation. Provider arms impact both on the management focus of an organisation's leadership and on their thinking about service delivery and priorities. Having both commissioners and providers within the same organisation might inhibit both.

Although the power to shape the future of the NHS may have switched to commissioners, decisions about the provider side of the NHS are at the heart of any discussion about independence. In the eyes of the public, hospitals remain the major part of the NHS. The foundation model, at least in its present form, may need rethinking.

The NHS in 2007 is still a service driven from the centre by national targets and a strong system of performance management. There are some signs that this is about to change, but the pressure from the centre and from the SHAs that represent it on the ground continues to be strong, particularly for those organisations that are experiencing financial problems. The Department of Health has in recent times shown its willingness to remove those boards and chief executives who do not deliver financial balance and meet vital targets. The Department retains substantial influence over the appointment of chief executives of NHS field authorities. Foundation trusts also find that their regulator is interested in the make-up of their top management teams.

Change in the balance of clinical care

Section 1 referred to the political road for change, but the NHS is also undergoing a profound internal shift in the balance of clinical care from the hospital sector to primary care, which should in due course (if it continues) affect the balance of professional power within the system. Alongside this is a realignment in relative power between those who commission NHS services and those who manage provision. The dominance of the hospital sector is starting to decline slowly as commissioners become more expert and more confident.

A modest change in the balance of provision between the public and private sectors is also under way. The principal expansion points for the private sector have been non-emergency surgery and diagnostics, but there is growing private sector involvement in primary care, notwithstanding the fact that general practice has, since the inception of the NHS, been largely small business based. The public sector providers, which include foundation trusts, still have a strong monopoly that should influence decisions about regulation.

The Labour Government's modernisation of the NHS in England has been heavily influenced by economic thinking about the interplay between patient choice, mandatory national targets, economic incentives related to patients treated, the power of competition within a regime of national tariffs and an extended network of independent providers of NHS services located in both the public and private sectors.

If policy formation had started from a different position, such as how to develop a system that would be capable of delivering complex multi-professional care to individual citizens at acceptable cost, different solutions might have emerged. The Scottish NHS, with its emphasis on integrated planning and management, is just one example of an alternative way forward from within the UK.

AN INDEPENDENT NHS: A REVIEW OF THE OPTIONS

The final driver for change, and the one that always ends up as the most potent in the longer term, is the advance of medical science and technology which continues apace and brings with it the need for even more complex and integrated delivery systems.

The public still view the NHS as a national service. What might be seen by some as a monolith will be viewed by others as an extended family of organisations working together to serve the wider public and individual patients. In fact it has never been quite like this, because of the strength of professional and institutional competition.

What is currently independent?

For the most part people understand, in outline at least, the distinction between those who commission health care and those who provide it. Primary care trusts are increasingly recognised as the organisations that channel local NHS funding to both general practice and hospitals. They are also recognised, partly as a result of negative publicity, as the organisations that make decisions about access by individual patients to unusual treatments or new drugs that have not been assessed by NICE.

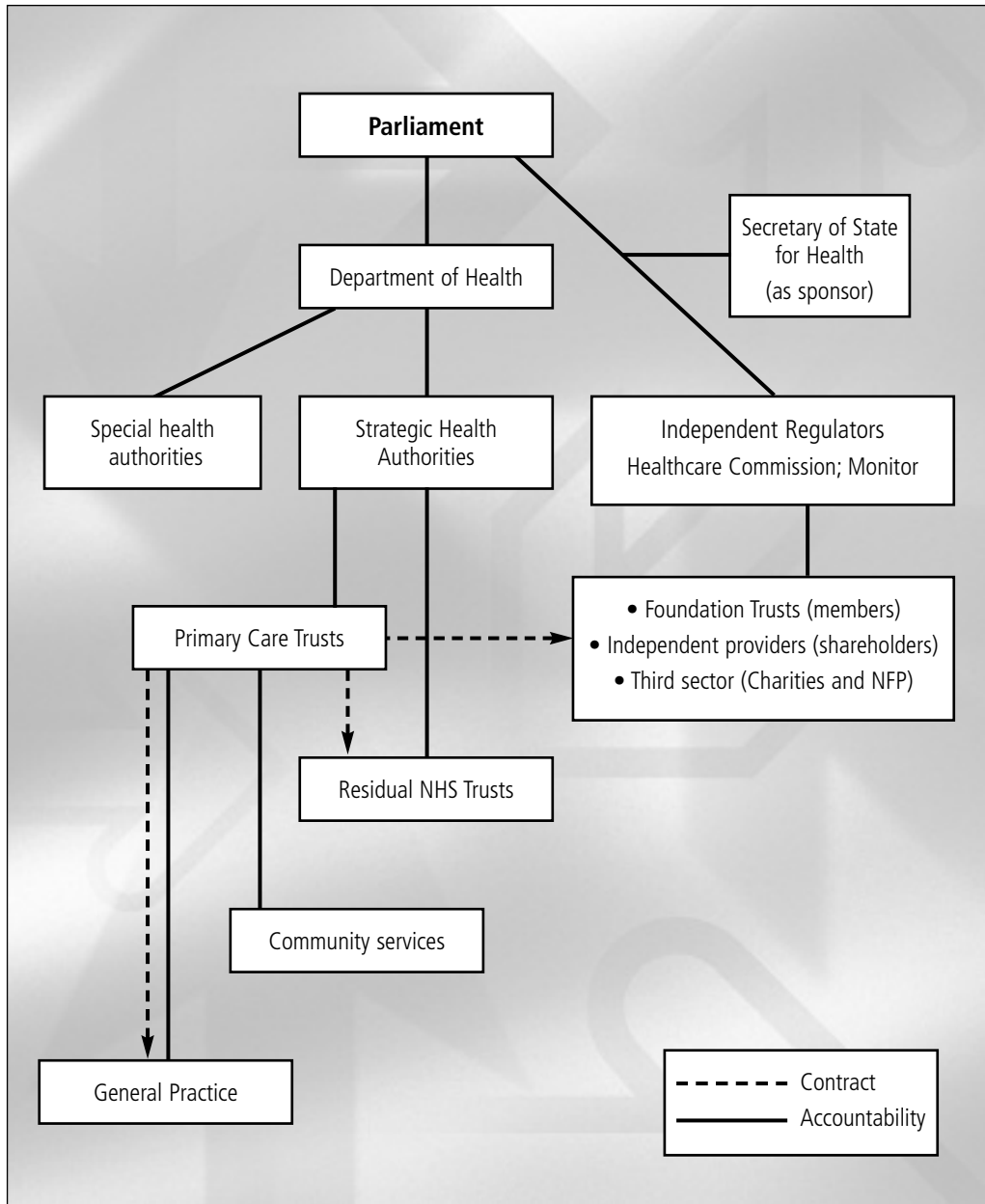
What the public does not fully appreciate is that within the relatively near future almost all hospitals will be free of direct ministerial control. They will be either foundation trusts that are accountable to their members, private sector organisations that are accountable to their shareholders, or third-sector organisations operating mainly as charities. The decision by Tony Blair and Alan Milburn to exclude foundation trusts from the list of bodies to which a Secretary of State could issue a statutory directive was deliberate, considered and political. Primary care is already led by independent general practice.

Monitor does have a duty to exercise its regulatory functions in 'a manner consistent with the Secretary of State's duties'.¹⁸ Some think that this provides an indirect avenue for ministerial intervention. Even if this were true, Monitor's role is limited to ensuring that foundation trusts are well managed and financially strong, and Monitor has limited powers to force change in the public interest or in the interests of the wider NHS.

The independent regulators are already accountable to Parliament.

Within a short time only the policy and commissioning arms of the NHS, a few remaining NHS trusts that have failed to secure foundation status, and the residue of directly managed community services will remain under direct ministerial control. Unless the status of foundation trusts is to change, the independence debate will have to focus on these remaining functions.

The NHS: England 2007



2. THE CONTINUUM OF PUBLIC SERVICE CHANGE AND GOVERNMENT AGENCIES

Background

Government agencies in their modern form began to appear after the Ibbs Report (sometimes called the Next Steps Report)¹⁹ was published in 1988. Sir Robin Ibbs was the Advisor to the Prime Minister on Efficiency and Effectiveness, and Director of the Efficiency Unit. His report recommended that the civil service should be reduced to a small core of policy makers, with other officials being transferred to work under free-standing agency boards.

The Prime Minister accepted this advice and agreed that to the greatest extent practicable the executive functions of government, as distinct from policy advice, should be carried out by units that were clearly designated within departments and referred to as agencies. Each agency would have its own chief executive who would be accountable to a minister. The minister would delegate managerial responsibilities to the chief executive, but he or she would have the authority to decide how best to run the agency and get the job done within the allocated resources. Each agency had a framework agreement with its home department and its ministers, which set out the tasks allocated to it, as well as its financial and service targets.

In parallel with these changes, the government took powers to create trading funds to finance designated central government functions (e.g. the Royal Mint).

By the mid-1990s, the agency was the principal organisational model for many forms of service delivery, including prison administration, welfare provision, many regulatory functions, and much of the logistical, procurement and administrative support for the Armed Forces. By 1997, over three-quarters of civil servants were working in agencies.

A new Labour Government in 1998 endorsed the agency model but did not envisage it expanding much further. The new emphasis was on making agencies work well by ensuring

that their targets were sufficiently demanding and transparent. The Labour Government was also looking for better horizontal working within and between Departments of State. The result of all this was Public Service and Service Delivery Agreements that fed through to the targets that ministers set for their agencies.

The latest agency review, *Better Government Services: Executive Agencies in the 21st Century*,²⁰ was completed in 2002. It concluded that the agency model had been successful in improving and in some cases transforming services and functions delivered by central government. It had brought customer focus and a performance culture into the civil service.

The most outstanding problem identified in the review was that some agencies had become detached from their ministers, and that this needed to be corrected.

Ministers and their permanent secretaries were urged to value delivery as highly as policy generation. Government agencies are not free agents – they are firmly locked within the major Departments of State. They have a measure of operational freedom, but they remain firmly accountable to ministers. The review did consider whether agency chief executives should be accountable to ministers or to the permanent secretaries, but reached no firm conclusion. Those in favour of making them report to permanent secretaries argued the case for joined-up management. Those who were against the idea were concerned about blurring lines of accountability, second-guessing operational decisions, and increased risk aversion. In any other organisation, the man or woman at the top – the permanent secretary – would have been firmly in the chain of command. Ambiguity, which is often valued in political organisations, is not highly rated in a managerial environment.

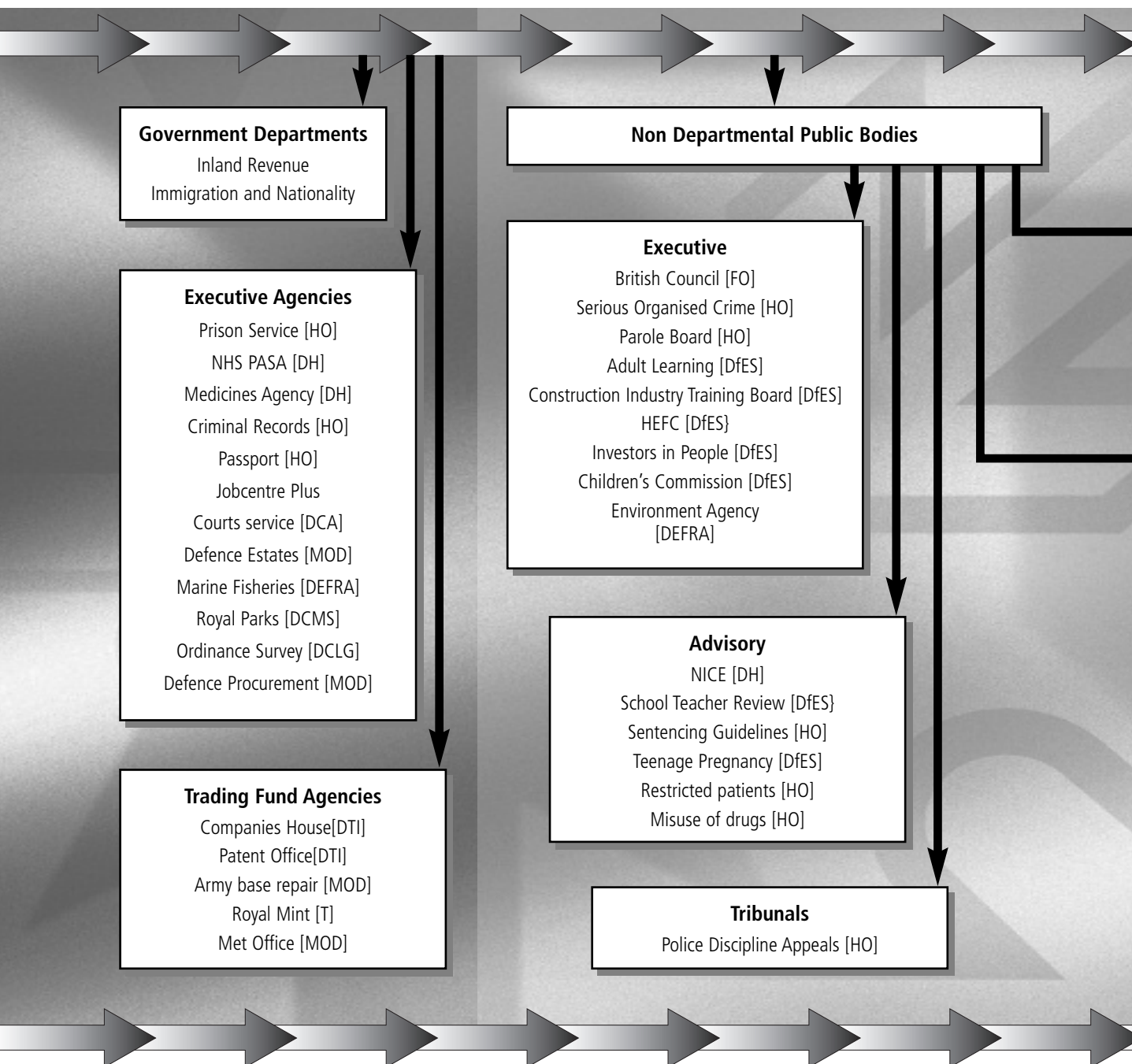
Agencies work within 3-year plans, but the range of delegated freedoms varies, with many Whitehall departments continuing to control inputs rather than specify clear outcomes. Agencies such as Companies House or the Patent Office, which are discrete businesses, have a large degree of autonomy as trading funds.

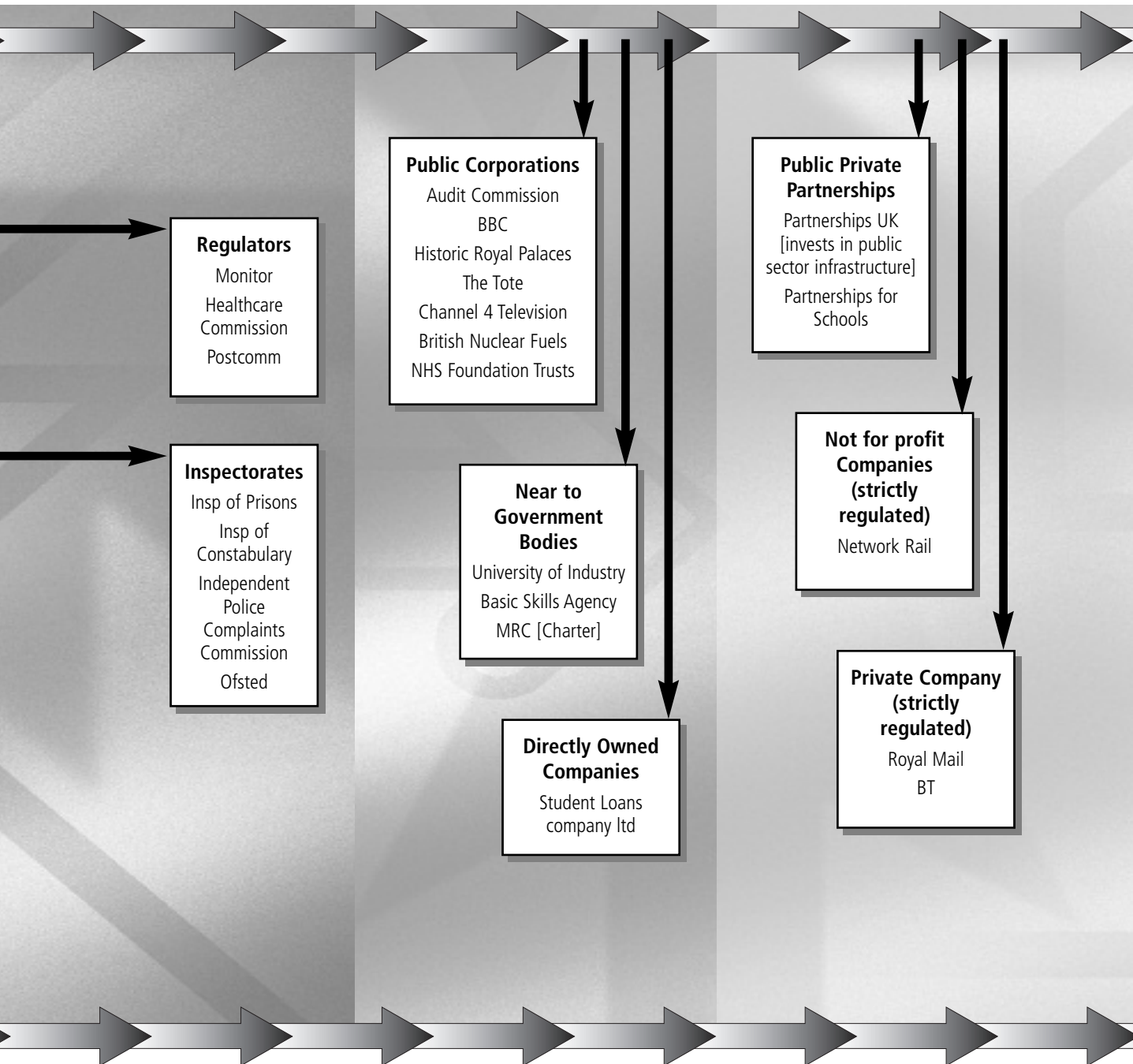
By the end of 2002 there were 127 agencies, of which 92 reported to Whitehall departments. They range in size from Jobcentre Plus, with around 90,000 staff, and the Prison Service, with 42,000, to the Wilton Park Conference Centre, which has 50 staff.

Of the 127 agencies, 49 deliver services to external customers, 45 deliver services to internal customers (mainly to the Ministry of Defence), 12 offer mainly research services, and 21 are Regulators.²¹

Only a few of these agencies have made the transition to the private sector (one being NHS Logistics, formerly part of the NHS Supplies organisation). Some, like National Savings, operating in a competitive environment, come close. The Agency now employs just over 100 staff to manage the contract and give strategic direction to an external provider which employs 2000 former civil servants.

Continuum of distance from political process





Non-departmental public bodies

NDPBs have been created in order to demonstrate independence (or perceived independence) from Ministers. Although some have the title agency in their name, such as the Food Standards Agency, they are distinctively different from the agency model. They are more independent, and have a board to whom the chief executive or their equivalent reports. They often have the right to issue reports that they judge to be in the public interest. Many have a duty to present reports to Parliament. Some NDPBs, such as the Medical Research Council and the British Council, have a charter. They are usually accountable to Parliament through a minister. In the case of the Food Standards Agency, it is accountable via a health minister in England, or to the devolved administrations in Scotland, Wales and Northern Ireland. NDPBs can be classified into four categories.

Table 2

Four categories of NDPBs

Executive NDPBs	British Council Parole Board Higher Education Funding Council Environment Agency Healthcare Commission Monitor
Advisory NDPBs	National Institute for Health and Clinical Excellence Advisory Board on Restricted Patients Sentencing Advisory Panel
Tribunals	Police Discipline Appeals Tribunal
Inspectorates and ombudsmen	Inspector of Prisons Independent Police Complaints Commission OFSTED

Public corporations

This group includes the BBC, the Audit Commission and the Tote. NHS foundation trusts are described as independent public benefit corporations. Foundation schools have governing bodies that appoint staff and own the land and buildings in much the same way as NHS foundation trusts do.

In recent years, ‘near to government’ organisations have emerged. Other bodies, such as the University for Industry and its operations arm, Learn Direct, are public/private partnerships that operate in a commercial environment with large tranches of public funds. Another example is Partnerships UK (PUK),²² which is a public/private partnership that operates solely with and for the public sector in accelerating the delivery of infrastructure renewal. It led the LIFT initiative in primary care, which was a fifty-fifty joint venture between the Department of Health and PUK. Now that the 42 LIFT companies are established, PUK has sold its 50% stakeholding back to the Department of Health.

A small number of companies are directly owned by government, such as the Students Loans Company Limited. More joint ventures and partnerships with third-sector organisations are likely, as is the growth of Community Interest Companies with their not-for-profit stakeholder governance.

The 2002 *Review of Agencies*²⁰ offered advice on how to choose a model once public service provision had been decided. The crucial factor in their view was the need for ministerial involvement or the value of independence (or perceived independence) from ministers:

Where independence from ministerial involvement is desirable, an NDPB with its statutory statement of aims and an independent Board will probably be the best option. Where the functions or services are especially politically sensitive, ministers will want to be aware of daily operational decisions. This will tip the balance towards providing the service directly via a departmental directorate or an Agency.

Separating policy and delivery has always been difficult, and the *Review of Government Agencies*¹³ argues for a tighter fit between the two across Whitehall. Agencies seem to work best when they have clearly defined tasks within established policy frameworks. NDPBs have a wider range of discretion, but again they operate within well-defined policy boundaries. Even public corporations are constrained by their Charters or foundation instruments. Within the public sector there is no such thing as absolute freedom.

Health and its agencies

The Department of Health has not followed the same agency path as the rest of Whitehall, but it does have a wide range of arm’s length bodies (ALBs) handling aspects of its work. It reviewed them all in 2004.²³ The special health authority, with its statutory base but accountability to ministers, was the health variant that was used most often.

In 2003–4 there were 38 ALBs, with a total spend of £4.8 billion and 25,000 staff. The decisions that flowed from the 2004 review resulted in a planned major reduction from 38 to 20 ALBs, which included a number of mergers. Savings of the order of £500 million are forecast from both a reduction in operating costs and increased efficiencies. The most likely future shape of the Department of Health’s arm’s-length arrangements is set out below.

Regulation

ALBs in this field hold the health and social care system to account. They often have their own primary powers under Acts of Parliament, and extra independence from direction by Ministers. According to the *Arm's Length Bodies Review*,²³ the most likely future configuration will be as follows:

The Health and Social Care Commission
Independent Regulator of NHS Foundation Trusts (Monitor)
Regulatory Authority for Fertility and Tissue
Council for Regulation of Health Care Professionals
General Social Care Council
Postgraduate Medical Education and Training Board
Medicines and Healthcare Products Regulatory Agency

Standards

National Institute for Health and Clinical Excellence

Public welfare

National Patient Safety Agency
Health Protection Agency
National Treatment Agency for Substance Misuse

Central services to the NHS

NHS Blood and Transplant Authority (special health authority)
NHS Litigation Authority (special health authority)
Appointments Commission
NHS Institute for Learning Skills and Innovation (special health authority)
NHS Health and Social Care Information centre (special health authority)
National Programme for IT (agency)
NHS Business Services Authority (special health authority)
NHS Purchasing and Supply Agency (agency)

NHS Direct became a foundation trust in April 2007. NHS Estates will be abolished and its trading arm, Inventures, disposed of.

Although some of these bodies play a role in policy formation, none of them has this as its primary aim. Policy is the role of the Department of Health, not its arm's-length bodies.

Those bodies that report to Parliament do so via the Secretary of State, who acts as their sponsor.

It is clear from the above that the Department of Health has made significant progress in generating operational freedom for some parts of its organisation, and that its regulators have an appropriate measure of independence from ministers.

Over the next few pages, this report describes different examples of industry governance which are to varying degrees controlled by government, and as such provide an insight into the possible outcome for the NHS if it were to follow such a pattern.

The most commonly cited example is the BBC, but closer observation suggests that a clear fit with health is far from obvious.

Is it ever going to be possible in health to get a working separation between policy and delivery?

The British Broadcasting Corporation

Operating income £4213 million • Staff 23,500

The constitution of the BBC²⁴ changed radically on 1 January 2007. It has a Royal Charter which will run until 2016, and which defines its public nature, objectives and constitution.

The charter makes it clear that the BBC exists to serve the public interest. It expressly allows the BBC to engage in commercial activities provided that they directly or indirectly promote the public interest and are properly proportionate to the main task.

The charter states that the BBC is to be ‘independent in all matters concerning the content of its output, the times and manner in which this is supplied and in the management of its affairs.’

The BBC Trust is the sovereign body within the BBC. It can require the executive board to act in ways that it deems appropriate, and its decisions are final. The chairman of the trust is to be known as the chairman of the BBC. The BBC Trust has its own support team and a budget which is separate from that of the director general. The executive board is responsible for delivering the BBC’s services in accordance with the priorities set by the trust, and for all aspects of operational management.

Although these two bodies are the British Broadcasting Corporation, they will never act together as a corporate body, and the charter stipulates that the trust must maintain its independence from the executive board.

BBC Trust

The trust is made up of a chairman, a vice chairman and 10 ordinary members appointed by the Queen, on advice from ministers, after an open appointments process. All four countries of the UK have at least one seat. The remuneration of trust members is determined by the Secretary of State. The trust is the guardian of the licence-fee revenue and the public interest of the BBC. It has to secure the independence of the BBC, assess the views of licence-fee payers, exercise rigorous stewardship of licence-fee monies, and ensure that the BBC observes high standards of openness and transparency. It must also ensure that in exercising its functions it has regard to the competitive impact of the BBC's activities on the wider market.

The functions of the BBC Trust are defined in some detail in the charter, and include:

- setting the overall strategic direction for the BBC within the charter and any framework agreement with ministers
- approving high-level strategy and budgets (including individual proposals which have a significant impact). They can commission value-for-money studies
- assessing the performance of the executive board, and holding it to account for its performance. In doing this it will define performance criteria, quality guidelines, and the framework within which the executive will deal with complaints.

It is the trust's responsibility to adopt and publish protocols that will govern how it discharges its functions, engages licence holders and addresses in detail its working relationship with the executive. The trust has its own chief officer and staff, and minutes of its meetings are available to the public.

BBC Executive Board

The BBC Executive Board is made up of 10 executive directors and 5 non-executive directors, and is chaired by the director general, who is the chief executive officer and its editor-in-chief. The chair/director general is appointed (and can be dismissed) by the BBC Trust.

In addition to the above tasks, the executive board appoints its own directors provided that they have been proposed by a properly constituted nomination committee. In the case of non-executive directors, the nomination committees' proposals go direct to the BBC Trust for approval before being formally confirmed by the executive board. The full executive board plays no part in determining the merits of proposals relating to non-executive directors. Premature termination of the appointment of any member can only be initiated by the chairman of the board. The board may create as many committees as it judges appropriate, but must have audit and remuneration committees upon which only non-executives can serve.

The Executive Board is responsible for:

- delivery of BBC services
- the direction of the BBC's editorial and creative output
- operational management
- legal, regulatory and BBC Trust compliance.

Framework agreement

The charter provides for agreements between the BBC and the relevant Secretary of State. The current agreement has 109 clauses. It elaborates the purposes and functions set out in the Charter, and details the agreed channel services (e.g. BBC Two, BBC Parliament, BBC Radio 4, etc.). Each of these channels has a licence issued by the BBC Trust in accordance with the rules and procedures set out in the framework agreement.

The agreement bans charging for public services, and sets out the requirements for public value tests for new services and market impact assessments undertaken jointly by the trust and Ofcom. The steps needed to switch to a digital service are detailed, as is the requirement for the trust to establish content standards and comply with programme code standards (with regard to children, etc.) laid down in the Communications Act 2003. There are rules about party political broadcasts, regional programmes, and the percentage of programmes that must be made by independent producers.

BBC commercial services have to be organised separately from BBC core services, and have to fit with the broad purposes set out in the charter. The BBC commercial strategy has to be agreed by both the executive board and the BBC Trust. There are detailed rules about financial accounting, equal opportunities, staff training, complaint handling, and the duty to cooperate with Ofcom.

Audience Councils

The charter makes provision for there to be Audience Councils, the purpose of which is to bring the diverse perspectives of licence-fee payers to bear on the work of the BBC Trust. They have a right to be consulted about major changes or reviews of service licences, and they produce an annual report assessing how well the BBC is meeting the needs of licence-fee payers. Each national member of the BBC Trust will chair the Audience Council on behalf of their country.

Comment

Although the director general of the BBC and his senior team do have very substantial operational autonomy, they are subject to significant external and internal checks and

AN INDEPENDENT NHS: A REVIEW OF THE OPTIONS

controls. The charter itself defines core functions and sets out in some detail the constitution of the corporation and the roles of its separate components. The Department for Culture, Media and Sport exerts substantial influence and control via the statutory agreement(s) that sit alongside the Charter.

The BBC Trust and its dedicated staff (who are explicitly independent from the executive board) monitor the performance of the executive board and approve its operating plans and budgets. Borrowing limits for commercial undertakings are set by the Secretary of State. Internal oversight is provided by non-executive members of the executive board (described as ‘critical friends’). Appointments to the executive board are significantly controlled by the BBC Trust.

The BBC has a duty to live within its income, predominantly derived from the licence fee, which is set by government. The BBC is also subject to the oversight of and industry-wide rules set by Ofcom.

Ofcom, which was established under the Communications Act 2003, is the regulator for UK communications industries, with responsibilities across television, radio, telecommunications and wireless communication services. It is accountable to Parliament for furthering the interests of citizens in relation to communication matters, and of consumers in relevant markets by promoting competition where appropriate.

One particularly interesting role of some relevance to the health sector is a power to intervene where there is a specific statutory duty to work towards a public policy goal that is unachievable with markets alone.

This is a very constrained operational independence.

The railway industry

Following privatisation, British Rail was divided into two main elements. The first element consisted of the national rail network (track, signalling, bridges, tunnels, stations and depots), and the second element consisted of the commercial operating companies whose trains run on the network. Trains are usually leased from a rolling-stock company. Stations are leased to whichever train-operating company is the major user of the station, with the exception of the major terminals, which Network Rail maintains itself.

Network Rail,²⁵ which owns and operates the infrastructure, is a private not-for-dividend company which reinvests operating surpluses into the network. It operates with an annual budget of £5.146 billion and is regulated by the Office of Rail Regulation (ORR),²⁶ which regulates cost and safety as well as setting the terms for access by operators to the network.

ORR enforces consumer protection within operating licences. In the financial year 2004–5 it imposed a 31% cost improvement programme on Network Rail.

The Department for Transport²⁷ awards and manages franchises to train operators (passenger and freight) as well as being responsible for overall railway strategy. Some franchises have subsidy built into them. The Department also prepares the technical strategy for systems, signalling and rolling stock. In addition, it manages the relationship with other statutory bodies, including local authorities, passenger transport executives and Transport for London. The Scottish Executive has the same responsibilities in Scotland as the Department for Transport has for England and Wales. They both sponsor the Rail Passengers Council.

Following the Railways Act of 2005, the Department for Transport created a rail group within the ministry which combines the department's overarching strategic and financial responsibilities for railways with many of the functions formally carried out by the Strategic Rail Authority. The rail group inside the Department for Transport has the following objectives:

- to ensure delivery of improved operational and financial performance and safety by the railway
- to secure appropriate rail passenger services at an acceptable price through effective specification and procurement
- to develop and deliver a robust, affordable and sustainable strategy for the development of the railway that supports wider transport objectives
- to ensure the cost-effective and timely delivery of major rail projects, many of which it sponsors.

There is an agreed protocol for handling the management of third-party plans and projects between the department and Network Rail. There are seven passenger transport executives covering the principal metropolitan areas outside London, that are funded by local district councils, which finance local rail services, offer subsidies to bus companies and provide a local transport policy framework.

Comment

This industry started life after privatisation in the 1990s with a much higher degree of separation from government than exists today. Until it was wound up in 2006, the Strategic Rail Authority was a non-departmental public body set up to provide strategic direction for the UK's railway industry. It failed mainly because its legal powers to intervene were inadequate, and what power did exist was jealously guarded by the rail

regulator. Gaining agreement to change was a slow and ponderous process. Modernisation of the railways required substantial government investment. A poor safety record did not help, and the pressure for change became inexorable.

The Department for Transport now has a strong grip on strategy, with the closure of the Strategic Rail Authority. Network Rail has substantial operational freedoms with regard to the maintenance of the network, but operates on a not-for-profit basis and has a powerful independent regulator that handles both price and safety. The train operators are constrained by the franchise licence that specifies services but not passenger price. Local authorities fund local rail services.

Timeliness and rolling stock have improved significantly, and investment in safety has increased substantially in recent years. Passenger numbers have increased, as have fares.

The railway industry experience has some relevance to the health sector debate. If government creates a number of organisations with linked but separate and legally defined functions, it is vital that mechanisms and incentives are in place to ensure that they work productively together. This did not happen in the newly privatised rail industry. Checks and balances are fine until they become blocks and barriers to sensible progress. In the case of the railways, the regulators became narrowly focused on their statutory duties, Network Rail became focused on upgrading a worn out track, and operating companies were left with unachievable service targets.

What mechanisms and incentives would ensure that any NHSA, health regulators and a mix of public and private providers were able to work together rather than getting in each other's way?

Postal services

Royal Mail Holdings plc is a commercial company that incorporates the postal services, the Post Office Network and Parcelforce.²⁸ It has a growing European parcels business. It made a profit of £537 million in 2004–5, of which £200 million went to staff in their employee profit-share scheme. The Post Office Network continues to be the part of the business that is under greatest economic pressure. Internet shopping is fuelling the postal business. The monopoly that Royal Mail had held on postal services for 350 years ended in 2006.

Royal Mail is regulated by the Postal Services Commission,²⁹ whose job it is to protect the universal service and make sure that postal operators, including the Royal Mail, meet the needs of their customers throughout the UK. It is responsible for introducing choice to a market that had been a closed monopoly for 350 years. Postcomm issue licences to postal operators. Operators that deal with mail that costs less than £1 to deliver and weighs less than

350 grams must have a licence. The Postal Services Commission regulates the prices and quality standards of Royal Mail, in view of its dominant position in the market, but not of other licence holders.

Postcomm is made up of 7 commissioners, including a chairman and chief executive. It was established by the Postal Services Act 2000, and is classified as a non-ministerial government department. It describes itself as being accountable to (but not controlled by) Parliament, explaining that in practice it is accountable to the Trade and Industry Committee and the Public Accounts Committee. Postcomm can be directed by the Secretary of State principally in matters of national security and in order to ensure that the UK complies with EC Postal Service Directives. It can be asked by the Secretary of State for information and advice in relation to postal services. Its budget and pay are approved by the Treasury, and decisions made by the Commissioners can be judicially reviewed and considered by the ombudsman. It produces an annual report.

Comment

This is an industry in transition from a long-standing public monopoly. The regulator has strong powers to secure this transition by introducing choice and competition while at the same time protecting important public values, including the universality of services throughout the UK. As the dominant provider (96%), Royal Mail is strictly regulated in terms of price and quality. In February 2007, reports began to emerge that Royal Mail was finding it difficult to settle a long-delayed funding package with the government at a time when it was losing some of its bigger customers (including some government departments) to competitors. A proposal to give staff a 20% equity stake in the business has been watered down to a 'phantom share scheme' – a profit-share arrangement rather than ownership. The pension fund remains a major problem, as does the generation of funds for modernisation. Over £1 billion is being sought as a loan at commercial rates.³⁰

This model might fit with parts of the provider side of the NHS, particularly the regulator's obligation to introduce competition into a market dominated by former public-sector players. The key difference between Postcomm and Monitor is the ability of Postcomm to regulate price.

British Telecom

The history of the telecommunications industry offers an interesting long-term perspective on state involvement in a sector that was to experience rapid technological change, and it has some interesting echoes for the current debate about the NHS.

A number of privately owned telegraph companies operated in Britain from 1846 onwards. The Telegraph Act of 1868 passed control of these companies to the newly formed GPO (General Post Office). From 1876 onwards it began to provide telephone services from some of its telegraph exchanges. However, in 1882 the Postmaster General started to issue licences to operate a telephone service to private businesses, and the telephone system grew under the GPO in some areas and through private companies in others.

GPO's main competitor, the National Telephone Company, emerged in this market by absorbing other private companies until it was itself absorbed into the GPO in 1912. A few municipally owned services remained outside GPO control. In 1969 the GPO, a government department, became part of the Post Office. Twelve years later Post Office Communications was renamed British Telecom (BT), and became a state-owned corporation independent of the Post Office. In 1982 its monopoly was broken with the grant of a licence to Mercury Communications. The company was privatised in 1984 with the sale of 50% of the shares in the company. The remaining state holdings were sold in 1991 and 1993.

Comment

BT is designated as a provider of universal services, which imposes upon it special conditions, including allowing access to the telephone network, schemes for consumers with special needs, and public call-box services.³¹ The company is regulated by Ofcom.³² This is an example of the State being in ownership at one stage of an industry's development and eventually moving out of ownership into regulation. Health may also follow this path in the longer term.

Public regulators

Almost all of the industries and services that have moved from direct public service management to a more independent status are regulated either directly or by an industry-wide body, and often by both. The role of the regulator varies significantly from sector to sector, but the range of regulation includes quality, price and comprehensiveness of service, safety and competitiveness. Independence is highly valued by the regulators and is important to the political process.

Table 3Some of the most significant regulators³³

SECTOR	NAME	ACCOUNTABILITY	ROLE
Postal	Postcomm	Parliament	Introduction of choice and competition; issues licences to operate; regulates Royal Mail price and quality
Rail	Office of Rail Regulation	Parliament	Cost and safety; terms for access to network; consumer protection
Broadcasting communications	Ofcom	Parliament	Optimal use of electro-magnetic spectrum; ensuring wide range of electronic services is available throughout UK, as well as TV and radio of high quality and wide appeal; protects audiences against offensive and harmful material, and protects privacy
Education	Ofsted	Parliament	The inspectorate for children and learners in England; inspects and regulates childcare, schools, colleges, teacher training, children's services and youth work
Energy	Ofgem	Secretary of State for Trade and Industry	Protects customers by promoting effective competition and regulating the monopoly companies which run the gas pipes and electricity wires
Prisons	Prisons Inspectors	Home Secretary	Inspect prisons

Health has its own regulators in the Healthcare Commission³⁴ and Monitor¹². The Department of Health is currently consulting about future arrangements. It has assumed that independent regulation will be essential to support changes designed to 'give people the best and the safest care possible, with the best possible value for money.'³⁵

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The government also wants to see:

effective management of the system backed by regulation that would give patients and service users confidence that whichever provider they choose, whether public, private or third sector, they can be assured of a safe and high-quality service.³⁵

The current consultation is looking at combining the Healthcare Commission with the Commission for Social Care Inspection and the Mental Health Act Commission in England. Monitor would stay in place to ensure that foundation trusts meet the requirements in their terms of authorisation, as well as approving new entrants to foundation status. Both are to be NDPBs.

In granting foundation trust status, Monitor will describe the services that the future trust is licensed to provide. For example, the foundation trust could not launch into major new clinical areas or shed responsibility for providing Accident and Emergency services without Monitor's agreement. The authorisation will also define the limit for private non-NHS work, as well as the trust's borrowing limits. Monitor has the power to intervene in the running of a foundation trust in the event of a failure in its health care standards or financial control.

Under current plans, price setting via the national tariff would remain with the Department of Health, as would competition rules, although it is envisaged that when a dispute arises that cannot be resolved by SHAs there could be an appeal to the new regulator.

One option that does not appear to have been given much weight would see commissioners undertaking their own quality assurance inspections (or creating an agency to undertake them on its behalf, like the Quality Assurance Agency for higher education), with an Independent Inspector of Health Services reporting directly to ministers.

The independent Chief Inspector of Prisons for England and Wales is appointed by the Home Secretary, from outside the Prison Service, for a term of 5 years. The Chief Inspector reports directly to the Home Secretary.

3. THE OPTIONS FOR CHANGE IN THE NHS

There are many ways of organising a health system. The models set out below assume that the founding principles of a service that is free to all on the basis of need and paid for out of general taxation will remain intact. However, it will be accompanied, as always, by health care that is paid for by private insurance and patients' own pockets.

It is not the purpose of this report to grade each model according to its fitness for purpose – this would be a much larger project. In this case, the models are represented in a loose continuum from direct ministerial control to a position whereby the government retains responsibility for funding and major priorities, but little else. The models are reasonably discrete, to aid discussion, but in practice they overlap and features of one may well fit into another.

However, there are eight criteria against which the models can be compared, as independence from political process should not be the sole criterion. The models have different impacts on issues such as democratic engagement or the ability to generate complex but integrated care pathways for patients. In a larger study, these criteria could be used to rate the different models under discussion, both in order of importance to the delivery of services, and in order of the ability of the model itself to maintain them.

The criteria are as follows:

- perception of independence by public and staff
- a managerial rather than political culture
- ability to respond quickly to changing patterns of clinical practice, and to reshape delivery systems appropriately³⁶
- ability to make difficult and sometimes controversial decisions

- visibility of leadership
- respect from health professionals
- transparency and openness
- political risk and democratic engagement.

Model 1: A modernised NHS Executive within the Department of Health

The creation of an NHS Management Board and later an NHS Executive, from 1965 onwards, was an attempt to separate out health policy from the day-to-day management of the NHS. The latter would be undertaken by the chief executive of the NHS and a top team, most of whom would be experienced managers rather than civil servants. In an attempt to create distance between the two, the executive arm was based primarily in Leeds.

The former NHS Executive was never an agency. It never had a formal constitution, standing orders or delegated powers. The chief executive and his team were expected to act as civil servants in support of ministers, with whom all decisions formally rested. The chief executive and his team had substantial influence with ministers, but few direct powers. NHS field authorities were accountable to the Secretary of State, not the chief executive. Over time, the planning and performance management functions moved steadily across to the executive so as to secure the link with funding and delivery.

Model 1 would see an executive operating in agency mode and charged principally with day-to-day management and delivery. Primary care trusts would become accountable to the NHS Chief Executive. The Chief Executive and his or her team would operate under powers formally delegated to them by the Secretary of State. A scheme of delegation of the kind operated by all major organisations would be devised. Ministers would define what decisions they would retain themselves. An early priority would be to safely transfer existing NHS trusts to foundation status.

Planning would sit uncomfortably between the Secretary of State and his or her policy team and the executive, but mechanisms could be found to bring policy and delivery as close together as possible. Major strategy would remain with ministers, but detailed clinical and managerial policies could be located primarily within the executive. Media handling would be a problem unless it was clear to all that the Chief Executive and his or her team would handle all matters within their delegated powers.

However, because the final accountability would remain with ministers, the temptation and the pressure for them to stretch across the line would be enormous. This issue arose when Michael Howard was Home Secretary. He decided that he would define the boundary between

policy and operations with regard to the prison service, and change it whenever he thought this necessary. Alan Milburn closed down the NHS Executive in 2001, declaring that it was ‘a nonsense and a fiction’. He put policy and delivery back together under a joint Permanent Secretary/Chief Executive, but Patricia Hewitt separated them out again subsequently. For this model to add any significant value, the delegation of powers and authority by ministers would need to be much more explicit than it has ever been before.

The Chief Executive, who would almost certainly be a civil servant, even if his or her career background was outside the civil service, might operate through a board which might be able to conduct some of its business in public (although this would not be the normal mode of operation for Executive Agencies). It would be by far the largest agency in government, and firmly rooted within the Department of Health. As a permanent solution, this model does not score highly as a radical new platform for modernising the NHS, although it might serve as a useful transition to later, more radical changes.

Model 2: An NHS Commissioning Authority (the HEFCE model)

A model rather like Higher Education Funding Council for England would operate as an NDPB at arm's length from the Secretary of State. It would have its own board appointed by the Secretary of State, or the Independent Appointments Commission if he or she so wished. There would be opportunity for leading professional organisations and staff to have a seat on such a board, alongside patient groups. The NHSCA would have a constitution or charter. Primary care trusts would be accountable to it, but would not need a statutory base. They would act as the local delivery arm of the NHSCA.

The NHSCA would operate within a broad planning and financial framework, agreed with ministers and embodied in an annual memorandum that was made public. Its Chief Executive need not be a civil servant. It would allocate funds to local commissioning organisations according to a formula agreed with ministers. It would consult on and produce its own 3-year commissioning plan setting out how it and its primary care trusts intended to:

- meet the targets and priorities agreed with ministers, and
- put investment into areas identified in any Health of the Nation plan.

Its primary task would be to develop commissioning skills within the NHS, set standards for NHS-commissioned care, and take the lead in building integrated pathways of care. It would be a clinically focused organisation.

Is there any purpose in having a statutory base for primary care trusts?

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As always, the difficulty would be in separating out the principal policy framework set by ministers and the planning and performance management functions of the NHSCA. National Service Frameworks of care would rest with the authority and its professional advisers. Ministers might conclude, for example, that Accident and Emergency services had a high priority for investment, but they would leave decisions about configuration to the NHSCA. The crucial test for this model is whether ministers could accept the fact that controversial configuration decisions had been made by an independent body acting after proper consultation, thus limiting any appeals to them to questions about due process. It would only work if there was a high level of trust and interaction between the Secretary of State and the NHSCA.

NICE, retaining its independent status, would present its advice to this Authority rather than to ministers. It would undertake its own provider inspections or rely instead on the NHS Commission. It would have patient focus groups to help to set commissioning standards. Providers of health care would be predominantly autonomous bodies that were separately regulated. Residual NHS trusts and special health authorities could be managed either by the Department of Health or by a stakeholder-based federation.

This model offers a means of accelerating the development of the commissioning role within the NHS. It would be able to demonstrate a significant degree of independence from ministers and build a public identity of its own. It is the model that is most consistent with current policy trends. It would leave a mix of public and private providers to respond independently to commissioned contracts for NHS work. Providers would no doubt create an association of their own, although they would of course be independently regulated.

Model 3: An NHS Corporation – as a fully managed national service

This would be a BBC-type model. The NHS would be managed as a national service incorporating both commissioning and provision. All publicly owned health assets would transfer to the corporation, including those currently in the ownership of foundation trusts. The NHS Corporation would be firmly in control of the whole system, even though it might operate in a devolved manner and have semi-autonomous provider trusts. It would be set up as an independent public corporation operating under its own charter and Act of Parliament. It would be accountable to Parliament, with the Secretary of State for Health as its sponsor.

It would be charged with managing and developing the NHS in England within a broad strategic framework established by ministers. Like the BBC, its relationship with ministers would be handled by means of a formal memorandum and a 3- to 5-year financial settlement. The parallel with the BBC might be the corporation's right to make decisions about clinical

process, provided that this could be defined satisfactorily. This model would accommodate a hypothecated health tax.

As a public corporation, it would conduct much of its business in public. The Secretary of State would require default powers in the event of a serious crisis.

Ministers would remain the guardians of the founding principles of the NHS, and the Corporation would not be permitted to vary them (e.g. by introducing part payment by patients) without ministers' express approval. The founding principles could also be embedded in the charter that might serve to enhance the Corporation's ability to generate public trust. Its non-executive members would be appointed by the Secretary of State (on the advice of the Appointments Commission, to emphasise independence). A proportion might even be elected from some kind of electoral college involving patient groups, the health professions and trade unions. The membership of the Executive Board could also be defined in the charter, or the memorandum associated with it, although the selection of individuals to fill these roles would rest with the Chief Executive and the main board.

A separation of powers of the kind created between the director general of the BBC and the BBC trustees would not be required. A more traditional board would be more appropriate. Primary care trusts would be appointed by the Corporation and would be accountable to it. These could have statutory or non-statutory boards that could include representatives from local government. GP commissioning could be one mode of commissioning care, but other models might also be applied, including local authority commissioning franchises. The Corporation would receive its funding from the Treasury and, like the BBC, it could be given powers to operate commercially in related business areas. Its capital borrowing would no doubt be capped by the Treasury. The process and formulae by which funds would be allocated to primary care trusts and thereby local communities would need to be agreed with ministers, at least in principle. The corporation would have a statutory duty not to overspend, although year-to-year flexibility could be organised in the memorandum of agreement. The Corporation would negotiate pay and also terms and conditions of service for NHS staff.

The Corporation would probably operate with regional directors as main board members, but without strategic health authorities. The directors would be charged with building the links with local government, and would be located in regional government offices. This model would not preclude the creation of integrated Health Boards for defined communities, accountable to the Corporation. There would be a national commissioning plan and defined local commissioning freedoms that could be exercised by local commissioners without prior approval. The Corporation would set standards for commissioned services. NICE could remain independent, but would report to the Corporation rather than to ministers. The Corporation might decide to run its own inspection teams, perhaps alongside an Independent Inspector of Health Services who would report to ministers.

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Foundation trusts would have semi-autonomous status, and would retain almost all of their existing operational and financial freedoms. In order to reassure existing foundation trusts, these would need to be redefined in some detail and incorporated into either the charter or (more likely) the memorandum of agreement associated with it. The Monitor oversight role relating to corporate governance and financial discipline could be performed in house. However, they would operate under service rather than legal contracts, and be subject to direction by the Corporation if required. The Corporation might want to approve trust chair and chief executive appointments and have the power to dismiss either if the trust failed in its duties.

There would need to be a robust organisational boundary between the commissioning and providing arms of the organisation, in order to avoid breaching competition rules. This could represent a major and perhaps insurmountable problem for this model.

A Monitor-type regulator would probably be required to oversee private and third-sector providers, and perhaps to regulate the prices charged by foundation trusts, because of their market domination, in the same manner as the postal services are regulated. The regulator might also have powers to check that the internal competition boundaries within the Corporation were not being breached.

The Corporation would manage or contract out core NHS services. It would have total control over IT policy and system development, and would enforce take-up within the system. It would be able to organise services in whatever way it judged would produce the best results for patients, although there would no doubt be a process, agreed with ministers, that ensured proper public consultation prior to decision making. For some specialties, the Corporation could choose to commission services for patients via clinical networks, which it would have the power and authority to create. It could also impose clinical and safety standards on its provider network, and it would have patient focus groups and professional liaison mechanisms.

The Corporation would present an annual report to Parliament, on which it could be questioned by a select committee. As an organisation, it would have to remain politically aware and neutral. The essence of this model is the control that the Corporation would exercise over the NHS system. The tension point would be the scale and range of the Department of Health's strategic planning function, within which the Corporation would be required to operate. The Department's role should focus on wider public health issues and resulting health system priorities.

The departmental role should not extend to organisational matters beyond those established in the charter. The manner in which clinical services are organised and the clinical service frameworks that underpin the commissioning process would be matters for the Corporation,

not for ministers. Any national priorities required by ministers would need to be incorporated into the annual memorandum of agreement. Ministers might demand to see improved waiting-list times, but would let the Corporation set the targets and decide how they were to be achieved. The Corporation would own its targets.

A decision would need to be taken about the right place for manpower planning and investment for the whole of the health economy. This area requires a fundamental review. The principal challenge presented by this model is its sheer size. The NHS is and would still be one of the largest centrally managed organisations in either the public or the private sectors anywhere in the world. Could it be managed as a single organisation? Could it avoid becoming dominated by its provider arm?

These are crucial questions, but we have little experience to guide us. The NHS has never been managed by an organisation independent of ministers. There are examples of large and successful organisations, but the complexity and scale of the NHS puts it in a category of its own, which must represent a significant risk.

Comment

This model is closest to what the public perception of an independent NHS would look like. However, it does represent a significant shift in policy with regard to foundation trusts, by making them accountable to the Corporation. It would be perceived inside the NHS as a centralising model. It is the only model that would enable the system to be managed as a single entity. The Corporation would find it challenging to keep an appropriate degree of separation between commissioning and in-house provision. However, it would be able to handle the impact of the one on the other by, for example, ensuring that increasing quality standards were reflected in the contract pricing. It would be a very large organisation with a strong public identity and very visible leaders. Within this model, integrated local health boards could emerge with a clear accountability to the national Corporation.

Model 4: An NHS Corporation – as a planning and commissioning organisation

This model involves a corporation along the lines of Model 3, but its role would be limited to planning, commissioning and inspecting NHS services in England. It would operate within a broad planning framework created by ministers. It could have a charter that embodied the founding principles of the NHS. Primary care trusts would be appointed by and accountable to the Corporation, and would not need a statutory base.

Primary care trusts would handle the vast bulk of commissioning for their communities, although some specialist commissioning (e.g. rare diseases) might be done nationally. The Corporation would set commissioning standards and priorities, produce model contracts and probably operate its own inspection process, although this could be done by an independent regulator. It would use its contract relationship with providers to ensure that its commissioning plans were delivered. It could commission services for patients via clinical networks involving multiple providers, although this would have to be negotiated rather than prescribed.

Primary care trusts would contract-manage general practice and other community professional services. The Commissioning Corporation (or primary care trusts) would have no directly managed services unless this was specifically provided for in the memorandum of agreement with ministers. It would negotiate GP and other primary care professional contracts payments.

Providers would operate independently under a Monitor-type regulator who would establish their statutory service obligations as well as overseeing their corporate governance and financial health. They would probably want to set up a federation to handle pay negotiations, among other things. Residual NHS trusts could be managed through to foundation status by a body that was set up on a short-term basis with this function. Special health authorities could either remain as they are or be managed by a stakeholder organisation.

The Corporation and the regulator would need to agree a process for arbitration in the event of a breakdown in contract negotiations. It would need some mechanism for collaborating with the licensed provider network so that it could share its longer-term plans with them, such as the provider association referred to earlier. The relationship would need to grow beyond the legal contract. The similarity to the relationship between large retailers and their suppliers does fit, but does not reflect the complexity of a health contract, which is for professional services rather than mass-produced goods. The Corporation would no doubt run its own patient focus groups, which would inform commissioning standards and priorities. The requirement for this could be build into the charter under which the Corporation acted.

The Department of Health would have the broad planning role envisaged in Model 3, although it could be expanded to include areas such as manpower planning for the whole health economy.

Comment

The challenge with this model is whether the commissioning levers are strong and flexible enough to deliver a modernised service to patients, and how long it would take to develop the skills to use them. A crucial test is whether the commissioning process can create or stimulate complex delivery pathways for patients, with incentives to make them seamless and effective.

The essential difference between this model and Model 2 is the extra distance from the political process that a powerful charter would provide. The title 'NHS Corporation' gives it a strong identity. It would not be able to create integrated health boards, but it would provide a powerful platform for the development of commissioning.

Model 5: A regionalised NHS

In this model, statutory regional organisations would manage their portion of the NHS within a broadly based health policy framework created by the Department of Health. There would not be a national NHS plan, but a series of linked regional plans. Like the other models for independence, there would be an annual memorandum of agreement with the Department of Health that would cover national priorities and finance. The statutory regional organisations could be either NDPBs or public corporations. They would be open to public scrutiny, and they would deal with all planning and commissioning for their communities through their network of local primary care trusts and GP commissioners.

The statutory regional organisations would have a strong local identity. They would build consortia to handle common or shared services such as IT infrastructure or pooled risk under the NHS litigation authority. They would operate a shared investment bank, although decisions about allocations to regions would have to remain at the centre. They could each have a provider arm, or more likely would conduct inspections of licensed providers. Perhaps most importantly, they would begin to build integrated services and promote the emergence of cancer and emergency networks. It might be possible to legitimise and demonstrate a value in regional variation under this model, although this would be easier if these organisations had a solid democratic platform. This implies a close working relationship, and perhaps shared membership, with local and regional government.

Which organisation should handle workforce planning for the whole health economy?

Health systems can be managed on a regional basis, as they are for example in Sweden and Spain. Under this model, regions could try different approaches, including integrated boards on the Scottish model (although this would need a statutory change to accommodate existing foundation trusts) and closer independent-sector engagement in commissioning. The regions would no doubt build their own centres to interface with the Department of Health.

There would be significant variations in patterns of investment and access standards.

Comment

This model would be at its strongest if England ever moved to regional government. However, without such a step, this approach seems unlikely. Some of the other models could work with regional organisations.

Model 6: An NHS commissioned by local government

A variant on the regional model would be to transfer health commissioning to local authorities. Joint health and social commissioning is already a reality in some parts of the country, albeit within relatively narrow boundaries. Some cities, such as London or Birmingham, would be large enough to do it themselves, but most would have to operate in concert in order to create a large enough risk pool.

London is an interesting example because of government plans to give the Mayor of London and the London Assembly new and extended powers, including some in the public health field. The Mayor will have explicit responsibility for reducing health inequalities in addition to his existing duties to seek improvements in the health of the citizens of London. The 31 primary care trusts in London could be made accountable to the Mayor, thus securing for the local authority a skill base in health commissioning.

Rather than simply transferring a service that would be wholly funded from national taxation to local authorities, they could perhaps be invited to take on the commissioning role under franchise from the Department of Health or another independent NHS body. In so doing, they would have to operate within NHS rules just like any other franchised commissioner.

Comment

This model might warrant an independently evaluated trial in one of the larger conurbations or cities.

Model 7: An NHS as a public insurance company

Under this model, either the Department of Health or an NHS Commission would license independent organisations to commission health services for individual citizens on its behalf. The NHS would thus be redefined as a public insurance company funded by taxation and drawing on the economic power of mutuality. This option stretches beyond the existing policies of any of the major parties, although it does not challenge the founding principles of the NHS. Licensed commissioning organisations could be primary care trusts or GP commissioners, or commercial organisations with an insurance background, or even large employers or trade unions. All of them would operate within the founding principles of the NHS, but in due course could move away from a rigid geographical base and offer real choice to citizens, based on speed of access and the quality of arrangements with providers. Allowing them to offer extra services that went beyond a core national entitlement (e.g. dangerous sports coverage) would be politically contentious but practicable.

Core national entitlement would have to be defined. NHS providers would be gradually moved into full not-for-profit commercial organisations. There might be a substantial short-term gain for the Treasury from the release of equity in the NHS estate. The additional management costs of this model would be substantial. Commissioners and providers would operate as autonomous bodies with a regulator who would set entry standards and rules for governance. Given the amount of public money involved, the regulator would need unfettered access to accounts and financial processes. The fundamental change under this model would be an NHS built to service the individual needs of citizens.

Comment

This model would present a major political challenge to all political parties, despite the fact that it could operate within the founding principles of the NHS. It would be a very different NHS.

Regulating an NHS Authority: the options

The question that needs to be addressed is whether the establishment of an NHSA would obviate or change the need for independent regulatory bodies. The latter are expensive and bring with them a significant level of bureaucracy. One of the principal reasons for establishing them is to gain independence from government. As Ofsted has stated, ‘Our independence means that you can rely on us for impartial information.’³⁷

With the distance from politics already secured with an NHSA, would another independent body add much value? It could also be argued with some force that the commissioning function in the NHS would be strengthened if it undertook the inspectorial role relating to

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providers who were contracted to treat NHS patients. Primary care trusts or an NHSA could create an organisation to do this for them, thus securing national inspection standards. In effect, they would take over much of the current role of the NHS Commission.

If ministers still wanted an independent inspector on top of this, they could create an Inspector of Health and Social Services, with a small national staff and complete and unfettered access to the whole system, to handle high-profile problems of national concern.

The case for regulation of providers is significantly affected by the NHSA's role in relation to them. The case is strong if the policy objective is to commission services from a wider range of providers in the public, private and third sectors. Non-NHS providers will always need external regulation.

Foundation trusts do not have to be regulated separately. They could be regulated in-house with regard to corporate governance and financial discipline. The move to NHS trust status in the 1990s was handled in the Department of Health by the former NHS Executive. So why were foundation trusts handled differently? Why was an independent regulator needed to oversee the transition from NHS trust to foundation status? In any other large organisation, this would have been a task for corporate headquarters, given its importance and the risks that it posed of compromising the continuity of patient care.

The answer lies in ministers' determination to demonstrate independence from the start and to do more than simply change the name on the door of NHS trusts. Foundation status had to be earned by demonstrable competence and financial discipline. It also made the process independent of politics. There was no room for special pleading or the weighing of political sensitivity. Once in foundation mode, Monitor has acted as a block to intervention by ministers and officials when problems hit the press. Monitor has also acted decisively when individual foundation trusts have got into financial difficulties, providing special support teams to work with the new managers. If an NHSA did have a provider arm, it would be forced to operate with Chinese walls, which an external regulator might have to inspect from time to time in order to ensure that they were working.

An NHSA would always have political problems if its commissioning arm put a trust in crisis by transferring contracts to a private-sector provider. For the Department of Work and Pensions to cancel a large postal contract with Royal Mail is one thing, but putting a local hospital at risk is quite another. Balancing the respective powers of all the organisations involved in the health sector will require fine judgement, as will the design of mechanisms and incentives for all to work constructively together. Checks and balances can easily turn into blocks and obstructions. Over-regulation will stifle initiative and enterprise, and weak regulators will not be able to protect the public interest.

All of the regulators in the models that are listed below are set up as NDPBs accountable to Parliament, with the Secretary of State for Health as their sponsor.

Option A: Two regulators

This is the Department of Health's currently preferred option.³⁵ A reconstituted NHS Commission would incorporate the Commission for Social Care Inspection and the Mental Health Act Commission. For the first time, health and social care inspection would be integrated. The commission would license and regulate non-NHS providers.

Monitor would continue to regulate foundation trusts, ensuring that they met the requirements of their terms of authorisation as well as approving new entrants to foundation status. The Department of Health would set tariff prices and issue competition rules.

This option leaves ministers with significant powers to control the NHS. Setting the tariff price for the whole health economy is an extremely sensitive and sophisticated decision, with dire consequences if they get it wrong. Ministers would still be very much in the firing line.

Option B: A single regulator

Under this option, an NHSA would operate with a single powerful regulator that would license providers of all kinds, and perhaps commissioner organisations as well. It would oversee foundation trusts and operate with a Postcomm-type brief to stimulate choice and competition across the whole health economy. It would inspect for quality and safety, and it would regulate price for foundation trusts in view of their market dominance, but not perhaps for other providers. It would set fair competition rules and arbitrate on disputed reconfigurations if appealed by local authority oversight committees.

Option C: Provider regulation only

Under this option, an NHSA would handle its own commissioner-based inspection process. It could work with a legal obligation to make inspection reports public. Monitor would regulate all providers, both public and private. Ministers might set a balance between the two, as is the case in other industries and has been the case recently in health, with ministers creating targets for non-emergency procedures contracted with the private sector. Monitor would need to consult closely with commissioners and regional directors about expanding the independent-sector market in particular localities. Monitor would also need to be involved in price setting for foundation trusts, perhaps based on an annual negotiation with the NHSA, with ministers in reserve to arbitrate. Monitor could also negotiate fair competition rules with the NHSA and the Office of Fair Trading.

Option D: Independent regulator

This option introduces the idea of an Independent Inspector of Health and Social Care who reports directly to ministers and has a small staff funded by the Department of Health. This would be over and above contract adherence inspections by commissioners and foundation trust regulation by Monitor.

4. SOME DIFFICULT QUESTIONS

This report has discussed the lessons from other sectors moving away from direct ministerial control, and has proposed a series of models. However, serious questions remain to be answered before any further change can be implemented. The status of the NHS in public perception means that major changes to its governance will be regarded as political acts, and will need consideration beyond their managerial benefits. Some of the implications of change are addressed below.

Democratic deficits

In a service that will remain predominantly publicly funded, questions about democratic oversight and public-sector values loom large.

The potential diminution of parliamentary accountability has always been one of the most powerful arguments against an independent NHS Corporation. However, all of the models described in this report retain accountability to Parliament, either directly or through the independent regulators. Foundation trusts have a line of accountability to the local members, while the commissioning organisations currently show the greatest democratic deficit.

This could be corrected in part at least by one or more of the following;

- a strong local authority presence on primary care trusts and any NHTA
- inviting local authorities to volunteer for an NHS commissioning franchise for their community. They might also provide integrated community services under contract
- direct elections to primary care trusts organised alongside local government elections
- elections to serve on a national NHTA via an electoral college involving the major health professions, patient groups, trade unions and independent members. This would do little to correct the democratic deficit, but could be a way of involving powerful groups within the NHS and securing their commitment to modernisation

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- elections or nominations to serve on an NHSA from an electoral college comprised of parliamentarians, elected local government members, a balance of health professionals and independent members appointed by the Secretary of State.

If the NHS is to get out of the postcode lottery trap, it needs a stronger democratic platform to legitimise variation.

Challenging an NHSA

Performance-managing an NHSA would remain the responsibility of the Department of Health unless independent status left judicial review as the only method by which organisations and individuals could challenge their decisions. Organisations such as Postcomm have found judicial review a cumbersome and expensive process. All of the models described in this report envisage a clear accountability to Parliament via the Public Accounts Committee and select committees. The most appropriate solutions will vary with the models, but the more they involve the Secretary of State the more they will diminish the perception of independence. Retaining the Independent Review Panel is one way forward, although it currently has only an advisory role to the Secretary of State. Final decisions lie with ministers. The panel could be given powers of decision or alternatively required to act rather like planning inspectors who hold the larger inquiries in public and allow the parties to be legally represented.

Appeals access to the panel could be limited to local authority oversight committees. Individual appeals against, for example, primary care trust decisions about entitlement to unusual treatment could rest with whatever is the higher tier of NHS organisation, or an independent panel created for this purpose.

Appointing an NHSA

If members of any NHSA are to be appointed rather than elected, the decision as to who should make the appointments will be crucial to the perception of independence. Ministers could ask the Appointments Commission to make the appointments, or limit themselves to the appointment of the chair. The process for appointing executive officers would depend on whether or not they were civil servants.

Funding questions

The Department of Health would no doubt expect to handle the principal negotiations with the Treasury about NHS investment. It would be sensible if any NHSA were a party to any discussion, particularly if the Treasury wanted to impose conditions. Once the broad settlement was fixed, there would still be decisions to be made about the basis for allocation to primary care trusts and the extent to which they were weighted for factors such as morbidity and poverty.

Significant geographical adjustments would be politically sensitive. This would probably have to be covered in the memorandum of agreement between the Department of Health and any NHTA. Pay settlements should be a matter for the NHTA, with providers having the freedom to set local pay. The independent pay bodies could continue, and the Treasury would no doubt wish to retain the power to set limits or ranges for settlement. Ministers would probably want to set borrowing limits for capital investment.

The overall NHS budget would lie with an NHTA that would be responsible for ensuring overall financial balance. We assume that an NHTA would hold reserves and operate a national health investment bank. The Chief Executive of the NHTA would be the Accounting Officer, and as such would report to the Public Accounts Committee. A 3-year operational plan would work well. A hypothecated health tax would fit any of the models.

Quality and price

There must be a connection between quality and price if the system is to stay in financial equilibrium. The economic notion that with standard prices competition can be about access and quality has yet to be thoroughly tested in the real world. Whoever determines the national tariff must have some regard to the increased cost placed on providers by other organisations within and without the system. Imposing crude cost improvement targets across the whole system is not sensible.

The decision about tariff determination is extremely important. Initially at least it would be very risky to leave this entirely with a commissioning-only body, although this might work in the longer term. An independent regulator could undertake tariff determination, at least for foundation trusts, or the responsibility for this could remain with the Department of Health. The NHS is not ready for unregulated pricing.

Price control could of course be limited to NHS providers only, in view of their market dominance. This would leave non-NHS providers to challenge them on cost as well as access and quality. The postal sector experience is very relevant in this context.

The decision about who sets the national tariff is one of the most important questions in this debate, as it goes to the heart of the power balance between all those involved in regulating and delivering healthcare.

Economic levers

The powers of any NHTA to shift the economic levers, including whether to have a tariff or not, would need to be clearly established. Could they, for example, significantly change the GP commissioning policies by expanding or limiting their role? Could they experiment with patient-held budgets? Could they introduce new penalties and incentives for providers?

There are also questions about the powers of providers. The Royal Mail wanted to share some of its equity with its employees, but was barred from doing so by the Treasury. Instead, it operates an annual bonus scheme that tracks the value of its shares. One assumes that Treasury approval would be required for any shared-equity schemes in the NHS.

This area would need careful consideration if an NHSA was to be created and given a chance to be effective. If its freedoms were too restrained, the likely benefits would diminish sharply.

Capital investment

An NHSA needs to be able to raise capital, and would probably be obliged to use the Private Finance Initiative as its primary source. Any memorandum of agreement between the Department of Health and an NHSA would have to specify limits, incorporating any limits provided for foundation trusts. There would need to be clarity about ownership of NHS assets, particularly if primary care trusts did not have a statutory base. Rules about sharing equity with private-sector organisations would need to be clear.

Internal organisation and the statutory base

The assumption is that any NHSA would shape its own organisation. However, if subordinate organisations such as primary care trusts had a statutory base, this would be cumbersome and difficult and would require primary legislation. A statutory base does demonstrate independence, but offers a limited degree of protection for an executive team that wants to challenge the centre. Some would argue that primary care trusts are the NHS with a supporting national structure, and this is why a statutory base is so essential to protect their local identity and authority.

If the NHS is to operate in a more managerial style, a statutory base for primary care trusts makes little sense and builds in inflexibility. Boards could still have appointed members. But what if an NHSA wanted to break the link with local government boundaries because they judged that it enabled more effective commissioning? For some services it might wish to commission on a regional basis or perhaps by client group. Would this be within their powers, or is it another example of a decision that would need ministerial agreement and thus have to be built into the memorandum of understanding between ministers and the NHSA? Government would have to be careful not to leave too much organisational concrete in place that would block change and innovation.

How free could a Health Corporation be to shape its own organisation? Could it, for example, break the PCT boundary linkage with local government and move it upwards towards a regional level if this was judged to be more effective?

Providers, on the other hand, do need a managing board of some kind with a legal or statutory base.

National controls over management costs would seem inappropriate. Moves to make the NHS more patient focused will lead to increased investment in administrative and IT infrastructure at a point close to patients and health professionals. Ministers might wish to exercise some control over the pay of board members.

Intermediate tier: strategic health authorities

The NHS is an extremely large organisation, even if only in commissioning. It will need some form of intermediate tier to relate to operations in the field, interface with other parts of regional government and facilitate cooperation and change in local health economies. If an NHSA retained an inspection role, this might be the place to locate the bulk of the inspection teams.

The case for a statutory base for an intermediate tier is weak if in reality regional directors are to act on behalf of the Chief Executive and a national board of which they are probably a member. If the intermediate tier did not have a statutory base, the regional teams would sit well alongside public health in the regional offices of central government.

Regional directors and their teams would no doubt have a performance management role with primary care trusts and residual NHS trusts, as well as a role in market management, including helpful facilitation and intelligence. If they felt that they had to intervene because of poor performance or problems in a local economy, it might be easier for them to do so with their national hat on.

Independent foundation trusts

The independent status of foundation trusts represents a problem for those seeking models that provide the opportunity to manage the NHS as a total system. The die may already have been cast, and commissioner contracts and competition may have to be the drivers of change.

An alternative would be to find a way of creating semi-autonomous organisations with almost all the freedoms possessed by foundation trusts, apart from their exemption from direction. The role of Monitor could be performed inside the NHSA by a Director of Provision. They could retain their freedom from performance management while in balance, and even have agreed borrowing levels for capital development. They could probably retain their membership structure as independent public benefit corporations. However, if they were to be part of an NHSA it would need to have powers of direction.

The foundation world will be opposed to the reintroduction of direction, even if these powers could only be used in exceptional circumstances in order to strategically reshape provider services. If foundation status remains the preferred model for NHS providers, the role of any NHSA has to be focused on the commissioning role.

Workforce planning

A decision would need to be taken about who would best handle workforce planning for the health sector and take crucial decisions about investment in health professional training and development. This is a predominantly national role. It could be undertaken by the Department of Health, an NHSA or an independent organisation that was charged specifically with this task. It would make the case for investment to and draw its funds from the NHSA. It might of course be moved away from the NHS altogether, and moved across to other parts of government relating to manpower and higher education. An independent body at arm's length from ministers but involving the professions is worth exploring, as is the option of asking HEFCE to manage the contracting process.

Separation of policy and delivery

Separating policy from delivery in a sector as complicated as health is extraordinarily difficult. Previous attempts within the Department of Health have never produced a wholly satisfactory answer. It ought to be possible to create some degree of separation between public health policies and NHS policy matters. Matters affecting clinical practice, such as National Service Frameworks, should be decided by an NHSA. Getting these boundaries flexible and right will be crucial to success.

Transparency

Any NHSA could and should operate largely in public, but could a modernised NHS Executive Agency do the same if that was the chosen, interim way forward? We doubt that it could, for it would remain firmly in central government. Models beyond this, including NDPBs, could operate largely in public.

Savings

All reorganisations are expensive, and promised gains are rarely achieved. The changes outlined in this paper are no different. However, significant cost savings should be possible with some options. It is the commercial operation of the NHS that is most likely to generate the highest level of increased cost, because of its business focus on individuals.

For other models, savings in overheads are achievable provided that tight control is exercised over exit costs, with natural wastage being the preferred mode of reducing staff in some parts

of the organisation, and increasing staff in others. One area for investment rather than cuts might be in the administrative and financial support to clinical teams as they reshape practice.

A remodelled NHS working within a clinical business model could reasonably set itself a target of overall efficiency gain of 10% over 3 years by bringing the whole sector closer to the clinical efficiency levels already secured by those at the leading edge of performance, shifting to more appropriate skill mixes, reducing duplication and faults in clinical process, and using the capital asset base far more productively. This would create developmental resources of around £8 billion to consolidate recent investment by government.

The Department of Health

What would happen to the Department of Health if an NHSA was created? There will always be a need for a minister, as a member of the Cabinet, to be charged with securing the public health and planning with this in mind. There will also be a need for some degree of ministerial oversight over any NHSA, given the scale of its public funding. It will be ministers who set up the memorandum of agreement with the NHSA and regularly update it. Ministers will want to act as the guardians of the founding principles of the NHS and have a default role in the event of major problems arising. The system could not be allowed to collapse for whatever reason.

Ministers would probably want to handle international and European policy matters in the health sector. There will also be a need for someone in central government to comment on the health impact of wider government policies. We see the Chief Medical Officer as the principle adviser to ministers in most of these areas. It would be a much smaller department than at present, with fewer ministers. Many of its current staff would transfer to an NHSA.

Summary of the arguments for and against an NHS Authority

Arguments for an NHSA

- A permanent and easily identifiable leadership for the NHS that transcends the electoral cycle.
- A clear NHS view available to government and the public.
- Planning and resource decisions taken by an independent body.
- Decisions, and the discussions that lead up to them, made in public.
- Less of a political football (but still a major political interest).
- The possibility of giving the professions and unions a seat at the top table.
- Space at the top of the Department of Health to shift the focus on to major public health issues.
- Some of the options significantly increase local government involvement with health and reduce perceived democratic deficits.
- Decision making will have a more sound clinical, managerial and economic foundation.
- Political bias in decision making might be reduced. It is easier to engage in public debate about controversial options.
- Some of the options introduce competition into commissioning and, as a consequence, extended citizen choice.
- Managerial competence would be the prime skill at the top of the organisation.
- Overhead costs would be reduced.

Arguments against an NHSA

- It would mean more organisational change when the NHS wants stability.
- It is never going to be possible to remove health from politics.
- There is a better chance of increased funding if politicians remain accountable and under pressure.
- Decline in Parliament's ability to hold ministers to account for the NHS.
- It is more difficult for the Treasury to make short-term funding shifts.
- Any structural change will have short-term set-up costs.

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