BODY POLITIC **Nigel Hawkes**

Can Jeremy Hunt please explain?

Will the new health secretary do a better job of communicating his government's vision for the NHS than the last?

Explaining the Health and Social Care Act was a task that constantly eluded Andrew Lansley, even though he was its author. Will his successor as England's health secretary, Jeremy Hunt,[1] do any better? He was appointed to the job apparently because Number 10 Downing Street believed him to be a better communicator, though evidence for this is scant. Certainly he communicated well enough with News Corporation during its unsuccessful bid for Sky, but I'm not sure that this is quite what the prime minister had in mind.

Looking on the bright side, however, Hunt does have certain advantages. Lansley's narrative, such as it was, related to what he believed the act to be. But the result of the endless trims and tucks that enabled it finally to be enacted meant that what he said and what was actually happening were wildly divergent. Hunt is liberated from that constraint, giving him a better chance of telling it like it is. That's an admittedly small consolation, but he must make the best of it he can.

The intention of the bill was to liberate and decentralise: to delegate decision making to the most local level possible and to remove the power of the centre to dictate policy. General practice commissioning groups were supposed to be fleet footed risk takers, in close touch with patients and willing to think the impossible in recasting services in new and patient friendly ways. They would need help, but that could come from a variety of sources, opening up the NHS to fresh ideas from outside. Whole rafts of managers would be shed (this part actually happened) and clinical priorities, not bureaucratic targets, allowed to rule.

What's the actual outcome? True, we have clinical commissioning groups, but they look increasingly like the primary care trusts they replaced. The principal difference is that they have lower management budgets, because many of the functions of PCTs have been hived off to commissioning support organisations or the NHS Commissioning Board.

As for fleetness of foot, the aversion to risk that is the hallmark of the NHS has firmly put that where it belongs: behind a network of constraints that are likely to bind the commissioners as tightly to terra firma as the Lilliputians bound Gulliver. This summer the first wave of commissioning groups has been going through the authorisation process, which involves 138 "domains" requiring documentary evidence, which, neatly assembled, is said to make a pile six feet high.

It can be argued, rightly, that commissioning groups will be spending large amounts of public money and need to be properly organised. But once they're up and running, what's to hold them back? Well, most are likely to take their advice from a new level of NHS bureaucracy, the commissioning support services—23 organisations around the country employing 8000 people and costing around £700m a year. You can think of these bodies, not too inaccurately, as PCT staff scattered in the diaspora but recongealing as new organisations with all the overheads, authorisations, regulatory frameworks, and general paper pushing that the NHS is so expert at.

And then there's the Commissioning Board, the new fiefdom of the NHS chief executive, David Nicholson, whose responsibilities know few limits. It will have 27 local area teams, all of which will be responsible for commissioning general practice, dental, pharmacy, and some optical services and 10 of which will have additional responsibilities as specialised commission hubs. These 10 will have budgets that dwarf those of most commissioning groups, with the London Local Area Team alone spending £4bn a year. You can think of these, again not too inaccurately, as the diaspora of the abolished strategic health authorities reconstituting themselves under another name.

"Not much is going to be left for the commissioning groups to do, but they'll have plenty of people around to tell them how to do it—the same people, of course, who ran the system before"

"Great to see we have recreated the SHA [strategic health authority] map from 2002 to 2006," commented an anonymous manager (they're always anonymous) in the *Health Service Journal*. And then there are the clinical senates, and the health and wellbeing boards, and Monitor, a regulator that suffers from a hyperactivity disorder.

Amid all this confusion, almost everybody with any experience of the NHS is trying to exploit uncertainty to increase their power and reach. Thanks to the legislation, the only person who won't have enhanced power is Hunt. He'll have less because the aim of the act was to reduce the power of the secretary of state to meddle. That sounds fine when you're in opposition and the direction of meddle is not to your taste, less so when you're in power and things are happening that the voters hate.

So all eyes will be on Hunt to see how he views efforts to reconfigure hospital services, one of the acid tests of the act. Most people, including the Royal College of Physicians,[2] believe that reconfiguration is necessary, but it's never popular, and Lansley hoped to insulate ministers from the political fallout of its implementation. Long delayed change was beginning to seem possible. But if Hunt's appointment signals a softer approach, you can forget that.

A second test will be the final wording of the mandate given by the Department of Health to the NHS Commissioning Board. This is by way of a farewell note as ministers hand over power, laying out the ground rules to be followed by the new, unelected power holders. Lengthy, target filled, and highly prescriptive, as the Treasury and Number 10 want, or broad brush and aspirational, as the NHS Commissioning Board would prefer? You can be sure every word will be scrutinised with the greatest care.

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References are in the version on bmj.com.
Cite this as: *BMJ* 2012;345:e6208