

# NEVER AGAIN?

## NEVER AGAIN?

The story of the Health and Social Care Act 2012

*A study in coalition government and policy making*

*Nicholas Timmins*



Never Again?  
Or  
The story  
of the Health and  
Social Care Act 2012

A moderne drama  
In Five Incompleted Acts



By Command of  
Her Majestie's Governanc

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# Synopsis

'Never Again?' tells the story of how and why the Health and Social Care Act 2012 – by far the most controversial piece of NHS legislation in more than two decades – became law.

It relates the story of a political thriller – from the legislation's origins 20 years ago, through the development of the 2010 white paper "Liberating the NHS" and the resultant bill; a bill so controversial that it appeared at times as though the Government might lose it.

It does so from the view point of opponents and critics, but also from the point of view of the man with whom this legislation is uniquely identified – the current health secretary.

On the way, it explains just what it was that Andrew Lansley was trying to do and why the bill was so vast and controversial.

It details the events that shaped it – most notably the Coalition's now partly forgotten "programme for government". That document – cooked up purely by the politicians in Downing Street over 12 days immediately after the election in May 2010 – radically reshaped the health secretary's plans.

Sorting out the "disaster" in the "programme for government" turned what would have been merely a large shift of power and accountability within the NHS into a huge structural upheaval: one that allowed the reforms to be written up as the biggest reorganisation in the 63-year history of the NHS; and one that could become this Government's "poll tax".

'Never Again?', in particular, is a story of coalition government and coalition policy making. The act is uniquely identified with Andrew Lansley, but without the Liberal Democrats it would have been a very different bill. At the same time, without the Liberal Democrats, there would have been much less fertile ground within government for opponents to sow the seeds of their dissent. Without them, it would have undergone fewer amendments. And yet, in another twist to the coalition tale, without Liberal Democrat votes the legislation would not have passed.

'Never Again?' recounts:

- how Andrew Lansley was banned from talking about the detail of his plans ahead of the election
- what happened at the meeting that called "the pause" on the legislation
- how Sir David Nicholson came to be appointed chief executive designate of the NHS Commissioning Board
- how Andy Burnham revived the opposition to the bill
- and how the Coalition finessed its legislation through the House of Lords.

'Never Again?' also seeks to draw some early lessons from what is widely regarded as a "car crash" of both politics and policy making. But at the same time it explains why the health secretary believes that never again – or at least for the foreseeable future – will the NHS need to undergo another big structural change and raises the possibility that Andrew Lansley could yet emerge as something of a hero of public sector reform.

## About the author

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# Foreword

## Never Again?

The first two years of coalition government in the UK have been dominated by the economy, deficit reduction – and the reform of the NHS. The first two were well trailed before the election. But few expected an argument about “top-down reorganisation” of the NHS to dominate the political debate.

The Health and Social Care Act merits attention as a case study of policy making and coalition government. It is also an important milestone in the history of NHS reform – not least since one of the reasons for Andrew Lansley’s full frontal approach was to put the NHS changes onto a more permanent basis – where they could only be undone by legislation, not secretary of state fiat. That is why Institute for Government and the King’s Fund asked Nicholas Timmins to produce a “first draft of history”.

Here Nick tells the story to date – judgements, as Nick says, will need to wait for the outcome of the reforms. The Institute for Government’s work on policy making suggests that good policy has to get the right blend of technocracy and politics. Even at this juncture, it is clear that the NHS reforms have required the Government to expend a huge amount of political capital to get the bill through and lose public confidence on an issue that was crucial to David Cameron’s detoxification of the Conservative party. Whether or not the act succeeds in its objectives, there was a failure to get the politics right.

The case study looks at how that came about. It brings out important lessons on policy making in opposition, preparation for government, on the dangers of rushing out policy announcements during the first hectic period of transition into office and the particular challenges of coalition government, which are all themes that the Institute has studied. It also sheds important light on the inner workings of the Government in a key policy area – on the role of Number 10, the Treasury and the Centre. The separate Institute for Government commentary goes into those wider lessons in greater depth.

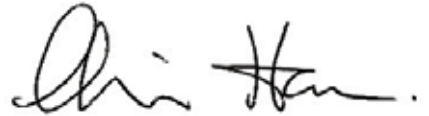
The King’s Fund warned early on that the reforms were going “too far, too fast”. Nick’s account of the process of reforms confirms that the Government was in a rush, motivated by a concern to avoid New Labour’s self-confessed mistake of failing to be bold in its first term. In the event, speed was at the expense of engagement, leading to a rising crescendo of opposition that led the prime minister to introduce a pause in the passage of the bill through parliament in order to listen and respond to the concerns of stakeholders. How far the subsequent amendments to the bill amount to substantial changes or cosmetic revisions remains a matter of debate. What is clear is that the pace of reform continues unabated, creating major challenges as the NHS seeks to achieve efficiency savings on a level unprecedented in its history.

The impact of the reforms will depend as much on how they are implemented as on the provisions of the Health and Social Care Act. In the detailed debate on the wording of the legislation, the importance of implementation was neglected and yet history shows the many opportunities for the intentions of radical reformers to be altered and distorted as

they are carried into action. The NHS has proved to be remarkably resilient in the face of efforts by successive governments to make major changes in how it is run and there is no reason to expect things to be different this time round. Lessons about policy making need to be married with lessons about implementation, and The King's Fund will be playing its part in analysing the impact during the remainder of this parliament.

A handwritten signature in black ink that reads "PJR Riddell" followed by a horizontal line and a small dash.

Peter Riddell

A handwritten signature in black ink that reads "Chris Ham" followed by a horizontal line and a small dash.

Chris Ham

*“The history that happens underneath our noses ought to be the clearest, and yet it is the most deliquescent.”*

*Julian Barnes*

*“If one day subsequent generations find you cannot make commissioning work, then we have been barking up the wrong tree for the last 20 years.”*

*Kenneth Clarke, former Conservative health secretary, speaking at 60th anniversary of the NHS in 2008*

*“Labour secretaries of state have got away with introducing private sector providers into the NHS on a scale which would have led the Labour Party onto the streets in demonstration if a Conservative government had ever tried it. In the late 1980s I would have said it is politically impossible to do what we are now doing. I strongly approve.”*

*Ibid<sup>1</sup>*

*“You cannot encapsulate in one or two sentences the main thrust of this.”*

*Simon Burns, minister of state for health, March 2012<sup>2</sup>*

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1 *Rejuvenate or retire? View of the NHS at 60*, Nuffield Trust, 2008

2 The Report, BBC Radio 4, 22 March 2012



# Prologue

In the best tradition of the digested novel, the story of the Health and Social Care Act 2012 – which proved to be something of a political thriller – is well known. It can easily be told.

A man in a hurry who was part of a coalition government (that just weeks earlier had promised the country “no more top-down reorganisations” of the National Health Service) launched arguably the biggest restructuring it had seen in its 63-year history. He did so without having told anyone what he was up to – at least as far as most of the public and the staff of the NHS were concerned.

So great was the resistance – not least from the grass roots of one part of the coalition – that the Government was forced into an unprecedented “pause” over its legislation. The pause, however, failed to silence the critics. There were times when it looked like the bill would be lost. In fact it got through. It did so, in part, thanks to the obduracy of a man with a mission, whose big idea this was. It was passed, however, at enormous political cost.

Commentators from both the right and the left predicted that these reforms would prove this government’s “poll tax” (the radical idea for a new form of local taxation that became a key factor in the downfall of Margaret Thatcher) and that it could cost the Coalition the next election.

The lessons are obvious: don’t do anything so radical to one of Britain’s best loved institutions when the electorate and the staff do not believe that you told them about your plans. And certainly don’t do it this way.

And all of the above is true, at least up to a point.

But the full story of how the Government got into what is widely seen as a “car crash” in terms of both policy and politics is inevitably more complex than that. And the lessons to be learned may not be just the obvious ones.

After all, this set of changes – whose roots go back more than 20 years, not just into the history of the previous Labour government but that of the Conservative administration before it – may work, in which case the lessons will be very different.

Either way, the story of how and why they happened is worth telling, not least because it raises issues of interest to both the Institute for Government and the King’s Fund who jointly commissioned this work.

Where did the ideas come from? Why were they such a surprise? Particularly when they contained little or nothing that was new, save perhaps in degree? What does the experience reveal about the preparations for government? The transition to it? And the nature of policy making and its presentation?

In particular what does it tell us about this Coalition government? For while the act came to be seen as the property of essentially one man – the Conservative health secretary Andrew Lansley – the package, without the Liberal Democrats, would have looked very different.

It would almost certainly have involved less immediate structural upheaval. Without Liberal Democrat votes, it is inconceivable that a minority Conservative government could have got this bill through. But then again, without them it would have been a different bill. Furthermore, and almost paradoxically, without the Liberal Democrats, there would have been much less fertile ground *within* government on which opponents could grow the seeds of their dissent.

David Donnison once remarked that social reform is a process, not an event – a kind of drama.<sup>3</sup> What follows, therefore, is a drama in five acts, with the sixth and most important – implementation – yet to be written.

This introduction comes with two warnings. It opens with two chapters to set the scene – scenes one and two – before Andrew Lansley gets involved and the story really takes off. Readers are welcome to try skipping them. But without a little early graft to understand the history, it is difficult to fully understand what the current health secretary was trying to achieve.

The second warning is a related one. Given the length of this, there will be a temptation to jump to Act Five to look at the still somewhat tentative lessons and conclusions. Readers are, of course, welcome to do that. It might, however, be a little like watching only the last scene of a Jacobean drama in which there are plenty of bodies lying around the stage – but you get no real idea of how and why they got there, or why there is still at least some light at the end of the tunnel.

As time goes by, far better accounts than this will be written of the near two-year struggle to get Andrew Lansley's mighty reform of the NHS on to the statute book. More documents will become available. Many more people will feel free, both on and off the record, to relate what happened and why.

History will also provide a judgement that right now is impossible: how far the act proves a success, how far a failure; whether it will really transform the way the NHS functions, for good or ill; or whether, as indeed is most likely, the most radical edges of this package get knocked off in the same way that, intentionally or not, the impact of most previous attempts at reform have been muted by both politicians and by the NHS itself. The service has a distinct tendency to revert to type.

History will also demonstrate whether – as Andrew Lansley hopes and believes – this will prove to be the last great structural reform of the NHS, at least for many years.

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3 *The Politics of Poverty*, David Donnison, Martin Robertson 1982

What is already clear, however, is that this is by far the most contentious change to the way the service functions since Kenneth Clarke's original introduction of the purchaser/provider split in to the NHS in 1991 – a change arguably far more revolutionary than Lansley's reforms, given where the NHS then was.

And not in my journalistic lifetime – with the possible exceptions of the poll tax and the recent rise in tuition fees – has a piece of legislation been so bitterly contested *within* a government while still becoming law. All that makes it worthy of serious study.

A note about sources is essential. Much of this is drawn from the published record: daily newspapers, weeklies, journals, websites, social media, *Hansard*, and the notes and research papers of the libraries of the Houses of Commons and Lords.

In addition, however, well over 30 people – politicians, special advisers, officials, commentators and assorted players in these events – generously found time for interviews, providing insights and understanding that simply had not dawned on me. These ranged from a few minutes on the phone to a couple of hours or more with a digital recorder. In addition, more than a dozen people both inside and outside government read drafts or part drafts of this in various stages of preparation. All of them saved me from errors of fact and interpretation. The ones that will inevitably remain are all mine – and particularly the errors of interpretation as there are many prisms through which these events can be viewed.

Where material is drawn from interviews rather than published sources the present tense is used in order to reduce footnotes: "x says", or "as x puts it", rather than "x said".

Each category of interviewee, however, also provided a range of comments, accounts, observations, analysis and stories that were not for attribution – in other words they were not to be personally identifiable. I am very keen to protect that.

So in this unusual situation so close to events, we have taken the highly unusual step of not producing a long list of thanks to those who helped so much, even when their contribution was entirely on the record, and decidedly large. They all know who they are and the Institute, the Fund and I are all immensely grateful. As time goes by, and if a later version of this is ever produced, it will be possible to indulge in much more public thanks.

I made no attempt to interview either David Cameron or Nick Clegg. I simply judged they would be too busy. One or two key players – notably Oliver Letwin and Danny Alexander – declined to be interviewed. I trust that spares me from any complaints from them about inaccuracies and misinterpretation.

All the others gave up their time because they believe – like the Institute and the Fund, and indeed Andrew Lansley in his interview for this piece – that there must be lessons to be learned from this experience; even if not all of them will agree what those lessons are, or with the ones drawn here.

What follows has the advantage of being recorded when memories were fresh. Even this close to events, however, there are differing recollections of precisely what happened, when and why. Far from everyone involved has been interviewed and later history may show that some of the journalistic reporting on which I have relied was not entirely accurate – including my own.

So this cannot be a comprehensive account of the creation and passage of the act. I hope nonetheless that this is an honourable attempt at a first rough draft of the history, presented dispassionately enough to let others draw their own conclusions, and on which others will build.

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# Act One: Out of the Ark

## Scene One: The pipers at the gates of dawn

“This is really, really revolutionary.” The words, uttered to colleagues in private, are those of Sir David Nicholson, the NHS chief executive, in June 2010 just six weeks after the general election.<sup>4</sup>

“This” was Andrew Lansley’s plan for reforming England’s National Health Service – the NHS being “the closest thing the English have to a religion,”<sup>5</sup> in the famous phrase of Nigel Lawson, a former Conservative chancellor.

Less than a month later, a government that in its detailed statement of intent (its “programme for government”<sup>6</sup>) had promised that “we will stop the top-down reorganisations of the NHS that have got in the way of patient care”, launched what was arguably the biggest reorganisation the service has seen in its 63-year history – and what was certainly the biggest shift in power and accountability it had ever seen.

Its white paper, *Liberating the NHS*<sup>7</sup> – produced far faster than any previous health white paper, in a record 60 days after the Coalition government was formed – announced that family doctors were to take over the commissioning of NHS care.

Their work was to be overseen by a new national commissioning board. The entire existing superstructure of the NHS (the 10 regional health authorities and 152 primary care trusts) was to be abolished.

A new economic regulator was planned to oversee choice and competition, both of which were to be extended. From the private and voluntary sectors, “any willing provider” was to be allowed to supply NHS care at agreed NHS prices. The existing public health body, the Health Protection Agency was to be absorbed in to the health department, but with an appreciable chunk of the public health budget transferred to local authorities. Health and Wellbeing Boards were to be created in local government to join up the commissioning of NHS services, social care and prevention. And a new patient’s voice organisation, Healthwatch, was to be created.

These were just the main headlines of a remarkably slim white paper – a mere 50-odd pages. There were plenty of other changes. The package involved arguably the biggest structural upheaval in the health service’s history – certainly since the 1974 reorganisation of the NHS, which transferred a whole bunch of former local authority functions to the health service.

It was certainly the biggest shift ever in power and accountability, with GPs *required* to assume the driving seat of commissioning, while whole tiers of the existing management of

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4 *Financial Times*, 18 June 2010

5 *The view from Number 11*, Nigel Lawson, p 613

6 HM Government, ‘The Coalition: our programme for government’, 19 May 2010 (accessed 1 June 2012)

7 Department of Health, ‘Equity and excellence: Liberating the NHS’, 12 July 2010 (accessed 1 June 2012)

the NHS were to be abolished. Ministers were to give the commissioning board a mandate – a set of mainly outcome targets such as reducing cancer mortality. But the plan was that ministers would then stand back from day-to-day management. The legislation, in the words of the white paper, would limit “the ability of the secretary of state to micromanage and intervene” in the running of the health service.

Over the next two years, however, the NHS reforms were to become by far the Government’s biggest domestic political headache, outside of the deficit. At the same time they would place bigger strains on the Coalition than even the introduction of hugely increased tuition fees for higher education, which were implemented in direct contravention to a Liberal Democrat manifesto pledge.

At times it looked as though the mighty bill to implement the NHS changes might be lost. Near the end of the legislative process even Conservative supporting commentators were freely warning that the reforms might well prove to be the Coalition government’s “poll tax”.<sup>8</sup>

What follows is a study of how the Coalition government’s reforms came to be; why they came to be such a headache for the government and the health service; and what might be learned from that.

It is deliberately not an analysis of the merits of the changes – although there will be plenty of views of their merits expressed by various voices along the way.

Rather it is a study in government. Despite the reforms being almost universally known as “Lansley’s reforms”, it is also in particular a study in Coalition government as (at least on this analysis) the existence of a coalition, as opposed to a single-party Conservative government, has had a profound impact on events and on the shape of the changes.

To understand the health secretary’s proposals – and particularly for readers who are not specialists in the management of the NHS – it is necessary to dive a long way back into a somewhat tortured history.

The NHS has undergone plenty of reorganisations before, many of them controversial. After a period of marked stability between 1948 and 1974 which saw no material change, the service has since been subjected to something like 20 reorganisations, depending on precisely how you count them.<sup>9</sup> In other words, on average, around one every two years – to the point where “organisation, re-organisation and re-disorganisation” might well be dubbed the NHS disease.

The most dramatic of these reforms before 2010 – and arguably far more revolutionary, given how the NHS then operated – was Kenneth Clarke’s white paper *Working for Patients* in January 1989, a set of changes that actually took effect in 1991.<sup>10</sup>

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8 ‘The unnecessary and unpopular NHS Bill could cost the Conservative Party the next election. Cameron must kill it’, Tim Montgomerie, Conservative Home (accessed 1 June 2012)

9 ‘Reorganisation of the NHS in England’, *British Medical Journal* 2010; 341 doi: 10.1136/bmj.c3843

10 *Working for Patients*, Cmnd 555 HMSO 1989

This heralded the introduction of the so-called “internal market” to the NHS – the first building blocks of what was to become Lansley’s reforms.

Instead of health authorities directly managing hospitals, there was to be a purchaser/provider split. The NHS, arguably for the first time, would decide what care it wanted and then purchase it on contracts from “self-governing” hospitals to be known as NHS trusts, which were given a limited range of new operational freedoms. Hospitals, in effect, would have to compete for patients. The belief was that the injection of at least an element of competition would increase efficiency, and – it was hoped – quality, as the provider parts of the health service responded to market signals from the health authority purchasers.

In the most innovative of these changes, and in recognition of the fact that patients would have to follow the contracts that health authorities held, family doctors were offered the opportunity to become “fund holders”. That involved taking a cash budget for their patients, with which they could buy an initially limited range of care. The budgets covered, for example, elective (waiting-list) operations, services such as physiotherapy, and the GPs’ own prescribing. They could buy from whoever they wished – not just from the NHS, but from the private and voluntary sectors – while also being free to set up new services themselves.

The idea was that at least for some treatments “money would follow the patient” so that hospitals that did more work would earn more. Hospitals that failed to attract patients would earn less – the hope being that they would up their performance in response to competitive pressure.

At the Cabinet meeting before the white paper was launched, Clarke says:

“I told colleagues we were going into Tavistock House [the headquarters of the British Medical Association, the doctors’ trade union], lifting most of the tablets of stone and smashing them on the pavement in front of their eyes.”

There was, he says, “going to be one hell of a political row”.<sup>11</sup>

He was dead right. With Margaret Thatcher still at the height of her powers, the creation of “self-governing” hospitals was seen by critics to be merely the first step towards their complete privatisation. GPs fell out bitterly over whether it was morally right to take budgets. There were widespread worries about what would happen if they ran out of money. Others feared an irretrievable breakdown in trust between doctors and patients once GPs were responsible for allocating resources between patients and staying on budget. GPs who became fundholders were accused by colleagues of being “Quislings”.

The British Medical Association launched a £3m advertising campaign against the reforms – well over £6m worth in today’s money. It produced memorable posters including a simple picture of a steamroller captioned “Mrs Thatcher’s plans for the NHS”. Another asked: “What do you call a man who ignores medical advice? Mr Clarke.”

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11 Quoted in *The Five Giants: a Biography of the Welfare State*, Timmins N, Harper Collins, 1995 p 466



The Government lost at least two by-elections in Conservative held seats – by large margins – in which the issue of the NHS reforms took centre stage. Critics were warning that the changes marked “the end of the NHS as we know it” taking it down a road towards US-style privatised care.

Clarke, however, backed by a big Commons majority, and a Conservative dominated House of Lords, refused to compromise on the plans, rejecting pleas to water them down, pilot them, or otherwise amend them.

If that sounds remarkably like the stance that Andrew Lansley, the current health secretary, sought to take, there were also crucial differences.

The Conservative plans – in many ways like the public perception of Andrew Lansley’s plans – had not been trailed ahead of the 1987 election. Indeed, NHS reform had not even been on the Conservative agenda.

Shortly after the 1987 general election, however, the service plunged into the worst financial crisis in its history – triggered by an impossibly tight spending settlement and the postponement, on political orders, of measures to tackle that ahead of the general election.

Thousands of beds closed and screaming headlines told of operations being impossibly and sometimes lethally delayed. In January 1988 Margaret Thatcher announced that a review of the NHS was underway. A year later, *Working for Patients*, implemented in 1991, was the result.<sup>12</sup>

By contrast, the Coalition government’s upending of the NHS in 2010 came not amid an NHS financial or performance crisis but after the longest period of sustained spending increases in its history. Waiting times were the lowest they had ever been. International surveys of health systems, while being clear that the service still had its problems, nonetheless put the NHS high in the league tables on many measures. Just as the white paper was launched, public satisfaction with the NHS and its services was recorded by the British Social Attitudes Survey to be at its highest ever in a polling series that runs back to 1983. The health department’s own patient surveys were showing the same thing.

To be sure, the NHS was far from perfect. There had been a series of truly awful outbreaks of hospital acquired infections. A public inquiry was underway into Mid-Staffordshire hospital over appalling tales of patient neglect and the likelihood that there had been scores, possibly many more, of preventable deaths. Official surveys showed that in almost one in 10 NHS trusts, fewer than half the staff said they would be happy for a friend or relative to be treated there.<sup>13</sup> On a number of measures the UK still performed less well than leading European health care systems.

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<sup>12</sup> For an account of this see Nicholas Timmins, *The Five Giants*, Fontana 2001

<sup>13</sup> [2010 NHS staff survey](#) (accessed 1 June 2012)

The service was about to face the fiercest financial squeeze in its history. But for all that, there was no immediate spending crisis, nor any immediate performance crisis to trigger the Lansley plans.

Furthermore – in contrast to the 2010 white paper’s proposal for all family doctors to be required to be in GP consortia by a given date – Clarke’s proposals for NHS trusts and for GP fundholding, while revolutionary in concept, were evolutionary in implementation.

Hospitals were allowed to volunteer to become NHS trusts, and becoming a fundholder likewise was voluntary. Both changes were rolled out in waves, rather than imposed overnight. Well before 1997, when Labour took power, all hospitals had become NHS trusts and half of all GPs were fundholders.

Many family doctors, nonetheless, maintained their objection to GP fundholding on principle – not least because fundholders could line their own pockets with some of the savings they made on patient care. In response, GPs invented other forms of commissioning group to try to influence what health authorities bought on their behalf.

Fundholding did have an impact. GPs used their new financial power to demand shorter waiting times and/or lower prices from hospitals. Some moved physiotherapy or outpatient appointments out of hospital, or undertook minor day surgery in their premises. None of this, however, led to a radical reshaping of what happened in hospitals. And the best academic analysis of the changes broadly supports the conclusion of an Audit Commission study in 1996.<sup>14</sup> That suggested that the top 10% to 20% of GP fundholders made some real difference but that the rest were probably not worth the extra administrative costs involved.

Furthermore, it was never quite clear how the two sets of purchasers – health authorities and fundholders – were meant to mesh together in the long run. The range of services fundholders could buy was slowly extended. But it was never certain whether they were meant to end up being the dominant, or sole, purchasers of care, while the refusal of around half the country’s GPs to take up fundholding led to accusations of a “two-tier” service. At least in theory, and sometimes in practice, the patients of fundholders could get a more responsive service than those of non-fundholders.

Partly to address these issues the arrival of Stephen Dorrell as secretary of state for health in 1995 (he had been a junior health minister at the time of *Working for Patients*) saw the launch of low-profile but significant experiments in “total purchasing pilots”. Under these, GPs – many of whom had not been fundholders – took responsibility for the entire local health budget, including accident and emergency, maternity, and mental health care.

In hindsight, these total purchasing pilots look remarkably like the GP consortia that Andrew Lansley proposed in his white paper – with the crucial difference that they did not directly control the cheque book. The statutory responsibility for paying the bills was retained by their sponsoring health authority.

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14 Audit Commission '*What the Doctor Ordered*', 1996. (accessed 1 June 2012)

It is also worth noting that throughout this period of history there were various attempts, largely unsuccessful, to separate out the running of the NHS from its direct management by ministers and the department.

In 1985 a remarkably short-lived “supervisory board” of ministers and civil servants was set up separately from a “management board” – a change that included creating, for the first time, the post of NHS chief executive.

The supervisory board functioned for barely a year. But the management board went through a whole string of incarnations that culminated in the establishment of the NHS Executive in 1989 – which was itself restructured on a number of occasions.<sup>15</sup> How effective this was in distancing ministers from the management of the service always depended on the character and opinion of the minister of the day. Some were happy to try to run the service more at arm’s length; others wanted to be clearly and intimately in charge.

All of these were administrative arrangements – the various boards and the executive were never statutory bodies. And in 2000 Alan Milburn as health secretary scrapped the idea entirely. He merged the posts of NHS chief executive and permanent secretary to the department. This was, to put it one way, the moment when the lunatics took over the asylum. Managers were plainly in the ascendant in the health department and the department’s policy-making capability suffered as a result.<sup>16</sup>

That unhappy experiment ended with the departure in 2006 of Sir Nigel Crisp, the only person to hold the joint appointment. On and off over the years however, the idea entered the policy debate that the NHS might be run by an independent board – perhaps on the lines of the BBC. Each time it died in the face of what most saw as the political reality – that in a tax-funded system the public and Parliament would never let ministers not be answerable for what happened in the service.

If Clarke’s reforms were the first big step towards a more market-like NHS, the 1990s also saw some steps back from the idea. Even though the purchaser/provider split remained, NHS trusts gradually lost much of their nominal freedom as health authorities slowly reinstated oversight of their activities. And whenever it looked as though the purchasing side might produce disruptive changes to hospital services, ministers tended to intervene to damp that down. There was a marked reluctance to let these market-like reforms rip.<sup>17</sup>

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15 A good and detailed account of all this is in *The Executive Years of the NHS* by Brian Edwards and Margaret Fall, Nuffield Trust 2005

16 See 2007 *DH Capability Review*, (accessed 1 June 2012)

17 See *The Five Giants: A Biography of the Welfare State*. Timmins N, Harper Collins, 1995 p 482

## Scene Two: Labour in power

If the 1990s was a mix of two steps forward, one step back and then some reinvigoration of the market like mechanisms, the arrival of Frank Dobson as health secretary was a distinct step away from them.

His tenure between 1997 and 1999 saw the most determined effort in NHS history to run the service by “command and control” from Whitehall.

Labour had pledged to “scrap” the internal market. In practice it kept the purchaser/provider divide between health authorities and hospitals, although purchasing was renamed “commissioning” – partly to convey the idea that commissioners were meant to shape services, not just buy the wares that hospitals happened to offer.<sup>18</sup>

As the manifesto had promised, however, GP fundholding and the total purchasing pilots – which had run “live” for only a year – were abolished. And Dobson strongly discouraged what limited use the NHS was making of private hospitals.

What remained of GP commissioning went through a bewildering array of incarnations. By 2002 these resulted in GPs having some limited influence over primary care trusts (PCT) – the commissioning bodies that eventually replaced not only GP fundholding and the non-fundholding commissioning groups, but also the lower tiers of the pre-existing health authorities.

By mid-2001, however, more money and pure “command and control” – for example targets for waiting times – appeared to be producing little in the way of enhanced NHS activity. Under Alan Milburn as health secretary Labour gradually reverted to the Conservatives’ more market-like approach. It did so, however, in an appreciably more sophisticated form.

For a start, even ahead of 2001, Labour had created an NHS inspectorate (currently the Care Quality Commission). NICE, the National Institute for Health and Clinical Excellence, had been set up to recommend which treatments the NHS should and should not adopt, while providing guidelines on best practice.

Milburn went on to announce legislation for NHS Foundation Trusts. These received a much stronger statutory underpin of independence than NHS trusts had ever enjoyed. They were set up as public benefit corporations – a sort of half-way house between the public and private sectors – and they also received additional freedoms. Not only were they to own their land and be able to set their own pay rates, they were also freed to borrow from the public or private sectors; to run joint ventures with the independent sector; and to make surpluses and losses so long as those surpluses are spent to the benefit of NHS patients.

They remained, nonetheless, subject to oversight by a regulator known as Monitor which has extensive powers to intervene, replacing boards and chief executives where necessary. Even so, their statutory independence – where their boards and chief executives were

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<sup>18</sup> For a good account of the Labour years see *Understanding New Labour's Market Reforms of the English NHS*, King's Fund, 2011

prepared to exercise it – significantly limited the ability of the NHS chief executive, and of strategic health authorities, to direct their operations.

Yet again, however, foundation trust status was rolled out gradually, encouraged but not imposed. The original goal was that all NHS hospitals would “have the opportunity” to become foundation trusts by April 2008.

Alongside these changes, a fixed NHS price, or tariff, was developed for a range of hospital treatments. This provided something crucial that the 1991 reforms had lacked – a standard currency for NHS treatments. It meant that this time money really did follow the patient – or at least it did for the roughly 70% of the activity of a typical district general hospital that the tariff covered. By using a fixed price, the goal was to get the NHS and independent suppliers to compete on quality and the structure of services – not waste time, effort and money merely haggling over the price of treatments at the margin, as many fundholders had done.

The tariff also made it possible to restore patient choice. One of the wholly unintended side effects of the 1991 reform was that choice had been heavily restricted. From 1948 to 1991 – more than 40 years – GPs had been able to refer patients to any hospital in the country. After 1991, if the GP or health authority did not have a contract with the hospital in question, patients had to go through a cumbersome bureaucracy of “extra contractual referrals” that was inconsistently applied.

Once a price list was available, if a patient went to a hospital with which the purchaser did not have a formal contract, the fixed sum for the treatment could simply be taken from the purchaser’s budget and used to pay the provider.

Thus from 2004 on, with the most waiting-list type treatments covered, Labour initially ran some pilots. Then from 2006 gradually restored not just the GP’s but the patient’s ability to choose where to go for such care. By 2008, that choice was extended to include any private hospital willing to treat patients at NHS prices.

None of this reintroduction of competition and choice, however, was without controversy – some of it fierce. Indeed Tony Blair nearly lost his Commons majority over the introduction of foundation trusts.

Equally controversial (while not requiring legislation) was the decision to invite the private sector to run “independent surgical treatment centres” (ISTCs). These surgical factories had a three-fold role: first to increase capacity to help cut NHS waiting times; second, to provide NHS hospitals with an element of competition; and third to undercut the UK’s indigenous private hospitals which frequently charged 30% to 50% above the tariff – and in some cases much more – for NHS waiting-list operations when hospitals or primary care trusts used them to meet waiting time targets.

Faced with competitive new entrants, and falling NHS waits that threatened to reduce the demand for private care, the private hospitals adapted. Many currently offer NHS treatment at NHS prices rather than the far higher margin of the past. Well over 400,000 patients a year are now choosing private hospitals for their NHS care.

There was heady talk that 15% or more of NHS waiting-list type treatments could one day be provided by the private sector – although the proportion in fact has yet to reach 5%.

As part of the reintroduction of these market style mechanisms, Labour also had a policy (which was never fully implemented) that primary care trusts should divest themselves of their so-called “provider arms” – services that they ran such as district nursing and physiotherapy and in some cases community hospitals and even the odd GP practice. A wide variety of alternative models of ownership was touted – including allowing staff to set themselves up as social enterprises – as Labour sought to reinforce the “commissioner/provider” split.

Most of this happened under Tony Blair’s premiership. Much of the drive for it was diluted once Gordon Brown became prime minister.

If that was the state of the NHS market just ahead of the general election, what had become of GP commissioning?

The answer is that the ghost of it lived on. Although it had never proved that effective in the 1990s,<sup>19</sup> by the mid-2000s Labour ministers had come to feel that something had been lost in its disappearance, with GPs merely having a not very effective influence on the commissioning by primary care trusts.

So in 2005, in another example of a step forward following a step back, it received a re-launch in the shape of “practice-based commissioning”. Again, it was never clear whether GPs in the long run were to become the main purchasers of care. In theory, at its highest level, it allowed GPs to take full control of the entire local budget, although primary care trusts would remain responsible for signing the cheques. Adopting it, however, was voluntary, as fundholding had been. And there was nothing that family doctors could do to demand and enforce it.

In practice, relatively few PCTs proved keen on fostering it. There were some notable exceptions. In Cumbria, Cambridgeshire – most notably the area of Andrew Lansley’s constituency – Tower Hamlets and a few other places, primary care trusts were working towards total devolution of the budget to GPs. Elsewhere, it operated on a very limited scale. Indeed, in October 2009 – four years after its launch and a year after another attempt to reinvigorate it – David Colin-Thomé, the health department’s lead doctor on primary care, declared it to be a “corpse”. A corpse which he judged was “not for resuscitation”.<sup>20</sup>

A less colourful assessment by the King’s Fund was that it had largely dealt in small-scale projects.

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19 See page 12 above

20 *Health Service Journal*, 14 October 2009

“Thus far, practice-based commissioning has not demonstrated that it can advance commissioning, especially of secondary care, and it is therefore not clear that [it] provides value for money.”<sup>21</sup>

If practice-based commissioning was more rhetoric than reality, there was also a growing view that commissioning as a whole had not lived up to its promise in the two decades since *Working for Patients*. In the very dog days of the Labour government – in March 2010 – the cross-party Commons Health Select Committee, then chaired by the Labour MP Kevin Barron, produced a highly critical report on its effectiveness.

The purchaser/provider split had increased transaction costs, the committee said, but PCTs were mainly passive buyers of care, not active shapers of services.

“Weaknesses are due in large part to PCTs’ lack of skills, notably poor analysis of data, *lack of clinical knowledge* [my italics] and the poor quality of much PCT management. The situation has been made worse by the constant re-organisations and high turnover of staff.”

If PCTs were to be retained, the committee said, they needed to be strengthened. But if PCT commissioning “does not begin to improve soon, after 20 years of costly failure, the purchaser/provider split may need to be abolished”.<sup>22</sup> In other words, primary care trusts had few friends, and notably very few friends in Parliament.

This broadly was the state of play on 6 May 2010 when David Cameron’s hopes of a Conservative majority at the general election were dashed, and when – following a “big, open and comprehensive” offer to the Liberal Democrats, and in just five days – the UK saw the first coalition government formed at Westminster since the end of wartime coalition in 1945.

### Scene Three: Back to the beginning

An inescapable question in understanding what went so wrong politically with Lansley’s reforms is why the July 2010 white paper *Liberating the NHS* came as such a bombshell – not just to the public but to the vast majority of those working in the health service.

After all, Andrew Lansley by the time he became secretary of state had held the shadow post for an unprecedented six and a half years. Leaders in the service knew him well. He had spent that time tramping around any and every NHS conference and gathering, both developing his ideas and outlining them. He had made countless speeches. He had published myriad party documents about his plans, or at least about elements of them.

“It is completely untrue,” says Matt Tee, a former director of communications at the Department of Health, and the Government’s permanent secretary for communications at the time the Coalition government was formed, “to say that those in and around the health service were in any doubt about what Lansley’s policy platform was going to be as health secretary.”

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21 [House of Commons Health Committee, Commissioning, Fourth Report of Session 2009–10, Volume I, Para 102](#) (accessed 1 June 2012)

22 *Ibid.* Conclusions

Or as one health department official puts it: “There is no excuse for not knowing what the Conservatives were planning to do on health. It must have been one of the most closely pre-advertised plans in history.”

Pretty much all of it – the commissioning board, clinically-led commissioning with GPs purchasing care, a new economic regulator, “any willing provider”, Healthwatch – had been there in dozens of speeches and documents.

So much so that by the time of the election the health department civil servants had a dossier of documents with which to start drawing up Lansley’s reform plans for the traditional briefing packs that departments create for each party ahead of the election.

When officials met Lansley in the pre-election access talks (that shadow secretaries of state are entitled to ahead of polling day) Lansley himself was armed with them, referring to them, at times page by page and line by line, as he set out what he wanted to do.

For the shadow health secretary and for Kremlinologists, both in and outside the department, it was all – or pretty much all – as clear as day. Yet on 12 July 2010 – the day of the white paper’s publication – the sheer scale and scope of what was being planned took the public and the health service itself aback. Why?

To fully understand that, it is necessary to go back to 2005, but also take into account the personality and style of the man who became health secretary in 2010.

The son of a pathologist, Lansley comes from family of public servants. His brothers are a teacher and a policeman. His first wife was a GP. He had been a high flying civil servant, including being principal private secretary to Norman Tebbit – a man he was later to describe as one of his political heroes. Tebbit at the time was privatising BT.

He left the Civil Service to become director of the British Chambers of Commerce before finally entering politics as head of the Conservative research department in 1990. There he worked with both a young David Cameron and a young George Osborne – working relationships that generated a degree of personal loyalty all round, about which Lansley was open and proud, even referring to it in the opening of his first speech as secretary of state for health.<sup>23</sup>

As head of the Conservative Research Department, Lansley was credited with playing a significant part in John Major’s 1992 election victory – for which he was awarded a CBE.

That summer, at the age of only 36, he suffered a minor stroke, and few who met him in the six and a half years he spent as shadow health secretary doubted his genuine attachment to the NHS.

In his first 18 months as shadow health secretary, he loyally supported a policy in which he patently did not believe. He had inherited from his predecessor, Liam Fox, proposals for a “patient passport”. It would have allowed people to take the NHS cash for their operation

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23 Andrew Lansley, ‘My ambition for patient-centred care’, 8 June 2010 (accessed 1 June 2012)



and spend it in the private sector – with top-ups if necessary. He was not allowed to dump it, but he never looked comfortable defending it.

He disposed of it as soon as he could after the 2005 election. Indeed his section of the Tory party website lists as his two proudest political achievements helping win the 1992 election and “transforming the public’s view of the Conservative Party’s support for the NHS”.<sup>24</sup>

He has repeatedly stated that the health job is the only one he has ever wanted. But while he is now a senior politician, the former civil servant in him lives on. He prefers submissions on paper with which to make his mind up rather than face-to-face argument, those who have worked closely with him say. Asked a question, he tends to feel the need to have the answer. Once his mind is made up on an issue, he can be difficult to shift. Even one of those who has worked most closely with him over the years says he is “very difficult to challenge and argue with”.

Furthermore, once a piece of policy is plain to him, he finds it hard to believe that others do not see it. As he said in an interview for this account, when asked why people had not understood his plans, he replied: “what’s not to understand?” Or as one official says, not just with critics but with Cabinet colleagues, “he got exasperated when they didn’t understand it”.

Liberated by the election defeat in 2005, Lansley was free to set out his own ideas – the roots of his grand plan being traceable all the way back to a speech he made to the NHS Confederation’s annual conference that year, five years before *Liberating the NHS*.

Tellingly, the speech draws on that formative experience of working for Tebbit, when as a trade and industry civil servant he had been involved in utility privatisations. The speech sets out the conditions needed for a market in utilities to work. It does draw distinctions between those markets and the provision of health care. But it then lays out how lessons can still be learnt from them and applied to the NHS.

In it, the future health secretary sets out the need to maximise competition in the health service in order to improve services for patients. There is, he argues, a need for “new and independent providers” to have a “right to supply” NHS care.

With some provisos, it says price competition should be permitted. Budgets should be delegated to GPs – because they are the people who know their patients best, and their decisions on prescribing and referral are one of the key drivers of cost in the NHS.

That, of course, was the key argument for GP fundholding and for Total Purchasing Pilots in the 1990s and for practice-based commissioning under Labour – although in truth GPs’ decisions are only one of the big cost drivers. Those made by consultants in hospital are at least as important.

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24 Andrew Lansley, ‘[The Future of Health and Public Service Regulation](#)’ speech, 9 July 2005, 1 (accessed 1 June 2012)

The budgets the GPs should receive, Lansley said in his confederation speech, should stretch “across the whole range of NHS planned care and primary care” so that family doctors become “active purchasers, including negotiating offers on quality *or price* [my italics] that help them better to utilise their budget for their patients”. The role of primary care trusts should be “limited to strategic or temporary interventions and specialised services”.

Crucial to this was that GPs should have real cash budgets, as fundholders had, so that they could redeploy the savings they made on new services. Lansley wanted to prevent GPs lining their own pockets with the savings. But without a genuine ability to spend savings on services as they thought fit, he believed there was little incentive for GPs to take a budget if someone else – a health authority, say – then decided how savings were to be spent.

To help make all this work, Lansley said in his speech, a new competition regulator would be needed. It would rule on mergers that would restrict competition, and operate a failure regime if providers get into trouble. This regulator should not be neutral, but should be a “pro-competitive regulator”, licensing health care providers and having concurrent powers with the Office of Fair Trading in order to apply competition law actively. A new patient voice organisation – dubbed Healthwatch – should be created.

In other words, the commissioning board aside, the essential bones of what was to emerge in the Coalition’s 2010 white paper were already there in this 2005 speech.

The problem was that no-one was listening. Tony Blair had just taken Labour to a record third election victory. The Conservatives had yet to replace Michael Howard as leader. And Lansley was a long, long, way from power. The speech can now only be found in the dustier bits of the internet’s archive.

Lansley was soon, however, to get a bigger platform for his ideas. For in the autumn of 2005, Cameron became party leader.

Ever since 1945, when the Conservatives voted against the establishment of the NHS, the health service had been in essence a Labour issue. That remained true despite the fact that even by the 2010 election the Conservatives had still run the service for more years in government than Labour, and had presided over, on occasion, significant spending increases. Labour’s claim that “you can’t trust the Tories with the NHS” still resonated with the electorate.

One of Cameron’s earliest acts was to seek to “detoxify” the NHS as an issue for the Conservatives. In a speech to the King’s Fund in January 2006, he first pointedly and publicly dumped the “patient passport” proposal. “We should not use taxpayer’s money to encourage the better off to opt out”, he said, later condemning the policy as “opt-outs for a few” when “rising expectations demanded a better NHS for everyone”.<sup>25</sup>

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25 David Cameron, ‘[We stand for social responsibility](#)’ speech, 1 October 2006 (accessed 1 June 2012)  
David Cameron, [speech to King’s Fund](#), 4 January 2006, (accessed 1 June 2012)

But he went much, much, further. He unequivocally committed the Conservatives to a tax-funded NHS, largely free at the point of use, with a promise of no switch to any form of medical or social insurance.

The service would remain “free at the point of need, available to everyone,” he declared, adding in answer to questions that he would “never” go down the route of transforming it “into a system based on medical insurance”.<sup>26</sup>

By the Tory party conference in the autumn of 2006, the apparent strength of this commitment had sunk in with the British public. For the first time in decades, a Populus opinion poll for *The Times* put a Conservative leader ahead of Labour ones on the NHS. Fifty per cent of the public agreed that Cameron “believes in the principles of the NHS and wants to improve it,” against 42% for Tony Blair and 45% for Gordon Brown – Labour’s chancellor who was hovering in the wings, ever more impatiently awaiting his chance to move to centre stage as prime minister.

Cameron built on this unparalleled position. He told the party faithful in his conference speech that while Tony Blair had declared his priorities to be “education, education, education”, “I can do it in three letters: N.H.S.” He provided further reassurance, promising “no more pointless and disruptive reorganisations” of the health service. At the same time, however, he endorsed Lansley’s developing ideas for how the health service should be run.

The full detail of these was to emerge in June 2007 in what the Conservatives dubbed an “*NHS Autonomy and Accountability White Paper*”<sup>27</sup> – the “white paper” claim being somewhat cheeky given that they were still the opposition.

The essence of what was to be in this paper, however, was spelt out by Lansley, with Cameron at his side, at the party conference in a media event outside the main hall.<sup>28</sup>

Almost all the core ideas from Lansley’s 2005 speech were there: a new economic regulator; all hospitals to become foundation trusts; the right for the private and voluntary sectors to bid for NHS work, so that there would be no “artificial limit” on the share of NHS services that they might take; competition used to drive up standards and so on.

There were some notable additions. There was to be an NHS commissioning board, there “to take the politics and politicians out of day-to-day management of the NHS,” as Lansley put it – and indeed, on the day, this was the idea that attracted most attention both in the media and from think-tanks.<sup>29</sup> And Lansley made it clear that GPs were to be given “real budgets, not just shadow ones”.<sup>30</sup>

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26 *Financial Times*, 5 January 2006

27 Conservatives.com, ‘[NHS Autonomy and Accountability, Proposals for legislation](#)’, (accessed 1 June 2012)

28 Conservatives.com, ‘[The NHS matters too much to be treated like a political football](#)’, (accessed 1 June 2012)

29 Both the King’s Fund and the Nuffield Trust were to produce reports on that issue

30 *Financial Times*, 5 October 2006

All this, Cameron and Lansley said, was to be set out in the forthcoming *Autonomy and Accountability* paper, and then in an NHS “independence” bill, which was finally produced in November 2007. Cameron – who at this stage was painting himself as “heir to Blair” – was to use it to challenge Gordon Brown, the heir presumptive. Would he back it? If not, then Brown would clearly be “the road block to reform”.

If all this sounds like the essential elements of Lansley’s “really revolutionary” white paper in 2010, it was – even if not all the fish were yet in the barrel.

Yet these ideas, at the time, attracted relatively little media attention. And they were certainly not presented as, or perceived to be, a revolution. Again, the question has to be asked, why?

The answer lies in what Labour, when Tony Blair was still prime minister, was already doing by 2006 and 2007.

Practice-based commissioning, in which GPs were intended progressively to take control of NHS budgets, had been launched in 2005. Patients were already being given a gradually widening choice of where to go for treatment, including to a private hospital, with more private providers entering both the hospital and non-hospital market.

Labour had a policy of gradually splitting off the provider arms of primary care trusts into various forms of self-governing organisation, which could include the private sector, social enterprises or foundation trusts, as a way of reinforcing the purchaser provider split – although progress was proving minimal.

It was already Labour policy for all hospitals to have the chance to become foundation trusts by 2008 – a target that was to be missed by a mile. And a long and tortured debate had been underway for years – one that would run on and on – over how to establish a proper “failure regime” for foundation trusts, should one ever go bust. In other words, there was a huge stretch of common ground between the two parties’ policies.

To cap it all, just a week before Cameron and Lansley had announced the idea of a national commissioning board to “take politicians out of the day-to-day management of the NHS”, Gordon Brown had floated the self-same idea, as part of his pitch to show that the chancellor had big new ideas for when, he assumed, he would become prime minister.<sup>31</sup>

Labour was later to attack the commissioning board as “the world’s biggest quango”. And it was anything but crystal clear what Brown expected his independent board to do. The somewhat vague briefing was that it should “separate the making of policy from the execution of policy” – something that the various incarnations of the NHS Executive had attempted, although not in statutory form.

As a result, when Cameron and Lansley launched their version of the idea, Rosie Winterton, then Labour’s minister of state for health, dubbed it “an idea worth looking at”<sup>32</sup> – even

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31 *The Independent, The Guardian, Financial Times*, 25 September 2006

32 *Financial Times*, 10 October 2006

if Brown's tentative floating of the concept split Brownites and Blairites. The latter feared that Brown really saw a national board as a way of slowing down or diluting Blair's market based changes.<sup>33</sup>

Hewitt and Johnson, Labour health secretaries under Blair and Brown respectively, both gave the idea consideration – although the fact they had done so did not emerge into the public domain at the time. Andy Burnham too was to examine it in 2009. "I thought about that – the BBC Trust model and all of that," he says, "but quickly came away from the idea."

It was "nice in theory", Burnham says. However, early on in his tenure he felt he had to intervene over the head of Monitor in order to get a new chief executive and chair into the crisis torn Mid-Staffordshire hospital. That showed, he says, that "the theoretical case falls down in the real world very quickly".

Back in 2007, however, it wasn't just politicians who were playing with the idea of an independent board. Even the British Medical Association was floating the idea<sup>34</sup> and there had been plenty of other advocates for it over the years.

In other words to many observers what Cameron and Lansley were proposing looked to be broadly a faster extension of where Blairite policy was already heading. That was a view taken by pro-reform civil servants in the Department of Health. On the day the Conservative ideas were launched one official described them as "a credible – indeed, given the [Labour] government's current policy, a logical – way forward".<sup>35</sup>

There was also no suggestion that any of this would involve the abolition of primary care trusts (PCTs) and strategic health authorities (SHAs). Indeed, quite the opposite. The *Autonomy and Accountability* white paper clearly stated that both would remain, with PCTs retained as "local commissioning bodies".

The grand plan clearly did involve significant new organisations – a proper economic regulator and a commissioning board, for example. But these were additions to the existing superstructure, not a replacement for anything that already existed.

So despite that scale of change, there was no real challenge at this point to Lansley's and Cameron's endless promises of "no more pointless and disruptive organisations".

The accountability and autonomy paper stated that "in October 2006, soon after Labour's ninth reorganisation of the NHS since 1997, we ruled out any more such pointless organisational upheavals which have done so much damage to the NHS".

In a speech to the King's Fund just days after the 2006 party conference Cameron underlined that was "a key component of our approach". The Conservatives, he said, will "end the damage caused by pointless and disruptive reorganisations of the NHS. We will

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33 *ibid*

34 Nicholas Timmins, 'Take politics out of day-to-day NHS management, urge doctors', *Financial Times*, 1 June 2006, (accessed 1 June 2012)

35 *Financial Times*, 9 October 2006

not mess around with existing local and regional structures; we will allow the current structures to settle down and bed in”.

Rather than rip everything up, he said, “we will work with the grain of the government’s reforms where they are doing the right thing. So we will go further in increasing the power and independence of GPs and PCTs [primary care trusts], putting them in the driving seat”.<sup>36</sup>

Or as Lansley put it, in the most evolutionary of statements, the changes planned were merely “essential to make the current [Labour] reform work better”.<sup>37</sup> Given where Labour party policy was at the time, this hardly sounded like a plan to upend the structures of one of England’s best-loved institutions.

Moreover, while the essential ideas that were to become *Liberating the NHS* were there, many details were missing and many ambiguities remained. The *Autonomy and Accountability* white paper said both that the independent board would be responsible “for the commissioning of NHS services” and that “primary care commissioners [not specifically GPs] would be responsible for the majority of the NHS budget” – and at the time, PCTs already dispensed the majority of the budget. Later in the paper, however, the GP’s role was underlined in the statement that “we support the return of powerful, clinician-led commissioning in primary care – like that engendered by GP fundholding in the 1990s”.

One of the many shocks contained in *Liberating the NHS* was that all GPs were going to have to be involved in commissioning from a set date – whether ready, willing or able; whether they liked it or not.

Whether that was to be the case, however, remained ambiguous all the way from 2007 right up to the 2010 general election and beyond.

Lansley was at times clear that the GPs would take control of “the majority of the NHS budget”. A lengthy party policy paper in September 2008 had buried away in the small print the statements that “GPs should control the budgets that NHS patients are entitled to” and that “GPs – rather than remote managers – should be responsible for reconciling the available resources with clinical priorities and patient choice”.<sup>38</sup>

In August 2009, Sally Gainsbury in the *Health Service Journal* reported as something of a scoop that the journal “understands” that the Conservatives “are likely to require all GP practices to become practice-based commissioners” and that was likely to produce “an organic” reduction of PCTs. It would be up to the PCTs themselves, however, to choose whether to merge.<sup>39</sup>

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36 [David Cameron, speech to King’s Fund](#), 9 October 2006,

37 [Financial Times](#), 9 October 2006

38 [Conservatives.com](#), 29 September 2008,

39 [Health Service Journal](#), 27 August 2009

At other times, however, both party policy papers and Lansley himself talked about “giving” GPs budgets, or “enabling” them to take them – an evolutionary, even voluntary, approach, more like fundholding or practice-based commissioning, not a compulsory, revolutionary one. Indeed the party’s last words on the subject ahead of the 2010 general election – in its draft and final manifestos – are far from crystal clear. The detailed draft said that “we will give GPs the power to hold patients’ budgets and commission care on their behalf” – wording that by no means necessarily implies compulsion, and which had to be set against the stated intention to retain primary care trusts.

The final manifesto said: “We will strengthen the power of GPs as patients’ expert guides through the health system by:

- giving them the power to hold patients’ budgets and commission care on their behalf
- linking their pay to the quality of their results
- putting them in charge of commissioning local health services.”

Here again, “giving them the power” to hold budgets, and putting them in charge of commissioning “local” health services does not necessarily add up to GPs compulsorily taking control of the majority of the NHS cash.

The requirement for all GPs to be involved may also have come as a shock because both NHS leaders and many commentators were conditioned by their history. Fundholding, after all, had been voluntary, and had been rolled out in waves. Changes after 1997 that saw what remained of GP commissioning evolve into primary care trusts had been precisely that – a staged evolution.

Practice-based commissioning, likewise, was voluntary and evolving, if evolving very slowly. For many, there was an unspoken assumption that GP consortia – as Lansley was later to dub these primary care commissioners– would also evolve over time, not be introduced everywhere, compulsorily, on a fixed date.

By the time of the 2010 general election, even those most closely involved in commissioning were collectively uncertain whether it was to be compulsory or not.

Dr Michael Dixon, chairman of the NHS Alliance, a body that had emerged in the 1990s, formed by GPs who wanted to commission care but who were opposed to fundholding, and whose conferences were among the many that Lansley addressed, says:

“On the question of whether it was going to be compulsory or not, I don’t know. I think they hoped that everyone would want to do it ... I think, before the 2010 election, they thought this was a popular movement that they could re-inspire, and that it would capture the imagination of GPs.

“The complaint about practice-based commissioning from most GPs was not that it was wrong or going in a bad direction. There were no theologians against practice-based commissioning, as there had been with fundholding. The complaint was that it was not being allowed to happen.”

He is not sure, he says, whether the issue of compulsion had been decided or had even “crossed their minds ... because they thought it would be so acceptable and desirable”.

By contrast, Dr Johnny Marshall, chairman of the National Association of Primary Care, another pro-commissioning grouping of GPs, is clear that Lansley’s intention was to require all GPs to be involved. The shadow health secretary had been “trailing the comprehensive nature of it” although he adds that he only became personally clear about that after “a private meeting” between the shadow health ministers and the association – and even then wasn’t certain about what would emerge if the Conservatives won power.

Against that, one of Lansley’s closest advisers says that ahead of the election: “There was a vision that all GPs would eventually be involved, but not that it would be compulsory.”

Nigel Edwards, the former policy director for the NHS Confederation, and its acting chief executive at the time says that when he met Lansley ahead of the election, at that point “it was an evolutionary process in which GPs would adopt this with enthusiasm and primary care trusts would wither on the vine”.

Edwards’ memory on this is likely to be accurate, not least because primary care trust membership fees were a key source of income for his organisation. Their disappearance would cause big financial problems. Edwards says:

“His vision was clear that eventually he wanted all GPs to be involved in commissioning, or have someone do it on their behalf, and they would be accountable for it. But it was much more evolutionary than what appeared in the white paper. His view was that GPs would be enthusiastic about this and adopt it. GPs would grow their functions, and PCTs would wither away.”

Although the timescale for all this, he adds, “was far from clear”.

If those closest to the policy action were not certain about the shadow secretary of state’s intentions, it is hardly surprising that the public, or those working in the NHS, did not have much of a clue.

Lansley himself now says that the final decision to require all GPs to be in a consortia was only taken “in late May or early June” after the 2010 general election, although “I was always thoroughly disposed towards that anyway, because of the experience of fundholding. I didn’t want us to arrive at a 50/50 split again” where half of GPs were involved and half were not.



Ambiguity aside, there were other reasons for the disappearance from public debate between 2007 and the general election of what – back in 2007 – did not appear to be a particularly revolutionary set of proposals.

One was the credit crunch. As the world lurched into financial turmoil in 2008, with at one point the cash machines of British banks within 24 hours of being inoperative, highly detailed technicalities over NHS reform fell right off the agenda. Such issues do not make the mainstream media at the best of times. In the worst of them, they were nowhere on the page as first Northern Rock, then Bradford and Bingley and finally HBOS, Lloyds and the Royal Bank of Scotland had to be rescued as Britain's borrowing hit record levels.

As recession started to follow financial crisis and the deficit mounted, the technicalities of who might do the NHS commissioning and whether the service needed an economic regulator hardly seemed the most salient issue. Indeed, during the election campaign, the NHS barely featured.

There were other reasons. Conservative party polling ahead of the general election showed that talk of Lansley's plans for revamping the NHS did not go down well. That is hardly surprising. As one senior health department official puts it: "Talking about reform almost seals its fate.

"The public hate this discussion ... going on the Today programme to talk about commissioning or economic regulation of health, is a) fundamentally boring, and b) it's not what people want to hear ... people don't want you to talk about the wiring."

And indeed, in the face of the polling evidence, the closer they got to the election, the less the Conservatives talked about how all this would work. Cameron's and Lansley's speeches, focused more on patient choice, on bashing bureaucrats and on putting professionals in charge, and on Lansley's slogan of "no decision about me without me" – but with fewer and fewer of the specifics of how this was to be achieved being highlighted.

To use the football terrace chant, "it all went quiet over there" in terms of precisely what these reforms, which still had their lacunae and ambiguities, would involve.

"The political strategy was to be quiet, to be emollient about the NHS," one of Cameron's closer advisers says, noting that "was a contrast to other bits of the reform, on schools, on welfare to work and prisoner rehabilitation, for example. For the NHS the message was simply 'Oh, we love it'."

Rather than talk about the wiring, the party talked up its pledge to maintain NHS spending in real terms in the face of the cuts to come – something to which neither Labour nor the Liberal Democrats were committed. The essence of the message was that "the NHS is safe in our hands", hence Cameron's giant billboards in January 2010 promising to "Cut the deficit, not the NHS".

Lansley himself confirms there was a deliberate decision to stop talking about the wiring – a decision he implies was taken by George Osborne who was in charge of election strategy.

"I can remember it being said explicitly to me that 'our presentation will be radical reform on education and reassurance on health'. And the reassurance was about spending," Lansley says.

According to some of his advisers, when Lansley protested that "he was not being allowed to set out his stall and that might lead to trouble," he was over-ruled.

By polling day in 2010, the message of reassurance about health had worked so well that while Labour was still rated to have the best policies on health care, the gap was narrow and the smallest it had been at almost any point since 1997.<sup>40</sup>

In hindsight, Conservative politicians have claimed that the commitment to no more reorganisations, which also ran strongly in the run up the campaign, applied chiefly, if not entirely, to what the NHS in its jargon refers to as "re-configurations" – the merger or closure of hospital services – rather than structural NHS reorganisation. Indeed the pledge of no more top-down reorganisations appears in neither the final nor the draft manifestos.

The promise certainly did apply to reconfigurations. Lansley won considerable credit within his party – though no votes from NHS managers, nor from clinicians who saw the need for change – for turning up in marginal seats up and down the land, promising to halt the unpopular closure of maternity units, accident and emergency departments and the like, if the Conservatives won.

But, despite the attempt to rewrite history the "no more reorganisations" pledge applied equally and consistently to restructuring. Throughout 2009 Cameron continued telling NHS audiences – the royal colleges of surgeons, nurses and pathologists among others – that "there will be no more of these pointless re-organisations that aim for change but instead bring chaos". Or that "we will not persist with the top-down restructures and reorganisations of the NHS that have dominated the last decade in the NHS" causing "terrible disruption, demoralisation and waste".

Under the Conservatives, he declared, there would be no more such reorganisations. "And yes, we will immediately stop the proposed closures of vital local services that are happening under this government too."<sup>41</sup>

What neither the public nor most commentators noticed, however, was that in all these promises there was always a qualifying adjective or clause. Not a simple promise to halt all reorganisations, rather always to halt "top-down" reorganisations, or "pointless" or "meddlesome" ones.

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40 [IPSOS/Mori polling 1997-2010](#).

41 [Conservatives.com](#), May 2009  
[Conservatives.com](#), August 2009  
[Conservatives.com](#), November 2009

In Andrew Lansley's conception, his grand reorganisation was certainly not pointless. Nor was it "top-down". It was to be "bottom-up" led by GPs and by patients as they were given information and the power to choose. Or as Cameron once put it: "I make this commitment to the NHS and all who work in it. No more pointless and disruptive reorganisations. Yes, change is necessary in the NHS. But that change must come from the bottom up, driven by the wishes and needs of the NHS professionals and patients."<sup>42</sup>

If those closest to NHS policy formulation (and, as we shall see, many of Mr Lansley's colleagues) were still not entirely clear about what he was planning in the immediate run up to the 2010 election – and indeed if he himself did not yet have the answer to every question about how it would work – it is crucial to understand that the health secretary himself was absolutely clear about the essential drivers behind all this.

Blairite Labour ministers, when they moved out of their "command and control" phase after 2000, had repeatedly talked of trying to turn the NHS into a "self-improving" organisation:<sup>43</sup> one in which choice and competition, money following the patient, independent regulation of foundation trusts, quality inspection from an inspectorate, the use of the tariff and a greater variety of NHS providers, would produce an organisation whose performance would improve as a result of these assorted pressures, penalties, incentives and oversight; one whose performance would increase without the repeated need – or, at least, with much less need – for ministerial direction. Or as Patricia Hewitt, Labour's health secretary put it in 2005, a system that was to move from being a "politician-led to a patient-led NHS".<sup>44</sup>

The shadow health secretary's big idea was to take that to its ultimate conclusion while fixing it all in legislation – producing, if you like, the final NHS reorganisation of all time, or at least one that would last many years and could only be changed by further legislation.<sup>45</sup>

The purity of the concept was simple: ministers would indeed remain responsible for the NHS, but rather than run it from Whitehall they would commission a set of outcomes from a national commissioning board and hold it to account for delivering them. The board would be responsible for overseeing commissioning, while itself looking after the more complex specialist services.

GP commissioners – with hard budgets, but at this stage still working with primary care trusts and strategic health authorities – would increasingly decide on what services were bought locally, while patients would have their ability extended to choose where, when and by whom they were treated. Any willing provider would be able to supply NHS services at tariff prices.

A new economic regulator would ensure that competition law was applied to the NHS to facilitate choice and competition. And ministers absolutely, major crises aside, would

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42 Quoted in *Daily Mail*, October 4 2006

43 Department of Health, *Health Reform in England: Update and Next Steps*, 2005

44 Ibid

45 Paxman: "Can you guarantee that if this bill goes through it will be the last reform of the NHS that you can foresee for the next ten years?" Lansley: "Yes"

then be able to stand back and simply let it all work – allowing to run what some in the department were later to dub a “clockwork universe”, or as one of Cameron’s adviser’s labelled it “this perfectly incentivised, perpetual motion machine”. Or as Labour ministers had put it, a “self-improving” one.

As part of this deal, it was also proposed that the health department would become the Department for Public Health. The existing Health Protection Agency was to be absorbed back into the department, but with parts of its public health budget devolved down to local directors of public health. The department would become a proper health department, with the NHS – the sickness service – run as a sort of subsidiary operating on auto-pilot with little involvement from ministers other than to renew its mandate (the outcomes it was expected to achieve) from time to time.

Crucially, this would all be laid down in legislation, and in a way that, without further legislation, would tie the hands of both the current health secretary and his successors.

The driver for this was that under both Conservative and Labour since 1991, these market-like reforms to the NHS had gone through a repeated process of two steps forward and one step back, depending on the ministers in charge.

Under the Conservatives, NHS trusts had in practice lost many of their nominal freedoms. Health authorities had been encouraged to be unaggressive purchasers as ministers fretted about the impact on services if the purchaser/provider split had been fully let rip. Under Frank Dobson as health secretary between 1997 and 1999, significant elements of the quasi market had been reversed: fundholding was abolished and the NHS was told to use the private sector “as a last resort”.

Few of the elements of the revived market introduced during Milburn’s, Reid’s and Hewitt’s tenures – foundation trusts, more independent sector treatment centres, practice-based commissioning, the search for a failure regime – had been seen through consistently, as ministers chopped and changed and policy was battered by events.

Indeed, at the dog end of Labour’s time in office, Andy Burnham had come in as Labour health secretary and announced that far from continuing the previous policy of extending competition for NHS services, NHS organisations were to be the service’s “preferred provider”, being given a first and then a second chance to improve before their services were put out to tender.

Lansley wanted to remove this ministerial discretion over these structures and levers; to nail down the changes so that in future it would take legislation, not ministerial whim, to alter them; and to let a disseminated and devolved set of organisations operate autonomously with the right incentives producing great results. The “autonomy” bit in the *Autonomy and Accountability* document was as crucial as the accountability bit – that GPs should hold budgets and be accountable for them.

As he put it in an interview for this piece: “What we were setting out to do was recognising that while there had been many efforts at health service reform, many of which had the right components, they were partial. They were, in the literal sense half-baked. And they

ended up never getting baked at all. For example, fundholding ended up where 50% were and 50% weren't.

"You had Labour doing choice and competition and then Andy Burnham coming along and doing preferred provider. There was never a consistent programme of reform carried through over a period of time."

So it had all to be put into legislation to nail it down, to ensure that the next secretary of state could not just come along and change it without fresh legislation. "The evidence of the past was very clear," Lansley says. "That because of the nature of the [existing] legislation, you change the secretary of state and you can change the policy on virtually everything in the NHS."

"Because the health service at any given moment was basically whatever the secretary of state under the legislation decided it would be. So organisations would come and go. You would get *Shifting the Balance of Power*<sup>46</sup> published and then it would be overtaken."

"What I set out to do was entrench a consistent and coherent structure of reforms so that the NHS would be able to take a more autonomous long-term view of their own role ... [knowing] that things would not change just at the behest of a change of secretary of state, or even more a change of government."

And to the future health secretary, this was not, in his eyes, a top-down reorganisation. As one official puts it: "It was just the thing that had to be done in order to ensure that there could be no more top-down reorganisations – because the thing would run itself."

To be sure, ahead of the election, Lansley never spelt out this aim with that sort of clarity. It was, however, always there. The absolute driver behind what he was doing.

It remained true that the policy contained many unresolved issues with which Labour itself had repeatedly struggled. Just how did GP commissioning fit with commissioning by PCTs and oversight by SHAs? Just how well qualified were GPs to be the purchasers of all hospital services? How were potential conflicts of interests to be resolved between these producers (GP practices are in the main small businesses) and their commissioning role? What did the failure regime that this system required look like, given that the active promotion of competition was bound to lead to some failures? In a tax-funded NHS, just how far and for how long was it possible in practice for a health secretary to say that the board, or the GP consortia, rather than the secretary of state, was responsible for running the NHS? And so on.

In the years after 2007, little of this made it into the headlines. Indeed, aside from the strategic decision to stop talking about the wiring ahead of the election, crucial bits of this plan appeared to have vanished from sight. The final manifesto, for example, makes only passing reference to a commissioning board and none to a new economic regulator.

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46 A 2001 Labour policy document on shifting power to "frontline" staff. (accessed 1 June 2012)

To many commentators and think-tanks, it was clear that Andrew Lansley was appreciably keener than Labour had proved in practice on GP commissioning. But it was far from clear that this involved compulsion. Few imagined it did so. It was clear that the shadow health secretary wanted to set up a national board, although its precise role was still uncertain. And it was clear that he wanted a new economic regulator – but Labour had already acquired one, in advisory rather than statutory form, in the shape of the NHS Co-operation and Competition Panel.

If the Kremlinologists in the Department of Health and the Conservative policy wonks could legitimately claim that the outline of the plan was all there in full blown technicolour for those who cared to look – though not yet, as we shall see, in all its glorious detail – the public and most NHS staff could equally and legitimately argue that they had next to no clue about what was soon to be visited on them.

The election campaign failed totally to shed any light on that. Indeed, when asked by the *Financial Times* to do an interview during the campaign on his grand plan, Lansley politely declined. There were no votes to be had in talking about the wiring. Indeed, more likely only votes to be lost.

As Chris Ham, chief executive of the King's Fund think-tank, a former head of strategy at the Department of Health and a seasoned NHS policy watcher puts it, the shadow health secretary was "very clearly committed to more choice and more competition. In a sense a continuation of what he had inherited.

"There were clear messages about cutting back on management costs, about cutting back on top-down targets and on performance management. There were lots of warm words about relying much more on clinical leadership and devolution and on trusting in frontline clinical teams. There was a very clear commitment to no more top-down reorganisations of the health service. And there was a clear commitment to putting GPs in the driving seat which looked pretty much to be like practice-based commissioning writ large – back to what people thought practice-based commissioning was all about when it was first introduced.

"Any new secretary of state wants to make their mark. So you expect them to come up with eye catching new ideas. But I had no concept that it would look like the white paper that appeared in July 2010."

# Act Two: “Run fast ...run very, very fast”

## Scene One: Transition to government

The Conservatives prepared for government in a way they had never done before. While David Cameron was deeply wary of appearing in any way to presume victory by “measuring the curtains” of Number 10, the party nonetheless set up an implementation unit looking at how it would put key policies into practice once in government.<sup>47</sup>

This brought some distinct advantages – the so-called “structural” or “business plans” that were published shortly after the election, specifying what each department was expected to do by when.

The unit was chaired by Nick Boles, the founder of Policy Exchange, Cameron and Osborne’s favourite think-tank, and a prospective Tory MP who duly won his seat when the election came. But the exercise had its limitations.

The unit, Boles stresses, was not there to look at the politics of the party’s plans. “As far as it could be, it was purely about implementation planning. It was not about policy development, or only in the sense that there was a feedback loop if we came to the conclusion that something was unfeasible.” That happened, he says, with parts of the prison reform and the “rehabilitation revolution” where some of the timetable and benefits looked unrealistic. The policy was modified as a result.

The unit, he also notes, could only help in so far as the leading party spokesman wanted help. “Politicians are pretty suspicious about anyone in party headquarters coming around and second-guessing what they are up to. So we were very clear that we needed to provide our political leaders with what they wanted.

“So with health, as in all of these areas, we were dependent on the shadow secretary of state engaging with us and welcoming help.”

That went well in some key areas – schools policy, welfare to work, the criminal justice changes and on some of the green issues. It clearly went less well with health. Boles chooses his words carefully.

“In Michael Gove’s case [education], he had very clear principles, but he welcomed help in understanding exactly what the current legislation said, what current institutions did and didn’t do, and about how he could implement what he wanted to do. That was less the case with Andrew, who had, after all been in the shadow job longer than anyone else, and had published a draft bill. So we didn’t start work with him until relatively late. And when we did, he asked us to work on some quite specific things.”

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<sup>47</sup> For a fuller account see *Transitions: lessons learned* from the Institute for Government

These included issues around Healthwatch and some work on the commissioning board, Boles recalls.

So while the unit “did do some work in health, it wasn’t comprehensive by any means”. And among the small team of secondees from management consultancies and elsewhere that the Conservatives had assembled to help with this work, “it wasn’t done by someone who had a deep knowledge of the health service”.

More specifically, he adds: “I don’t remember doing for health something we did do for the Work Programme and for education – and we did it because we were asked to – and that was an assessment of whether and to what extent legislation was required. We certainly did that in the other two cases. And that was a contrast [to health]. There has been relatively little legislation for the academies and the Work Programme.”

Both those programmes also specifically acknowledged the degree to which the policies “explicitly built on the foundations laid by the last government,” Boles notes. And while that was arguably true also for health, that was not how the reforms came to be seen.

Others involved in the implementation unit, paint Lansley’s involvement with it in a harsher light. “Getting any information out of him before the election was very difficult,” one says. “He refused to open up about what he was planning, unlike everyone else.”

It should, of course, be noted that it is far from the case that the senior Conservatives – Cameron, Osborne and Letwin, for example – were ignorant about what Lansley was up to. Cameron had personally helped launch the *Autonomy and Accountability* white paper. He had made plenty of speeches about the Conservatives plans. And, as one Tory official puts it, the myriad policy papers that followed the original paper “were written through the Oliver Letwin process” – Letwin holding a position as sort of policy overlord for Cameron’s new style of Tory politics.

“Oliver held the ring on a lot this stuff,” one Conservative special adviser says. “James O’Shaughnessy [Cameron’s director of policy] would have penned quite a lot of the words. And all those things were cleared by a policy board chaired by Cameron. So the idea that Cameron didn’t know what was in it ... He and Oliver Letwin helped write the green papers.”

Nonetheless, and despite the scattering of policy documents across the years, the scale of what Lansley was planning was clearly not common knowledge across the party. At a fringe meeting at the Conservative party conference in 2009, Stephen Dorrell, the former Conservative health secretary, made clear he was not entirely sure what Lansley was up to.

Dorrell was in no way part of Lansley’s team. But he had been commissioned by David Cameron shortly after he became leader to take a broad look at how to improve public services and as a former health secretary he had a particular interest in the health element of them.



What was needed, Dorrell told the meeting, was for “a little sunlight” to be allowed in on the shadow health secretary’s plans. “We want to see not so much a new idea, but a clear view – I think Andrew has got it actually – it’s a more professionally led, less centrally driven, more localised, more flexible service. But it’s that which needs filling out.”<sup>48</sup>

Outside of Conservative party circles, there was also a perception that the shadow health secretary, while speaking repeatedly at health service conferences, was not seeking much in the way of assistance in translating the broad outlines of his plans into the detail of practice.

The National Association of Primary Care (NAPC) is a small organisation that is far from a household name. But within its ranks sat much of the NHS’s expertise on GP commissioning – the body having been formed from those who had been GP fundholders and those who were advocates of other forms of GP commissioning.

Dr Johnny Marshall who was chair of NAPC in the run up to the election says: “We had all the expertise, and we certainly tried to provide the opportunity to be used in that way. But, wherever Mr Lansley was getting his technical advice as to how you actually make this work in practice, it wasn’t from us.”

Likewise, Dr Michael Dixon of the NHS Alliance, a body originally founded by doctors who objected to fundholding but who favoured commissioning, says Lansley “had clearly read a lot, and he talked a lot, and we had a number of interviews with him and Freddie Howe”. (Earl Howe was an opposition health spokesman in the Lords and who was to become the Lords health minister, steering the bill through).

“They sensed there was something wrong with practice-based commissioning, and wanted to know how to make it work. But there was no discussion about the wholesale destruction of PCTs. And there wasn’t a lot of detailed discussion about the technicalities of how he [Lansley] wanted GP commissioning to work. I think a lot of the details weren’t worked out. We didn’t talk a lot about the details of how you might implement all this.”

If Dorrell’s plea was for “a little sunlight”, the general election campaign did nothing to provide it.

There have been elections where the NHS has loomed large. The 1992 campaign produced “the war of Jennifer’s ear” – a stupendous row over a Labour party political broadcast about a girl who had an operation for glue ear postponed. Tony Blair ended his 1997 campaign with the warning: “We have 24 hours to save the NHS.” In 2010, however, health barely featured, either from day to day or in the three great televised debates between the party leaders.

Most of the newspaper commentary – and much of the commentary from the think-tanks – was not on how sweeping and radical Lansley’s plans were going to be, but on how essentially similar the three party manifestos appeared.<sup>49</sup>

This was unsurprising. It was not just that the Conservatives who had stopped talking about “the wiring” in public. The world had also changed in the years since the now famous *Autonomy and Accountability* white paper and its subsequent Lansley-drafted opposition bill.

In the wake of the credit crunch, the rate of increase in NHS spending had already started to come down from its previous record levels. By 2009, it was clear that public sector as a whole was about to face some fearsome spending cuts to deal with the deficit – cuts that were eventually to prove the biggest since at least the Second World War.

Labour health ministers had no wish to talk in public about what that meant for the NHS. But Alan Johnson, in one of his last acts as Labour’s health secretary, licensed the NHS chief executive, Sir David Nicholson to do so. In a speech to the Healthcare Financial Management Association in the summer of 2009 he warned that the service would need to make completely unprecedented efficiency savings of £15bn to £20bn over the three years from 2011 to 2014 as the increase in spending ceased or became marginal – what Dorrell was later to dub “the Nicholson challenge”.<sup>50</sup>

That June, Lansley had pledged that the NHS itself would receive “real-terms” increases – declaring that other departments would have to suffer at least a 10% cut to pay for that (for many departments the cuts in fact proved to be more like 25%). The pledge for the NHS proved not to be quite as generous as it sounded. In the wake of the financial crisis, the real-terms increase eventually turned out to be only 0.1% a year.

By the time of the election, Andy Burnham for Labour and Norman Lamb for the Liberal Democrats, had both declined to match that, although both parties were pledged to protect “frontline” services, without the precise meaning of “frontline” being entirely clear to the electorate.

For the Lib Dems, the NHS was never a central campaigning issue. The Conservatives had decided to stop talking about the wiring, concentrating only on the essential message that the service was safe with them. And Labour did not – perhaps for once could not – play the NHS card. It knew that the financial squeeze to come would be bad. It had no desire to set out what that was likely to mean in practice. Given the deficit and the cuts to come, Labour could not promise to outspend the Conservatives, and indeed was not prepared even to match the promise of overall real-terms increases. It could not, therefore, credibly accuse the Conservatives of planning cuts. As a result, and for differing reasons, it suited none of the parties to make the NHS a big issue in the campaign.

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49 [Conservative manifesto](#)  
[Labour manifesto](#)

50 [Daily Telegraph](#), 13 June 2009

With Lansley debarred from talking about his grand plan in public, the party manifestos offered little by way of difference for the media to get its teeth into.

Instead all three manifestos focused heavily on cutting management costs and achieving efficiency gains as the politicians indulged in one of their favourite pastimes – bureaucrat bashing. The Conservatives promised a 30%, or £4.5bn cut, in the cost of NHS administration. Labour promised in its manifesto to “cut red tape” and make the £20bn of efficiency savings. Neither manifesto filled in the detail of how that was to be achieved. The Liberal Democrat version was, honourably, somewhat more specific. It included a pledge to halve the size of the Department of Health, to scrap strategic health authorities, and to replace primary care trusts with elected local health boards – promises that were eventually to have a big impact on Lansley’s plans.

Given the bitter controversy to come, it is also notable that all three parties also backed independent sector involvement in the provision of NHS care.

Labour promised an “active role” for the independent sector. That was to include “end of life care and cancer services”. Patients requiring elective care, the manifesto said, “will have the right, in law, to choose from any provider who meets NHS standards of quality at NHS costs”. The Conservatives pledged to give “every patient the power to choose any healthcare provider that meets NHS standards, within NHS prices”. The Liberal Democrats promised much the same in rather more convoluted language. Health boards, the party’s manifesto said, would have the freedom to commission services “from a range of different providers, including for example staff co-operatives, on the basis of a level playing field in any competitive tendering – ending any current bias in favour of private providers”. Patients, Lamb said, should also have the right to go private at NHS expense if the service failed to treat them on time.<sup>51</sup>

In other words, all three parties endorsed at least a degree of choice, competition and use of the private sector in the provision of NHS care.

In so far as there was disagreement over the NHS during the campaign, it came chiefly in a small spat which attracted little attention when Lamb described Lansley’s idea for an independent commissioning board as “crazy” and “a nonsense”. “To have an independent, non-elected quango responsible for £100bn of public money is simply incredible,” Lamb said. He added that the Liberal Democrats would not back that in the event of a minority government.<sup>52</sup>

In the department, officials waited for the “Jennifer’s ear” moment, or the confrontation between Tony Blair and Sharon Stoner, the relative of a cancer patient outside the Queen Elizabeth Hospital in Birmingham during the 2001 election. That might have propelled the health service into the centre of the campaign. In turn that might just have exposed more of the parties’ policies. But it never happened.

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51 *Health Service Journal*, 23 April 2010

52 *Financial Times*, 29 April 2010

## Scene Two: "A united vision for the NHS that is truly radical"

The apparent similarity of much of what was in the manifestos, the Conservatives decision not to talk about the wiring, and the absence of any real controversy over the NHS in the campaign, all helps explain why during the "five days in May" – during which the Coalition government was formed – the NHS barely featured in the talks between the Liberal Democrat and Conservative teams that put the coalition together.

These negotiations centred entirely on those areas where the parties saw potential for their biggest disagreements. The issue of NHS funding was settled early, the Liberal Democrats agreeing to the Conservative formulation of real-terms increases. The talks then moved on to the areas where rifts were most likely and compromises or concessions would mostly clearly be needed – over Europe, tuition fees, a referendum on the alternative vote, banking reform, a pupil premium, free schools, tax cuts for the lower paid and much else.

There are sections in the Coalition Agreement,<sup>53</sup> to name but a few, on deficit reduction, the EU, education, pensions and welfare, civil liberties, and political reform – with some areas covered in immense detail. On the environment, for example, there are no fewer than 17 specific commitments – down to the level of agreeing the rollout of smart electricity meters and the creation of wildlife corridors to preserve biodiversity.

By contrast, the NHS – Britain's biggest public service, consuming £100bn a year and approaching a third of all departmental spending – gets little more than half a sentence: "The parties agree that funding for the NHS should increase in real terms in each year of the parliament, while recognising the impact this decision would have on other departments". And that's all.

The spending pledge was settled during the key early discussions which agreed to a "significantly accelerated" deficit reduction over Labour's plans to halve it over a parliament.

After that, according to a senior Liberal Democrat: "We didn't have any other discussions about the NHS of any kind during those few days. We didn't discuss reform. I think if I'm honest the assumption probably was that the NHS was going to be an area where a degree of stability would be expected. NHS reform hadn't been one of our lead areas within our manifesto so there were no policies that we were particularly looking to promote ourselves. It wasn't one of our key negotiating areas.

"The Tories didn't mention anything about the NHS during the talks other than the budget situation. And therefore I think there was probably an assumption on both sides, or certainly our side, that what we would be seeing on the NHS is incremental change within the tramlines set by existing policy."

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53 HM Government, 'The Coalition: our programme for government', 19 May 2010, (accessed 1 June 2012)

Indeed it was only right at the very end of the talks that the negotiating teams realised that the NHS had barely got a mention. That explains why the funding pledge is shoved into a portmanteau paragraph on the spending review headed “NHS, Schools and a Fairer Society” – an attempt to give it at least some prominence and substance. It was soon to acquire a great deal of both.

Agreement on coalition reached, ministers were appointed, and the next 10 days were spent producing a much more detailed “programme for government”.<sup>54</sup>

The task fell to Oliver Letwin, the Conservative’s policy guru and “minister for government policy” and Danny Alexander, who at this stage was secretary of state for Scotland, and Nick Clegg’s key adviser. Both had been part of the coalition talks. Their key advisers over the 10 days were James O’Shaughnessy, Cameron’s director of policy, and Polly MacKenzie, Clegg’s strategy adviser.

The document covers 31 policy areas, and the section on the National Health Service was to cause no end of trouble. But the context in which it was negotiated is crucial.

Over the five days in May as the Coalition was formed, something formative happened. It was not just that the Coalition agreed to eliminate the deficit over a Parliament – twice as fast as Labour had planned – but it also agreed to fixed-term parliaments.

That gave the Coalition all of five years in which to govern, but possibly only five years if the economy did not pick up. And the Conservatives in particular had absorbed – or, arguably, over-absorbed – Tony Blair’s statements at the end of his premiership and in his autobiography that he had somehow “wasted” his first term by not being bold enough on public service reform.

These two factors combined to make the Coalition immensely bold. It launched easily the most ambitious programme for government since the Attlee administration of 1945. In three short years, the Attlee administration had introduced a national health service and a new social security system; nationalised the Bank of England and a clutch of utilities including coal and electricity; found the extra teachers and classrooms to raise the school leaving age; legislated for Indian independence and built half a million new homes despite material shortages.

The Coalition programme came close to matching that ambition. There was to be not just the NHS reform but a radical restructuring of tuition fees; the introduction of “free” schools; a new “universal” credit in the benefit system; a “rehabilitation revolution” in the criminal justice system; a major restructuring of the Financial Services Authority and the Bank of England; a merger of the Competition Commission and the Office of Fair Trading; elected police commissioners; more elected mayors; a big reform of public sector pensions; a new “localism” offering individuals new rights and powers below the level of local government; a referendum on reform of the voting system; reform of the House of Lords; a redrawing of parliamentary constituency boundaries and much else – all while eliminating the deficit, imposing by far the biggest cuts to government spending in living memory,

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54 HM Government, ‘The Coalition: our programme for government’, 19 May 2010, (accessed 1 June 2012)

and while slashing civil service running costs by a third. It was in time to be labelled “the Breakneck Coalition”.<sup>55</sup>

This ambition was also driven by the two sides having surprised themselves over how easy the Coalition agreement had proved to negotiate. As the more detailed programme for government was being put together, Clegg and Cameron had held their first joint press conference in the Rose Garden in Number 10, variously described by the media as “a wedding”, a “love-in” and “a love fest”. There was much talk of highest common denominator policies emerging from the coalition negotiations, not lowest common factor ones.

As Cameron and Clegg were to say in the introduction to the programme for government, they had “found that a combination of our parties’ best ideas and attitudes has produced a programme for government that is more radical and comprehensive than our individual manifestos”.

As the programme for government was being negotiated, “there was,” says Matt Tee, the Government’s permanent secretary for communications at the time, “an almost drug-infused desire to get on with each other. The summer of love! There was nothing that could not be sorted out by people of goodwill in the interests of the country”.

Furthermore, Tee adds, there was “a race” between departments to get their legislative proposals out fast. The Tories had always planned to move quickly. Letwin, as minister for government policy, had been drawing up “business plans” of precisely what was to be expected from each department. He was soon to have a white board in his office detailing what each department was to do by when, and how it was all meant to mesh together.

Everyone from Cameron down wanted to move fast, to not waste the early years. Gove wanted his academies bill as quickly as possible. Lansley originally wanted a “paving bill” to set up early some of his newer institutions such as the commissioning board and economic regulator, ahead of more substantive legislation. Iain Duncan Smith was working on the white paper that would set out his universal credit. “There was a real drive to get some proper policy out there ahead of the summer break,” Tee says.

“Having proved that they could negotiate a coalition agreement in four to five days rather than the 45 or whatever that European governments typically took, they wanted to get on and prove they could act – quickly.”

Tee also notes that the Cabinet Office ahead of the election had drawn up a list of difficult issues that the Coalition would have to agree on. “Health did not feature on that list,” he says.

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55 *Financial Times*, 29 November 2010.

Up to the weekend of 14 and 15 May, the Letwin, Alexander, O'Shaughnessy and Mackenzie team worked their way through the various outstanding policy areas: from more details on banking reform to scrapping ID cards, to the creation of a green investment bank, the goal to raise the personal allowance for income tax to £10,000, and much else. The eventual programme for government was to contain some 400 policy pledges.

Health did prove one of the more difficult areas. It was put off until after the weekend. There was after all, as one Number 10 insider put it, "a fundamental distinction" between the two parties' approaches. "The Conservatives believing in markets [as the way to reform the NHS], the Liberal Democrats [with their manifesto commitment to elected health boards] believing in democracy."

There were other factors in play. The programme for government was an entirely political exercise within Number 10. Health department civil servants – who were already working feverishly away on Lansley's grand plan – were not involved in any way. Nor was the new health secretary given much chance for input.

"I did have conversations with Oliver Letwin from time to time," Lansley says. "But to say they covered every aspect ..."

Equally Paul Burstow, the Liberal Democrat who had been somewhat unexpectedly parachuted into the health department, displacing Norman Lamb as the party's health spokesman and minister, describes himself as merely "a consultee" on the programme for government. He was, he says, certainly not a "co-producer ... it was very much those two people [Letwin and Alexander] who were leading it".

This lack of serious consultation over the programme for government, and lack of involvement of departmental civil servants, applied equally in other areas.

But there was an extra factor for health – nobody in Number 10, or anywhere else in the top of government outside Lansley – knew much about it. Cameron had experience as a Treasury and Home Office special adviser and had shadowed education. George Osborne had been a special adviser at agriculture and fisheries and been a shadow work and pensions minister. There were advisers in Number 10 who had shadowed business and other departments.

"There were enough people who had worked across a range of departments over the years to sort of know what went on in the major areas," one Number 10 insider says, "but not at health. At the senior level, the top tier at Number 10, there wasn't anybody who had even been in health at the Conservative research department or something like that. It wasn't a well understood area."

The special adviser on health in Number 10 was Sean Worth who had been in the Conservative research department. But he did not claim to be anything like a complete expert on the subject, and his time had been and was divided three ways – between health, transport and business.

The lack of specialist special advisers, so to speak, was in part a reflection of the way Cameron had decided to govern. In opposition, the Conservatives had been highly critical of Labour's top-down, target driven regime, where the Prime Minister's Delivery Unit drove for results in schools, on crime, in transport and in health – notably on waiting times – from the centre. In the Conservative view, targets were disempowering, distorting and centralising. The unit was instantly abandoned.

So too, however, was the idea of a prime minister's policy unit: a group of (often, but not always) policy experts who shadowed, or "man-marked", individual departments. Andrew Adonis had done that for schools before going on to be an education minister. A string of often heavyweight special advisers – Robert Hill, Simon Stevens, Paul Corrigan, Julian Le Grand, Greg Beales and others – had done that for health. As the Coalition was formed, there was no equivalent.

Furthermore, although the Government was a coalition, Cameron had got in place key Conservative ministers who had been developing policy in detail in opposition.

Iain Duncan Smith had been put into work and pensions, armed with his hugely detailed plans for a single universal credit. Chris Grayling and Lord Freud – the latter originally an adviser to Labour – had well worked-up plans for the Welfare to Work programme. Gove had been developing his plans for "free" schools and a massively expanded academies programme. And Eric Pickles, an ex-council leader at the communities department, had been set free to apply to local government his idiosyncratic view of how it should work. Lansley had been shadow health spokesman for an unprecedented six and a half years. And, as many commentators have noted, Cameron's instinctive style, initially, was to be chairman of the board not chief executive – although he was later partly to amend that approach as a result of experience, not least over health.

"The prime minister was determined that his approach was going to be 'I trust my secretaries of state and I will let them get on with it,'" Tee says.

Or as Lansley puts it: "We made no bones about it, and David [Cameron] was very clear about it. He had people in post across government who he intended would come into office with the reform agenda mapped out. And he was a direct participant in it. He launched the paper on outcomes not targets in 2006, he launched the *Autonomy and Accountability* paper in 2007."

If Number 10 was short of health expertise, Oliver Letwin, the Tories' overall policy chief, did understand Lansley's plan, but at a somewhat high level. For him the devolution of commissioning to GPs and the use of choice and competition were all part of a much wider philosophy of government that travelled at various times under various labels – from Cameron's "big society: not big government" to Letwin's preferred formulation of "government in a post-bureaucratic age".

GP commissioning, for Letwin, was merely part of a programme that included: getting all hospitals to foundation trust status; liberating schools; encouraging choice and accountability in health and education; using payment by results to rehabilitate prisoners and undertake welfare to work programmes; insisting on total transparency on central and



local government spending; producing crime maps; electing police commissioners; opening up government data; electing more mayors; providing a general power of competence for local authorities; creating local housing trusts; giving local voters the ability to trigger referenda; transferring powers, including some planning powers, to below the level of local government; and encouraging staff to quit public sector employment while selling their services back through social enterprise.

All of this, he had argued ahead of the election, was intended to “strengthen society rather than the state; to give more power to the people through increased localisation, transparency, choice and accountability; and to encourage enterprise by liberating individuals, communities and businesses from the dead hand of excessive bureaucracy.

“And the direction in which the programme seeks to take Britain is into a post-bureaucratic age. The ambition is to liberate the energies and reinforce the social bonds of our people so that they can achieve what has not been achieved and will never be achieved by the mechanisms of centralised bureaucratic micro-management.”<sup>56</sup>

He had always acknowledged that such proposals for fundamental reform “will take time to bear fruit.

“Even the most enthusiastic proponent of the Conservative policy programme could not reasonably assert that schools, hospitals, the welfare system, the criminal justice system, the housing system, local government and central government will improve out of all recognition overnight, or that the Conservative reforms will immediately produce efficiencies great enough to solve our grotesque public sector deficit.”

But they should over time, he argued, reduce the demands on the taxpayer “partly through the progressive strengthening of social responsibility, and partly through progressively increasing efficiency – engendered by increased transparency, increased accountability and increasingly liberated enterprise”.<sup>57</sup>

Lansley’s plans in Letwin’s eyes were all part of this. But Letwin would never have claimed to be a health expert, any more than Danny Alexander would.

The result of their deliberations on the NHS over the Monday, Tuesday and Wednesday of the week beginning 16 May was, according to taste, “a spatchcocked mess”; a neat synthesis of the two parties’ opposing philosophies (markets versus democracy); or, as one Number 10 insider has put it “a cut and shut” job (the process where the good back half of a crashed car is welded to the good front half of another wreck to produce a vehicle that may look roadworthy but is in fact potentially lethal). Or as another Number 10 insider describes the outcome, with the benefit of hindsight, a “half horse/half donkey”.

Or as Tee puts it: “It was a fudge between the Tories and Lib Dems, which sort of made both feel okay. But it wasn’t really designed by either of them.”<sup>58</sup>

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56 Oliver Letwin, ‘*Tories have no lack of policies*’, *Standpoint*, October 2009. (accessed 1 June 2012)

57 Ibid

58 Ibid

The 30 bullet points in the health section contained much that had been in the Conservative manifesto. It included a cancer drugs fund; the introduction of value-based pricing for drugs; an independent board “to allocate resources and provide commissioning guidelines” and turning Monitor into an “economic regulator that will oversee aspects of access, competition and price-setting in the NHS”.

The document promised to give every patient “the power to choose any healthcare provider that meets NHS standards, within NHS prices” – at least an element of that idea having been in all parties’ manifestos.

The power of GPs as “patients’ expert guides” would be strengthened by enabling them to commission care – although again there was no hint that family doctors would be required to become commissioners.

But the document also contained two elements that were to be the source of much future trouble. It repeated the pledge that had gone missing in the Tory manifesto: “We will stop the top-down reorganisations of the NHS that have got in the way of patient care”.

And, in a partial acknowledgement of the Liberal Democrats’ strong desire for elected health boards and a stronger local government voice, it proposed that in future primary care trusts should be a bizarre mix of directly elected individuals to give patients locally “a stronger voice”, with the remainder of the board appointed by local authorities but with the chief executive and other principal officers appointed directly by the secretary of state – a power the secretary of state did not currently have. There was no mention of strategic health authorities, despite their abolition being a Liberal Democrat manifesto pledge.

Quite how this structure was meant to work is utterly unclear. A body with at least some democratic legitimacy would be operating beneath an administrative body – the strategic health authorities – that had none, while also being answerable to the new, but entirely appointed, not elected, independent board. It would not be responsible for hiring and firing its chief officers who would be directly answerable to a secretary of state – something that hardly fitted with the overarching coalition theme of devolution and localism. And there would be the cost of elections at a time when the NHS was facing the biggest efficiency challenge in its history.

Worse yet, in the heady post-election atmosphere of anything being sortable if people of goodwill worked together to solve the country’s problems, Cameron and Clegg in the foreword to the programme for government chose to single out the NHS part of the programme as evidence that “a combination of our parties’ best ideas and attitudes has produced a programme for government that is more radical and comprehensive than our individual manifestos”.

“For example, in the NHS, take Conservative thinking on markets, choice and competition and add to it the Liberal Democrat belief in advancing democracy at a much more local level, and you have a united vision for the NHS that is truly radical: GPs with authority over commissioning; patients with much more control; elections for your local NHS health board. Together, our ideas will bring an emphatic end to the bureaucracy, top-down control

and centralisation that has so diminished our NHS.”<sup>59</sup> No one now seems quite able to remember who drafted that.

Lansley did get some sense of what was going on. “He didn’t like it,” one adviser says. A draft was sent over to the department. On Lansley’s behalf his office emailed back a bunch of comments and proposed amendments. These were studiously ignored. According to officials:

“He did have an opportunity to comment. He did see it in draft and he was fighting back and saying this is completely nuts. He fought back and didn’t win. There wasn’t basically a discussion.”

Or as a Conservative adviser in Number 10 put it: “Andrew was quite reluctant, if you like, to water down his carefully created vision. But then lots of ministers were not terribly enthused about things that got compromised in the programme for government. But they just thought ‘Oh well, let’s just get on with it’. That was the mood at the time”.

The speed at which this was done also militated against closer consideration in places other than the Department of Health. The document went to David Laws as chief secretary to the Treasury and as a Liberal Democrat member of the original coalition negotiating team. By the time the programme for government was completed, however, he was deep in to the £6bn of public spending cuts that the Treasury was proposing for George Osborne’s initial emergency budget. He looked through the document with Treasury eyes, looking for potential spending commitments, not political bear traps. The NHS proposals did not appear to contain any of the former.

“There wasn’t a lot of consultation in the Liberal Democrat party and I suspect not very much in the Conservative party,” Laws says. “I don’t think it went to Cabinet. I certainly saw it for a very short time.

“As chief secretary to the Treasury, I was chiefly looking at any spending commitments, rather than what it was saying about areas that were subsequently to become controversial.”<sup>60</sup>

Amid the welter of other policy promises in the document, the NHS section received relatively little attention when it was published. The attention it did receive was not encouraging. James Gubb, director of health at the think-tank Civitas, said the proposals appeared full of “unresolved tensions and contradictions”. The proposals for PCTs “will create many confused lines of accountability, leading to deadlock in many places,” he said. “Who will have the ultimate say? The elected members, the local authority, or the independent board?”

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59 HM Government, ‘[The Coalition: our programme for government](#)’, 19 May 2010 (accessed 1 June 2012)

60 David Laws at Institute for Government seminar on Transitions, 28 November 2011

Chris Ham, chief executive of the King's Fund, noted that the idea of the independent board was to distance politicians from the day-to-day running of the service, yet the health secretary was taking a new power to appoint PCT chief executives. "Why would he want to do that when the thrust of other parts of the changes points in the other direction?"

Back in the department, the programme for government was regarded quite simply as "a disaster". First there was the pledge to stop the "top-down reorganisations of the NHS" – a phrase that was to haunt the debate about the NHS reforms throughout their parliamentary life.

Second there was the proposed arrangements for PCTs. "It was almost impossible to conceive of a worse piece of policy making really," one official says. "Every single element of the proposal is crazy, really."

The third disastrous element was that the document sowed the seeds that were later to bloom into wholesale opposition from grass roots Liberal Democrats over Lansley's reforms. As opposition to the white paper and bill mounted, they were able to argue that what they had been signed up to in the programme for government was very different to what eventually emerged – and that there were elements in both that, as Cameron and Clegg had underlined in their introduction, had not been in either manifesto. Hence, the argument that was to come that there was no mandate for the reforms.

### Scene Three: "In one stroke we were free" – the run up to the white paper

At this point, the department's role becomes crucial. Here again, context is critical. Ahead of the election, Sir Gus O'Donnell, the Cabinet secretary, had worked hard to prepare the Civil Service for a change of government.

At one meeting of the Top 200 – the most senior officials – he had asked "How many of you were here in 1997?" Half the hands went up. "In 1979?" Under a quarter. "In 1974?" Four hands went up. So, he noted, less than a quarter of civil servants had experience of two transitions.<sup>61</sup>

As the Institute for Government's report on the transition observes, "None of this is surprising given the long intervals between changes of power over the past three decades, first 18 years, and then 13 years." But it meant that at Health, as in other departments, there was limited direct experience of a switch of political power, although Sir Hugh Taylor – the permanent secretary who, along with some other permanent secretaries, had been asked to stay on by Sir Gus to ensure both continuity and some collective memory – had seen governments change.

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61 *Transition: Lessons Learned*. Institute for Government. 2011

Nonetheless, “it was the first time there had been a change of government in almost anyone’s memory in the department,” one official says. “And there was lots of discussion and seminars with Gus about what it might mean. The message was you must get their trust quick. Because if you don’t you will fall into the [same] trap [as] when Labour came in, when if your face didn’t fit you were out of the door.”

And the department did have a powerful and painful memory of the transfer of power to Labour in 1997. Labour had pledged in its manifesto to abolish GP fundholding. The top officials then had tried to persuade Frank Dobson, the incoming secretary of state, and Alan Milburn, then merely the minister of state, that, despite the pledge, there was some merit both in the better bits of fundholding and in the total purchasing pilots. Could they not find some way to retain an element of these, even if they abolished fundholding in name?

That advice came against the repeated claims by Labour during the Conservative’s long tenure of power from 1979 to 1997 that the Civil Service had become “Thatcherised”. And Labour had come to believe its own rhetoric. So the desire of senior officials to keep a piece of Tory policy that they believed had merit merely convinced the incoming Labour ministers that their instincts were right – and that the department had gone native on a Conservative policy. It did not seem to occur to them that the civil servants were arguing for the retention on an element of fundholding, or total purchasing, on the grounds that it was working.

“We were told that they [the new Labour ministers] had become very, very suspicious [of the civil service],” one official says, relying heavily on the special advisers that they had brought into government with them. “So what happened was that the department was absolutely determined to give him [Lansley] what he wanted, whatever it was. Everybody was in that mood.”

Furthermore, for a significant bunch of policy officials, Lansley’s original plan was easily viewed as mainly an extension of where Blairite health policy had been going – and indeed, more strongly than that, as uncompleted business from the development of competition and choice under Labour.

There had been those many cases of two steps forward and one step back under successive Labour health secretaries – including under Andy Burnham, Labour’s last health secretary, the “preferred provider” policy. If that policy had delighted the opponents of choice and competition such as the British Medical Association and Unison, the biggest single health service union, it had frustrated those civil servants who had come to believe that an element of choice and competition was at least one tool in the armoury needed to improve the performance of the National Health Service.

For these officials, one of their senior colleagues says, the arrival of Lansley and his determination to complete this agenda “was their moment in the sun. They had been waiting for this forever really”. And while Number 10 had been working on the programme for government, officials had been working with Lansley to turn his plans into a white paper.

Faced with the “cut and shut” of the programme for government, the question was what would or could Lansley and the department do about it? The health secretary’s essential response, one official says, was that “he ignored it. He didn’t like it. His reaction was ‘let’s find a way round it. Let’s show how it is unworkable and [then] we can deal with it’.”

Or as Lansley puts it, it became “increasingly obvious to all of us”, ministers and officials, that this thing “was never going to fly”.

Officials certainly believed that half-elected, half-local government appointed PCTs were mad. A quick back of the envelope calculation revealed that elections to PCTs could cost anything from £200m to £300m at a time when the NHS was meant to be saving tens of billions of pounds through efficiency savings. The question was how to circumvent it?

Here, the health secretary’s plans for public health came into play. A further strand of Conservative thinking was that under Labour too many decisions which they regarded as essentially political in nature had been farmed out to arms’-length bodies and various other forms of quango.

Even though Lansley’s plan paradoxically involved creating a powerful new quango – the commissioning board – across the rest of government Conservative policy was to bring such decision making back into departments with ministers responsible for it. That applied to the school curriculum, funding for regional growth, school IT and much else. The health contribution to this was that Lansley’s pre-election plan, outlined in the papers he had already published, was to abolish the main public health body, the Health Protection Agency, and bring it back into the department.

At the same time, some of the public health money would be devolved down into the NHS. Indeed, at times, Lansley had talked about renaming the department the “Department for Public Health” – with the NHS almost being run as a subsidiary of the department, via the commissioning board. Indeed, the idea of a department for public health had survived into the Conservative manifesto.<sup>62</sup>

What had also become entirely clear to officials, from the new health secretary’s access talks onwards, was that Lansley wanted all GPs involved in commissioning. This may have been ambiguous at best in the party’s pre-election public pronouncements. According to officials, once Lansley was in touch with the department, that ambiguity soon vanished, even though Lansley himself now says that the final decision to require all GPs to be in a consortia was in fact only taken in “late May or early June”.<sup>63</sup>

Wherever the truth lies on the final timing, he was, according to officials, “absolutely clear” that all GPs would have to be in a consortium, even if not themselves directly involved in the commissioning. “He was determined it would be universal,” one official says, “because that way you would avoid the two-tierism there had been with fundholding, where some GPs were in it and some were not”.

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62 General Election 2010, Conservative Manifesto

63 See page 25

Lansley's argument, another says, was that "if you were not a member of a GP consortium you couldn't be a GP. The thing was accountability. You refer patients, you prescribe – in other words you are a commissioner – therefore you should take the accountability. And he absolutely held on to that right the way through".

There were, officials argue, good policy reasons for the approach. "If GPs really were going to lead commissioning, issues such as pooling the risk for expensive patients between them became easier if all GPs were involved."

And challenged as to what the general practice committee of the BMA might think about compulsion, Lansley's response was "'I've got them on board'. Now whether he said it and they weren't listening ... or whether he said it clearly enough..." A key member of Lansley's pre-election team confirms the view that "we genuinely thought that they were signed up to the main ideas" in the health secretary's plan.

Dr Laurence Buckman, chairman of the BMA's GP committee confirms that he spent "many hours" with Lansley ahead of the election.

"It is true that I did tell him that we thought that GP commissioning was a good idea. I still think it is, though not in the way it has turned out. But I don't think I realised quite how prescriptive he was going to be."

On the plans more generally, including on issues such as choice and competition where the BMA was always going to disagree, Buckman says: "When we said 'don't do that, or do this, or why are you doing that?' I can say that I was listened to but I wasn't heard."

On GP commissioning in particular, Buckman adds: "I don't think he knew how to implement it".

Lansley himself now says that without the decision to require all GPs to be involved, "the transition would have been a nightmare. Have a chat if you haven't already, with David Nicholson about his advice on the management of transition. Trying to manage unknown waves of people ... and he would have had two systems of financial control and two different kinds of statutory bodies. He was in favour of doing it all together at one time".

As the department sought to unpick the programme for government, and as they sought to meet the Liberal Democrat demand for more local democratic accountability, a logic emerged.

"We were in a world where we were going to reduce expenditure on SHAs and PCTs by more than a third – by something like a half – and so what Andrew and colleagues had to face up to was 'what were these PCTs actually going to do?'," one official says.

"They had nothing left to do. What they were going to do was possibly a little bit of public health. But they were going to be bossed around by a public health department and by the local authority which still actually had most of the stuff that makes a difference on public health at local level. They were going to hold the contract for pharmacy and for the GPs.

And we had already agreed that community services were going to be split away' (the completion of a Labour policy)".

Paul Burstow, the Liberal Democrat minister at health, helped drive that argument. A former deputy leader of Sutton council, a leading light in the party's councillors' association, and the party's health spokesman between 2003 and 2005, Burstow's key focus had long been the specific issues of care of the elderly and social care, ahead of broader NHS issues. Indeed he was installed in the department as the minister for long-term and social care, not as the middle-ranking health minister.

Burstow is a long-standing advocate for transferring all of NHS commissioning to local government. His primary concern was to get local government a bigger role in health – and in a way that would integrate health and social care more closely.

Unlike the department and Lansley, he had not greeted the programme for government with "a sucking of teeth" as he puts it. Its proposal for part-elected/part-council-appointed PCTs fitted his wish to deliver the long-standing Liberal Democrat goal of a bigger role for councils as part of its desire to devolve power from Whitehall.

But he rapidly came to see the problems with the idea. And, he says, he "certainly argued very strongly [about] what were PCTs going to do in this new world? All they were going to be left with was a residual role in public health". Why have that, Burstow says, "when it makes more sense for the public health role to be put into the local authority?" Local government has "more of the levers for driving the wider determinants of health".

At the same time, the parallel idea that was being developed of health and wellbeing boards – aimed at bringing GP commissioners and councillors together. Again an idea that Burstow promoted. That offered a chance of better integrating health and social care together with prevention, and in a way that might give local authorities at least some influence over NHS commissioning,

The solution, as one official puts it, "was to recognise that local authorities had always had a role in public health". Indeed, between 1948 and 1974 local government had run public health through local authority medical officers for health (when the transfer of public health to the NHS caused as much controversy as its transfer back was to cause between 2010 and 2012). So the answer was to give it back to them. Besides, as one official puts it, in these negotiations and discussions the Conservatives "had to have something to give the Lib Dems".

Once it was determined that GPs were to be required to do the bulk of the commissioning, that public health was to go to local government, and that community services were to be separated out, there was indeed nothing, or virtually nothing, left for PCTs to do. "They were a shell," one official says. There was no need for them.

"In one stroke we were free [of the programme for government proposals]," one official says. "And at this stage primary care trusts had no friends. Indeed when Andrew announced their abolition in Parliament it was one of the few things he said that got a roar of approval from MPs."



The deal came out of “Andrew’s black and white approach to commissioning” – that all GPs would be required to be involved – and Paul Burstow’s and the Liberal Democrats demand for more local democracy. “So the PCTs death warrant was signed by that, really.”

As another puts it, it was the programme for the government “that was the catalyst that led to the abolition of PCTs. Without that, they would probably have been left to wither on the vine for a bit longer, and we would have sorted them out in a tidying up bill a couple of years later”.

Abolishing PCTs had one other advantage. It settled an issue and an ambiguity that had been hanging around in the background ever since *Working for Patients* in 1991. Namely who in the long run was meant to be the main commissioner of health – the health authority or PCT, or GPs through the various iterations there had been of GP commissioning?

With the PCTs gone, of course, there was no need for the SHAs to oversee their commissioning role. And another key part of the SHA’s job – overseeing NHS trusts – was set to disappear as all hospitals were intended to become foundation trusts. The Liberal Democrats anyway had a manifesto pledge that Burstow was keen to honour to scrap SHAs, even if it had not survived into the programme for government. And the department itself had put a management argument to Lansley about their future. That with a statutorily independent board – and with huge cuts in management costs being demanded – it no longer made sense to have independent SHAs beneath the board. With four reasons for no longer having them, they too went.

Lansley did clear the idea of handing public health back to local government with Eric Pickles, the communities secretary. Pickles knew he was going to have to take the axe to local government spending. Indeed, of all departmental spending, local government was to take the biggest single hit once the deficit reduction plans were announced in the autumn. Offered a boost in local government’s role, “he loved, the idea,” one official says, declaring “it’s like Christmas”.

The result of this deal, however, was that what had started out as a big shift of power and accountability within existing structures – transferring the commissioning of care to family doctors – suddenly also became a huge structural upheaval. Two entire tiers of NHS management were to be removed. On paper, it had an elegant purity. In practice, it involved a spectacular reorganisation.

At this point it is important to note that whoever had won the election, there would have been big changes to the structure of both primary care trusts and strategic health authorities. It would never have been business as usual.

Faced with £15bn to £20bn of efficiency savings, “we were going to have to reduce overheads,” one official says. The 30% in their running costs that Labour had already announced would have meant many fewer primary care trusts and many fewer, if any, strategic health authorities, officials say.

“It would have happened in a different way. And it would itself have been very controversial. But the idea that we could make savings of the order needed simply by cheese paring away at the existing organisations was never on.” Detailed plans of precisely what would have happened were never drawn up. But left to itself, the department might well have chosen to abolish strategic health authorities, creating perhaps only 28 or 30 primary care trusts to fulfil the joint functions of PCTs and SHAs. In other words, there would have been a serious question mark over the future of SHAs regardless of who won the election – and there would have been a big reorganisation of commissioning arrangements regardless.

Civil servants did realise the sheer scale of what was being proposed. And they, if not Lansley initially, did understand the context in which this was all happening.

“The biggest challenge was trying to get the secretary of state to focus on the money – the £20bn and the sheer scale of the financial challenge,” one official says. His attitude, however, was that “I am going to do these reforms anyway, irrespective of whether there are any financial issues. I am not going to let the mere matter of the financial context stop me getting on with this because I think they are the right thing to do. And I’ve thought them all through”.

Another says: “We did point out to him that his plans were written before the big financial challenge, and didn’t that change things? He completely did not see that at all. He completely ignored it”.

Or in the words of another: “His answer was that ‘there is never going to be a good time to do this and this will help with the money’.”

That is a view that the health secretary holds to this day. Fundamental reform was necessary, he says. “If we did not do this thing the result would be a crescendo – a rising profile of serious problems across the NHS all the way through to a potential financial and performance crisis at the latter stages of the parliament.”

Officials also warned – even ahead of the changes produced by the programme for government – that the health secretary’s plans would cause an enormous row. “We were pretty blunt in the papers about the previous attempts at reform, and the scale of what he was doing, and the likelihood of comparing it back to the Ken Clarke and the Milburn reforms, and the scale of the reaction to those,” one official says.

“We may not have got out the 1990 posters over Clarke’s reforms. But we were very explicit, both in papers and orally that there would be a really serious row about this. He said ‘I am going to do it anyway. I am not going to be distracted by that’.”

Lansley indeed confirms that those warnings were delivered, adding that Nicholson in particular told him that there would be a huge reaction. It is doubtful, however, that he remotely grasped the scale of what was to come. Indeed, he now says: “One of the lessons [from this exercise] is that if you want to achieve anything you had better expect there to be hell of a bucket load of trouble heaped all over you as you go along. That’s how it works.”

Equally officials insist they did offer the health secretary the option of much less legislation than the mighty bill that finally emerged. Indeed, Lansley himself was later to observe: “I could have done most of this without the legislation.”<sup>64</sup>

Accounts differ over how quite vigorously the department pushed the case for that. One official says “nobody tried very hard to stop him” chiefly because, as Lansley says, without the bill he would not have got the “consistent, coherent and comprehensive” set of reforms he wanted that were to be made “permanent” by the legislation.<sup>65</sup> He was determined to settle for nothing less.

“Clearly Andrew had pre-agreed with the powers that be that there was going to be legislation on health, that there was going to be a white paper within some ludicrous timetable, which indeed there was,” one senior official says. And it wasn’t just Lansley, the official stresses. The department had been given Letwin’s draft business plan, setting out the timetable, ahead of the election. “It was all to be done as quickly as possible because they were obsessed with the timing of the next election ... It is difficult to exaggerate how much this was a plan ... We had our marching orders and our job was to get all that stuff ready.”

The department had in fact drawn up papers on alternatives, including alternatives to GP commissioning. “But it was clear that having posed the question of did he want to see other options, that Andrew was not very interested at all in us presenting alternatives.”

A wide range of permutations was possible. For example, GP commissioning could have been done by administrative fiat by making GPs the chairs of primary care trusts and putting significant numbers of family doctors on to their boards. PCT chief executives could have been told that their careers depended on making GP commissioning happen. The numbers of PCTs and SHAs could have been radically reduced under existing legislation, as would have happened whoever won the election. The commissioning board could have been set up – as indeed it has been for the interim – as a special health authority. It could then have been run for a year or two before being made statutorily independent. Ministers could simply have carried on taking the advice of the existing Co-operation and Competition Panel, or it could have been made statutory to provide the economic regulator, with Monitor left as the free-standing foundation trust regulator. That would have avoided the conflicts of interest that Monitor now faces in having to be responsible not just for the financial health of foundation trusts, but for price setting and for regulating competition. Even a fair chunk of the transfer of public health to local authorities could have been done through existing grant mechanisms.

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64 Hansard, April 4 col 782, *Financial Times*, 15 April 2011

65 See page ??

All of that could have been presented as an evolution of Labour policy – as Lansley himself had once put it back in 2006 changes that were “essential to make the current [Labour] reform work better”. It would have required only one genuinely new body – the commissioning board – while turning an advisory body, whose track record the Government could point to, into a statutory organisation. That could have been done in one piece of legislation or in stages.

“We took him through it,” one senior official says, sharply contradicting the view that the department did not try very hard on alternatives.

“GPs on the board of the PCT; abolish strategic health authorities; make the Co-operation and Competition Panel statutory – so you can have one strategic health authority and the competition policy, and we had to do something about the membership of PCTs, and that was it.

“He argued that was incremental change. It wasn’t nailed down. And the next secretary of state who came along could undo it.”

His view, another says, was that to proceed that way meant “you wouldn’t get the benefit of changing everything at once to make this new system work. And the next secretary of state could come along and change it, just as Andy Burnham had come along and said he wanted the NHS to be its own ‘preferred provider’. It wouldn’t be nailed down”.

As the white paper was being developed, the department did worry about the degree to which the health secretary had full political backing for his ideas. The Treasury was alerted, and so too were civil servants inside Number 10.

But the new structure of government that Cameron had created – no policy unit, no delivery unit, no strategy unit and a desire to let trusted ministers get on with it fast – meant there was no easy route by which civil servants could raise political fears.

With a degree of exaggeration to make the point, one official says that under Labour the department had become “a wholly-owned subsidiary of Number 10”.

“Number 10 ran health policy. And suddenly there was no Number 10. There was absolutely no one to talk to. We had always had a health policy wonk [in Number 10] but there was nobody. There was no Prime Minister’s Delivery Unit, there was nothing. And in that environment by the time they [the Centre of government] woke up to what was happening it had gone too far.”

The special advisers that Andrew Lansley had brought into government were not health specialists and were themselves signed up to his project. Sean Worth in Number 10 supported it. Indeed there is a story of him literally ripping up a memo from a Downing Street civil servant to the prime minister, a memo which highlighted some of the risks in all this, as it was being put into the prime minister’s red box. And for Oliver Letwin it was all part of a grander reform of government for a post-bureaucratic age.

Under Labour, the health department frequently found Downing Street's oversight of its activities irksome. But the politically well connected health specialists Labour had at Number 10 meant that "there were people to talk to. People got alerted, and were able to think about the consequences of what the department was doing". They acted as a counterbalance to the department and its secretary of state while providing, in effect, a political as well as policy feedback loop for the department.

The absence of such a channel of communication was compounded by speed. The sheer drive, not just from the health secretary but across the Coalition more generally, to get its programme out there.

As the white paper was being drafted, the first signals indicating the scale of change began to emerge. At the end of May, the Queen's Speech still did not fully spell out the scale of what was to come. It announced a commissioning board that would produce guidelines to *allow* [my italics] GPs to commission care. On the same day, however, a circular went out from the department announcing that "subject to legislation" strategic health authorities would be abolished from April 2012, although, notably, the circular was not press released.

On June 10, Sally Gainsbury in the *Health Service Journal* reported a health department official declaring that primary care trusts "are screwed. If you have got shares in PCTs, I think you should sell. They are under more threat than strategic health authorities".<sup>66</sup>

And a week later, Nigel Edwards, the acting chief executive of the NHS Confederation was writing to members warning that most commentators had "underestimated" how radical Lansley's plans were going to be. "I have little doubt the health secretary's programme has the potential to radically alter the way the NHS is run, funded and held accountable," he said.

On 18 June, the *Financial Times* reported that the NHS was to face its biggest structural upheaval in decades, with GPs to take over the bulk of commissioning and Sir David Nicholson, the NHS chief executive, telling colleagues privately that the health secretary's plans were "really, really revolutionary". There were rumours that perhaps 500 GP consortia would replace the 152 primary care trusts and 10 strategic health authorities, with family doctors taking control of perhaps £70bn to £80bn of the £100bn NHS budget.

In the most surreal of its annual conferences ever, the NHS Confederation gathered in Liverpool aware that something huge was on the way, without quite knowing what. The health secretary's speech did nothing to disabuse them over the scale of what he was up to, but equally did nothing much to enlighten them beyond his declaration: "I intend that general practice should take control of commissioning."

Sir David Nicholson, in his speech to the conference, characterised his boss as "a man in a hurry" making clear that the health secretary wanted the commissioning board operating by April 2012, with GP consortia buying the vast bulk of care. In what was to become a constant refrain of the next two years, Sir David outlined the dangers.

The Coalition, he said, was still debating how long this would take, but “even the most optimistic people would not say we will get [all of] this new system up and running in the next couple of years”.

Seventy per cent of big change programmes, he told his audience, “don’t work; they fail – a real possibility in these circumstances”.

“Of the 30% that do work, what are the defining characteristics? Well, the defining characteristic is not the brilliance of the vision. You can have the most fantastic and coherent vision available, but unless the management of change, unless the transition is properly led, you simply won’t deliver it.”<sup>67</sup>

He acknowledged that the Treasury was worried about the NHS’s financial performance amid all this upheaval. “But so am I,” he declared. “I am not going to put financial grip at risk. Never mind the Treasury.”<sup>68</sup>

This speech of Nicholson’s, in public, about both the money and the broader risks, and delivered ahead of the white paper, strongly undermines the case of those who would like to argue that the department did not warn Lansley about the potential impact of what he was up to.

The speech was also the start of one of the most intriguing minuets in the whole saga. Throughout, Nicholson, as the department’s second permanent secretary and NHS chief executive, was entirely loyal to Lansley as a civil servant. He helped develop the plans. He saw some real opportunities to improve the way the NHS functions.<sup>69</sup> And he had, by all accounts, some very clear exchanges with Lansley, as did other civil servants, about what might and might not work: what did and did not make sense.

So throughout he was engaged in a twin exercise of policy development and damage limitation; protecting the service and what he regularly called “our people” as best he could to make sure it kept going through this massive upheaval and was in a state to continue and improve; dealing with the risks of the white paper and the bill – as he put it in that confederation speech “how can I mitigate them? How can I stop the worst excesses of them?” while still developing Lansley’s new universe; and, given that he was a civil servant, taking a remarkable operational freedom, even for an NHS chief executive, to express his views about them in public.

At this stage, his relationship with Lansley was still somewhat tentative. It was widely believed, both in the department and the upper echelons of the service that Lansley before his arrival in the department had made clear to Nicholson that he did not see him having a long-term future, and that he certainly did not see him as the potential head of the commissioning board.

Lansley himself now denies that. But there was a widespread expectation both in the

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67 Sir David Nicholson, *speech to NHS Confederation*, 25 June 2010

68 *Financial Times*, 26 June 2010

69 See for example, *Financial Times*, 22 February 2011 on benefits of commissioning board

department and the service that Nicholson might well go in September when he had completed five years as chief executive. Indeed the usually well informed *Health Service Journal* regarded Nicholson as a man “on borrowed time”.<sup>70</sup>

“I think it is absolutely true,” one official says, “that anybody who told Andrew Lansley and company before the election that David would end up being appointed to the national commissioning board, they would have absolutely been laughed out of court.”

Nonetheless, Lansley’s and Nicholson’s relationship gradually built – a combination of “competence on David’s side and the fact that Andrew needed a friend within the NHS,” as one official puts it.

As the white paper was nearing completion, and as Nicholson told the NHS Confederation, the Treasury health team was indeed worried. But the Treasury as a whole had much bigger fish to fry. Aside from the initial £6bn of spending cuts announced in May, Treasury officials across the summer and far into the autumn were buried deep in devising what were to be by far the biggest spending cuts in living memory as the Coalition moved to eliminate the deficit over a single parliament. Worries about the health plans were a long way from the top of its priorities.

Even so, just ahead of the white paper there was indeed a wobble. A meeting of the Coalition committee with all the most senior Coalition members present launched into an unexpected discussion of Lansley’s plans with the health secretary absent. There were worries about financial control, worries about handing so much power to GPs.<sup>71</sup> And, according to officials, “the political antennae of Osborne and one or two others began to twitch for the first time about what all this really meant. I think they thought we’d said no reorganisation of the NHS yet this looks like a massive reorganisation”.

This was, in hindsight, a critical moment. The one when it dawned collectively on a bunch of Conservative as well as Liberal Democrat Cabinet ministers, that the white paper was neither Lansley’s original plan, which would have involved much less structural upheaval, nor was it the programme for government – again involving a very different structural change to that now being proposed. A thorough pause at this point might have led to revisions.

Instead, when word got back to the department that the white paper was in danger, Number 10 officials say that once the health secretary had calmed down over the discovery that his plans were being pulled apart at a meeting at which he was not present, his reaction was: “Leave this to me to sort out, they all used to work for me.” This was a reference to his time as head of the Conservative research department when both David Cameron and George Osborne worked for him, along with Steve Hilton who was with Lansley in Tory central office for the 1992 election campaign and was now Cameron’s highly unconventional strategy chief. In the end, according to Lansley, the white paper emerged a mere week later than planned.

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70 [Sir David Nicholson, hsj](#) (accessed 1 June 2012)

71 *Financial Times* 3 July 2010

By now the NHS Confederation was warning that a major structural upheaval would be another case of “the triumph of hope over experience”. Chris Ham, chief executive of the King’s Fund, was talking of “a serious risk of loss of financial and performance”. Dr Laurence Buckman, chairman of the British Medical Association’s general practitioners’ committee, was warning that family doctors are “not wildly enthusiastic about commissioning”. He added, however, that many felt “if it is the PCT or me, it might as well be me”.

On 9 July, a report from Andrew Porter, the *Daily Telegraph*’s political editor, confirmed that GPs were to be handed some “£60bn to £80bn” of the NHS budget in “the biggest revolution in the NHS since its foundation 60 years ago”. It was, the paper reported, “a victory for Andrew Lansley” after the prime minister had overruled worries from the chancellor, George Osborne, over handing so much control over so much NHS cash over to family doctors.<sup>72</sup>

The white paper was now through the relevant Cabinet committees – one of the department’s prouder trophies, in the light of subsequent events, being a warm letter from Nick Clegg as chairman of the Home Affairs Committee signing it off. The committee is made up of the vast bulk of Cabinet ministers other than the prime minister, the foreign and business secretaries.

On 12 July, just 60 days after the Coalition government was formed, the NHS white paper *Liberating the NHS* was published.

At the press conference to launch it, Lansley spelt out some of its key elements but handed over to Burstow the task of explaining why PCTs were being scrapped. Burstow was more than happy to. He outlined the bigger role for local government and the greater integration with social care that had been his chief concerns as the white paper was put together in the department.

“I had my priorities in terms of what I was particularly focusing on,” he says of its development, “and all of those things were pretty much landed in the white paper”. And at the time, one of his colleagues on the bill team says, he regarded those achievements as “a major victory”.

More generally, by the time of the white paper “he had drunk the Kool Aid at least as much as Andrew Lansley had,” one senior Liberal Democrat adviser says. “He [Burstow] liked him and thought he was well intentioned, and knew he was not trying to privatise the NHS.”

Burstow himself now says that he and his senior party colleagues in government – Danny Alexander and Nick Clegg – underestimated the “deep-seated distrust” of the Conservatives on health among Liberal Democrat activists, despite the long years the Tories had spent seeking to “detoxify” the NHS as an issue. And more generally they “underestimated the extent to which the competition aspects of the white paper would be seen and portrayed”.

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72 *Daily Telegraph* 9 July 2010.



He notes, however, that his party's manifesto had contained a commitment to any willing provider, which implied competition and choice. "It was very carefully phrased," he concedes, "but it was very clearly there."

# Act Three: “Liberating the NHS”

## Scene One: “A challenging and far reaching set of reforms”

The evening before the white paper’s publication, Stephen Dorrell, the newly elected chairman of the Commons Health Select Committee, ran into one of the ministers who had read it. “You will be surprised,’ he said to me. I was indeed surprised.”

However far back into the mists of time Lansley’s plans can be traced, Dorrell says, “the big politics” at the time of the election was that the NHS had been “put to bed. No top-down reorganisation – nobody had striven officiously to correct that interpretation – and the expectation on election day was that there’d be a bit more engagement from GPs, there would be tweaking at the edges, but it would be tweaking at the edges.

“There was certainly no understanding on my part, nor do I believe a significant level of understanding by those who were more intimately involved in it at that stage than I was, that there was going to be any attempt to write it all out on a clean sheet of paper.”

The clean sheet of paper was a mere 50 pages long, but it was stuffed with change. And it was presented as a radical and bold vision, not as a policy, that had many continuities with what Labour had been doing.

Sections in the original draft had emphasised that continuity: Labour’s focus on outcomes and quality following Lord Darzi’s appointment as a health minister; its drive for competition and choice; for practice-based commissioning; for getting all hospitals to foundation trust status; for separating the provider arms out of primary care trusts; and for using the private and voluntary sectors more, for example.

The argument in the draft was that Labour had been doing the right things but had failed to implement its reforms properly or see them through – in essence the arguments that Simon Stevens and Julian Le Grand, both former health advisers to Tony Blair when he was prime minister, were about to make in support of Lansley’s plans.

All that got stripped out. Partly at the insistence of the health secretary. Officials and advisers, both in the department and at Number 10 say that unlike Iain Duncan Smith at work and pensions or Michael Gove at education, he had no desire to give Labour any credit for doing, or attempting to do, the right thing. And partly because Sir David Nicholson, the NHS chief executive, saw the criticism of poor implementation as a criticism of the NHS leadership and management cadre.

Instead, the picture painted on the day and to the media was one of revolution: “a challenging and far-reaching set of reforms” in the white paper’s own words. Ones that amounted to “a major de-layering, which will cause significant disruption and loss of jobs and incur transitional costs between now and 2013”. The white paper’s impact assessment put the managerial job losses at 20,000 and the transitional costs at £1.7bn – figures that no-one believed at the time and which were, indeed, to rise steadily as the months went on.

The plans were in part so sweeping because they did involve completing much of Labour's unfinished business – getting all hospitals to foundation trust status, and separating out the provider arms of PCTs, for example. Both those involved significant work at the provider level.

But that was nothing compared to some of the other requirements, including:

- all family doctors to be involved in commissioning consortia, with strategic health authorities to be abolished in 2012 and primary care trusts to go in 2013
- the establishment of an “autonomous” commissioning board
- a new economic regulator to be charged with “promoting competition” and given current powers with the Office of Fair Trading “like other sector regulators, such as Ofcom and Ofgem”
- patients to be given a choice of “any willing provider” wherever possible
- new measures aimed at “limiting the powers of ministers over day to day NHS decisions”
- cuts to management costs, which had now risen to an awesome 45%
- the establishment of a new patient organisation Healthwatch
- public health to be transferred to local government
- new health and wellbeing boards to join up the commissioning of health care by GP consortia with the commissioning of social care and public health improvement
- new proposals for the National Institute for Health and Clinical Excellence (NICE), which appeared to limit its role in recommending which treatments the NHS should and should not adopt, thus devolving that decision to individual doctors or consortia.

There was much more buried away in the 50-odd pages of the white paper. It declared hopefully that “many will welcome our vision and clarity of intention, our insistence on transparency, and our real sense of urgency”.

Others it acknowledged presciently, “will find it too challenging”. Forlornly, at least in the short term, the paper hoped that the debate on health would “no longer be about structures and processes, but about priorities and progress in health improvement for all”. And in a sign of some of the obduracy over the proposals to come, the paper declared repeatedly that “we will maintain constancy of purpose”.

“Narrative” in politics has become a tainted word, associated too often with the worst days of Labour spin. But having a story to tell about why a set of reforms is necessary

is an essential part of policy making. Missing entirely from the white paper's pages was any convincing narrative over why the reforms were needed. More particularly there was no explanation over how these reforms – done at this time and in this way, and with the disruption that the paper itself acknowledged was inevitable – would in fact contribute on any recognisable timescale to the £20bn of efficiency savings needed.

Indeed, the need for the savings is there almost as an afterthought – the last substantive point, point seven, of the white paper's introduction.

The one attempt at a narrative in the foreword – that patients would be at the heart of the NHS, that success would be measured by the outcomes that the NHS achieves and that clinicians would be empowered to use their professional judgement about what is right for patients – sounded fine; but a little like motherhood and apple pie.

## Scene Two: “Too far and too fast”

The opposition to the white paper and subsequent bill over the next 20 months was to fall into three broad, but overlapping, phases.

Initial concerns were over the scale of reorganisation, and the nature of GP commissioning, in the face of demands for huge efficiency savings. When the bill emerged, the focus shifted to furious debate about the scale and nature of competition in the NHS, with the charge of “privatisation” coming to the fore. Finally, there was to be a long argument over whether the bill retained a requirement for the health secretary to provide a comprehensive NHS.

The warning signs were all there on day one, however. The British Medical Association, for a start, had never been fully reconciled to the introduction 20 years earlier of the purchaser/provider split in the English NHS. Indeed, in 2008, its annual representative meeting had voted to drop that entirely, adopting the more direct management approaches being used in Scotland and Wales, seeking “an NHS untarnished by a market economy”.<sup>73</sup>

More particularly, despite most GPs themselves being independent contractors to the NHS, and despite around half of consultants doing some private practice, it had never been remotely reconciled to the involvement of the private sector in the NHS and the competition that implied.

Year after year its annual representative meeting had passed resolutions attacking a market in health care.<sup>74</sup> It had condemned the introduction of independent sector treatment centres. And it had worked with Unison, the biggest health union, with the NHS Consultants Association, some of whose leading lights were veterans of the campaign against Ken Clarke's original internal market, and with Keep Our NHS Public, and others, on what the BMA itself dubbed an “anti-privatisation campaign”.

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<sup>73</sup> *Financial Times*, 8 July 2008

<sup>74</sup> Eg *Financial Times*, 23 September 2005, 29 June 2006, 8 July 2008

Indeed, during the 2010 general election it had launched a costly exercise, including a “Look after Our NHS” website and an online video with Twitter links while distributing packs of leaflets to every GP practice and hospital in England, arguing for a “publicly funded, publicly provided” NHS. Big business, the BMA argued, was “taking money out of the NHS” and putting “profits before patients”.<sup>75</sup> It was never going to be reconciled to Lansley’s drive for more competition and choice.

Indeed, in an intriguing view of the health secretary’s plans, as the white paper was emerging Dr Hamish Meldrum, chairman of council of the BMA was telling his members that if GPs took control of the cash, they might even be able to pervert Lansley’s reforms to the point where they could “bypass, if not ignore, the Government’s market philosophy” by ensuring that NHS organisations were indeed the “preferred provider” of NHS care.<sup>76</sup>

The BMA’s stance was not, of course, shared by all doctors, let alone by all GPs. And there were, as there had been ever since the 1990s, enthusiasts for GP commissioning. For them, the white paper was indeed the liberation in its title. “My short response to it was ‘wonderful,’” Dr Michael Dixon of the NHS Alliance says. For GP commissioners “it was very emancipating – all that we could have asked for.”

The National Association of Primary Care was equally welcoming. GPs being given apparently freewheeling freedom to design their own consortia, plus a huge chunk of the NHS budget, was the sort of reform they had long been seeking - although how cuts in management costs of 45% were to be squared with speculation that 500 commissioning consortia would replace the 152 primary care trusts was never clear.

Even among the enthusiasts, however, there were notes of caution. “Only about 5% to 10% of GPs are ready to take on hard budgets to buy care within the next few months,” Dr Dixon said as the white paper emerged. “Perhaps 50% will be within 18 months. Others will take longer.” He equally warned that managerial talent in primary care trusts – people whom the junior health minister Anne Milton was shortly to describe, and to their fury, as bureaucratic “pen pushers” – needed to be retained.

If commissioning enthusiasts were enthused, others on the day, not least the BMA, were much more cautious. The reaction of many think-tanks, notably the King’s Fund and Nuffield Trust, was to focus on the sheer scale of change and potential disruption. The Nuffield Trust also warned that “many previous reforms [of commissioning] have struggled to win the support and engagement of GPs, and this will again be a crucial issue”.

There were other, less hostile, voices. Simon Stevens, formerly Blair’s health adviser in Downing Street and now president of global health at United Health in the US, declared that “the proposals come 10 years after Tony Blair, then prime minister, took the first steps down this path. What makes the Coalition’s proposals so radical is not that they tear up that earlier plan. It is that they move decisively towards fulfilling it”.<sup>77</sup>

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75 <http://lookafterournhs.co.uk/> and Financial Times February 13 2010

76 *Financial Times*, 30 June 2010

77 *Financial Times*, 15 July 2010

Such voices, however, were a distinct minority. Perhaps most worryingly for the Government, it did not even find friends in places where it might have expected them. Nick Seddon, the deputy director of the pro-market think-tank Reform who had taken a special interest in health care, wrote:

“The most obvious concern about Mr Lansley’s plans is that we don’t know whether GPs will be better commissioners. There is no evidence to suggest that they have the skills needed ... And the vast majority of the GPs that I have spoken to say they don’t even want to do it.

“What this means is that Andrew Lansley is taking a very big gamble with a very large amount of taxpayers’ money. Informed opinion among policy wonks is that this is likely to generate a greater deficit, burning more money, not less.”<sup>78</sup>

As for the political reaction, whatever the very real continuity with parts of the Blairite reform agenda, Andy Burnham, the former health secretary and now Labour’s health spokesman – and, perhaps crucially, at the time a candidate for his party’s leadership and in need of health service union votes now that Gordon Brown had resigned as party leader as well as prime minister – was having none of it.

As Lansley presented the white paper to the Commons, Burnham declared that while Labour supported practice-based commissioning “what we do not support is the wiping away of oversight and public accountability, and the handing over of £80 billion of public money to GPs, whether they are ready or not.

“Is not the handing of the public budget to independent contractors tantamount to the privatisation of the commissioning function in the NHS?” he asked. Added to that, the Government “is bringing a series of market reforms into hospitals. He tells us that the first role of Monitor will be to promote competition, and he talks of any willing provider and freedoms for foundation trusts. Is not that the green light to let market forces rip right through the system with no checks or balances?” The commissioning board would be “the biggest quango in the world” with no transparency over how it would be accountable to Parliament.

The white paper, he declared, represents “a roll of the dice that puts the NHS at risk – a giant political experiment with no consultation, no piloting and no evidence.” The health secretary was “removing public accountability and opening the door to unchecked privatisation”.

It would “turn order into chaos. We will oppose it,” Burnham said.

On day one, it was clear that serious battle lines had been drawn - even as Nick Clegg was briefing political correspondents that the white paper – different though it was to the programme for government – was “a highly effective conflation of Tory and Lib Dem ideas”.

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78 *Daily Telegraph*, 12 July 2010

On 12 July, the white paper may have only just rolled off the presses. However, in the time honoured manner of the NHS, it was already beginning to be implemented, something the department has always initiated whenever a government proposes reform.

Lansley's goal might have been to create a well oiled, entirely devolved machine that would run itself. To get there, however, there would be huge quantities of ministerial direction in the form of preparation for implementation of the legislation, along with the fiercest period of centralisation the NHS had seen in years.

On the day of the white paper, Sir David Nicholson wrote to the service, telling it that the scale of change "is unprecedented and affects all parts of the service ... I intend to strengthen central controls on quality, finance, operations and [improvement] delivery through the next two years whilst we build the new system".

With the first two years of the £20bn efficiency savings depending crucially on an already instituted NHS pay freeze and big cuts in management costs, Nicholson moved to dragoon the 10 strategic health authorities into four, and the 152 primary care trusts into 50 PCT "clusters" – shedding staff and requiring many people to re-apply for their jobs. The department also moved to encourage GPs to form consortia, announcing before the end of the year that the first of them had been created in shadow form.

Negotiations were opened with the BMA on a variation to the GP contract which required family doctors to be members of these consortia once they were up and running. The outline, though not the precise detail of that, was agreed by the autumn – a tacit acceptance by the association that the Government was more than likely to get its way.

Despite that, GP leaders at the BMA – worried about their own positions relative to what would clearly be diehard opponents in their own ranks – re-ran the old arguments from the days of fundholding. There were worries that the doctor/patient relationship would be damaged if not destroyed once they were directly responsible for the budget, not just for the patient in front of them. The apparent removal of NICE as a shield for doctors over which treatments they did and did not provide, led to fears of "medical tourism" with patients seeking out consortia who would provide treatments that others denied.

A mere fortnight after the white paper's publication on 14 August, and in a sign of trouble to come, Baroness Shirley Williams, in an 80th birthday interview with *The Guardian* declared she was "very worried about health". One of the "gang of four" who had broken away from Labour to found the Social Democratic Party in 1981, Williams was still a much loved and respected figure in the Liberal Democrats. She had not, she said, fully engaged yet with the white paper. But "what I do know is that if there was any sign we were moving towards the privatisation of the NHS, a lot of Liberal Democrats would not put up with that".

As the enthusiasts for GP commissioning thought all their Christmases had come, the chief executives of big hospitals were horrified by the proposals. Many had little love for primary care trusts. But they loved the idea of the average GP being in charge of buying the bulk of

their services even less. Silent in public, they could be heard in private spluttering that the idea was the equivalent of “letting the local garage take over BP” or “the local corner shop run Sainsbury’s”.<sup>79</sup> Their fears were telegraphed over to David Cameron in Downing Street.

By September, Dorrell was making it clear that the new Health Select Committee wanted to influence policy making as it went along, not merely comment on it once it was completed. Dorrell was in a strong position. One of the changes the Coalition government had made was for the chairs of select committees to be elected by all MPs, rather than appointed after horse trading among the parties’ whips. This gave the committee chairs much greater independence from government and appreciably more authority. Dorrell was making clear from early on that he and the other committee members were far from convinced by the Government’s proposals.

“The key question,” he said, “is whether the plans address the weaknesses of NHS commissioning as it has been developed over the past 20 years.” He noted there were marked similarities between what Lansley was proposing and both the total purchasing pilots and Labour’s first incarnation of GP commissioning, the primary care groups. But “it has been rather easier to make the speech” on clinical involvement in commissioning, “than it has been to deliver,” he noted.

By October, as the formal consultation on the white paper closed, profound scepticism about Lansley’s plans was to be heard everywhere. The King’s Fund, for example, condemned the whole plan as “too far, too fast”, urging the government to “think again”.

It added: “We question the need to embark on such a fundamental reorganisation as the NHS faces up to the biggest financial challenge in its history” saying that the case for change on this scale “has not been made”.

At worst, requiring GPs to take up the vast bulk of commissioning could lead to “disintegration” as they failed to control budgets, while it estimated the true costs of the reorganisation to be more likely £2bn to £3bn. It urged a much more incremental approach.

Dorrell, in an interview, started a recurring theme to the effect that the “main game” was achieving the efficiency savings, which should take precedence over the reforms. The select committee was shortly to warn that the 4% per annum efficiency savings for four years that were needed “have never been achieved by any health system anywhere in the world” let alone by the NHS.

“I am in favour of liberalising the system,” Dorrell said, “But I am not in favour of imagining the secretary of state isn’t accountable for what’s delivered tomorrow in every surgery in every part of the NHS, because he is.” Voters, he added, “won’t buy the idea” that the health secretary can claim if a foundation trust gets into trouble, that it is “nothing to do with me, squire”.<sup>80</sup>

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79 *Financial Times*, 15 August 2010

80 *Health Service Journal*, 17 November 2010



In November, Dr Clare Gerada succeeded Dr Steve Field as chairman of council of the Royal College of General Practitioners, one of the bodies that might have been expected to be an enthusiast for Lansley's plan. Field, a former Labour party member who saw at least as much continuity in Lansley's plans as difference, had steered a careful course. He was broadly supportive of the principles in the white paper, while accepting that his membership had divided views. Soundings showed that the college's younger GPs were appreciably keener about the idea of taking control of the budget than its older members.

In its formal response to the white paper, the college said "our members are enthusiastic about the opportunity for GPs to play a leading role in shaping services for their patients". But that headline support for the principle was heavily caveated by worries about what it would do to the doctor/patient relationship, about the "proposed scale, pace and cost of change", the loss of PCT expertise, the "imperative to offer choice" and "an increased dependency on private providers". It fretted that "in the context of economic strictures" GPs would be held personally responsible for consequent shortcomings in services. It was, at best, a Janus-faced response.

The arrival of Gerada, however, rapidly changed that tone. The daughter of a GP who had accompanied her father on home visits to 1960s slums, she described herself as shaped by those experiences and the "socialist environment" in which she grew up.<sup>81</sup>

Trained as a psychiatrist but a GP in Lambeth since 1991 she was a partner in what had become one of London's largest group practices, with a particular commitment to dealing with some of the NHS's toughest patients – those suffering from mental health conditions and substance abuse. She had been a health department adviser and by the age of 41 had been awarded an MBE for services to medicine and substance misuse. Animated, passionate, occasionally impulsive, in her first interview in her new job, she declared that the reforms would mean "the end of the NHS as we know it".

It would no longer be "a national unified health service, with central policies and central planning in the way that [Aneurin] Bevan imagined," she said. Making GPs "the new rationers" could break the bond of trust between doctors and patients. The English health system would look more and more like America's.<sup>82</sup>

Shortly afterwards, at a select committee hearing, Sir David Nicholson, sitting alongside his boss, conceded in answer to a question from Dr Sarah Wollaston, a Conservative MP who was also a GP, that primary care trusts were "in meltdown" as staff took voluntary redundancy and as PCTs were being merged into clusters.

"You are absolutely right," Sir David told her, adding that he was putting in place "Stalinist" controls to keep a grip on the finances. He provided the first hints that not all GP consortia would be ready by 2013 and that primary care clusters might survive beyond that.

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81 *The Guardian*, 19 November 2010

82 *The Guardian*, 20 November 2010

Alongside him, the health secretary challenged his own chief executive's view of PCTs being "in meltdown", but also found himself having to deny that his plans amounted to "a nuclear device" going off inside the NHS. Late in the day, he tried to paint the reforms as anything but a revolution, arguing they were merely "an evolution" of Labour's practice-based commissioning.<sup>83</sup>

By now, the department had drawn up an extensive register of the risks both to the NHS and of getting the bill through. At the end of November, John Healey, Labour's health spokesman, issued a freedom of information request asking for it. It was to be the start of a 19-month-long battle to get the department to publish it, as first the information commissioner and then a tribunal ruled that its release was in the public interest. Eventually, in May 2012, after the bill had become law, the Cabinet resorted to its last-ditch means of turning such requests down, formally vetoing its release – a procedure only used three times in the previous decade.<sup>84</sup>

### Scene Three: Kicking the tyres

In the face of all this opposition and scepticism, the alarm bells had started to ring in Downing Street.

The Treasury and the chancellor – having announced the biggest spending cuts in well over a generation in the October spending review – now had a chance again to focus on the NHS reforms. Officials fretted about the money. Osborne was worried about that and the politics. Treasury officials could be heard declaring: "We have now to get a grip on this." Cameron and Clegg both appeared to be taken aback by the mounting scale of opposition.<sup>85</sup>

Oliver Letwin and Danny Alexander were whistled up to crawl all over the plans to see if they made sense as the command paper – the Government's response to its own consultation – was pushed back. The bill, which had originally been promised for the autumn, was also delayed to allow for this review.

Again, the lack of health expertise within Number 10 was being felt. "Andrew has all the answers when he is asked the questions about how the implementation of all this will work," one Number 10 insider complained. "We are just not sure they are the right ones."<sup>86</sup>

The Letwin/Alexander review was a serious undertaking. The two had seven or eight meetings with the department, both in Richmond House and in Number 10, meetings that eventually involved "a cast of thousands", from Clegg and Cameron's special advisers down to departmental and Treasury officials, with Osborne again fretting about control of the money. They went through not just the mechanics of the NHS reforms but the plans for winter. Cameron was fearful there would be a winter crisis, on top of his worries about how the transition might work. As the NHS chief executive, Nicholson played a big part in explaining all that.

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83 [Health Select Committee hearing](#) 23 November 2011

84 *The Guardian*, 8 May 2012

85 *Financial Times*, 1 December 2010

86 *Ibid*

The review, however, appears to have focused far more on the mechanics than the politics. One Liberal Democrat adviser says: "There were a lot of meetings, but there was never a proper political look at it. And Oliver is a purist, and intellectual. If you have a political problem you don't ask Oliver to solve it for you.

"He's a deeply apolitical creature. So he goes and takes a close look at the policy and he decides it makes sense. So does Danny Alexander. And he more than had his hands full. He'd just finished doing the massive, deficit cutting spending review. With the loss of David Laws [who had resigned over a Commons expenses claim] Danny was trying to do three jobs at once: as chief secretary to the Treasury, which is no small undertaking; as member of the quad and as our minister for government – sort of man-marking Oliver Letwin. And Danny is not a health policy expert."

One of those Letwin consulted was Dorrell. "I had several meetings with Oliver and I said that 'I don't have a broad problem with the policy, although I don't understand why it had to be legislated."

What Dorrell was worried about was the politics. "It seemed to me to be extremely high risk and very damaging." The select committee was seeking to draw attention to the economic challenge facing the health service "which I still believe is overwhelmingly more important than any of this structural stuff, and the discussion I had with Oliver was that 'we have to have a real plan which demonstrates how you're going to deliver quality and value and 4% efficiency gain four years running. That's the real challenge'".

Dorrell says Letwin listened and engaged. But after two or three conversations over three weeks Letwin came back and said: "We have reflected on what you've said and we respect your view, but we don't agree with it ... We think we have got an answer." Letwin's argument, Dorrell says, was that direct cost controls such as the NHS pay freeze and cuts in management costs in the early years would deliver the first part of the efficiency gain, with the new system with its automatic universe delivering the gains thereafter.

As the review took place, the headlines for the NHS only got worse. Robert Creighton, a highly regarded PCT chief executive who had been principal private secretary to Virginia Bottomley when she was health secretary, exploded during a conference at the King's Fund, declaring that the reforms were "heading for a train crash".

As health ministers, including Lansley, repeatedly attacked managers as bureaucrats and "pen pushers" Creighton said he and his staff felt that everything they had been doing over the years was being belittled. He was doing nothing but interview people for jobs in the reshaped "clusters" with staff doing "nothing about patient care, money, or anything else". The service was "at risk of blowing it," he said. This, he added, could be "a bloody awful train crash. It could collapse".<sup>87</sup>

The following day finance officers at the Healthcare Financial Management Association's annual conference were treated to a lecture by Simon Burns, the minister of state for health, on how choice and competition would solve all the service's problems, before Nicholson spoke. When he did so, he produced one of the two great sound bites of the entire saga.<sup>88</sup>

Nicholson said he had been consulting management gurus from around the world. "No one could come up with a scale of change like the one we are embarking on at the moment. Someone said to me: 'It is the only change management system you can actually see it from space – it is that large'." Giving GPs control of the money, he added, "turns the whole system on its head". His mixed message, again, was that most big change management programmes fail but that he had "absolutely no doubt" that the NHS could deliver.<sup>89</sup>

At this stage even some of the Government's friends in the private sector were trying to warn ministers over just what it was they were planning to do. One private sector management consultant who had been trying to point out to Letwin, other senior Conservatives and people in Downing Street just how risky all this was, said: "They all hear the words, nod wisely, but give no outward sign that they are going to challenge what is going on. It is going to be very messy."<sup>90</sup>

The chief executive of one of Britain's biggest private hospital groups was reported as saying of Lansley: "If I went to my board and said that I'd told my senior management that I was merging all their posts before making them redundant in two years' time; that I'd told all my finance people they too will be going; and that I was going to get some other people to run the business; and that while I can't yet define it precisely, it will involve the nurses – well, I think it would be me who was out of a job."<sup>91</sup>

Even at this stage, however, it was hard for Cameron and Clegg fully to focus on the reforms, much though they were causing unease at the heart of government. Both were involved in the tense battle to get the big rise in higher education tuition fees first through the Commons and then through the Lords. Getting the NHS reforms right was important, but at that stage less important than surviving the Coalition's first big parliamentary test.

The conclusion of the Letwin/Alexander review, in essence, was that Lansley's plans were given a clean bill of health, provided the transition was carefully handled.

As Lansley puts it: "A lot of it [the review] was, quite understandably, 'Explain to us how all this works?' And when we had explained to them how it all worked, they said: 'Okay'."

Nicholson's performance throughout had impressed the senior politicians. Aside from the go-ahead, the chief outcome of the review was that Sir David was appointed as chief executive designate of the commissioning board.

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88 The other being Simon Burns: "You cannot encapsulate in one or two sentences the main thrust of this."

89 *Financial Times*, 9 December 2010

90 *Financial Times*, 14 December 2010

91 *Ibid*

This was something of a turn up for the books, given Lansley's well known reservations about Nicholson when he became health secretary.

Lansley certainly had other candidates in mind for the board job, and ones that he would have believed to be more enthusiastic about his market-related philosophy: Mark Britnell, an NHS chief executive who had been a director of commissioning in the department and who had left the department to work for KPMG in the hope that the private sector experience would increase his chances of getting the commissioning board job; or Simon Stevens, Blair's former health adviser.

Tough, controlling and happy to make jokes about his Communist past with his assertions that he would put "Stalinist" controls in place to retain financial control, Nicholson had expressed plenty of reservations in the past about how far market-like mechanisms could be used as the central, or almost sole, driver to reshape the NHS.

He had always agreed that the NHS needed help from the private sector. He had repeatedly said that its role was likely to grow. But what the "ideologues around reform" failed to understand "is that they think all you need to do is put the right incentives and penalties into the system and the service will respond. Well, of course it doesn't...

"The NHS is not just a whole set of separate organisations with their own autonomous responsibilities," he had argued back in 2009, but a group bound by "values and principles" which transcend that. Because of those values and principles "you have to take our people with you".<sup>92</sup>

Immediately after the election, other senior officials had worked hard to make sure he was retained. A born and bred NHS manager, he knew how the system worked. He could point out pitfalls to the health secretary. And above all he knew better than anyone else inside the department how to hold the service together amid this whirlwind of controversy and change. And paradoxically, his public warnings about the scale of the change and the challenge had convinced Cameron, Osborne and others that if anyone could handle the transition it was Nicholson. Furthermore, since the election, he and Lansley had discovered that they could in fact work well together.

There are two versions of his appointment. One is that its coincidence with the outcome of the Letwin/Alexander review is just that – a coincidence. Una O'Brien had just been appointed in late October as the department's new permanent secretary and was making her dispositions, which included settling Nicholson's future. The other version – and several accounts bear this out – is that the appointment was, quite simply, "a condition for proceeding". The two versions are not entirely incompatible.

There was an odd dance on the lines of Lansley and Nicholson separately being asked: "If he would do it, would you ask him?" and "If you were asked, would you do it?"

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92 *Financial Times*, 12 December 2009. (accessed 1 June 2012)

Nicholson himself had begun to accept that his days were numbered. In the first week of December he was in the Cabinet Office negotiating his severance deal. He was planning to go over Christmas. But Lansley rang, and on the Wednesday over a breakfast meeting of scrambled eggs at Inn the Park, the health secretary offered him the job of chief executive designate of the commissioning board. He apparently thought about it over the weekend and said yes.

A week later his appointment became public. "There was a neat conversation," Matt Tee says, "in which someone said 'David, congratulations on getting appointed, that came as a bit of surprise to us'. And David said 'not nearly as much as it came as a surprise to me'."

As one official puts it: "David emerged as the saviour of the day. [Nicholson] basically convinced a tremulous Treasury and Number 10 that he could hold the budget and deliver it. And they liked him I think, and he gave them quite a lot of confidence. And they realised that what the system needed wasn't a reforming zealot but somebody to hang on to the bloody thing."

Lansley's version of this is that: "David and I had not had any relationship before I became secretary of state because David was chief executive and that would not have been proper. But I think very rapidly we got to a good place.

"And the reason why is because he understood that I had the interests of the NHS at heart and I understood he did. We might have started from different places. We might actually have had different instincts. But he is not only an NHS man and boy, but also accepted that we had been elected and we had a mandate. And we had a mandate for change.

"From his point of view, he said the NHS needs change. It needs modernisation. I think it would be fair to say, and I am not putting words in his mouth, but I would think he saw this as an opportunity for delivering some of the changes he thought the NHS needed. So for example he must have wrestled for years with the fact the ministers came and went and things changed, and it all got turned over, and people were utterly fed up with that.

"And the idea that there should be greater autonomy for the NHS as an organisation, and that autonomy would give the NHS institutional stability long term, I think for David was a real bonus, a real potential opportunity. And he I think saw it, and has frankly taken it."

Lansley adds: "From my point of view it became immediately obvious, in order for reform to be achieved, there could not be a deterioration in performance. Business as usual had to be maintained. And the way David himself has said, the idea that different people could be building the new architecture separately from those who are responsible for the current architecture is always a nonsense.

"If we had gone down that path and there were two people now, one of whom was chief executive of the NHS and one of whom was chief executive designate of the commissioning board ... people would have done divide and rule, inevitably. Because David has a foot in both camps, that has worked very well."

Nicholson's appointment, however, made him unquestionably, and for the immediately

foreseeable future, by far the most powerful person in the NHS. He returned to the top of the *Health Service Journal's* annual (though not entirely serious) "top 100" people with the most influence on the NHS – ahead of the health secretary. For the moment, few had the locus to argue against anything that Nicholson saw to be necessary to hold things together.

News of his appointment coincided with Lansley publishing his formal response to the consultation on his white paper.<sup>93</sup> Some 6,000 responses from the supportive in principle to the downright hostile had come in. But the command paper contained next to no change. There was some minor strengthening of the local authority role. The commissioning of maternity services, which had been something for the commissioning board, was transferred back to GP consortia. On the day of publication, Nicholson wrote to NHS chief executives indicating that some GP consortia might only receive "conditional" authorisation to operate in 2013, stressing that "different parts of the system will move at different speeds".

Lansley's "constancy of purpose" promise in the white paper held. All that did was raise the temperature further. "Nothing much had changed," Dr Hamish Meldrum, chairman of council of the BMA says: "They didn't appear to be listening ... there was virtually no tangible response to the consultation."

That view is confirmed by officials. During the consultation, one says, "Andrew wasn't really interested in compromising. All the conversations we had with stakeholders were not really about making any changes. It was about explaining that this is what the Government had decided to do, and that it was going to do it." Transmission, not reception, as another puts it.

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93 [Liberating the NHS: legislative framework and next steps Cm 7993 10 December 2010](#) (accessed 1 June 2012)

# Act Four: It was the bill wot did it

## Scene One: "I commend the bill to the House"

As 2010 turned to 2011, the focus of concern over the reforms shifted. In a new year message to his members, Nigel Edwards, acting chief executive of the NHS Confederation, underlined the degree to which the state "will be withdrawing from the day-to-day management of health care", with the service becoming "like a regulated industry" on the lines of telecommunications, water and the energy industries. It could, he warned, "trigger a major reshaping of the way care is delivered with services closing and changing".

Others began to take up the theme, pointing out that while the key focus to date had been on the decision to hand over the purchasing to GPs while abolishing PCTs and SHAs, the more profound change was the shift from a directly managed system of care into something much more like a regulated industry of competing providers – and one over which the secretary of state would no longer have day-to-day control. The *Financial Times* pointed out that this amounted to a "cultural revolution".

"I do not think most people have grasped the scale of this change," Mr Edwards said at the turn of the year. "By 2014, the NHS will no longer be a system which still contains the characteristics of an organisation. Instead it will be a regulated industry in which that management chain no longer exists." Amid "any willing provider", services would have to become more responsive to patients. But in a system with no real financial growth that would mean that new providers would have to replace existing ones. "There will have to be an element of Joseph Schumpeter's 'creative destruction'," he said.<sup>94</sup>

Meanwhile in *The Guardian*, Dr Wollaston, the Conservative MP and Health Select Committee member who had emerged as a critic of the reforms, took up a theme that was to run throughout the next 15 months. Wollaston had a particular standing in the debate as both a GP and as the first MP ever to be selected in an "open" primary contest, in which all voters had chosen her to be the Conservative candidate at the general election. She warned that the changes opened up the NHS to the stringencies of EU competition law.<sup>95</sup>

This was one of the most furiously fought, if most misunderstood, elements of opposition to the changes. In fact, in the view of many lawyers, actions Labour had taken meant that competition law already applied.

Back in 2006, as Labour was creating an NHS price list, re-introducing choice, commissioning independent sector treatment centres and encouraging competition between NHS and private hospitals, Norman Warner, the health minister of state in the Lords, had asked for a legal opinion. While heavily qualified, it said the combination of these changes certainly opened up the possibility that the courts would decide that EU law applied.

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<sup>94</sup> *Financial Times*, 16 January 2011

<sup>95</sup> *The Guardian*, 31 December 2011



Competition law aims to prevent anti-competitive practices that act against the interest of consumers. In the public sector, it is closely allied to procurement law. The two combined seek to protect the interests of both the consumer – the patient – and the taxpayer. Competition law, for example, aims to prevent monopolies restricting choice, and with it comes the implication that more services might have to be put out to tender to ensure best value for money.

The legal opinion that Warner commissioned was not published. But the health department's then commercial director, Ken Anderson, who had procured the independent surgical treatment centres (ISTCs), effectively spelt its conclusions out in public shortly after his departure.

"My personal conviction is that once you open up NHS services to competition," he told the *Financial Times* early in 2007, "the ability to shut that down or call it back passes out of your hands. At some point European law will take over and prevail ... In my opinion, we are at that stage now."<sup>96</sup>

In recognition of that, the health department in late 2007, and with notably little publicity, issued a set of *Principles and Rules for Cooperation and Competition*. Without mentioning EU law – which is, of course, also UK law – it effectively applied a version of it to contracting for patient services.<sup>97</sup>

In a more substantive recognition, an advisory body, the inelegantly named NHS Co-operation and Competition Panel, was announced in 2008 and instituted in early 2009.<sup>98</sup>

During the debate over the bill, even legal opinions sought by those opposed to the application of competition law to the NHS accepted it almost certainly applied. One – produced by the campaigning group 38 Degrees once the bill was published – acknowledged: "It is likely that, even as matters stand, and in view in particular of recent non-statutory reforms which increase the involvement of the private and third sector in health services provision, competition law already applies to PCTs and NHS providers." It noted that "the reforms introduced by the bill ... will serve to reinforce that conclusion".

But it added that there could be "nothing in the bill which has or can have the effect of preventing the application of competition law" since prohibitions on anti-competitive conduct "gives rise to actionable claims in the High Court by any person affected".<sup>99</sup>

In practice, the advisory Co-operation and Competition Panel had been quietly applying its interpretation of the law since early 2009 – advising on NHS mergers and handling complaints about anti-competitive practices by hospitals and primary care trusts.<sup>100</sup>

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96 *Financial Times*, 16 January 2007

97 Department of Health, *Principles and rules for Cooperation and Competition*, 13 December 2007 (accessed 1 June 2012)

98 *Financial Times*, 16 March 2008. (accessed 1 June 2012)

99 [http://38degrees.3cdn.net/b01df9f37ac81ffb2e\\_zhm6bnldz.pdf](http://38degrees.3cdn.net/b01df9f37ac81ffb2e_zhm6bnldz.pdf) (accessed 1 June 2012)

100 *Financial Times*, 27 and 29 July 2011

This had been, however, almost a reform by stealth. Most of the world was utterly unaware that the panel existed.

The white paper and the bill in particular made all this much more explicit, and the economic regulator was to be charged with “promoting competition, where appropriate”. But a long war was to be fought to seek a way of “protecting” the NHS from the application of a piece of legislation to which it was already subject, even if no-one yet had gone to court complaining that NHS commissioners were in breach of it.

In the run up to the bill’s publication – which, it was slowly becoming clear, was to be large, far bigger than the original 1946 Act which set the service up – the Government was hit by fresh problems.

The NHS Operating Framework – the annual edict from the department which gives the service its marching orders for the year – for the first time allowed a limited amount of price competition over services covered by the NHS tariff, stating that the tariff would be a “maximum” price in the coming year: something the bill would shortly confirm. The fact that this was coming had in fact been trailed in the 2009 operating framework under Labour. But no-one had picked that up in a way that made it a political issue.

This time it was spotted by bunch of health economists – Zack Cooper at the London School of Economics and Carol Propper of Imperial College, London and the Centre for Management and Public Organisation at Bristol, along with Anita Charlesworth, the chief economist at the Nuffield Trust.

Cooper and Propper, in separate pieces of work, had shown some benefits from competition when patients were given a choice between hospitals which were being paid the same price per treatment. Propper’s work on GP fundholding in the 1980s, however, had also shown some worrying signs of a decline in quality when GPs were allowed to negotiate prices for treatment downwards. Some US literature also showed that competition over price lowered quality.

The academics attacked the operating framework, warning of a “race to the bottom on price that would almost certainly threaten quality” – a concern that was echoed by the NHS Partners Network, the trade body for private and voluntary providers of NHS care, which declared itself “very nervous about the idea”.

Zack Cooper, the LSE health economist, said: “I am about as pro-competition in health care as you are going to find. But price competition would be a hugely retrograde step. To introduce it is not to learn the lessons from the NHS’s own experience and from abroad.”

Julian Le Grand, another advocate of choice and competition in the NHS as Blair’s health adviser, echoed the concerns.<sup>101</sup> Shortly afterwards, in a letter to *The Times*, the leaders of six health service unions expressed their “extreme concerns” over price competition. The Government had managed to unite reformers and opponents, and it floundered. It took

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101 *Financial Times*, 6 January 2011

weeks finally to rule out price competition over services covered by the NHS tariff.

With pressure building, the prime minister in mid-January – two days before the bill was published – set out the case for public sector reform more generally and for the NHS changes in particular. The Coalition, he declared had a “once in a lifetime opportunity to transform our public services”, and the NHS changes were a prime example of that.<sup>102</sup>

He once again drew attention to Tony Blair’s remarks that he had wasted his first term. “I have to say to people: ‘If not now, when?’ We should not put this off any longer.”

On the day Cameron was making his speech, Philip Stephens, the *Financial Times* political columnist, who had run a series of columns asking what question was it that the NHS reforms were meant to answer, made the first prediction that the reforms “could become Cameron’s poll tax”.<sup>103</sup>

It was one of those rare columns that really struck home – not least with Baroness Shirley Williams whose concerns over the white paper had been mounting.

On the 18 January, the Commons Health Select Committee produced a report that did nothing to help the beleaguered health secretary.

The way he had gone about his business had “blunted” the service’s ability to make £20bn of savings, the committee concluded. The plans to shift commissioning to GPs, abolish PCTs and SHAs, and to set up a commissioning board and new regulator were causing “significant institutional upheaval” and “widespread uncertainty”. As a result, the risks “of an already high-risk strategy” had risen. The decision to hand over all commissioning to GPs in 2013 has not yet “been sufficiently explained given the costs and uncertainties generated by the process”.<sup>104</sup> At the press conference to launch it, Dr Wollaston declared that the reforms “feel as though someone has tossed a grenade into PCT land”.

It was however the bill, published the next day, that provided the detonation which turned the reforms into a full-blown political crisis for the Government.

For a start it was vast – more than 280 clauses plus 22 schedules, some 550 pages in all – three times the size of the 1946 Act that founded the service.<sup>105</sup> Unison, the largest health union which had been campaigning against its contents from the beginning, condemned it as a mistake “of Titanic proportions”.

It was so huge partly because it touched almost every part of the NHS – setting out how the system would work, as Dorrell would later put it “on a clean sheet of paper”.

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102 David Cameron, [speech on modern public service](#), 17 January 2011 (accessed 1 June 2012)

103 *Financial Times*, 17 January 2011

104 *Commissioning*, Commons Health Committee, Third Report session 2010-11.

105 The 1946 Act has 80 clauses, 10 schedules and covers some 120 pages. However the 2006 NHS Act, a consolidating piece of legislation, has 278 clauses and 22 schedules.

It was also enormous because to achieve in legislation Lansley's goal of the secretary of state being able to step back from day-to-day management of the service, it had to redefine the relationship between the minister and virtually every part of the service. "If you're going to try to redefine the relationship between ministers and the NHS ... then you have to really change fundamentally the legislative structure," one official involved in devising it explains. That was to prove a key source of future trouble.

Its publication did prove that civil servants do have a sense of humour. Its clause IV – an echo of the famous old clause IV of Labour's constitution which promised the common ownership of the means of exchange and production, and which Tony Blair had symbolically ditched to demonstrate that "New Labour" was no longer "Old Labour" – contained a duty on the secretary of state to "promote autonomy", for the myriad new bodies the bill created, for the new economic regulator, the commissioning board, the GP consortia and so on. It was the desire to create that "autonomy", with the secretary of state no longer responsible for the day-to-day management of the service that in part made the bill so enormous, as did an element of sorting out who was to do what among the residual duties of the PCTs and SHAs that were to be abolished.

In addition, more than 80 clauses were devoted to the role of the new economic regulator and the changes that flowed from that. Monitor's main duty was defined as "promoting competition where appropriate" while using "regulation where necessary".

The sheer scale of the bill opened up not just the health secretary's front but his flanks and rear to attack. It was so vast and complex that it allowed any opponent to quote selectively from it – opponents of private sector involvement and choice and always highlighting Monitor's duty to "promote competition" without any of the qualifiers about "where appropriate" while using regulation "where necessary".

Essentially what it did, says Stephen Dorrell, "was to give all the different interests permission to go back into their trenches, [and] to refight all the battles that had been fought over the previous 20 years" since *Working for Patients*.

"All those whose instinctive preference was not a purchaser-provider or commissioner-provider split in which commissioners have choices had concluded [up until the bill], some 20 years after the original legislation ... that this was likely for the foreseeable future to be the only show in town. There [had been] a willingness to engage with that model to make it work. The effect of the legislative process was to provide two years to refight all the old battles rather than to engage with real life."

Or as Matt Tee, the former permanent secretary for government communications and a former head of communications at the health department puts it: "The bill provided people with a clause by clause opportunity to vent their anger at the overall policy."

Indeed, Lansley himself concedes that it was only when the bill was published that many people finally woke up and said: "Hello, what's all this?"<sup>106</sup>

Dr Hamish Meldrum says the effect of the bill was “to set even more hares running”. It made it, he says, “very difficult to convince those who were sure that the Government had a very clear agenda of privatisation – of effectively dismantling the NHS – that that might not be the case because actually an awful lot of the Government’s avowed intentions could be done without legislation. Therefore some of the areas around the role of secretary of state and the workings of Monitor and various other things ... led one to suggest that actually the Government did have an ulterior motive, or several ulterior motives”.

Perhaps more importantly, first the white paper and then the detailed provisions in the bill opened up unhealed wounds within the Labour party. The party’s manifesto for the 2010 election may have been pretty Blairite in tone. But that had not been the case once Andy Burnham had become health secretary in 2009.

Conservative MPs were to become furious over the way Labour attacked the bill’s provisions on competition and choice, on any willing provider, and on the creation of an economic regulator. They saw that as mere political opportunism, given that Labour had pursued virtually those policies in government, even if their regulator – the Co-operation and Competition Panel – had been advisory rather than statutory.

But there is another way of looking at it. “Too much was assumed on the Tory side that Labour itself had reached a resolution on these issues,” says one health department official bruised by the experience of getting the legislation through.

“But if you look closely, the battle over choice and competition was unresolved within the Labour party. If you watched the niceties of what happened between 2007 [when Brown became prime minister] and 2010, you would have seen actually that there was a significant body of opinion within Labour that was not reconciled to choice and competition – for example Burnham’s policy of the NHS being its own preferred provider. So there was much more fertile ground for an anti-campaign to engage with politically [than the Conservatives assumed].”

The BMA’s reaction on the day was to describe the bill as “a massive gamble” as it promised to campaign against its extension of competition and use of the private sector. By now the impact assessment had raised the estimated redundancy and transition costs to £2bn – with 26,000 managerial jobs set to go – although Lansley claimed that once they had vanished the service would be saving £1.7bn a year in reduced management costs.

Among the many hares released was a suggestion in the impact assessment that private providers may face a 14% price disadvantage to NHS providers when bidding for health service work – chiefly due to the taxpayer’s subsidy of the NHS pension and the lower cost of public sector capital. Heavily qualified though that assessment was, and despite the fact that it noted that there were off-setting factors such as the private sector not having to meet the training costs that the NHS covered, its implication was that the private sector might have to be paid more for NHS work than the NHS itself, in order to avoid allegations of state aid. Critics seized on that, declaring it to be “a bung” to the private sector.<sup>107</sup>

The few friendly voices – Julian Le Grand argued again that the reforms were “a logical, sensible, extension of [changes] put in place by Tony Blair” – were again drowned out by criticism from places where the Government might more normally have expected support.

The right-of-centre think-tank Civitas published a piece by Sir David Varney. Varney was a former chief executive of British Gas, chair of the Inland Revenue, adviser to Gordon Brown on public service transformation and chair of an NHS Trust. He declared it would be “a modern miracle” if the reforms delivered the benefits claimed, with the scale of change putting the efficiency savings at risk.<sup>108</sup>

Reform, the pro-market think-tank, judged the jury still to be out. Policy Exchange, arguably David Cameron’s favourite think-tank, fretted that the reforms were coming in too quickly, and that it was unclear how the NHS and the private sector would work together – while the prime minister himself on a visit to west London health centre disclosed that his cardiac specialist brother-in-law had complained that he was giving too much power to GPs.<sup>109</sup>

On the Andrew Marr show, Nick Clegg struggled to explain the logic of the bill, declaring – incorrectly – that the Liberal Democrats had promised to scrap primary care trusts in their manifesto, while Lansley faced a torrid time attempting to explain the reforms at the bill’s second reading on 31 January. John Healey, by now Labour’s health spokesman, declared the health secretary to be a man “struggling to sell his plans. The more people learn about them, the less they like them”.<sup>110</sup>

Over the succeeding weeks, the pressure mounted as some of those who would have to put the plans into effect gave their views on how it would work. David Bennett, the new chairman of Monitor, who had been a senior partner at McKinsey and head of the Downing Street policy directorate and strategy unit under Tony Blair, caused a storm when he gave an interview to *The Times* in which he described the regulator’s new role in promoting competition.

“We did it in gas, we did it in power, we did it in telecoms,” he said. “We’ve done it in rail, we’ve done it in water. So there is actually 20 years’ experience of taking monopolistic, monolithic markets and providers and exposing them to economic regulation.”

It was, he declared, “too easy to say ‘How can you compare buying electricity with buying healthcare services? Of course they are different. I would say ... there are important similarities and that’s what convinces me that choice and competition will work in the NHS as they did in those other sectors’”.<sup>111</sup> In other interviews he declared that ruling out price competition completely was “neither necessary nor sensible”, despite the Government itself starting to become increasingly edgy about the idea.<sup>112</sup>

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108 Civitas, Risk, ‘Equity and Excellence’: A commentary on the NHS White Paper (accessed 1 June 2012)

109 *Daily Mail*, 1 February 2011

110 John Healey, *Hansard*, 31 January 2011, col 619

111 *The Times*, 25 February 2011.

112 *Financial Times*, 28 February 2011

His vision of the future drove up the temperature. Meldrum declared that “comparing the NHS to the gas electricity and rail markets is not only completely inappropriate, it’s dangerous ... This is not what the medical profession, nor the public, wants. The Government needs to change tack, and very quickly”. Healey commented that “this confirms that the Conservative’s true purpose is to drive free-market ideology through the heart of the NHS”.<sup>113</sup>

Over the succeeding weeks, any and every concern about the reforms was raised including public health doctors writing to the medical journal, *The Lancet*, arguing that moving public health to local government risks “fragmentation, budget cuts and political inference” while moving the Health Protection Agency into the health department would “strip those transferred of an independent voice”.

Critically, publication of the bill also provided the focus for a grass roots Liberal Democrat rebellion because its provisions made crystal clear just how far the final legislation departed from the Coalition’s original programme for government.

If the white paper and bill reopened the debate within Labour on NHS policy a decade after Blair and Milburn had reinstated competition and choice, for the Liberal Democrats it forced the party, arguably for the first time, seriously to try to decide its own position on these issues.

Like almost any party, the Liberal Democrats are themselves a coalition, and a pretty complex one at that. One element are the so-called “economic liberals”, the “Orange Bookers” named after the Orange Book they published in 2004, which emphasised, among other things, the role of choice and competition in public services. Key authors of its chapters included those who held the party’s most senior ministerial posts in the Coalition – among them Clegg himself, Chris Huhne at environment, and David Laws who had been chief secretary to the Treasury, with Laws having advocated in the Orange Book a switch to social insurance as the means for funding the NHS. Danny Alexander, a key member of the Quad, the committee for settling key Coalition disputes, was firmly in their camp.

A second element is the veteran SDP-ers who had left Labour in the early 1980s because it was threatening to become too socialist rather than social democratic. Their views on choice and competition were mixed although some, by staying true to their beliefs, had ended up being to the left of where Tony Blair had taken the Labour party. A third strand was might be called the old “liberal left” who, when it came to the organisation of public services took at least as statist a view of them as those on Labour’s left, harbouring profound suspicion about the private sector’s involvement in their delivery.

For the Liberal Democrats, Baroness Shirley Williams was soon to become a key voice. She had raised her concerns with Nick Clegg in the autumn, ahead of the bill, and by December influential Liberal Democrats near the centre of the Coalition were urging reporters to “talk to Shirley”.

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113 *The Times*, *ibid*

"I did see it coming down the track," she says, and Philip Stephens's column about the reforms potentially being Cameron's "poll tax" had caught her eye. Over Christmas she had read the white paper and its follow up documents. Her concerns rose and she began to talk to medical and nursing organisations and the think-tanks.

She adds, however: "I didn't realise quite how large a monster this was until the bill was published." She took the February parliamentary break to retreat to her home in Hertfordshire and read it in detail.

"I read the bill, I read the impact statements, the quality statements, all these huge documents. I have never ploughed through so much. I have been in politics a very long time and I don't think I'd ever seen a bill that was so incomprehensible, so detailed, so long, so impossible to understand – and I've seen some pretty complicated bills."

The white paper, she says, "didn't tell you very much. You had to read the bill".<sup>114</sup>

With remarkable energy she threw herself into talking to anyone and everyone. Between December and February "I think I had something like 60 or 70 meetings with every possible health organisation."

Buried away in the documents were bits of policy such as removing the cap on the amount that foundation trusts could earn from private patients, and a host of other measures. "I don't know if they were deliberately hidden or just lost in the civil service flam," she said.<sup>115</sup> But her conclusion, as she declared in a piece in *The Times* at the end of February 2011 was that "I cannot support the Coalition plan for the NHS".

She listed a whole host of problems – the accountability of GP consortia, the use of price competition, the end of the private patient cap – while noting how well the NHS had just scored in an international comparison of health systems published by the New York-based Commonwealth Fund. "Why we should dismember this remarkably successful public service for an untried and disruptive reorganisation amazes me," she said.<sup>116</sup>

She was far from the only one in her party with strong reservations. The Liberal Democrats had doctors of some standing in its ranks. Dr Graham Winyard, a former deputy chief medical officer who was now chairman of the Winchester party; Dr Charles West, a popular GP and chairman of the Shrewsbury Liberal Democrats; and Dr Evan Harris, an MP until the 2010 election, who was a former health spokesman and also a former member of council of the BMA where he still had good contacts. Harris loved the detail of argument, was absorbed by the process of politics, and took a barrack room lawyer's delight in drafting motions and legislation.

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114 BBC Radio 4, 'David Cameron's Big Idea', (accessed 1 June 2012)

115 *The Guardian*, March 12 2011

116 *The Times*, 28 February 2011



These, and half a dozen other doctors, were crucial, Williams says, "particularly with the conference because they were able to claim professional knowledge and that was very important. They carried a lot of weight".

This growing band of medically led sceptics wanted a motion at the Liberal Democrat spring conference opposing the reforms, underlining just how far they differed from those in the programme for government. Williams had decided to back it.

She went to see Clegg. "I told him I was going to support a motion of deep worry at the Liberal Democrat spring conference. I was certain I could carry it. And that was partly a wake up alarm call for Nick. To be fair, Nick then realised [and] began to read the bill."<sup>117</sup>

Meanwhile Dr Meldrum was facing the problem that every chairman of council faces when the BMA gets into a major dispute with the government of the day. A chunk of the association's membership always wants confrontation while the council's officers almost always believe that remaining engaged with ministers is more likely to produce results.

The usual outcome is a demand by members for a special representative meeting, and indeed the pressure grew on Meldrum and BMA leadership to call one – the first since Clarke's 1990 reforms. There was press speculation that Meldrum's position as chairman of council was at risk.<sup>118</sup>

Lansley by now was beginning somewhat desperately to seek support wherever he thought he might find it. Having agreed to Nicholson as chief executive of the commissioning board, on 28 February he invited in Alan Milburn, Labour's reforming health secretary. It was Milburn who, in Labour's time, had first introduced foundation trusts, independent sector treatment centres and choice and competition into the NHS. He wanted to ask him if he would be prepared to chair the commissioning board.

Milburn, who had become an independent reviewer to the Coalition on social mobility, was gobsmacked. "I thought I'd been invited in to offer him a bit of advice," he says. "Instead he asked me if I would be a candidate to chair the board. I said to him 'do you think I have the letters M.U.G. tattooed on my forehead? Why would I use my political capital to rescue you from the mess you have made of yours?' He said it was a matter of public service. I said I had done plenty of that over the previous 18 years. Andrew asked me to think about it. I did, and said no."

To add injury to insult, Milburn then went public. While criticising Labour's all out opposition on competition, he underlined one of the Government's central problems, declaring that the politics of the programme "mystifies me. The four words, 'cuts, health, privatisation and Tory' are always going to be bad for the Tories. Either these policies are an evolution or a revolution, but they cannot be both".<sup>119</sup>

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117 *The Guardian*, 12 March 2011

118 *The Guardian*, 15 February 2011

119 *The Guardian*, 16 March 2011

Fresh from that rebuff, Lansley in early March finally announced that he would table amendments to the bill not only to rule out price competition, but to prevent the regulator from setting differential prices for the NHS, private or voluntary sectors, and to prevent it from setting any particular quota for the provision of care by any sector.

These were to be the first of what would eventually be well over 2,000 amendments to the bill, although that gives a very false impression of how much it was changed. The vast majority were mere changes of name – from GP consortia to clinical commissioning groups – in the bill and in other related legislation.

Lansley claimed – despite all the evidence from the *Autonomy and Accountability* paper onwards – that it was simply “wrong” that he wanted to introduce price competition. But he equally made clear that GP consortia would still be able to put services out to tender and agree local prices where these were not covered by the tariff. In practice that meant that for the many services for which is no nationally set tariff, an element of negotiation over price remained likely, not least when services were contracted out to the private or voluntary sectors.<sup>120</sup>

As the motions for the Lib Dem conference were being prepared, and Milburn’s strictures on the reform became public, Norman Lamb, a Liberal Democrat whip, emerged from the shadows.

Before the election, Lamb had been his party’s health spokesman. He and Lansley had clashed, however, ahead of the election over the future funding of social care. There had been a bitter battle between Lansley and Andy Burnham, over the latter’s plans as health secretary to pay for it by compulsory contributions from the elderly that could be met out of people’s estates. Lansley labelled this approach “a death tax”.

Lamb’s attempt to hold the ring had not endeared him to Lansley and the widespread belief in Westminster was that the health secretary had vetoed Lamb as a Lib Dem health or social care minister. The job had gone instead to Burstow. Lamb had become Clegg’s chief parliamentary and political adviser and a party whip.

His removal as health spokesman had left him reluctant to intervene visibly on his old patch, and reluctant too to intervene too visibly even within government. Even so, he had kept an eye on Lansley’s plans and fed his views regularly to Clegg.

Lamb had been tolerably happy with the agreement in the programme for government but increasingly alarmed at both Lansley’s plans and the mounting opposition to them. He could be heard telling friends how it was remarkable that the health secretary appeared to have managed “to unite both Luddites and reformers” in opposition.

It was also his view that the departure from the programme for government proposals had been “a fatal mistake”. Publicly, he declared that the spring conference was “the chance for the party to have its say. We are determined they will have their say”.

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120 *Financial Times*, 3 March 2011

Indeed they did. A motion prepared by the leadership welcoming much in Lansley's plan was then amended by the Sheffield conference with a string of qualifiers that in practice rejected great chunks of the legislation – in particular “the damaging and unjustified market-based approach that is proposed” while demanding a bigger say for local councillors in the running of the service.

The motion underlined the undeniable fact that “some of the proposed reforms have never been Liberal Democrat policy, [and] did not feature in our manifesto or in the agreed Coalition programme, which instead called for an end to large-scale top-down reorganisations”.

Shirley Williams led the charge. As she had warned Clegg she would, she carried the day by a huge margin. Accountability under the new structures was “lousy,” she declared. Private firms would be able to “cherry pick”. In her peroration she told the conference: “We cannot be bound by those issues that have never been agreed by us, and in particular where the actual outcome in policy is specifically different from what we thought it was going to be. This is not the moment to embark upon a reorganisation of the most trusted public service in the whole of the United Kingdom.”

The result of the vote, she declared afterwards, “is that Nick Clegg has to go back to Lansley with the other Lib Dem members of the Cabinet and say: ‘I can’t get this through

my party. We will have to make amendments”.<sup>121</sup> Cameron and his advisers were soon to recognise the truth of that.

Up until the Lib Dem conference, Williams says, Clegg “certainly didn’t know a great deal about [the bill]. But he knew a great deal about politics. He understood he was now up against an issue of passionate interest to Liberal Democrats and therefore he simply couldn’t go by on the other side. Once that lesson dropped [he realised] there was an awful lot at stake. And he did then fight like hell. He fought like hell I think it’s fair to say, all the way through to July [when the Future Forum report was published]”.

Three days later on 15 March, an angry and emotive special representative meeting of the BMA demanded that the bill be dropped – despite a plea from Meldrum not to tie their negotiators’ hands. Getting it scrapped, he told his members, would be “an unachievable feat”. The meeting rejected that view, and only by a narrow margin did it stop short of passing a motion of no confidence in the health secretary.

Cameron’s immediate reaction to these twin events was to tell his backbenchers at a private meeting that there would be “no retreat”.<sup>122</sup> The problem, he told them, was one of “presentation not substance” at a time when sources inside Number 10 were beginning to conclude gloomily that “there is no policy solution to what is in fact a political problem. We need to reform the politics of this”.

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<sup>121</sup> *The Guardian*, March 12 2011

<sup>122</sup> *Financial Times*, March 15 2011

With the Government apparently facing almost nothing but opposition, the impact of social media – a challenge the Clarke reforms had simply not faced – was also beginning to be felt.

38 Degrees, the web-based membership campaign that was using Twitter and Facebook to assemble petitions and campaigns (and which had just claimed to have had a hand in the Coalition's retreat on selling off Forestry Commission woodlands) had started to turn its attention to the NHS – launching a petition against them, and, later on assembling legal opinions on their effect.<sup>123</sup>

Sean Donnelly, otherwise known as the rapper MC NxtGen, uploaded to YouTube a video that managed to combine humour, straight forward invective – “Andrew Lansley, greedy, Andrew Lansley, tosser/the NHS is not for sale, you grey-haired manky codger” – and rhymes about the abolition of primary care trusts, bodies that no-one in their wildest dreams would ever have predicted would gain such street cred. It rapidly acquired 200,000 hits.

Unison, which, it turned out, had funded the video, set up a mock eBay site to “sell off” the NHS. Meanwhile Michael Moore, the director of *Sicko*, an excoriating attack on US healthcare, produced a YouTube video pleading with the UK not to go down the US route.

At a hearing of the Commons Health Committee on 23 March, Lansley gave no indication of any retreat, although he did disclose for the first time that the GP consortia were likely to control “only” £60bn of the £100bn NHS budget rather than the £70bn to £80bn that had been speculated.

Shortly afterwards, Lord Owen – David Owen - who like Shirley Williams was an original member of the Gang of Four that founded the SDP, produced a pamphlet whose message was contained in its title “Fatally Flawed”.

Back in the late 1980s, Lord Owen had courted considerable controversy by backing the Conservatives' original “internal market” reforms to the NHS. He now emerged not only to damn the “destructive external market” that the health secretary was proposing but also to demand that Lansley be sacked. The former Labour health minister labelled the reforms as “incoherent,” warning that the Lords would feel free to amend the bill substantially because “the Coalition lacks a mandate for many of the policies set out in the bill”.<sup>124</sup>

Meanwhile advocates of GP commissioning were reacting with alarm to the demands of the Lib Dem spring conference for councillors to have a bigger role in NHS commissioning. Dr Michael Dixon of the NHS Alliance described that as “overkill” while the NHS Confederation, whose members would have to implement Lansley's grand vision, was wringing its hands over the increasingly “polarised and entrenched debate”.

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123 <http://www.leftfootforward.org/2011/03/38-degrees-andrew-lansley-nhs-plans-petition/> and [http://www.38degrees.org.uk/page/s/Protect\\_our\\_NHS\\_Petition](http://www.38degrees.org.uk/page/s/Protect_our_NHS_Petition)

124 *Financial Times*, 31 March 2011

Nigel Edwards, its acting chief executive, said the Government desperately needed “a compelling narrative” with which to answer its critics.<sup>125</sup> By now Ed Miliband, the Labour leader, had issued the first of his many calls for the bill to be scrapped.

Officials both at Number 10 and in the health department, were fretting about what to do. Jeremy Heywood, the Number 10 permanent secretary, sent to a memo to the health department demanding that something be done to communicate the plans better – leading one exasperated official to ask “Just what are we meant to do? Get another secretary of state?”

The department thrashed around for an idea, wondering if there was any chance, even at this late stage, of a “big tent” engagement exercise – the approach it had taken to the NHS Plan in 2000, to changes to community services in 2006 and the Darzi plans for quality and information in 2008/9.

For more than a fortnight now, the alarm bells had been ringing all over Downing Street. “The opposition was just overwhelming,” one Conservative special adviser says. “We had to do something.”

The polling numbers on the NHS changes were dreadful. And local elections were due on 5 May, along with the referendum on whether elections to the Commons should use the alternative vote rather than the traditional “first past the post” polling system. Agreement to hold that referendum had been one of the big Conservative concessions to the Liberal Democrats when the Coalition was formed – though it was agreed that the Conservatives could campaign against the change. Strains were already emerging as the coalition partners campaigned against each other over the issue. In time it was to lead to their most vicious falling out to date.

With the local elections due, “everyone was very worried about Labour running a ‘30 days to save the NHS’ campaign,” one Number 10 adviser, says, “with us getting a hammering as part of that. So all that together meant that something serious needed to happen”.

The bill was completing its committee stage virtually unamended. But it still had to go to the floor of the Commons on report stage with the possibility that some Liberal Democrat MPs might now vote against. Much more worrying, however, was the Lords.

In the decade since the bulk of the hereditary peers were ousted in 1999, the upper chamber had become a far more effective revising chamber.

It no longer had an inbuilt Conservative majority. And with approaching 200 cross-bench, or non-party peers, “it is genuinely a ‘hung’ chamber,” Robert Hazell, head of the Constitution Unit at University College London, says. No party has a majority, not even the Coalition.

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<sup>125</sup> *Financial Times*, 31 March 2011

The change in its make up, Hazell says, “has transformed its sense of its own legitimacy”. Furthermore, peers who do belong to a party are far less whippable than MPs. “There is no real prospect of preferment, and no real sanction as the threat to withdraw the whip does not mean they will lose their seat at the next election.”

As a result, the Constitution Unit has calculated, during the 13 years that Labour was in power, the government was defeated just five times in the Commons but over 500 times in the House of Lords. Many of these defeats were, of course, reversed by the elected chamber. But roughly four in 10 of them held. So the Lords now has “a very significant amending impact,” Hazell says.

“Over time, the astute non-governmental organisations and lobbyists became aware of that and focused their lobbying efforts on the Lords. If you want to get an amendment passed, that is where you concentrate your efforts.” This was indeed what opponents and critics of the health bill were to do, using every available tool from traditional briefings for peers to email, Twitter and other parts of the social media.

Government departments have also come to recognise the changed nature of the Lords. “It was the big focus when we developed the bill,” one official says. “Ninety per cent of our effort went into planning and managing the Lords. It is what all government departments do, because it is only really in the Lords that the ultimate shape of any bill gets determined. Will the Government achieve its policy objectives given the different nature of the debate there, the quality of debate, and the mathematics?”

Compounding the problem for the health bill was that the peers from one part of the Coalition now felt answerable to the motion from their grass roots members at the Lib Dem spring conference. On top of that, the cross benches contained a large contingent of lawyers and medical peers. Many of the latter, simply because of age and experience, were unlikely to look favourably on sweeping changes to the NHS. At the very least they would take a lot of persuading. And finally the Lords contained a number of decidedly independent minded former health ministers from both Labour and the Conservatives who could not be guaranteed to toe either of their parties’ lines.

As a result, senior Liberal Democrats were warning that without concessions, there was “no chance at all” of getting the bill through the Lords unscathed. The Conservatives too recognised the problem.

There was at this stage at least some debate about whether to “kill the bill” – essentially to withdraw it and start again. Certainly some Liberal Democrats advocated that. “Politically it was a rare opportunity,” one key adviser says. “The Tories were running scared asking ‘what the hell are we doing?’ There were backbench Tories – Tory modernisers – coming up to us to say ‘please save us from ourselves’.

“We were partly deterred from killing it because if we did the Tories could have painted us as anti-reform, putting the handbrake on everything as it were. And we were concerned about that.

“But we didn’t kill it. And the reason we didn’t was that Nick [Clegg] took the view that it would be worse for the health service to abandon it altogether than to proceed with an amended bill. The changes had gone too far. PCTs were being rolled up, people were leaving, the labour market was moving. And there was a chance that with a pause and a listening exercise we could get some of the medical profession on side – although as it turned out, of course, we didn’t.” So, instead, “the pause” was born.

## Scene Two: “Pause, listen, engage and amend”

On Thursday 31 March, as the bill completed its committee stage, Lansley and his top officials were summoned to Number 10. Over the previous days phone calls had been flying back and forth across the Atlantic where Clegg was on a trade mission to Mexico followed by a meeting with Hilary Clinton, the US Secretary of State. As he flew in from Washington on the “red eye” overnight flight, the meeting was deemed so urgent that he received his first “blue light” police escort from the airport to get to it. “That’s how bad the health issue had become,” one adviser says.

Once he arrived, Cameron and Clegg told the officials they needed 10 minutes with the health secretary to finalise something.

That left a large cast of Downing Street advisers and officials milling around outside the meeting, speculating about what was going on inside it. The cast on the outside included: the Number 10 permanent secretary Jeremy Heywood; Paul Bate, a former health specialist in Tony Blair’s delivery unit, who had recently been appointed as Cameron’s health adviser in recognition that Number 10 needed a specialist; plus Clegg’s permanent secretary; plus a string of special advisers including Richard Reeves, Clegg’s director of strategy and Ed Llewellyn, Cameron’s chief of staff, plus the health department contingent.

Ten minutes became much closer to an hour. “Eventually we were called in,” says one of those present. “Lansley was sat on the settee. Cameron was sat in his chair, Clegg off to one side with about 20 officials and advisers in the room. Cameron read out a form of words about the pause and Andrew started to argue with him, saying they couldn’t just stop everything. He slapped Lansley down. Then Nick Clegg said something, and Lansley started to argue with him. Clegg absolutely slapped him down and said ‘Andrew the reason why we are here is because you have put the ideological cart before the political horse.’” A Lansley sympathiser says: “He looked like a wounded animal. It was quite sad, actually.”

As *The Guardian* later reported: “It was a case of summoning a Cabinet minister to No 10, giving him a pen and notepad, and telling him what will happen.”<sup>126</sup>

The meeting ended with the health officials told to go away and come back within 24 hours with a plan to make “the pause” work. The plan became the Future Forum.

Over at the department, Simon Burns, the health minister, was throwing a party for the team that had slogged its way through the bill's committee stage – the longest in almost a decade, and one which had seen a near record 100 divisions, if scarcely any amendment.<sup>127</sup> Someone wondered whether they should be told their work had just been in abeyance. “No. Leave them to their party and tell them afterwards,” was the view.

A visibly distressed Lansley returned to his office to write a memo, attempting to set out his bottom line on the reforms. An eight-page draft developed by one part of the department was eventually condensed down to two pages by another and despatched.

Lansley himself insists that at no point in this saga did he consider resigning, even for a second. But Whitehall saw it as a “moment of maximum danger”. Downing Street was in contact with the department telling them it was their duty to ensure he did not quit.

The next day, Friday 1 April, April Fool's Day, Dr Steve Field, who until the previous November had been chairman of the Royal College of General Practitioners, took a call from Sir David Nicholson. Field had met Lansley from time to time as college president, and says he knew him “reasonably well ... but I wasn't involved at all in giving any advice on the reforms”.

He'd talked more to Mark Simmonds, Lansley's number two in opposition, who had failed to get a ministerial position in the horse trading over posts as the Coalition was formed. The discussions, he says, had been chiefly around the college's specific interests – “clinical leadership, patient centredness, a new public health system ... education and standards and training”. These, Field says, were “the college's role ... we didn't really talk about the details” [of how commissioning would work].

Since ceasing to chair the college, Field had been working with the BMA, the NHS Alliance, the National Association of Primary Care and the College on how GP consortia might work, while talking to doctors in Staffordshire about how far such consortia might provide answers to the scandal at Mid-Staffordshire NHS Foundation Trust. In the January, he had been a shortlisted candidate for the role of chief medical officer.

His view of the white paper – although “I had no input into the writing or the design of it at all” – was: “I liked it actually. I thought the vision was good.”

The principles “I was absolutely behind. But I didn't see them personally [as] any different to where Labour were at. I disagreed with David when he said it was the most radical reform ... I believed it was a continuation of Labour's reforms but with world-class commissioning just becoming clinically-led commissioning”. At the time of Nicholson's call, like most people, he had not, he says, read the bill.

Nicholson told him “that the chancellor, the prime minister and the deputy prime minister had met and decided that because of the reaction in Sheffield and the noise in the system, they wanted to get a better understanding of what the problems were.

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127 [Hansard, Public Bill Committee, Health and Social Care Bill, March 31 2011 column 1309-10.](#)



“He told me my name had been discussed about potentially chairing this Future Forum and that they were going to make a decision, but if I was asked by the minister would I do it?”

He said yes and was told to expect a call from Number 10, while the department worked hard on assembling names for four working groups to tackle the areas the department saw as most problematic – choice and competition, clinical advice and leadership, patient involvement and public accountability, and education and training (the issue ministers always remember last in any structural reform of the NHS).

On Monday 3 April Lansley was forced by Cameron and Clegg to the Commons to announce – to jeers from the Labour benches opposite – that the “natural break” in the legislation between committee and report stage was to be used to “pause” the bill and consult.

Faced with media reports that Cameron was furious with his handling of the communications and that he and Clegg were to take over the sales pitch, the health secretary cut a lonely and dispirited figure on the government front bench.

No senior Cabinet colleagues sat alongside him. He accepted there were “genuine concerns” over the legislation. But his reluctance to accept the turn of events was transparent. While he promised to “pause, listen and engage,” the prime minister’s official spokesman was using a different formulation: “pause, listen, engage *and amend*”.

In a little noticed aside during the debate, Lansley himself made the point that “I could have done most of this without the legislation”.<sup>128</sup> Sharp-eyed MPs could have noticed Dorrell leaning over to a colleague and muttering: “Then why on earth didn’t he?”<sup>129</sup>

As Lansley was speaking, the Commons Health Select Committee that Dorrell chaired was adding to his woes, as was his political hero Norman Tebbit. Tebbit had told the *Daily Mirror* that existing competition between the public and private sectors was “unfair”.

Tebbit, whose wife had been left in wheelchair after the Brighton bomb at the Conservative Party Conference in 1984, chaired a charitable trust that supported the NHS’s Nuffield Orthopaedic Centre. A private hospital had been contracted locally to cut NHS waiting lists, he said, but “the private sector hospital had neither any obligation, nor wish, to take on the more difficult and complex surgery. It had no obligation to teach the next generation of surgeons the skills they would need to deal with such work”. The damage done to the NHS hospital’s finances and training capability had been “considerable”.<sup>130</sup>

If Tebbit was attacking the plans for choice and competition, the Health Select Committee holed another part of Lansley’s plans below the waterline – the idea that GPs would design for themselves, “bottom up”, just how their new freewheeling consortia would operate.

Such a “sofa government” approach was unacceptable, Dorrell said. Each consortia was likely to control on average a budget of at least £200m, bigger than any district council.

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128 *Hansard*, 4 April 2011 : Column 782

129 *Financial Times*, 15 April 2011

130 Norman Tebbit, *Daily Mirror*, 4 April 2011 (accessed 1 June 2012)

“Would we contemplate district councils meeting in private, without public access to papers and proper minutes and declarations of interest? Of course not. It is self-evident that there has to be proper governance.” The committee recommended in addition a lay chair, a chief executive and a finance director to provide that.

In addition, it demolished the idea that consortia should be composed solely of GPs. That proposition should be dropped in favour of much more widely based commissioning authorities, it said. These should include a hospital doctor, a nurse, a public health and a social care expert plus a local councillor.

These authorities should be made up of a majority of GPs, the committee conceded. But it was “misleading” to suggest that care could be commissioned merely by family doctors.

The committee’s proposals looked more than a little unwieldy, producing a board that would be a minimum of 17 strong if GPs had the majority. But the idea that GPs alone would run commissioning to their own design had effectively died.

On the Monday, Field was in London for a meeting at the Athenaeum where, he later, discovered, his mobile had no reception. Calls from Lansley’s office over an hour and a half failed to get through.

Finally on a train back to his home in Birmingham a call came through from Simon Burns, on behalf of Cameron and Lansley, formally asking him to chair the new Forum. On the Tuesday, he was called by Lansley’s office and told to be at Frimley Park Hospital the following day for the Forum’s formal launch – by which stage the chairs of the four working groups had been chosen with the rest still being decided.

The only issue of real controversy in the appointments was that of Sir Steve Bubb as chair of the group on choice and competition. Bubb, a one time Labour councillor in Lambeth who had been surcharged for failing to set a legal budget also had 15 years’ experience as a non-executive on London hospital boards. More importantly he was chairman of Acevo, the Association of Chief Executives of Voluntary Organisations. It had been campaigning hard for a much bigger role for the voluntary sector in the delivery of public services across government, not just in the NHS. Outspoken, with a distinct tendency to shoot from the hip, Bubb was a decidedly controversial figure.

He had, he says, been in touch with Lansley just ahead of the pause, “about what we could do about promoting the idea of voluntary sector providers in the reforms”. Over the weekend, he was called by Simon Burns, the health minister to be asked to chair the competition work group, following that with an hour-long conversation with Field who spent it pacing around his garden. Field was happy with Bubb’s appointment. The department’s civil servants weren’t so keen. Lansley, however was, according to Bubb, noting that he was “the only NHS outsider, so to speak” on the Forum. “The department opposed me being on it. It had to go to No 10 for clearance and I presume Cameron gave it the okay.”

Throughout the Forum's deliberations, Bubb was to be a key voice in public and in private, arguing that competition and choice needed to be retained<sup>131</sup> – particularly in the absence on the Future Forum of anyone from the now politically highly sensitive private sector.

The private sector was distressed at being excluded. Members of the NHS Partners Network – the trade body for private suppliers of NHS care – were by now supplying more than £2bn a year of NHS care from waiting-list operations to mental health and services outside hospital. When it protested at its exclusion it was passed from pillar to post between Number 10 and the department. Each blamed the other for its exclusion. Then the argument became that it would be too embarrassing to add private sector participants to the Future Forum once the full list of names had been announced.

Throughout the Forum's deliberations, Bubb was "our only real route in" David Worskett, director of the NHS Partner's Network, says. "He fought valiantly to ensure that an element of competition remained in the system." The outcome from the Forum was "pretty pro competition" Worskett says, "more so than we anticipated when it was happening. And that was mostly, though not entirely, down to Steve Bubb".

At Frimley Park on the Wednesday, Cameron, Clegg and a woe-begone Lansley addressed staff and reporters from behind three tall white lecterns that made the trio look almost like figures nailed to crosses on a political Calvary.

Cameron was smooth and upbeat, promising to "pause, listen, reflect on and improve our NHS modernisation plans" – pledging not "to take risks" with "our most precious national asset".

Cameron and Lansley acknowledged "colleagues across the NHS" would need to be involved in commissioning. Steve Field told the meeting: "I have never seen how this could just be GP commissioning. There needs to be wider clinical involvement to make this a success".

Clegg acknowledged that the reforms would "strengthen the role" of the private and voluntary sectors but "we will not allow them to cherry pick services".

Lansley – looking in the judgement of clinicians present, somewhat depressed – was now talking about "GP-led commissioning" rather than GP consortia.

What followed was eight weeks of NHS visits by Cameron and Clegg, and what seemed at the time to all those involved to be "endless discussions" – meetings within the Forum, within the quad, between Downing Street and the department, and between the department and the Forum's leaders. At around this time Sean Worth, the Number 10 health adviser, and Abbie Sampson, a Number 10 press officer, were despatched over the road to the health department in an attempt to boost Lansley's political advice and communication skills.

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131 *Financial Times*, 13 April, 5 May 2011.

Field is adamant that his review was “independent”. He had that assurance from Cameron and a phone number to call when he hit problems. But with the terms of reference of the working groups drawn up by the department, its membership agreed with Field – and with ministers from Cameron down hearing the same concerns that Field’s working groups were tangling with – there was almost an inevitability that the Government and the Future Forum would reach broadly the same conclusions.

Not that there was any shortage of heat on the way. Norman Lamb appeared in public on the BBC Politics show to appeal for the changes to be slowed to avoid real financial risk. Having told Clegg he would resign as his parliamentary adviser if he had to, he declared that “the sensible thing to do is to test it and see how it works. To do it in one fell swoop is very risky”. He would quit as a government whip, he said, unless major changes were made.

Details then emerged of a speech that Mark Britnell of KPMG had made the previous October to a bunch of hedge fund managers in New York, telling them that the NHS was in the process of moving to be a “state insurer, not a state deliverer of care” and that the reforms would show “no mercy” on the NHS. That presented, he said, “a big opportunity for those companies that can facilitate the process”.

Britnell had harboured hopes of returning to the NHS as chief executive of the commissioning board, and his name was included in a long list of NHS specialists and health experts that Paul Bate had thrown together to provide a sounding board for Number 10. He had thus, in the eyes of the media and critics of the bill, become “an adviser to David Cameron”. In practice, he was no such thing. But that did not prevent the story having legs and confirming all the worst fears of those who believed the Government’s plans would “privatise” the NHS.

Lansley then faced the humiliation of the annual congress of Royal College of Nursing in Liverpool passing a vote of no confidence in him, with just six out of almost 500 nurses voting against – a 98% majority. He was accused of being gutless by sending his junior minister, Anne Milton, to address them. The next day he trailed up to Liverpool, fearing eggs and assault, to accept “the rebuke”, telling a selected meeting of 65 nurses: “I am sorry if what I am setting out to do has not communicated itself.”

If that reflected Lansley’s basic view that critics of his reforms were either ideologically opposed or had simply not understood them, the man now repeatedly accused of failing to explain his reforms with any clarity did produce, for once, one decent sound bite. “I would be joining you in voting against me if I thought the product of what I was doing was to undermine the NHS,” he told his nurse critics.<sup>132</sup>

On 5 May, the Liberal Democrats were hammered in the local elections. They not only lost 500 seats but the referendum on the alternative vote – with the divisive campaign over that having marked the final end of the Coalition’s honeymoon.

Recognising the hits Clegg had taken, Cameron accepted that on the NHS changes the Liberal Democrat leader needed to make a mark.<sup>133</sup> Clegg contributed to the obfuscation of language that conflated competition in the NHS and the use of private providers with the “privatisation” of the NHS as a whole – privatisation on the demand as well as the supply side. He would not allow it he said, when the bill did not in fact propose that.

He demanded an end to “arbitrary deadlines” in the handover of commissioning and declared that “as far as government legislation is concerned, no bill is better than a bad one”.

“There must,” he declared, “be no change in the way competition law operates in our NHS. No to establishing Monitor as if health care was just like electricity or the telephone, and no to giving anyone in the NHS a duty to promote competition above all else,” he declared. These things, Lansley protested, were not in the bill.

Setting up Monitor as an “economic regulator” was “clearly a misjudgement,” Clegg added, stating that “I have come to the conclusion that we must not make this change. This is a veto”.<sup>134</sup>

That veto proved to be a semantic one, Monitor later coming to be described as a “sector” regulator rather than an “economic” one – a distinction with no meaning.

There was much talk of the need for the integration of NHS care, and of collaboration in patients’ interests being more important than competition. The eight weeks of debate saw some opponents of the bill, for example Unison, demanding that it be dropped to end the threat of competition in the NHS. At the same time, however, some supporters of the principle of competition such as Julian Le Grand were calling for it to be scrapped for precisely the opposite reason – to preserve the degree of market-based reforms that already existed amid signs that the Future Forum might entirely substitute “collaboration” and “integration” for “competition”.<sup>135</sup>

By the end of the listening exercise, however, the Future Forum and Cameron and Clegg were pretty much lined up – the Government accepting on the day after the Forum’s report, all its recommendations bar one.

But the adage that the reforms had become as much about politics as policy held true. Ahead of publication of the Future Forum’s report on 13 June and the Government’s response on 14 June, everyone was claiming victory.

Nick Clegg briefed his backbenchers that 11 of the 13 “red lines” set by the Liberal Democrat spring conference had been met. “We have achieved all we set out to achieve. It is a job well done.” The changes would take place more slowly, would be evolution not revolution, with no preference given to the private sector and proper accountability for commissioning groups, he said. “All these things have been very, very handsomely met.”<sup>136</sup>

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133 *Financial Times*, 12 June 2011

134 *Financial Times*, 18 May 2011

135 *Financial Times*, Julian Le Grand, 25 May 2011

136 *The Guardian*, 30 June 2011

By contrast, David Cameron was telling his backbenchers that the essence of the reforms remained, including more competition, with Lansley telling them that his own “red lines” had not been crossed, and that no real ground had been conceded.

Ironically, for someone who in the eyes of the outside world had become an isolated, almost bypassed figure, the effect of the pause – distressing though it had been for Lansley himself – had been to strengthen his position with his own backbenchers, and most notably those on the right of the party.

At the time the listening exercise was announced, Conservative backbenchers were blaming the Liberal Democrats for its necessity. By the end, and amid Clegg’s claims of victory, their mood was described as “sulphurous” with Nick de Bois, an unofficial voice for the backbench 1922 committee, accusing the Liberal Democrat leader of “kindergarten politics”.<sup>137</sup>

Key conclusions from the Future Forum and the pause were that Monitor should now be not just a competition regulator but should also be charged with promoting “integrated care” where that was in patients’ best interest – “integrated care” being a phrase subject to almost as many definitions, many of them differing, as there are letters in it.

Instead of “promoting competition”, its task was to be tackling “anti-competitive practices”. And rather than being scrapped, the existing advisory Co-operation and Competition Panel was to be retained and transferred to Monitor.

A token hospital doctor and nurse was to be put on each commissioning group, with the idea of pure GP consortia now consigned to history.

Commissioning groups were to have proper governance and would only fully take their budgets when ready. They were now to be required to engage with a hugely expanded range of interests – patients, the local Healthwatch, local health and wellbeing boards, “clinical senates” (newly created, but, as it turned out, non-statutory advisory bodies of specialists), along with clinical networks to advise them on integration and reconfigurations in particular specialities.

Much more emphasis was put on the need to integrate health and social care, with the health and wellbeing board’s role in that beefed up, helping meet the Liberal Democrats’ endless desire for a bigger role for local government. During the pause “the Liberal Democrats [were] pushing really hard to get more and more local involvement, with the Tories very resistant to that,” one official says. “The expanded role of the health and wellbeing boards was crafted out of all of that.”

There was much talk of measures to prevent the private sector “cherry picking” and the Government agreed that the health secretary must remain “ultimately accountable” for the NHS. At one point, Cameron was promising to restore the opening wording of the 2006 Act – that the secretary of state must “provide or secure the provision of services” – to underline that.

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137 *The Guardian*, 14 June 2011

That never quite happened precisely because it was that concept and wording that Lansley was determined to get away from. It was one of his central aims to create a legislative structure where others would do that “autonomously” within the health secretary’s overall responsibility for the service.

Under the Future Forum’s recommendations, local government retained the right to challenge major changes to hospital services. In future, however, they would be required to take into account the impact on NHS finances and the quality of care in so doing.

To many commentators, the overall impact of the Future Forum looked less an assault on bureaucracy than a compounding of it.

There remains plenty of room for debate about its long-term impact. On one level, it completed the shift that had been coming from what the command paper had called “assumed liberty” for free-wheeling GP consortia to “earned autonomy” for clinical commissioning groups once they had demonstrated to the commissioning board that they were up to the job.

There was a clear duty of partnership and a duty of integration scattered around the system. Subject to EU law, it became clearer that it would be the commissioners who decided when to use competition, rather than Monitor actively promoting it. There was a sense that at least some management would remain in the system, not least through the commissioning board. And the Forum’s report did form the basis for the negotiations to come in the Lords.

Some 1,000 amendments – mainly technical, some 720 for example changing the name of GP consortia to clinical commissioning group – were tabled to the bill. For a brief moment the prime minister felt entitled to believe that the job had been done.

Lansley was barracked by Labour MPs as he announced the review’s conclusions. But he received a generally warm welcome from Liberal Democrat and Conservative MPs. Dr Clare Gerada, chairman of the Royal College of General Practitioners who had by now become one of the bill’s most consistent and vociferous critics, hailed the outcome of the pause as “a monumental u-turn”.<sup>138</sup> It would not be long before she was demanding that the bill be scrapped.

### Scene Three: “Still not a done deal”

Any sense that a Rubicon had been crossed, allowing the bill to proceed relatively peacefully on its way, was to last little more than 24 hours.

On the day after Lansley announced the changes that the Future Forum had produced, Milburn used the *Daily Telegraph* to condemn the Government’s health reforms as “the biggest car crash in NHS history”.

From the outset, he declared, “they were devoid of advocacy and advocates”. Rather than building on what Labour had been doing, Lansley had “ineptly promised a privatisation

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138 *The Guardian*, 15 June 2011

revolution and free-for-all competition". Monitor's new duty to promote "integration" would be a signal to the NHS to weaken competition not strengthen it, he said. The debacle, he concluded, "has set back for a generation the cause of market-based reform in the NHS".<sup>139</sup>

Dr Evan Harris, a key mover behind the Liberal Democrat spring conference revolt, instantly discovered "new threats". He argued that the exercise of choice by patients could undermine existing NHS services, even if the regulator no longer actively promoted competition; that it was still not clear that the health secretary had a duty to provide a comprehensive service; and that the commissioning of care could still be farmed out to private sector companies by commissioning groups.<sup>140</sup>

A fortnight after the Future Forum report, the BMA's annual conference turned over its leadership yet again to call for the bill to be withdrawn, with doctors attacking the changes as a "re-spray". One was to charge that it remained "a monster with lipstick".<sup>141</sup>

Shortly afterwards, Sir Roger Boyle, the Health Department's "heart czar", retired, declaring he had decided to go partly because he fundamentally disagreed with the reforms. The Government had been "so busy condemning what happened before," he said, that it was not prepared to learn from what had worked well.

It was "completely baloney" to say the service was over managed and by "tossing out" PCTs and SHAs, corporate memory and valuable networks were being lost. This "substantial reorganisation" was not needed, he said.<sup>142</sup> He later told the BBC's Today programme that "we could have got to the same point without this huge disruption ... it is horrific that the NHS's future is threatened".

Shirley Williams told the NHS Confederation conference that the changes "are still not a done deal". The amendments left the bill still looking in places "confusing, obscure and ambiguous." The concessions still did not "add up to a duty to provide a comprehensive health service as laid down in the NHS Act 2006".

Thus the opposition to the bill entered its third phase. After the initial concerns about how GP commissioning would work and the concerns around "privatisation", the constitutionalists and the lawyers came into play.

38 Degrees re-entered the fray publishing a legal opinion to the effect that the autonomy provisions left the secretary of state with a duty only to "promote" a comprehensive health service rather than to provide it, as previous NHS acts had stipulated. The "hands off" or "autonomy" clause effectively allowed the health secretary to "wash his hands" of responsibility for provision of the NHS, handing that duty over to the board and the commissioning groups.<sup>143</sup>

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139 *Daily Telegraph*, 15 June 2011

140 *The Guardian*, 18 June 2011

141 *The Guardian*, Jacqueline Davis, 7 July 2011

142 *Health Service Journal*, 4 July 2011

143 38 Degrees, [NHS Expert Legal Advice](#)



The House of Lords Constitution Committee too was fretting over that, publishing a report making much the same points in far more restrained language.<sup>144</sup>

To some critics, this was a core issue. To other commentators it appeared a sideshow. The brute political reality, they argued, was that whatever the law said, in a tax-funded NHS the health secretary would remain ultimately accountable for the provision of services.

As Stephen Dorrell had repeatedly put it – and as the former Conservative health minister Tony Newton was to argue in the Lords, seeking changes to the bill – if services got into trouble, it would be impossible for the health secretary of the day to say it was “nothing to do with me, gov”.<sup>145</sup>

More worrying for others was less the secretary of state’s duties than the sheer complication of the NHS universe that the Future Forum had helped create. As Lord Darzi, the former Labour health minister, was to put it: “We now have health and wellbeing boards, clinical commissioning groups, clinical senates, local healthwatches, the NHS commissioning board, a quality regulator and an economic regulator ... At the end of the day, who is responsible for making sure that the NHS saves more lives this year than last? Who is accountable for how its budget is spent? Who will inspire NHS staff to lead the difficult changes?”<sup>146</sup>

Meanwhile Lansley had pushed ahead by naming eight new areas where provision was to be opened up to “any qualified provider” – the language having been changed from “any willing provider” in an attempt to make private sector providers appear less threatening. Commissioners were told they had to open up at least three of eight types of provision to competition – ranging from wheelchairs for children to hearing tests in the community to talking therapies. Potentially the eight areas covered a £1bn market.

On 7 September the much amended bill cleared the Commons ready for the assault it was to suffer in the Lords. On 4 October, 400 public health doctors wrote an open letter to the Lords urging it to reject the bill.

Here again, the power of the internet was present. Assembling 400 signatories to a letter back in Ken Clarke’s day would have been a gargantuan task. With email, it was relatively simple.

The bill, the doctors declared, “ushers in a significantly heightened degree of commercialisation and marketisation that will fragment patient care; aggravate risks to individual patient safety; erode medical ethics and trust within the health system; widen health inequalities; waste much money on attempts to regulate and manage competition; and undermine the ability of the health system to respond effectively and efficiently to communicable disease outbreaks and other public health emergencies”.<sup>147</sup>

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144 [Constitution Committee, Health and Social Care Bill](#), 14 September 2011 (accessed 1 June 2012)

145 *Lords Hansard*, 9 Nov 2011 : Column 261

146 *The Independent*, 13 October 2011

147 *Daily Telegraph*, 4 October 2011

As the autumn party conference season kicked in, an attempt by Liberal Democrat opponents to hold a further vote on Lansley's reformed package was ruled out by the party's federal conference committee. Had one been held, it would almost certainly have resulted in rejection.

A debate was held without a vote, but both in that and at fringe meetings Shirley Williams made clear that peers would still be seeking "substantial further concessions". She noted that the whips were much less powerful in the Lords and that a "powerful and influential" group of medical peers were "taking an acute interest" in the bill, adding that "we must get rid of the autonomy clause".

The Lords committee stage opened with a failed attempt to get the sections relating to the secretary of state's responsibilities referred to a special select committee – a move that would have delayed the bill by a good three months and possibly, therefore, wrecked it. What followed was 30 days of debate in committee and at report stage and third reading.

As the Lords agonised over the legislation, Professor Malcolm Grant, newly appointed as chair of the commissioning board, told the Commons Health Select Committee at his pre-appointment hearing that the bill was "completely unintelligible" – a performance that led to his appointment being supported by the committee only on the casting vote of Dorrell as its chairman.

While the secretary of state's ultimate responsibility played a significant part in the Lords debate, almost every other aspect of criticism of the bill also got a hearing including the accountability of GPs and the potential conflicts of interest they faced between commissioning and providing care, not least because some of them had stakes in companies that supplied care.

The Lords debates ran on amid a continued swell of opposition outside Parliament. The BMA again called for the bill to be withdrawn. A representative survey of 500 GPs and 500 hospital doctors by the King's Fund and doctors.net showed that just over 60% believed there were GPs locally capable of leading the reforms. That piece of at least relatively good news for the government was offset by the finding that only 23% believed the changes would improve patient care with 25% disagreeing.

Despite that, over the autumn a sense grew that while the bill would clearly be amended in the Lords, its passage was now assured.

As Parliament re-assembled from the summer break, Conservative backbench MPs were making clear that they believed the Coalition had given all the ground it should over Lansley's bill. Equally, Nick Clegg and Norman Lamb were telling the party and its peers that the deal had been done over the Future Forum. Their part of the Coalition could not keep going back "for a second and third bite," as one senior Liberal Democrat put it.

As a result, in late October in a letter to *The Guardian*, 32 peers – including most of the leading Liberal Democrats including Williams and Paddy Ashdown and David Steel, two former party leaders – declared that "the time for declaratory statements is past" and that the task was to subject the bill to rigorous scrutiny. Patients and staff needed "certainty

about the future of the health service” and politicians who played “party political games with the NHS would be open to justified public criticism”.<sup>148</sup>

The letter was widely interpreted as the Liberal Democrat peers ending their “war” with the Conservatives over the reform. That, however, proved to be wide of the mark.

Williams now says that “I’m not sure looking back I was wise to sign it. But it was an attempt to show that we had gained quite a lot and to try to indicate that we weren’t simply being obstructive. I think it arose out of something of a Conservative backlash”.

In practice, issues in the bill would not go away. Rising up the scale of concern came the so-called “private patient cap”. Ordinary NHS trusts had no cap on how much private patient income they could earn. However, under the original legislation that set up NHS foundation trusts, their private patient income was limited to the percentage they received at the time that the legislation was passed. That had been a last-minute concession by the Blair government to get the legislation through, amid Labour backbench concerns that the more independent nature of foundation trusts might let them concentrate on private care at the expense of public patients.

Monitor had originally applied a broad interpretation of what private patient income meant – not counting, for example, specialist drugs that the eye hospital Moorfields made and sold to other parts of the NHS and the private sector; or occupational health work that NHS organisations undertook for private sector companies; or joint ventures the NHS had launched with the private sector to provide services that the NHS either did not provide, or was rationing – for example in vitro fertilisation. In 2009, however, Unison had won a court case overturning that interpretation.<sup>149</sup>

Furthermore the cap had become a barrier to a small number of hospitals achieving foundation trust status because their private patient work had expanded since the foundation trust legislation had passed in 2003. The most notable example was the Great Ormond Street children’s hospital which had chiefly expanded its private patient work by treating more overseas patients.

In truth, there were not many more than half a dozen hospitals where the cap was posing a problem. There was a relatively simple, almost administrative, solution available. The Government could have allowed them to apply to Monitor for an increase in their cap which would have been granted only on condition that extra private work did not damage NHS provision. Rather than opt for that, however, the Government – partly for simplicity’s sake, partly as a form of autonomy and local decision making – proposed to abolish the cap altogether. That opened up the fear that NHS hospitals would chase private patients at the expense of their service to publicly funded ones.

In an attempt to deflect that charge, the Government tabled an amendment that effectively placed the cap at 49% of a trust’s income. The 49% cap, however, also partly came about from the activities of the Liberal Democrats.

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148 *The Guardian*, 25 October 2011

149 *Financial Times*, 10 December 2009 (accessed 1 June 2012)

The party in the Lords accepted that competition law almost certainly already applied to some NHS activities – waiting-list surgery for example. Equally, many though not all Liberal Democrat peers acknowledged there was a role for competition. What they did not want, however, was competition red in tooth and claw forced on to the service. As far as it was possible so to do, they wanted to constrain its application.

Lord Clement-Jones – a former Liberal Democrat health spokesman, a managing partner with the law firm DLA Piper, and part of the Liberal Democrat team in the Lords for the health bill – had clocked the 38 Degrees legal opinion that the bill, as then constructed, extended its application.

The worry was that without a cap on foundation trust private patient earnings, they would undoubtedly be judged to be economic “undertakings” under competition law, and thus subject to its full force.

Clement-Jones assembled a clutch of competition lawyers to advise him. He consulted David Bennett, the chair of Monitor. And he came to the conclusion that a limit of 49% on private income – so that the majority of income would always come from NHS patients – would make it more likely that foundation trusts would be judged to be there for a social purpose, rather than being economic undertakings.

By coincidence, Shirley Williams had chaired a lecture given by a European Commission competition official. He had told her: “What you need to do is make it completely clear that this is not going to serve a majority of private interest. So while he couldn’t guarantee ... that a majority of public patients would do it, he said it would go quite a long way to indicating that this was not an undertaking but a social agency – like the French railways, for example.”

Clement-Jones entered into a lengthy battle with the health department’s officials and lawyers. Ironically enough, he says, they only really began to understand the issue when Isabel Letwin – Oliver Letwin’s wife and the department’s legal services director – got involved.

The outcome was the 49% figure was reluctantly supported by Lansley as an attempt to offset the “privatisation” charge, and more enthusiastically by Williams, Clement-Jones and others as a means of seeking to constrain the application of competition law.

All that turned out to do, however, was to pour petrol on the fire. John Pugh, the Liberal Democrat MP who had most consistently attacked the bill in public and who was chairman of his party’s health committee, declared it was now time to debate the real motivation behind the Government’s plans.

“Blurring the boundaries between public and private provision is part of a programme to curtail or end the state’s role in the provision of public services,” he said. It was “a coherent, clear ideological drive to create a more feeble state which has never been openly discussed”.<sup>150</sup>

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150 *The Times*, 27 December 2011

How much of a market there might conceivably be for NHS hospitals to take more private patients – there never had been a cap on ordinary NHS trusts – barely got a hearing in the debate as Dr Peter Carter, general secretary of the Royal College of Nursing said that if allowed to go ahead “the removal of the cap could lead to the fundamental erosion of key NHS principles”.

### Scene Four: Burnham re-enters the fray

The 49% cap was seized on by Andy Burnham who had returned, in his words, “fired up” in the autumn to replace John Healey as health spokesman, his reappearance injecting new energy into Labour’s campaign against the bill. He declared the move to be “the clearest sign yet of David Cameron’s determination to turn our precious NHS into a US-style commercial system, where hospitals are more interested in profits than people.

“With NHS hospitals able to devote half of their beds to private patients, people will begin to see how our hospitals will never be the same again if Cameron’s health bill gets through Parliament.”<sup>151</sup>

Burnham’s first act on his return had been to talk to a whole string of those who were opposed to the bill, deeply sceptical about it, or merely worried.

“The thing I got back from pretty much everybody,” Burnham says, “was ‘it’s awful, but we’re kind stuck with it because we’ve had the pause, and if there was going to be a time when we could have killed this, it’s gone. We’re stuck with this.’ I immediately thought, I’ve got to change that.”

Ten days before Christmas, Burnham called a meeting of the heads of all the royal colleges and the health service unions in one of the grand Pugin wall-papered, oak-panelled rooms that line the committee corridor of the House of Commons. He was both surprised and delighted by the size of the turnout.

He had commissioned a paper from the House of Commons library which argued that, were the bill to be stopped, much of what it aimed to do – GP commissioning, the board as a special health authority, any willing provider, closer working with local authorities – could still go ahead under existing legislation. Burnham dubbed this his “NHS stability plan”.

When the meeting convened, Burnham was, according to Dr Linda Patterson, clinical vice-president of the Royal College of Physicians, “very clever and very subtle”.

“He told us that he quite understood if the colleges felt they could not oppose the bill outright. And he understood that the colleges were charities and could not be political.

“He told us: ‘This is not about supporting the Labour party.’ But he did urge us to think about our own positions and the big reservations we all clearly had about the bill. And he said that if we did all come out with a united position then it was possible that the bill could fall.

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151 Ibid

“It did make people think. I think most of the colleges up to then had simply seen the bill as inevitable. They didn’t like it and had been lobbying hard about various aspects of it. But it did plant the idea that it might be possible to stop it.”

The meeting ended at around 6.00pm. By 7.30pm an account of it was on *The Guardian’s* website, with a headline about Labour’s plans to “derail” the reforms.<sup>152</sup> Burnham wrote to all concerned next day suggesting that the leak was not his responsibility. He explained that while it was “not ideal, it became clear yesterday that the press had got wind of last night’s meeting and we thought it better in the circumstances to provide a straightforward, factual account of our aims”. The leak, however, planted a worry in the mind of some college officials that they were being used.

A second meeting followed on 6 January and a week later, the Royal College of GPs released a survey of its members purporting to show that 98% wanted the bill to be dropped, ideally under a “joint approach” with the other colleges.<sup>153</sup>

The fact that a mere 2,500 of the college’s 34,000 English members had voted in the online ballot – and that it was conducted using a polling system that allowed more than one vote – barely got noticed in the media coverage. Dr Gerada called for significant changes, noting that “should the situation warrant it” there was “strong support within the profession” for “the withdrawal of the bill itself”.

On 19 January the Royal College of Nursing (RCN), which – despite their humiliation of the health secretary the previous April had not in fact so far called for the bill to be withdrawn – did so.

On 24 January the Academy of the 20 medical royal colleges met. During the meeting a draft statement was drawn up declaring that the royal colleges “are not able to support the bill as it currently stands”. That fell short of the demands from the British Medical Association, RCN and others to drop it. Coming from the entire academy, however, it would still have been a big blow for the Government.

The College of GPs was strongly in favour of a collective decision not to support the bill. “There wasn’t a person in the room who was fully supportive of the bill,” Dr Tony Falconer, president of the Royal College of Obstetricians and Gynaecologists says. “Every college had serious reservations. But certain colleges felt that outright opposition would be a very political statement. And there were also worries about excluding ourselves from continuing negotiations over it if we did.”

It also became clear during the meeting that the surgeons would not support the draft. Indeed they were preparing to issue a statement of their own saying that despite continued concerns it still supported “the aims of the reforms” – measuring the NHS by its outcomes, involving patients more and letting clinicians lead.

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152 *The Guardian*, 14 December 2011 (accessed 1 June 2012)

153 *GP*, 12 January 2012 (accessed 1 June 2012)

The meeting broke up on the basis that the rest of the colleges would support the statement, but with a further meeting set for the 26th.

The next morning, to the fury of many of those who had attended, the draft statement was leaked to *The Guardian*. Ministers and their advisers reacted with alarm. At scale, they hit the phones, warning of the loss of influence that colleges feared, and asking royal college presidents, most of whom had little direct experience of raw politics, whether they really wanted to be lined up with Labour.

As that was happening, however, the reservations held by the obstetricians and gynaecologists and some other colleges were already hardening. Some felt it would lack credibility so late in the day to move to more outright opposition.

The obstetricians and one or two other colleges made clear to the academy that if the surgeons were not prepared to sign up, neither were they. That without a unanimous voice, the academy should not act. The decision to issue the statement was rescinded. A second meeting of the academy did follow. But by then the die had been cast.

The meetings of the academy remain one of the great “what ifs?” of the bill’s passage. As Burnham hoped, united opposition from the colleges might just have proved fatal to the bill, or to parts of it – although by now David Cameron had so much invested that a complete u-turn would have been immensely politically damaging.

“I felt at the time they could stop it, and I think I was right in that judgement because they very nearly did,” Burnham says – even though the draft statement did not call directly for withdrawal, and even though it stated that the colleges wanted to be closely involved in implementation. Even one of Burnham’s fiercest political critics concedes that “he almost played a blinder”.

The reason that, despite the inconclusive meetings of the academy, the colleges appeared very nearly to halt the bill – at least to the eyes of the outside world – was that, once again, the power of the internet came in to play. Opponents of the bill who were dismayed at the academy’s stance began to exploit some ancient college rules which allowed as few as 20 to 25 members to call various forms of emergency meeting, at which votes could be taken or demands for ballots passed. The demand for those rising rapidly thanks to a cack-handed decision that Number 10 was shortly to take.

Among many others, Dr Clive Peedell, a consultant clinical oncologist who was a member of the BMA council and co-chair of the NHS Consultants Association, itself part of the Keep our NHS Public campaign – a man with some 3,500 Twitter followers and an almost daily determination to keep them satisfied – was using the medium to point doctors to draft letters they could use to demand college meetings. College members were being told that the future of the NHS was now “in the hands of the medical royal colleges”.

At the very end of January the *British Medical Journal*, the *Health Service Journal* and *Nursing Times* published an unprecedented joint editorial condemning the bill as “an unholy mess”.

The upheaval caused by the reforms “has been unnecessary, poorly conceived, badly communicated, and a dangerous distraction at a time when the NHS is required to make unprecedented savings ... we must make sure that nothing like this ever happens again”.<sup>154</sup>

Two days later on 2 February Gerada went further than just threatening to call for withdrawal of the bill. She did so.

The Government had just tabled a string of amendments in the Lords. But Gerada said that “while the Government has claimed that it has made widespread concessions, our view is that the amendments have created greater confusion”. Despite the changes the bill would “cause irreparable damage to patient care and jeopardise the NHS,” she said, adding that the decision to call for withdrawal “was not taken lightly. It is clear that the college has been left with no alternative”.<sup>155</sup>

As she hardened her stance the first fruits of the Twitter and email campaign to get doctors to demand that their colleges call for the bill to be scrapped began to bear fruit. First the physiotherapists, then the public health doctors, then the radiologists, and so on – to the point where it felt that almost daily across February another professional organisation was demanding that the bill go.

“It was like a drum roll,” one special adviser says. Ministers took what cold comfort they could from the fact that many of the turnouts were decidedly low.

At one extreme, the Royal College of Radiologists with approaching 5,000 members in England held an emergency meeting at which 52 members turned up and 36 voted for the college to call, in public, for the bill’s withdrawal. Even in the bigger ballots the turnout rarely topped 15%. The department eventually calculated that among the colleges that held one style of vote or another only around 10,500 doctors out of total college memberships of more than 120,000 called for withdrawal.

Each one, nonetheless, made a headline, even if the low turnouts helped steel ministers against the idea that the bill had to be scrapped.

Encouraged by the apparent tsunami of demands to “kill the bill”, Ed Miliband again attempted to turn up the political heat by declaring in *The Observer* that “it is not too late to stop this bill”, urging the public to join a three-month campaign to halt it.<sup>156</sup>

Once again, those who might have been expected to be Lansley’s supporters turned on him. Dr Michael Dixon, chairman of the NHS Alliance, and Dr Charles Alessi, a pioneering fundholding GP who was about to become chairman of the National Association of Primary Care, said they feared that GPs would be “suffocated, not liberated” by the changes.

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154 *The Nursing Times*, 31 January 2012. And from whose final sentence the title of this is taken. (accessed 1 June 2012)

155 *The Guardian*, 3 February 2012 (accessed 1 June 2012)

156 *The Observer*, 5 February 2012



“What we are hearing and seeing are the same old messages and the same old structures, albeit with new nomenclatures,” Alessi said.<sup>157</sup> Chris Ham, chief executive for the King’s Fund, said the arrangements for commissioning now looked like “a Heath Robinson machine”.<sup>158</sup>

Rachel Sylvester in a column for *The Times* quoted a Number 10 insider as declaring: “Andrew Lansley should be taken out and shot. He’s messed up both the communication and the substance of the policy.” An intriguing idea was circulating in Downing Street, she said, that Alan Milburn should be elevated to the Lords and put in charge of health.<sup>159</sup>

There was never a chance of that. But the NHS reforms were, yet again, all over the headlines and they dominated prime minister’s questions – Cameron declaring that Lansley’s career prospects were better than those of Ed Miliband, the Labour leader. Worse was to come, however.

Conservative Home, the influential website run by Tim Montgomerie joined the “kill the bill” brigade. He reported that at least three Cabinet ministers were now ringing alarm bells over the legislation: one saying that the bill should be dropped; another that Lansley should be replaced; and a third likening the reforms to the poll tax. His report generated more hits than anything he had posted before.

Illustrating the blog with a picture of Cameron sitting on a burning stick of dynamite labelled NHS, Montgomerie declared the reforms to be an “unexploded bomb” for the Conservatives that could indeed prove “this Government’s poll tax”. The bill, he said, “must be stopped before it is too late”.<sup>160</sup>

At a meeting of the 1922 Conservative Back Bench Committee, Simon Burns, the health minister received a mauling from MPs over the bill’s handling. But as Westminster swirled with speculation over whether it might indeed be dropped or lost, and as to who the three Cabinet ministers were, George Parker, the *Financial Times* political editor, noted that the guessing game over their identity was “essentially pointless, since virtually every cabinet minister has privately expressed despair over the handling of the legislation”.<sup>161</sup>

Nick Clegg, who by now had expended a huge amount of personal political capital on the bill, attacked the unnamed Conservative Cabinet ministers for undermining their own legislation,<sup>162</sup> while David Cameron over the weekend went out of his way to underline that he was “at one” with his health secretary.<sup>163</sup> The *Daily Mail* reported him banging a table in frustration, declaring that “we’ve not shed blood on these proposals not to go through with them”.<sup>164</sup>

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157 *The Guardian*, 7 February 2012

158 *The Times*, 8 February 2012

159 *The Times*, 7 February 2012

160 ‘The unnecessary and unpopular NHS Bill could cost the Conservative Party the next election. Cameron must kill it’, Tim Montgomerie, [Conservative Home](#) (accessed 1 June 2012)

161 *Financial Times*, 10 February 2012

162 *Ibid*

163 *Sunday Times*, 13 February 2012

164 *Mail on Sunday*, 13 February 2012

Labour, the prime minister said, had started sensible reform. “We need to build on this and that is what the bill does ... I want to reassure people that the change we propose is evolutionary, not revolutionary.”<sup>165</sup>

Amid all this fever, the Liberal Democrats were all over the place. On the same day as Cameron underlined his support for Lansley, Simon Hughes, the deputy leader of the Liberal Democrats, went on television to say that the time would come shortly when Lansley should move on. That prompted Clegg, his boss, to declare that the health secretary was “the right man for the job”.<sup>166</sup> At precisely the same time, however, Shirley Williams was saying that the Government should drop the 80-clause part three of the bill that covered competition and the new role for Monitor.<sup>167</sup>

By contrast Dorrell was telling the *Financial Times* that “withdrawing the bill means we launch another discussion about the future [NHS] management structure. I simply don’t think that it’s a realistic option.

“I wouldn’t have done it in this way, but I think that the key thing is to get beyond this discussion and to get on with dealing with the Nicholson challenge [to make the £20bn of efficiency savings].”

As the Coalition leaders signalled increasing determination to get the bill through come hell or high water, Downing Street – displaying all the sure-footedness that had marked its handling of the NHS reforms from the start – called a meeting of medical and health organisations to discuss the next stage: implementation.

The health department had put forward names of those “constructively engaged” in the reforms. Officials claim that they had not anticipated that only those would be invited. In practice, Number 10 used only that list, excluding bodies such as the Royal College of GPs, the BMA, the RCN, Unison and the Faculty of Public Health.

They reacted with anger, the Government finding itself being accused of a policy of “divide and rule” of a “bunker mentality” and of listening to its critics but not hearing them. Dr Peter Carter, the RCN general secretary, said that “anyone would say” that a bill that had already been subjected to 1,000 amendments “has not been thought through”.

As Lansley headed across Whitehall to the meeting which had been trailed in the media, he and his advisers had failed to spot that it was being picketed by Unison and other opponents of the bill. Lansley found himself harangued live on television by the 75-year-old June Huatot, a former Unison rep.

The meeting to discuss implementation turned largely into those present underlining their continued reservations about the bill – the prime minister emerging to say it was clear that there were “quite a few myths” that the Government needed to bust. “Choice for patients is a good thing; integrated care is a good thing; making sure that GPs not bureaucrats are

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165 *Sunday Times*, 13 February 2012

166 *The Independent*, 14 February 2012

167 *The Guardian*, 13 February 2012

making decisions is a good thing.” Reform, the prime minister remarked almost ruefully “is never easy”.<sup>168</sup>

The meeting had another downside. Some of those who had attended found themselves under attack from their members. Thirty-five fellows and members of the Royal College of Physicians wrote to the *Daily Telegraph* accusing Sir Richard Thompson, the college president and a former Queen’s physician, of a “political act” in agreeing to be there when key medical organisations had been excluded. He found himself accused of being used as a “political pawn at this pivotal time in the history of the NHS”. Again the power of email came into play, some of the signatories having urged Sir Richard over the weekend not to attend, and then going on to call an extraordinary meeting of the college which demanded a ballot that, very late in the day, came out largely in opposition to the reforms.<sup>169</sup>

As that row rumbled on, Lord Crisp, the former chief executive of the NHS and permanent secretary at the Department of Health emerged on *The World This Weekend*, to describe the legislation as “as mess”. The bill was, he said, “unnecessary ... confused and confusing” and would set the NHS back. Dr Sam Everington, a GP in Tower Hamlets who at one time had been a Labour health adviser and deputy chairman of the BMA, joined the criticism. Despite those links, it had been Dr Everington’s pioneering Bromley-by-Bow practice that Lansley had chosen for his first speech as health secretary – as a model for the changes he wanted to see.

“Your rolling restructuring of the NHS compromises our ability to focus on what really counts – improving quality of services for patients,” Dr Everington said. “Your Government has interpreted our commitment to our patients as support for the bill. It is not.”<sup>170</sup>

## Scene Five: The end game

Through the autumn of discontent and alongside the escalating spring fever, the Lords had been working its way through the bill. The Government – the Coalition – had no majority. It needed at least 20 or so crossbenchers to vote for it to be sure of winning if Labour opposed. What the Government did have, however, was Earl Howe.

The hereditary peer had been a banker, farmer and much else. But he had also been the Conservative’s health spokesman in the Lords since 1997 and part of Lansley’s team throughout.

As Baroness Williams puts it, “he has got a very strong understanding of the NHS ... he has a real feel for it ... some of the time we had this extraordinarily strong impression that Freddie was on our side”.

If Lansley’s communication skills drove his colleagues and advisers to despair, Howe could explain to peers with a limpid clarity just what it was the Government was trying to do and

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168 [The Daily Telegraph](#), 20 February 2012 (accessed 1 June 2012)

169 [Daily Telegraph](#), 23 February 2012

170 [Pulse](#), 28 February 2012 (accessed 1 June 2012)

why.<sup>171</sup> He was also, in the words of one civil servant, an “emollient genius”. Lord Warner, the Labour former health minister, says “his silky skills got the bill through”.

Howe faced not just Labour opposition and strong Liberal Democrat dissent on key issues. Among the crossbenchers there were lawyers and medical peers with a distinct interest in the health service. In addition, there were several former Conservative health ministers, some of whom were distinctly independently minded – most notably Tony Newton, who was dying but dragged himself and his oxygen cylinder to debate after debate (the concerns he expressed all the more powerful for that) and Brian Mawhinney, who had been a health minister under Major.<sup>172</sup>

Both still retained strong health service links. Their voices mattered on issues such as the responsibilities of the secretary of state and of Monitor. While they were instinctively loyal, Howe knew that their votes could not simply be assumed. As Lord Warner puts it, “they hovered like hawks over the proceedings”.

Howe’s fear was not so much that the bill would be lost but that it would take such a mauling as to render chunks of it meaningless.

Always ready to listen, to reason, and to listen to reason, Howe and the department held an unprecedented number of well attended seminars for all peers – those in parties and those on the cross benches – attempting to explain what the bill did and did not do. That huge effort reflected the department’s view that it was in the Lords that the bill’s final nature, and possibly its fate, would most likely be decided.<sup>173</sup> Those seminars overlapped and followed on from a series that Baroness Thornton, Labour’s leader on health in the Lords, had held with a wide range of medical and NHS organisations over the summer – again open to all parties.

Early on, when the upper chamber’s constitution committee had become concerned over whether the secretary of state still had a duty to ensure a comprehensive service, Howe took a calculated gamble.

He invited the committee to produce its own amendments to satisfy the concerns of a bunch of heavyweight peers that included Baroness Jay, the committee’s chair, a former Labour health minister and former leader of the Lords, and Lord Mackay, the lawyer who had been Lord Chancellor for a decade under Margaret Thatcher and John Major. His understated and almost apolitical approach carried real weight across the house. Howe promised to do his best to look favourably on the committee’s suggestions as it and he spent many weeks in cross-party talks on the issue. In addition, a crucial meeting was held at which Lord Laming, a cross-bench peer, independently chaired an all-party and no-party seminar on the issue.

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171 One of the clearest accounts of what the bill is about is Earl Howe’s introductory speech to the Lords second reading, *Lords Hansard*, 11 October 2011, col 1472

172 Tony Newton [Baron Newton of Braintree], Minister of State for Health 1986-88, Secretary of State for Social Security 1989-1992; Brian Mawhinney [Baron Mawhinney], Minister of State for Health 1992-1994.

173 See page 83 above

Howe's second big concession was to take on board the concerns of the medical peers, most notably the cross-benchers, that a whole bunch of issues of particular concern to the royal colleges were missing from the bill – the protection of education and training, and of research, for example.

Lansley had planned a second, later, bill to wash some of these issues up. But as Norman Warner puts it, "no-one in the Lords believed that Cameron would be so foolish as to let Lansley loose with another health bill ... Things had to be dealt with in this one".

Howe persuaded a somewhat bemused Lansley of the need to settle such issues. Step by step, amendments to set up a revamped system for education and training were put in place. Issues covering research were also dealt with. That helped change the mood. Concessions built trust. So while at the earlier committee stage a majority of cross-bench peers voted with the Government just 35% of the time, by report stage they did so 75% of the time.

On top of that Howe spent literally hundreds of hours listening to the concerns of peers on the big headline issues that were whipping up the storm outside Parliament and on the internet. On choice, competition, any qualified provider, the impact of EU law and much else.

Shirley Williams says that at crucial times and on crucial issues "there could be as many as two or three meetings a day each lasting 45 minutes and an hour ... You always got the feeling that Freddie would carry your message back [to Lansley] in an honourable way. But I wouldn't say three times out of four, but certainly one time out of two he would be just told 'no' in no uncertain terms".

At many of these meetings, particularly with the department, Williams appeared to be almost conjoined to Lord Marks of Henley-on-Thames, the Liberal Democrat lawyer who was able to produce amendments phrased in a way that the department could not rule out for being badly drafted.

At the end of January, just before report stage, Howe was able to write to peers saying that, with one or two minor changes that he had agreed with the constitution committee, he had accepted their amendments over the health secretary's responsibilities.

That, he judges, was one of two important "psychological moments" – the other being the agreements with cross-benchers on the education and training, research and other issues. The concession on the constitutional issue, however, also proved crucial in another way.

As the tumbrils appeared to be sounding for the bill outside Parliament, with college after college, nominal supporter after nominal supporter, abandoning the bill – or that at least is what the headlines felt like – the Liberal Democrat spring conference was looming.

Amid all the extra-parliamentary opposition, there was a real threat that the party might repeat the previous year's conference and perhaps go even further, joining the "kill the bill" brigade.

Williams went to see Clegg one more time. Clegg – along with Lamb, his political adviser and a party whip in the Commons – had taken the view that once the pause was over the Liberal Democrats, as a member of a Coalition government, had got all they could get. That it would be pointless, “almost just prolonging the agony”, to carry on.

Williams, however, was able to point to the fact that the Government had now shifted on the constitutional issue: the health secretary’s responsibilities.

“It took a while to get Nick to it,” she says. “But we could point to the fact that we had achieved that one. And I think as a result he began to understand that there was a real possibility that the Conservatives would concede more than he thought.”

It was by now clear that the Government was not prepared to drop entirely part three of the bill – the section that dealt with Monitor and competition. But without more concessions, Williams warned Clegg, the party conference might well revolt and there was a real risk that “we won’t go on – the Liberal Democrats won’t go along with passing the bill. That was primarily in the Lords, but also an element of the Commons”.

On 27 February a small group of protestors chained themselves to the Downing Street gates, just as, by coincidence, Clegg and Williams wrote to their MPs and peers setting out a further string of “final” amendments that the party would seek in the Lords.

The points included removing provisions for the Competition Commission to conduct seven-yearly reviews of – in effect – whether Monitor was doing enough to promote competition; retaining Monitor’s role indefinitely as a specific overseer of foundation trusts; putting additional safeguards around the private patient cap; removing a requirement for NHS organisations to provide space – facilities – for any willing provider; and requiring anyone involved in commissioning, most notably GPs, to declare any conflict of interest, for example a stake in a private health provider.

“Once these final changes have been agreed, we believe conference can be reassured that it has finished the job it started last March and the bill should be allowed to proceed,” Clegg and Williams said.<sup>174</sup>

Although Cameron had been warned, the letter’s publication produced confusion in Downing Street. The prime minister’s official spokesman first denied that any significant changes were on the way. Later in the day the line was that “some people require further reassurance on issues relating to competition. We are happy to provide that”.

On 6 March in the Lords, Earl Howe agreed some of the Clegg/Williams amendments and indicated sympathy for most of the remainder.

At his spring party conference, Cameron declared that he was prepared to “take a hit” in terms of popularity over NHS reforms that were “right”. At the Liberal Democrat one, party activists achieved the remarkable feat of voting not to have a vote on what should happen to the bill – but then rejecting a motion calling on their peers to support it at third reading. Recriminations followed. But the end game had finally been reached.

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174 Nick Clegg and Baroness Williams, [letter to Liberal Democrat members](#), (accessed 1 June 2012)

On 6 March, Gerada wrote to Cameron offering an olive branch in apparent recognition that the bill was now inevitable – and tacitly reflecting the fear that the college would no longer be listened to.<sup>175</sup>

While the college still did “not agree on the need for, and potential impacts of, parts of the proposed legislation,” she said, “I assure you that our mutual concern remains providing and planning the best possible quality of care to our patients”. She hoped the Government and the college could find an “acceptable way forward” to work together on implementation.

The letter became public on the 13 March. She somewhat spoiled the effect by going on the Today programme to declare that the college was “still asking for withdrawal of this bill”. But the fact was, she said, that it would be the 34,000 GPs having to implement it, and “doesn’t it make sense that we are around the table?”

When the Lords resumed the report stage Howe accepted a further set of amendments that included a provision that – while the private patient cap was still to be set at 49% – the governors of foundation trusts would have to approve any increase of more than 5% in a trust’s private patient income and that Monitor would need to be satisfied that did not damage NHS provision.

By now, in the upper chamber, a sense of exhaustion had set in.

Despite the unusually long parliamentary session (something that helped the bill get through) the Coalition’s legislation was piling up. There had been a stack of defeats in the Lords on the welfare reform and legal aid bills. On these, the Government indulged in what is known as “ping pong” – the Commons overturning Lords amendments and seeing how far the Lords would stick to its guns by sending the amendments back.

But with those two bills still in play, “Conservatives in both houses really could see nothing but an unending stony road ahead,” Williams says. “Everything looked like it was just not getting anywhere and they just wanted to get the hell out of there.”

Howe’s assessment of those final days is that many other peers, including the cross-benchers, had also had enough. The final concessions were made, including a sort of “pre-failure regime for foundation trusts”, and on links with social care. On one or two items – notably the famous, and in Lansley’s eyes, crucial “autonomy” clause – Lansley dug in. Howe appeared to have no concession to make. Finally the duty to promote autonomy was made subservient to the duty to secure a comprehensive service.<sup>176</sup>

A last gasp bid by Labour asking peers to refuse to pass the legislation went down by 269 votes to 174, a Government majority of 95 – large in Lords’ terms.

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175 Dr Clare Gerada, [letter to David Cameron](#), 6 March 2012 (accessed 1 June 2012)

176 For a much fuller account of changes made to the bill in the Lords see: House of Commons Library note 12 March 2012. Health and Social Care Bill: summary of Lords Committee and Report stages.

As the bill headed back to the Commons for its final approval, some 2,000 amendments had been made.<sup>177</sup> The overwhelming majority were technical: names changed in assorted other pieces of legislation as well as the health bill. In a measure of Howe's skill as a negotiator – both with peers and with Lansley – there had in fact been just two defeats over this hugely contentious piece of legislation. Both were on relatively minor matters.<sup>178</sup> All the remaining changes were government agreed amendments, the result of a complex mix of Liberal Democrat, cross-bench, Labour and on occasion even Conservative pressure.

As he wound up, Howe noted that ministers had accepted 375 substantive changes, although a bunch of these involved provisions on issues such as education, training and research which were missing from the original bill rather than being the main bones of political contention. The number of genuinely substantive changes in those areas was far smaller; something over a dozen, depending on how you count them.

Fifty days of debate in Parliament had produced a piece of legislation even longer, more complex and in some areas – notably on the regulator's duties – appreciably less clear, than the original huge edifice; even if Earl Howe was to argue that “we have made a bill whose key principles command wide acceptance: more joined-up, clearer and, in certain aspects, less risky”.<sup>179</sup>

Lansley's verdict, once some of the dust had settled, was that “a lot of those amendments were practical things in order to give further reassurance. They did not really fundamentally change the principles [of the bill] at all”.<sup>180</sup>

A final attempt in the Commons by Andy Burnham to hold the bill up until the risk register was published was defeated. As it cleared its final parliamentary hurdle and headed off for Royal Assent, ministers banged the Cabinet table – though that, surely, had to be in relief rather than jubilation.

Almost two years earlier, they cannot have imagined that the National Health Service, which had merited a mere 19 words in the original Coalition Agreement, would have left them where they were.

Yet for all the fury and passion at Westminster, the YouTube and Twitter campaigns, the 600,000 strong e-petition assembled by 38 Degrees opposing the changes, the millions of words of press and broadcast coverage, the issue had not cut through deep to the British public.

An Ipsos/Mori poll showed that just 22% of the electorate in February 2012 rated the NHS as the most important issue facing Britain, way behind the economy and unemployment and even below concerns about immigration.<sup>181</sup>

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177 [Health and Social Care Bill: summary of Lords Committee and Report stages](#), (accessed 1 June 2012)

178 The inclusion of mental health in a definition of NHS services and a concession on VAT for charities and social enterprises

179 *Lords Hansard*, 19 March 2012 col 713

180 Management in Practice, '[Lansley admits Health Bill's 'fundamental principles' remain](#)', 18th April 2012 (accessed 1 June 2012)

181 [Economist/Ipsos MORI February 2012 Issues Index](#), 21 February 2012 (accessed 1 June 2012)



Whatever the outcome of the bill, however, it had ensured that heading for half way through the Coalition government's anticipated term of office, it had wrecked, at least in the short term, David Cameron's drive to "detoxify" the NHS as an issue for the Conservatives.

An Ipsos/Mori poll showed that Labour now had an 18-point lead over the Conservatives as the party with the best policies for the health care – even if Labour's policies seemed to add up to little more than outright opposition to most of the bill, and indeed to some of the policies they had themselves applied in government.

Labour's lead on health was its largest since 2002, although not as large as the 32-point gap it had enjoyed before the 1997 election. That 18-point advantage, however, contrasted with just a three-percentage-point lead for Labour in the same series of polling back in 2008 when Cameron had been promising continued tax funding of the health service and "no more pointless and disruptive reorganisations".<sup>182</sup> As for the Liberal Democrats, the same poll showed that just 8% of the electorate now believed that they had the best policies for health. For both parts of the Coalition, a huge political price had been paid, at least in the short term.

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182 <http://bit.ly/xEKSFn>

# Act Five: “Never again”

*“So let me first make clear what our reforms won’t look like. We will not persist with the top-down re-structures and reorganisations that have dominated the last decade in the NHS. They have caused terrible disruption, demoralisation and waste, and the people who work in the NHS have just had enough of it.”*

*David Cameron, August 2009*

*The NHS “had been put to bed. No top-down reorganisation ... and the expectation on election day was that there’d be a bit more engagement from GPs ... [and] some tweaking at the edges. There was certainly no understanding on my part ... that there was going to be any attempt to write it all out on a clean sheet of paper”.*

*Stephen Dorrell*

*“The moment in a way when the Civil Service is weakest is at the beginning of a new government. You have to show that you’ve understood what the new government wants to do. And you have to show willing to do it, really.”*

*DH official*

*“It is the only change management system you can actually see from space – it is that large.”*

*Sir David Nicholson, NHS chief executive.*

*“My short response to the white paper was ‘wonderful’. The short response to the bill was ‘oh dear’.”*

*Dr Michael Dixon, chairman of the NHS Alliance.*

*“I could have done most of this without the legislation.”*

*Andrew Lansley*

*“Legislation is something that needs to be an accurately targeted rifle shot, not a strategic bombing.”*

*Stephen Dorrell*

*The debacle “has set back for a generation the cause of market-based reform in the NHS”.*

*Alan Milburn<sup>183</sup>*

*“He wanted to do a Butler. He wanted the Lansley Bill, as Butler had the education act.”*

*Conservative backbench MP*

*“You cannot encapsulate in one or two sentences the main thrust of this.”*

*Simon Burns, Minister of State for Health<sup>184</sup>*

## Scene One: Ever again?

As ministers banged the cabinet table with relief, the reaction of almost everyone in and around the NHS was “never again”.

Never again must the NHS – or, equally importantly, any other part of the public service – be subjected to such a car crash of policy making. One that had caused both its proponents and its opponents within government huge political damage while creating an act that is, in many people’s eyes, a complex mess. As one of the more senior civil servants puts it: “Our job is to try to make it work” with the emphasis on the word “try”.

But there is another version of “never again”. It is the health secretary’s. His underlying aim, after all, was to create what Labour dubbed a “self-improving” service, one that would run more or less on autopilot.

A service where ministers would deliver a mandate to a commissioning board that would buy in and organise the more specialised services while overseeing clinically-led – particularly GP-led – commissioning; that would operate within a framework of choice and competition, overseen by a proper economic regulator. One where ministers could stand back from day-to-day involvement, with a duty to “promote autonomy” among NHS organisations because this perfectly oiled machine would itself deliver better outcomes and better value for money. As a result, never again – or at least not for many years – would politicians need to fiddle with the structure. And if they did, they would have to legislate to do it.

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183 *Daily Telegraph*, 15 June 2011. And Institute for Government seminar 27 March 2012

184 *BBC Radio 4*, The Report, 22 March 2012.

As Earl Howe elegantly put it at the start of the second reading in the Lords: “The bill is long and complex because for the first time in statute it seeks to define the functions and duties of every element in the chain of accountability within a reformed healthcare system, and to join up those functions and duties into a coherent whole.

“Whereas in the past it has been possible for a government to change the NHS simply by direction, in the future it will be impossible to do so without recourse to Parliament.”<sup>185</sup>

And despite the many amendments to the bill, it is hard to argue that the core of what Andrew Lansley was after is not still in the act. As he has put it, the amendments “did not really fundamentally change the principles [of the bill] at all”.<sup>186</sup>

To be sure, the reforms were not precisely the ones Lansley had set out to achieve, either originally, nor in the white paper. In key respects their negotiation through, and enactment by, a coalition had produced changes.

They involved much more structural upheaval than Lansley originally planned. The transfer of much of public health to local government, combined with the requirement for all GPs to be members of commissioning groups had led to the abolition of PCTs and SHAs – rather than the reduction in their numbers that would otherwise more likely have occurred, with PCTs left with a residual role that would have withered on the vine. As a result of the Coalition, councils play, at least potentially, a much bigger part in the new dispensation than Lansley ever envisaged.

Furthermore opposition *within* the Coalition, as well as support from it (it was Liberal Democrat votes that helped defeat Labour’s attempt to halt or abandon the bill) has seen some of the snow-white purity of the original white paper sullied during its passage through Parliament.

Some of this was inevitable – proper governance for commissioning groups, for example. But Monitor’s remit has been changed from *promoting* competition where appropriate to preventing anti-competitive behaviour, while having a load of other duties imposed on it. The most important of these was for it to enable services to be provided in an integrated way where that promotes, among other things, quality and efficiency – the very tortuousness of that language, taken from the act, illustrating the complexity of its final role.

The secretary of state retains the cherished duty to “promote autonomy” in the behaviour of NHS institutions. But it is now subservient to a duty to promote a comprehensive health service and to “secure that services are provided” to that effect.

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185 *Lords Hansard*, 11 October column 1472

186 Management in Practice, ‘Lansley admits Health Bill’s ‘fundamental principles’ remain’, 18th April 2012 (accessed 1 June 2012)

The department has not become the department for public health. The Health Protection Agency will lose its current degree of independence but its replacement Public Health England will survive as an executive agency rather than being fully absorbed into the department.

It now appears, although this is still not entirely clear, that the service will be expected to accept advice from NICE on which treatments the NHS should and should not adopt, rather than its pronouncements being purely advisory, with GP consortia deciding.

Clinical commissioning groups are now heavily GP-led rather than solely GP-run, and they will have to engage with a bewildering array of organisations and interest groups about their plans. Some can request reconsideration of the plans, although only the commissioning board will have a formal veto over them.

Health and wellbeing boards have given local government a far larger role than Lansley originally envisaged. This may offer improved integration of health and social care. It is, however, too early to judge whether that will happen; whether their impact on NHS commissioning will be positive or negative; or whether they will prove largely to be talking shop.

A bunch of measures has been put in place that, their proponents hope, will constrain the application of competition law. These include the 49% cap, the 5% threshold for increases in private patient activity, and the fact that foundation trusts have not been set free – or set freer – in quite the way the health secretary envisaged. Monitor will continue specifically to oversee them for the foreseeable future, rather than their governors taking almost the sole responsibility for their quality and viability. Proponents hope all this will reduce the chances of them being judged to be “economic undertakings”. It should be noted, however, that competition law is highly complex and there is very little case law for it in health. It may take a number of legal judgements before the extent of its application to the NHS is finally settled.

Some of the timetable has slowed. The whole system may look a lot more gummed up, and appreciably less freewheeling, flexible, autonomous and market-like than the original concept. Certainly in the early years, it will be a lot more managed – by the commissioning board. But it is impossible to argue that the essential principles behind Lansley’s original vision do not survive.

Furthermore, as many a commentator noted in the less fevered moments of the act’s passage, there is marked continuity between what it provides and the direction in which Blairite health policy was heading. It can easily be seen as an extension, a logical outcome even, not just of what Blairite health ministers had been up to but of what was intended – or at least implied – way back in 1989 when *Working for Patients* first introduced a quasi-market into the National Health Service. In the great long sweep of history, it can certainly be viewed that way.

For despite the “radical” nature of Lansley’s plans, there was little that was entirely new.

Everything – from the need for a failure regime and an economic regulator once foundation trusts were created and private sector provision expanded, to the idea of a commissioning board (arguably something that the original creation of the purchaser/provider split demanded in order to separate out policy from provision in the Department of Health), to the need for more clinical involvement in commissioning, to the requirement for some final clarity over who was to be the main purchaser (GPs or some form of health authority) – was part of the commonplace debate among health policy wonks, ministers, civil servants and NHS leaders as Lansley drew up his plans in opposition.

The new elements were perhaps three: the insistence that all GPs had to be in a GP consortia – now a commissioning group; the extent to which Lansley wanted to turn the NHS into a version of a regulated industry, creating a form of self-improving machine that required minimal ministerial oversight; and his determination to legislate for all this in such a way that it would take further legislation to change the key building blocks in the new dispensation.

Added to that was speed and the complete dismantling of the PCTs and SHAs – a by-product of coalition politics. It was the combination of those five factors that turned evolution into something that, as Nicholson argued, can be seen as revolution.

In terms of completion of the past, however, the act does indeed nail down earlier attempts to create a separation between policy and operations, the original NHS Executive, through the creation of the commissioning board – although whether, with some 3,500 staff it will be quite the “lean and expert” organisation envisaged in the white paper remains to be seen.

It may have settled a 20-year-old unanswered question over who should be the key purchaser – GPs or health authorities – by the creation of something that is an amalgam of the two: clinically led commissioning organisations.

It provides at least the potential for more clinical input into commissioning. It increases the accountability of doctors and GPs in particular for how NHS resources are spent – a long-standing goal of many a health policy analyst. And it is just possible the commissioning groups, because they are clinically led, may prove more effective at tackling poorly performing GP practices than PCTs were.

As Simon Stevens noted on publication of the white paper “what makes the Coalition’s proposals so radical is not that they tear up that earlier plan [the Blairite health reform]. It is that they move decisively towards fulfilling it”.<sup>187</sup>

Furthermore, over the past two years what the public has overwhelmingly heard amplified through both the old and new media is the voices of those opposed to, or sceptical about, the reforms. The voices of those who see opportunities in this new dispensation have been silent or muted.

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<sup>187</sup> *Financial Times*, 15 July 2010

So this might, after all – and despite the current consensus view among commentators, analysts and many senior figures in the NHS – prove over the long run to be not only the most successful piece of NHS legislation since the founding act in 1946 but its last major structural reorganisation, at least for many years. Stranger things have happened, though perhaps not many of them – particularly given the endless propensity of health ministers over 40 years to reorganise the way the service functions.

Indeed, if this does not at some level work, then the dominant thrust of health policy for the past 20 years has been heading in the wrong direction. It would be time to think again.

This close to the legislation, it is impossible to tell which version of “never again” is right.

So much will depend on how it is implemented. If all this does prove over the long run largely to work – relatively few policies are either an entire success or complete failure – the lessons to be learned, to which we will return, are somewhat different to those to be taken on board if it does not.

The consensus view right now, however, is that it will largely fail, and at many levels. For a start: can the health secretary in practice stand back from day-to-day involvement with the service? Lansley’s own actions suggest not. All restructuring of NHS hospitals was put on pause by Lansley as his first act as health secretary, before being subjected to new tests that have now in large measure been overtaken. The Government has gone from appearing to abandon waiting time targets to, overnight, re-instating them. Nurses have been told they must do hourly checks on patients, and so on.

A huge premise behind the legislation falls if in practice, when things go wrong, ministers cannot say that it is purely a problem for the board, or Monitor, or local government, or some other part of the new universe – unless the problem is deemed, as the act puts it, “significant”.

There remains a strongly held view that the NHS’s immediate problem is not how it should be restructured to produce a perfectly oiled, self-regulating machine, but how to make some £20bn of efficiency savings over the next four years – and many billions more of such savings thereafter in the years to 2017.<sup>188</sup>

On this view, the large sums to be spent on the redundancy and other costs of the restructuring will undermine that in the short term, while the sheer disruption of disbanding PCTs and SHAs and creating commissioning groups and the board will exact a huge opportunity cost, as staff are diverted to trying to make the new structures work rather than improving the quality and value of care.<sup>189</sup>

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188 *Financial Times*, March 19 2012 (accessed 1 June 2012)

189 Patrick Dunleavy, ‘With a likely cost of £4 billion, the Health and Social Care Bill has all the hallmarks of an avoidable policy fiasco’, *British Politics and Policy at LSE*, 24 January 2012,

It is true that most of the £20bn has to come out of providers, not the commissioning superstructure. But if the commissioning superstructure does not make a difference to the performance of providers, what was the point of reorganising it?

It is equally true that the 30,000-plus managerial jobs to go will in theory produce savings that over a few years pay back the redundancy costs. That assumes, however, that the management jobs will indeed prove to be redundant. In practice the commissioning groups and the board may well discover they cannot do the job on the shoestring they are being offered – so the numbers will creep back up. Indeed, it is one of the more bizarre bits of these reforms that while GPs are being entrusted with billions of pounds worth of NHS money, they are not being trusted to decide their own level of management expenditure – a cap has been set on it.

Clinical commissioning groups will now have to get involved with an enormous range of bodies – patients, patient groups, Healthwatch, health and wellbeing boards, clinical senates, clinical networks – in drawing up their plans. Local authorities will retain the right to challenge significant service changes. Although in future, in a move that may make it easier to get such reconfigurations through, they will have to take into account quality and NHS finances in doing so.

To many, this looks like a more bureaucratic approach to commissioning than the one it replaces, while the structure of commissioning groups looks increasingly like clinically-led primary care trusts. There may well be more of them, at least initially, than there were PCTs.

For some, missing from this structure is some sort of intermediate tier – call it a regional or strategic authority – that can undertake, or organise, the larger scale reorganisation of services across hospitals that conventional wisdom says is needed on both quality and financial grounds.

Nigel Edwards once famously quipped that the only things guaranteed to survive nuclear war are cockroaches and regional health authorities – and the local offices of the commissioning board [the remnants of the SHAs] may well fill this vacuum. But they will not be statutory bodies in their own right.

Monitor now has a wide range of apparently conflicting duties which may not be irreconcilable but which will take some reconciling: not just the twin duties to prevent anti-competitive behaviour and promote integration, but also tackle health inequalities, promote research and much else. Its senior executives are unclear whether this welter of duties in practice gives it much freedom of action, or whether it lays it open to endless legal challenge.

The commissioning board – certainly in the early days – will be hugely powerful. Until it approves the vast bulk of commissioning groups, it will control, directly or indirectly, the large majority of the NHS budget.



Even when all commissioning groups are fully authorised the board will still be commissioning up to half of the activity by value of some of the larger, more specialist hospitals – a position that will leave it with huge influence over their activities. Thus the apparent freedoms being offered commissioning groups, foundation trusts and independent sector providers may prove to be subject to far more command and control – far more management – than the legislation implies. Right now ministers and the board are talking the talk to reassure commissioning groups that will not be the case.<sup>190</sup> But the Centre – whether the department, the executive or the politicians – has a long history of recidivism when it comes to letting go. And NHS performance may well get worse as the money tightens.

Moreover these half dozen points do not even begin to engage with the arguments about how far choice and competition will be exercised in practice – and what effect that will have on services – or how well competition and choice fit with the duty for integration.

Even assuming these changes work, previous studies of NHS reform have suggested that things often get worse before they get better. That happened even when the changes to the NHS involved injecting more money in the early 2000s, let alone when it is flat-lining financially in the face of rising demand.<sup>191</sup>

## Scene Two: As the smoke of battle clears

So, on the argument that the reforms fail more than they succeed, what might the lessons be from the passage of the act? There are perhaps 10 of them, often overlapping.

### 1. *Have a story to tell*

What was missing from the entire exercise was a narrative, a definition of precisely what problem this mighty piece of legislation was meant to solve, and how – done in this way and at this time – it did indeed solve it.

Good policy requires a clear definition of the problem, and a clear explanation of how the policy proposals will fix it. And that explanation needs to be set out in a way that maximises support and minimises opposition. All of that was missing.

To be sure there was a case that on some measures the NHS does not perform as well as other western health systems, for example cancer mortality. On others it does. In some areas it outperforms them, notably on public satisfaction which was at an all time high. A strong case can be made that while performance on a whole range of measures had improved during Labour's tenure, it had not improved enough given the scale of the extra spending – a doubling in real terms – and commissioning had not lived up to its promise.

But in the context of a demand for massive productivity improvements, there was no story to tell about how these changes on this timetable and done in this way would help over the first four years of that enormous squeeze. Rather, in the short term at least, given the disruption they would cause, the opposite was more likely.

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190 [Health Policy Insight](#), 10 May 2012, (accessed 1 June 2012)

191 Chris Ham, '[Lessons from the past decade for future health reforms](#)' BMJ, 28 October 2009 (accessed 1 June 2012)

The white paper did set out some attractive sounding principles that did, and still do, attract support: that the NHS should be measured by the outcomes it produces, including clinical performance and patient satisfaction; that patients should be at the centre of everything it does; and that clinicians should be given more freedom to innovate in both the commissioning and provision of care.<sup>192</sup>

These, however, are ideas that it is difficult to be against. The question was: how were they to be implemented and what was the precise problem they were meant to solve? The white paper set out the means of achieving them as simply a good thing to do in their own right. The need for £20bn of savings is included almost as an afterthought – the last substantive point, point seven of the white paper’s introduction, something happening alongside this principled set of changes, rather than being driven by them.

If the definition of the problem was not clear, and if, as a result, the explanation of how the policy proposals would fix it was absent, missing too was a strategy to maximise support and minimise opposition.

Apart from an emphasis on measuring the NHS by its outcomes there was nothing in the reforms that spoke to patients – aside from Healthwatch, itself a new bureaucracy, and a slogan around more information for patients to allow them to exercise choice and have more say over their treatment – “no decision about me without me”.

As Alan Milburn put it at an Institute for Government seminar, picking up a broader analogy about the Government’s programme that was made by the Rachel Sylvester in *The Times*: “All that the Tories and Lansley talked about was the abattoir, not the hamburger – about how the hamburger would get made, not about what it would do for patients.”<sup>193</sup>

Equally, there was nothing that spoke to most NHS staff other than a message of disruption as PCT community arms were split away and as hospitals that were struggling financially were forced to try to make it to foundation trust status – Labour’s unfinished business.

There were really only two audiences that this reform addressed directly. First the family doctors, among whom there were some undoubted enthusiasts for GP commissioning. Many, however, had no particular wish to be involved. Dr Michael Dixon, chairman of the pro-commissioning NHS Alliance, says that the idea that commissioning would be so wildly popular with GPs that they would simply adopt it wholeheartedly was “clearly a misjudgement”.

“And what we didn’t anticipate was the extent to which some of our peer GPs would have an ideological commitment against venturing outside the surgery and having a real hand in allocating resources.”

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192 Department of Health, [Liberating the NHS: Legislative framework and next steps](#), 15 December 2010 (accessed 1 June 2012)

193 Institute for Government seminar 27 March 2012

The second audience was managers – the people who would, in practice, have to make much of this happen. They, however, were simply being told they were going to be sacked in droves, but that didn't matter because they were ineffective “pen pushers” and bureaucrats.

The reforms, as presented, spoke to no-one else: not just hospital doctors, not hospital and community staff as a whole, who were there simply to be commissioned (and not merely commissioned but faced with more competition) and not to patients or the public. From beginning to end, there was no narrative. A major communication failure over a set of changes that were so complex, and so much to do with the wiring, that they proved impossible to explain.

Perhaps the most telling assessment of the problem comes from the mouth of Simon Burns, the health minister who took the bill through the Commons: “You cannot encapsulate in one or two sentences the main thrust of this.”<sup>194</sup>

Today, Andrew Lansley says: “I was always clear, with my colleagues, that if we did not do this, the result would not be a quiet time. If we did not do this thing the result would be a crescendo – a rising profile of serious problems across the NHS all the way through to a potential financial and performance crisis at the latter stages of the parliament. And in order for that not to happen, fundamental reform was necessary, including, and this is not unimportant, the achievement of a major reduction in administrative costs and delivery of those resources to the front line. It will achieve that.”

## *2. Beware lack of internal challenge*

This is a difficult one. After all, civil servants complain when they get a minister who is ignorant or does not know his or her mind. But in this particular case, one issue has to be Lansley's unprecedented length of tenure in the health job in opposition.

After the trouble the Tories faced at the 2005 election over the “patient passport”, Lansley had played an important part in the “detoxifying” of the NHS as an issue for the Conservatives.

As document after document was produced around his ideas, Lansley became, within the Conservative party, his own health policy expert. His position became more or less unchallengeable.

“If you talked to Andrew about this [in opposition] he always had some very well thought through and argued answers,” according to one Number 10 adviser who helped oversee some of the many policy documents that the party published on Lansley's plans. “And it was always a relief in a way. But I think the danger is that because he'd thought so long about all this stuff he had a perfectly formed system that was too abstract and rational in a way, because it had been so long in his head.”

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194 BBC Radio 4, The Report, 22 March 2012

Because he had cornered the market in Conservative NHS thinking, there was very little internal challenge. Those who did have a grasp of the plans, indeed helped develop them – Osborne, Cameron, Letwin – went along with them. And as he was not a natural communicator, it is transparently clear that huge swathes of his parliamentary colleagues, let alone the country at large, had no real idea what he was up to.

The transition to government was another key moment. Here it seems plain that Lansley cooperated with the Conservative transition/implementation team less than any of his future Cabinet colleagues. This was another moment when the party's relative lack of health expertise - or its refusal to use the expertise it in fact had, by running the politics as well as the policy of the plans past Dorrell or Ken Clarke for example – came into play.

There was a lack of challenge, not just over whether the policy was sound, but over whether it remains politically wise given the NHS's and the country's changed financial circumstances since the proposals were first drawn up.

*3. Don't go quiet on plans ahead of an election; or misrepresent them. Do recognise that the world can change.*

It is easy for non-politicians to say politicians should be more open about ideas that may not poll well ahead of an election. But the decision to stop talking about the wiring and provide merely reassurance on the NHS meant that the service itself and the public were told less and less about these changes the closer it got to election day. Clearly, in terms of the professional and public reaction, a heavy price was paid for that.

The same applies to the repeated mantra of “no more top-down reorganisations” ahead of the election when clearly a significant reshaping of the NHS superstructure – even without the abolition of PCTs and SHAS – was planned. A new commissioning board and a statutory economic regulator are significant changes in their own right.

And that ties in to a failure to recognise that the world had moved on from 2006 and 2007 when that formulation was first put together.

For a start large parts of Labour's business, which should have been completed in 2008 or 2009 – the shift of most hospitals and mental health services to foundation trust status, the separation of provider arms from primary care trusts, for example – remained unfinished, for good reasons as well as bad. As the Government is discovering, without lowering the bar, getting all hospitals into a sufficiently financially robust state to become foundation trusts is not easy. And if the bar were to be lowered that would merely be storing problems up for the future.

Second, Lansley more or less declined to recognise that Labour had since then created a Co-operation and Competition panel that was in fact applying EU law to NHS procurement. He didn't want to use it, opting instead for his preconceived idea of turning Monitor into the regulator – even though the panel was eventually to live on as part of the reformed Monitor.

And third, there was the money, which had changed radically since 2007. If there ever was a narrative that could explain how these reforms – done in this way, at this time, and with all their disruption and costs – were going to contribute directly by 2014 to the £20bn of efficiency savings needed, then it was never found.

In the longer run, as Letwin had argued before the election,<sup>195</sup> these changes might indeed improve efficiency and outcomes – even if many currently doubt that they will, given the form in which they have finally emerged. How they were to contribute over the next few years of immediate spending pressure was never articulated – probably because there never was a way of explaining how they would, given that the key changes would not in any case take effect before 2013.

#### *4. The coalition negotiations; take more time, involve some expertise*

An absolutely critical moment was clearly the way the programme for government was put together – again without the advantage of any health expertise and with no involvement from the health department. The Civil Service offered help but it was rejected, the exercise being seen as a purely political one. That, of course, applied to other parts of the coalition programme. In health, however, it proved critical.

The Downing Street team created a version of primary care trusts that made no sense to anyone. It was the need to unpick that, and to try to meet Liberal Democrat demands for a greater say for local government in health, that turned what was already a sweeping set of reforms – GP commissioning, a new board and a new regulator – into a massive structural upheaval.

Unpicking the programme for government led to the shift of public health to local government and the consequential abolition of primary care trusts and strategic health authorities. As one official puts it: “the death warrant [of PCTs] was signed by the Liberal Democrats” as their insistence on some more democratic involvement in health combined with Lansley’s by now “black and white view” that all GPs must be involved in commissioning.

It was the scale of the resulting structural upheaval that allowed the plans to be written up as “the biggest reorganisation in NHS history” – something that clearly most Conservative MPs, let alone the public, did not believe they had signed up to ahead of polling day.

It propelled from the inside pages to the front page what could otherwise have been a somewhat dry story about a new independent board, and what might otherwise have seemed a rather technical bill to give an existing advisory body – the competition panel – statutory powers. It made the bill spectacularly larger than it would otherwise have been as the residual duties of PCTs and SHAs had to be redefined.

It is crucial to recognise that there would have been major changes to PCTs and SHAs whoever won the election – at the very least a marked slimming of their numbers as a contribution to the efficiency savings. It would never have been business as usual. In all

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195 Oliver Letwin, ‘Tories have no lack of policies’, *Standpoint*, pages 41-42, October 2009. (accessed 1 June 2012)

likelihood, however (one can never know) that would have been done within existing legislation.

All that, coming so soon after the reintroduction in the programme for government of the promise of “no more top-down reorganisations”, was clearly risky politics. It was a product of coalition policy making by ministers, with neither putting the propositions to their parties.

The Conservatives do not have a natural way of doing that. But the Liberal Democrats do, it being the last of the three major parties to have a policy-making machine that, at least up to a point, involves its members.

Because the reforms then differed to the programme for government it allowed those among the Liberal Democrat grass roots who opposed the proposals to argue that they had never signed up to key elements of the plan. “We signed up to that, not to this”.

All that clearly makes a case for taking more time, involving more people, and drawing on at least some departmental and policy expertise, when forming not an initial coalition agreement, but a more detailed governmental programme.

As David Laws, a member of the original coalition negotiating team, put it at an Institute for Government seminar: “I think [on another occasion] there needs to be a slightly more deliberative and consultative process, although that must not be done in a way that allows the parties to renegotiate the agreements that they have already made.”<sup>196</sup>

## *5. The need for a strong centre*

The programme for government also displayed the weaknesses of Number 10, and the mistake, now acknowledged, of disbanding the old policy unit, staffed by people with subject expertise.

That was reinforced by David Cameron’s initial approach to how he wanted to govern – acting as chairman of the board rather than chief executive, seeking to trust key Conservative ministers across a range of crucial policy areas, not just health but schools, benefits and welfare to work.

Throughout most of this story, certainly until it was too late, the mix of check, challenge and political sensitivity over what departments were up to that Labour’s arrangements provided in Number 10 – notably on health but also in other areas of government – was missing. In seeking to abolish Labour’s targets and micro-management from the Centre, Cameron and the Coalition had thrown out the baby with the bathwater.

In December 2011, the policy unit started to be rebuilt in the wake not just of the furore over the NHS reforms but the failure to spot a number of other issues that failed to fly – the Forestry Commission sell off for example – along with a sense that the Centre did not have a firm enough understanding of what departments were up to.

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<sup>196</sup> Institute for Government seminar on Transitions, 28 November 2011

The revived policy unit, however, still does not have the acute political antennae that the Blair unit often displayed. Partly because it has to serve both a Conservative prime minister and a Liberal Democrat deputy, it is staffed by civil servants rather than the mix of civil servants and political animals with policy expertise that characterised the Blair years.

The question can also be asked why senior civil servants in Number 10 did not spot the need for more oversight from the Centre of the health reforms, or insist on it. This study cannot answer that question. But part of it must lie in overload – that the Coalition was doing so much so fast in so many areas, while also drawing up huge deficit cutting plans, that the health proposals simply never got to the absolute top of the agenda until it was too late.

The centre of government, in the sense of the Cabinet committee structure, also failed to grasp how big a political battle it was launching ahead of the white paper – a white paper made much more structurally radical by the existence of the Coalition.

The meeting of the Coalition Committee just ahead of the white paper clearly did, for a moment, grasp the fact that it was about to propose something that was neither Lansley's original plan, nor the programme for government proposals – and that it clearly contravened the programme for government's promise of "no more top-down reorganisations".

However, neither that meeting, nor the gatherings of the Home Affairs Cabinet Committee, chaired by Nick Clegg, led to any proper reconsideration of whether this was a wise thing to do in all the circumstances. A genuine pause for thought at either stage might have led either to something of a rethink, or to a far better strategy for communicating what was to done.

#### *6. The role of the Civil Service: recognise the weakness of the Civil Service in the face of a determined minister; weigh up sound advice.*

This, like Lansley's tenure in health, is another complex area. At a change of government – or even a change of minister – the Civil Service can be at its strongest if the minister does not know what they want to do. Faced with one who knows pretty much precisely what they want, departments are there to serve.

The bitterest opponents of the bill believe the department should have done far more to stop its minister. The Civil Service, however, is there to serve the government of the day, so long as what it is up to is not itself illegal.

To the suggestion that top officials should have gone so far as to seek a formal direction from Lansley over his plans – well, that is not the way the world works. Formal directions (and there have been more of them recently<sup>197</sup>) come essentially over issues of value for money or legality – over the decision to spend money on the Pergau Dam in Malaysia to take an early example, or John Denham's more recent insistence as communities secretary

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<sup>197</sup> 'A sense of direction', *Civil Service World*, 29th March 2012 (accessed 1 June 2012)

that it was worth spending several million pounds to revamp Blackpool Tower.

As one official puts it: "This was the policy of the Coalition government. You cannot have a set of senior officials taking on the elected government of the day and saying 'we are not going to do it'."

What is nonetheless clear is that department felt at its weakest in the face of an absolutely single-minded incoming minister and government, and shorn of the support it might otherwise have received from a stronger centre.

Civil servants are not politicians. They were, however, acutely aware of the potential political ramifications of Lansley's policies. But in the absence of a policy unit, and amid the tsunami of other legislation and the creation of the deficit reduction plan, there was no-one to listen when they tried to find out just how much political backing – and crucially how much political understanding – there was for the Lansley plan.

Sir David Nicholson did present it at one of the permanent secretaries' regular Wednesday meetings just ahead of the bill. "There were a lot of very good points made all around the table, not least of which was whether the performance of the NHS would suffer as all of this went through," according to one account.

"There was a general reaction that 'ooh, we knew we had some pretty big reforms going on, but we had health down as one of the more business as usual areas. This does sound pretty radical'. But that was kind of it. You have to remember the context – that at the time we were getting one of these a week. So the welfare one – 'you are going to do what? – move to a single benefit while joining two computer systems together?' The justice reforms: huge. Gove and his education reforms: pretty massive. We weren't short at the time of people bringing reforms to the table that you could see from outer space."

Within the department there are differing views over whether it over compensated for the lessons learnt from the transition from Conservatives to Labour in 1997 and tried too hard to meet Lansley's wishes.

One official says: "I have thought about that quite a lot ... And I don't know the answer ... If you talk to people who were in the room at the time of these discussions, we had some pretty big arguments about all of this. We didn't just kind of lie back and not do anything ... But I think the department was over-zealous in its attempt to please ministers, to delight ministers. Very much so."

Others take a different view and it is clear that the department did spell out the risks – indeed the lengthy battle not to publish the risk register itself demonstrates clearly that it did so. Nicholson spelt the risks out in public.<sup>198</sup> It also warned the health secretary that there would be a mighty row about all this – and Lansley acknowledges that.

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198 See pp 53,64 and 66 though these may change in editing



Furthermore it did offer the alternative of much less, or even no, legislation, although quite how vigorously it pushed those options is unclear. It did suggest that an engagement exercise to try to win some friends for these proposals would be a good idea. The health secretary wanted none of that; he was determined to press ahead regardless.

But to illustrate the complexity of this issue, the department, having felt weak during the construction of the white paper may now feel relatively strong as the bill moves out of Parliament and on to implementation.

From the beginning that has been Sir David Nicholson's key concern: the combination of the transition to the new world and its implementation. Relatively few ministers (Lansley may prove an exception) are interested in or good at implementation. And history shows that even among those who are, very few last long enough in post to see through the legislation they have passed or framed: neither Clarke, nor Milburn did.

Finally, when asking what the Civil Service should or should not have done differently, it is important to remember that it is not an institution with a single voice, however much its proponents and critics may treat it as such. Within the department there were differing views of the merits of different parts of what Lansley was trying to do. The white paper and bill were the outcome of those internal debates and the decisions the health secretary took.

### *7. "Legislation should be an accurately targeted rifle shot, not a carpet bombing"*

A critical question is how far all this could – as Lansley himself once remarked and indeed acknowledged in an interview for this study – have been done without the legislation. The answer to that depends on what is meant by "this".

Certainly the national board could have been set up as a health authority, or even as a purely administrative entity, and been given its mandate. After all, no-one ever legislated for the NHS Executive. The Co-operation and Competition Panel could have been left to apply the EU-based principles and rules of competition, with ministers determinedly taking its advice. PCTs could have been heavily cut in number with GPs put in charge of them. Ministers could have taken a vow of chastity and resisted too much day-to-day involvement in the running of the service. Local government could have been given a bigger public health role through grant mechanisms. No legislation would have been needed to do any of that. "You could have done virtually everything without it," one official says.

All that, however, would have relied on a change of behaviour by ministers that later ministers could change back. And even then there would have been controversy over the big reduction in the number of PCTs and SHAs that was inevitable whoever won the election.<sup>199</sup>

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199 See page 49 tho this might change in editing

A less minimal version might have involved making the board and the existing competition panel statutory. That could have been done in one bill, or two spread over time. Making the competition panel statutory would, nonetheless, have been a major piece of legislation; creating Monitor as the economic regulator accounted for more than 80 of the clauses in the Act.

Those steps alone – legislating for the board and the regulator – would not have been without large-scale controversy. More importantly from the health secretary’s point of view, they would not have put in place in one step the “consistent, coherent and comprehensive” set of reforms that was Lansley’s central aim. The perfectly functioning universe or “clean sheet of paper” as Dorrell puts it, that would have been alterable only by another bout of legislation. And Lansley was not interested in anything but the full works, including GPs statutorily responsible for the spending.

“He had this story he wanted to tell about how, after five years, I want to be able to put my feet up in the Department of Health and not worry about the NHS – taking the politics out of it and all that stuff,” one official says.

“Andrew really did want to make a new constitutional settlement most of which wasn’t really necessary when you cut it. You could set up the NHS Commissioning Board without it, you could have done virtually everything without it.”

Lansley’s own take on the “no legislation” or “minimal legislation” routes is clear. “The point was I said much of this could have been done without legislation. But I went on to say that nobody would believe it would be something that would be entrenched for the future.

“And yes, I could have put a bunch of GPs on PCT boards. But it wouldn’t have lasted because the system would have taken over again, and the moment I walked out of the door the first thing they would have had was a submission saying we have to reconstitute the boards of PCTs. And the GPs would not have done it ... they would not have joined in because they would not regard it as serious if we did not legislate for it. Because they had been there before, with fundholding and practice-based commissioning.” It would not, Lansley says, “have been permanent”.

Monitor’s powers, he says, could not have been extended without the legislation and the commissioning board would not have been permanent. “We have been here before. This is the point of so much of this. The NHS executive was designed to be that [a form of independent board] and it ended up being completely enmeshed in the department. You have to legislate for these things. The statutory provision makes the difference. It entrenches it.”

Even so, there has to be an argument for minimal legislation. Not just in the NHS but across departments – in criminal justice and education for example – governments legislate too much, perhaps because ministers see that as the way to make their mark. That particularly applies if a central assumption of the act – that ministers will in practice be able to stand back from the running of the service – proves inoperable.

The legislation also raises a much more fundamental question to which only time will provide the answer. Is it better, as the act does, to try to nail down, transparently and in a way that can only be altered by another piece of legislation the way the NHS should function? Or, for all the way it has seen management policies adopted, dropped, reinvented and altered, is the sheer flexibility of the earlier legislation in fact an advantage? What is the balance of gain and loss here?

## *8. Revolution v. evolution*

This applies to both the policy and the politics. The no, or minimal, legislation route would clearly have been an evolution rather than the revolution that it came to be seen. Evolution – certainly if it involved legislation on the regulator and board – would doubtless have caused a deal of controversy in its own right. But probably not the knock-down, two-year, 15-round fight that the NHS bill became, with all its attendant political damage. In policy terms, a quieter, more evolutionary, approach might even have got at least some of the changes in more quickly than will now prove the case. That, however, did not happen for all the reasons set out in the narrative – chiefly that incremental change was never the goal of the legislation.

The issue also plays into political tactics as well as policy strategy. Michael Gove, Iain Duncan Smith, Chris Grayling and others all went out of their way to emphasise – while still scoring their party political points – that much of what they were doing was building on what Labour had done: evolution not revolution.

In an institution held – rightly or wrongly – in such sacred regard as the NHS, avoiding the sense that the whole apple cart is being turned upside down is probably even more crucial than elsewhere.

Lansley was never really prepared to do provide what one Number 10 adviser describes as “a kind of bipartisan heritage for the reforms”.

“Andrew never tried to generate one by paying at least lip service to what Milburn and others like him did, who were genuinely trying to move to a more patient-centred NHS rather than a top-down one. Not in the way Gove, for example, lavishes praise on Andrew Adonis.

“He was quite closed and stubborn in a way. So when times got tough the pro-reformers are against you as well. So there is no Milburn or Corrigan or people like that saying, ‘do you know what? There’s something in this’.”

In practice, there were a few voices – such as that of Julian Le Grand – prepared to do that, as the narrative above makes clear. But nowhere near enough.

Nick Boles, MP for Grantham and Stamford and head of the Conservative’s implementation team ahead of the election says that, “with the benefit of hindsight, which is a wonderful thing, maybe the introduction and implementation of these reforms would have been less painful if we had done that more and acknowledged that a lot of what we were doing was building on what Labour had done, not least because it would have made it much harder

for Labour – in the way it has unscrupulously done – to oppose many of the things that are in fact extending what they were doing anyway”.

In the first draft of the white paper, there was a decent-sized passage explaining the continuity of the reforms, according to civil servants. It got excised.<sup>200</sup>

### *9. Don't overestimate how far key arguments over reform have already been won*

Again with the benefit of hindsight, it is clear that the Conservatives massively overestimated the degree to which key arguments over NHS reform – notably over choice and competition – had been won.

Labour's Blairite ministers may have been using and extending those twin tools from 2001 on. Labour may, as Kenneth Clarke noted on the 60th anniversary of the NHS, have introduced the use of the private sector on a scale that would have put the party “on the streets” if the Conservatives had tried it in the 1980s or 1990s. Labour's 2010 election manifesto may, on a superficial reading, have been easily read as a pretty Blairite document on health.

But it turned out that the argument over competition and choice had not been settled inside Labour. That is crystal clear in hindsight given the party's opposition to these elements of the bill. But the fact was entirely visible even when Labour was in power. It is not just that much of the oomph went out of the pre-existing NHS reforms when Gordon Brown became prime minister. The Conservatives had watched Andy Burnham adopt his NHS “preferred provider” approach when health secretary in 2009.

Burnham had renewed orders for the provider arms of PCTs to be separated out in the months running up to the general election. But his preferred model was that they went to NHS trusts and foundation trusts as a way of providing integrated care, not greater competition. And Milburn and others had been attacking in public Burnham's shift to “preferred provider”, and the Brown administration going soft on competition.<sup>201</sup>

The white paper and the bill led to all those wounds re-opening. There may indeed have been an element of “unscrupulous” behaviour by Labour as the Tories saw it – though it would have been naïve for them to believe that Labour would not find grounds for opposing Conservative changes to the NHS. But it was also a case of the party fighting anew and within its own ranks battles in a war that had not been won. Milburn and others may have been urging Labour not to abandon choice and competition during the passage of the bill, but others wanted to, and Burnham, Healey and Ed Miliband clearly wanted it to play a role far smaller than Lansley wished, or indeed than the Blairites wanted.

The unresolved nature of the issue within Labour provided party political support for others opposed to choice and competition, whether from genuine concern about its impact on the NHS, or from a vested interest.

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200 See p. 57

201 *Financial Times*, 28 September 2009

Worse still for the Conservatives, was that their coalition partners, the Liberal Democrats had even less of a clear idea about what they thought about the twin issues. The Orange Book liberals favoured competition and choice. The ex-SDP part of the party had mixed views. The old Liberal left was opposed. The party in its 2005 manifesto had argued that rather than choice, all that patients really wanted was a good hospital at the end of the road. Its 2010 manifesto did endorse an element of choice and competition, but in highly convoluted language to ensure there was no internal party row. Earlier, non-manifesto, Liberal Democrat documents were more clearly in favour.

Never having been in government, the Liberal Democrats had not had to reach a resolution on where they stood on the issues. That led to the remarkable sight of the Liberal Democrats – *while in government* – attempting to decide what their attitude actually was to choice, competition and the use of the private sector. They did so over three party conferences – spring 2011, the autumn annual conference, and spring 2012 – while debating the issue within their own ranks in Parliament.

Thus both Labour and the Liberal Democrats provided far more fertile ground for political opposition on these issues than the Conservatives had assumed.

### *10. Build a consensus; or at least some support*

“I thought we had learned the lessons,” says Clive Smee, a former chief economist at the health department who while in office wrote two papers on how to do NHS reform, based on his and the department’s experiences of the 1989 *Working for Patients* white paper and the NHS Plan of 2000.

The conclusion on the 1989/1991 reforms was two-fold, Smee says. First that the then Conservative government and the department could have done a better job of communicating the need for change. “It is actually quite difficult, if you look at *Working for Patients*, to see why there was a need for change,” Smee told the Nuffield Trust’s annual health summit in 2012. A case for it was written for that white paper, he says. But it got excised back then, just as it got excised in 2010.

By contrast for the NHS plan in 2000, “more time was devoted by civil servants and political advisers in that paper to why the health service needed to change than any other. That was completely forgotten in 2010. So we had the same argument again about ‘why are we doing all this?’”

“The second point was obtaining ownership as far as one can from the public, the staff and key interest groups before you produce your white paper, not afterwards. Again completely forgotten in 1989, but masterfully orchestrated in 2000 by Alan Milburn by getting all the vested interests to sign up to a preface, having had a chance to comment, with major public and staff consultations.”

Not everyone, he acknowledges, will agree with the proposals of the government of the day. But a case for change can be constructed and some support flushed out into the open.

Smee might have added to the 2000 plan, the 2006 exercise around changes to community services and the much more recent exercise by Lord Darzi, the Labour health minister, in getting the NHS to sign up to the increased publication of outcome data as a means of raising quality.

"I thought we had learned the lessons," Smee says. "Now maybe the Department of Health has had so many reorganisations since 2000 that they have absolutely no institutional memory, or maybe they faced a government that was so determined to forget the lessons of the past that the civil servants were ignored. Those seem to me to be the simplest lessons to learn. And they apply not only to health."

The answer to Smee's question about whether the department had forgotten, or had been ignored, has to be the latter. Although, facing a newly elected and very determined government, and having no allies elsewhere in Whitehall, it was wary about how hard it could push its advice. But under the "breakneck coalition" in general, and Lansley in particular, there was no desire to take time to argue the case for the white paper ahead of its production. When an attempt at such a "big tent" was made – the pause – it was too late.

"We did offer an engagement exercise," one official says. "His response was 'I have been shadow secretary of state for six and a half years and I've done all the engaging I need to do.'" That view still held when it was pointed out to him that it is the disaffected who are keenest to talk to politicians in opposition, and that people might say one thing to him in opposition, but another in government.

Asked now what he would have done differently, Andrew Lansley says that having different style of consultation to simply issuing the white paper and asking for responses is an important lesson. "A better thing to have done would have been to have had the Future Forum in the autumn of 2010 [after the white paper and before the bill]. Then we would probably have hit the legislation in early 2011 in a stronger place to have made some of the amendments that we subsequently made."

Having senior people from within the service "engaging thousands of people across the country in an active conversation about what their expectations are, what their response is ... that gave us a whole load of good stuff". It is, he now says, "an important lesson" ... one that is "a transferable lesson to the rest of government". Burstow, too, says "we relied too much on traditional methods of consultation" rather than "co-producing" the white paper. "We had to co-produce retrospectively which is what the Future Forum was about."

In practice, however, Lansley largely declined to engage with his critics. It was not just that the original consultation on the white paper was "all transmission, no reception".<sup>202</sup>

"If people were opposed to it they were either ideologically opposed or they simply hadn't understood it," one official says – something that Lansley confirms in his own words, citing the vigour of the BMA's campaign.

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202 See p 69

If they had not understood it, however, that was never quite his fault. As he put it to the Royal College of Nursing: "I am sorry if what I am setting out to do has not communicated itself."

Or his assessment that what had become "obvious" when the row erupted over the bill and ahead of the pause, "was that, firstly, lots of people had not really read any of this and, secondly, that even if they had read it they had not really understood it or engaged with it".<sup>203</sup>

Shirley Williams, who played a key role within the Coalition on the amendments to the bill and who was to be named *The Spectator's* Parliamentarian of the Year for her efforts, says of Lansley: "I have met him in my whole life for two minutes. He never, ever, asked me to come and see him, ever. And on the occasions when I have rung up the department and said I would like to come and talk to the minister I was always given the brilliant Earl Howe."

Asked whose fault it was that people did not understand, Lansley, says: "What's not to understand?" He adds that: "To be honest, it is an idle pursuit to imagine that you could ever get to a place where the great bulk of people understand how the internal workings of the NHS work. They never did and never have done. And there is a degree of why would you want to?"

"If you know that doctors and nurses are responsible locally for commissioning, there is a national commissioning board that ensures fair allocation of resources and does national specialised commissioning, on a level playing field for all providers, and we continue to have quality inspection?"

"People wanted to agitate. They kept saying 'we don't understand it'. And I kept saying 'what is there not to understand about that?'"

### Scene Three: An act is still not action

Aside from the lessons that might be learnt, there are some observations worth making. The first and most important of these is that passing the legislation is not the same as implementing it. Indeed implementation has proved the Achilles's heel of previous attempts to reform the NHS on these lines. And despite the goal of "nailing down" a set of "permanent" changes, with "autonomy" built in, the act does not guarantee that will happen.

In fact, huge uncertainties remain. Take just a few. How detailed will the commissioning board mandate eventually be? How focused purely on outcomes? And how prescriptive? A page of A4 – or 30 to 300 alleged priorities or targets? And will one minister make the mandate slim and another large, effectively using it as a way to manage the service despite all the autonomy provisions? It will depend on what happens.

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203 Management in Practice, 'Lansley admits Health Bill's 'fundamental principles' remain', 18th April 2012, (accessed 1 June 2012)

There may be an autonomy clause, but the secretary of state retains strong powers of appointment and dismissal, plus the ability to intervene in cases of “significant” failure. The definition of significant, while it has a legal meaning, will doubtless vary from one minister to another. The commissioning board, partly for reasons set out above, has the capacity to be a very powerful beast. How will it exercise those powers, not just in the first year of these reforms but in succeeding ones? Just how will Monitor behave within its now complex remit? How will local authorities seek to use their new-found influence? As a partner in changes that the NHS requires, or as an antagonist to it?

Guidelines have been set for what the board commissions and what falls to the commissioning groups. But that line is not in legislation. A change of balance there over the years could change the balance of how the act operates.

As one civil servant notes, for all the “permanence” Lansley sought in the legislation “there is a lot of flexibility in the act ... the big question is will there be the willingness for all those involved to work with a common purpose rather than getting out the act and questioning their powers to each other? If that happens, it will fail. It will be behaviours that decide whether it succeeds or fails”.

On this view, what needs to change is the culture and behaviour within the NHS, which in turn begs the question of how much can legislation actually achieve that?

Furthermore, throughout his tenure to date at health, Lansley’s focus has inevitably been on getting the bill through. Implementation and risk control has been Nicholson’s domain. For as long as he is there, and Lansley’s tenure has already almost reached the average for a health secretary, how good will he prove at implementing these big ideas rather than dreaming them up? Most ministers believe too easily that to pass the legislation is to have implemented it. Will the current health secretary fall into that camp?

A second observation is that the act is a prime illustration of just how important the Lords has become as the amending chamber – and arguably even more important given that there is a coalition. All the changes of substance were made in the Lords.

Lords’ debates barely get reported in the mainstream media. And it is true that a reading of them in this case illuminates the issues rather than explains what happened. What happened is that it became clear that on certain issues there was common cause between cross-benchers and significant elements across all three parties in the upper chamber – common ground that threatened defeat in a house whose preferred solution to problems is to seek a consensus if one can be found. As a result deals were done between peers and Earl Howe, and between Howe, Lansley, Clegg and Cameron.

Third, although the internet and social media have been around at growing scale for a decade, this was the first piece of government legislation to be seriously battered by them. The emergence of 38 Degrees, the use of email, Facebook and Twitter to organise opposition and later on to put pressure on the royal colleges had a real impact.



By the end, this may have become counter-productive. Some of the internet commentary was sufficiently abusive to generate sympathy from cross-benchers for those such as Shirley Williams who wanted to amend the bill not kill it; with that sympathy helping ensure the government got its bill, even if it was an amended one.

To this day Williams remains angry that the Liberal Democrats are painted by opponents as wanting all NHS hospitals to earn up to 49% of their income from private patients when the purpose of that change, in her eyes, was to limit the application of competition law. "The argument was put out on all the social networks that the Liberal Democrats had accepted 49% in all foundation trusts," she says. "That never was true but it was like chasing after a departing car, you'd never catch up with it, and we haven't caught up to this day. People still believe it."

By contrast, while the internet has become a powerful tool for opposition, the Government has yet to find a way to use it back, other than to try to correct what it sees as outright misrepresentation. If there is a way to use it to make its case in a way that does not appear to be simple propaganda, it has yet to find it.

Fourth: the story illustrates yet again just how hard it is win the argument for change in the way health care systems are run. More than any other public service, health care touches everyone and their friends and relatives throughout life. No other public service has such a vast range of professional interests whose interests do not always align with each other – witness the campaign by nurses to be involved in commissioning. Furthermore the interests of these groups, despite their rhetoric, may not always align with those of patients. Feelings run high. And suspicion over the profit motive runs deep, even if at the same time polling shows that most of the public does not mind if they are treated in public or privately run facilities so long as their NHS care remains free at the point of consumption.

All that may be exacerbated by the tax-funded nature of the NHS. But it would be a profound mistake to believe that this is unique to the UK. There have been huge battles over health reform in other countries, including those with social insurance systems. France, for example, saw strikes by doctors and nurses over reform in the not so distant past. In the US, which has the lowest level of tax-funded health care among leading Western democracies, "Obamacare" has been bitterly divisive. There, even attempts to introduce NICE-style organisations aimed at restricting spending to cost-effective care, have led to allegations that "death panels" are being formed. In other words, reforming the delivery of health care is just difficult.

Fifth: will this prove to be this government's poll tax? This has to be a personal view. My suspicion is not. It may feel like that this close to the heat of the battle. But Clarke's reforms generated at least as much controversy as Lansley's, yet – launched later in a parliament than these changes – they proved anything but decisive in the 1992 campaign. Then the focus, in a recession, was on the economy and who the electorate trusted most to leave it better off.

Admittedly the Clarke reforms in 1991 were lubricated by a huge short-term increase in spending and that clearly will not be available this time. This is not to argue that the NHS will not loom large at the next general election. But when it does it is likely to be far more over the effects of the big financial squeeze that the NHS is undergoing rather than whether these changes have caused the problem. The two will, of course, be conflated. But by 2015 – assuming it is 2015 – it will be hard to make the argument that these reforms are the root cause of any perception that the NHS is in crisis. It will be the money, stupid.

### Scene Four: A very different conclusion

The “lessons” above stem chiefly, though not entirely, from the currently accepted wisdom that the reforms have not just been a short-term political disaster but will prove a long-term policy one.

If that proves not to be the case, different conclusions will be drawn. Any assessment of the passage of the act has to take into account what the health secretary was trying to do – however badly he explained it on the way.

To the charge that he has squandered the huge political capital that David Cameron had built up by “detoxifying” the NHS as an issue for the Conservatives, Lansley would probably reply that he had spent it well putting in place a set of reforms that will pass the test of time.

As a former civil servant, Lansley understood the intricacies of legislation. All down the line, he got the requisite clearances from Cabinet committees. He had the advantage of an unusually long session of Parliament, the longest since 1945. On his calculation the bill became law only two months later than the original timetable. And, for all the endless criticism there has been of his political skills, his view as a politician was that he had only one chance of getting this through.

The immense speed with which the white paper and the bill were introduced was entirely intentional. Indeed, Lansley had originally wanted a paving bill ahead even of the white paper to ensure that he got the basic building blocks of his reforms in early.

To have gone slowly, to have done it in stages, would have risked a repeat of what he saw as the failed history of NHS reform over the previous decade and more.

To the charge that because everything was not done at once as a comprehensive set of changes, set down in legislation, there had been endless backsliding, reinvigoration and re-invention – to be followed yet again by non-completion – of the measures that both the Conservatives and Labour had introduced over the preceding 20 years, “his view was basically that ‘I had to do it under the radar, given that I couldn’t put it in the manifesto,’” one civil servant says, “‘and I will run very, very fast’. That if he tried to achieve a consensus, he would only have got 50% of what he wanted ... while going for 100% he would get 85% or 90% of it. And run – very, very fast”.

Or as Lansley puts it: "The evidence of the past was very clear: that because the nature of the legislation was that you change the secretary of state and you can change the policy on virtually everything in the NHS, because the health service at any given time was basically what the secretary of state under the legislation decided it would be."

The point of the act, he says, was to make it "permanent". "What I set out to do was entrench a consistent and coherent structure of reforms so that the NHS would be able to take a more autonomous long-term view of their own role ... [knowing] that things would not change just at the behest of a change of secretary of state, or even more a change of government." He adds: "I think the chances now of the architecture of the NHS becoming stable are much higher."

Two very powerful groups, he says, local authorities through health and wellbeing boards, and clinicians through commissioning are now "thoroughly engaged". And because of that "even a government that thought about it would now balk at reversing what is in the act".

His other argument for the speed is that "you can have big rows in the first two years of a parliament. It is best not to have big rows in the last two years of a parliament. And my colleagues are very clear why pushing forward, doing this now, reform now, enables us to focus on improvement without anything else getting in the way. There will be constant focus now on improvement for three years to the next election".

He concedes that the judgement the electorate will make "will be overwhelmingly determined by what has actually happened ... by April 2015 have we actually improved the quality of services for people in the NHS? And the answer is yes, we will have done".

The consensus view, right now, is that the money, or lack of it, will have overwhelmed that.

If the act proves even a qualified success, and the new structure lasts for a significant period without another bout of "re-disorganisation" Lansley will emerge as an unlikely and somewhat awkward hero of public service reform – a Ken Clarke for his day. If it does not, all the strictures will apply: about appalling communication; the huge financial and opportunity costs of such a large-scale change in the face of an enormous financial challenge; about too great an obsession over defining and driving a public service market, while somehow taking politicians out of it; and about how in doing that the case for such reforms has been set back. Time alone will tell.

If that is the case, however, this will be fifth or sixth successive failure in 20 years to get commissioning and the purchaser/provider market really to "work" and deliver undoubted and big benefits, which, as Ken Clarke observed on the 60th anniversary of the NHS, will raise its own questions.

*“All truth passes through three stages. First it is ridiculed. Then it is violently opposed. Then it is accepted as self-evident. We are somewhere between stages two and three at the moment. I am hoping that three will arrive before May 2015.”*

*Andrew Lansley quoting Arthur Schopenhauer*



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