THE DEPARTMENT OF HEALTH AND THE CIVIL SERVICE

FROM WHITEHALL TO DEPARTMENT OF DELIVERY TO WHERE?

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Foreword

The Nuffield Trust is pleased to publish this very timely report on the structure of the Department of Health. The report grew out of the research grant awarded to Scott Greer at UCL for a study on Devolution and the NHS. The project has explored different aspects of how changing government structures have affected health services, and this report discusses how the NHS after devolution might necessitate a redesigned Department of Health. It focuses on the possible transition of the Department of Health from an "overseeing" Whitehall department in the conventional mode to an organization focused on detailed delivery.

The Trust is pleased to continue its support of Dr Greer, an outstanding academic health policy expert at the School of Public Policy, University College London and the University of Michigan.

Kim Beazor
Chief Operating Officer
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Executive summary

The years 2000-2005, when Nigel Crisp was both Permanent Secretary and Chief Executive of the NHS, will be seen as a turning point in the Department of Health. Those years marked the end of an era that began in 1983 and which will be remembered for the slow transformation of the DH from an ordinary civil service department to a distinctive department, a department with much less Whitehall in its genes (or its staff) than others, a department that is much more interpenetrated with the services it runs and far more managerial than others.

This report analyses the DH, looking at it both as a highly distinctive Whitehall department (a potential harbinger for the rest of Whitehall) and as a department that now has a chance to resolve some basic tensions in its design at the top. The first section is historical, explaining how the DH shifted over the years from being an ordinary part of Whitehall to being a department dominated by the NHS. The answer lies in the Department's role, first and foremost, as the Department of the English NHS, and the desire of politicians to manage that service. The combination of central intervention and the development of a strong, professional managerial cadre made it possible for the managers to take on crucial roles in the Department as well as in the NHS, displacing classic civil servants from power in much the same way as they displaced medical and other professionals.

The second part examines the DH today through a scan of its top leadership. It finds something startling and almost never noticed: *the Department of Health has almost seceded from Whitehall.* In summer 2005, the top leadership (30 people) included only one classic Whitehall civil servant. In May 2006, there is still only that one person- and in December he was confirmed as Permanent Secretary. The top leadership of the department is dominated by NHS managers, clinicians, and a number of recruits from the private and broader public sectors. The importance of non-departmental public bodies and the quangos (also known as non-departmental public bodies, NDPBs, or arms-length bodies, ALBs) that make up the NHS further distance the DH from its Whitehall kin. This reflects and contributes to the often noted predominance of ministers, their special advisors, and consultants in policy formulation; while they are not the focus of this study, they fashioned this department, and make much of its policy. A close examination of the DH reveals a department overwhelmingly merged into the management of the NHS, freer from the Whitehall model, more focused on subject expertise, and far closer to its constituency than any other departments. On present trends, that means that it is the future of other departments, and they will face the problems it faces today. The conclusion analyses the transformation of the DH- the factors that created it, positive and negative lessons, and the challenges of organizational memory, expertise and human resources that it faces. An appendix enters the debate about what models the DH might want to establish at the top.

Introduction: Balancing goals in the Department of Health

The Department of Health's structure and leadership must manage a variety of tensions:

- *Between policy and management*; The same 1983 reorganisation that introduced general management into the NHS (and the then-DHSS) created a formal split between management and policy that ended in 2000 with the merger of the Department and Management Executive and has now been reopened (Ham 2004:160-1). The idea is simple: politicians should make the broad strategic decisions ("policy") while managers implement it. The division is problematic. Politicians under pressure will often choose to intervene in managerial decisions, even if it is destructive. Meanwhile, policy made without managerial skills and input is likely to fail. The result is that seventeen years of departmental organisation (1983-2000) presupposed a division that was difficult to make work. That division is now being reinstated.

- *Between being the Department of the English NHS and being a wider department of Health for the United Kingdom*. It is easy to see why the DH would focus on the English NHS. The sheer size of the English NHS and its political salience each are powerful enough reasons. But that means that the DH always risks losing attention to its wider role as a DH, not a DENHS. This wider role can mean a broader focus on health, through a greater focus on public health and social care, such as that developed in all three devolved health systems. It can also mean the increasingly important "constitutional" role of the DH as the coordinator and switchbox for four health systems and their interactions with the European Union and world.

- *Between the need for democratic accountability and the unquestionable organisational benefits of stability and a coherent strategy*. Instability has always been both a feature of politicised policymaking in health and a menace to good policy or even simple administration and management. What politicians often want to do is reorganise, whether for good or bad reasons, and that means that a department geared to deliver that policy will not shield the NHS from reorganisations that are bad ideas in themselves, or become bad ideas when attempted in the midst of too many other changes.

None of these problems are unique to the Department of Health, or even to government in the United Kingdom, but the solutions that have emerged in the DH are distinctive, as are the costs and benefits.

Right now, the department is very strongly tilted towards one end of each scale: it is a department of management rather than policy, a department built around the English NHS rather than health in England or the UK; and a department focused more on democratic accountability than on a stable strategy. These decisions come about for good reasons, and have been made through countless smaller decisions by different governments since the 1970s. But balancing a department towards management rather than policy, or towards the English NHS rather than health, does not make problems go away. It empowers some groups and obscures some problems, but does not resolve the tensions. A rebalancing might be in order.

The DH is also especially important in broader debates about the future of the civil service. More than any other department, it is the Whitehall that governments want. It is one of the purest product of the delivery-oriented, businesslike “new public management” that has been orthodoxy in the UK since the 1980s. Relative to the other departments, it is focused on “delivery” rather than policy analysis; the top ranks are almost completely free of the generalist civil servants that have so often frustrated politicians; it is extremely politically responsive; it operates through an array of quangos rather than directly administering or providing services; it has a strong managerial ethos that includes accountability for failure. It is also, more than any other, the department that politicians want in that it is fragmented, incessantly reorganizing, and quite possibly is too willing to take on the implementation of political decisions that cannot be implemented. On present trends, it is the future of Whitehall, and that means that its strengths and weaknesses should be examined by more than health policy analysts.

1. Becoming the Department of Delivery

The story of the Department of Health, unsurprisingly, is deeply entwined with the history of the English NHS[1]. The DH has become the department of the English NHS, and that means that politicians have increasingly shaped its structure to allow them to make NHS policy. This has meant both increasing centralization – so that politicians can control the immense beast that is the English NHS – and increasing penetration of the Whitehall department by the NHS management that has been, since 1983, government's chosen tool with which to intervene in the NHS.

"The politics of the double bed" 1948-1983

The creation of the NHS in 1948 did not so much mean the wholesale restructuring of health services as much as it meant a shift in the financing of the existing English health care infrastructure (Powell 1997). Hospitals, professionals, and facilities remained in place but the state now owned them. What changed from the point of view of the patient was that the service was now free and universal at the point of service. The NHS had shifted the burden to the taxes. What changed from the point of view of the local hospitals and boards was that local boards no longer controlled hospitals; they now fell under several tiers of NHS authorities.

While the state now owned the hospitals, employed many doctors, was the sole significant contractor with GPs, and had the power of the purse over all of them, it took decades before it began to truly use those powers. This is the origin of Rudolf Klein's famous analysis of the politics of the "politics of the double bed" in the NHS. It was at bottom a bargain between the state and the medical profession in which the medical profession received professional and organisational autonomy while the government received a relatively cheap and efficient health service. That is because of the reality of medical power grounded not in powerful lobbies but in the role of professionals in delivering the care that justifies the NHS (Klein 1990). Interventions such as Enoch Powell's Hospital Plan of the 1960s or the Resource Allocation Working Party (RAWP) were focused on inputs; the Hospital Plan attempted to rationalise the inherited stock of hospitals, expanding where needed, while the RAWP formulae tried to equalise expenditures that were historically highly uneven (Mohan 2002). In neither case was there much management; even in areas where the state intervened often, such as London's hospitals, its intervention was more focused on planning region-wide services and distributing money than on managing what went on within hospitals (Rivett 1986). Day and Klein remark that the style of its early years that they owe a lot to "its pre-1948 mode when many health services were provided by local authorities which were guided by circular and legislation but in no sense managed. It was policy making through exhortation" (Day & Klein 1997:4)

This hands-off style of management fit with a particular kind of departmental organisation. The Department of Health had, before the NHS, been a complex department involved in health services as well as a substantial range of local government work. After the creation of

[1] Until 1998 policies in Northern Ireland, Scotland, and Wales generally tracked those in England, although there were some significant policy differences and very significant differences in implementation. Devolution meant that policy and administrative decisions made in and for England were no longer applicable elsewhere. Greer SL. 2004. *Territorial Politics and Health Policy*. Manchester: Manchester University Press, Jervis P, Plowden W. 2003. *The Impact of Political Devolution on the UK's Health Services*. London: The Nuffield Trust.

the NHS and the loss of most of its local government role, it became dedicated to oversight of the NHS and a few associated issues such as social care. Between 1968 and 1988 it was not even a department of state. It was part of the Department of Health and Social Security, with a minister of state in charge of health care. The sections of DHSS concerned with health were relatively hands-off; the NHS bodies such as regional and teaching hospital boards were allowed to make most decisions, and the closer a decision lay to the front lines, the more likely it was made by doctors with no policy or even administrative input. Their charge, the NHS, was quite stable until 1974. Its organisation, like the distribution of care and resources, was complex and largely shaped by the pre-1948 inheritance and the Hospital Plan's new buildings.

The 1974 reorganisation of the NHS reaffirmed the basic principles of autonomy. From one perspective, it was immensely centralizing and uniform; a "Grey Book" contained detailed prescriptions as to how every part of the NHS was to work. But the design was intended to strengthen devolution within the health services, putting the emphasis on frontline decisionmaking wherever possible, and leaving responsibility for most decisions with professionals and consensus committees rather than Whitehall (Jaques 1978). Instead, a combination of consensus management (which built on professional representation in decisionmaking and demanded consensus decisions) with strong territorial boards meant that the service itself made most decisions (Schulz & Harrison 1984). The DHSS was left with the problems that the regional boards- themselves important contributors to the overall stability of the system- could not solve. That was, by design, a relatively limited role. A small part of a big department could do that. Furthermore, the role was largely confined to policy and firefighting, and Whitehall civil servants were apparently thought to be just as capable of doing that in health as in other areas.

This structure was, however, doomed. From 1983 onward the story of health policy would be one of a progressively closer embrace between central government and the health service and the progressive rise of NHS management. The causes are difficult to pin down, but it is undeniable that as the press became increasingly interested in and critical of the health services, governments took on more and more responsibility for health and began to want the power to intervene in the NHS commensurate with the likelihood that they would be blamed for perceived inefficiency or failure on its part. In a Westminster system that centralises power and accountability at the top, and offers few checks and balances, governments were able to restructure not just the NHS but also the civil servants that dealt with it.

1983 and management

In historical importance, only the creation of the NHS and the creation of the first internal market under Margaret Thatcher rival the 1983 Griffiths letter (NHS Management Inquiry 1983) and subsequent introduction of general management in the NHS (Klein 2000:124-30). Managers joined the health professions, civil servants, politicians and interests as a key set of actors in health politics. The impact of general management on health services has been much studied and was indeed momentous, but the impact of management on the DH itself would also turn out to be very important.

There is one very widely cited justification for the management, taken from Griffith's short letter:

> "If Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge" (12)

Its literary qualities may have distracted observers from a fuller statement of the purpose of general management, one that explains why it was so important to have somebody "in charge" of the health services:

> "By general management we mean the responsibility drawn together in one person, at different levels of the organisation, for planning, implementation, and control of performance [which means that] there is no driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation, and monitoring actual achievement … it appears that … the NHS is so structured as to resemble a 'mobile': designed to move with any breath of air, but which in fact never changes its position and gives no clear indication of direction" (11-12)

In other words, the purpose of general management was not just efficiency; it was to introduce a direction of change – make top-down reform possible. It would allow government the option of changing the terms of trade; rather than essentially funding the professions for whatever care they delivered, it would now be able to intervene in the organisation of care and services. Managers would improve the health service not just through improved organisation of care and support services (something the consensus committees and their predecessors, "hospital administrators", were supposed to have done), but through introducing a direction and allowing the government to shape the NHS. It would not so much turf the doctors out of bed as add managers.

The first impact of the Griffiths letter was to create a general management cadre within the NHS. This meant creating responsible positions of chief executives and managers responsible for finance, human resources and other such functions at each level of the NHS. The NHS – the principal preoccupation of the DH (and of the health sections of the old DHSS) – was now to be run by managers. The development of general management across the various NHS organisations (before and after the creation of the internal market) created a substantial health services management labour market that appeared to offer more relevant skills and attitudes for NHS reformers than the Whitehall civil service.

The second impact was on the DHSS/DH. At the top, the government adopted the Griffiths view that there should be a separate management function and, at the top of the NHS, two boards and top managers sitting on them. The two boards were a policy board (Health Service Supervisory Board) and a separate NHS Management Board focused on implementation. Ministers did not opt to give either board their statutory responsibilities or powers, which hobbled both. The former advised the Secretary of State, but it could not realistically make decisions, and it turned out that its role depended on the Secretary of State's willingness to use it as a source of advice (Edwards & Fall 2005:64). The latter, meanwhile, had more lasting strength but faced the same problem- there was no obvious case for a separate board when policy and management were both often collapsed into a decision by the politicians leading the department. The effort to make the NHS look like a state-owned industry or quango, with a semblance of independent strategy and leadership fell at the first hurdle with the creation of boards that could be little more than advisory, or window-dressing. Boards would continue to come and go at the top of the Department, and the rest of Whitehall, but none had enough power to be significant structural parts of the system. The lasting consequence at the top was not the board chair, but the creation of the position of the Chief Executive (in 1986), replacing the chair of the Management Board as the top manager. Less

formally, but with enormous impact, the move to management at the top meant that there was now pressure to hire people with managerial skills and outside (or NHS) background and style rather than career civil servants.

From the top down, the key development was the Management Executive (NHSME, or ME). The Management Executive was born in 1989 as a “headquarters team” and replacement for the boards. Duncan Nichol, its Chief Executive, told NHS managers in a circular that “separating the role of managers from ministers will be a prime consideration. The implementation of policy will be the responsibility of the ME” (Edwards & Fall 2005:82). The purpose of the ME was to introduce a solid central NHS management; while it had to adhere to basic civil service principles (such as acting in the name of a minister and being tightly accountable to the ministers), it was a vehicle to introduce managerial skills and outlooks into the centre, and carve out an area of management expertise at the highest levels (the Chief Executive legally remained an advisor).

The idea of introducing managers who could use their talents and discretion on the ground to make a difference presupposed some long-term goals and strategies- policy. Policy expertise, was of course, also the chief claim of the civil service. In practice, what began to happen was that influence shifted to the managers at the top because their responsibility and expertise- the NHS- far overshadowed the other responsibilities of the Department, and it was difficult to explain succinctly why a generalist civil servant would do a better job of NHS management and policy than an NHS expert manager. The combination of a strong management function in the centre and the NHS combined with a decision to keep decisions and responsibility centralised in the Secretary of State meant that management, including clinician-managers, inexorably became a major tool of government intervention. It also meant that the case for a civil service role overseeing the system became questionable. If the department’s main activity was managing the NHS and that was now in the hands of managers, the case for a civil service depended on the existence of coordination and policy tasks outside the management needs of the NHS. Otherwise, the shift of central functions such as human resources or finance to the Executive meant shifting them away from the Whitehall civil servants. The physical move of the Executive to Leeds in 1992/3, whose chief beneficiary has been the railway network, led many officials to take early retirement rather than move to Yorkshire and allowed the Executive to be restocked with recruits of a more managerial ethos (Day & Klein 1997:14). It also failed to provide much distance from politics; “to the extent that the managers of the NHS Executive have displaced the civil servants of the wider DoH, so they have also been forced to assume the minister-centred role” (Day & Klein 1997:25). The development of the internal market under the Conservatives, reconstructed by Labour, was a further boost to the role of management. This development was largely at the expense of professionals, who found that in the new, more disciplined, trusts, high-profile managers were more able to make a mark and play a role in day to day decision-making.

The final element in this brew was the longstanding impulse towards greater centralisation and government influence in health services management (Greer 2006b). The development of general management within the NHS took place alongside the longstanding increase in the political salience and central management of the NHS. Managing the NHS became something that politicians more and more wanted to do. Reorganisations – which if nothing else require exhaustive inventories of what the preceding organisations did – increased central capacity. The skills and attitude of managers, compared to civil servants, made them more attractive agents of the government. Thus, the expansion in central capacity to control the system

mostly took place within the NHSME rather than in the DH, and came through the employment of managers in central departmental functions.

The DH since 2000

The logical endpoint of these developments came in 2000 when the jobs of Chief Executive and Permanent Secretary were merged, and the Executive folded into the DH. The core of the problem was that Secretary of State Alan Milburn and others were not able to see the justification for a separate Permanent Secretary or a Management Executive. The department, tilted firmly towards being the department of the English NHS, did not offer too much else to do, and what there was to do in social care or relations with the EU was not as politically interesting and important as the management of the NHS (in 1994 there were already more officials in the ME than in the DH)(Edwards & Fall 2005:117). The DH was the Management Executive writ large in the eyes of many, and it consequently made little sense to have, above the Chief Executive, a theoretically superior administrator (the permanent secretary) with smaller and more marginal responsibilities (even areas marginal to NHS management, such as social care or mental health legislation) were under the ME; see Fig. 1). An obvious indicator of this development is the declining number of Public Accounts Committee requests for an appearance by the Permanent Secretary. The issues that interested the MPs were the issues of the Chief Executive, not the Permanent Secretary (Edwards & Fall 2005:190). Frank Dobson said of the Permanent Secretary: “He did not have a real job to do” while Alan Milburn called the Executive “complete fiction” (Edwards & Fall 2005:159,73).

The problem with the old two-headed structure was simply that the political environment of the NHS and government strategies meant that there were obvious answers to the questions about how to balance policy and management, the English NHS and health, or central control and long-term coherence. Labour, convinced that it had to save the NHS through a programme of increased funding and deep-reaching structural change, made its decisions with all the same force and much more money the Conservatives (who had made many of the same decisions). It opted to have a management-dominated, delivery-oriented department focused on putting ideas about the reform of the English NHS into action. Wider departmental concerns, NHS autonomy, and a separation of the idea of policy were almost irrelevant to the Labour programme because they were largely irrelevant to fundamental change in the English NHS.

Merging the two top jobs and merging civil service Department with the Management Executive, to the detriment of the civil service in both cases, was another step towards turning the Department into a device for implementing NHS policies that were not always formulated within the Department. Indeed, some major strategy and policy decisions were being made outside the department’s formal structures. The prominent role of special advisors in government, which became more pronounced since 1997, is well documented. Many of the most obvious architects of the new NHS are special advisors connected to the Prime Minister (such as Simon Stevens and Paul Corrigan) or members of central units (such as the Prime Ministers Delivery Unit) rather than civil servants or managers in the Department or NHS.

The Department’s reorganisation of 2000 into business groups provided interesting evidence of the actual activities of the DH. If we assume that any departmental reorganisation is primarily about clumping functions rather than developing new ones, the three “business groups” (fig 2) that replaced the old subsections (fig 1) are quite coherent. One, “delivery,” is the core activity of the ME – management. The Chief Medical Officer’s group “Standards

and Quality" is fairly coherent and consistent across time – medicine. If we exclude those two, we are left with "Strategy and Business," a small and fairly incoherent group of functions. In other words, once we have identified the medical and managerial functions of the DH, it is difficult to find much else. The interim organisation since January 2006 shows the same problem. The medical/ public health areas remain much the same, reporting more and more clearly to the CMO, and classic NHS management functions such as HR and IT – the mainstays of the "delivery" group and the ME before it – are now the province of the Chief Executive. The middle section, directly responsible to the Permanent Secretary, is still incoherent but is more important because now social care and care standards have been moved out of NHS clinical or managerial work and are under the Permanent Secretary. All three organisations show something striking: the difficulty of finding a DH that role is neither clinical work (under the CMO) nor management of the NHS.

Meanwhile, the role and power of the DH has been changing as the government pursues agendas of contestability that include a more hands-off approach, greater use of market mechanisms, and disengagement from line management. In place of line management, what are required are regulators and enablers. These are, in practice, quangos – although they are known as non-departmental public bodies (NDPBs). Regulators ensure quality in keeping with standards set at the top; enablers, such as the National Patient Safety Agency, were created as instruments to help the centre change clinical practice after the managerial structure proved unable to do this. The result of these two drives to regulate and enable the health services led to an explosion of DH quangos. It should hardly be surprising that Secretary of State John Reid, in keeping with the efficiency drive that would produce the Gershon reforms, would order a mass cull (merger), of the many quangos as part of a DH reduction called the "Change Programme" (tables 8 and 9). But there is scope to question whether the refurbished system of quangos will deliver the accountability and direction that departmental line management did, or the local creativity that was possible before 1983.

3. Profile of the new DH

The DH that is implementing (and sometimes developing) new policies such as the diversity and choice agendas, or the NHS IT programme, is no longer the Whitehall department that administered the Hospital Plan or the 1974 reorganisation. The next section describes its demographics. It is a small department, and its top ranks are overwhelmingly not civil servants. This is partly because of the incorporation of the ME into the DH and partly because job descriptions are often written to emphasise managerial or clinical experience, and attempt to attract candidates from outside the Whitehall civil service. Many other departments have tried similar "openings" to experts and outsiders; the DH, by virtue of the dominance of the NHS in its work and the dominance of managers in that work, has done it.

This comes with the important role played by special advisors and consultants in formulating its policy. Our focus is not on them, because their influence is through the ministers who have done so much to create the DH as it is today. Still, it is worth remembering their role in fashioning the department- and in trying, however successfully, to fill in the gaps created by the transformation of the DH into a "department of delivery."

What are the key aspects of this new DH?

It is a small department
The DH has never been a particularly large department; a small number of officials develop policy for and keep watch over the million people in the NHS. It has been cut already and might be cut again, making it even smaller (and probably increasingly disorderly). Table 5 shows its small numbers compared to the others, Table 3 shows that it is biased towards SCS (upper-level) officials rather than the lower-level civil servants who dominate, for example, HM Revenue and Customs, and Table 7 shows that it does not spend much on itself as Whitehall spending departments go. Whether this is a slim and policy focused department or an awfully large number of people for a department that directly provides almost nothing depends on one's perspective.

It is scarcely a Whitehall department
Table 1 shows the biographies of the top 32 officials in the DH. Sixteen are former NHS. Six are former private sector. Only one is a career civil servant. While there are career civil servants in the lower ranks of the department, the large number of civil servants who were merged in from the Management Executive (seen in the number of civil servants based in Leeds, where the ME had the bulk of its operations, even though workforce has hived off to the NHS Confederation). But is a focus on the top ranks misleading? It is never a good idea to focus exclusively on the very top of any organisation; lower ranks (here, the lower ranks of the SCS) are very important (Page 2005). In the DH, *the lower ranks of the SCS where we might expect to find Whitehall civil servants have been radically thinned out.* Table 6 shows the increase in agency heads and other high earners, and the pruning carried out at the bottom end of the senior ranks– total numbers of SCS officials dropped from 437 to 286 between 2001 and 2005. In other words, at the top ranks the DH might have more of a "public sector" (NHS, local government, professional) ethos than a civil service ethos; civil service culture would have to be tremendously powerful to dominate a senior leadership with 1 career civil servant out of 32 and a much reduced SCS underneath it. The number of NHS managers and clinicians, combined with local government and private sector hires, should certainly give it a more managerial style.

It is a constantly changing department
Consider the last six years: three major reorganisations of the DH itself (figs. 1-3) with a high probability of another one in the months to come; the Change Programme (which reduced the DH by 720 staff, more than a third); a Gershon review commitment to savings of £6,470 million in 2007-8 (the highest 'efficiency savings' of any department); the mass reorganisation of the NDPBs that came as part of the Change Programme (which meant a 50% cut in their numbers, as shown in Tables 8 and 9, as well as a 25% staff reduction and £500m savings by 2008, the pressures of which have spawned a dedicated division in the DH in the latest organisation chart); the Lyons review (moving more than 1000 staff out of London, although the large operation in Leeds gave DH a head start, see Table 4); and one-off moves such as the transfer of most of the old ME Human Resources function in Leeds from the ME to the DH and thence to the NHS Confederation, where they became NHS Employers. This turbulence is reflected at the top, where most senior staff (excluding ministers) have fewer than five years in their posts (Table 2). Interestingly, the number who have short times in post remained broadly constant or increased from 2005 to 2006. This signals that retention problems, with consequent problems of organisational memory, morale, and knowledge management, are constant or getting worse.

It faces tremendous policy and implementation challenges
That list of internal changes excludes the even more difficult changes in the NHS that the DH has been responsible for designing and implementing: *Shifting the Balance of Power,* the diversity agenda, foundation hospitals, the NHS IT initiative, Agenda for Change and the two doctors' contracts, PCT and SHA mergers, the shift of care into the community, Payment by Results, and the simple challenges of spending the enormous new sums wisely.

Internal organisation is both consistent and unclear
The DH clearly divides into three groups: Medical, Managerial, and Muddle. This is consistent since 2000, and can to some extent be seen earlier, whether when the division was between the ME (managerial), the CMO (medical), and the DH (muddle), or in the three business groups under Crisp, or in the evolving structure today. This raises one problem: is the non-medical, non-managerial muddle an adequate foundation on which to build a department around the CMO and the CE? The constant reorganisations, meanwhile, have contributed to a lack of clarity about who does what within the structure. The 2004 annual report, for example, had a blank space for the "strategy" group and omitted the Commercial Directorate. This raises day to day problems that must be resolved by good high-level networking- for example, ministers' responsibilities do not connect well with any of the internal departmental organisations. It is inconceivable that this has not degraded the DH's effectiveness or ability to formulate and implement policy. Even if policy is increasingly formulated outside the DH, implementation suffers from instability even more than policy formulation.

It is the department the Blair government and Brown Treasury want
Number 10 has been deeply involved in the DH and the Treasury has cited it as a model department. It is clear enough that it is doing much of what the government prescribes. It is doing well with the Lyons (decentralisation) agenda, principally because it can build on its large Leeds operation (which famously led to senior staff returning to London and everybody spending a lot of time and money on trains). It has the largest Gershon savings target, has already completed its change programme, is moving on its rapid timetable to merge and cut NDPBs, and has strong links with the centre. Its Independent Sector Treatment Centres were

cited by the Gershon report as an example of good practice and its Commercial Directorate was established on the back of that success. The Commercial Directorate, in turn, is notable primarily for not having significant numbers of permanent staff, opting for temps, secondments, and fixed-term contract staff in the name of flexibility, commercial-mindedness and a low profile. Crisp's departure has been taken in many circles as an admirable sign of a managerially-minded willingness to punish failure (although the nature of the failure is unclear).

It is the department governments want
While the pace of reorganisation, new policy, hirings and firings, and other changes has clearly increased under Labour (in line with the budget), the trends that produced this department are hardly unique to the Blair government. They are, rather, the ones identified in section 1. The DH as it is today is a function of many decisions by governments since 1983: decisions to focus on managing the NHS from the centre; decisions to avoid traditional civil servants and favour managers; decisions to opt for a department of the English NHS rather than a department focused on wider health issues; and above all decisions to reorganise the NHS and the Department incessantly- decisions that over time would weed out those who would object. There is no way that Labour could have created this department, so far from the civil service norm, if it were not for Conservative policies and the creation of a managerial cadre that could be hired to staff the DH.

The DH comes closest to being the department many politicians want when they seek to make the bureaucracy more responsive- small, working through agencies, almost free of civil servants at the top (and maybe middle) ranks, less committed to job security, relatively focused on delivery of political objectives rather than policy or risk analysis, weak in policy research capacity but willing to respond to central direction, and filled with subject specialists rather than generalists. That is why it might be the future of Whitehall.

Table 1: DH Top Team by Most Significant Previous Work Experience (excluding ministers)

	May 2005	May 2006
NHS (Clinical/Management)	19	18
Private Sector	6	6
Career Civil Servant	1	1
Local Government	1	2
Other Policy	3	5
Total	**30**	**32**

Source: www.dh.gov

Table 2: DH Top Team by Time in Post (excluding ministers)

Time in Post	Number of Staff May 2005	Number of Staff May 2006	Significant Events
Under 1 Year	4	8	Payment by Results, Crucial implementation stage of Choice, Diversity and IT strategies
1-2 Years	4	4	Gershon Review published July 04, Reid announces ALB review 27/7/04, Rollout of Agenda for Change 1/12/04
2-3 Years	6	5	DH Change Programme begins Oct 2003 cutting 38% of staff, Lyons Final Report published March 04
3-4 Years	4	5	Implementing Shifting the Balance, Development of Diversity Agenda, including Foundation Hospitals
4-5 Years	7	5	Shifting the Balance published 27/7/01
Over 5 Years	5	5	Nigel Crisp becomes first to combine PS and NHS CE roles Oct 2000, NHS Exec abolished 2000, NHS Plan published 1/7/00
Total	**30**	**32**	

Source: www.dh.gov

Table 3: DH Permanent Staff by Level at 1st April 2004

Department (including agencies)	Responsibility Level	All Staff	As % of Total for All Departments
Department of Health	SCS level	370	8.2%
	Grades 6/7	960	3.6%
	All other levels	2,940	0.6%
	All staff	**4,280**	**0.8%**
All Departments	SCS level	4,510	
	Grades 6/7	26,830	
	All other levels	509,460	
	Unknown	13,310	
	All staff	**554,110**	

Source: Cabinet Office Staff in Post, April 2004 (Mandate and departmental returns)

Table 4: DH Staff by Region (Full-time equivalent, excluding advisory and ad hoc bodies)

	London	South East	South West	West Mid	North West	North East	Yorkshire and The Humber	East Mid	East of England	All regions
Department of Health (excl. agencies)	1,700	10	20	20	40	30	870	30	30	2,750
Medicines & Healthcare products Regulatory Agency	660	10	..	0	10	0	10	0	10	700
National Health Service Estates	20	0	10	10	0	0	110	0	..	150
National Health Service Pensions Agency	0	0	0	0	280	0	0	0	0	280
National Health Service Purchasing and Supply Agency	30	120	..	0	100	0	60	0	0	310
Health Total	2,410	140	30	30	420	30	1,040	30	40	4,180
All Departments and Agencies	86,840	57,360	52,630	34,800	61,580	35,710	39,140	23,180	31,100	523,580

Source: Cabinet Office Staff in Post, April 2004

Table 5: Civil Service staff employed by central government departments, 1998-99 to 2003-04

	Rank	Full-time equivalents (thousands) 1998-99	1999-00	2000-01	2001-02	2002-03	2003-04
Defence	1	103	101	99	92	89	86.1
Work and Pensions	2	87	83	82	123	130	128.6
Inland Revenue	3	53	64	67	67	71	77.3
Home Office	4	51	50	56	61	63	67.8
Education and Skills	5	34	33	36	6	7	4.5
Health	15	5	5	6	5	5	4.8
All Departments		451	458	469	474	493	506.2

Source: Cabinet Office Staff in Post, April 2004 (Mandate and departmental returns)

Table 6: DH Senior Civil Service by Salary, 1997-2005

	1997	1998	1999	2000	2001	2002	2003	2004	2005
Up to 44,999	32	14	20	3	4	-	-	-	-
45,000-49,999	73	47	57	31	15	-	-	-	-
50,000-54,999	78	75	63	60	60	25	8	-	-
55,000-59,999	101	83	85	76	52	47	26	19	17
60,000-64,999	36	71	67	68	76	66	52	40	21
65,000-69,999	26	31	34	60	75	59	61	65	44
70,000-74,999	17	28	21	21	34	55	72	59	45
75,000-79,999	12	13	15	25	25	22	30	33	28
80,000-84,999	8	14	16	13	26	18	19	23	24
85,000-89,999	4	5	8	22	13	24	21	22	15
90,000-94,999	11	7	7	9	20	17	10	9	13
95,000-99,999	4	7	6	7	7	11	18	18	8
100,000+	8	12	16	23	30	39	52	56	71
Total	**410**	**407**	**415**	**418**	**437**	**383**	**369**	**344**	**286**

Source: DH Departmental Reports, 1998-2006;
The largest number in each year is shaded

Table 7: DH Central Department Administration Costs

£ million

	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006 Plans	2006-2007 Plans	2007-2008 Plans
Staff in Post (Full Time Equivalent)	3809	3390	2964	2050	2245	2245	2245
Gross Administrative Costs							
Paybill	151	142	142	113	116	115	103
Other	135	162	155	165	162	116	126
Total Gross Admin Costs	286	304	295	278	278	231	229
Total Net Admin Costs	**278**	**296**	**283**	**268**	**263**	**227**	**225**

Source: DH Departmental Report 2006: 131

Table 8: DH Plans for Non-Departmental Public Bodies

Date	Number of NDPBs
2003/04	38
April 2004	37
April 2005	33
April 2008	20

Source: Department of Health (2004) 'An Implementation Framework for Reconfiguring the DH's Arms Length Bodies': 12

Table 9: Past, Present and Future NDPBs

Name	Acronym	Type	Function	To Be Axed?	Start Date	End Date	Government Funding	Staff
Commission for Health Improvement	CHI	EB	-	Y	Nov-99	Apr-04	-	-
Commission for Patient and Public Involvement in Health	CPPIH	EB	Regulatory	Y	Jan-03	Aug-06	33,313,000	192
Commission for Social Care Inspection	CSCI	EB	Regulatory	N	Apr-04	-	-	2500
Council for Healthcare Regulatory Excellence	CHRE	EB	Regulatory	N	Apr-03	-	-	-
Dental Practice Board	DPB	SHA	NHS	Y	Oct-93	Oct-05	23,695,000	268
Dental Vocational Training Authority	DVTA	SHA	Regulatory	Y		Apr-06	255,000	3
Family Health Services Appeal Authority	FHSAA	SHA	-	Y		Apr-05	870,000	13
Food Standards Agency***	FSA	-	-	N	-	-	-	-
General Social Care Council	GSCC	EB	Regulatory	N	Oct-01	-	65,272,000	186
Health and Social Care Information Centre	HSCIC	-	-	N	Dec 04-Apr 05	-	-	-
Health Development Agency	HDA	SHA	-	Y		Apr-05	1,320,000	131
Health Protection Agency	HPA	SHA	Public Welfare	Merged	Apr-03	-	107,276,000	2518
Healthcare Commission	HC	EB	Regulatory	N	Apr-04	-	-	728
Human Fertilisation and Embryology Authority	HFEA	EB	Regulatory	Y	1991	Apr-08	4,211,000	159
Human Tissue Authority	HTA	-	-	Y	Apr-05	Apr-08	-	-
Medicines and Healthcare Products Regulatory Agency	MHRA	EA	Regulatory	N	Apr-03	-	-	-
Mental Health Act Commission	MHAC	SHA	Regulatory	Y	1983	Apr-07	3,758,000	43
Monitor (independent regulator of NHS trusts)	-	EB	Regulatory	N	Apr-04	-	3,414,000	33
National Biological Standards Board / National Institute for Biological Standards and Control	NBSB	EB	Public Welfare	Y	DH Funded since 1976	Apr-06	10,907,000	315
National Blood Authority	NBA	SHA	NHS	Y		Oct-05	58,471,000	5920
National Care Standards Commission	NCSC	EB	-	Y		Apr-04	87,826,000	2586
National Clinical Assessment Authority	NCAA	SHA	-	Y	Apr-01	Apr-05	6,000,000	98
National Institute for Clinical Excellence	NICE	SHA	Standards-focused	Merged	Apr-99	Apr 05 (merge with HDA)	18,144,000	100
National Patient Safety Agency	NPSA	SHA	Public Welfare	N	Jul-01	-	17,000,000	170
National Radiological Protection Board	NRPB	EB	-	Y		Apr-05	6,385,000	315
National Treatment Agency for Substance Misuse	NTA	SHA	Public Welfare	N	2001	-	9,111,000	111
NHS Appointments Commission	NHSAC	SHA	NHS	N	Apr-01	-	3,448,000	48
NHS Blood and Transplant	NHS BT	EB	-	N	Oct-05	-	-	-
NHS Business Services Authority	NHS BSA	EB	-	N	Oct-05	-	-	-
NHS Connecting for Health (National Programme for IT)	NPfIT	EA	NHS	N	Apr-05	-	-	-
NHS Counter Fraud and Security Management Service	CFSMS	SHA	NHS	Y	Jan-03	Oct-05	14,715,000	249
NHS Direct	-	SHA	NHS	New Status 'outside the	-	Apr-06	-	4054

				ALB sector'				
NHS Employers Organisation*	-		Part of the NHS Confederation			-	-	-
NHS Estates	-	EA	NHS	Y		Apr-05	-	-
NHS Information Authority	NHS IA	SHA	-	Y	1999/2000?	Apr-05	266,409,000	631
NHS Institute for Learning, Skills and Innovation	NILSI	EB	NHS	N	Jul-05	-	-	-
NHS Litigation Authority	NHS IA	SHA	NHS	N	1995	-	181,560,000	164
NHS Logistics Authority	NHS LA	SHA	-	Y / New Status		Apr-06	2,200,000	1385
NHS Modernisation Agency	NHA MA	EA	-	Y		Jul-05	-	-
NHS Pensions Agency	NHS PA	SHA	NHS	Y		Oct-05	-	355
NHS Professionals	-	Not-for-profit service	NHS	New Status 'outside the ALB sector'		Apr-06	-	829
NHS Purchasing and Supply Agency	PASA	EA	NHS	TBC	Apr-00	-	-	-
NHS University	NHSU	NHS Body	NHS	Y	Dec-03	Jul-05	13,304,000	234
Postgraduate Medical Education and Training Board	-	EB	Regulatory	N		-	-	-
Prescription Pricing Authority	PPA	SHA	NHS	Y		Oct-05	64, 196,000	2919
Public Health Laboratory Service	PHLS	EB	-	Y		Apr-05	931,000	69
Regulatory Authority for Fertility and Tissue	RAFT	EB	-	N	Apr-08	-	-	-
Retained Organs Commission	ROC	NHS Body	-	Y		Apr-04	1,165,000	25
Social Care Institute for Excellence*	-	Not-for-profit company	-	N		-	-	-
UK Transplant	UKT	SHA	NHS	Y		Oct-05	9,153,000	121

Sources: Department of Health (2004) 'An Implementation Framework for Reconfiguring the DH's Arms Length Bodies', Cabinet Office (2004, 2005) 'Public Bodies'

The various agencies are classified as follows (in order of proximity to DH, closest first):

EA - Executive Agency

EB - Executive Non-Departmental Public Body

SHA - Special Health Authority

These three categories are covered by the ALB Review, the DH web site subdivides them by function as follows:

Regulatory ALBs

Standards-focused ALBs

Public Welfare ALBs

ALBs Providing Central Services to the NHS

**The DH web site lists these bodies as 'other organisations that work with the DH'. These are separate from ALBs.*

***Responsibility for reviewing PASA / NHS Logistics lies with DH CD through the Supply Chain Excellence Programme*

****The FSA is not mentioned in the ALB review, but is 'accountable to Parliament through Health Ministers' www.food.gov.uk/aboutus*

3. The DH: How it got there, and where to go now?

"Some departments have gone too far. The Department for Health, is the best example, where the traditional mandarin is a species threatened with extinction. The danger here is that the DH runs the risk of almost perfect producer capture"

- 2006 interview with a permanent secretary (Lodge & Rogers 2006)

This history is of the transformation of the Department of Health from its 1948 incarnation as a civil service department overseeing a congeries of regional and local boards to a department that was more the centre of a broader hierarchy of NHS management that stretched from the smallest parts of a PCT to Nigel Crisp. This reached its culmination in 2000 after a seventeen-year transition from being part of an ordinary civil service department (in 1983) to 2000 when the merger made it clear that the DH was, predominantly, the old ME.

These decisions meant that the DH has developed a distinctive way of balancing the different values identified at the start of this report:

- *Between being the Department of the English NHS and being a wider department of Health for the United Kingdom*. The DH, for all practical purposes, is the DENHS. Its social care role is generally agreed to perform poorly (like much of social care), but that is not new. It is poor at working on wider determinants of health and coordinating the work of other departments to healthy ends. All three of the devolved health departments put the DH in the shadow, but here the organisation of the DH reflects the clear English political preference for a focus on health services rather than wider determinants of health (and what useful coordination does go on is often in Government Offices, where Regional Directors of Public Health can work with their colleagues). Research on its international role – principally its role in connecting the *four* health systems of the UK with the increasingly important EU – did not identify any failings (Greer 2006a). The UK (including the DH) could and should be more active in shaping debates and agendas in European health policy, but that does not mean they are doing anything wrong. The DH's performance as a "federal" department responsible for coordinating between the four health systems has been deteriorating rapidly since 1998, and the Change Programme, according to interviewees in Northern Ireland, Scotland, and Wales, finished off most of the networks that had once come in handy when a coordination issue arose. Officials within the DH have to figure out who does what when they are in daily action, but a Northern Irish official complained that phones ring unanswered at the DH. The relatively clean division of responsibilities in health policy, devolved reluctance to get too much advice from London, and the DH's consequently limited role in devolved politics (Lodge & Mitchell 2006), have minimised the negative consequences of this breakdown.
- *Between policy and management*. Day and Klein concluded in 1997 that "The story of the DoH's evolution- its successive attempts to reorganise itself internally as well as its relationship with the NHS- can be read as a cautionary tale about the problems involved in separating steering from rowing" (Day & Klein 1997:4) The DH, until January 2006, had inclined further and further towards a focus on management at the expense of policy. Ironically, the secular trend towards increasing central management of the health service spanned the period- 1983-2000- in which various DH structures attempted to separate policy and management. All the while, the DH

was turning into part of the NHS management structure (and much policy was being moved to special advisors and consultants). The current government's NHS policies are intended to disconnect the DH from frontline management, replacing direct management of the NHS with regulation by and support from quangos that depend on the DH and ministers. This is far from complete; huge areas of the NHS remain under direct management and the DH must accommodate ministers if they want to reorganise PCTs or acute services. Cynics might argue disengagement defies the laws of politics and will never happen.

- *Between the need for democratic accountability and the unquestioned organisational benefits of stability and a coherent strategy.* The current DH certainly does not enjoy the benefits of stability itself, but that is largely a result of the decisions of its political masters. Neither does it shield the NHS from the storm of reorganisation. The point that too much change, even well-thought and justified change, is extremely damaging has not percolated through British government. The only potential sin is that the DH is by now, with its managerial ethos, even more likely to enable destructive levels of change and self-contradictory policies than other Whitehall departments. Media-driven rapid changes, made worse by genuine efforts to implement all the policy ideas at once, are endemic in health and the DH reflects this (Greer 2005).

As with many problems in the civil service, the problems here are ultimately the ministers. If politics demands a department geared to centrally managing the English NHS, and often managing it very badly, then the civil service will provide such a department. But there is still scope to examine the extent to which the organisation of the top levels of the DH could rebalance the department in order to pay more attention to the organisational needs of the NHS (and itself) and pay more attention to its potential role as a UK department of health rather than the English NHS.

The DH as it exists today is consistent with its past and with trends, but (consistently) lacks coherence. Consider the example of the two top jobs: Permanent Secretary and Chief Executive. The Permanent Secretary's position, currently occupied by the only career civil servant in the top ranks of the department, is obscure because the department is so overwhelmingly the responsibility of the Chief Executive and CMO. Ministers are unlikely to ask the Permanent Secretary to devise policy and pass it on to the Chief Executive for implementation when they can just talk to the Chief Executive. They certainly never did in the past. What is the Permanent Secretary there to do? It was not clear in the late 1990s, which is why the job was abolished. Meanwhile, there is also some lack of clarity about what the Chief Executive is to do. Griffith's NHS, a single large corporate organisation akin to a state-owned industry, could have a plausible Chief Executive and Board. What does it mean to be the Chief Executive of today's NHS, looking out over a landscape of hundreds of other Chief Executives, each one connected to the Secretary of State? In practice, it means being the government's top official responsible for the NHS- a policy job by any description, but one likely to be filled by a manager.

The damaging consequences of reorganisation

A careful study of the effects of reorganisation in the NHS gave us the three year rule: an organisation will take three years to recover from a reorganisation (Fulop et al 2005). Three years after its reorganisation, it will have more or less attained the level of functioning it had when the reorganisation began. This should be taken as both a guide to organisation and a

reminder of something most serious students of management and public administration know well: reorganisation can be very destructive, even if done well and for good reasons. The DH (and the NHS), if we think about it in terms of the three-year-rule, has had every reason to decline in efficiency and effectiveness almost every year since 2000. Some of the results of the survey suggest as much: when only 10 percent of DH employees agree that "change is well managed in the department" and a remarkable 71 percent disagree, it may be that there is such a thing as too much change to be managed by anybody (otherwise, about a third of employees are usually positive, a third neutral, and a third negative, as seen in reactions to statements such as "the department is well led" (27 percent yes, 37 percent no) or "I would recommend the department as a good place to work" (36 percent yes, 31 percent no)(Department of Health 2005).

The result is not just to damage morale (especially when combined with sizeable cuts). It is also to damage the departmental knowledge base. How well do we understand what people do and know in the DH? How many people have been in their jobs long enough to understand the human and policy issues involved? How well do the networks connect people who should be speaking about complex policy and implementation issues? Any managerial theory would suggest that the answer would be "badly." Problematic human resources policy leads to bad knowledge management.

Policy and management - again

The inevitable challenge facing anybody in the DH is that of running the NHS. Day and Klein titled their study of the DH "Steering not rowing", in a reference to the challenges the Department then faced when trying to create and adapt to a more complex model of NHS governance (Day & Klein 1997). If the DH has been laboriously rebuilt to be about managing the English NHS from the centre, then there is a serious policy challenge looming. The management focus of the DH was consummated in 2000 – just around the time that the government began to focus on disengaging from services. The government, relatively unconcerned about the wider DH or about a DH suited to make policy, had identified micromanagement as a key problem (partly after discovering firsthand its appeal and the problems it creates). Disengaging from the front line became an increasingly important preoccupation in policy since 2001, and the regular reorganisations have usually had important components that were intended to release frontline services from central control. The most prominent example of this form of "devolution" within the English NHS is the foundation hospitals idea. The foundation trusts "earn autonomy" through good performance on a wide range of scorecards. Foundation status liberates them from much direct management through the DH structures (principally the Strategic Health Authorities, but also the central DH). Instead, they are subject to a regulatory model in which a special finance-focused regulatory (Monitor) and a quality regulator (the Healthcare Commission) police them. Instead of being managed, runs the theory, they will be regulated. This will, among other effects, put them on a much more even footing with the various independent (mostly private) sector projects such as treatment centres that are being brought into the NHS.

For the DH, the consequence of this policy trajectory will be declining demand for its line management function. While, for a foundation hospital, the Healthcare Commission and Monitor are supposed to loom larger than the line management capacities in the DH, those two organisations will receive their "steer" from, and their work will be influenced by, the Secretary of State. This is, if anything, more centralised than any previous NHS structure, because it gives the centre the ability to influence the very powerful regulators without incurring the costs of actually implementing policy and managing change (it also leaves open

direct DH involvement if politicians really want it). It does, though, reduce the scope for micromanagement and high-level political intervention in any one hospital's problems. Constant centralisation in the name of decentralisation is an ironic theme that runs throughout English health policy since 1974 (Greer 2006a). It also raises fundamental questions about the structure of the DH. A department that was finally, in 2000, turned into the top rank of a relatively unified NHS management structure now must adapt to the new mix of NHS autonomy, regulation, private sector contracting, traditional top-down management and non-NHS responsibilities as diverse as EU policy, social care standards, and international professional mobility. There is no reason to expect that NHS managers should be particularly well qualified to work in this environment.

Sacking Sir Humphrey: Civil servants, managers, and others

In addition to these issues in the top jobs, there is a basic question that the DH has, until now, been answering without many people noticing. That is: should jobs be held by career Whitehall officials or outsiders- and if outsiders, who? Governments have repeatedly opted to write job descriptions and run searches targeted to NHS managers and people from outside the civil service, hoping thereby to bring in management expertise that civil servants are thought to lack. They have been startlingly successful in the DH, in part because they can draw on the large NHS managerial labour market. But the 2006 changes in responsibilities raise the question, one that is echoed by other Whitehall departments and many polemicists, of whether and why it is a good thing to have career Whitehall civil servants.

The answer requires rehearsing some of the virtues classically ascribed to them: policy expertise; an independence that allows them to put the brakes on bad policy decisions; networks and common ways of work spanning government, and they have a combination of political attentiveness and policy expertise that is rare and admired by other countries (Campbell & Wilson 1995). These are all the envy of many other comparable countries, which cope with problems of bad policy and bad coordination that overshadow those faced in the UK. The UK, for example, is widely known to have, along with France, the best policy machine in the EU for dealing with EU affairs, and this is because the UK civil service is very good at identifying contradictions and ironing them out in formulating a coherent "line" – a direct result of its centralisation, uniformity, and consistent ways of working compared to systems with more subject specialists. Career civil servants offer a small brake on bad, fragmented, government because they allow officials to both communicate with each other on common terms and block or edit bad policy decisions. They support ministers, often with considerable political savvy. Finally, the civil service is politically neutral; the machinery of government can run independently of the politicians who come and go. Calls for greater "delivery" from the civil service, from Labour and Conservative governments alike, often shade over into demands that the civil service sacrifice political impartiality in order to deliver that most important goal- good news stories.

The case against civil servants starts with the fact that the civil service has no good mechanism for identifying and dealing with any but the most egregious (illegal) forms of failure. This means that its potential policy expertise is weakened. The generalist tradition means that officials, especially at the middle levels, are much more likely to work out policy based on a "steer" than to identify and protest at bad policy ideas coming down from above than some theorists of the civil service would like. Managers, culturally, might be less likely than civil servants to question bad policy (trying instead to deliver it), but there is not much evidence of that and the loyalty of Whitehall civil servants to their ministers can easily overwhelm their loyalty to what they might consider good policy.

In the end, the lesson of the DH for debates about the virtues of the career civil service is probably that replacing civil servants with outsiders does not solve the problems that it was supposed to solve. It does, apparently, erode the networks that make intra-governmental coordination and intergovernmental relations work well. But it does not obviously improve the quality of policy much, and it is difficult to identify the likely extra contribution of managerial expertise at the top because it is so often drowned by waves of self-contradictory policies. If the DH is the DENHS, then there is little case for career civil servants; their networks and ways of working across departments have less value when the DH is focused on running the NHS. If it is a hub for regulatory and enabling quangos, then there might be a strong case for civil servants with policy expertise, supported by units such as the Commercial Directorate that would be called in for technical tasks. The ideal would be a department with policy analysis skills that could draw on Whitehall political neutrality and networks, stand up to ministers and managers, and still have the expertise of the NHS management as well as its culture of accountability for success and failure.

But in the meantime, it is difficult to say that the politicians' favourite solution to policy problems – blaming Whitehall civil servants – really solves much. It is very important that the DH has moved so far away from anything like Sir Humphrey while resolving so few of the problems of inefficiency, instability, and policy failure that such a move was expected to solve. The Government is proud to report in a summary of its capability reviews that there is increased hiring from outside the career civil service; the DH experience suggests that this will produce a loss of coherence, knowledge, and esprit de corps without necessarily improving policy, management, or "delivery" capacity. Sacking Sir Humphrey doesn't do the trick, so perhaps the problem lies in structure.

Conclusion

The DH is the department politicians want. It has become, more than any other Whitehall department, what Alan Milburn asked it to become: a "Department for Delivery". This is the product of many years of clearly expressed preferences of Conservative and Labour politicians for outsiders with NHS managerial expertise. That means it has shared the fate of the NHS- just as doctors and other professionals saw their power reduced by a management cadre that could promise more of the strategy and practical outcomes that politicians want, the Whitehall civil servants were edged aside as management became the way politicians interacted with the NHS and the salience of the NHS made politicians more likely to interact with it. Managers promised to do a better job than doctors or civil servants in running the NHS, and politicians over time have agreed. As politicians come to depend less on their departments and more on special advisors, the Treasury, and the Prime Minister for policy, they are presumably more prone to demand delivery, rather than questions, analysis or strategy, from their departments.

The DH became this way:

- Because of organizational changes intended to sharpen and extend managerial capacity. New units such as the ME and the Commercial Directorate carve out areas of non-Whitehall expertise and culture, and because they fit government priorities came to occupy more and more of the space.
- Because of hiring decisions designed to bring in outsiders, often because of a vague sense that hiring more managerially minded officials would solve problems. It is an irony that the main effect was to fill the Department with NHS managers, rather than the desired, presumptively efficient, outsiders.
- Because of the focus of the DH on managing the English NHS. Ultimately if that is what ministers want, that is what the DH will look like. The question is whether ministers will continue to want to manage the English NHS (political history suggests that they will), and whether it will continue to be accepted that the way to do that is to hire managers.

This balance - towards the English NHS, towards management, and towards political responsiveness - has changed the makeup of the department itself, in structure and staffing. The result is a combination of two problems:

- Problems of human resources. The DH's level of instability is by any account detrimental to organisational functioning. It should be no surprise if the DH, the Government's tool to reorganise the NHS, bends when politicians try to use it.
- Consequent bad knowledge management- lack of organisational memory and understanding of the phenomenally complex creature that is the NHS. Subject expertise is valuable, but not if it comes at the price of poor networks, information flow, and misunderstanding. This shows in both implementation problems and in difficulties with policy formulation.

Solutions might be:

- Less reorganisation. Ministers might see many reasons to reorganise, but the effects are damaging and the DH is past the point at which any organisational change, no matter how sensible, damages teams, morale, coherence and knowledge management.

If nothing else, there seems to be a trade-off between reorganisations: the more the DH is reorganised, the less capable it is of reorganising the NHS.

- The problem is no longer lack of experts and outside perspectives- it might even be a surfeit of them. Government policy for decades has been mostly about changing official culture and staffing to be more managerial and outward-looking. With 31 of 32 top officials coming from jobs outside Whitehall, it is hard to see how this could go further in the DH.
- Individual memory is the building block of organisational memory, and memory is crucial in complex areas such as health. Do we know what knowledge of the NHS and organisational memory exists in the DH, where it is, and how it can be best used?
- Organisational memory and joined-up government often come through stable staff. What incentives are there to encourage retention, and should the DH perform better?

The DH, then, is NHS-dominated, with a strong managerial ethos and very little civil service representation at the top. This is the outcome of a long process in which managerial skills came to be valued more than those of the civil service and the management of the NHS more than the broader remit of health. The process was much the same as the better-studied one by which management dislodged professionals in the NHS. The DH is now also as turbulent as the NHS because, like the NHS, it is a victim of media-driven policymaking and the plasticity of much English public administration. And that almost certainly means that the organization and staffing of the DH itself has contributed to the confusion and contradiction that marks much health policy today.

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Appendix: Models for the future

The three-year-rule and reasons not to reorganise

In thinking about the organisation of the DH, the three year rule means that the first goal should be to minimise change. The three-year rule suggests that if change stops now, the DH will, in 2007, start to attain the level of performance it enjoyed in 2005 when the Change Programme began, and the NDPBs should be running properly in 2011. Given the pace of change in the NHS, it would be helpful to have a DH that was able to focus entirely on the NHS and not be challenged by its own problems. Looking at the essential stability of core functions in different organisations (medical, managerial, and muddle), it is difficult to see much case for the reshuffling of organisational units anyway.

Jobs at the top

The rule of minimizing change can be bent at the very top levels because it involves relatively small numbers of people, each with considerable power, and personality politics will necessarily influence their relationships. But history shows that job descriptions and lines of authority very much matter. There are two issues in considering them. One is the design of the jobs. The other is whether jobs should be filled by traditional Whitehall civil servants or by recruits from outside (which usually turns out to mean the NHS). It is worth remembering that in the new English NHS performance management should be less important than working with regulators and enablers, commissioning, and coping with complex questions of finance, and managers might not be the obvious best choices to do these tasks.

In thinking about the design of the jobs, there are a number of more or less radical options. Some of the most interesting and radical have been foreclosed for the short term by the decision to opt for a Permanent Secretary and a Chief Executive, but they can have some value for future reorganisations at the top (which are never that far away in DH time) and highlight important issues:

- The two-headed model. This was in effect from 1985 to 2000, and is about to return. On paper, this model looks coherent- a permanent secretary responsible for Health and policy, and a manager responsible for running the NHS well. One informed commentator explained that returning to it also might improve the quality of policy: “the permanent secretary could act as a counterweight to over-enthusiasm for change” (Cowper 2006:10). The problem, over and over again, is that for ministers and most officials alike the DH is the DENHS – that is, the Chief Executive’s territory – and the Permanent Secretary ends up without a role commensurate with the title. Very different Chief Executives, Permanent Secretaries, and ministers have repeatedly found this to be a problem. We can expect that it will be a problem again (Edwards & Fall 2005). The only way to get around this is to use the presence of a Permanent Secretary to rebalance the DH away from being the DENHS. This would involve an explicit job definition and mission to improve the DH’s function as a coordinator, an international representative of the UK, and an advocate for cross-governmental work on the wider determinants of health (in the latter, it would follow the devolved health departments). Such a move would be completely coherent with the government’s focus on disengaging from managerial questions. The skills and stature of a

Permanent Secretary of a great Department of State could make DH start to harken back to the pre-1948 days when it worked across a broad range of fronts, without a public health role limited to overseeing the formal "public health function" and strong ties across Whitehall and the public sector. Nobody below the rank of a Permanent Secretary is likely to have any chance of being able to mount a consistent challenge to unhealthy policies in other departments. If the ministerial will - the absolute requirement for such policies - is there, then a Permanent Secretary could carry out this task. More prosaically, almost nobody but a Permanent Secretary can effectively perform the role of cross government liaison. If the division does not come with such a change of focus and job description - one that could make it easier to implement much government policy - then the pressure will build once again not to have two NHS bosses when there is only job enough for one.

- The one-headed model. This was the model under Nigel Crisp- a Chief Executive in charge of, basically, the NHS. If the DH is the DENHS, then there is not much case for a Permanent Secretary looking after corporate services and social care and otherwise getting in the way between the Chief Executive and the Secretary of State. The one-headed model at least makes things clear that the focus of the Department is running the English NHS (directly or via quangos), and letting other policy areas operate on autopilot. If the DH has adequate investment in policy analysis capacity, and is able to identify and propose solutions to issues such as EU policy without having a dedicated person at the very top of the organisation, this is a completely coherent structure for a DH of more limited (but still vast) ambition.

- Primus inter pares. One option, not taken this time but open when the Chief Executive post next comes vacant, is to keep a Permanent Secretary responsible for health including the NHS and then have not one but a number of top directors for the DH. This model is especially appealing if the government's pluralisation agenda continues, with more work done through DH-directed quangos and less management. The DH should, under such a model, be involved in financial framework decisions, workforce planning, research, and a number of such discrete categories. Overall general line management by the DH should have been engineered out of the system wherever possible. This in turn raises the question: why does the NHS then need a top line manager such as the Chief Executive? The Permanent Secretary could then be first among equals with directors of finance, workforce, research, Chief Professional Officers, and (probably pre-eminent among them) the CMO. Territorial directors responsible for regions could also be valuable. In other words, rather than identify running the NHS as the main thing that the DH does, it could identify its role as supporting the NHS in regulation, finance, workforce, etc. The Department could identify and focus on its existing functions by having directors for each who answer to the Secretary of State, with the Permanent Secretary to arbitrate, coordinate and develop an overall *health* strategy. This option is precluded for the short term, but organizing the tier of jobs just beneath into clear and useful roles could pave the way for it in the future, as discussed next.

Beneath the level of the two top jobs, there are other questions about the structure of the most senior management tiers of the DH.

- How should directors be appointed? There is a sturdy tripartite organisation in the DH, made up of management, medicine, and muddle (also known by titles such as

"strategy" and "business"). The third, muddled, section could benefit from some clear thinking about the functions it performs. Above all, this is a tier at which there is some scope to institutionalise the DH as a department of Health. Much work has been put into connecting social care with the NHS, but there is also a good case that social care, now disconnected from the NHS, could be given a higher profile and its leadership encouraged to work across the DH as well as broader Whitehall on issues such as children, local government reorganisation, and communities.

- Then, there is an implicit decision to manage the NHS functionally, with managerial divisions such as workforce and IT. Before such a decision is taken, there are other options to consider. One is to bring the DH structure, currently not very regional (table 9) into line with the developing regional structure of the rest of England; rather than have functional lines of authority, the DH could build on the England's regional map (already the template for Regional Directors of Public Health and the new Strategic Health Authorities). This would fit with the increasingly interesting functional regionalism of the government. Elected regionalism might have died ignominiously, but ever more departments organise themselves around the eight "standard regions" because it works (Sandford 2005). Many of the unheralded successes of joint working are in regional Government Offices, where small size and multi-departmental working mean we find public health integrated into EU funding bids or a small breach in the walls that separate transport and local government in Whitehall. Going far down this route could require substantial legislative change to the NHS (by, for example, severing the direct accountability of trusts to the Secretary of State, routing it instead through regions/SHAs and making them jointly responsible with quangos for commissioning and managing local health economies). One small change that could be made now would be to incorporate the new SHA leadership into any DH board. The justification for trying to do this would be that it would put the DH leadership more in touch with the incredibly complex situations on the ground in the NHS today, situations whose complexity can be obscured by functional divisions, and incidentally would make the DH more sensitive to cross-departmental work. Given departmental boards' permanent tendency to become mere ornament, there is not much to lose and potentially valuable lessons about organisation to be gained.

- In the functionally organised parts of the DH – such as commercial, IT, workforce, and so forth – there is a case for the roles to be clearly defined as the jobs are renewed. The exercise might be valuable in itself, smoothing out problems, but it would be particularly valuable as a method to identify misfits between the structure of the DH, the responsibilities it has, and the responsibilities it is supposed to have in five years (for example, "Access" should mean something wholly different in a few years when waiting lists are shorter and trusts are increasingly regulated by quangos).