

## Written evidence submitted by Dr Michael Lambert (DEL0071)

### Profile and Reason for Submission

I am an academic historian of the welfare state in twentieth century Britain specialising in governance processes from the centre to periphery in the implementation of policies.

I completed my doctoral thesis on decision-making in local authority social services (primarily children and families) in the North West of England from 1943 to 1974, funded by the Economic and Social Research Council (ESRC) at Lancaster University in 2017. I have submitted evidence to Public Accounts Committee (PAC) Inquiry into the Troubled Families Programme in 2016 and the Housing, Communities and Local Government Committee of Inquiry into the Funding and Provision of Local Authorities' Children's Services in 2018 based on this research, and published in peer-reviewed journals including *People, Place and Policy*, *Social Policy and Society*, and *Children and Society*.

From 2017 to 2019 I was a Research Associate on the Governance of Health project directed by Professor Sally Sheard at the University of Liverpool funded by the Wellcome Trust. My strand of the project examined decision-making in the National Health Service on Merseyside from 1948 to the present. I have submitted evidence, with colleagues, to the London School of Economics (LSE) and Lancet Commission on the Future of the NHS in 2018, published several witness seminars on aspects of change in the NHS, and authored a report on archives and records management in relation to this research.

During 2019 I was commissioned by The Prince's Trust to undertake a report assessing policy and practice responsibilities in relation to the activities of the Fairbridge (Child Migration) Society for the Scottish Child Abuse Inquiry (SCAI).

Since 2019 I have been a Postdoctoral Fellow in Social Inequalities at Lancaster University, with a research focus on the centrality of care to global understandings of, and developments of alternatives to, social and economic inequalities.

As a result of my academic trajectory and each of these research roles, I have accumulated considerable experience and expertise in analysing policy- and decision-making processes, structures and cultures in both health and social care in twentieth century Britain, centred on the North West of England, with a focus on Liverpool and Merseyside. I am therefore able to understand how past histories of delivering core NHS and care functions influence and shape their potential future.

This evidence provides a historical dimension to understanding current dilemmas in the NHS centred on (a) the hollowing of institutional structures which mediate the centre and periphery; (b) the decline of public and population perspectives in conceptions of health and social care; (c) the impact of recurrent reorganisations on institutional memory at both central and local levels.

## Executive Summary

1. The hollowing of institutional structures which constitute the levers of power in the NHS have resulted in an elongation of lines of responsibility and accountability between the centre (the Department of Health and Social Care) and the periphery (providers, commissioners and local authorities). Vacillating or uncertain central direction is aggravated by a lack of an intermediary authority. This has reduced the ability of local communities and organisations to effectively respond to crises.
2. The decline of public and population health perspectives, and their professional positions within institutional structures in the NHS, has fatally undermined the ability of local communities and organisations to be involved in effective decision-making. Empowered public health professionals, particularly in urban centres, have been the lynchpin of organised responses to epidemics in the past. Their peripheral role is not conducive to planning responses to crises in the future.
3. The Coronavirus pandemic represents an unprecedented challenge to the NHS. However, the cumulative impact of decades of restructuring, reorganisation and fragmentation in both managerial *and* medical domains at the centre and periphery has produced a loss and devaluing of institutional memory which is intensified by hollowing and a lack of public health leadership.

## Hollowing NHS Institutional Structures

4. Nick Timmins' (2016: 10) view that 'the NHS is not one organisation but many hundreds of organisations' encapsulates the difficulties involved in running the NHS throughout its history. The successive creation and reorganisation of NHS institutional structures from 1948 to the present day reflect efforts by the centre – both Westminster and Whitehall – to exert control over actions at the periphery.
5. The hollowing out of NHS institutional structures involves: (1) removing layers of bureaucracy between the centre and periphery; (2) reducing the role of clinical expertise in decision-making; (3) diminishing accountability and democracy in the interests of efficiency. Each of these forms of hollowing are evident at the central, intermediate (regional) and local levels in the NHS.

## Centre

6. Prior to 1919 the Local Government Board (LGB) oversaw the expansion of the British state's diverse public health responsibilities during a succession of epidemic and infectious disease outbreaks along with a range of sanitary measures (Porter, 1999: 111-27). Part of the impetus behind the establishment of the Ministry of Health in 1919 was the failure of the LGB to respond to Spanish Flu, leading to a governmental consolidation of functions (Honigsbaum 1970; Honigsbaum, 2009).
7. The purview of the Chief Medical Officer (CMO) and the medical civil service staff expanded from 1919 (Sheard & Donaldson, 2006: 25-30, 67-72), which grew in 1948 through involvement in policy-making and the provision of medical advice across the NHS (Sheard, 2010). Since 1979, reductions in staffing have narrowed the purview of medical civil servants, intensified with the rise of new public management after 1983 (Rayner, 1994: 29-

31; Day & Klein, 1997: 6-16). The merger of medical and administrative civil service streams has further subsumed the role of medical expertise and advice at the centre (Sheard & Donaldson, 2006: 78-86). These trends have been aggravated by organisational separation through executive agencies: the Health Protection Agency from 2003-13, and Public Health England since 2013.

8. Concomitant with the demise of medical advice in decision-making has been the rise of managerialism and strength of executive authority, represented in the creation of the NHS Management Board in 1984 (Edwards & Fall, 2005). As Greer & Jarman (2007: 6) argue, the centre has transformed from the department of health to delivery, with its sole purpose being the performance management of the English NHS. This culminated in the parallel creation of NHS England in 2013, cementing the centre's nominal role as managing and regulating the resurrected internal market.

### *Region*

9. Regional governance in the NHS was a creation of 1948, although it reflected existing preferences towards regional cooperation and coordination nurtured by the Ministry of Health (Honigsbaum, 1989; 22-9; Webster, 1988: 8, 44-8, 55-62). Regions were not unified, but divided between Regional Hospital Boards (RHBs), which Richard Crossman (1972: 11, 1978: 466) saw as ineffectual and lacking in responsiveness to the centre, and Boards of Governors with direct responsibility to the centre (Webster, 1988: 395-7). Rivalry and antagonism between them were rife (Ham, 1981). However, both regional institutions were pivotal to the growth and modernisation of the NHS in the post-war period (Mohan, 2002). Regional structures remained bifurcated until 1974 with the creation of Regional Health Authorities (RHAs); delayed until 1982 in London because of political antagonism associated with the teaching hospitals (Rivett, 1986: 333-9; Webster, 1988: 294, 727).
10. From 1974, the role of region has been characterised as a 'buffer' (Tuohy, 1999: 192) between centre and periphery. However, those working at the centre and within region also saw them as a 'lightning rod' (Lambert et al, 2020: 36) for transmitting peripheral practices to the centre. Regional structures were instrumental in enabling pioneering ventures, including the new public health agenda (House of Commons Health Committee, 2016: 28; Ashton, 2019: 43). Following the introduction of the internal market in 1991, regional roles changed to market umpires (Hughes & Griffiths, 1999) and were merged in 1994 and transformed to become regional offices of the NHS Management Executive in 1996 (Dopson & Stewart, 1997).
11. Region was revived in 2003 with the creation of Strategic Health Authorities (SHAs) which, like RHBs and RHAs, were statutory authorities and obtained local legitimacy through appointment and accountability processes (Klein, 2013). Their abolition in 2013 represents the hollowing out of the regional tier within the NHS (Lorne et al, 2019: 45-6) with no buffer between the centre and periphery. The establishment of Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) at sub-national level provides support for health system leadership (Timmins, 2015) and promoting voluntary cooperation and coordination (Timmins, 2019) but without authority, resources or expertise. City regional mayors, with health powers, present a different approach as an intermediate tier of health governance, rather than a reinvention of previous regional capacity (Lorne et al, 2019).

### *Local*

12. The hollowing out of expertise, autonomy and capacity in the NHS at the centre and periphery has most impacted the periphery and locality. Nick Timmins' (2016: 3) interviewees featured in *The chief executive's tale* speak of a 'an NHS in which autonomy was increasingly circumscribed and regulation ever present' with a 'high personal cost' which is 'hard to exaggerate'. Similarly, the impact of the 2012 Health and Social Care Act on the capacity of middle managers – the comparable intermediate tier at the local level – has been dramatic (Hyde et al, 2016). In short, the elongation of lines of responsibility and accountability and the hollowing of the institutional structures of the NHS, rendered visible by a brief summary of their creation and consolidation, have had a detrimental impact on the front line in terms of expertise, autonomy, capacity and empowerment.

### **Devaluing Public Health**

13. Mirroring the emergence of the Ministry of Health in 1919, the role of public health and its professional servants – the Medical Officer of Health (MOH) – reflected a series of culminating responses to a plethora of population crises and epidemic diseases (Chave, 1974) which constituted expansive empires in urban local authorities (Lewis, 1986). The interwar period marked the zenith of their authority, with responsibility for preventive and curative services, municipal hospitals, housing and slum clearance, and a range of other functions (Webster, 1986; Gorsky, 2007; Levene et al, 2011) which was mirrored in associational and educational activities (Lewis, 1991).
14. Public health was demoted in 1948 with the tripartite division of the NHS, leaving MOsH with a residual range of responsibilities within local authorities (Welshman, 1997). Their duties were further eroded, notably in personal social services, until 1974 when MOsH were abolished and their functions transferred to Area Health Authorities (AHAs) under Community Physicians (Lewis, 1986; Webster, 1996: 487-96). The creation of Directors of Public Health (DsPH) in 1985 at district level were mirrored regionally, particularly following the 1991 purchaser-provider split. This was consolidated with the creation of Primary Care Groups (PCGs) and Trust (PCTs) from 1998 and 2003, with a focus on partnership, commissioning and reducing health inequalities (Smith & Goodwin, 2006).
15. The replacement of PCTs with Clinical Commissioning Groups (CCGs) in 2013 saw the abolition of Regional DsPH and the public health function 'returning home' to local authorities for the first time since 1974 (Gorsky et al, 2014). The return of DsPH to local authorities saw a resumption of their residual role with limited leverage, resources and portfolio (Jehu et al, 2017) largely focused on health promotion and lifestyle change. As former SHA and DPHs have noted (Brennan, 2020; Scally, 2020) this has left public health emasculated, emaciated and without status at local or regional levels, and unable to serve the necessary instrumental role in developing meaningful local approaches in responding to public health crises.

### **Restructuring, Fragmentation and Organisational Amnesia**

16. The cumulative impact of decades of restructuring, reorganising and fragmenting the NHS which constitute a hollowing out of capacity at the centre and periphery – in both managerial and medical spheres – has served to devalue institutional memory. The vortex of

transformation which accompanies these reforms is deeply problematic and leads to the movement of staff across roles, positions and functions – along with the enormous loss, demoralisation and disempowerment of dedicated public servants through a competitive churn – which leads to roles and relationships necessary for systemic change to be rebuilt on a Sisyphean basis. The structural loss of local public health leadership has limited the ability of the centre to devolve decision-making in the current COVID-19 crisis (Ham, 2020) let alone its willingness, as the 2009 Swine Flu pandemic response indicates (Chambers et al, 2012). This has, in turn, accentuated the dependency of the NHS and health services on the centre. When this is found wanting, vacillating or expresses any margin of error or uncertainty, the precariousness of the system is fatally exposed.

## Conclusion

17. Historical perspectives on the current COVID-19 Coronavirus crisis allow decision-makers to understand the circumstances which have given rise to the capacity of the NHS and government machinery to respond. In recent history; (1) the hollowing of the state, particularly with the loss of a regional tier of management has magnified its incapacity to respond to an already unprecedented and challenging threat; (2) the devaluation and marginalisation of public health professionals and perspectives has eroded the capacity of the periphery to provide broader policy responses; (3) the cumulative impact of hollowing and devaluing through recurrent NHS restructurings has been the loss of organisational memory which is essential for the health economy and system to operate.
18. History may not repeat, but it rhymes. The future of the NHS can, and must, learn from its past. Although the COVID-19 Coronavirus pandemic represents a problem to every major health service in the world, it has exposed underlying and unresolved problems of governance, capacity and organisation. Should these lessons fail to be heeded, history will repeat.

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