

INDEPENDENT NHS SIMPLER QUANGOS

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Independent NHS, Simpler Quangos

Summary of Recommendations

Introduction

- The byzantine structure of Department of Health and Social Care (DHSC) and its 19 quasi-autonomous non-governmental organisations (quangos) is expensive, to some extent counter-productive, confuses lines of accountability, allows ministers and civil servants to interfere with the NHS. In short, it prevents NHS managers from managing the NHS.
- This paper is only concerned with the operational independence of the NHS and the arms-length bodies of DHSC and not inner functioning of the NHS.
- Furthermore, it does not address adult social care because it has no quangos at all and appears to have had minimal attention from the department even though it has had this responsibility since 2012.¹
- We propose a simplified DHSC quango structure, with responsibilities more clearly delineated, bodies merged where possible, scrapped when unnecessary. Furthermore, the NHS needs independence to be more effective both from the DHSC and its quangos.

Make NHS England a publicly-owned corporation/transfer governance to an independent board

- As now constituted, NHS England is the UK's largest quango. But the quango model was never designed for huge, multi-billion pound organisations. Such monoliths need constitutions with enough independence to govern themselves and prevent interference from politicians, quangos and civil servants which damages morale and performance.
- The BBC and the Bank of England are possible models for NHS England. The board would still be accountable to, and have long-term budgets set by, ministers, but day to day management left to the NHS itself albeit with external quality control and regulation.

Changes to quangos

- We distinguish quangos engaged in regulation and inspection to raise quality standards, such as the Care Quality Commission, from those merely providing advice to management. The former need to be retained, at least to some extent, whereas NHS performance should be improved without the interference of the latter group.
- Abolish the Independent Reconfiguration Panel, National Information Board and NHS Improvement – they blur responsibility across different bodies and make management more difficult. Their sole purpose is to tell NHS managers how to do their jobs. Yet if advice is necessary, management can consult with appropriate experts – there is no reason to maintain a plethora of parallel organisations.
- Merge Public Health England, Health Education England and the Health Research Authority into a single organisation responsible for public health – functions of HEE should be given over to universities, while the HRA duplicates much of what is already being done by the Medical Research Council.

¹ <https://www.adamsmith.org/blog/care-about-adult-social-care>

- Merge National Institute for Health and Care Excellence (NICE), British Pharmacopoeia Commission, Commission on Human Medicines, Medicines and Healthcare Products Regulatory Agency into a single organisation responsible for medicines and technology. Whilst the products under consideration differ, the approval processes are much the same.
- Such reorganisation would reduce the number of quangos from 19 to seven save approximately £750 million a year and, perhaps more importantly, release top managerial time to realise the efficiency that can be made in the system, e.g. improved use of surgeons and operating theatres, and reducing unnecessary administration. In addition, a reduction in the number of quangos needing management, care and communications could save up to half the DHSC staff and save a further £40 million per year.

Introduction

“The NHS more and more resembles an organisational shantytown in which structures and systems are cobbled together or thrown up hastily in the knowledge that they will be torn down in due course.”

Kieran Walshe, Professor of Health Policy Management, University of Manchester, 2003

Arguments about the state of public healthcare in Britain tend to fall into two categories. Firstly, there are those that call for more money. Secondly, there are those that call for more or less specified reforms. This one falls into the latter category.

Everyone agrees that the British healthcare system is complicated. Many agree navigating it is too difficult. And some even agree it could and should be simplified. But when it comes to the question of how to do it, remaining consensus vanishes, save perhaps the warnings to not make it even more complicated.

Andrew Lansley’s reforms which brought us the system of Clinical Commissioning Groups (CCGs) in England also gave rise to a single point of consensus: no more top-down reorganization of the NHS. Such was the trauma of uprooting the old system and getting the creaky oil tanker ready for the new one, any suggestion of doing that again is unlikely to win over many people.

What is being proposed here is not a reorganization on an Andrew Lansley-like scale. It’s merely a clean-up of the byzantine mess which is the never-ending labyrinth of Department of Health and Social Care arms-length bodies, known as quangos. They are the primary means through which the department spends its allocated budget – in 2016/2017, over 96 per cent of health funding (£117.5 billion) was spent that way.²

Many of us heard of NICE (National Institute for Health and Care Excellence) or CQC (Care Quality Commission) or Public Health England, but what about NHS Improvement, Independent Reconfiguration Panel or National Information Board? What are they? What do they do? How much do they cost? Do we really need them? Those are just some of the questions that will be answered here.

² National Audit Office, *A Short Guide to: Selected arm’s-length bodies*, December 2017, available at <https://www.nao.org.uk/wp-content/uploads/2017/12/A-Short-Guide-to-Selected-health-arms-length-bodies.pdf> (last accessed 20/03/2018)

The case for NHS Independence

NHS England is the UK's largest quango – in fact, it is arguably the largest organisation of this type in the world.³ As an arms-length body of the Department of Health and Social Care, the ultimate responsibility for its activities and performance is borne by the Secretary of State for Health and Social Care.

Yet this is a somewhat unique situation. The quango model was never designed for huge, multi-billion pound organisations. Such monoliths need more independence to govern themselves. A typical quango is a small team of experts supporting their government department in a technical management task, such as oversight of a market (Ofgem and Ofwat) monitoring quality of service provided by another, larger organisation (Ofsted and Care Quality Commission) or pooling expertise to adjudicate on highly technical choices, such as which medicines and treatments to subsidise (National Institute for Health and Care Excellence) whether or not to block a merger (Competition and Markets Authority) or whether to grant a licence to a new airline (Civil Aviation Authority).

Neither of these bodies actually provides a service to the public, or is highly dependent on resources in order to deliver its objectives, making them relatively easy to manage. This is most certainly not the case with NHS England. It deals with the public in the closest possible sense, and depends on a steady stream of resources for its day-to-day functioning, not just in order to pay the wages of its staff but also to purchase equipment and supplies, something other quangos do not have to worry about. This inevitably means it is far more difficult to manage, and far more politically sensitive, since it is a huge call on public resources whilst providing a vital service. This makes for a fatal combination of politics with inadequate management structure, with the results clear to see every time something goes wrong.

Most importantly, it creates a vicious cycle where the NHS is constantly in crisis – sometimes real, sometimes perceived, and sometimes purely a product of the opposition's narrative because it suits them politically. The result is a bidding war on who will pump more money into the creaking machine against a backdrop of shambolic reorganisations as whoever is in charge attempts to make it look like something is being done without having to spend money on it. This is worst of both worlds – either pointless rearranging of deck chairs on the Titanic, or the pouring of more resources into a bottomless pit. It happens because those on whom the responsibility falls – the politicians – have no expertise, but are subject to electoral cycles, which pressurise them to do something visible and easily understandable, like increasing funding before an election and reducing funding thereafter. And the opposition seeks to frustrate any improvements that can be made. By contrast, those who do have the expertise – NHS England managers – do not have the independence to make executive decisions, because they're not the ones ultimately responsible; they end up being puppets in the hands of politicians, frustrated they are not allowed freedom to make the changes they know will work. Glasby, Peck, Ham and Dickinson put it in the following terms:

Behind all these quotes, examples and issues is a strong sense that the NHS is so politically important that being seen to do something is often more important than doing the right thing. This manifests itself in a myriad of ways throughout every level of the health service, and often leads to policy statements that central government

³ Buchanan, K, 'Meet the biggest quango in the world: NHS England', *Daily Express*, 13 October 2013, available at <https://www.express.co.uk/life-style/health/436350/Meet-the-biggest-quango-in-the-world-NHS-England> (last accessed 20/03/2018)

will seek to 'shift the balance of power' closer to the front-line (Department of Health, 2001). In practice the government seems to have found it hard to let go – seemingly believing in the need to devolve decision making, but not quite trusting those at ground level to do it properly. This then results in a rhetorical commitment to devolution, coupled with ongoing micro-management of everyday NHS activities, which infuriates managers and clinicians alike.⁴

In 2007, an idea of an independent board was put forward by then prime minister Gordon Brown.⁵ The board would handle day-to-day management of the NHS, whilst politicians would only be charged with setting the budget. This was intended to create a situation where Department of Health and Social Care ministers – and by extension, every MP on the government's side of the House – are not forced to defend everything that is going on in the NHS, because they are seen as directly accountable for it. In reality, running the NHS is just one thing they are charged with and there is little they can do to influence such a complex organisation without the deep institutional knowledge of NHS England managers. They should therefore stop trying, and be solely responsible for setting the organisation's budget.

How much we spend on healthcare is a political decision, but how we manage the NHS – less so. The point is that they are two different issues, and require different approaches. You cannot substitute necessary reforms with ever more money, and we should not delay internal reforms with never-ending debates about resources. According to polling commissioned by *Reform*, a think-tank, 64 per cent of respondents agreed that 'It shouldn't matter whether hospitals or surgeries are run by the government, not-for-profit organisations or the private sector provided that everyone has access to care.'⁶

These issues need to be separated. Ministers should set the amount of money that as a society we are willing to spend on healthcare, and in agreement with NHS management, set some targets together with performance indicators, based on what kind of health service we would like as a society given resource constraints. They should monitor the functioning of the system and ask questions if targets are not being met, but they should step back, and let the managers do the best they can. It is impossible to take politics completely out of something as political as healthcare, but it is possible to reduce the pathological impact it has on the rational governance of it. As the seminal 2007 Nuffield Trust report puts it:

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

⁴ Glasby, J, Peck, E, Ham, C, Dickinson, H (2007) *Things can only get better? – the argument for NHS independence*, Health Services Management Centre, University of Birmingham, available at <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.451.5963&rep=rep1&type=pdf> (last accessed 20/03/2018)

⁵ BBC, *Brown plans an independent board*, 23 September 2006, available at <http://news.bbc.co.uk/1/hi/health/5372920.stm> (last accessed 20/03/2018)

⁶ Reform, *Reform 2018 health poll: The majority of electorate believe NHS requires reform more than extra money*, February 2018, 15, available at <http://www.reform.uk/wp-content/uploads/2018/02/Reform-Populus-NHS-poll-2018.pdf> (last accessed 20/03/2018)

*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.*⁷

Support for an independent NHS is also present within the organisation itself. In a 2007 report, the British Medical Association (BMA) has called for a number of organisational reforms, including the establishment of an independent board in order to insulate the NHS from political wrangling.⁸ It was but a single element in a fairly radical reorganisation proposal, which would see the Department of Health and Social Care primarily concerned with public health, leaving the day-to-day running of the NHS completely in the hands of independent governors.⁹

Alternative model 1: Bank of England

The Bank of England is one of the institutions cited as providing a possible blueprint for the NHS.¹⁰ It was given independence in 1997 as one of the first acts of the then-newly minted chancellor Gordon Brown, who cited the need to make monetary policy 'free of political manipulation.'¹¹

The problem he was referring to is a well-known conundrum in monetary economics, but applicable to a much wider range of political and policy problems – that of 'time inconsistency' or 'dynamic inconsistency.' In the context of monetary matters, the problem lies in the following: generally low inflation is preferable to high inflation, but expansionary monetary policies – which tend to increase inflation – also tend to reduce unemployment, which is also a good thing. When a monetary institution announces contractionary monetary policies (such as high interest rates) and market actors adjust their operations accordingly, they are then under an incentive to renege on the promise, because that will lead to higher employment. But if this is done repeatedly, an institution will lose its power to influence the market, because nobody will believe its announcements, and we will end up with both higher inflation and higher unemployment.¹²

Now consider who is better suited to handle this problem: experts with security of tenure, or elected politicians. It is easy to guess what tends to happen when it is handled by the latter, especially in the run up the election – the temptation of a pre-election employment boost or

⁷ Edwards, B (2007) *An Independent NHS: A Review of Options*, The Nuffield Trust, 23, available at <https://www.nuffieldtrust.org.uk/files/2017-01/an-independent-nhs-web-final.pdf> (last accessed 20/03/2018)

⁸ British Medical Association, *A rational way forward for the NHS in England*, May 2007, 12, available at <http://www.bps.org.uk/sites/default/files/A%20Rational%20Way%20Forward%20-%20consultation%20paper.pdf> (last accessed 20/03/2018)

⁹ *Ibid*, 12

¹⁰ Pagano, M, 'Take the NHS out of politics and make it independent like the Bank of England' *Reaction*, 3 January 2018, available at <https://reaction.life/take-nhs-politics-make-independent-like-bank-england/> (last accessed 20/03/2018)

¹¹ Elliott, L and White, M, 'Brown gives Bank independence to set interest rates' *The Guardian*, 7 May 1997, available at <https://www.theguardian.com/politics/1997/may/07/economy.uk> (last accessed 20/03/2018)

¹² The seminal work in this area was carried out by Kydland, F and Prescott, E, 'Rules rather than discretion: The Inconsistency of Optimal Plans', *The Journal of Political Economy* (1997) 85(3) 473-92, available at https://www.sfu.ca/~kkasa/prescott_77.pdf (last accessed 20/03/2018)

avoiding extremely negative headlines is difficult to overcome. Therefore, an institution not subject to political pressure tends to work a lot better in these circumstances. By delegating the decision to an apolitical body with security of tenure (a guarantee that they will not be dismissed from their post if the government does not like one of their decisions) a government is able to 'credibly commit' to a politically unpopular but economically sound course of action, because they have bound their hands – just like Odysseus bound himself to the mast to resist the sweet but ultimately fatal call of the sirens.

But there are a number of more granular issues also subject to the time inconsistency. Rhema Vaithianathan and Geraint Lewis pointed to four aspects of NHS management which in their view needed to be completely freed from political influence: they cite decisions regarding cost effectiveness of medicines and treatments, structural reorganisations, service reconfigurations and patient safety.¹³ These are good illustrations of the problem in the context of British healthcare.

To take just one example: closing hospitals inevitably leads to immense backlash from the local community, who understandably take a dim view of having to travel further to receive even urgent care. However, it is also true that centralising healthcare in larger agglomerations can not only make significant savings but also deliver improvements in the quality of care, since hospitals earmarked for closing are often struggling and suffer from problems such as understaffing. One example is the centralising of stroke units in London from 32 into 8 which led to a reduction in stroke deaths.¹⁴ It is a classic example an otherwise sound decision which is nevertheless difficult to implement for political reasons – transferring it to a non-political body, therefore, should make it much easier, though the issue of local accountability will need resolution.

Alternative model 2: The BBC

Another structure worth exploring is that of the BBC. One criticism which can be levelled at comparing the NHS to the Bank of England is that the former delivers a vital public service whilst the latter is more of a manager, which means they are subject to very different political dynamics. The BBC does deliver a service on a daily basis; does interact with the members of the public; does something which the public understands and can engage with. On the other hand, its funding is less contentious because unlike the NHS – aside from the obvious point of costing far less and providing a service which is a lot less vital than healthcare – it has considerable means of generating its own income from licencing its programmes to other broadcasters and other commercial operations.

Arguably the most important element in the BBC management structure is its royal charter. It acts as its constitution, outlining all other governance and funding arrangements, as well as the BBC's mission. The mission acts as a yardstick for measuring BBC's performance, outlining its obligations to the licence fee payers. Overseeing the BBC is the BBC board, which sets the organisation's strategic direction, establishes its creative remit, sets its budget and determines the framework for assessing performance. In a way, it performs the hypothetical

¹³ Vaithianathan, R and Lewis, G, 'Operational independence of the NHS' *BMJ* 2008;337:a497, available at <http://www.bmj.com/bmj/section-pdf/186550?path=/bmj/337/7666/Analysis.full.pdf> (last accessed 20/03/2018)

¹⁴ Morris, S et al, 'Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis', *BMJ* 2014;349:g4757, available at <http://www.bmj.com/content/349/bmj.g4757> (last accessed 20/03/2018)

job of the health ministers in an independent NHS. The board has a number of sub-committees, one of them being the executive committee which is chaired by the BBC's Director-General. That committee is responsible for the day-to-day running of the organisation, much like Gordon Brown's independent NHS board was envisaged to do.

How good is the BBC's structure at insulating it from political wrangling? And does it directly cause it to be better run as a result? It is hard to deny to the BBC frequently finds itself in the news for the wrong reasons. In what is but the latest instalment of a lately never-ending saga, the BBC stands accused of forcing some employees to set up personal service companies for tax reasons.¹⁵ Before that, it was facing accusations of a gender pay gap amongst a high-profile resignation of its China Editor.¹⁶ That's before the almost daily accusations political bias aimed at its news and current affairs offering.

Naturally, as discussed above, it is perhaps unfair to compare the two since given the NHS is in the business of saving lives, whilst the BBC merely entertains us, it is unsurprising the former is much more politically potent. The barriers to political meddling which may work at the BBC, therefore, may not work as well at another institution. But they do seem to be working. For all the grievances at overpaid stars and accusations of bias, there is very little direct political involvement. It can be argued – given the problems – that may not necessarily be a good thing, and some have argued that the BBC board is in fact *too* isolated, preventing proper scrutiny.¹⁷ Nevertheless, though by no means a perfect comparison or a silver bullet for all of its problems, the BBC shows that it is possible to govern large, expensive and politically sensitive organisations without micromanagement from ministers.

¹⁵ Singh, A, 'The BBC is lying about its tax affairs and we have emails to prove it, 170 presenters say', *The Daily Telegraph*, 4 March 2018, available at <https://www.telegraph.co.uk/news/2018/03/04/bbc-lying-tax-affairs-have-emails-prove-170-presenters-say/> (last accessed 20/03/2018)

¹⁶ Ruddick, G, 'Trust is broken at BBC over equal pay, Carrie Gracie tells MPs' *The Guardian*, 31 January 2018, available at <https://www.theguardian.com/media/2018/jan/31/bbc-in-real-trouble-over-equal-pay-carrie-gracie-tells-mps> (last accessed 20/03/2018)

¹⁷ See for example Purnell, J and Collins, R (1995) *The Future of the BBC: Commerce, Consumers and Governance*, Institute for Public Policy Research

How arms-length are health quangos?

"If left unpruned, quangos would spread like rhododendrons, individually displaying exotic blooms but collectively blighting the scenery."¹⁸

Nigel Hawkes for BMJ, 2010

One important impact quangos have on the NHS is that whilst seemingly at arms-length, they can essentially become tools through which the health and social care secretary can micromanage the NHS. To a large extent, this depends on the disposition of each individual minister. Whatever may be said about his reorganisation, Andrew Lansley reportedly stayed out of the day-to-day running of the NHS, whereas Jeremy Hunt is said to prefer the 'hands on' approach – and he uses heads of varying NHS arms-length bodies to do so.¹⁹ As one report states:

Such is the health secretary's modus operandi that Professor Chris Ham, chief executive of the King's Fund health thinktank, says: "Effectively Jeremy Hunt has become the executive chairman of the NHS." Hunt can seek a detailed report into one hospital's failing finances, ask to be briefed on the planned reorganisation of hospital services somewhere in England – the potential political fallout from the rundown of any hospital so close to the election is a priority – or demand improvements in a hospital's A&E performance if it is not treating the required 95 per cent of patients within four hours. There is widespread concern at senior levels of the NHS that Hunt's tendency to routinely ask the bosses of the ALBs to look into things, take action and then report back on progress takes up much of their week and amounts to unjustified direction and interference in their work. There is an "understated threat in his approach", according to one NHS insider.²⁰

Quangos, or ALBs (Arms-length bodies) as they are sometimes referred to, are a hugely significant and wield considerable power, since they are effectively extensions of the Department of Health and Social Care and speak with its voice. Each one was set up in good faith, and charged with carrying out a task hard to disagree with on face value.

NHS Improvement states its job is to "support foundation trusts and NHS trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable."²¹ Health Education England says that it "exists for one reason only: to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place."²² NICE's motto is "Improving health and social care through evidence-based guidance."²³ All sound important, benevolent and vital.

¹⁸ Hawkes, N, 'This is no way to cull the quangos', *BMJ*, 16 October 2010, available at <http://www.bmj.com/content/bmj/341/7777/Observations.full.pdf> (last accessed 20/03/2018)

¹⁹ Campbell, D, 'An NHS free from day-to-day political interference is far from reality', *The Guardian*, 27 March 2014, available at <https://www.theguardian.com/society/2014/mar/27/nhs-political-interference-jeremy-hunt> (last accessed 20/03/2018)

²⁰ *Ibid*, own emphasis

²¹ <https://improvement.nhs.uk/>

²² <https://hee.nhs.uk/>

²³ <https://www.nice.org.uk/>

But as Nigel Hawkes puts it, “if left unpruned, quangos would spread like rhododendrons, individually displaying exotic blooms but collectively blighting the scenery.”²⁴ They can also become a significant cost – last year, a staggering 600 quango chiefs received six-figure salaries.²⁵ The landscape of DHSC quangos is a result of many years of ad hoc additions, all with good intentions, but with little apparent overview. As Professor Parkinson demonstrated nearly 70 years ago, the primary objective of every organisation is to grow.²⁶ Too bad if this is at the expense of sibling organisations.

Two types of health quangos: quality control and management advice

Organisations such as the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE) are essentially regulators. The CQC sets certain standards, inspects the providers in order to ascertain whether or not they are being met, and keep score, possibly intervening with one of their enforcement powers if necessary. NICE is charged with producing national-level guidance and best practice for medical professionals across the country and developing quality standards and performance metrics against which they can be reviewed. These functions are necessary because the managers should not be judges of their own cause– data and information is necessary in order to ascertain how good of a job they’re doing. Medical professionals also need access to the guidance produced on the basis of latest advances in medicine. Au fond, they maintain the quality to which we are entitled.

But this very different from bodies like Monitor, NHS Trust Development Authority, National Reconfiguration Panel and National Information Board, which are solely devoted to advising NHS England about management about how to do their jobs. In principle, wanting to bring expertise together is a good thing, and managers should rightly consult where they feel third-party expert opinion is necessary. This is different from having a situation where there is a plethora of organisations solely charged with trying to do NHS England’s job better than them. No other organisation functions in this way.

These organisations can also undermine the effort to – as advocated by this paper – make NHS independent. Using heads of quangos as means of exerting control is a tried and tested technique which some Health Secretaries use to micromanage. But Department of Health and Social Care should stick to its business, and NHS England should be left alone to get on with theirs. If it requires advice, there are channels to ask for it – there is no need for an army of organisations whose sole job it is to tell NHS England chief executive how to do his job.

Specific recommendations are set out in the Appendix with broad discussion of some of the conclusions below:

1. As part of NHS independence, abolish those quangos purely concerned with advising management

Body	Annual expenditure	Comment
Independent Reconfiguration Panel - core function is to provide advice	Staff costs between £200,000 and £300,000, overall cost varies year to	The panel exists because the secretary of state has it within their power to block

²⁴ *Supra* note 14

²⁵ Donnelly, L ‘More than 600 quango chiefs on six-figure salaries amid NHS cash crisis’, *The Telegraph*, 5 March 2018, available at <https://www.telegraph.co.uk/news/2017/03/05/600-health-quango-chiefs-six-figure-salaries-amid-cash-crisis/> (last accessed 20/03/2018)

²⁶ The Economist, ‘Parkinson’s Law’, 9 November 1995, available at <https://www.economist.com/node/14116121> (last accessed 20/03/2018)

<p>to the secretary of state for health in relation to the right of referral granted to Local Authorities, under Section 22(3) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, in relation to contested proposals for NHS reconfigurations or significant service change.²⁷</p>	<p>year depending on demand, latest figures available 2014-15²⁸</p>	<p>service reconfiguration decisions made by NHS England, and can ask the panel for advice. It is questionable to what extent they should have that power. Having reconfiguration decisions taken by an independent expert body is sound in principle, but in that case the panel should be integrated into NHS England and given real responsibilities and powers instead of issuing non-binding opinions to ministers.</p>
<p>National Information Board - senior advisory group which guides and agrees strategy, requirements and priorities for information and technology across the health and care system; and commits to ensuring that system leaders also align their businesses to deliver the necessary business change for the system-wide strategy.²⁹</p>	<p>NIB is advisory with low (unreported) costs and the relatively large costs of NHS Digital (2,800 staff, >50% management)</p> <p>No savings taken as the switch is from DHSC to the NHS. Some (small) social care statistical work would remain with DHSC</p>	<p>Another body, NHS Digital, is already charged with delivering all aspects of NHS' IT and technology strategy. Given the generally poor track record of IT projects in the NHS,³⁰ it is worth considering whether it would be better either for NHS Digital or indeed NHS alone to set the strategy, given this is what happens in any large organisation.</p>
<p>NHS Improvement – this organisation combines a number of bodies, the most significant ones being Monitor and the NHS Trust Development Authority. Monitor ensures independent trusts are well led and</p>	<p>£75.2 million in 2016-17³³</p>	<p>A key issue in NHS management is the blurring of lines of responsibility between organisations charged with similar tasks and goals. The ever so slightly different remits mean that organisations eventually</p>

²⁷ Department of Health, *Triennial Review of the Independent Reconfiguration Panel (IRP): Review Report*, March 2015, 5, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418014/irp-review-report.pdf (last accessed 20/03/2018)

²⁸ *Supra* note 15, 17

²⁹ National Information Board, *Annual Report*, September 2016, 4, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/572415/NIB_Annual_Report_NovA.pdf (last accessed 20/03/2018)

³⁰ *Supra* note 1, 25-26

<p>ensures continuity if a trust gets into trouble.³¹ NHS Trust Development Authority focuses more on tackling service delivery challenges faced by trusts.³²</p>		<p>develop different priorities and cultures, and a very different idea of how to get to the same, overarching goal. For instance, both the CQC and NHS England are responsible for service quality, yet have quite different aims, cultures, and ways of working.</p>
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Regulation is important for maintaining NHS standards but we do not need more than one regulator. Accordingly we propose rolling the Independent Regulator of NHS Foundation Trusts into CQC, saving the costs of the former.

NHS Improvement vs. Care Quality Commission

NHS Improvement is one of the biggest and most powerful health quangos and abolishing it may seem radical. But for all its resources, it sits in an awkward middle ground between NHS England and the CQC. It is not management, because its role is advisory. Neither is it in position to inspect or enforce changes on trusts, because that is the job of the CQC. Indeed, the two organisations can at times have differing aims. The CQC being primarily concerned with quality of service, frequently tells trusts they are understaffed. NHS Improvement often tells them the opposite, as they are primarily concerned with finances. As any middle manager in a large network of organisations knows, there is nothing worse than two superior bodies unable to see past their own priorities and as a result asking for the impossible.

The CQC is the independent regulator – it should, and does, act as the ‘enforcer’ of standards set by NHS England as dictated by priorities set by ministers. Having another organisation in the mix, charged with telling trusts how to do their job and sometimes having divergent priorities, is a needless distraction.

NHS Improvement is a useful pool of management knowledge and expertise, and these elements could be folded into the CQC. What should be removed, however, are the elements which interfere with the day-to-day running of trusts, duplicates work done by the CQC or complicates the setting of targets by acting as a competing source of priorities.

Independent Reconfiguration Panel

The Independent Reconfiguration Panel (IRP) is, according to its documentation, “...the independent expert on NHS service change. The Panel advises Ministers on proposals for NHS service change in England that have been contested locally and referred to the Secretary of

³³ *Supra* note 1, 15

³¹ NHS Improvement, *Monitor: annual report and accounts 2016/17*, HC 235, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/630185/438953_Monitor_Annual_report_and_Accounts_2016-17_WEB.pdf (last accessed 20/03/2018)

³² NHS Improvement, *NHS Trusts Development Authority: annual report and accounts 2016/17*, HC 233, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/630193/438987_TDA_Annual_report_2016-17_WEB.pdf (last accessed 20/03/2018)

State for Health. It also offers support and generic advice to the NHS, local authorities and other interested bodies.”³⁴

Its main job is to act as an adviser in case of a dispute when a proposed change to the service is contested locally. If local authorities in an area which is being affected are – pursuant of their rights under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 – not satisfied that there has been sufficient consultation prior to the decision, that reasons given for the decision are adequate, or that the proposal would be in the interest of the health service in the area, it may refer the decision to the Secretary of State for Health and Social Care, who may then ask the IRP for advice.

But as discussed above in the context of NHS England independence, such a decision should not be within the remit of the Secretary of State or any other minister or politician. Resource pressures and regional demand variations mean that sometimes closing hospitals can free up resources more needed elsewhere. But this otherwise good decision will be subject to intense political pressure, a problem particularly around election time. The decision should be in the hands of an independent body – NHS England, or a liberated Independent Reconfiguration Panel.

2. A single organisation responsible for Public Health & Research

Body	Annual expenditure	Comment
Public Health England - exists to protect and improve the nation’s health and wellbeing and reduce health inequalities through world-class science, advocacy, partnerships, knowledge and intelligence, and the delivery of specialist public health services. ³⁵	Expenditure for 2016-17 was £4.5 billion, of which £3.4 billion was spent with public authorities on local projects. ³⁶ In the same year, the organisation had 5,035 full-time staff. ³⁷	The body has two main roles: encouraging healthy life styles and research into topical major health crises such as pandemics. Prevention may be better, and cheaper, than cure but there is little evidence that money spent on this way works unless backed up by legislation or the threat of it. The science can and should be out-sourced to universities.
Health Education England – responsible for training of healthcare professionals in England by spending £4.8 billion a year on UG and PG education and training, through loans and sponsoring clinical placements, as well as	Expenditure for 2016-17 was £5.1 billion, 89% of which was spent with education institutions, providers of clinical placements, covering parts of tuition fees and living costs as well as junior doctor’s salaries. ³⁹ The organisation had 1,871 full	The training of healthcare professionals is a task carried out mainly by universities and colleges. NHS England can choose to allocate dedicated funding to it – such as subsidising fees, loans, bursaries – but does it need an almost 2,000 staff

³⁴ *Supra* note 23, 5

³⁵ Public Health England, *Annual Report and Accounts 2016/17*, HC 281, 18 July 2017, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/629803/PHE_annual_report_2016_2017_web_version.pdf (last accessed 20/03/2018)

³⁶ *Ibid*, 119

³⁷ *Supra* note 1, 9

providing continuing professional development. ³⁸	time staff. ⁴⁰	organisation to do so?
Health Research Authority - tasked with protecting and promoting the interests of patients and the public in health and social care research, including publishing policy and guidance on the good management and conduct of research and promoting transparency in research. ⁴¹	In 2016-17 the organisation had a net expenditure of 12.8 million, including £8.7 million on staff costs. ⁴²	Before a research project can go ahead, it needs a stamp of approval from the HRA, which requires a research proposal to adhere to adequate ethical as well as legal standards concerning the involvement of members of the public in research. But does this need a13 million pound organisation given another body – the Medical Research Council – already exists and is dedicated to supporting medical research? ⁴³

3. A single organisation for approving Medicines and Technology

Body	Annual expenditure	Comment
National Institute for Health and Care Excellence – NICE was set up in 1999 to help reduce variation in the availability and quality of NHS treatments and care. It provides national guidance and advice to promote high-quality health, public health and social care. It also produce quality standards, performance metrics and a range of information services for those providing, commissioning and managing	Expenditure in 2016-17 was £54.6 million. Staff costs for that same year were £35 million, up from £33.9 million the previous year. ⁴⁵	NICE is the second-largest health quango after NHS England. In line with the discussion of NHS independence, it is a good example of an independent, apolitical body making decisions in a rational way which would be subject to the time inconsistency if they were made by politicians. It could be the foundational stone of a new, single independent agency charged with medicines and

³⁹ *Supra* note 1, 21

³⁸ HEE, *Annual Report and Accounts 2016/17*, HC 159, 13 July 2017, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/629039/HEE_annual_report_2016_2017_web_version.pdf (last accessed 20/03/2018)

⁴⁰ *Ibid*

⁴¹ Health Research Authority, *Annual Report and Accounts, For the Year 31 March 2017*, HC 199, 11 July 2017, available at <https://www.hra.nhs.uk/about-us/what-we-do/annual-report/> (last accessed 20/03/2018)

⁴² *Ibid*, 39

⁴³ Medical Research Council, *Annual report and accounts 2016/17*, HC 174, 13 July 2017, available at <https://www.mrc.ac.uk/publications/browse/annual-report-and-accounts-2016-17/> (last accessed 20/03/2018)

services across the spectrum of health and social care. ⁴⁴		technology. However, its functions relating to social care should be reconsidered, and possibly given over to a new organisation charged solely with administering all things related to social care.
British Pharmacopoeia Commission – the Commission has three formal functions: firstly, publishing British Pharmacopoeia, a publication of publicly available standards for active pharmaceutical ingredients and finished dosage forms of pharmaceutical products, secondly, providing advice to the UK delegation to the European Pharmacopoeia Commission, and thirdly, selecting or devising names to be used at the head of monographs, which are subsequently published as British Approved Names (BANS). ⁴⁶	Negligible ⁴⁷	The publication of British Pharmacopoeia is a necessary task, but could the commission be incorporated into the new single organisation?
Commission on Human Medicines – established in the wake of the thalidomide tragedy in the 1950s-60s, its job is to advise the Health Ministers and the Licensing Authority on matters relating to human medicinal products, to promote the collection and investigation of information relating to adverse reactions to human medicines, and to work with the Licensing Authority (body which gives approval for selling and marketing human	£300,000 – funded out of licencing fees ⁴⁹	The division of labour between the Commission on Human Medicines and the Medicines and Healthcare Regulatory Agency (MHRA) is unclear. Whilst it is true that it essentially acts as an appellate body to the MHRA should an applicant take issue with a refusal of a marketing licence, it would be possible to establish an appellate body with a clear remit, transferring all other responsibilities to a single medicines and technology

⁴⁵ *Ibid*, 13

⁴⁴ NICE, *Annual Report and Accounts 2016/17*, HC 63, 13 July 2017, available at https://www.nice.org.uk/Media/Default/About/Who-we-are/Corporate-publications/Annual-reports/NICE_annual_report_2016_2017.pdf (last accessed 20/03/2018)

⁴⁶ Department of Health, *Triennial Review of the British Pharmacopoeia Commission: Review Report*, March 2015, 11-12, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417678/bpc-review-report.pdf (last available 20/03/2018)

⁴⁷ *Ibid*, 19

medicines in the UK) which can refer difficult cases for consideration by the commission. ⁴⁸		organisation.
Medicines and Healthcare Products Regulatory Agency – the Agency is the ‘Licencing Authority’ for human medicines in the UK – it is responsible for granting and withdrawing marketing licences, and its objectives are to ensure that all human medicines marketed in the UK meet appropriate safety standards. ⁵⁰	In 2016-17 total expenditure amounted to approximately £154 million, though majority of its income (£129 million) was generated from trading activities, i.e. fees payable on licence application by a manufacturer. ⁵¹	

4. Estimated savings

Organisations abolished or partially abolished	Running costs 2016-17 (£)
NHS Improvement (Monitor + NHS Trust Development Authority)	174,000,000
National Reconfiguration Panel	200,000
National Information Board	n/a
SAVINGS	174,200,000
Merger of medicines and technology approval bodies	
National Institute for Health and Care Excellence	71,300,000
British Pharmacopoeia Commission	n/a
Commission on Human Medicines	n/a
Medicines and Healthcare Products Regulatory Agency	25,000,000
SAVINGS	38,520,000
Merger of Public Health bodies	
Public Health England	532,800,000
Health Education England	561,000,000
Health Research Authority	8,700,000
SAVINGS	551,250,000
TOTAL QUANGO SAVINGS	763,970,000
+ £40 million DHSC savings	803,970,000

⁴⁹ *Ibid*, 11

⁴⁸ Department of Health, *Triennial Review of the Commission on Human Medicines: Review Report*, 26 March 2015, 10-11, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/417625/chm-review-report.pdf (last accessed 20/03/2018)

⁵⁰ MHRA, *Annual Report and Accounts 2016/17*, HC 268, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/630517/MHRA_Annual_Report_and_Accounts_16-17.pdf (last accessed 20/03/2018)

⁵¹ *Ibid*, 88

Conclusions

Two linked arguments have been advanced in this paper. Firstly, taking politicians, quangos and civil servants out of day-to-day management of the NHS, leaving them solely in charge of setting budgets and agreed targets with the transference of all day-to-day management to NHS England would be a positive step towards addressing the problem of the NHS being used as a political weapon, to the detriment of the organisation, its staff and its patients. The level of funding is a political decision, but its management is not. We should therefore leave the ministers in charge of the budget, and let the managers manage. In addition streamlined regulators will be required to licence new medicines and technology and monitor delivery quality.

The linked problem is responsibility. NHS England and its CEO are notionally at the top, but some quangos are solely charged with management, all with different priorities. No similar organisation functions like this, because it results in different parts of the monolith pulling in different directions. Those quangos whose role is to regulate and inspect quality have a legitimate role to play, since they are not involved in management but merely check if the management is performing well and meeting targets. But quangos solely concerned with management should be either absorbed into the structures of NHS England (if they really are helpful) or scrapped.

It is not easy to estimate the savings resulting from the recommendations outlined here, since the long-term management benefits are impossible to quantify accurately. We propose the number of DHSC quangos should reduce from 19 to seven and save approximately £750M (see appendix for methodology) and, perhaps more importantly, release top managerial time to realise the efficiency that can be made in the system, e.g. improved use of surgeons and operating theatres, and reducing unnecessary administration. In addition, a reduction in the number of quangos needing management, care and communications could save up to half the DHSC staff and save a further £40 million per year. Thus, these reforms could free up as much as £790 million for frontline services.

Methodology:

- 1. Bodies to be abolished** – this will always be an approximation. In the case of NHS Improvement, National Reconfiguration Panel and the National Information board, figures for total annual expenditure are used. In the case of the former, it's because we are proposing abolishing the body entirely, without handing its functions to anyone else. In the case of the latter, it's because they do little other than produce reports, which means they have little expenditure other than staff costs.
- 2. Single organisation for medicines and technology** – original figure for NICE expenditure is kept, as it is envisaged that it would become the main body into which others can be incorporated. British Pharmacopoeia Commission has negligible running costs as it employs no full time staff, and the Commission on Human Medicines is funded entirely out of product licencing fees. Medicines and Healthcare Products Regulatory Agency also had a substantial income from licencing fees which covered most of its expenditure, but the leftover amounted to £25m. We assume that when 4 bodies are replaced with 1, 60 per cent of the original combined cost can saved.
- 3. Single organisation for public health and research** – the figure for Public Health England was arrived at by taking total expenditure for 2017-18, and subtracting the amount spent on local authority public health grants and income from the sales of vaccines. For Health Education England, the amount was calculated by taking total expenditure for 2017-18 and subtracting the sum of funding earmarked for operating activities such as university grants etc. Health Research Authority figure was taken from their disclosure documents where it's marked 'staff costs.' We assume that when 1 organisation replaces 3, as is the case here, 50 per cent of the original combined costs can be saved.
- 4. £40 million saved in reducing DHSC workload** – this is an estimate in savings resulting from, firstly, greatly reducing the role Ministers – and therefore civil servants – have to play in NHS management, and secondly, from reducing the number of quangos which have to handled.

Appendix:

	Department of Health and Social Care quangos	Future as is	Future closed	Saving (£m)	Merge	Reduction in quangos
1	Public Health England			551	1, 13, 14	2
2	Health and Care Professions Council			0	2, 9, 16, 17	3
3	Genomics England Limited	1		0		
4	NHS Trust Development Authority				See 6 below	
5	Human Fertilisation and Embryology Authority	1		0		
6	Care Quality Commission				4, 6, 7, 15	3
7	Monitor			81.5	See 6 above	
8	National Institute for Health and Care Excellence			38.5	8, 18, 19	2
9	Professional Standards Authority for Health and Social Care			0	See 2 above	
10	Human Tissue Authority	1		0		
11	NHS Digital		1	0		1
12	Health Research Authority		1	13		1
13	Health Education England			80	See 1 above	
14	Healthwatch England				See 1 above	
15	Independent Reconfiguration Panel				See 6 above	
16	NHS Pay Review Body			0	See 2 above	
17	Review Body on Doctors' and Dentists' Remuneration			0	See 2 above	
18	Medicines and Healthcare Products Regulatory Agency				See 8 above	
19	NHS Blood and Transplant				See 8 above	
	TOTAL	3	2	764		12

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