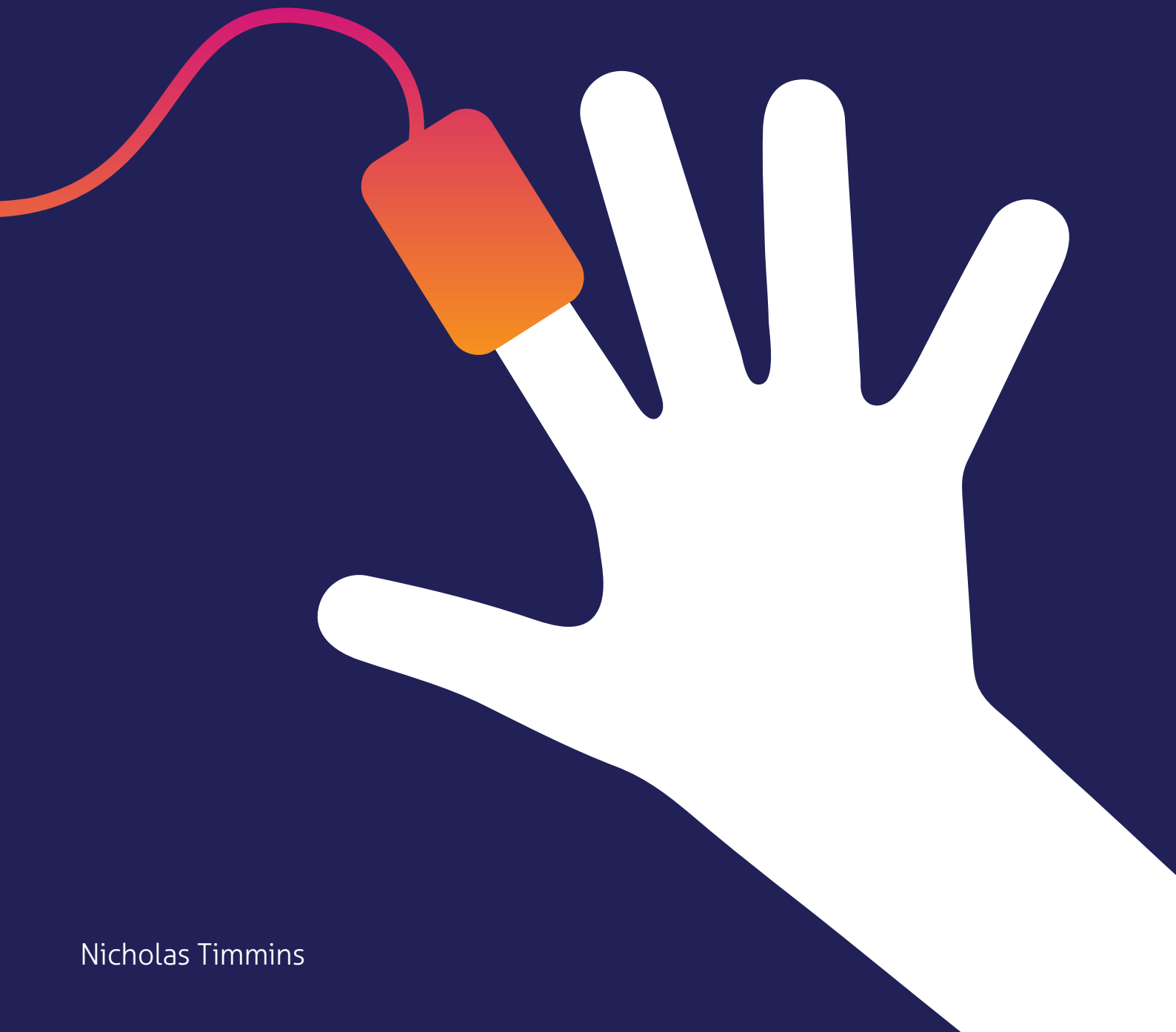
The King's Fund

INSTITUTE FOR GOVERNMENT

'The World's Biggest Quango'

The First Five Years of NHS England



Nicholas Timmins

About this report

Five years ago, the Health and Social Care Act 2012 created NHS England – a statutorily independent commissioning board for the NHS.

This report – drawing on extensive interviews, many of them exclusive, with some of those most intimately involved in the first five years of its existence – asks "What happened next?"

The answer is something distinctly different from what the Act intended.

The World's Biggest Quango

Or

Never Again? Parte Two

Otherwise Known as
The First Five Years of NHS Englande

A moderne drama
In Five Still Incompleted Acts

By Command of Her Majestie's Governance,
altho with consequences Her Majestie may not
entirelee have forseene

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"If you ask me what is the best way of running an organisation as massive and complicated as the health service, I would not say that it was to have all the strands going back to the health department. It would be much better to have it run as you would run any other big organisation, but with that organisation being responsible to the minister."
Norman Fowler
Secretary of State for Social Services (and thus for health), 1981–87, in a 2008 interview[1]

"There is the inherent difficulty of the whole thing. Is it possible, in any business or in any organisation, truly to separate policy from execution?"
William Waldegrave
Secretary of State for Health, 1990–92, and former aide to Arnold Weinstock at GEC[2]

"I was actually quite attracted by the idea of an NHS commissioning role... the independence, or greater degree of independence of NHS England, and the very clear responsibility that they have got for the NHS is, I think, helpful... [Although]... the distinction between policy and implementation is never as clear as people sometimes pretend."
Patricia Hewitt
Secretary of State for Health, 2005–07[3]

"If politics has a respectable role it is obviously in providing accountability for taxation. And if that does not apply in respect of the NHS, then what does it apply to?"
Andy Burnham
Secretary of State for Health, 2009–10, and opposition health spokesperson, 2010–15[4]

"If the problem is the way politicians behave, then why don't politicians just change their behaviour?"
John Appleby
Chief Economist, The King's Fund, in 2006[5]

"If the purpose of setting this all out in legislation, as Andrew [Lansley] has said, was to make it permanent, so that it could not be changed... well, it hasn't been changed. It's just been ignored!"
David Bennett
former Chair and Chief Executive of Monitor[6]

"[The Health and Social Care Act was] our biggest mistake in government"
Anonymous Conservative cabinet minister in 2014,[7] echoed by Stephen Dorrell, Secretary of State for Health, 1995–97, and chair of the Health Select Committee, 2010–14[8]

"We have to recognise that we are a democracy. And people want to hold people like me, rightly, accountable, for over £100bn of public money. So there are always going to be times when the Health Secretary has to involve themselves in operational issues."
Jeremy Hunt
Secretary of State for Health, 2012–present, at a Nuffield Trust summit in 2014

Contents

Acknowledgements 5

Foreword 6

Introduction 8

Prologue 10

Act One – From Bevan's slops to Lansley's liberation: 1948 to 2010 13

Scene One – From administration to planning: 1948 to 1983
"The Promised Land" 13

Scene Two – From planning to management: 1983 to 1987
"Looking for the lady with the lamp" 18

Scene Three – From management to the internal market: 1987 to 1997
"To market, to market" 21

Scene Four – Targets and terror – and markets: 1997 to 2010
"Eye of the Tiger" 25

Scene Five – Autonomy and accountability meet 'self-improvement'
"Anything you can do, I can do better" 28

Act Two – 'Liberating the NHS': 2010 to 2013 33

Scene One – Lansley legislates...
"They used to tell me I was building a dream..." or *"Ship of fools"* 33

Scene Two – Building the board
"River deep, mountain high" 37

Act Three – NHS England's first 18 months: 2013 to 2014 49

Scene One – Jeremy Hunt arrives... and so does Robert Francis
"Sturm und drang" 49

Scene Two – *"Tell me why... I don't like Mondays"* 54

Scene Three – *"Lawyers, guns and money..."* 61

Scene Four – Policy and operations collide
"How independent is independent?" 63

Act Four – Unpacking the Health and Social Care Act: 2014 to 2017 65

Scene One – A change of chief executive
"Will ye no come back again?" 65

Scene Two – The *Five Year Forward View*
"See my tailor, he's called Simon... I know it's going to fit" 66

Scene Three – The money arrives... and goes out of the window
"Out of control" 70

Scene Four – The workarounds begin
"Round, round, get around, I get around..." 72

Scene Five – Out of the European Union...
"Now that you are gone..." 75

Scene Six – And away from the purchaser/provider split...
"Come together" 76

Scene Seven – And out of favour...
"Tubthumping" 76

Act Five – 2017 to 2018: *"Putting Humpty Dumpty together again"* 79

Scene One – Hunt adapts his approach
"Getting it right the first time..." 79

Scene Two – For this much you can have that much
"Can't give you more..." 81

Scene Three – Trying to tie a knot
"Love and marriage..." 83

Scene Four – Judicial reviews
"You bring your lawyer and I'll bring mine..." 86

Scene Five – Give me money
"I will, I will, I will" 87

Analysis and conclusion 93

Timeline 114

Glossary 116

References 118

Acknowledgements

This piece was conceived back in 2012 as the Health and Social Care Act became law. We – The King's Fund and the Institute for Government – set out to try to tell the tale of what happened subsequently through interviews as it went along, rather than simply going back some years later, and asking what had happened – an attempt, in other words, to capture how it felt at the time, rather than just asking some of those involved to reveal their view in retrospect, adjusting it for what subsequently happened.

That was only possible because a considerable number of people agreed to be interviewed, often more than once, on a 'not for direct attribution' basis, but on the understanding that, at the time of writing, we would see what could, and could not, subsequently be put on the record. That involved a very considerable degree of trust, for which the author in particular is deeply grateful. As the text illustrates, much has gone on the record; some has had to remain non-attributable.

Thus, the author in particular is deeply indebted to all those who helped so much – without them this piece would have been impossible – and to those, both inside and outside the story, who read assorted drafts of the text. Those outside, or partially outside, included Jill Rutter, Chris Ham, Patrick South, Bill Morgan and Andy Cowper. It is invidious to name those inside, but they know who they are. Matthew Batchelor and Rowena Mayhew edited the text, as ever, with élan. All of these improved it no end, correcting facts and challenging analysis and opinion. For all their immense help, they cannot be held responsible for any errors of fact, let alone of judgement or opinion; although both The King's Fund and the Institute for Government, and I, trust we have not traduced anyone.

Foreword

Nicholas Timmins' account of the Health and Social Care Act 2012 – *Never Again?*[1] – told the story of the biggest and most complex piece of legislation in the history of the NHS. The story ended just after the Act reached the statute book, leaving uncertain what would happen next. In this new study, commissioned jointly by the Institute for Government and The King's Fund, Nicholas explores the fate of one of the central provisions of the Act, NHS England, established as a statutorily independent board with the aim of distancing politicians from the day-to-day running of the NHS.

The story that unfolds in the pages that follow draws on interviews with those involved in the work of NHS England, either directly or indirectly, to illustrate how there are 'many opportunities for the intentions of radical reformers to be altered and distorted as they are carried into action', to borrow from our Foreword to *Never Again?* Far from functioning at one step removed from the NHS, as Andrew Lansley had intended, health ministers continue to be closely involved in its operations. Despite this, NHS England has asserted its independence on a number of issues, demonstrating that relationships between ministers and arm's-length bodies cannot be reduced to a zero-sum game.

The growing financial and operational pressures facing the NHS in the five years since NHS England was established help explain why politicians retain close involvement in its performance. Survey evidence shows that the public see the NHS as one of the most important issues facing the country and also that there is rising anxiety about its future.[2,3]

Whatever the intentions of those who framed the 2012 Act, the Health Secretary of the day will be held to account by Parliament for the performance of the NHS and will be expected to intervene when things go wrong, as happened so spectacularly in the case of harm to patients at Mid Staffordshire NHS Foundation Trust.

If the buck stops with the Health Secretary, then there are still choices to be made by the occupant of that office on how to discharge his or her responsibilities. Nicholas shows that Jeremy Hunt brought his own distinctive approach to the role, reflected in regular Monday morning meetings with leaders of the various national bodies involved in the NHS. These meetings often focused on detailed aspects of NHS performance, underlining the inherent difficulty of separating policy from operations. Hunt also took on the mantle of the patient's champion, using the report of the inquiry into Mid Staffordshire to shift the focus away from Lansley's technocratic vision to patient safety and how it could be improved.

If the importance of personalities is one of the themes of this study, then the part played by Simon Stevens as Chief Executive of NHS England since 2014 is just as important as that of Jeremy Hunt. As a former special adviser to Tony Blair and Alan Milburn, Health Secretary between 1999 and 2003, and also a former NHS manager, Stevens brought a combination of experience and intellect that was exceptional in a leader of an arm's-length body. This helps to explain his willingness to use the statutory independence of NHS England to speak out on the funding of the NHS and what it could deliver within available resources. It is difficult to imagine this being done by those who had served as chief executives of the NHS before the creation of NHS England.

One of the consequences was that Stevens and Hunt became increasingly aligned in making the case for additional NHS funding. The close identification of secretaries of state with the departments and services for which they are responsible is of course a well-understood aspect of life in Whitehall. In Hunt's case it was reinforced by the length of time he served as Health Secretary. The arguments of Hunt and Stevens for the NHS budget to be increased initially fell on deaf ears but were eventually heard when the Prime Minister announced in evidence to the House of Commons Liaison Committee that the Government was preparing to announce a multi-year funding settlement for the NHS in recognition of the need for a sustainable funding solution.

To emphasise the role of personalities is to leave open the question of what might have happened under a different health secretary or indeed a different chief executive of NHS England. For now, Nicholas's account provides riveting reading for NHS insiders on a critical period in health policy and an invaluable case study into the relationships between departments of state and arm's-length bodies. We are grateful to Nicholas and all those who agreed to be interviewed by him for producing another first draft of history.

Bronwen Maddox, Director, Institute for Government

Chris Ham, Chief Executive, The King's Fund

May 2018

Introduction

This is, so to speak, *Never Again? Part two.*

Never Again?[1] told the story of what preceded Andrew Lansley's hugely controversial Health and Social Care Act 2012, and how it became law. The legislation caused the single biggest political row about the NHS since the implementation of Kenneth Clarke's *Working for Patients*[2] – the white paper that back in 1989 led to the original purchaser/provider split in the NHS. It also produced easily the biggest NHS reorganisation since at least 1974.

At times it looked as though Lansley's bill might be lost.

As the Act was passed it was seen by its bitterest critics as the springboard for mass privatisation of the supply side of the NHS. Many, many more services would be contracted out to the private and voluntary sectors.

And, for some of the critics at least, that was merely the presumed prelude to privatisation of the demand side – the way the service is charged for and funded. The aim, they believed, was to use it as a staging post to the introduction of many more charges, or a new form of private or social insurance to replace the essentially tax-funded and largely free-at-the-point-of-use nature of the NHS. To its fiercest opponents, the Act was designed to dismantle the NHS.

By contrast, its author – Andrew Lansley, who had been Conservative health spokesperson for an unprecedented six-and-a-half years – saw it as an essential piece of legislation, not just to maintain and improve the NHS but also to depoliticise its management. Its aim was to set the service free, in the words of his white paper *Equity and Excellence: Liberating the NHS*,[3] from the "political micromanagement" and "political interference" by ministers that – in his view, and that of many others – had dogged the NHS since its inception in 1948.

One of the key means of doing that was to create, for the first time, a statutorily independent commissioning board (later known as NHS England), a board that was instantly dubbed – thanks to its £100 billion budget – "the world's biggest quango"* by Andy Burnham, the former Health Secretary and, at the time, opposition health spokesperson.[4]

The aim of the board, allied to other changes in the legislation, was to put an end to the "excessive bureaucratic and political control" of the service, in the words of Lansley's white paper. The NHS would move instead to "a system of control based on quality and economic regulation, commissioning and payments by results, rather than national and regional management".[5]

* NHS England is not, of course, 'the world's biggest quango'. For example, the federally run Medicare programme in the United States is bigger. But it is easily England's biggest.

If *Never Again?* told the story of how and why Lansley's Act became law, the aim of this report is simply to ask the question: what happened next?

It is important to state at the outset that this is not an attempt to analyse the whole of the effect of the Act. That is a huge task, which others will no doubt undertake. Among the multitude of things it does not do, for example, is examine how well clinical commissioning groups, or health and wellbeing boards, or Public Health England, or Health Education England or Healthwatch England – all products of the Act – have performed, let alone how well the 'sustainability and transformation plans' and their successors, integrated care providers, are doing, or, in any detail, how the health service as a whole has performed since 2010.

It has a much narrower focus – to ask: Were Lansley's aims for his statutorily independent board fulfilled or disappointed? Were the critics right? And, given that much of what has happened has turned out to be distinctly different from the aims of the legislation, what might be learnt from the first five years' existence of "the world's biggest quango"?

Towards the end, I take the view that the Act essentially failed. But that where it has been a success – in the creation of an independent voice for the NHS – it has turned out to be so in ways rather different from the hopes of its originators.

I hope, however, that there is enough of a dispassionate take here – one that reflects at least some of the conflicting views among some of those most intimately involved – to allow readers to make up their own mind.

Finally, I apologise, without really regretting it, for the appropriation of assorted song titles, bits of lyrics and quotes as scene (or chapter) headings. One or two were so apposite as a way of summing up what was going on at the time that I could not resist trying to find others. At the very least, they lighten the load of what is, inevitably, a fairly lengthy read.

Prologue

Five years ago, on All Fools' Day 2013 – the 1st of April that year – 'the world's biggest quango', otherwise known as NHS England, came into existence. The white paper published in July 2010 that formally announced its creation – *Equity and Excellence: Liberating the NHS*[1] – promised that this new, statutorily independent board would be "a lean and expert" organisation.

In practice, it started life with some 6,700 direct employees, plus another 9,000 odd in 19 'commissioning support units', whose task was to support general practitioners (GPs) who were to become the key purchasers of NHS care.[2] But it had been thrown together at such speed that in the early months it had trouble paying some of its staff on time.

Its core tasks were fourfold:

- to license and then oversee some 210 newly created clinical commissioning groups – bodies led by GPs whose task was to buy services on behalf of their patients
- to channel to the clinical commissioning groups some £80bn of NHS expenditure with which to do that
- to itself commission some £20bn of more specialised services – the remainder of the budget for NHS services
- as a statutorily independent board, to contribute to ending what the white paper had described as the "political micromanagement" of the health service – by its very existence, it was there, so to speak, to depoliticise the NHS.

> [what Andrew was trying to create was] a perfectly incentivised perpetual motion machine

The aim of this, in the words of Lansley's white paper, was to move to "a system of control based on quality and economic regulation, commissioning and payments by results, rather than national and regional management".[3] In other words, the NHS was to operate rather more like a market – a 'quasi-market' in the jargon – given that patients did not pay for the health services they received and many other features of a normal market were missing.

Getting to that involved not just the creation of NHS England and the clinical commissioning groups, but also many other elements that would create – in the somewhat despairing words of one of David Cameron's special advisers when he saw what this involved – "a perfectly incentivised perpetual motion machine",[4] one that would essentially run itself with next-to-no ministerial involvement other than providing it with its marching orders – what was known, in the white paper, as the board's "mandate".

The other elements in this quasi-market included a renewed drive to ensure that all hospitals and services became freestanding – and competing – NHS foundation trusts. The preceding Labour Government had set a target for all hospitals and services to at least have the chance of becoming foundation trusts by 2008. But by 2010, only around a half had made it to that status. It was already obvious that some would never pass the tests needed to get there, which included operating, on their own, as financially viable institutions.

Foundation trusts were licensed and overseen by a regulator, named Monitor. Under the legislation, Monitor retained the name and that role. It also became a full-blown economic regulator, operating under concurrent powers with the-then Office of Fair Trading, to oversee, and if necessary enforce, the application of competition and procurement law in the NHS. In addition, it also became partially responsible for setting 'the tariff' – the price list that was already being used to pay hospitals for a significant proportion of their treatments.

All of this had been set down in highly detailed legislation so that the change would be – in Lansley's words – "permanent". He had, Lansley said, to "entrench it", so that no longer when "you change the secretary of state... you can change the policy on virtually everything in the NHS".[5]

An overarching aim of all this – a statutorily independent board allied to the other elements of a quasi-market – was to create an NHS "free from frequent and arbitrary political meddling".[6] Sixty-two years after Aneurin Bevan had declared in March 1948 that "every time a maid kicks over a bucket of slops in a ward, an agonized wail will go through Whitehall",[7] the aim of the legislation was to put an end to that. Ministerial direction and management was to be largely removed. Instead, ministers would set "a short formal mandate" for the new and independent board once every three years or so.

The white paper had declared, in half-a-dozen different ways across its 57 pages, that the forthcoming bill would not just create an NHS "free from frequent and arbitrary political meddling", it would also end "political micromanagement", "political interference" and "excessive bureaucratic and political control", while introducing "provisions to limit the ability of the Secretary of State to micromanage and intervene".*

Those statements, of course, beg clarity on a number of issues, not least precisely what is meant by "political micromanagement" and which parts of the NHS's operations are meant to be free from "excessive bureaucratic and political control". This is particularly pertinent given that every MP, councillor, staff member and contractor – leave aside the patients (the most important people in all of this) – has a stake in the NHS. They all want at least a voice about it all.

But those statements – those desires – were what many in the NHS, and a fair number outside it, had long wished for: an end to 'political micromanagement' of the NHS in a way that would, somehow, depoliticise its operations.

* Reserve powers of intervention do, of course, remain.

This little drama starts with a lengthy dose of history in its first act. Readers may be tempted to skip it. But, at least in the author's view, that background is needed because it is important to understand why NHS England became the sort of independent board that it became, and because it contains the views of a string of health ministers, more fully expressed elsewhere[8], who themselves grappled with the issue of how far politicians should be involved in the management of the NHS. And their views are worth recalling when thinking about how these arrangements might be modified in the future.

Act One
From Bevan's slops to Lansley's liberation: 1948 to 2010

Scene One – From administration to planning: 1948 to 1983
"The Promised Land"

Almost from the moment it was created in 1948, there were voices wishing that the NHS could be 'depoliticised'. To its fullest extent, that has always been, and will always remain, an opium-driven pipe dream, not least because all health care systems are political.

Who is covered for what, at what price and in what way, and precisely how the system operates, are the very stuff of politics in every country in the world. That applies regardless of whether health care is funded by social insurance, private insurance, general taxation, specific taxes or out-of-pocket payments as people fall ill. No country has an entirely pure version of any one of those funding mechanisms. All have a mix.

In England's case, the NHS is a universal service, funded overwhelmingly out of general taxation, and largely free at the point of use. But even the English NHS has some limited charges, for example for prescriptions and (where you can get it) dental care. There is an entirely notional contribution from the national insurance fund – the money that comes in from employers' and employees' national insurance contributions. And alongside the NHS there exists private medical insurance, which offers a form of supplementary health cover that varies considerably in scope and scale for those who can afford it, or whose employer provides it. And some people still pay for private medical treatment out of their own pocket.

So it is important to recognise that health care, its funding and its operation are political everywhere – including in France and Germany, countries that run social insurance schemes. The structure of these schemes does indeed mean that there is less ministerial involvement in the management of their health care systems. But ministers still get dragged into debate about the cost and efficiencies of the system, into pay disputes, and often into major service reorganisations. Another example is the United States. It has one of the most privatised health care systems in the developed world, although half of its health care is in fact tax funded. But one only has to mention the word Obamacare – and witness President Trump's travails in seeking to dismantle it – to remove any doubt that health care is political.

So it is worth stating at the outset that it is pretty much impossible to completely 'depoliticise' the NHS, although it may be possible – and at times has been in the past even in England – to have ministers less involved in the day-to-day decisions about how the service operates, so perhaps less politicisation and, maybe alongside that, less centralisation, although the two ideas are often muddled together.

Bevan's famous line about the "bucket of slops" – or the alternative version about a bedpan being dropped in Tredegar (his constituency) echoing around Whitehall – is most often presented as though the "wail in Whitehall" is precisely what he wanted. In other words, that Bevan desired and designed a highly centralised NHS – one run by 'command and control' by the Minister for Health and his department, and one in which they would be answerable for everything that happens. But that is in fact one of the great founding myths of the NHS. It is plainly not what Bevan wanted. It is certainly not the way he set it up.

In the speech from which the "bucket of slops" quote comes, to the Institute of Almoners in March 1948, Bevan noted that the Health Minister will be "the whipping boy for the health service in Parliament" because the new service would produce "a cacophony of complaints", putting "a megaphone in the mouth of every complainant", with "the limelight of publicity... brought to bear upon every aspect of the health service".[1]

But it was far less clear than commonly assumed that Bevan believed that it was for the Health Minister to solve all these problems. In a speech a few weeks later to the Royal College of Nursing, for which there appears to be only a report in *Nursing Times* rather than a full text, he declared that after 5 July "every mistake you make, I shall have to bleed for. I shall be going about like Saint Sebastian, bleeding from a thousand javelins, so many people will be complaining". But as time goes by, he pronounced – somewhat optimistically as it turned out – that chorus of complaints will dwindle, because "*you* will be attending to them. All *I* shall be is a central receiver of complaints".[2]

> administration will be the chief headache for years to come

I have added emphasis there, and as far as I am aware there is no recording of these speeches which would give a sense of the extent to which it was said with irony. But they do not sound like the words of someone who wanted the NHS to be run by some system of centralised political 'command and control'. And, indeed, that is not the way he set the service up, though he did note, in the same speech, and with remarkable prescience, that "administration will be the chief headache for years to come".

After an initial battle with Herbert Morrison over whether the service should be run nationally or by local government – the London County Council of which Morrison had been Leader was, at the time, arguably the largest hospital authority in the world – Bevan did indeed nationalise the hospitals, in part as a way of solving the existing divide between the voluntary and municipal hospitals, neither of which were prepared to bow to the other.

These nationalised hospitals, however, were to be run by regional boards, which, while appointed by ministers, were not outposts of the Department of Health. GPs were to be, as many remain, independent contractors. And when in 1950 Sir Cyril Jones, a senior civil servant, was appointed to study the financial workings of the NHS on the first occasion that it appeared that the finances were running out of control, Bevan rejected Sir Cyril's recommendations. These included turning the hospital boards into planning bodies while the hospital management committees beneath them should,

Sir Cyril said, become "subject to direct control by the ministry", with civil servants posted on to them to ensure that happened.[3]

Bevan's response was as follows:

"There would have been no theoretical difficulty – there is none now – in having from the outset a tightly administered centralised service with all that would mean in the way of rigid uniformity, bureaucratic machinery and 'red tape'. But that was not the policy which we adopted when framing our legislation.

"While we are now – and rightly, I think – tightening up some of the elements of our financial control, we must remember that in framing the whole service we did deliberately come down in favour of maximum decentralisation to local bodies, a minimum of itemised central approval, and the exercise of financial control through global budgets." [4]

So the NHS started out firmly as an administered service, not a managed or a 'command and control' one. Rather, it was one in which the Department of Health sought change by exhortation, influence and circulars (there were many circulars – roughly one every three days in the 1950s). As Rudolf Klein, the distinguished historian and analyst of the NHS, has put it, even when the centre had a clear view of what was desirable in the 1940s and 1950s, "it did not perceive itself to be in a position of command. It could educate, it could inspire, it could stimulate. To have done more would have run counter to the values of localism... and challenged the right of [clinical] professionals to decide on the content of their work." It was a case of "policy making by exhortation".[5]

Even Enoch Powell's great Hospital Plan of 1962 – which sounds like, and up to a point was, central planning – proved in Klein's words to be a "negotiated order". It promised 90 new hospitals and the remodelling, on various degrees of scale, of some 490 more. But as civil servants told a parliamentary inquiry, the Department of Health could "advise" the regional hospital boards, it could "discuss" the plan and seek to "persuade", but it would not dictate what got built where – not least because "it is not easy for us centrally... to form a judgement of the precise needs of each regional board".[6]

Thus, much of the management story of the NHS for its first 30 years, and arguably for appreciably longer, was that it was much more of an administered service than a managed one, chiefly characterised by successive health ministers' search for a set of levers that, when pulled at the centre, did in fact make things happen on the ground.

Richard Crossman, Secretary of State for Social Services (and thus for health) at the end of the 1960s, when safely out of office, put the position like this:

"You don't have in the regional hospital boards a number of obedient civil servants carrying out central orders... You have a number of powerful, semi-autonomous boards whose relation to me was much more like the relations of a Persian satrap to a weak Persian emperor. If the emperor tried to enforce his authority too far he lost his throne, or at least lost his resources, or something broke down." [7]

On other occasions, Crossman described the chairs of the regional hospital boards as acting like "feudal barons".[8]

It was the mighty 1974 reorganisation of the NHS that brought in the first serious attempt at an element of 'command and control', via the mechanism of 'planning'. Many of the parts that had been left behind with local government in 1948 were brought into the NHS, for example: public health, district nursing and health visiting, midwifery, school services and the ambulance service. The hospital boards went, to be replaced by health authorities, which had a much broader remit – responsibility for the health of their local population, not just for the hospitals. They remained ministerially appointed. But they were not outposts of the Department of Health.

> [the 1974 reorganisation became] a case of 'tears about tiers'

Ministers, however, did now sit at the top of a planning system, seeking to set priorities and order initiatives that were to be delivered through the new structure of regional, area and district health authorities. This reorganisation brought some real gains: the 'population health' approach plus the unification of the parts, listed above, that had been left with local government. But with the new structure came the concept of 'consensus management' – that decisions had to be agreed by everyone in the local management team, from the medic, to the nurse, to the administrator. The laudable aim was to stop any one interest dominating the other. But the effect was to give everyone a veto. And the result was a distinct tendency for lowest common denominator decisions rather than highest common factor ones, and an incentive, when difficult decisions arose, to pass them up and down the hierarchy. The new structure proved to be excessively bureaucratic and cumbersome. The reorganisation rapidly became, in the words of Sir Patrick Nairne, the permanent secretary who inherited it, a case of "tears about tiers".[9]

Partly as a result of that reorganisation, the voices grew louder that called for less day-to-day political involvement in the NHS, or the creation of some sort of separate national board, or public corporation, to run the NHS.

According to Charles Webster, the official NHS historian, the idea "had been advocated since the earliest discussions of the NHS". It was promoted in the 1950s by Stephen (subsequently Lord) Taylor, a physician who was head of Home Intelligence in the Ministry of Information during the Second World War. He became a prominent medical journalist and, for a time, a Labour MP. The idea was briefly considered by the Guillebaud Committee in the 1950s, when it was set up to examine NHS finances. Enoch Powell took a look at it when he was Health Minister between 1960 and 1963 but did not act on it. And it was raised again by the Treasury in 1966 when Kenneth Robinson as Health Minister embarked on the first of the failed attempts to achieve what became the 1974 reorganisation. "Devolving the administration of the NHS to a separate board seemed to offer the prospect for a unified management structure, thereby freeing the health departments from irksome, routine management responsibilities," Webster records.

The idea, however, foundered, thanks to opposition from the Department of Health and the failure of the idea even to command a consensus within the Treasury. "The idea was abandoned because of the likely Parliamentary opposition, where it would be seen as undermining the detailed financial accountability of Parliament for the NHS

budget, and limiting the ability of MPs to make representations in the interests of their constituents on health service affairs," Webster records.

The idea was again raised – promoted this time by the Civil Service Department – during the debates that led to the 1974 reorganisation. But by 1971 the Treasury had completely rejected the idea of a public corporation, "which it regarded as naïve and impracticable".[10]

A British Broadcasting Corporation, a University Grants Committee, a Post Office or a Manpower Services Commission?

Even so, the Royal Commission on the National Health Service, reporting in 1979, declared that "the establishment of an independent health commission or board to manage the NHS was one of the solutions most frequently advocated in evidence". It stated that there "are a number of possible models including the British Broadcasting Corporation, the Post Office, the University Grants Committee, and the Manpower Services Commission", and that many of the arguments in favour are "attractive". But it said that it was unpersuaded, offering a string of reasons against, including duplication of effort between the board and the Department of Health.[11]

> the establishment of an independent... board... was one of the solutions most frequently advocated in evidence

But in those possible models lies a rub to which I will return: What sort of board or corporation? Running what sort of NHS management model? The Royal Commission's examples, in a sense, give the game away.

The BBC had its own, dedicated, income stream – the licence fee. It was run by a board of governors who appointed their own director general and were responsible for strategy. But while the governors were all appointed by a Secretary of State, and while the Secretary of State's permission was required before the BBC launched a new service, it had its own Royal Charter as a guarantee of independence, and it was formally accountable to Parliament rather than a minister.

The University Grants Committee, by contrast, for all its power and influence, was, at the time, technically only a non-statutory advisory body to the Department for Education, having started life as a semi-independent committee of the Treasury. It enjoyed its power to make decisions about how grants to universities were distributed because ministers allowed it to. And those freedoms were shortly to be constrained, not long after the Royal Commission reported, as the committee evolved through various incarnations into what became the Higher Education Funding Council.

The Post Office, by contrast, was a business – a public corporation that received some subsidy from government but which essentially charged customers for its services.

The Manpower Services Commission meanwhile was a non-departmental public body, carved out of the Department of Employment in 1973 as, in effect, an operational agency headed by a board, which was made up of representatives from industry, the trade unions, local authorities and educational interests. It commissioned employment programmes. But it was anything but free of ministerial involvement.

These were four very different governance models, operating in four very different environments and sectors, their very variety illustrating how unclearly thought out was the definition of 'an independent board' to run the NHS.

In 1982, the NHS structure was simplified a little by the abolition of area health authorities, but with that came a further rise (after a brief journey in the opposite direction under Patrick Jenkin)[12] in 'command and control'.

Norman Fowler as Secretary of State for Health, and Kenneth Clarke as Minister of State for Health, organised annual performance reviews of the regions, which the regions then replicated with the districts. Targets were agreed and progress towards them set. The first (admittedly rather crude) performance indicators were created as computerisation began to provide more timely and sophisticated data on NHS performance. These were fed into the performance reviews. Clarke was later to complain that the NHS at the time "did not have a management system worth the name"[13] as he and Fowler undertook a whole string of central initiatives intended to cut non-clinical costs as the health service went through several years of very tight financial settlements. The initiatives included setting staffing targets, the sale of nurses' homes, and a requirement that cleaning, catering and laundry services be put out to competitive tender. The politically appointed chairs of health authorities who failed to co-operate were not re-appointed – "The only lever I had," according to Clarke, "and the one I continued to pull all the way."[14]

Scene Two – From planning to management: 1983 to 1987
"Looking for the lady with the lamp"

As this was ratcheting up, Roy Griffiths, the Managing Director of Sainsbury's, was whistled up to take a look at the NHS – and what was to emerge was a much clearer idea than in the 1970s of what a board to run the NHS might look like, although one well short of statutory independence.

Griffiths' report of 1983[15] is chiefly remembered for the introduction of 'general management' into the NHS. Its landmark phrase was that "if Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge". Griffiths recommended that such people be appointed and that the 'consensus management' that the 1974 reorganisation had introduced, should be scrapped. Thus, 'general managers' were created to replace the NHS's administrators (Griffiths was particularly keen that a proportion of these should be clinicians). And these general managers in time came to restyle themselves as the 'chief executives' of the NHS's myriad organisations.

But with these general management appointments lower down the system came the creation of an NHS management board at the top. Griffiths' view was that "a small, strong general management body is necessary at the centre (and that is almost all that is necessary at the centre for the management of the NHS)", and that this management board, with its chair acting as a general manager or chief executive for the NHS as a whole, should be answerable to a supervisory board, chaired by the secretary of state,

with the permanent secretary, the chief medical officer and the management board chair on it, along with two or three non-executives.

This was all decidedly, and deliberately, non-statutory. The NHS could not afford a "Hamlet-like soliloquy," Griffiths said – nor a wait for legislation, even if ministers had wanted to legislate, which at this stage they most definitely did not.

> a small, strong general management body is almost all that is necessary at the centre for the management of the NHS

But it was a more business-like, corporate, structure for the NHS, although one that looked more like German forms of corporate governance than British ones. And it was a first, formal, attempt to distance politicians from the day-to-day management of the health service.

The secretary of state was to chair the supervisory board, not the management one. The role of the supervisory board was to be 'oversight' of the NHS. Its task was to set objectives, approve the budget, take strategic decisions and receive reports on performance. It was not there to manage the health service. That, in theory, was for the management board.

After much agonising, all this was indeed created in 1985 by Norman Fowler, the Secretary of State for Health at the time. But the experience was not a happy one.

The first chair of the management board – in effect the health service's first chief executive, although, notably, he did not have that title – was Victor Paige. A 59-year-old businessman, he had been Personnel Director at Boots before joining the National Freight Corporation. There, as Deputy Chairman, he had been involved in its 1981 privatisation by Norman Fowler when he was Transport Secretary. He also knew Kenneth Clarke well, at the time Minister for Health. And he came to the post after also being Chair of the Port of London Authority, where he had successfully undertaken a major restructuring of its operations.

There were, however, instant tensions between this new management board and the politically appointed chairs of the 14 regional health authorities – Crossman's "feudal barons". Their role gave them a direct line into Fowler as the Secretary of State. They had created their own inter-regional secretariat and saw themselves as the political management of the NHS locally. They wanted "to keep their hands on the reins of power," in the words of Brian Edwards, a senior NHS manager at the time who has documented this period well.[16]

More seriously, Fowler reacted badly when the management board sought to take decisions, rather than acting, in effect, as another ministerial adviser rather than a management body. The Permanent Secretary of the day, Kenneth Stowe, put round a note to senior colleagues as early as November 1985 saying that the Secretary of State had reacted "very sharply recently when he saw papers saying that the management board had decided something. The Secretary of State is concerned – and rightly – that

ministers' position and authority are not undermined. We have to take the trick 'of operating with authority without usurping it'."[17]

In June 1986, 18 months after the management board was created, Paige resigned. His carefully coded resignation letter noted that "ministers and the chairman of the management board can approach the same issue with different perspectives, priorities, objectives and restraints".[18] In other words, he couldn't really do the job. Fowler, in his memoir, acknowledged that Paige "had a point". Paige "was not the chief executive of a big corporation, but in an uneasy no-man's land between the Department of Health and the service".[19]

Paige's own recommendation to the Department of Health on his departure was that, given ministers' reluctance to surrender much in the way of decision making to the management board, then either a minister had to chair the management board or something much more radical was needed – setting the board up as a proper independent corporation.[20]

The first part of that recommendation was followed, with Tony Newton, the Minister for Health, chairing the board from late 1986 until early 1989, with Len Peach, its former Personnel Director, acquiring the title of Chief Executive. But the role, despite the title, was not one that anyone in outside industry would have recognised, chiefly because Newton, the minister and chair – and who genuinely did believe in the devolution of management – remained the one who effectively made the management board decisions.

As for the supervisory board, within two years of its creation it was to fall into desuetude under John Moore, Fowler's hapless successor – its role never having been clearly established.

Griffiths' report was, nonetheless, a key event in the NHS's history. If there was doubt before, this was clearly the moment when the NHS moved from being essentially an administered service to a much more managed one – through the appointment of general managers all down the line. But with that came the idea – by way of the supervisory board – that politicians should also be more distanced from the day-to-day management of the service.

It proved back then – as it does even these days – remarkably hard to separate policy from operations. The supervisory board – or perhaps more particularly the ministers on it – found it immensely difficult to live with a distinction that made them responsible only for setting objectives, approving the budget, receiving reports on performance and holding the management board or executive to account when, in practice, both Parliament and the media held them to account for performance.

Despite the failure to make these non-statutory arrangements work well – or perhaps because of that failure – Norman Fowler was to say the following two decades later, in 2008, when the idea of an independent board to run the NHS received another moment in the sun:

"By the end of my time [1987] I was basically in favour of a Health Service Commission, one that would have been one step away from the Department of Health.

"The Department had some extremely good advisers in it but the management knowledge, the direct experience of running and managing big organisations, was not actually a skill the department had. A health commission, with a separate board, separate chairman, separate chief executive, but with power, would have been the right way forward.

"I remember putting this once in conversation to Margaret Thatcher, and she thought about it and said 'No, I don't think we can do that. They'll say we're just doing this as a prelude to privatising.' And that, regrettably, is exactly what they would have said.

"I'm interested now to see [in 2008 when Gordon Brown and Andy Burnham were known to be looking at the idea] that it tends to be something that the left of politics actually puts forward, as opposed to the right. I hope it could successfully take some of the day-to-day politics and the day-to-day ministerial involvement out.

"It's certainly never going to be problem free because there are issues that come up which are obviously profoundly important, and there's no way round that. But if you ask me what is the best way of running an organisation as massive and complicated as the health service, I would not say that it was to have all the strands going back to the health department. It would be much better to have it run as you would run any other big organisation, but with that organisation being responsible to the minister." [21]

Scene Three – From management to the internal market: 1987 to 1997 *"To market, to market"*

At the end of the 1980s, several years of financial stringency led to the financial crisis of 1987, which in turn led to Margaret Thatcher's review of the NHS. And that in turn produced, in 1991, the purchaser/provider split, or what was often, and somewhat misleadingly, dubbed the NHS 'internal market'.

Under this, health authorities and GPs were to become purchasers, or in more recent parlance, 'commissioners', of NHS care. They were to buy the care from competing providers, whether NHS hospitals or private and voluntary sector providers – so the market was more than just internal. For GPs, taking a budget with which to buy their patients' care – that is, becoming a 'GP fundholder' – was voluntary and only around a half of practices had done so by the time fundholding was abolished in 1997.

To help achieve the market, NHS hospitals turned into nominally more independent, and competing, NHS trusts – given the ability to set their own terms and conditions for staff, own their own land and buildings and retain their surpluses. They were, in theory at least, to be organisations that were less directly managed from above than in the past – something a little closer to freestanding businesses.

The underlying idea behind all this was that, in a sense for the first time, the NHS was to consciously decide what health care it wanted to provide and where, and then purchase it from whoever seemed best placed to provide it. Under these contracts, the theory was that 'money would follow the patient', so that hospitals that did more got paid more, with the resulting competition driving up efficiency and quality. These changes, it should be noted, were immensely controversial.

However, spending, after an initial surge, got progressively tighter over the 1990s and the centre pulled away the freedoms that the new-style trusts had been granted, not least their ability to retain surpluses. But it was the creation of this purchaser/provider split that, many years later, as we shall see, was to define the nature of NHS England.

And in the run-up to the 1991 reforms, Kenneth Clarke, now Secretary of State for Health, did make one more effort at distancing politicians from the day-to-day management of the NHS by creating a 'policy board' – a revamped attempt at the failed supervisory board – while turning the management board into a management executive, operating inside the Department of Health. Its chief this time was not a minister and not an outsider. The job went to Duncan Nichol, a senior NHS manager. Again, this was a non-statutory arrangement.

William Waldegrave, to whom fell the final implementation of the purchaser/provider split, recalls that the policy board brought back "the inherent difficulty of trying to separate the management from policy".

"I didn't want anybody else, perhaps wrongly, to be chairman of the policy board. So I made myself the chairman of it. It was implicitly saying that the secretary of state should not just be policy, but should also be an executive. Perhaps I shouldn't have chaired it. But then this is the inherent difficulty of the whole thing – is it possible, in any business or in any organisation, truly to separate policy from execution?

"I certainly thought then that to see the policy through [the implementation of the purchaser/provider split], I had to retain the strategic control of what was happening with some kind of non-party political support – although doing anything was inherently political, and Duncan Nichol [the NHS Chief Executive] was under political attack as well as management attack.

"I saw the board's role to be overseeing of the establishment of the policy, of the structures. This was, of course, the grave difficulty. We had a great seminar at Chequers all about it just as the first trusts were being established. And the first thing that happened in one of the first trusts to be established – Guy's – was that a lot of nurses were fired.

"And so Chequers was surrounded by furious journalists and it was all hopeless. One could see that actually, the famous and hopeless Aneurin Bevan remark about the bedpans and all that was always going to be true – which is fundamentally what's wrong with the system.

"The policy board didn't do all that much. But I think it was a way of saying that there was something that the secretary of state had to do, which wasn't just saying, 'we've passed this Act of Parliament', but also saying that 'we have to see that the outcome bears some relationship to what we've done'.

"It had some reasonably independent people on it. And I think it did some good in the early days, because we were going very fast. You always are in politics. You can't stop and say, 'We're going to wait and see what happens for a bit.' But its role was never thoroughly satisfactory." [22]

The policy board survived through Virginia Bottomley's time as Health Secretary between 1992 and 1995, but as an increasingly poor and bedraggled thing. With its non-executive members drawn from outside the health service, she saw them as being "outside advisers". The board met alternately with the bi-monthly meetings of the-then still very powerful and politically appointed regional health authority chairs, a grouping whose views Bottomley valued highly as her "eyes and ears" who would tell her uncomfortable truths that the managers might not. The policy board, she says, "might have been very useful when the NHS reforms were being set up [as an advisory group for introducing more market-like measures into the NHS]. But creating agendas for both [the policy board and the regional chairs] became ridiculous. You tell me Stephen abolished it. Well, he was completely right."[23]

> Chequers was surrounded by furious journalists and it was all hopeless

The Stephen here is Stephen Dorrell, who followed Bottomley as Health Secretary between 1995 and 1997. Dorrell says he first attended the board when he was a junior health minister and Kenneth Clarke was Health Secretary while personally "not really getting it – what it was for... There were these various panjandrums from the world of business and elsewhere, who were going to tell the Department of Health how to run a multi-billion-pound corporation."

When he was Secretary of State, he says, "I think I cancelled two or maybe even three meetings of this assembly at short notice, thinking I had better ways of spending my time. And it became an embarrassment. It had got to the point where it either had to meet or I had to abolish it. So I abolished it."[24]

By now we are in the mid-to-later 1990s. But as so often in the story of the NHS, it was full of paradox.

The political rhetoric around the purchaser/provider split and the 'internal market' – with health authorities and GPs doing the purchasing from freestanding NHS trusts and others – was all about 'decentralisation'. Indeed it was Virginia Bottomley, as much as anyone, who contrasted all that in her speeches with the "bad old days" of "Soviet-style command and control". And it was the case that the internal market did for a time – until

the ever-tightening money eroded it – provide a degree of greater freedom of action for hospitals and GPs. But every aspect of the market was driven from the centre by ministers and the executive – from ensuring that all hospitals became NHS trusts, to issuing planning guidance, setting annual priorities and giving advice on land sales.

As local purchasers – health authorities and GP fundholders – became stronger, that inevitably called into question the role of the 14 regional health authorities that had previously overseen the more managed system. Added to that was mounting political sensitivity over 'the men in grey suits' because the purchaser/provider split was driving up management costs as hospitals, health authorities and GP fundholders negotiated with each other.

So the 14 regional authorities were turned into eight regional offices of the NHS Executive, which were later reduced to four before being abolished entirely, while a review aimed at tackling the confusion between departmental responsibilities and those of the increasingly powerful NHS Executive was launched. The conclusion of the Banks review in 1994 was that the NHS Executive should become responsible for "all aspects of health policy work and policy implementation".[25]

A decade on from the Griffiths report, that might be viewed as the initial triumph of the managers over the civil service. The Banks report stated that "policy and implementation must be as closely aligned as possible", with Rudolf Klein not being alone in seeing this as "an obituary of the notion that policy and management could be separated".[26]

What all this produced, in the words of Sir Alan Langlands, the Chief Executive of the NHS Executive from 1994 until 2000, was for the first time "a single corporate management structure at the centre of the NHS" as the NHS Executive sought actively to manage the market that health ministers had created and shape the policy around it.[27] In other words – and here is the paradox – as the purchaser/provider split brought an element of competition, decentralisation and marketisation to the NHS, the centre in practice also increased its grip. As Rudolf Klein has put it, "almost 50 years after the NHS was first created, in the second half of the 1990s it became a *national* service". In place of a loose conglomeration of different services, it became one "where the lines of accountability are firmly and unambiguously to the centre".[28]

But even as the Banks report concluded that policy and implementation should be more closely aligned, the nagging idea that somehow the NHS should be run more at arm's length from ministers would not go away.

For just as Norman Fowler from the 1980s says he eventually came to the view that an independent NHS commission was a good idea, so Virginia Bottomley from the 1990s was later to say that, for all the difficulties in trying to make the policy board work, and for all the fact that she did not act on it, and for all the fact that – more than most health ministers – she fretted and sought to intervene in any health service story that

hit the headlines, "I came to like the idea of an independent board... some distance from ministers for the NHS".[29]

And so it was to run on into the 2000s – a not terribly well-defined idea for which many inside and outside the NHS longed, with calls for an independent board featuring repeatedly, for example, on the agenda of the annual representative meetings of the British Medical Association.

Scene Four – Targets and terror – and markets: 1997 to 2010
"Eye of the Tiger"

The idea of an independent board did not, however, feature in the NHS policy debates of Labour's early years. In its first term, in health as in much else, it took to heart Blair's pre-election statement that "we will run from the centre and govern from the centre".[30] Between 1997 and 2000, this produced what was arguably the NHS's greatest period of 'command and control'. GP fundholding was abolished, and ministers and Number 10 decided in remarkable detail precisely how every penny of new cash should be spent – on new walk-in centres, ward cleaning, modernised accident and emergency (A&E) departments and NHS Direct; on a new web-based and telephone-run helpline; and indeed on the service's first proper exercise in branding so that all NHS organisations now use its blue and white logo.

A terrible winter of NHS performance in 1999/2000 was followed first by Tony Blair's pledge on the television programme *Breakfast with Frost* to get health spending up to the European average – dubbed by the wits as "the most expensive breakfast in history" – and then by a change of direction: the re-invention, in a much more sophisticated form, of the Conservatives' more market-like approach to running the NHS.

In brief, this involved the creation of NHS foundation trusts as a much more freestanding version of the original NHS trusts, their independence and additional freedoms this time being underpinned by statute. Independent sector treatment centres – in effect privately run surgical factories for routine operations for NHS patients – were created. These provided extra capacity but also competition for NHS hospitals. A price list, or 'tariff', for many NHS operations and treatments was created, which allowed the restoration of patient choice of hospital – something that had, entirely unintentionally, largely gone missing as part of the Conservative reforms. Hospitals that did more now finally got paid for doing more. And with that came a gradual extension of the right of NHS patients to go to any private hospital willing to treat them at NHS prices. NHS hospitals had to pass financial tests, set by an independent regulator known as Monitor, in order to become foundation trusts, and Monitor then oversaw their performance and intervened – its chief power being to fire boards and managers – when it went awry.

The policy for all of this was largely devised by Alan Milburn as Secretary of State for Health, aided by his powerful special advisers – Simon Stevens and Paul Corrigan, who both went on to work for Tony Blair. But, in one of yet another of the many paradoxes that litter the history of NHS management, with these new market-like mechanisms,

which were intended to get the service to respond to financial and other incentives – putting an end to 'top-down control' – came centrally driven targets, most notably targets to cut waiting times for operations and in A&E departments. Blair created a Prime Minister's Delivery Unit, which focused week in, week out on these and other targets, with ministers facing monthly 'stocktakes' with Blair on progress. A key task of the Department of Health was to deliver these targets.

To emphasise the department's 'delivery' role, and with the policy, if not the operation of this more sophisticated quasi-market, largely in place, Milburn took the remarkable decision to merge the posts of permanent secretary and chief executive of the NHS. The job was given to Nigel Crisp, a senior NHS manager, in what amounted to the final, if relatively short-lived, triumph of the managers over the Department of Health. On one calculation, by 2005, shortly before this unhappy experiment ended, and the posts of permanent secretary and chief executive were separated out again, just one of the department's top 30 leadership positions was held by a classic civil servant – the others being NHS managers, clinical 'czars' or recruits from the wider public and private sectors.[31] Meanwhile, in final proof that, since 1974, 'organisation, reorganisation and re-disorganisation' had become the English NHS disease, the management tiers were subject to repeated reorganisation. That ended up with some 150 primary care trusts doing the purchasing, with 10 strategic health authorities above them, their task being to manage the primary care trusts and oversee those hospitals that had not reached foundation trust status.

Aside from the waiting-time targets, the reinforcement of the purchaser/provider split was driven hard from the centre by Milburn and his successors. The aim, in the later words of Patricia Hewitt as Health Secretary, was to turn it into a "self-improving organisation", [33] one that would respond to this more market-like approach so that less ministerial involvement was needed – a service that would "look out, not look up," as David Nicholson put it in his first annual report as chief executive.[34]

> 'Why have so many health secretaries been unable to resist restructuring the NHS?' David Nicholson asks Jeremy Hunt. Hunt looks blank. 'Biggest train set in Europe', Nicholson replies with a shark-like grin.[32]

And with this came a series of mechanisms intended to distance ministers from day-to-day decisions about the NHS – Milburn having declared that the old "top-down" model of the health service, with control from the centre, "cannot deliver for the 21st century".

These included, in Labour's first term, the creation of an independent inspectorate initially for NHS hospitals, its remit, through various reconstructions and mergers, gradually extending to cover private hospitals, social care and eventually GP surgeries. Again in Labour's first term, the National Institute for Clinical Excellence (NICE) came into being (now named the National Institute for Health and Care Excellence). Aside from

publishing guidelines on best practice, it recommended which new technologies (notably new pharmaceuticals) the NHS should and should not provide by assessing their cost-effectiveness. Technically, NICE was an advisory body. But in practice its existence meant that it was no longer ministers who decided whether the NHS should provide beta interferon (for multiple sclerosis), for example, or the newest and most expensive cancer drugs. NICE made the recommendations, and ministers honoured them.*

In 2003, Labour created the Independent Reconfiguration Panel, an advisory body of clinical and other experts to which changes to hospital services – mergers, closures and significant shifts in where services were provided – could be referred. It recommended to ministers adoption, amendment or refusal – its usual verdict being one of the first two. It began operation in Hewitt's time, allowing ministers, in effect, to hide behind its recommendations by supporting them. It still exists at the time of writing. It rarely attracts the headlines, but it has, over the years, taken a little, if far from all, of the steam out of service reconfigurations. As Alan Johnson, Hewitt's successor, was to put it, "I didn't entirely tie my hands" by saying he would never overturn its recommendations. But he did tell Parliament "I can foresee no circumstances in which I would intervene".[35]

In addition, as it began to look increasingly certain that both competition and procurement law now applied to the NHS as a result of the more market-like mechanisms that Labour was introducing, the Government created an inelegantly named Co-operation and Competition Panel. Its role was purely advisory. But it pronounced on whether mergers should or should not go ahead, and on when and whether services needed to be put out to tender. Again, its recommendations were honoured, both by the Government and by the private sector – keeping cases out of the courts.

By the mid-2000s – in Patricia Hewitt's day as Health Secretary between 2005 and 2007 – the logic of the NHS being increasingly seen as a commissioning organisation led to the idea of an independent board resurfacing, this time to do the purchasing.

Hewitt says that she was "quite attracted by the idea", which was batted back and forth between officials and special advisers. Papers were written on the idea by, among others, Bill McCarthy, the Department of Health's Head of Strategy, and by David Nicholson, the new NHS Chief Executive. The response of many of her officials, Hewitt says, was that "it is impossible. You can't give away responsibility for £100bn." But "I felt very strongly that there were far too many issues, including clinical issues, coming onto my desk in a very Nye Bevan way. The bedpan dropped in Tredegar. It was quite ludicrous." And the creation of an independent commissioning board was "in a sense the next logical step" in Labour's reforms, she says.[36]

* For an account of the history of NICE, see Timmins N, Rawlins M and Appleby J (2016) *A Terrible Beauty: A short history of NICE*, Health Intervention and Technology Assessment Programme, retrieved 15 April 2018, www.idsihealth.org/wp-content/uploads/2016/02/A-TERRIBLE-BEAUTY_resize.pdf

After all, by this stage, the Department of Health had within it a director of commissioning and a separate director of 'provider development'. The task of provider development was to help all hospitals get to foundation trust status, and to encourage staff to form social enterprises that would see them leave NHS employment while selling their services back to the NHS. According to one senior civil servant who worked on the idea of an independent commissioning board, "Patricia came very close to doing it".

Little of this saw the light of day, although Andy Burnham, the Minister of State for Health, did in 2006 and 2007 hint at more operational independence for the NHS, on the lines of a "BBC charter".[37] In the autumn of 2006, just ahead of the Labour Party conference, Gordon Brown, who was still Chancellor but was hoping to take over from Tony Blair as Prime Minister any day, allowed his aides to trail the idea of 'an independent board', apparently to illustrate that he had big new ideas for when he became Prime Minister.[38] Quite what this board was to be, or what it was to do, was not spelt out.

Scene Five – Autonomy and accountability meet 'self-improvement'

"Anything you can do, I can do better"

In the meantime, David Cameron, in 2005, had become Conservative Leader after the Conservative Party's third election defeat. He set out to "modernise" his party in the same way that Blair had. One of his first acts was to "detoxify" the NHS as an issue for the Tories. Where Tony Blair had named his three priorities as being "education, education, education", Cameron told his party conference that he could do it in three letters: "N.H.S.".

> Tony Blair explained his priorities in three words (education, education, education). I can do it in three letters: N.H.S.
>
> David Cameron

He dumped the 2005 election policy of a 'patient passport', which would have allowed patients to take the cash for their NHS procedure and spend it in the private sector, 'topping it up' if necessary. "We should not use taxpayers' money to encourage the better-off to opt out," he said. And he unequivocally committed the Conservatives to a tax-funded, largely free-at-the-point-of-use NHS, with a promise of no switch to any form of private or social insurance.[39] As a result, for the first time since 1948, the Conservatives in opposition did not at least look at an alternative way of funding the NHS.

Cameron had inherited, and retained, Andrew Lansley – his former boss when he was a young researcher at Conservative Party central office – as health spokesperson. Lansley had already been in this role for two years and was delighted to see the 'patient passport' proposal (which he himself had inherited and in which he had not believed) dumped.

Lansley's background was that of a trade and industry civil servant who had worked closely with Norman Tebbit in the 1980s on the privatisation of utilities. Immediately after the 2005 general election, and before Cameron became leader, he set out in a speech to the NHS Confederation how the lessons from that could be applied to the health service:

- GPs should once again be given hard cash budgets with which to buy care.
- New and independent providers should have 'a right to supply' NHS care.
- A new and 'pro-competitive' regulator should be established to operate a failure regime for providers, to rule on whether mergers would reduce competition, and to ensure that procurement and competition law were applied in the NHS.[40]

By September 2006, to this had been added the idea of an independent board, possibly at the instigation of, among others, Steve Hilton,* Cameron's bare-footed and Bart Simpson-dressed Strategy Adviser. The result was that barely a week after Brown had hinted at an independent board, Lansley, with Cameron alongside him at the Conservative Party conference, launched what they dubbed an "autonomy and accountability" plan for the NHS.

This contained the core of what was to become the Health and Social Care Act 2012 – GPs to do the commissioning, all hospitals to become foundation trusts, a new economic regulator for the NHS to promote competition and the right for the private and voluntary sectors to bid for NHS work – and an NHS commissioning board "to take the politics and politicians out of the day-to-day management of the NHS".[41]

This package in fact caused relatively little media stir because much of it seemed to be so much in line with what Labour was up to and where it was going. On the day, one senior Department of Health official dubbed the package as "a credible – indeed given the [Labour] Government's current policy, a logical – way forward".[42] Lansley himself said that while it was "essential" it was there "to make the current [Labour] reform work better".[43] Rosie Winterton, the Junior Health Minister who was close to Brown and who was presumably aware of Hewitt's musings, declared an independent board to be "an idea worth looking at".[44]

The politicians were far from alone in being attracted to the idea. Earlier in the year, for example, the *British Medical Journal* had noted that Gordon Brown's first act as Chancellor had been to make the Bank of England independent. "His first act as Prime Minister should be to give independence to the NHS," its editor, Fiona Godlee, declared.[45]

Others were more questioning. Chris Ham, former head of the Department of Health's strategy unit, asked of Lansley's proposal: "How do you draw a real distinction between the strategic issues that would remain with the politicians and the operational matters, that inevitably produce political conflict, that are for the board? If that contract cannot be clearly drawn, it is a recipe for muddle and confusion." [46]

John Appleby, Chief Economist at The King's Fund at the time, acknowledged that while there was a widespread wish for ministers to be less involved in day-to-day

* That certainly is the memory of Bill Morgan, Lansley's special adviser.

management, "I am not sure this sort of structural change will achieve that. If the problem is the way politicians behave, then why don't politicians just change their behaviour?"[47]

The idea of an independent board was now attracting sufficient political attention across party divides for the Nuffield Trust health think tank to commission a shrewd paper from Brian Edwards, former regional general manager of the NHS and a historian of its executive years. In this paper he set out the challenges that would inevitably be involved in creating an independent board – not least deciding precisely what it would do and how it should be constituted.[48] Likewise, Anna Dixon and Arturo Alvarez-Rosete at The King's Fund produced a paper entitled *Governing the NHS: Alternatives to an independent board*, which irked Andrew Lansley by being decidedly sceptical about the idea.[49]

Neither Brown's outline idea nor Lansley's proposal was universally popular in Labour's ranks. Alan Milburn, former Health Secretary, attacked it,[50] as did Blair in one of his final speeches as Prime Minister in May 2007. An independent board, in Blair's view, would "fall prey to vested interests" and would "block reform".[51]

Alan Johnson, who succeeded Hewitt and became Health Secretary as Gordon Brown became Prime Minister in 2007, was decidedly not a fan. His view was that the Health Minister was accountable. "There is," he was to say in 2014, "no way I would have set up this huge quango [NHS England]."[52] The point was well illustrated in 2009 when the scandal of the appalling care that patients had received at Mid Staffordshire NHS Foundation Trust first hit the headlines. A mighty meeting was convened in Johnson's office that included the Department of Health, the NHS Executive and the regulators – Monitor (the foundation trust regulator) and the inspectorate (which was then known as the Healthcare Commission). Johnson turned first to David Nicholson, then Chief Executive of the NHS, who told him that, as a first step, there was no choice but to get rid of the chief executive and chair. "Fine," Johnson replied. "That's what we will do."[53]

Mid Staffordshire, however, had recently become a foundation trust – indeed it was the financial squeeze that it applied to its operations in order to qualify for foundation trust status that had led to many of the problems at the hospital. As a foundation trust it was, under Labour's legislation, now legally subject to Monitor, its regulator – not to the Department of Health or the Health Minister. It was Monitor, rather than the Health Secretary, which had the power to dismiss the boards and chief executives of foundation trusts. So Bill Moyes, Monitor's Chair and Chief Executive, intervened to ask – entirely legitimately – "under what legal authority, secretary of state, do you plan to do that?" To which Johnson replied: "Look, this is what we are going to do. I've spoken to the Prime Minister about it. I am up in the House... answering questions about it. I am the Secretary of State for Health. And I'm responsible. And that's what we are going to do. I don't give a damn what the legislation says."[54]

Johnson concedes that "Bill Moyes was probably right that the legislation said that he was responsible... and it would be very nice politically if you could get away with it and say 'that's yours, that can of worms'. But I told him, you know, 'Piss off, I am dealing with this.' You are the secretary of state. There is public money going in there. You are responsible."[55]

In practice, of course, and in line with the legislation, the formal removal of the chair and chief executive was indeed undertaken by Monitor, and the initial investigations into what had gone wrong at Mid Staffordshire were "jointly" appointed by Johnson and Monitor in order to fulfil the legal niceties.[56] But it was clear that this was Johnson's decision. Indeed, according to one civil servant, "a process was set up whereby if Monitor had refused to act, Bill Moyes and his board would have been sacked". Johnson's decision – his behaviour – had in practice trumped the legislation.

> I told him... 'Piss off, I am dealing with this'.
>
> Alan Johnson

Something similar was to happen two years later, in Andy Burnham's time as Secretary of State for Health. In 2009, Burnham, as Johnson's successor, said that he was shocked to discover that the chief executive and chair who had been put into Mid Staffordshire back in 2007 were still interim appointments, not substantive ones. "Why," he asked, "have we now not got the best that the NHS has in there?" To which, he says, the Department of Health's answer was: "Oh well, [it is] Monitor – they don't want to put anybody in. And you [Labour] set up Monitor and it is your foundation trust reform."[57]

Monitor, to be fair, was in an odd position. It could put interim chairs and chief executives into foundation trusts. But the legal position was that the chair of a foundation trust was chosen by its governors, while the chief executive was appointed by the foundation trust's board. So while Monitor could make interim appointments, it could not technically – indeed legally – make permanent ones. The board now in place had sought to hire a new permanent chief executive. But despite employing costly head-hunters, it had failed to find one.

In practice, as the evidence to the Frances inquiry shows, once Burnham had focused on this, growing pressure from him on the Department of Health, and from the Department of Health on Monitor, and then from Monitor on the board, did lead to permanent appointments. Strictly speaking, the legal niceties were honoured. But it is crystal clear that it was Burnham's concern, and in effect his decision, that led to that. His behaviour had again trumped the legislation. It was honoured in the letter, but not in the spirit.

For Burnham, this helped to confirm his eventual view that real independence would not work. "You have to be able to over-ride systems, and the requirements for public safety, and good governance means that politicians will occasionally have to step in," he says, while recognising that ideally the Secretary of State should stay as far away from direct management of the health service as possible.[58]

Burnham confirms that:

"[The idea of an independent board] was discussed at the point of transition [between Tony Blair and Gordon Brown] and Gordon's team got interested in it. But when we thought about it, it quickly dropped away when you looked at the implications. You simply cannot have £100bn-worth of public money without democratic accountability. I remember people saying, 'You couldn't have MPs writing and the Secretary of State saying, "Oh, don't ask me"', which is kind of what happens now [in 2015, the time of this interview]. If politics has a respectable role it is obviously in providing accountability for taxation. And if that does not apply in respect of the NHS, then what does it apply to?" [59]

In 2015, at the time of that year's general election, Burnham, by then the opposition health spokesperson, was promising to repeal Lansley's Health and Social Care Act, "restoring proper democratic accountability for the NHS".[60]

Act Two
'Liberating the NHS': 2010 to 2013

Scene One – Lansley legislates...
"They used to tell me I was building a dream..." or "Ship of fools"

Here is not the place to repeat in full the tumultuous story of how the Health and Social Care Act 2012 came into existence.[1] It is the place to note, however, that as Lansley's plan was taken into government, a cock-up – as the Conservatives and the Liberal Democrats sought to marry their manifestos into a "programme for government"[2] – produced an initial proposal for NHS reform that everyone in the Department of Health regarded as "crazy".[3]

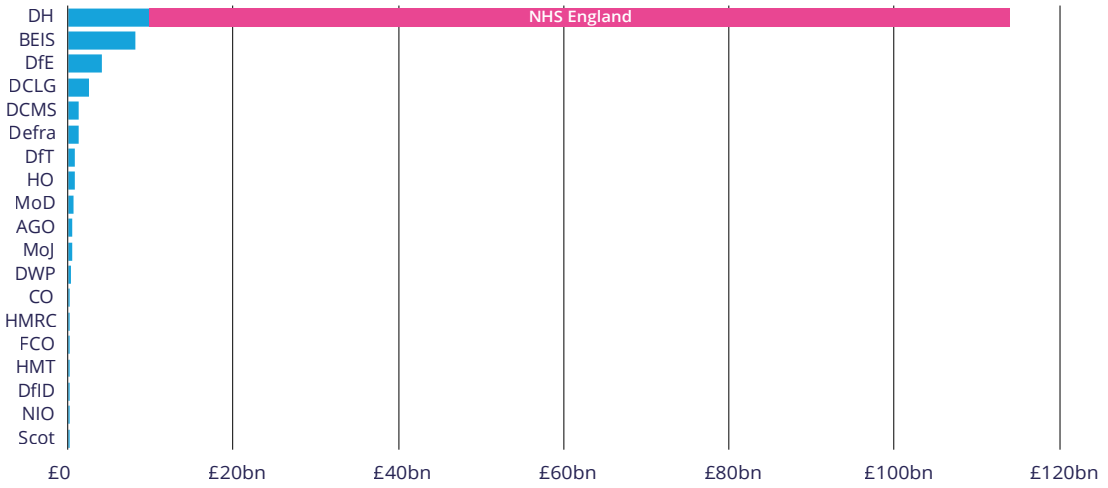
In the course of unpacking that, an awesome and awful logic set in, which led to the abolition of both primary care trusts and the strategic health authorities above them, with the Liberal Democrats' manifesto having contained a promise to abolish the latter.[4]

Thus, having originally promised to "stop the top-down reorganisations of the NHS",[5] the Government found itself delivering not just the big shift in power and accountability that Lansley's original plan envisaged – an independent board under which GPs would take the prime responsibility for commissioning NHS care – but also the biggest single structural upheaval in the history of the NHS, at least since 1974. And it was that mighty upheaval, allied to the reinforced quasi-market approach, that led to the *Liberating the NHS* white paper[6] landing like a bombshell on an unsuspecting public just after the May general election in 2010.

It is also worth noting – although as a bit of an aside – just how big a contrast the Coalition Government's approach to the NHS was to the rest of its programme. Rather than creating quangos – the Health and Social Care Act was to create or massively revamp at least six health quangos* – elsewhere the Government was subjecting them to a 'bonfire'. Other government departments, not least in education and welfare, were bringing back into the relevant departments tasks that had previously been offshored. Outside health, 28 executive agencies – more than a third of them – were abolished between 2010 and 2013.[7] In health, the Government, in the shape of the commissioning board, created easily the biggest, and one that is uniquely disproportionate to the size of its sponsoring department (see Figure 1).

* Health Education England, HealthWatch, Monitor, NHS England, Public Health England and the Trust Development Authority.

Figure 1: Government funding provided to public bodies, by department, 2017



Source: Institute for Government analysis of Cabinet Office (2017) *Public Bodies 2017*.

Note: **DH** Department of Health; **BEIS** Department for Business; Energy; Innovation and Skills; **DfE** Department for Education; **DCLG** Department for Communities and Local Government; **DCMS** Department for Digital; Culture, Media and Sport; **Defra** Department for Environment; Food and Rural Affairs; **DfT** Department for Transport; **HO** Home Office, **MoD** Ministry of Defence; **AGO** Attorney General's Office; **MoJ** Ministry of Justice; **DWP** Department for Work and Pensions; **CO** Cabinet Office; **HMRC** Her Majesty's Revenue and Customs; **FCO** Foreign and Commonwealth Office; **HMT** Her Majesty's Treasury; **DfID** Department for International Development; **NIO** Northern Ireland Office; **Scot** Scotland Office

But if here is not the place to set out how the Health and Social Care Act became law, it is the place to set out Lansley's vision of an independent board – the NHS Commissioning Board – and some of the reaction to it, not least the reaction of Her Majesty's Official Opposition (in other words, the Labour Party), given that the Liberal Democrats, as Coalition Government partners, were party to the 2010 white paper.

Let's start with the vision.

Liberating the NHS stated that the NHS Commissioning Board – what became NHS England – was to be a "lean and expert organisation, free from day-to-day political interference".[8] It would license and oversee the new GP-led clinical commissioning groups who were to purchase NHS care. It would itself commission some specialised and national services. It would provide leadership for quality improvement. And to avoid the conflict of interest in GPs in the clinical commissioning groups commissioning services from themselves, the board would commission the services of GPs – holding their contracts so to speak, along with those for community pharmacy, dentistry, eye tests and maternity. It was, however, to be strictly a 'commissioning' board. *"It will not manage providers or be the NHS headquarters."*[9]

> the headquarters [of the NHS] will be in the consulting room and clinic

"The headquarters of the NHS will not be in the Department of Health or the new NHS Commissioning Board but instead, power will be given to the front-line clinicians and patients. The headquarters will be in the consulting room and clinic," the white paper stated.[10]

Three tiers of NHS management were abolished. The first tier to be abolished was the NHS Executive, which operated partly in Leeds but was also embedded in the Department of Health: David Nicholson, Chief Executive of the NHS, had, like his

predecessors, a large office on the fourth floor of Richmond House in London, at the opposite end to that of the Secretary of State for Health – the fourth floor being where the power lay.

The second tier to disappear involved the 152 primary care trusts, which commissioned care locally. That task was to be taken over by GPs in what started out as almost 500 but eventually became 211 clinical commissioning groups. And with the primary care trusts gone, and all hospitals meant to become foundation trusts, the 10 strategic health authorities that sat above the primary care trusts, and which oversaw both them and the non-foundation trusts, were also scrapped – the third tier to go.

The NHS was, in Lansley's vision, to cease to be a managed service. NHS England, as the NHS Commissioning Board became, was not even to be *primus inter pares* among the new or refreshed arm's-length bodies that the Act eventually created. These included:

- Monitor, which was now to be not just the foundation trust regulator but also an economic regulator, enforcing the application of competition and procurement law, and itself helping to set the 'tariff' or NHS price list for procedures
- the Care Quality Commission – the existing regulator for, and inspector of, health and social care
- Health Education England, which was to be responsible for training
- Public Health England, which retained those parts of public health that were not being transferred to local authorities, and
- the Trust Development Authority, a new arm's-length body responsible for the hundred-plus hospitals that had yet to make it to foundation trust status, and whose task was to help them get there.

> [the NHS will be] free from frequent and arbitrary political meddling

As for the commissioning board, it was to operate to a three-year "short formal mandate" set by ministers and reviewed annually. This would lay down the outcomes that the government of the day wanted to see. But after that, the theory went, the board would then essentially be left to get on with it – leaving the NHS "free from frequent and arbitrary political meddling". The legislation would "limit the powers of ministers over day-to-day NHS decisions", with the Secretary of State for Health losing "existing powers to intervene in relation to any specific commissioner" other than for defined statutory responsibilities.[11] In other words, this was a very particular form of statutorily independent board – one that followed the logic of the Blairite health reforms, which themselves stretched back intellectually to the original purchaser/provider split in 1991.

But, in another time, it could have taken a different, more managerial, more corporate – more nationalised industry – form, or one on the lines of a BBC-type charter that others had favoured in the past. And even with the purchaser/provider split, it could, like the NHS Executive before it, have been something closer to "the headquarters of the NHS" or indeed a statutorily independent form of the NHS management board that was created as part of the Griffiths reform. Under Lansley's dispensation, however, it was not even to be first among equals.

It was the *Liberating the NHS* white paper that essentially became the bill that was published in January 2011, only for it to go through one of the more tortuous legislative processes of modern times. The many controversies included a new duty on the revamped Monitor to "promote competition where appropriate" while using regulation "where necessary", and charges that Lansley was seeking to undo the Secretary of State's duty to provide a comprehensive service.

So furious was the opposition that at one point the bill had to be formally 'paused' to allow a clutch of the great and the good, under the title of The Future Forum, to crawl all over it, before it underwent extensive amendments in the House of Lords, during which, at times, it even looked like the bill might be lost.

There is plenty of room for debate about how far the amendments fundamentally changed the bill. The "promoting competition" duty was changed to "preventing anti-competitive behaviour" and the phrasing of the Secretary of State's duties was changed. The most significant changes may prove, however, to have been that new duties were placed on Monitor, the NHS Commissioning Board and clinical commissioning groups to provide health services in 'an integrated way' – against the original bill, which laid no such duty on them.*

The final Act thus faced in more than one direction. It was a lot more complicated, and less of a pure vision, than the white paper had been. It contained many a provision that made clear that competition and procurement law now applied to NHS services. But it also contained duties to provide integrated health services – without offering any clear direction as to how those two potentially conflicting duties were to be reconciled.

Six years on from the Act, the full significance of that is still not entirely clear, although it may be about to be tested in judicial reviews of the way the Act is being implemented.

There was much more in the Act that will not be gone into in detail here. For example, it created other new bodies including health and wellbeing boards, which were intended to link the NHS and local authorities together to provide a form of joint collective oversight of NHS and social services – the goal being better integration of health and social care. There was to be a patient/consumer voice via HealthWatch, which became, in effect, a subsidiary of the Care Quality Commission. And both before and during the reform, a host of other bodies were created, some tangential to the reform, some as a direct result of it, although most were not technically part of the legislation – academic health science centres, academic health science networks, clinical senates, commissioning support units, commissioning support services, local education and training boards and much else. The result was absolute alphabet soup of new organisations, each of which was trying to work out its role in the new dispensation.

As this very brief summary makes clear, it was all immensely complex and multi-layered, to the point where, as Simon Burns, the hapless Minister of State for Health

* Bill Morgan, Lansley's special adviser, says that Lansley was relaxed about these amendments because the lawyers advised that integration was something that competition would or should itself be able to deliver (interview, 2018).

who had to guide much of the legislation through the House of Commons, put it, even ahead of the House of Lords' amendments, "you cannot encapsulate in one or two sentences the main thrust of this [Lansley's bill]".[12]

But as Nigel Edwards, Chief Policy Officer for the NHS Confederation at the time, shrewdly put it, what the reforms did was turn the NHS from something that, despite the existence of the purchaser/provider split, was still recognisable as an organisation, into something closer to "an eco-system" – one where commissioning, patient choice, provider competition, the tariff and the regulators, both new and old, would turn the service into the "self-improving" organisation that Labour ministers had desired.[13] It would no longer be a managed one. Instead, the theory went, the clinical front line would be freed up, with GPs doing the bulk of the commissioning, and providers (whether NHS providers or not) being "freed from government control to shape their services around the needs and choice of patients".[14] The NHS would innovate and improve with little or no interference from ministers.

To put it another way, as one of David Cameron's senior special advisers later, and somewhat despairingly, put it, what Lansley was seeking to create was "a perfectly incentivised perpetual motion machine", or as David Nicholson, the NHS Chief Executive put it to colleagues, "a clockwork universe" that would run itself.

Or, in the less colourful words of the white paper, "we are moving to a system of control based on quality and economic regulation, commissioning and payments by results, rather than national and regional management".[15]

And, for all the battles over the bill, that, essentially, is what went into law. One consequence was that, for the first time since 1948, it became impossible to draw an organogram that described, with any truth, how the NHS was meant to function.*

Scene Two – Building the board
"River deep, mountain high"

During the exceedingly rapid drafting of the white paper – completed a mere 60 days after the 2010 general election – flesh had to be put on the bones of the idea of an independent commissioning board, and then with more detail as the white paper moved to legislation and on to implementation. And, boy, was there a lot of work to do.

According to Bill McCarthy, who became the project manager within the Department of Health for the creation of the commissioning board, "despite Andrew's long experience in developing his plans [he had been opposition health spokesperson for an unprecedented six-and-a-half years], there was a lot that was not really worked out at all".[16]

* However, some entertaining attempts to do that were made. See for example: www.kingsfund.org.uk/sites/default/files/media/structure-of-the-new-nhs-animation.pdf. For a more sober attempt, see Ham C, Baird B, Gregory S, Jabbal J and Alderwick H (2015) *The NHS Under the Coalition Government: Part one: NHS reform*, The King's Fund, p. 59. Even that, it notes, "is not comprehensive".

He was far from alone in that judgement. Other senior civil servants variously describe the ideas around what the board would actually do as being "hazy", "ambiguous" and "un-thought through".

One says:

"I tried to write down, off the top of my head, a list of the five things the commissioning board should do, and thus what it should not do... and in practice pretty much everything ended up in there. The A&E target, the waiting-time targets, the money... trying to create a distinction between operations on the one side, and policy on the other, was clearly going to be immensely difficult."

Bill McCarthy says:

"The original conception was that it was going to be a regulator of the GP commissioners and not a lot else. It would have the money, allocate it, and fire the commissioners who were not up to the job. That was not sensible or realistic, and that is certainly not what it became.

"Furthermore, David [Nicholson] knew, and it was a judgement I entirely shared, that the Government was not simply going to give the commissioning board £100bn a year, write it a short mandate, and just leave it to get on with it. That was never going to be the reality."

> **the Government was not simply going to give the commissioning board £100bn a year, write it a short mandate, and just leave it to get on with it**[17]

The Department of Health did not start with an entirely blank sheet of paper.

Back in 2006, when Patricia Hewitt was seriously interested in creating an independent board for the NHS, McCarthy, then Head of Strategy in the department, and David Nicholson as the new Chief Executive of the NHS, had written papers on how that might work, "and it was clear," according to another senior civil servant, "that Nicholson was very attracted to the idea of a more independent way of running the NHS".

Furthermore, in the mid-2000s, Gus O'Donnell, as Cabinet Secretary, had launched a rolling programme of 'capability reviews' to assess each government department's ability to cope not just with its present operations but also with its future challenges. Nicholson and David Flory, at the time the department's Deputy Chief Executive, had found value in that. So, in the later 2000s, they undertook the same exercise with the 10 strategic health authorities. As one senior civil servant puts it: "Of course it turned out that the strategic health authorities did not all do exactly the same things – or do them equally well. So we had these big ring binders, one for each of the SHAs [strategic health authorities], which between them covered all their functions, and that definitely helped."

And then there was Nicholson's take on all of this. He was, so to speak, an NHS manager born and bred. By 2010 he had more than 30 years' experience of the service, having

held over a dozen posts, starting out in the vast mental health and learning disability asylums that then still existed but were set for closure, before moving through acute hospital appointments and on to a string of health authority jobs. He had worked in pretty much every part of the NHS other than primary care, with which of course, he had plenty of contact. He knew the service inside out – including its weaknesses.

He had, in both public and private, a nicely self-deprecating sense of humour, referring to his Communist past when he at times promised "Stalinist" controls over the NHS finances.[18] In another early interview as he became head of the NHS Executive back in 2006, he noted that he had been an amateur rugby union hooker. "I am used to armed combat, face to face," he grinned. "That's what I like. Not very fast but I get there. Perfect training for the job."

Opinions about him were divided. To some in the NHS he was a hugely supportive manager and mentor, willing to help in any way he could, those who were really trying, even when they hit big difficulties. To others he epitomised the worst of the 'command and control' culture, and the bullying 'performance management' approach that Lansley, with his 'liberation' plan for the front line, was determined to destroy. Indeed Lansley, as he was appointed, made it crystal clear to Nicholson that he did not see him being the chief executive of the new commissioning board. And Nicholson's relationship with the quasi-market reforms of the previous 20 years was a complex one.

In an early interview as NHS Chief Executive, he pointed out that as Chief Executive of Doncaster Hospital, back in the early 1990s, Doncaster had been "the very first" to become an NHS trust – the semi-independent, nominally freestanding precursor of foundation trust hospitals. Doncaster had been an early adopter, he said, because "it didn't take a genius to work out that we and the clinicians could run the hospital better for patients than the health authority or the region or Whitehall or anybody else". He saw power in another part of the purchaser/provider split – GPs holding budgets to buy care on behalf of their patients. "I understand the power of not being accountable to Whitehall and being able to manage and run your own affairs."[19]

Nicholson favoured an element of choice for patients over where, when and how they got treated – he was no paternalist from 'the patients should be grateful for what we provide' school. He accepted that the NHS should use private providers where that was in patients' interests. But he was no instinctive fan of quasi-markets, as the purchaser/provider, choice and competition approach is known in the jargon. Nor, despite his early adoption of NHS trust status, was he entirely a fan of the creation of the much more freestanding foundation trusts under Labour. "I knew from my own experience that local management of hospitals was very beneficial," he says, "but given that the NHS remained the single payer for their services, they were inevitably going to be constrained."[20] Thus, while he understood the power in the ideas, he worried about the fragmentation that the quasi-market approach brought.

So there had been some clashes with Bill Moyes, the Chair and Chief Executive of Monitor, as the first waves of foundation trusts came into being. Entirely honourably, Moyes had in effect appointed himself as the guardian of the Labour Government's legislation against itself whenever it crossed a line that, in his view, threatened the independence of the trusts.

For example, in 2008 Moyes had pointed out forcefully that neither ministers nor Nicholson could direct foundation trusts when Alan Johnson announced the appointment in every hospital of infection control nurses, along with 5,000 extra matrons. Nicholson put out a circular to all hospitals to that effect. But such "instructions" were "not consistent with the legislative framework," Moyes argued. Foundation trusts themselves were responsible for safety and for how it was achieved, with Monitor having the legal power to intervene if they fell down on the job.[21]

In a 2009 interview, still in Labour's day, Nicholson said that 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" but a group bound by "values and principles which transcend that".[22] In other words, despite all the quasi-market reforms, the NHS remained a system. Indeed Nicholson could get positively emotional as he recited from heart the opening phrases of the NHS Constitution, which had been put together in Andy Burnham's time. "The NHS belongs to the people... [it] is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it."[23] That is not the opening definition of a quasi-market.

Lansley came to recognise that he needed Nicholson

But against all that, both as a middle-tier NHS manager and then as chief executive, Nicholson had seen the way policy could swing in the political wind – from more or less support for a more market-like approach under successive ministers in the same government; from quality being seen as the essential feature of the NHS, to less interest in that; and from the development of out-of-hospital care being seen as crucial, to, again, a loss of focus on that.

So he was, like many others, attracted by the idea that the service could be run more independently of ministers, and thus perhaps with greater consistency and better long-term results.

And his relationship with Lansley evolved. It may not have started out well on Lansley's part. But as several people in the Department of Health have put it, "Lansley came to recognise that he needed Nicholson".

Lansley's own account of the evolution of their relationship, back in early 2012, was that:

"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 for change... 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 that was a real bonus, a real potential opportunity."[24]

Or, to change the tense from the time when this interview took place, Nicholson 'saw it and took it'.

Nicholson survived Lansley's original hostility for a number of other reasons, including the fact that, from the date of the 2010 general election onwards, the Department of Health's most senior officials worked hard to ensure that he was retained, not least because, according to interviewees, they recognised that he knew better than anyone else inside the department how to hold the service together amid the whirlwind of controversy and change to which it was being subjected. He was honest, as Lansley has acknowledged, in his advice in private to the Secretary of State, while also being, for a civil servant, remarkably honest in public about what was involved in Lansley's plans. And there was the small issue of the money.

> a reform so large you can actually see it from space

After the financial crash in 2008, it was clear that the heady days of 7% per annum real-terms growth in NHS spending were over. Nicholson had taken over as chief executive in the wake of the 2005 financial crisis when the NHS had achieved the remarkable feat of overspending at a time of record spending increases. Over the next couple of years, thanks to him and many others, financial control had been restored – to the point where, in 2008, the NHS had a £2bn surplus that, despite Treasury raids, was to help it get through the earlier years of the financial squeeze to come.

That year, licensed by Alan Johnson so to do, Nicholson had told the service that it needed to make some £15bn to £20bn of efficiency savings between 2011 and 2014 to meet demographic and other pressures[25] – a figure that Stephen Dorrell, the former Health Secretary and chair of the House of Commons Health Committee, dubbed "the Nicholson challenge". In 2010, with real-terms increases now written into government spending plans at a mere 0.1% per annum, Nicholson, famous for his 'grip', was promising – and only half-jokingly – "Stalinist" measures to retain financial control.[26]

Lansley, according to his civil servants, showed remarkably little interest in the money. Nicholson recalls saying to him early on that "this [Lansley's plan for a more clearly defined quasi-market] will only work in a system that is growing and expanding, so it can afford the excess capacity needed to make competition work. But we are about to enter a period of marked austerity." Lansley replied, according to Nicholson, "That's a very good point."[27] Or as another senior civil servant puts it: "We couldn't get Lansley to focus on the money – the £20bn and the scale of the financial challenge. 'I am going to do these reforms anyway – I am not going to let the mere matter of the financial context stop me from getting on with this, because I think they are the right thing to do'."

Furthermore, as an NHS chief executive who was technically a civil servant, Nicholson proved remarkably outspoken in public about the risks involved in Lansley's mighty upheaval. As opposition to the Health Secretary's white paper mounted, Nicholson warned in early December that it involved "the only change management system that you can actually see from space – it is that large", while warning that "it might not work".[28]

And that warning coincided with a review of Lansley's plans that an increasingly anxious David Cameron had commissioned from Oliver Letwin, Cameron's policy overlord in the Cabinet Office, and Danny Alexander, the Chief Secretary to the Treasury. The review essentially came down in favour of Lansley's approach, while being worried about the money, with the result, as one senior Department of Health official puts it, that:

"David emerged as the saviour of the day... He 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."

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Thus it was that Nicholson, having assumed that his days were numbered, had gone into the Cabinet Office in the first week of December 2010 to negotiate his severance deal. Only to receive a phone call from Lansley that led to a breakfast meeting of scrambled eggs at Inn The Park in London, during which the Health Secretary offered him the job of chief executive designate of the commissioning board. Nicholson thought about it over the weekend and said yes.[29] As a result, he continued the work he had already started on building the new commissioning board, knowing now that he would be the one, at least initially, running it.

Nicholson says:

"Immediately after the election, the commissioning board wasn't a fully developed idea. It was relatively thin. It was there to regulate commissioning, and to allocate resources, and that was about it. It wasn't clear that it would do specialised commissioning. That came later.

"What I wanted to do – and this is before I even got the job – was make sure that it had leverage. The first thing I wanted to ensure was that the new chief executive had a £1bn surplus to provide some flexibility, because it was obvious that times were going to be hard. And second that, whoever got the job, they had to be able to make change happen. So I was looking for levers I could build in to make things happen.

"I wanted the best people in there, and they would not go unless there was some way that they could make change. The government of the day was always going to want the board to deliver its policies, so a body that couldn't do anything, or couldn't do very much, would be in trouble right away. Because no matter what the theory said, the idea that the Government was just going to hand over £100bn and say 'go away and do your best' was simply unrealistic."[30]

One of the early agreements – somewhat to Nicholson's surprise – was that the board would allocate resources: controlling the funding formula that decides which parts of the country get how much.

Nicholson says:

"All that is in fact quite politically charged. It is a formula, but the formula involves judgements. What weight do you give to health inequalities, for example – 15%, 10% or 20%? It is a judgement informed by numbers. But it remains a judgement. And it affects which parts of the country get most – to put it very crudely, inner-city areas or rural ones? That's very political. And once you have a target for each area, there are judgements about how fast you move towards equalising them.

"All that, in the past, could get very political within the department – ministers making those judgements for obvious political reasons. But Andrew wanted the board to have it – part of his drive to separate politicians from the management of the service. So the board got it.

"The board was always going to be responsible for commissioning primary care – holding the primary care contracts. That was because the politicians – and not just the politicians – were worried about the conflict of interest in GPs commissioning the bulk of health care but also commissioning services from themselves. And then there was the specialist commissioning. Andrew's original idea was that the CCGs [clinical commissioning groups] would come together to do it.

"At that stage we were still talking potentially about 500 CCGs. My advice was, that was 'all very interesting, and maybe in the medium term... but these are crucial services, and if we get them wrong...'

"I mean, the idea that we would give the commissioning of paediatric cardiac surgery, which operates from a very small number of centres, to 500 CCGs? It would be much safer to have a national body doing that. And people had already started to look at the commissioning board as a safety net as some in government worried about giving everything to the GPs. So the political and the managerial came together, and the board got specialised commissioning.

"To do that you needed the expertise. So I talked to Bruce Keogh [the Department of Health's Medical Director], and it was obvious that we needed the clinical czars to help with that. So they all moved across, and not least because the board was to operate to a mandate, which was to be built around an outcomes framework – what outcomes did the Government want for its money? And I anyway wanted a clinical focus, so that it would not become another Monitor, just concerned about the money. So outcomes meant the clinical leaders."[31]

In addition, Nicholson believed in patient information and the power of the new digital age to inform patients, to help them take more control of their own care, and to help them choose – less in the sense of taking their money to another provider, more in the sense of helping them make informed decisions over the nature of their care, with their clinicians. So NHS Choices, the health information website on which patients could also look up the performance of their service locally, was brought in – the ambition being to help put patients at, or at least near, the centre of the commissioning board's activities.

But that was not all. The initial negotiations about what the board would do were handled on Nicholson's behalf by Bill McCarthy as the project manager for its development. The reasons for that included the fact that Nicholson still had the NHS to run as his day job, while assuming he would not be chief executive of the commissioning board. And also because there was bound to be, if not an argument, then at least a vigorous debate about turf. What would the Department of Health give up? What would the commissioning board take? Interviewees say that Nicholson knew that the more that the commissioning board took, the more it might look like a Nicholsonian 'land grab' – although when the results were known there were those both inside the department and outside it who accused him of that.

In practice, as one senior civil servant puts it, the reason why NHS England became something somewhat larger than the 'lean' body envisaged by the white paper:

"was down to Bill [McCarthy] and David [Nicholson], who, in their sessions with Lansley, asked these utterly left-field questions about what was going to go where – based both on their own knowledge and the knowledge contained in those strategic health authority capability reviews.

"And of course when we went through with Lansley what the department and the SHAs [strategic health authorities] did, we had to decide if it was needed or could be dispensed with – and almost all of it turned out to be needed. So then the question was where should it go? To the department, or the commissioning board, or somewhere else?

"So there was the white paper promise to hand over public health to local government, which meant the disbandment of the Health Protection Agency [HPA], which had been a genuinely arm's-length body to the department. But while a good chunk of public health could go to the local authorities, the HPA ran Porton Down, the old microbiological warfare centre, now dedicated to combating infectious disease and providing isolation for really dangerous pathogens. The HPA ran the national surveillance system for infectious disease, and the co-ordination plans for tackling any really serious outbreak, and so on. And national government clearly needed the ability to negotiate with industry over sugar and fat levels in food and what have you, and the ability to run national health education campaigns."

Lansley had originally wanted to turn the Department of Health into the Department for Public Health. But working out what was to go where, once the decision had been taken to hand much of public health back to local government, meant that the original white paper promised only a new Public Health Service, with details to come later in the year. The final outcome, after the split between the department's role and that of local authorities, was Public Health England.

One civil servant says:

"Then there was the foundation trust pipeline. Monitor would still be there as the foundation trust regulator but with a significantly extended remit as the market regulator. But getting NHS trusts to a stage where they could apply to be foundation trusts had lain with the department and the SHAs. The department's role in that had to end under Andrew's dispensation, and the SHAs were to be abolished."

The original Lansley plan had been to get all hospitals to foundation trust status by 2013. But the 'pause' in the bill put paid to that, with the target shifted to 2014 – after the rest of the Act was to take effect.

The same civil servant says:

"So we had to create another quango, the Trust Development Authority, to take on that role. And then there was workforce, where, it turned out that we had to create Health Education England to do the workforce things – because workforce did not fit with the commissioning board, it should not – in Andrew's dispensation – be in the department, and workforce went wider than the role of either Monitor or the Trust Development Authority.

"So more arm's-length bodies got created. And there were other things that the SHAs did, or the department did, that had to go somewhere – and many of them went to the commissioning board."

These included 111 – the telephone advice service for urgent medical concerns – and the overarching responsibility for ensuring that doctors undertook 'revalidation', a five-yearly requirement to ensure that they remained fit for practice.

"But good things came out of this," this civil servant says. "The classic example is clinical advice. Although we had clinical czars in the department, every SHA had a cancer adviser, and a cardiac adviser etcetera. And the creation of NHS England in effect nationalised all that. So we could get better people to do it. And that has definitely been a gain."

In all of this, it might be thought that the Department of Health, seeing its hegemony being shrunk, would resist. But Nicholson had a friend at the top in the shape of Una O'Brien who in December 2010 had become permanent secretary, having been closely involved in the white paper.

One senior civil servant says:

"She believed that NHS England was the right thing to do. She had sat on the NHS management board for six years and saw this fake board of SHA chief executives, herself, Richard Douglas [the department's Director General of Finance], and others who were technically overseeing the NHS and the work of Nicholson, Flory and many others. But it was a complete fake. It didn't have real authority. And what they did was anyway subject to ministers. Una favoured a considerable degree of operational independence for the NHS. And so, while there were some disagreements, she was broadly in favour of everything that David Nicholson took."

There was, as illustrated, a degree of inevitable, indeed awesome logic to this once the decision to destroy the existing NHS structures had been taken. But to many this looked like a 'land grab' by Nicholson, attempting to recreate the NHS Executive, and more, outside the department.

And then, of course, there was the mandate to construct.

In Lansley's eyes, this was the key document that would give his independent commissioning board its marching orders. The white paper had promised a "short formal" one. But what did that mean? Five hundred pages? Or a single side of A4?

"The Act was written," says one civil servant closely involved in it, "so that it could be either. If ministers wanted a 500-page mandate they could do that – and in fact be more centralist than ever before. Or it could be very light touch."

The first attempt proved to be more of the former than the latter. Another civil servant says:

"The idea – the concept of the mandate – went to the Home Affairs Committee of the Cabinet. And it inevitably went around the department. So of course everybody, and not just those in the department, piled in – terrified that if their tiny bit of the health care system was not in there, then nothing would happen. So the draft ended up being large."

the Act was written... so that... ministers... could... be more centralist than ever before.

It included five domains – the broad NHS responsibilities – with 60 indicators that made up an 'outcomes framework', 27 'improvement areas' and 22 'objectives', with a lengthy technical annex on how some of these would be measured.[32] It was widely regarded as an unwieldy and uninspiring shopping list.[33] But, in the first instance, with some simplification, it was largely this mandate that was adopted: a multi-year agreement running to 2015 but which would be refreshed annually. New items could only be added in year with the agreement of the board of NHS England. If their agreement was withheld, the Secretary of State would have to explain to Parliament why he had insisted on something new being inserted. The first version was in fact signed off by Lansley's successor, Jeremy Hunt, within weeks of his appointment. He sent a copy over to Nicholson with the wry note: "It's all down to you now David!"

The exercise to get the new dispensation in place was enormous. It involved recasting the NHS Executive into a statutorily independent commissioning board, initially created as a special health authority so that it could license, subject to the legislation passing, what turned out to be 211 clinical commissioning groups.

But that also involved closing down 152 primary care trusts and 10 strategic health authorities. Some 50,000 people changed jobs.[34] Around 600 departmental civil servants were moved across to what by now had become known as NHS England – tempted in some cases not just by the brave new world but also by the fact that NHS England tended to pay more in order to secure the best. In shadow form, Health Education England, Public Health England and the Trust Development Authority were also got going while Monitor, despite retaining its name, had to start to build a hugely extended remit as the market regulator and partial price setter for the NHS tariff.

Hundreds of offices were closed. Some new ones had to be found. Many thousands of computers had to be decommissioned and then safely recommissioned for their new roles as in total more than 170 organisations were closed and more than 240 new ones were created. NHS England ended up with at least some staff from 162 legacy

organisations. It was thus close to a miracle, and a tribute to all involved, that at the end of the day, the National Audit Office approved, without qualification, the Department of Health's accounts for the year in question, with the service continuing to deliver as the management costs, across the whole of the NHS, including the department, were cut by a third.

Those cuts, and the concomitant upheaval, helped to ensure that, as this mighty transformation took place, a ton of talent walked out of the door.

Amid the 50,000 redeployments and the 26,000 who left the service – most of them voluntarily but with 10,000 redundancies[35] – there was no obvious role for the chief executives of the 10 strategic health authorities, or indeed a chunk of their deputies, as management of the NHS was, in Lansley's words in his white paper, to be replaced by a system of "regulation, commissioning and payments by results".

Ruth Carnall, the Chief Executive of the London Strategic Health Authority, noted, with bitter-sweet sadness as she decided to leave, that this was the fifth NHS organisation that she had closed down in her career. Up in the north-west, John Ashton, the region's Public Health Director, pointed out that he had now applied for, and got, essentially the same job for the seventh time in his career as repeated reorganisations took effect.

But it was not just a string of senior NHS managers like Carnall who went – people who had been brought up via a series of jobs in different parts of the service, and who thus had a knowledge that stretched widely across it. So did far too many of the rising stars beneath them, many of whom had been running primary care trusts but who were offered posts in the new 'non-system' that left them feeling they would have too little influence, or which involved too much travelling.

Just by way of example, Sophia Christie, Chief Executive of the Birmingham East and North Primary Care Trust, who lived in the city, was married to a local clinician and had children in the local schools, was offered a post either in Leeds (the new headquarters of NHS England) or in London, but in a job that would clearly have less direct personal responsibility (she was an accountable officer as a primary care trust chief executive), and thus she would probably be less able to make things happen. She decided that it was better to move on.

An equally important impact of the change was that, after 2013, the old career trajectory from which Nicholson, Carnall, Flory and many others had learned – working one's way up across the whole system and thus getting at least *an* understanding of the whole – by and large disappeared. The ease with which that could be done shrank massively as people tended increasingly to work in the individual silos of the NHS that Lansley's reforms reinforced – whether in acute hospitals, mental health and community services, ambulance trusts or as commissioners – and many of the new commissioners, the clinical commissioning groups, were small.

There was no broader management role and, for a time, no ability to build one. Succession planning for the most senior roles went out of the window – in a way that will pose problems for the future in finding senior people who not only understand

one part of what the provision of a health service is about, but also have at least *a* grasp of *all* of it. And, perhaps inevitably, a fair chunk of the managers who did leave became management consultants, charging their services back to the NHS at a price as the service itself tried to make sense of this brave new world.

David Flory was Deputy Chief Executive of the NHS at the moment of change. In April 2013, as he moved to become Chief Executive of the new Trust Development Authority, he told the *Health Service Journal*: "I sat in my kitchen on Sunday reflecting on my last day as deputy chief executive at the department and looked through my contact book of the people who I regularly connect with. Forty-two per cent of them left last week. So the scale of change, and the loss of experience, is greater than I've seen in any reorganisation before."[36]

> the loss of experience is greater than I've seen in any reorganisation before

But after the political storm around Lansley's Act, and the navigation of the choppy waters involved in terms of what NHS England would and would not do, the new NHS dispensation was not to be launched into a calm sea. It was launched into something closer to a tempest: the Francis report.[37]

Act Three
NHS England's first 18 months: 2013 to 2014

Scene One – Jeremy Hunt arrives... and so does Robert Francis
"Sturm und drang"

Andrew Lansley was not allowed to see his great incarnation come alive. The Health and Social Care Act having received Royal Assent in March 2012, David Cameron, battered by its fall-out and despite a personal relationship with Lansley that stretched back the better part of 20 years, took the first decent opportunity to dispose of him as Health Secretary. He was made leader of the House of Commons. In the reshuffle of September 2012, Jeremy Hunt got Lansley's job.

In terms of the values of the NHS, the two had much in common. But in terms of style, presentation and ways of doing business, they were polar opposites. Lansley, the ex-civil servant, was fascinated by systems and by the theory that he was making a reality. He liked to deal in written submissions and he was awkward on public platforms. Hunt meanwhile was fluent in public, an entrepreneur by background, and a man who made his mind up by discussion and debate. He was used to running a small but highly profitable business that published university and other guides – the one that made him his money before he entered politics.

Lansley had been opposition spokesperson on health for six-and-a-half years before becoming Health Secretary. Hunt arrived from the Department for Culture, Media and Sport. There he had survived criticism of his handling of Murdoch's bid to acquire BSkyB, and had been in charge of the two-year run-up to London's successful hosting of the 2012 Olympics. Back in the mid-2000s he had for a time been opposition spokesperson on disability. But his association with the health service had chiefly been that of a local MP, when he had run a vigorous campaign to prevent his local hospital, the Royal Surrey County in Guildford, from being downgraded in a mooted NHS reorganisation of the time. If Lansley, at least in his own view, knew it all, Hunt knew he had a lot to learn.

Cameron appointed him in the final week of the Paralympics, Hunt asking if he could see those through as he took up his new post. At a swimming event, he ran into Tony and Cherie Blair:

"I asked Tony Blair who I should talk to about health, and he said: 'Paul Corrigan' [Blair's former special adviser in Number 10]. So I had Paul in, and Paul by background is an education expert before he got into health. We were talking about Michael Gove's big extension of the academy programme and Paul said: 'Yes. But the most significant reform in education is not what Michael Gove is doing now, but the creation of Ofsted [the school's inspector] back in 1992. And you can trace back the whole history of education reforms to that simple decision' – actually by Ken Clarke who was Education Secretary at the time.

"It gave an inspector the power to fail schools but then put them into special measures. And I was absorbing that, and in my first week in the job, I was taking home the original Francis report into Mid-Staffs.[1] And my first question was: Why can't we have Ofsted for hospitals?

"And, as you know, my biggest focus has been on safety and quality, and within that the single most important decision was to turn the Care Quality Commission into an Ofsted."[2]

Hunt declared becoming Secretary of State for Health "the biggest privilege of my life".[3] He had briefly to shake off a squib of a pamphlet that he had co-authored – along with 22 other Conservative MPs and candidates – back in 2005 in the wake of the Conservatives' third successive election defeat at Tony Blair's hands. Its chapters included one on the NHS, which argued that its core problem was that it was a state monopoly. The answer, it maintained, was to give direct power to patients.

Why can't we have Ofsted for hospitals?

Jeremy Hunt

"We should fund patients, either through the tax system, or by way of universal insurance, to purchase health care from the provider of their choice. Those without means would have their contributions supplemented or paid for by the state," it argued. That would "remove politicians from controlling the minutiae of care" while still "guaranteeing care for all, irrespective of their ability to pay".[4] The chapter headings had no authors. Hunt denied the words were his. And he said he did not agree with them.

According to one interviewee, his orders from David Cameron were simple and clear. "One: Implement the reforms but never talk about them. Talk about patients and services. And two: Look after David Nicholson." The first – "talk about patients and services" – Hunt did in spades. The second proved a challenge.

He achieved the first by instantly becoming 'the patient's advocate'. The second Francis report on Mid Staffordshire[5] – which was bound to reiterate the dreadful events that had taken place – had been hanging like a gibbet moon over the NHS for months. Everyone – including people in the media – knew it was coming. It was due on Hunt's desk just weeks after he took office, and his arrival in the post coincided with headlines over the sentencing of care workers for the criminal abuse of patients at Winterbourne View in Bristol, a privately run NHS facility for people with learning disabilities.

In his first major speech as Secretary of State for Health, Hunt seized on these examples to warn about "the normalisation of cruelty", which he said was "perhaps the biggest problem of all facing the NHS". His conversation with Corrigan was reflected in him announcing a study aimed at achieving simple 'Ofsted-style' ratings for NHS hospitals. And he warned that "we have to be much clearer about the consequences if leaders fail to lead, and fail to drive high-quality care throughout the organisation". He told managers: "You wouldn't expect to keep your job if you lost control of your finances. Well, don't expect to keep it if you lose control of your care."[6]

Managers were clearly in the firing line. Hunt was the patient's friend.

One senior civil servant says:

"Most previous health secretaries felt the need to defend the service, even as they acknowledged and criticised whatever the failure of the day was. NHS England wasn't up and running by this stage. But it was on its way. And the distance that provided allowed Hunt to be, much more plainly than before, the patient's advocate. And we had expected that the creation of an independent board was likely to make the Secretary of State the champion for patients. As the white paper put it, 'in future, the Secretary of State will hold the NHS to account for improving health care outcomes'."

Hunt's view is that:

"I don't think that had anything to do with the legislation. That was just me. I think it is the job of the Secretary of State to hold public services to account for how good a job they are doing. That's my view of what a Secretary of State should do. If I had been here before Lansley's Act, that's what I would have done."[7]

> **the normalisation of cruelty... [is] perhaps the biggest problem of all facing the NHS**
>
> **Jeremy Hunt**

In the succeeding weeks and months, Hunt continued to highlight assorted NHS failings: the death by drowning of a patient with dementia who fled the hospital he was in, despite being on a regime where he was supposed to be observed every 15 minutes; the cancer patient who eventually rang the police to get help after staff ignored him; and a new maternity scandal at Morecambe Bay. Hunt's repeated litany of the service's failings led some to fear that he was undermining the service – in the eyes of some of his critics deliberately so – by his repeated criticisms and apparent unwillingness to acknowledge that anything it was doing was good.[8] This got to the point where, a year in, his own Health Minister in the House of Lords, Lord Howe, was saying in public that:

"Whilst we don't want to cover up the bad... there is a need I think for more balance in the messaging... and the language that we use. I'm not keen on the phrase 'failing hospitals'... I've said to Jeremy Hunt, and he totally agrees, that ministers in particular have got to take the opportunity whenever possible to celebrate the excellent and the good."[9]

Hunt's highlighting of the NHS's undoubted failings in places other than Mid Staffordshire, however, simply gave the second Francis report,[10] eventually published in February 2013, even more oxygen than it would anyway have enjoyed. And it made Cameron's second injunction – looking after David Nicholson – appreciably more difficult.

The events at Mid Staffordshire were, by 2013, history. They had occurred between four and eight years earlier, and had already been subject to four investigations, including one by Francis himself. His 2013 report, however, was the first full-blown public inquiry. And it had a particular political salience.

The failures had occurred on Labour's watch. As Minister of State for Health, Andy Burnham, now the opposition health spokesperson, had formally supported the decision to allow Mid Staffordshire to apply to become a foundation trust, and as Secretary of State for Health, Burnham had been later involved in part of Labour's reaction to what had transpired.

The Francis report declared that it was "impossible" to say that Burnham's original decision to authorise Mid Staffordshire had been "unreasonable".[11] But aside from the very genuine concern about what Mid Staffordshire revealed, there was a political opportunity here to attack Labour's oversight of the NHS, which first Lansley, and now Hunt, were keen to exploit – aside from the report helping Hunt to shift the focus away from Lansley's reforms to the quality of care. This political salience, which revived the unsustainable charge that "up to 1,200" people had died at Mid Staffordshire, produced bitter political exchanges and what the chair of one of the many new arm's-length bodies was to describe as "appallingly childish" exchanges between the two front benches over who was responsible for what.

And, perhaps inevitably, David Nicholson was involved. In 2005 and 2006, during the run-up to Mid Staffordshire finally becoming a foundation trust in 2008, Nicholson had for 10 months been the interim Chief Executive of the Shropshire and Staffordshire Strategic Health Authority, in the part of the country where Mid Staffordshire is located. He was, at the same time, Chief Executive of Birmingham and The Black Country Strategic Health Authority, and interim Chief Executive of the West Midlands South Strategic Health Authority, as the three were being merged into a new, single, West Midlands Strategic Health Authority – part of a 2005 reorganisation that was to reduce the 28 strategic health authorities to 10. He had taken part in a review of Mid Staffordshire's initial attempts to become a foundation trust. He had judged it to be a long way from being ready, and he had been gone from the job for the better part of two years by the time Monitor approved its application.

The Francis report made no direct criticism of Nicholson, although those who came to seek his head could read implied criticism into it. But with the chair and chief executive of Mid Staffordshire by now long gone, the board replaced, and with others in the management chain and the regulators having all moved on, Nicholson was, so to speak, pretty much the last one standing and easily the most high profile.

In late 2010, in the eyes of Number 10 at least, Nicholson had been the saviour of the day. In late 2011, just after Mario Monti formed a government of unelected technocrats in Italy, an entertaining piece in *The Times* had named Nicholson "the ultimate technocrat", to be the Health Secretary should Britain ever do the same.[12] In early 2013, barely 15 months later, Nicholson was to go from hero to zero.

'Cure the NHS', the patients' action group at Mid Staffordshire, called for his resignation, and despite Nicholson's public apology ahead of the report "as a human being and as chief executive", for the way the NHS had let people down "in the most devastating way",[13] that call became a media fire-storm. The hunt was on for a head to roll, despite the stricture in the Francis report itself that "the temptation of offering up scapegoats is a dangerous one which must be resisted".[14]

The *Daily Mail* branded Nicholson a "man with no shame".[15] He and his family were repeatedly door-stepped. His expenses and relationships were crawled over. Not just the *Daily Mail* but the leader columns of *The Spectator*, *The Times* and *The Telegraph* were demanding that he go. Sarah Wollaston, the Conservative MP and former GP who sat on the House of Commons Health Select Committee, which she was later to chair,

declared that it was "inconceivable" that Nicholson could continue. "Should the individual who is so personally identified with implementing the NHS's targets culture, which led to such abysmal care, be charged with putting things right?" she asked. "How can we trust Sir David Nicholson not to be conflicted when dealing with the scale of the carnage in our hospitals?"[16]

David Cameron, Nick Clegg, George Osborne and Jeremy Hunt all stood by him – the Prime Minister very publicly. Five former Labour secretaries of state wrote to the newspapers declaring the case against him to be deeply unfair. But the price of Cameron and Clegg's support was a stipulation that, other than for his apology ahead of the report, he should remain silent. That might have been a well-intended attempt to protect him and limit the coverage, but it backfired. Its effect – a select committee hearing aside – was that Nicholson was unable to answer his critics, leading to the unedifying spectacle of him fleeing from the television cameras, or being smuggled in and out of meetings, whenever he was at a public event in the weeks leading up to the launch of NHS England. It was thus baptised in fire, at the very time that Nicholson was still both setting the organisation up and double-running as the continuing Chief Executive of the NHS.

The Mid Staffordshire inquiry itself proved to be close to indigestible – with almost 2,000 pages of report and appendices, and a truly remarkable 290 recommendations. It charted the sorry story of failure in both management and regulation. A significant part of its answer to the failure of regulation was to recommend more of it.[17]

Hunt's response was not so much more regulation but a significant change to the role of the Care Quality Commission (CQC). As a regulator, it already licensed health and care organisations in both the public and private sectors. But it had a troubled history – the result of it being a shotgun marriage that involved three widely different types of organisation. And while it did inspect, its inspectors were generic – expected to have the skills to inspect wildly different types of service, from hospitals (with often highly specialised services such as renal transplantation and intensive care), to care homes and nursing homes, to primary care and much else. Back in 2013 it inspired limited confidence or respect, particularly in the hospital sector. It was seen as a "poisoned chalice"[18] but had just acquired a new chief executive in David Behan, the former Director General for Social Care in the Department of Health.

In the wake of Francis – although this took some months to complete – Hunt gave the commission greater independence and a huge budget boost, and told it to appoint individual chief inspectors: for hospitals, general practice and adult social care. It switched from having generic inspectors to having specialists, aided by outside advisers – a shift that, over time, increased its standing and credibility. It was also told to develop an 'Ofsted-style' rating system for all services: outstanding, good, requires improvement or inadequate.

At the same time, a new regime of 'special measures' was created, aimed at turning round hospitals rated as 'inadequate'. This involved various means of intervention and support, chiefly supplied by Monitor and the Trust Development Authority.

For Hunt:

"This is probably the most significant thing I have done in terms of safety and quality. It puts everybody on a quality ladder, which says you are outstanding, good, require improvement or are inadequate. CQC puts everyone on that four-point scale and tells them why, and then tells them what they need to do to get to the next point up the scale. It is an inspection rather than a regulatory regime – though CQC can remove a licence in the last analysis. But I would argue it is actually a peer-review model of improving quality. It gets people looking at their peers and tells them what they need to do to improve. And while my biggest focus has been on safety and quality, within that the single most important decision was to turn CQC into an Ofsted."[19]

As part of the response to the Francis inquiry, Bruce Keogh, the Department of Health's Medical Director, was despatched to investigate the apparently high death rates in some 14 hospitals, given that a key event that had led to exposure of the scandal at Mid Staffordshire had been its apparently very high hospital standardised mortality ratios.*

the single most important decision was to turn CQC into an Ofsted

Amid all this turmoil, the NHS Commissioning Board formally came into existence on 1 April 2013. Just days before Hunt had written to Malcolm Grant, the board's Chair, formally approving the name change to NHS England. Hunt's letter, however, stipulated that NHS England would not have direct oversight of providers, other than through its commissioning role, that the purchaser/provider split would remain, and that the name change "does not mean that NHS England will now become the headquarters of the NHS in England".[20] In other words, Lansley's dispensation still ruled, although some senior figures in the other arm's-length bodies protested privately that the name change in fact implied, whatever the letter said, that NHS England was to be the headquarters.

Scene Two
"Tell me why... I don't like Mondays"

As that happened, the difference between Lansley's and Hunt's ways of operating became increasingly clear. Senior figures in the many arm's-length bodies that Lansley had created pretty much concur that Hunt's initial approach to the job was that of the – highly successful – entrepreneur, working in a relatively small organisation, that he had originally been. "He was used to appointing people, defining their job, watching how well they did and being able to get rid of them if they failed to perform," one says. "But that's not the way you can run something as huge as the National Health Service, even ignoring the idea behind the Lansley reforms, which was that the department was not meant to be running it."

Hunt himself agrees that he brought with him the approach that had served him well at the Department for Culture, Media and Sport – including ensuring that the Olympics arrived on time.

* Here is not the place to get into the value, or otherwise, of hospital standardised mortality ratios – other than to say they are controversial measures of the quality of care.

He says:

"I did do exactly what I did when I was Culture Secretary. The only difference is that there I had four distinct priorities – culture, media, sport and the Olympics – and I used to hold them one a day: one on Monday, one on Tuesday, one on Wednesday and one on Thursday.

"The difference at health is that the parliamentary scrutiny is so intense – Andy Burnham was going at me hammer and tongs – that I had to do all the meetings on the Monday. Parliament does not sit on Mondays until 2.30, and the first moment you can have an urgent question is 3.30. So if the meetings start at 8.30 in the morning you can get most of them out of the way before that. And you can do both the long-term thinking and know what is going on in the short term about which you can face questions." [21]

Nicholson says that Hunt "made clear at the start that he had a particular way of working, and that was to focus on three or four or five key priorities and focus on them all the time. So he would hold weekly meetings about them, chasing up on them, week by week by week."[22]

The priorities were, inevitably, to shift over time. His initial four were:

- getting some of the best survival rates in Europe for the 'killer' diseases such as cancer and heart disease
- ensuring that the quality of care was as important as the quality of treatment
- improving care for people with long-term conditions
- hugely improving care for people with dementia.[23]

But other issues soon came piling in. After three years of remarkably effective performance in the face of next-to-no real funding increases, waiting times in A&E departments were beginning to slip. Hunt wanted the people who could make a difference in his room. "His view was that 'if I want them there, then they will be there'," one senior civil servant says. That was one thing between September 2012 when he arrived and April 2013, a period when how to respond to Mid Staffordshire was a dominant theme. After April 2013, as the new dispensation took effect, it was another, not least because the NHS Executive was no longer located within the Department of Health.

As part of Lansley's wish and Nicholson's desire for the commissioning board to have distance from the politicians, NHS England was based in Leeds. It had a small London office in Maple Street, near Euston, but one nowhere near large enough to accommodate all of its senior figures. They were all housed in Leeds – a repeat of a far from entirely happy experience in the 1990s when Kenneth Clarke, as part of making the NHS Management Board more arm's length from the department, had also insisted that it operate from there. The result, in the wry words of Virginia Bottomley who inherited Clarke's dispensation in the 1990s, well before the chief executive's office was relocated back to the department,* was "a lot of first-class tickets"[24] as Hunt demanded to see those at the top whenever he wanted them there.

* Bottomley had a particular insight into this as her brother-in-law, at the time, ran the East Coast train line.

So as the Health and Social Care Act took effect, the chief executives of the various arm's-length bodies – the Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and the Trust Development Authority – found themselves summonsed to these weekly meetings. Given that there were four or five priorities, that rapidly became four or five meetings a week, at one point even six – wherever the senior staff were based. Each meeting tended to involve a pre-meeting to get the line right, and sometimes more than one when the various arm's-length bodies felt the need to sing from the same hymn sheet. And in most cases, these chief executives and their senior staff, who could also find themselves summoned, were still busy building new organisations. For example, Monitor's core running costs as it took on its new responsibilities tripled to £48m between 2011 and 2014 as it was expected not just to regulate foundation trusts but also to 'prevent anti-competitive behaviour' and 'promote integration'. In December 2013, a quarter of its posts were still vacant.[25] Each of these bodies was still seeking to define its role in the new dispensation.

> **six weeks in, and it was the same old performance management**

Hunt's approach gave them all a dilemma. Given that the Secretary of State was coming up with initiative after initiative, they could not afford not to be in the room to try to stifle what they saw as the dafter ideas. But they had their day jobs to do. As one senior figure said in the early days:

"This presents real difficulties... Do we stand on our laurels and say 'that's for us, not for you', or do we seek to influence? And you find yourself being sucked in. You find yourself agreeing to things which you then have to sell to your board, which is absolutely the wrong way round, because it is the board who is your boss. And if you are not there but your senior staff are, they come back saying 'the Secretary of State wants us to do this...' and we are going 'what!?!'. It produces real tensions."

One senior civil servant says:

"As early as May 2013, there were headlines about the length of time patients were waiting in A&E. So David Bennett [Chief Executive of Monitor], David Nicholson and David Flory [Chief Executive of the Trust Development Authority] were all called in to the Monday morning meeting, which was all about: What instructions were they going to issue to clinical commissioning groups and the providers in order to fix it? It was the same old performance management, and this was six weeks into ending the political micromanagement of the NHS!

"People say it was Jeremy Hunt's personality and way of operating, and it was partly. But I am not convinced that was all of it. I do not think, six weeks in to the new system, that Andrew Lansley would have been able to do anything else. The pressure was coming from Number 10, which was really worried about the targets."

Richard Douglas, the department's longstanding Director General of Finance to 2015, says:

"Jeremy's approach of weekly meetings on everything was totally not what Andrew wanted from this. Andrew genuinely wanted to do it in a hands-off way. Jeremy was the exact

opposite. Jeremy never recognised the distinct roles of any organisation in the system. So to him, whatever the rhetoric, NHS England was the headquarters of the NHS in England, not the commissioning board, which had been designed not even to be primus inter pares. *He didn't recognise what the Trust Development Authority was, or what Monitor was, or the distinctions between the two. This was not Jeremy's way of working. These were all people who were there to deliver the things he wanted. So it was a complete contrast of world views.*

"If you think of the world view from Lansley, it was that there are these very clear, legal structures. Each organisation with a clearly defined responsibility, and Jeremy just did not recognise that at all. So that bit never had the chance to work. It has been a little like socialism. We never really tried it." [26]

Hunt's view (see p.100) – and that of some others – was that there was no alternative to his approach if the fragmented system that Lansley had created was to be held together.

> [there] was a complete contrast of world views

There was a lighter side to all this. Nicholson's move to Leeds had left his spacious office at the end of the ministerial fourth floor of Richmond House in London empty, but with his name still on the door. The department initially used it for board meetings. But as Hunt's meetings multiplied, it got turned into a hot-desking room so that senior officials from the arm's-length bodies could get some work done as they queued to go into the meetings.

One civil servant says:

"There was this often massive cast list, both from the civil service and the arm's-length bodies, plus Hunt's advisers, and quite often Nick Seddon from Number 10, and you could spend hours queuing up outside. One lot could come out, and there would be lots of corridor chat – and it did give people from the different arm's-length bodies a chance to see each other so quite a bit of business got done in the corridor. And then the next lot would be ushered in to the massive oval table in the Secretary of State's office. It was always full, often with people perched on the surrounding chairs and sofas. And there was usually a bit of manoeuvring as to who sat opposite the Secretary of State and who sat alongside him, because that had some influence on who it was who felt they were being held to account. Some of it was quite hilarious.

"And it was difficult for the department. It was congratulating itself, quite rightly, for having successfully managed this massive transition, but there'd been little time for thinking about what it all meant for the DH [Department of Health] and how it was to operate. It was left with the questions: So who the hell are we, and what are we here to do?"

Another more senior civil servant says of Hunt's meetings:

"Early on it was dreadful; truly dreadful. They were running at almost five a week. So there was no time to do anything and he'd want people back in to know why things had not happened overnight. It took a long time to explain to him that you can't ask for something

to be done today, and that if people are coming back to you after four weeks, that's pretty remarkable because it would normally take six.

"And he never wanted to hear about the opportunity cost of what he was demanding... about the stuff that was not getting done as a result. He saw that, particularly when it came from civil servants, as obstructive."

By the autumn of 2013, the leaders of both NHS England and Monitor were in open revolt. Bennett had gone to Monitor in 2010 after spending two years as head of the policy directorate in Tony Blair's Policy Unit between 2005 and 2007. Before that he had spent 18 years as a consultant at McKinsey's, with much of his experience in the energy sector. His background made him decidedly sympathetic first to Labour's 'choice and competition' agenda and then to Lansley's Act.

> [Hunt] was instinctively a problem solver

In the February before the legislation took effect, Bennett gave a slightly unguarded interview to *The Times*, which he later regretted. Many a traditional NHS feather was ruffled as he said he wanted to break the "monopolistic, monolithic" NHS market in the same way that Ofgen and Ofcom had for energy and telecommunications. Where there was the option of a private or voluntary supplier for an NHS service, GPs as commissioners would have to talk to them under Lansley's legislation, he said. Not to do so would be "anti-competitive". And – despite Lansley having been forced to rule price competition out during the stormy passage of his Act – he added that he thought that "over time an amount of price competition will be appropriate", although Monitor would be "very careful" about forcing that "because there is a risk to quality".[27]

Today he says:

"I did believe at the time that – over time – a steady increase in the use of patient choice of various sorts, and an amount of commissioner choice and competition, would drive improvement and help patients to not only get a better result, but to feel better about it. David Nicholson took a different view. We didn't have a difficult personal relationship. We just disagreed." [28]

Nicholson, for example, was telling the Health Select Committee in the October that competition was "very effective when it is used as a rifle shot to deal with specific issues, rather than a carpet bombing".

Bennett says of Hunt's earlier meetings that:

"[The Secretary of State] did bring a lot of drive to tackling issues, and he was instinctively a problem solver. And that was good. His initial focus on the quality agenda was politically astute. But it also reflected the fact that he genuinely could not believe how certain aspects of the NHS delivered such poor-quality care, with Mid Staffs being the tip of the iceberg.

"But the meetings became impossible. You spent far too much time preparing for them, going to them and dealing with the aftermath. You could in no sense get on and do your

job. And he did have a very 'hire and fire' view of people management, which can sometimes be right but I felt was often unfair – because it failed to recognise the different circumstances that people found themselves in. There were things that we just disagreed on, and things I didn't do that he wanted me to do. He used to demand heads." [29]

Both Bennett and David Flory refused to fire the chief executives of 11 hospitals that were put into special measures after the inquiry into their mortality rates, although one did resign.

> **we're not going to run it through the mandate, we're going to run this through a different sort of process**

There was also a tension that, under the legislation, Monitor was a regulator that was meant to be independent of both the Department of Health and the NHS. The meetings reached such a pitch that Bennett and Nicholson started refusing to attend. According to one interviewee, Bennett told colleagues in the autumn of 2013 that they were so frequent "you can't do the day job. And I am really worried that all the focus is on the short-term tactical stuff, not on the big changes that are needed in order to get us through 2014, 2015 and 2016." The outcome was that Bennett went to the weekly Monday morning meetings, but not the others. Nicholson too was driven close to distraction, increasingly calling in by teleconference from wherever he was in the NHS, rather than being physically present.

A temporary accommodation with NHS England was reached as Hunt set out to refresh the NHS mandate in the autumn of 2013. There was again a tussle over its contents. Malcolm Grant, the Chair of NHS England, went public to warn that the new draft risked pushing the NHS back towards 'command and control' by seeking to 'prescribe process' rather than outcomes. As the negotiations went on, Hunt asked Nicholson whether he wanted a short, pithy mandate, or a long one. Nicholson's reply was: "Well, that's a hard question – I'd rather have the short one." To which Hunt said: "Well, you come to my meetings every week and you can have the pithy one." As Nicholson later put it: "The message from that was that the mandate is all very well and interesting, but actually I am going to run this. We're not going to run it through the mandate, we're going to run this through a different sort of process."[30]

Even as late as 2018, a senior figure in NHS England says that while the mandate is there – and there have been battles over it – it is not the driving force that Andrew Lansley intended: "It is of course, there. And formal accountability meetings are held over it, and it is all properly minuted, and what have you. And it does matter. But it is not, and never has been, the driving force of the relationship."

Another figure in NHS England says that under Lansley's conception:

"Success for us would be them – the ministers – putting their feet up on the desk in Richmond House and drinking tea, while we went in from time to time to tell them what we were doing and how we were fulfilling the mandate. But we got nowhere near that in the first year. We had Hunt crawling all over us."

> success for us would be them – the ministers – putting their feet up on the desk in Richmond House and drinking tea

The Secretary of State was, for example, demanding to see all 150 of the NHS's local plans for how it was to handle the winter – anything but the arm's-length relationship that Lansley's Act envisaged.

"Eventually," one senior civil servant says, "we got to a much more orderly sequence of what happened each Monday. So it might be looking at performance, but not every week, or safety and quality, but not every week, and not demanding that everything come back by next week when, in the real world, things cannot be done or changed that fast."

Furthermore, this senior civil servant says:

"Hunt's genuine interest in safety and quality – and his decision to go out weekly into the NHS to see it work on the ground – gave him a better understanding. It forced him to learn about systems. Because a huge amount of the stuff around health and safety is in systems. It is in health, as it is in the airline industry and in nuclear power. It doesn't work when, if something goes wrong, you just go out and look for whom it is you need to shoot. When you look at what has gone wrong, it is systems, cultures, equipment that lie behind a lot of this, not just individual errors which, often, though not always, are the result of the systems and the complexity in which people operate. So he opened himself up a learning curve about all that, and over time that helped make the meetings more rational."

Meanwhile, around this initially fevered atmosphere in the Secretary of State's office, everyone was trying to work out what implementing the Act meant in practice, and where the NHS was going as a result.

One board member of NHS England says:

"[That] was very difficult at first. The basic problem was that NHS England was not primus inter pares. *It wanted to work to a jointly agreed position about the future of the NHS and what it could do on a given level of funding. It could seek to take the lead on that. But it could not require, let alone compel, agreement.*

"And the result was something of a ritualised dance. After all there were four boards involved here, leaving aside Public Health England and Health Education England and NICE, along with four chief executives, each inevitably with their own egos, but equally importantly their own statutory duties and their place in the universe that Lansley had created. And there were differing views about what all that meant – about each body's role and about the priorities – not just between the chief executives but among their key advisers, not least their strategy directors."*

Or, as Lord Rose put it as late as 2015 in his report on NHS leadership: "There is no one system leader; so all are vying for territory. The loss of the strategic health authorities, for example, means there is no mandate for system leadership, and no eye on what is happening across the system."[31]

* The Care Quality Commission, Monitor, NHS England and the Trust Development Authority.

Various attempts were made to bring the new constellation together. There was an existing National Quality Board, which David Nicholson continued to chair. Una O'Brien, the Permanent Secretary, sought to bring the assorted arm's-length bodies together in monthly meetings, which, according to interviewees, most attendees felt to be unsatisfactory. But finding a common view proved difficult.

Bill McCarthy says:

"All the new bodies that the Act had created struggled in the early days to come together with a shared philosophy around how to make the system work. Right from the start, for example, there were clear disagreements about the role of competition and how it would be overseen. That just exacerbated the fragmentation that the Act had created. And it wasted NHS time and resources as those out in the field tried to interpret the signals from the central bodies. The fact that more recently they have started to work together better has been a good thing." [32]

> all the new bodies... struggled... to come together with a shared philosophy around how to make the system work

What did emerge, in July 2013, was *A Call to Action*, which all of the arm's-length bodies signed, with local government a signatory also. It declared the service to be on track to make the £20bn of efficiency savings by 2015 that made up 'the Nicholson challenge'. But, without productivity gains, there would be an additional £30bn spending gap between 2013 and 2020, and without "bold and transformative change" the NHS would not just become "financially unsustainable" – safety and quality for patients would also decline. The document consulted on the challenges and on ideas for change. But it was all very high level, its own declared aim being to "inform and develop" plans for the next five to 10 years.[33] And in a sign of the sensitivities that the new dispensation had generated, NHS England was listed last among the 10 signatories to the document, even though it was published under NHS England's banner.

Scene Three
"Lawyers, guns and money..."

Meanwhile, the Health and Social Care Act was playing out in ways that took many in the NHS aback. A first shock was the impact of the new regulation on the NHS. A second was the arrival of the lawyers.

Under Lansley's legislation, it was now crystal clear that competition and procurement law did indeed apply to the NHS. Monitor was responsible for most of that, but mergers that involved NHS foundation trusts were the responsibility of the Office of Fair Trading and the Competition Commission – what is now the Competition and Markets Authority.

At least in theory, the Office of Fair Trading could have intervened on competition grounds in the merger of a foundation trust with any other NHS body since the first foundation trusts were created in 2004. But while it had undertaken a number of studies over the years into private health care, NHS dentistry and the health service's pricing of private patient services (all of which patients were paying for as consumers), it had never touched core NHS services. Alerted by Lansley's Act, however, it referred to the Competition Commission the planned merger of Poole Hospital with the Royal

Bournemouth – two neighbouring foundation trusts. The commission blocked it, arguing that there was insufficient evidence that the merger would produce the benefits claimed.

Regardless of the merits of that debate, the decision sent shock waves through a health service that for some time now had seen the concentration of higher-end care in fewer places as one route to higher quality. The Competition Commission's view was that the merger would reduce GPs' choice for their patients for more routine procedures.

At the same time, Lansley's Act had alerted competition and procurement lawyers more generally to the potential of extra business from the NHS. At the NHS Confederation's annual conference in June 2013, the accompanying exhibition saw around a dozen law firms taking stands, rather than the half-dozen or so that traditionally dealt with the NHS.

> you have competition lawyers all over the place telling us what to do

By the November, Nicholson was complaining to the House of Commons Health Select Committee that the NHS was "getting bogged down in a morass of competition law", which was causing "significant cost". Clinical commissioning groups were new to the job and were uncertain about their position under the Act. So they were taking legal advice. As a result, "you have competition lawyers all over the place telling us what to do, which is causing enormous difficulty", hampering attempts at the better integration of care.[34] Bennett was equally alarmed, telling the committee that clinical commissioning groups did not understand the competition and procurement rules, which were in essence "hardly changed" from Labour's day. Too much work was being put out to tender and "there is an awful lot of misunderstanding and misinformation out there as to what those regulations do and do not require".[35]

Furthermore, Bennett made clear to the committee that in his view, in the Bournemouth and Poole merger the Office of Fair Trading had put too much weight on the benefits of competition and too little on how far a merger could improve the quality of care – even as he acknowledged that the two hospitals had needed to make a clearer case for the benefits they were claiming. There was mounting frustration all round.

The merger question became easier as NHS trusts learnt to put their case better – and as, perhaps, some weak merger cases were abandoned long before they got to Monitor and the Office of Fair Trading. And Jeremy Hunt, David Bennett and others worked hard to persuade the Office of Fair Trading and its successors that if the NHS was operating as a quasi-market it was in fact a market like no other. If the decision to block a merger was simply to leave a financially failing hospital in place, that was not good for patients as the hospital's performance was likely to deteriorate further. And, while Bennett, Hunt and his civil servants acknowledged that many NHS mergers in the past had indeed not proved to be a success, the risk of further deterioration in performance if a merger did not go ahead had to be balanced against any loss of competition – and quite often a relatively marginal loss. The Office of Fair Trading and its successors appeared to take that on board. Since Bournemouth and Poole, the former Office of Fair Trading and the Competition and Markets Authority have required some alteration to some merger proposals. But none of the subsequent seven cases have been blocked.

By 2017, the Competition and Markets Authority was acknowledging that the financial pressures on the service "have dampened the role of competition between the trusts".[36]

The lawyers' feeding frenzy around procurement was marginally reduced, although it was far from eliminated. Monitor issued clearer guidance to commissioners on that part of the law, while also offering an advice service on when services did and did not need to be put out to tender. However, an attempt to promulgate an agreed set of guidelines between Monitor and NHS England failed. Bennett says that NHS England wanted guidelines "that would have been in contradiction to the law".[37] Meanwhile, according to one interviewee, NHS England saw Monitor as being "over-purist".

Scene Four – Policy and operations collide
"How independent is independent?"

Meanwhile NHS England was working out quite how independent it was meant to be, or was going to be allowed to be. An early clash came as Hunt wanted to announce an extra £300m or so, over and above existing plans, to be spent on 'winter pressures' over the 2013/14 winter. NHS England pointed out that this was not provided for in its budget, and it disputed the Department of Health's argument that there was slack in there to allow that. Once again, policy and operations were colliding. The final resolution turned out to be the Secretary of State getting an extra £250m out of the Treasury.

But the tension was just one example that led to mounting frustration in Number 10. "They are meant to be independent, but not that bloody independent," one adviser exploded. And if that was a large example, there were plenty of smaller ones as the notion of independence and the difficult distinctions between precisely what was policy and what was operations played out.

Plans were already in place to create a 'Friends and Family Test' – a questionnaire asking patients if they would recommend the service they had just received to their friends and family. At the end of a video-link discussion – indeed dispute – between Number 10, NHS England and the Department of Health over precisely what should go into it and how it should operate, an adviser in Number 10 erupted: "£110bn of public money, and we have no levers!" One figure involved says:

> **£110bn of public money, and we have no levers!**

"[That] was symptomatic of Number 10 and the Department of Health trying to understand what it meant to create a mandate and hand it over to someone else to deliver, and of the difficulty of defining the difference between policy and operations. Having a Friends and Family Test is policy. But how you phrase the question, precisely what methodology you use and so on, crosses the line between policy and operations. And there were lots of examples of that in the first couple of years as everyone tried to work out how this new relationship was meant to work."

It didn't work too well, in the eyes of some. In June 2014, Jane Ellison, the Public Health Minister, at what was meant to be a private meeting of the Tory Reform Group, was recorded as saying that with Lansley's Act, "we pretty much gave away control of the NHS".[38] It did not feel like that to those heading the various arm's-length bodies, however. The heads of the three regulators – the Care Quality Commission, Monitor and the Trust

Development Authority – found themselves summoned to Downing Street to discuss with the Prime Minister how winter pressures were to be handled. And there was to be no shortage of initiatives.

Aside from Bruce Keogh, the Department of Health's Medical Director, being sent in to investigate the 14 trusts with apparently high death rates, NHS England was told to set up a taskforce to improve safety in surgery after NHS figures showed that 80% of the 300-plus so-called 'never events' a year – leaving operating instruments or dressings in patients, or operating on the wrong part of the body – occurred in theatres. There was a 'vulnerable patients' initiative from Hunt, which ran out of steam, as did a plan to map 'the loneliest places' in the country.

Ministers created a Better Care Fund, which transferred NHS cash – initially £1bn a year and then £2bn a year – into a pooled budget with local authorities in an attempt to integrate health and social care better. The remarkably ambitious target was that this would reduce emergency activity in hospitals by 15%. That was clearly policy. But, against that, NHS England's planning guidance for 2014 onwards pointed to the number of centres providing the most specialist care being likely to be reduced over time to some 15 to 30 – a shift that was clearly operational but which many would also see as a policy decision.[39]

Hunt issued standards on hospital food and guidance on car parking charges, while demanding that the name of the consultant ultimately in charge should be at the head of each patient's bed. All those might arguably be policy, not operations, but they were pretty micro-elements of policy and a long way short of 'an end to political micromanagement'. And as the performance slipped in A&E departments, Hunt took to phoning the chief executives of hospitals whose performance was awry. David Prior, the former Conservative MP who was now Chair of the inspectorate, the Care Quality Commission, described such a hands-on approach by the Health Secretary as "crazy".[40]

A Department of Health spokesperson said: "Jeremy Hunt would not be doing his job if he wasn't keeping in touch with hospitals on the front line in the run-up to winter and it is ridiculous to suggest he should not be talking and listening regularly to feedback about how things are going."[41] And Hunt's own explanation was that he was calling to understand the issues:

"If you speak to any of the chief executives I have spoken to about discussions about A&E, they would say, I hope, that it is not a call from the boss holding them to account. It is a call from the Health Secretary to try to understand what the pressures are and how we can help more than we are currently doing." [42]

As 2013 turned to 2014, the hunt was on for David Nicholson's successor. Having survived the calls for his head in the run-up to the launch of NHS England, Nicholson had announced in May 2013 that – after almost seven years as the Chief Executive of the NHS before becoming head of NHS England – he would go in April 2014. Quite remarkably, this did not turn him into a lame duck leader – his force of personality, and the loyalty of a key group of staff, ensuring that NHS England continued to make progress. But the relationship with Hunt was, by the end, decidedly strained. "They were," says one civil servant, "a little like a separated couple still living in the same house. It was all very civilised. The niceties were observed. But it wasn't a happy marriage." With the change of personnel, some change in the way the new dispensation operated was inevitable.

Act Four
Unpacking the Health and Social Care Act: 2014 to 2017

Scene One – A change of chief executive

"Will ye no come back again?"

As in 2006 ahead of his appointment, Nicholson's decision to depart led to a 'global search' for a new chief executive for what was now a commissioning board, rather than the job being chief executive of the NHS.

Back then, there had been attempts to persuade Simon Stevens, previously health adviser to Frank Dobson and Alan Milburn as health secretaries, and then to Tony Blair as Prime Minister, to take the job. A mere two years out of his Downing Street role at the time, he wisely declined.

A former NHS management trainee, Stevens had worked in mental health services in the north-east, been a group manager at Guy's and St Thomas' Hospital in London and organised a GP purchasing consortia on the south coast in the early days of the NHS 'internal market' before becoming a key architect of Labour's reinvention of the quasi-market.

He was closely involved in all the key developments from the creation of NICE and the first version of the NHS inspectorate, to the construction of the NHS price list, the establishment of foundation trusts and the introduction of independent sector treatment centres. After Downing Street he had, in 2004, joined United Health, a giant health management company and insurer in the United States, heading up first its European operations, then its Medicare division in the United States where he had spent time lobbying for 'Obamacare', seeking to make the-then President's extension of health insurance to the uninsured a success. He then took a global role that saw him work in South America and elsewhere. Stevens had intellect, personality and drive, and a knowledge of health care internationally that few could match. And over the better part of a decade he had stayed closely in touch with developments in the NHS.

In an article on Lansley's white paper in the *Financial Times*, back in 2010, he had declared that what made its proposals "so radical" was not that they tore up Tony Blair's plan for the NHS, but that "they move decisively towards fulfilling it."[1] So, given his role in devising that plan, there was to be a certain irony in the fact that five years later he was to be the one unpacking some of its core elements, not least the emphasis on competition and choice.

Cameron, Osborne and Hunt were all desperate to have Stevens back. Thus, while Nicholson always understood the political weather, Stevens, with his background, could, at least for a time, make it.

Stevens did his due diligence, calling up many of his NHS contacts to ask about the state of play and whether it was possible that the NHS could avoid a hard financial landing – the answer from many being no. Some suggested – it was not clear in 2013 that the country was facing an entire decade of austerity – that it might be in his personal interest to wait until next time round when the money might be easier. But with his heart as much as his head, he took the job.

His first act was to tell Cameron that he intended to set out what the NHS could, should and needed to do within the resources available to it – in a sense produce the document to which Nicholson's *Call to Action* had been the prelude.[2] Cameron agreed. His second act was to take a pay cut in acknowledgement of the pay freeze that most NHS staff were going through. His third act, on his first day in post, was to roll his sleeves up and go to Shotley Bridge Hospital in Consett, County Durham, where he had started his career, thus illustrating his NHS credentials – but also instantly taking the higher public profile than had been possible for Nicholson.

we're going to have to radically transform how care is delivered outside hospitals

The NHS, he declared, had managed the economic turbulence that had followed the financial crash better than any health system of which he knew, but it was also facing "the most sustained budget crunch in its 66-year history". To cope with the future, he said "we're going to have to radically transform how care is delivered outside hospitals. Our traditional partitioning of health services – GPs, hospital outpatients, A&E departments, community nurses, emergency mental health care, out-of-hours units, ambulance services and so on – no longer makes much sense."[3]

Scene Two – The *Five Year Forward View*
"See my tailor, he's called Simon… I know it's going to fit"

It was that analysis that, in October of 2014, became the *Five Year Forward View* – a strategy document for the new dispensation.[4] NHS England, of course, still remained only the commissioning board, not *primus inter pares*. So while the eventual document was undoubtedly Stevens' work, the core of it was negotiated through with the other arm's-length bodies whose co-operation and involvement would be needed to make it function.

When the *Five Year Forward View* emerged, it said, in truth, little that could not have been said, and indeed had often been said, over the previous decade or more – itself noting that there was "a broad consensus on what that future needs to be".[5] Thus, it emphasised the need "to get serious"[6] about public health and prevention to reduce ill-health and the demands on the service from people's lack of exercise, alcohol consumption and obesity, including a hint at the sugar tax that Stevens was later to call for publicly and the Government was eventually to implement. It emphasised the need to sustain social care, with the number of adults receiving publicly funded social care down by 30% since 2008, thanks to the big cuts in local government expenditure. It underlined the need for much more integrated services that would allow patients to take more control over their own care and treatment. And it promised a greater concentration of some specialist services in the interests of higher-quality results, and "decisive steps to

break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care".[7]

But it differed from what went before in five crucial ways.

First, almost uniquely for an NHS document, it said that the way this would be done would differ across the country. There would be no 'one size fits all' approach. Instead, a range of 'new models of care' would be tested. These might, at the two extremes, involve strong local general practice taking over the running of a hospital or a hospital taking over weak general practice. Either way, hospitals and their local primary and community services should form an integrated provider. At the most radical, these new providers might take responsibility for the whole of their population's health needs, receiving a delegated budget on the lines of the 'accountable care organisations' emerging in the United States and elsewhere. Or, to put it another way, they might produce a much more effective result, for both patients and the population at large, than the various incarnations of regional, area, district and strategic health authorities, with their responsibilities for population health planning, had achieved in the past.

That would require new payment systems, which would take time to develop. It would also require the many arm's-length bodies that now dotted the landscape to provide "meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied"[8] – something that was to prove vastly easier to say than do.

Second, it signalled a distinct break with the 'choice and competition' model that lay behind Lansley's Act and the Blairite reforms. If many in the NHS had welcomed Stevens' arrival, the fiercest opponents of Lansley's Act had feared that his past involvement in Labour's quasi-market reforms and his decade's worth of experience in the United States meant that choice and competition would be driven even harder. But the opposite was happening. Lansley's white paper *Liberating the NHS* refers to 'competition' a dozen times, while the *Five Year Forward View* does not contain the word at all. *Liberating the NHS* uses the word 'choice' – and chiefly in the context of the choice of provider providing competition – more than 70 times but the word appears just half-a-dozen times in the *Five Year Forward View*, and only once in a context where it might be seen as an economic driver of change, as opposed to it involving giving patients choice over their treatment.

In other words, as Stevens was later to explain, the NHS price list or 'tariff' might have been a fine driver in the 2000s when the priority was getting waiting times down. It encouraged, indeed rewarded, hospitals for attracting patients and doing more. But this 'click of the turnstile' approach was of much more limited use if the goal was better, more integrated care, outside hospital.[9] In other words, although the document did not put it so explicitly, the choice and competition model was passing its sell-by date.

Hunt himself was soon saying the same. Within a month of the publication of the *Five Year Forward View*, he declared that "there are natural monopolies in healthcare, where patient choice is never going to drive change". Market forces were not going to deliver the integrated care that the service needed. "The market," he said, "will never be able to deliver" on that.[10]

Third, the *Five Year Forward View* made an open and public bid for money. Nicholson, ahead of his departure, had been crystal clear in private that that needed to be done. The only question was about the timing – "ahead of the general election, or just after it".[11]

And settling that bid was the most fraught part of the document's construction. NHS chief executives had, of course, always had their say in the bids for NHS cash at every spending round. But the Department of Health decided the sum and the ultimate responsibility for its negotiation always lay with the Minister for Health. As a civil servant, it would have been impossible in the past for an NHS chief executive publicly to name a figure. The *Five Year Forward View* got to one, although only after pre-conversations between Stevens and George Osborne, the Chancellor. Norman Lamb, the Liberal Democrat Health Minister in the Coalition Government, who was already agitating for more cash, was also sounded out – and other parties were also kept in the loop about the document's key directions of travel. Interviewees said that Stevens' clear intention to bid for money infuriated Treasury officials. NHS England, independent or not, had no right at all in their view to put in a public bid.

Work on the money by NHS England and Monitor, and indeed calculations by outside bodies such as The King's Fund and The Health Foundation, had all broadly concurred with the assessment in the *Call to Action* that a £30bn a year gap would open up by 2020/21.[12] The question was how to fill it. And that was at least as much a small 'p' political judgement as a technical one.

Asking for £30bn amid continued austerity was out of the question. Efficiency and productivity clearly had to play a part. But how much? Three key scenarios were considered:

- Ask for £21bn and promise £9bn of efficiency savings.
- Split the numbers in two and ask for £15bn – that was the figure that David Laws, the Liberal Democrat minister, was later to claim that Stevens originally sought, although as a Cabinet Office minister he was not directly involved in these discussions.[13]
- Or would it make more political sense, in recognition that austerity still ruled, to go for a much lower initial cash bid?

The *Five Year Forward View* contains a number of calculations around the money, which, to anyone other than an NHS finance expert, remain totally opaque. It does not name a number. The final decision, made immensely late in the day, was to ask for £8bn – the number being named at the press conference to launch the report not by Stevens but by David Bennett, the Chief Executive of Monitor, who shared the press launch with him.

This was essentially a small 'p' political call. Thirty billion pounds was out of the question. So was £15bn. Eight billion, with conditions attached such as funding social care properly, was a sum that would at least get a political conversation going about how much the NHS was likely to need – the understanding being, certainly on the part of NHS England, that this was an opening bid, and that when – as was to be hoped – the economy improved, more would be needed and would indeed be forthcoming.

George Osborne confirms that there were indeed "back channels" during the construction of the *Five Year Forward View*, an initiative of which he, like

Cameron, approved:

"The Lansley reforms had genuinely given NHS managers a bit more autonomy and here was a politically savvy guy saying 'I am going to embark on a plan to work out what the NHS needs for the future and I will put a price tag on it.'

"I thought it was a clever device, and it would get us, as a party, back on track with the NHS – reaffirming our credentials after all the trouble we'd had over the Lansley reforms, about which I had always been very sceptical. This was something that patients could understand, rather than all the stuff we had had about structures. And the plan very much accorded with what the Treasury themselves were recommending to me as the route forward.

"I knew there would be a price tag. And we did talk him down a bit. The real negotiation, however, was less over the total sum; it was more over the frontloading of the money – over the profile of the spending – and that came after the election." [14]

The fourth difference between the *Five Year Forward View* and what went before it is a summation of the above. The Health and Social Care Act had turned the chief executive of the NHS into a public official – neither a civil servant, which Nicholson had been before the Act, nor an NHS manager, answerable to the NHS or the department, but a new creation, at least in NHS terms – an official with his own voice, answerable to an independent board, which, as it was to turn out, consistently backed him.

> I knew there would be a price tag. And we did talk him down a bit
>
> George Osborne

Thus, no previous chief executive of the NHS could have independently produced the *Five Year Forward View*, let alone have named a sum of money. However influential a former NHS management chief might have been, this production – with all its policy implications about how the NHS was to develop – would have had to be a ministerial paper. Hunt, however, was not allowed to see it until barely 48 hours ahead of its publication. This was NHS England transparently asserting its independence – the NHS's own view, so to speak, of what it needed to do and how it was going to seek to do it, and at least *a* bid for the resources that that would require. In that limited sense, Lansley's dispensation was working. For good or ill, the NHS had its own voice.

The fifth and final difference is that the *Five Year Forward View* also marked the start of a remarkable inversion of the Lansley model. This was its earliest sign. In publishing the document it was Simon Stevens who was acting more as the Secretary of State for Health – setting out the long-term vision and indeed the policy over how the NHS was to operate. Jeremy Hunt, as he had been from the start, was acting more like a chief operating officer: continuing to pursue, week by week, waiting times and other elements of NHS performance, while also pursuing his quality and safety agenda – with his one opening demand of Stevens as Stevens was appointed being, as one interviewee noted, that "you come to my Monday morning meetings". Stevens' arrival was to alter, initially slowly and then profoundly, the relationship between the chief executive of the commissioning board and the Secretary of State.

From within the NHS, and indeed among politicians of all parties, the *Five Year Forward View* received pretty glowing reviews. After the turmoil of the legislation and the tensions of NHS England's first year, here was a strategy for the service. But that, of course, did not stop Number 10, the Treasury and Hunt himself fretting about much more short-term performance. And shortly after publication of the *Five Year Forward View* it was to reach a new pitch.

After three years of continually expanding activity (more operations, more A&E attendances, more of most things),[15] performance was coming under growing strain. It was not just that A&E targets were increasingly being missed – so, despite the increased activity, were waits for routine operations. Furthermore, NHS hospitals were projecting an £800m deficit for 2014/15.

The result in January 2015 was a sudden switch in Number 10's focus from the front end of A&E admissions to the back end – delayed transfers out of hospital once patients were ready to go. These were putting pressure on both A&E departments and waiting times for elective operations. And Cameron was panicking ahead of the 2015 general election. A special Cabinet committee was formed. Its members included Eric Pickles, the Communities – that is, local government – Secretary, and Oliver Letwin, Cameron's policy overlord and trouble-shooter. The meetings in Hunt's office became evermore packed as the politicians demanded reams of information from all parts of the NHS as they sought to come up with their own ideas as to how to make things better. "Oliver Letwin was personally digging into the spreadsheets of the performance at his local hospitals," one civil servant says, "and there was a huge amount of pig weighing – demanding vast amounts of information to try to work out what was happening and what could be done when the answer, in the short term – ahead of polling day – was clearly pretty much nowt." But the exercise did see an additional £25m of Department of Health money handed over to councils for social care, with the stipulation that it be spent over the next three months on measures to get patients out of hospital faster, ahead of the general election.[16]

Scene Three – The money arrives… and goes out of the window *"Out of control"*

Just ahead of this extraordinary Cabinet committee, the first fruits of the financial bid in the *Five Year Forward View* had become evident. In the December *Autumn Statement* of 2014, Osborne came up, in his own words, with a £2bn "down-payment" on "the NHS's own plan".[17] The Conservative manifesto for the May 2015 general election then promised, after an intervention by Hunt, "at least" an additional £8bn in real terms by 2020[18] – a clear recognition that the £8bn in the *Five Year Forward View* was, so to speak, an opening bid and that, eventually, more was likely to be needed. And come the post-election Budget in July 2015 – one that imposed big new reductions elsewhere, including £12bn of welfare cuts as the deficit declined far too slowly – Osborne delivered the £8bn, without it proving to be quite what the headline seemed.

Cash was taken out of other parts of the health budget, including public health and capital, to help fund services. The arm's-length bodies, including the Care Quality Commission, received big, if phased, cuts of 25% in their administrative budgets. Student nurses in future would have to take out loans rather than receiving bursaries. The only help for social care, whose continued shrinkage was causing the NHS

increasing problems, was the right for councils to increase Council Tax by 2% to help protect it.

Osborne says:

"The real negotiation in health [was less about the total sum and more] about the profile of the spending. My most difficult deficit years were the ones out to 2017, and like any chancellor I was less interested in deficit projections for the later years, which were inherently less certain. Both Simon and Jeremy made a strong case for upfront investment, for frontloading the money. I was sceptical that it would really be used for a big investment programme, but both Stevens and Hunt said it would. They wouldn't come and see me separately, and they were quite tough.

"So we did settle on more of the money for the early years. And I always assumed that when we got near to the next election there would have to be another negotiation to get us across that." [19]

As those figures were being announced, chickens were coming home to roost. Both the 2014 and 2015 settlements included cash earmarked as 'transformation funds' to help develop the new models of care. But much of that money was soon to be swallowed up by the consequences of the Francis report.

In its wake, Hunt had repeatedly declared that unsafe staffing levels were 'totally unacceptable' while making clear that the jobs of hospital bosses were on the line over quality. The result was that hospital chief executives took an unspoken but collective decision. If they were going to be hung, it would be for the money, not for the quality of care.

So nurse recruitment went up to provide 'safe' staffing levels and the money went out of the window. And just to compound that, the effects of four years of pay restraint were also playing through. A small but growing number of staff, both doctors and nurses, worked out that they could earn more by becoming agency staff, either full-time or part-time. The agencies, of course, added their own margins on top. So the agency bill exploded, even as full-time nurse numbers rose. From 2011 to 2014/15, the agency bill roughly doubled, topping £3bn in 2014/15 – some 3% of the entire NHS budget. Simon Stevens accused the agencies of "ripping off the NHS".[20]

Rising demand, limited funding increases and the big increase in agency spend, saw NHS hospitals and other services overspend by a mighty £2.5bn in 2015/16. Eighty per cent of NHS hospitals were in deficit. That swallowed the transformation monies – the cash was needed simply to keep services going.

As it became clear in the autumn of 2015 and the early days of 2016 just how big the deficit was going to be, both NHS trusts and NHS foundation trusts found themselves subjected to 'control totals' – a financial envelope within which they were expected to live. The control totals covered not just their income and expenditure but also their use of reserves, and how they should handle annual leave, sick leave and deferred income. They were required to cut their spend on agency staff. As noted, this financial straitjacket was applied not just to NHS trusts but also to the nominally more independent foundation trusts, so these were not the freedoms that they were meant

to enjoy under Labour's legislation, let alone Andrew Lansley's. As The King's Fund observed at the time, their autonomy was being circumscribed "to the extent that there now remains little difference between them and NHS trusts" and that it was "a return of top-down command and control".[21] Chris Ham, its Chief Executive, declared that "the last vestiges of the former health secretary Andrew Lansley's ambitions to liberate the NHS by devolving responsibility for decision making have in effect been removed as NHS England and NHS Improvement increase their grip on commissioners and providers".[22]

With a £2.5bn deficit on the provider side, the Department of Health only managed to balance its books thanks to the commissioning side deliberately underspending by £600m, by shifting almost £1bn out of capital and into revenue and by the department failing to tell the Treasury that it had received some £400m more from the national insurance fund than had been intended. It also used a string of other one-off mechanisms, including accounting differently for the money it spent on treating English patients overseas under reciprocal health arrangements. The National Audit Office observed drily that "while these are technically justifiable, they would not be at the core of a credible plan to secure the financial sustainability of the NHS in England".[23]

Scene Four – The workarounds begin
"Round, round, get around, I get around..."

As history was repeating itself for foundation trusts – the original NHS trusts in the 1990s had also gradually lost their theoretical freedoms – the first formal steps to bypass Lansley's legislation were being taken. Two factors drove that.

> Monitor... are a bunch of academic pointy-heads who can't tell you anything without a massive PowerPoint slide pack
>
> Adviser to David Cameron

First, it was now self-evident, even if it had not been blindingly obvious before, that not all trusts were going to make it to foundation trust status. Some 150 had, but 100 had yet to. And, second, the difference between the two, in terms of both financial and operational performance, was becoming ever smaller. Of the 13 hospitals in special measures in 2015, eight were foundation trusts. Just five were ordinary NHS trusts. Financially, the best-performing NHS trusts were doing better than the self-governing flagships – the foundation trusts. And frustration over the split responsibilities for the two was getting ever greater, both in Hunt's office and in Number 10.

One of Cameron's advisers said at the time:

"The problem is that we are stuck with the Trust Development Authority, which has a real grasp of how the remaining non-foundation trusts work and how to help them manage to stay just about afloat. But it has no long-term strategic view of what we need to do about them, and it can't have really, in the current framework. And we have Monitor who are a bunch of academic pointy-heads who can't tell you anything without a massive PowerPoint slide pack and who have no understanding of how hospitals work internally. Their solution to pretty much any strategic problem is to say that they will hire McKinsey's or whoever on a long-term and extremely expensive contract."

From Hunt's side, according to one civil servant, "when it came to the money and the performance he felt that nobody was really taking responsibility – because nobody in fact had the overall responsibility. They all had different bits of it." And that included the problem that while Monitor was responsible for holding individual foundation trusts responsible for their financial performance, it was not technically responsible for ensuring that the foundation trust sector as a whole balanced its books.

the money and the performance are going away from us really, really quickly

In January 2015, David Flory, the Chief Executive of the Trust Development Authority, was lamenting in private:

"It's all so fragmented, and the money and the performance are going away from us really, really quickly. There's no one there to worry about the whole. Indeed I sometimes think we [the Trust Development Authority] are the only arm's-length body that still thinks of itself as part of the NHS. The language everybody else uses about the NHS is 'it' or 'them' or 'they'. I think we're the only bit that still says 'we'.

"I worry about the whole, because I always have. But I'm responsible for just one slice of it. And the bit I am responsible for feels as though it is subjected to unpredictable and inconsistent regulation and inspection, and sometimes irrational commissioning. The only place it all comes together is in the Secretary of State's office." [24]

As a result, in the summer after the 2015 general election, the decision was taken to merge Monitor and the Trust Development Authority. By then, pretty much everyone was in favour, Simon Stevens declaring that their twin task was increasingly "a distinction without a difference".[25]

David Bennett says:

"There was a confluence of views, including my own, that it was a good idea. The Secretary of State was increasingly demanding that the FTs [foundation trusts] were overseen in the same way as the non-FTs, and it was an observable fact that there was a big overlap. On the measures we had, the high-performing ordinary NHS trusts were doing better than the worst-performing FTs. So I completely accepted that the distinction was disappearing.

"And I accepted that a more 'command and control' management of the foundation trusts was needed because they had had a number of years of autonomy to sort themselves out and they frankly had not done very much with it, when the pressures were not great. Now the pressures were great and they still weren't doing enough with it." [26]

So the two bodies were merged into the inelegantly named NHS Improvement.

But there was a problem. Legally, under Lansley's legislation, they could not be merged, but equally there was no way that David Cameron's Government was going to legislate, so badly burnt had it been by the Health and Social Care Act. So a workaround was created. Monitor and the Trust Development Authority got the same

board membership, chair and chief executive – a *de facto* merger of two organisations with very different cultures – while they remained separate legal entities, publishing separate accounts and employing their staff on separate terms and conditions of service. The creation of NHS Improvement brought a change of cast. Flory and Bennett retired from their NHS roles and Ed Smith, a founding board member of NHS England, moved across to chair the new organisation in an attempt to align it more closely with NHS England.

Smith says:

"[The merger] was Jeremy Hunt's idea, and he was quite right. Malcolm [Grant, Chair of NHS England] and I had a clear understanding that I would take this on and we would build significant collaboration, and that one day we would have a unified, probably cross-membership board, subject to the legalities and all that kind of stuff. But it does require that you be around the table as equals, not around the table where one organisation is the boss, and the others are just the recipients of the tablets of wisdom. That doesn't work." [27]

Jim Mackey became the Chief Executive of NHS Improvement in November 2015, promptly declaring that the service was "in a mess" and that the efficiency levels being demanded were simply "not possible. We should not be surprised we have a deficit. It was entirely predictable and frankly bloody stupid."[28]

> the *Five Year Forward View* had provided a compass, not a map

But the creation of NHS Improvement was not the only workaround. Just ahead of the 2015 general election, and in a clear demonstration that the future was not going to be a 'one size fits all' arrangement, the Conservative Chancellor George Osborne agreed with the mainly Labour-led local authorities in Greater Manchester that they and the NHS locally could take control of the entire £6bn health and social care budget for the area. As bold an experiment as there had yet been in trying to align health and social care more closely, this was part of Osborne's 'Northern Powerhouse' agenda. But it suited equally Simon Stevens' drive for 'new models of care', so it won his enthusiastic support. Complex governance arrangements that did not require legislation were put in place to enable all that to function.

There remained, of course, the question of how the new models of care were to be constructed. As Stevens himself put it, the *Five Year Forward View* had provided "a compass, not a map".[29] How were the hundreds of NHS organisations and commissioning groups to be brought together to deliver the more integrated care promised? There was, in every sense of the word, no organisation to deliver it. In the past it would have been managed by the strategic health authorities. But they had been abolished and no one was about to recreate them.

The answer came in December 2015 with the announcement of local 'sustainability and transformation plans', which shortly afterwards divided the country up into the 44 areas that covered the most common patient flows. These plans were charged with bringing everyone together to work out how services would move between hospitals,

and from hospitals to community services and general practice, in order to achieve the integrated care now being sought, with local government also involved because of its responsibility for public health and social care.[30]

Even as these 'plans' then mutated into slightly more formal 'partnerships', they did not become legal entities. Their main authority lay in moral suasion and the widespread recognition, in both the health and care systems, that services did indeed need to change. They were another form of workaround – and another clear signal that 'planning' was taking over from 'choice and competition'. To some this looked like an attempt to recreate a version of the strategic health authorities without any legislative underpinning, although such suggestions brought firm denials.

Scene Five – Out of the European Union...
"Now that you're gone..."

What followed was an earthquake that had nothing to do with the NHS but which was bound to affect it. David Cameron called a referendum on the UK's continued membership of the European Union. In June 2016, he lost, by a margin of 52 to 48. Cameron quit and Theresa May became Prime Minister. George Osborne was sacked, Philip Hammond became Chancellor and Simon Stevens lost his direct line into what are normally the two most powerful people in any government.

Neither May nor Hammond had any ministerial experience of the NHS. The one, as Home Secretary, had cut police budgets hard as part of the Coalition Government's austerity drive. The other had cut defence. Both believed that their services had survived, despite the defence cuts, for example, leaving Britain with a couple of new aircraft carriers on the way, but no planes to fly off them for several years. Their opening attitude seemed to be that if other public services could be cut without the roof coming in, then the protected NHS, whose budget had in fact grown, should deliver on the £22bn of efficiency savings it had promised. Pleas for additional money would fall on deaf ears.

But if Cameron and Osborne had gone, Hunt remained. By June he had been involved in almost three years of negotiation over a new junior hospital doctors' contract, which in January and February, and then again in March and April, had produced escalating one-day strikes – the first by medics since the 1970s. Resumed negotiations led in May 2016 to a deal.

> [reports of my death have been] greatly exaggerated
>
> Jeremy Hunt

But a ballot had still to be held on that, and amid widespread rumours that Hunt was to be moved or sacked, he apparently persuaded the new Prime Minister that moving him would look like a victory for the British Medical Association. He emerged from 10 Downing Street with the NHS badge that he always wore – but which he had removed before going into Number 10 – back on, declaring himself on Twitter to be "thrilled to be back", with the reports of his death "greatly exaggerated".[31]

When the ballot result came in, it turned out that the junior doctors had voted against by a margin of 58% to 42%. Hunt announced that the contract agreed in May would

be phased in from October anyway, and junior doctor leaders announced a series of five-day strikes to start in September. In the end these were first suspended and then abandoned, as many, including the medical royal colleges, the General Medical Council – the doctors' disciplinary body – and Simon Stevens, warned that such action would inevitably put patients at risk.[32] Hunt thus won, though at the price of a deeply disillusioned workforce.

Scene Six – And away from the purchaser/provider split... *"Come together"*

Meanwhile, as work continued on the sustainability and transformation plans, it was becoming evermore clear that more elements of the market-like mechanisms were being unpacked. In the September of 2016, Stevens said that both he and Jim Mackey, the still relatively new Chief Executive of NHS Improvement, were "entirely open" to the idea that the NHS locally could stop using the NHS price list, otherwise known as payment by results or the NHS tariff, to pay for each 'click of the turnstile' in hospitals. Instead, local commissioners and providers could agree a budget between them on a programme basis. The nature of commissioning was evolving, he said, and "we are entirely open to the prospect that you choose to abandon [payment by results] as the currency for deciding where the funds should go".[33]

Five months later he went much further, telling the Public Accounts Committee that between six and 10 of the sustainability and transformation partnerships would be set up as "accountable care organisations or systems, which will for the first time since 1990 effectively end the purchaser/provider split, bringing about integrated funding and delivery for a given geographical population". This, he told the committee, "is pretty big stuff, and people are pretty enthusiastic about it".[34]

It wasn't just big; it was also extraordinary. Given that the original legislation on the purchaser/provider split, Labour's reinforcement of it through the creation of foundation trusts in 2000 and Lansley's reinforcement of it in the Health and Social Care Act, had produced three of the biggest parliamentary rows over the NHS in the previous 30 years, it was indeed utterly remarkable that its demise – or partial demise – was being announced not by the Health Secretary in Parliament but by the chief executive of the commissioning board to a bunch of MPs. Who was the Secretary of State now?

Scene Seven – And out of favour... *"Tubthumping"*

Not Simon Stevens was the view in Number 10, with it becoming clear that not only had Stevens lost the line to Cameron, but also there was no love lost between him and Theresa May's closest advisers.

With the £2.5bn overspend now fully confirmed, and with the providers struggling to get that down to a planned £580m for 2016/17, Chris Hopson, the Chief Executive of NHS Providers – the body that represented all 238 hospitals, and community and mental health services – went nuclear. He declared in September 2016 that "something now has to give. The NHS can no longer deliver what is being asked of it for the funding available". If more money was not found, the service would have to give up on the waiting-time targets, ration access to care, shut services or extend and increase charges.[35]

His warning more or less coincided with one from the Care Quality Commission, which said that the state of adult social care was "approaching a tipping point". There were worrying signs that the quality of care was declining, David Behan, its Chief Executive said. "Increased need" was colliding with "reduced access" – driven both by too little funding and by a number of private and voluntary sector providers handing their contracts back because, for the funding available, they felt they could no longer deliver them safely.[36]

In the October, Theresa May responded by telling both MPs and the *Manchester Evening News* that Stevens had asked for £8bn in the *Five Year Forward View*, "but the government has not just given him £8bn extra, we've given him £10bn extra... we have given the NHS more than the extra money they said they wanted for their five-year plan".[37]

Days later, at a Health Select Committee hearing, with an awkward Jeremy Hunt sitting alongside, Stevens contested that. May had used a different baseline for the calculation, he said – and with independent analysis, and then the UK Statistics Authority, confirming his view,[38] Stevens insisted that the figure was £8bn. The NHS could only manage on that, he pointed out, if other stipulations in the *Five Year Forward View* were met, such as social care funding rising to meet need.

When the *Autumn Statement* came in November 2016 – in effect Philip Hammond's first Budget – it was clear that neither he nor Theresa May was listening. The statement contained no more money for the NHS and nothing to help social care.[39]

> the emergency care system is on its knees

In the December, Stevens was called before a House of Lords committee on the sustainability of the NHS. He used the hearing to say that an "immediate" cash injection was needed for social care because of the knock-on effect it was having on the NHS. "If there were to be any extra money available any time soon then in my opinion social care should be front of the queue," he said. Not only did this involve the unusual sight of an NHS boss putting social care spending above the health service's immediate demands, Stevens also went on to suggest how, in the longer term, that could be paid for, for example by ending the so-called 'triple lock' on pension increases. "We need to go beyond just thinking about health and social care funding and also think about what's happening in the benefits system, the pensions system and so forth," Stevens said. To Number 10, this looked like Stevens stepping way beyond his remit and into politics, not least the politics of reforming the benefits system, not just the NHS.

Shortly after that, the NHS tipped over into the worst winter crisis it had seen in well over a decade. Waiting-list operations were cancelled. Huge queues and long waits built up in A&E departments. There were reports of patients dying on trolleys. Dr Mark Holland, the President of the Society for Acute Medicine, said: "People dying after long spells in hospital corridors shows that the NHS is now broken." The Red Cross, which primarily operates overseas, said it had been called in by more than 100 hospitals to help get patients home and that it was helping deal with "a humanitarian crisis". Dr Taj Hassan, the President of the Royal College of Emergency Medicine, said that "the emergency care system is on its knees",[40] with Professor Keith Willett, NHS England's

Medical Director for acute care, admitting that staff were under "a level of pressure we haven't seen before".[41]

Irked by Stevens' contradiction of Theresa May's spending claims, annoyed further by his sally into the future of social care funding, and worried by what the media was describing as "the chaos" engulfing the NHS, Downing Street sought to pin the blame on Stevens. *The Times* reported that Theresa May's "senior aides" – whom everyone understood to be Nick Timothy and Fiona Hill – "don't think he is enthusiastic and responsive enough and they don't think he is on board with the direction of travel".[42]

Stevens, however, was willing and able to hit back. On the afternoon the piece in *The Times* was published – and just two hours after Theresa May and Jeremy Corbyn had clashed over the NHS at Prime Minister's Questions, at which May declared the description by the Red Cross to be "irresponsible and overblown"[43] – Stevens was in front of the Public Accounts Committee. Going through the numbers yet again he told the MPs that "it is a matter of fact... that we got less than we asked for," adding that "it doesn't help anybody to pretend there aren't finance gaps". Against the advice of his communication directors, he brandished a *Daily Mail* headline stating that "NHS trails rest of EU for medics, beds and scanners". He pointed out that he had been "running a little campaign" about social care cuts – "enthusiastically I might add". He noted improvements in NHS performance, including "the fact that 2,400 people were alive with their families this Christmas, having survived cancer care in the NHS, who would not have been so a year ago". And in a barb aimed at those who believed that other parts of government had been cut without ill-effect, he noted that "our demands are quite different from, say, the criminal justice system". He pointed out that "we are spending 30% less per person on our health services than the Germans" and the way the money had been allocated meant that 2018 was poised to be "our toughest year". [44]

Such a confrontation may not have been quite what Andrew Lansley envisaged when he sought to separate policy from operations. "You are meant to be independent, but not that bloody independent", so to speak, to quote the Downing Street adviser from earlier. This was probably the nadir of Stevens' relationship with Number 10.

> **I am responsible**
>
> Jeremy Hunt

But something equally remarkable was happening on the other side of the equation that Lansley's legislation had created. As the – quite literally – weeks of awful headlines and television pictures ran on, Jeremy Hunt was able to go on the *Today* programme and other broadcast outlets and say that what was happening was "completely unacceptable", that there was "no excuse" for patients being trapped in hospital and unable to go home for lack of social care. "We are trying very hard to sort out these problems," he said, including advancing the *Five Year Forward View*.

Hunt, by now, had been Health Secretary for more than four years. But neither the media nor the Opposition managed to lay a glove on him. "I am responsible," he said. There was "no excuse".[45] But he survived. This too may have been Lansley's dispensation playing through. Just who was responsible for NHS performance?

Act Five
2017 to 2018: *"Putting Humpty Dumpty together again"*

Scene One – Hunt adapts his approach
"Getting it right the first time..."

If Stevens' relationship with Number 10 was decidedly strained, Hunt's relationship with Stevens was going better. The Monday morning meetings continued. When they occasionally reached deadlock, Hunt – as he did with the other arm's-length chief executives – would turn it into a private meeting "to do a deal", in the words of one interviewee.

But agreed – though moveable – areas of influence had been reached. Stevens was pursing the 'new models of care' of which Hunt approved, for example, while working on shared objectives that included mental health having 'parity of esteem' and the need to revive primary care. Hunt, while still chasing the performance figures, continued his drive on quality and safety.

Hunt's initial focus had been on more inspection through a more independent Care Quality Commission, allied to the publication of much more data on clinical performance, including the outcomes for individual consultants. But he came to see the limits of that. In early 2016, he acknowledged that his "biggest mistake" had been an over-reliance on his new and hugely enhanced inspection regime, which was now, anyway, undergoing a 25% budget cut. "It took me a while to understand that the most important thing that any organisational leader can do is think about how to change culture," he told the *Health Service Journal*. "I shied away from that because it felt so nebulous".[1] Acknowledging that "we tend to default too quickly to top-down" as the way of improving standards, he said "we do need to think about how we empower the process of peer review, which can have such spectacular results"[2] – peer review seeking to harness the natural competitiveness of clinicians to improve the outcomes for patients by, for example, putting in front of them all the data about their performance compared with others, with that being led by other clinicians, not by managers or inspectors. In other words, this was something that went beyond the Care Quality Commission inspection regime, which Hunt already saw as a form of peer review.

So Getting It Right First Time, a programme originally started in orthopaedics in 2012 by Professor Tim Briggs, President of the British Orthopaedic Association, was gradually extended, first to additional surgical specialties and then to almost all of medicine and surgery.* A scheme to reduce medication errors was launched along with the creation of a new Healthcare Safety Investigation Branch, based around the approach of the airline industry, to draw lessons nationally from some 30 deaths a year that were judged avoidable.[3]

* For a brief summary, see Timmins N (2017) *Tackling Variation in Clinical Care: Assessing the Getting It Right First Time (GIRFT) programme*, The King's Fund.

But, as in the airline industry, that required a 'no-blame culture' of honest reporting when things went wrong. And realising that would only ever get limited airtime in the mainstream media, Hunt embarked on a series of visits to NHS trusts – more than 90 of them to date – to spell out the need to move from a 'blame culture' to a 'learning culture'.[4]

His cause was later not to be helped by the case of Hadiza Bawa-Garba, a junior doctor convicted of manslaughter by gross negligence after she admitted mistakes in a case where much else also went wrong and a six-year-old boy died. To outrage in the medical profession, she was struck off, with the case due to go to the Court of Appeal. Hunt ordered a review of whether the manslaughter laws are fit for purpose in such cases. The aim of the review, he said, was "to ensure the vital role of reflective learning, openness, and transparency is protected so mistakes are learned from and not covered up".[5]

These changes of emphasis on what might lead to higher-quality services came in addition to, not as a substitute for, inspection and data publication. So with his 'Ofsted-style' rating of hospitals and other services now well in place, NHS England was told to introduce similar ratings for clinical commissioning groups in 2016 "to identify where NHS England intervention is needed". On the data side, in 2016, hospitals were told that by 2017 they needed to publish estimates of avoidable deaths as Hunt made clear that what he wanted to be remembered for was "a safety and quality revolution" in the NHS.[6]

But support was also needed in other ways, Hunt concluded. He commissioned Lord Carter of Coles to look at productivity and purchasing, and when the report calculated that improvements in both could save £5bn a year by 2020,[7] a unit to improve central purchasing and to support NHS trusts in their own work on productivity was established – rather than simply exhorting the NHS to get on with it.

He did so, working with a Department of Health that the Health and Social Care Act had radically reshaped. In the words of one middle-ranking civil servant at the time of the Act, now appreciably more senior, the department "lost caste" as the Act took effect. "There was a crisis of confidence, and a loss of faith, because the turmoil had been so great for many of the senior people. It took quite a while to work out what its role should be."

// much of policy has in practice moved to NHS England //

It has – along with many other central government departments – shrunk significantly. It has almost halved in size from 3,358 whole-time equivalent employees in 2010 to just under 1,900 in 2017 and is meant to reduce yet further by 2020. It has also been significantly restructured. "Its role now is more scrutiny than policy making," this civil servant says, "as much of policy has in practice moved to NHS England."

Scene Two – For this much you can have that much
"Can't give you more..."

Hunt's enhanced relationship with Stevens did not prevent a serious tussle over the mandate for 2017/18. This was reflected in the fact that it was only put to Parliament on the last day possible in March 2017.

There were two core issues. The first, one board member says, was that:

"Hunt, the department and the Treasury were very keen to put on us the responsibility for balancing the books overall. And the board was very clear that we would not accept that. We have no power over trust deficits, and the trust financing facility still sits inside the Department of Health. We can balance our books – and we have. The commissioning budget achieved an agreed £600m underspend last year. But we can't balance the books overall. Only the department can do that."

> We can't balance the books overall. Only the department can do that

The second issue was over what could be delivered for the money, given there had been no additional cash in the autumn budget. What could be delivered was set out in the March 2017 document *Next Steps on the Five Year Forward View*, which, ahead of the mandate being published, stated that while the service would provide additional elective operations over the coming year, "some providers' waiting times will grow".[8] The service had already failed in any month over the previous year to meet the overall 18-week waiting-time target for treatment. Now, longer waits were official.

Less urgent operations for joint replacements, hernias and cataracts were likely to wait longer to preserve improvements in mental health, cancer and GP services, Stevens said: "We are saying that we expect that the number of operations that the NHS pays for will continue to go up, but we recognise that [while] right now about nine out of 10 people get their operations in under 18 weeks, in some parts of the country that will be under pressure. There is a trade-off here".[9]

The response of Clare Marx, the President of the Royal College of Surgeons, was that that was "waving the white flag" on the waiting-time target. "It will," she said, "be difficult for the general public to understand how [that] is compatible with a vision of an improved health service. We risk returning to the days of unacceptably long waits for elective surgical treatment."[10]

Getting that agreed with Number 10 involved some tense exchanges as the politicians did not like the conclusion. But they were in the end forced by the finances to recognise that something had to give.

And that was a significant moment, because it was NHS England not just making the case for additional funding – which it was careful to recognise depended on, among other things, the state of the economy – but also then spelling out what could be achieved with the cash available. As one figure in NHS England puts it: "It was not as crude as saying that if you halved the NHS budget we could deliver this. Or if you

doubled it we could do that. It was saying to the politicians 'for this much money, this is what we can do'."

Again, this was NHS England, not Hunt, announcing that the waiting-time target would not be fully met – something that was both an operational and a policy decision. The ministerial recognition came only in a subtle rephrasing of the mandate. It left the achievement of the 18-week target as a 2020 goal. But it was silent on what would be achieved in the 2017/18 financial year when previous mandates had said that the standard would be met in year.[11] In other words, the mandate, far from giving the NHS its marching orders, was starting to reflect what had already been laid out by NHS England.

> for this much money, this is what we can do

And as that happened, Stevens continued to innovate in areas that in the past would have been ministerial territory. Earlier, in 2015, he had quietly revamped, to the point of changing its nature fundamentally, the Cancer Drugs Fund that Cameron and Lansley had created to pay for new products that NICE had judged to be insufficiently cost-effective. The fund had repeatedly overspent its budget. The drugs it covered had to be restricted several times. Its name was retained, but its operation was essentially put back under the NICE dispensation so that it was turned into a 'managed access fund'. In practice, Stevens essentially got rid of it, at a time when Cameron was heavily distracted in the run-up to the referendum on continued membership of the European Union, although according to one interviewee the decision produced "the only shouting match between Stevens and Cameron".

NICE was continuing, however, to recommend which other new drugs were sufficiently cost-effective for the NHS to adopt, and NHS organisations were legally bound to implement those recommendations. Even when cost-effective, however, the bill could be large. The initial crunch came in 2015 around new treatments for hepatitis C – a viral infection from which some 160,000 people in England suffered and which could lead on to very expensive treatment for cirrhosis of the liver and cancer. In 2015, NICE judged one of the new products to be clearly cost-effective. But a course of treatment typically cost around £40,000. The potential bill ran to an estimated £700m or more a year, even if in the long run it would save money. So a cash-strapped NHS England first sought a delay in implementing NICE's approval of the product, and then limited treatment initially to some 10,000 cases a year – starting with those most acutely ill.

But in 2017 it then went further. There was, Stevens said, "no reason in principle why extra spending on a drug treatment should automatically have a legal override so as to displace community nursing, mental health care or hip replacements".[12] So, despite Stevens having originally been a key protagonist of the legal requirement for the NHS to implement NICE recommendations back in the 2000s, NHS England published with NICE a joint consultation, which agreed that where a new product was likely to cost the NHS more than £20m in any of its first three years, NHS England could ask NICE to recommend how it should be phased in.[13] This was a very large policy change to the role of NICE. Instead of simply recommending which treatments were cost-effective, NICE was now to take on the role of rationing them – recommending how quickly they

should be adopted if the overall cost was judged to be too great to be absorbed immediately. In the past, this would have been a ministerial decision and ministerial announcement. This was, after all, more than just operational. But Hunt, in public, was nowhere near it, even though both he and the Department of Health knew what was happening.

In the public arena, it was decided jointly by two unelected quangos – NHS England and NICE – and with a minimum of public fuss. There were no 'Jeremy Hunt announces new drugs to be rationed' headlines around this. The new dispensation – Lansley's dispensation – meant that it went through under the radar. In practice, to date, NICE has not had to play that role, with the threat of the £20m cap leading pharmaceutical companies to agree lower prices.

Scene Three – Trying to tie a knot
"Love and marriage..."

Meanwhile, despite Andrew Lansley's determination that his Act should be 'permanent', the idea was gaining ground that it should in fact be amended.

The creation of NHS Improvement, with Ed Smith as its Chair having been a board member of NHS England from its inception, had been intended to lead to closer working between the two. Up to a point that had started to happen, and both Smith and Malcolm Grant, the Chair of NHS England, were coming to the view that not only was closer working needed, the long-run logic was also that the two bodies should in fact merge, creating a much more unified, corporate structure for the NHS. Both also came to believe that a proper legal underpinning for the sustainability and transformation partnerships, as they had now been renamed, and for the planned accountable care organisations that were meant to emerge from them, would not only be helpful but might also, eventually, be necessary.

Hunt – who had always tended to see NHS England as the headquarters of the NHS – could see the logic of both parts of that. In an interview with the *Health Service Journal* in December 2016, he did not rule either piece of legislation out, even if he presented them as a somewhat distant prospect. He said:

"My view about all these structural changes is that we had our fill in 2012 and I don't think anyone wants any big structural change now, but that is not to say anything is set in aspic. We have the STP [sustainability and transformation partnership] process that is just starting and I think there may well come a moment at the end of this Parliament where we look at the progress of STPs and the need for the NHS to move in every part of the country to some version of an accountable care organisation, and we then look at the legislative structures that we need to underpin that.

"I think it would be a mistake to try and predict that now. We should do our very best to make things work under current structures and then I think we will be in a much better position to make those judgements toward the end of this Parliament." [14]

In other words, the door to amending Lansley's legislation was opening. Something that for five years had been entirely off the agenda was creeping back on to it. And that became evident when, out of the blue, with Brexit battering both Labour

and the Conservatives, but the Conservatives comfortably ahead in the opinion polls, Theresa May called a general election for June 2017.

Labour's position during the campaign remained wanting a repeal of the Health and Social Care Act. But the Conservative manifesto – using the decidedly quaint language of the 'internal market' – backed the *Five Year Forward View* and stated: "If the current legislative landscape is either slowing implementation or preventing clear national or local accountability, we will consult and make the necessary legislative changes. This includes the NHS's own internal market, which can fail to act in the interests of patients and creates costly bureaucracy."[15]

> if you sit in a trust it feels as though the roof is off and it is permanently raining

It never became clear during the election campaign precisely what that meant. But at the least it seemed to imply some revision to the so-called 'section 75 provisions' of the Health and Social Care Act – the choice and competition elements that were continuing to provide a good living for lawyers. Much of that was in fact European Union law. But the Competition and Markets Authority was itself acknowledging that competition was becoming less relevant given the financial pressures the NHS was under (see above), and the UK was anyway on course to leave the European Union, which might well give it the opportunity to change that law. But the manifesto wording seemed also to hint at a legal underpinning for accountable care organisations. And if the need was 'clear national accountability' then that might also include an end to the divided accountability of NHS England and NHS Improvement.

Hunt says that the intention was to consult on all of that, including doing something about the procurement rules where "there is gold plating by clinical commissioning group [CCG] lawyers who continually advise the CCGs that this or that contract has got to be put out to tender when the centre do not believe that is always the case. That can be unnecessary, and unnecessarily disruptive." [16]

Theresa May's calling of the general election turned out to be, however, a terrible political misjudgement. Rather than gaining an enhanced majority for her "strong and stable" leadership, she lost the one she had, becoming dependent on a deal with Ulster's Democratic Unionist Party to have the chance of any majority at all. And with that disappeared the chance of amending Lansley's legislation. The relative paralysis across much of the rest of government that Brexit had already engendered was reinforced.

But if legislation to amend the Act was now off the agenda, steps to bypass it continued. Immediately after the general election, in July 2017, NHS England and NHS Improvement appointed joint regional directors for the south and the south-west – two of the five regions into which both had now organised their teams. The teams beneath were not merged – although logic said in time they might be – and Matthew Swindells, NHS England's new Director of Operations, was careful when announcing that, to say that this was "not a formal legal or employment change". But given that NHS organisations across the country were being urged to "put on one side their organisational interests and to focus on joint working", he said, the same had to apply to the two national bodies. Both were under pressure to "eliminate divisions arising from

our separate organisations within health systems that are trying to work together"[17] – in other words, to try to reduce the conflicting demands put on services by a commissioning body and a financial regulator.

As that was being put in place, Ed Smith, Chair of NHS Improvement, announced his departure, stating in an exit interview that:

"[The current architecture] just doesn't work. The structure is inarticulate and not fit for purpose. [The result is] that trusts get a regulatory battering. We have, at NHS Improvement, worked hard to work better with NHS England and to be not just a financial regulator but to help with performance improvement. But we have far too many regulators. Everybody thinks they own a piece of it. And if you sit in a trust it feels as though the roof is off and it is permanently raining. We badly need to deregulate and de-duplicate regulation." [18]

And that view was entirely shared by Jim Mackey, his Chief Executive. When he arrived at NHS Improvement, he said: "I couldn't believe the cost of the architecture." For those on the receiving end of all the regulation and assurance, "at a provider or local system level, it is incredibly chaotic". As he left the post, two years later to return to his trust in Northumbria, he declared that, "with a really serious effort", it might be possible to take a billion pounds out of the regulatory system – "really serious money".[19]

> **The need for more joined-up national and regional leadership... is self-evident**

Following the appointment of joint regional directors in July 2017, NHS Improvement and NHS England then went further. The legislation prevented the workaround that had seen NHS Improvement established – the same boards, the same chief executives and the same chairs, but with Monitor and the Trust Development Authority still continuing as separate legal entities. Instead, an even more tortuous approach had to be found. Richard Douglas, former Finance Director at the Department of Health, was appointed to both boards in January 2018, and David Roberts, the Deputy Chair of NHS England joined the board of NHS Improvement. To comply with the law, however, neither could be voting directors. Instead, a new role of 'associate (non-voting) non-executive director' had to be created: even the newspeak of George Orwell's *1984* would have struggled with that.

At the same time, a Joint Finance Advisory Group was established to ensure that the two organisations "are working from a common understanding of the financial targets and financial performance of the entire health system".[20] Again, that advisory group, while clearly there to do the business, could not technically have executive responsibility. Plans were also laid to hold some joint board meetings. As Sir Malcolm Grant, NHS England's Chair, put it: "The need for more joined-up national and regional leadership between both commissioners and providers is self-evident, particularly as we move towards increasingly seamless delivery across England of services to patients and the population at large."[21] As NHS Improvement echoed the need "to streamline our activities so trusts don't get duplication or directly contradictory instructions", Grant added that the aim was "to ensure *so far as possible* that there is a single voice across the NHS".[22]

This was not yet a marriage, with the law preventing the pair from getting to the altar. But it was Lansley's Act being slowly but surely unpacked, with the top of the NHS in England heading towards a more corporate structure – or as one figure in NHS England put it, after the huge fragmentation caused by the Act, "we are seeking to put Humpty Dumpty together again".

Scene Four – Judicial reviews
"You bring your lawyer and I'll bring mine..."

Below the national level, the picture looked like this to another senior figure in NHS England:

"We are trying to move the NHS from the model of the last 15 years with a purchaser/provider split, with transactions through contract, and with organisations asking 'What can we bill for?' and 'What can we charge for?' to a more population health management model – but without saying that out loud and without the legislation to support it.

"It is a big challenge. Because even when people do get the health system thinking going, the boards of individual organisations then say: 'Ah. But we have to balance our books.' And we are trying to say them: 'Don't worry about that. If we can give you an overall budget for the health system, that is the one that has to balance.' But the regulation does make it difficult.

"If we had legislation, would it help? I don't know. On my more optimistic days I think that if we can pull this off it will stick better, because people will have done it themselves, rather than if we had the old, top-down approach of reorganisation, which is what legislation might give you."

How far that would prove possible even within the current law suddenly became subject to legal challenges. These did not come, as one might have presumed, from the private sector fearing that integrated care systems would lead to less contracting out. Instead they came, out of a clear blue sky, from two sources: 999 Call for the NHS – a pressure group made up of some of those who most hated the quasi-market parts of Lansley's Act* – and CrowdJustice – a group that included a former Deputy Chief Medical Officer, Dr Graham Winyard, and the cosmologist Stephen Hawking.**

'Accountable care', with its name linked to developments in the United States, had proved a red rag to a bull. The opponents feared that such overarching population health contracts would be let to the private sector, and argued that there was no legal basis for them. And, quite remarkably, given their opposition to quasi-markets in health care, one part of their argument was that the planned integrated care arrangements went against provisions in the Health and Social Care Act to pay providers per procedure – the 'click of the turnstile' approach that had reinforced the purchaser/provider split. That, they argued, at least meant that providers were paid per procedure so that "if demand outstrips supply then providers are paid commensurately". Under a whole population contract, they argued, that would no longer apply.[23]

* See http://999callfornhs.org.uk/homepage-201718/4594123609, retrieved 15 April 2018.

** See www.crowdjustice.com/case/jr4nhs-round2, retrieved 15 April 2018.

The response of NHS England and Jeremy Hunt was to rename 'accountable care organisations' as 'integrated care providers' and resist the legal challenge. Simon Stevens was far from the only one to note that "irony is still alive", given that some of the Act's fiercest opponents "are seeking to use the courts to enforce absolute compliance with the 2012 Act".[24] The judicial reviews would, he said, "bring welcome clarity": either the courts would find "that it is possible to fund primary care, community health and hospital services in a combined way that is consistent with the statutory framework", in which case "that settles the question once and for all"; or they would find that to be unlawful, in which case "what we will be doing instead is the bulk of what the integration agenda looks like with the voluntary coming together of organisations to create integrated care systems".[25]

Scene Five – Give me money

"I will, I will, I will"

By April 2017, the imposition of 'control totals' and the placement of a number of hospitals into 'financial special measures' had seen the NHS broadly balance its books. The provider side overspent by £800m, against a planned overspend of £200m, but that was down on the £2.5bn the year before, and NHS England had underspent by £900m. Financial balance, however, had come at a price. Cash from the £1.8bn 'transformation' fund had been diverted to balancing the books, and another £1.2bn of capital was transferred across to revenue.[26]

And down on the wards it felt as though the service was inhabiting a Narnia-like land – 'always winter, never Christmas' – as the pressures on A&E departments continued throughout the year, not just over the winter.

In the autumn, the Care Quality Commission, having warned the year before that adult social care was "approaching a tipping point",[27] said that some areas of the country had deteriorated but some had improved thanks to the £2bn of additional social care support that had come through Council Tax rises. However, it warned that "the entire health and social care system is at full stretch" and that what was needed was "a long-term sustainable solution for the future funding and quality of adult social care".[28]

> adult social care [is] approaching a tipping point

On the health side, age-weighted spending per head was due to fall in 2018/19 – "our toughest year" as Stevens had put it[29]– thanks to the frontloading of the extra money the NHS had received. The three health think tanks, the Nuffield Trust, The King's Fund and The Health Foundation, combined to calculate that the NHS needed an additional £4bn for that year, while social care was facing a £2.5bn funding gap by 2019/20.[30]

Ministers were holding every spending line they could. For example, Amber Rudd, the Home Secretary, scolded chief constables for asking for more resources. But, reinforced by the health think tanks' assessment, Stevens went in to battle. He called for that £4bn. He warned that the numbers on the waiting list would rise from four million to five million without it, while provocatively recalling the Brexiteers' red battle bus with its slogan: "We send the EU £350m a week. Let's fund our NHS instead." Trust in democratic politics, Stevens declared, "will not be strengthened if anyone now

tries to argue: 'You voted Brexit, partly for a better-funded health service. But precisely because of Brexit, you now can't have one.'" The NHS "can no longer do everything being asked of it", and underfunding risked turning back "a decade of progress".[31]

This looked pretty close to Stevens putting his job on the line. Jeremy Hunt, who was the one negotiating for extra cash with the Chancellor, was left as the back-up band, agreeing that it was "impossible to argue anything else" if the question was "does the NHS need more money?".[32]

The Treasury was once again furious. Nick Macpherson, its Permanent Secretary up to 2016, tweeted that it was "time for Mr Stevens to step down as an unelected public servant if he wants to campaign for more NHS funding"[33] – misunderstanding that the Health and Social Care Act had in fact given Stevens the ability to do just that. Number 10 let it be known that the Prime Minister was holding Stevens "personally responsible" for performance over the winter, and the Chancellor, Philip Hammond, went on the BBC's *Andrew Marr Show* to say that the "plan is not at the moment being delivered... [we need to] get it back on track".[34]

NHS England's media account instantly responded by tweeting out figures from the Institute for Fiscal Studies showing that productivity was rising sharply, along with extracts from Stevens' evidence to the Public Accounts Committee.[35] When the Chancellor, later in the day, went on ITV's *Peston on Sunday* politics show, he did not repeat the charge. It would have been impossible for any previous NHS chief executive to have responded to the agenda of the day in that way, without ministerial approval.

Thus it turned out that, with the Government in its weakened post-election state, Stevens was once again making the political weather, even if the outcome was sunshine and showers rather than a full day in the sun.

Against the lack of new cash a year earlier, Hammond accepted in his autumn budget that the NHS "is under pressure right now". And so, "exceptionally and outside the spending review process", he delivered an extra £2.8bn, some £1.6bn of which was for the coming year for which Stevens had sought £4bn.[36] There was no extra money for social care, but a promise that a pay rise for nurses and other staff would be funded if agreement could be reached on a renegotiation of Agenda for Change that was under way – the pay framework that covers all NHS staff except doctors and senior managers. Sir Malcolm Grant, Chair of NHS England, welcomed the additional cash but warned that it was insufficient: "We can no longer avoid the difficult debate about what it is possible to deliver for patients with the money available."[37]

At its meeting eight days later at the end of November, the board made clear that yet longer waits for more routine surgery looked inevitable to protect planned investments in mental health, cancer and primary care. There would be money for more waiting-list operations, but not enough to meet the waiting-time standard in full. More scrutiny would be given to "unfunded new expectations that are loaded on to the NHS," the board said, and NICE guidelines on the best way to provide services would only be accepted if "they are accompanied by a clear and agreed affordability and workforce assessment at the time they are drawn up".[38]

An initiative to save some £190m a year by not providing medicines that could be bought over the counter was taken further. But the board warned that waiting time standards, "in the round, will not be fully funded and met next year".[39] By contrast, Hunt, on the same day, was saying that the Government was "absolutely committed" to those standards and "our absolute determination is to move back to hitting those standards".[40]

NHS England's warning that this time waiting times really would get much worse, brought a rapid political reaction. Very quietly, and with no public announcement, another £568m on top of the £1.6bn for the coming financial year was found, to seek to avert that.[41] Again this was the independent voice of NHS England as the operational manager playing back into the policy that was to be enacted. As a result, the mandate for the financial year 2018/19 became essentially a carbon-copy of that for the previous year.

Within three weeks of Hammond's Autumn Statement, the service was in what was now becoming a depressingly standard winter crisis, fed this time, unlike in the immediate preceding years, by a dose of flu in January and some serious snow at the end of February.

On 2 January, a panel that had been set up to deal with the winter pressures approved the postponement of all non-urgent routine care to free consultant time for A&E, along with day-case surgery and outpatient appointments "where this will release clinical time for non-elective care".[42]

Another run of dreadful winter headlines followed. Richard Fawcett, a consultant in emergency medicine at the Royal Stoke University Hospital, apologised to patients for the "third world conditions" in his hospital[43] while a consultant at the Charing Cross Hospital in London spoke of "battlefield medicine". The President of the Society for Acute Medicine said that conditions across the NHS were "as bad as I have known".

> "where we don't deliver the standards we aspire to, that is my responsibility"

Theresa May was left declaring that the NHS staff were "doing a fantastic job" while Hunt, as the year before, was left apologising to patients, saying that what was happening at Stoke was "not acceptable" but that "we are doing everything we can to support the staff at Stoke – it is not their fault". Postponed operations "is absolutely not what I want," he said. But the decision by "this independent panel" to advise that tens of thousands of operations could be postponed was a better way to do it than cancelling them in an unplanned way. "If you are someone whose operation has been delayed I don't belittle that, and I apologise to anyone who that has happened to... where we don't deliver the standards we aspire to, that is my responsibility."[44]

By now, as the NHS entered the year that would see it celebrate its 70th anniversary, a whole chorus of voices, including a call from 90 MPs that crossed party lines, was calling for a long-term spending settlement for both health and social care.

Hunt's own public conversion to that – after in earlier years criticising some of the demands for much more additional cash – came after reports of his death as Health Secretary had proved to be exaggerated for the third time.

In January 2018, Theresa May had a Cabinet reshuffle, triggered by the resignation of Damian Green as her first Secretary of State. Once again, Hunt went into Downing Street amid widespread expectations that he would be moved – although whether into Damian Green's old post or elsewhere was not clear. He emerged – after refusing to move, it was rumoured, to the Department for Business, Energy and Industrial Strategy – with the enhanced title of Secretary of State for Health and Social Care.

Social care policy had in fact always been part of the Department of Health's portfolio even if most of the money for it was routed through local government. But this had the effect of pulling back into the department work on a green paper on social care that had been taking place in the Cabinet Office, though chiefly with staff seconded from the Department of Health.

It also saw Hunt declaring that what the NHS now needed was a long-term 10-year settlement that would involve "significantly more funding". His own view, he said, was that "we need to build a national consensus as to how we are going to find that funding. And my own view is that we should try and do that for a 10-year period, not a five-year period."[45]

What was notable about the debate, however, was that it centred very largely on how to raise extra taxation for health and social care – a sharp contrast to the mid-to-late 1990s, the last time the NHS had been under such performance and financial pressure. Back then there had been loud voices arguing not for higher taxation but for much more dramatic changes to the way the service was financed – a switch to social insurance or some form of private insurance, with new and/or higher charges running alongside that, and/or the rationing of NHS care in ways that would see it provide a defined minimum package of care, which individuals could then top up.

In the mid-1990s, those calls were coming not just from the Conservative right, but from voices across a much wider political spectrum. Thus, the outgoing chair of the-then NHS providers' body had declared in 1995 that demand was such that the NHS would have to be reduced to "a safety net" for the "old and weak". The same year, Sir Duncan Nichol, the former NHS Chief Executive, chaired a pharmaceutical industry financed inquiry whose deputy chair was the future Labour Health Secretary Patricia Hewitt. It declared that taxation on its own would never close the funding gap and that higher user charges and "a clearer definition of what services will be provided free at the point of use" were likely to be needed. In 1996, a Rationing Agenda Group of health care luminaries, supported financially by The King's Fund, declared that "rationing in healthcare is inevitable", with the key question being not whether it happened but how to involve the public in deciding what would and would not be provided.[46]

In early 2018, in public at least, there were many fewer voices taking those lines. Instead, the debate seemed to be centred more around whether hypothecated taxation was the way to get more money into health and social care.

One reason for that was Brexit. Those Conservative MPs who might have been expected to lead the argument for a radically reshaped NHS were, in the main, those most in favour of Brexit. Having put on the side of their red battle bus that leaving the EU could provide an additional £350m a week for the NHS, they could hardly now be arguing, in public at least, that the service's problems should be solved by higher charges, or by rationing, or by private insurance.

Instead, in apparent recognition of the role that claim had played in the referendum result, some of those on the right of the party were becoming some of the strongest advocates for additional NHS cash – not just the mercurial Foreign Secretary Boris Johnson, but also Jacob Rees-Mogg, now a key figure on the Conservative right, who was calling for the 'Brexit dividend' to be spent on the NHS ahead of the UK actually leaving the European Union.[47] Thus, whatever problems leaving the European Union might or might not bring for the service in future, Brexit was, in this limited sense, and for a time, protecting the NHS and its funding model, and helping make the case for more money.

> a multi-year funding settlement... is a critical priority for me... we cannot afford to wait until next Easter

And all that – Steven's advocacy, Hunt's pressure, the Brexiteers' promise and the fact that the NHS looked likely to have only the most muted of 70th anniversary celebrations – seemed to come to a head when Theresa May went before the House of Commons Liaison Committee in March 2018. She promised "a multi-year funding settlement" outside of the normal spending round that would "build on the work of the *Five Year Forward View*" but also "look beyond it" – one that would also allow the NHS "to realise greater productivity and efficiency gains". This, she added, "is a critical priority for me". In the 70th anniversary year of the NHS's foundation, she said, "we cannot afford to wait until next Easter" – the date of the next Spending Review.[48]

It was not immediately clear whether this really was May's equivalent of Tony Blair's *Breakfast with Frost* moment. It was still "promises, promises" with the scale uncertain. Hunt for one was determined that this would be both a health and social care settlement – something which, if achieved, would certainly mark his place in history. In a sign that the Government was at least in part thinking more long term, he had already announced a 25% increase in doctor and nurse training places, along with the creation of five new medical schools, the aim being to make Britain 'self-sufficient' in doctors by 2025.

As May was making her announcement, Simon Stevens and Ian Dalton, the chief executives respectively of NHS England and NHS Improvement, were briefing their staff on the next steps to turn the two bodies into one. Their regional teams were all to be merged under a single regional director. Further work was under way to produce a single team, or closely aligned joint teams, at the national level – subject as always to what a piece of law that was now clearly getting in the way, permitted. The plan for joint board meetings was going ahead.

It was clear that this would not solve all the problems of split regulation and accountabilities that the Health and Social Act had created – or the sense, as Ed Smith had put it, that for many in the NHS it felt as though "the roof is off and it is permanently raining".[49] Indeed, Jim Mackey, the former Chief Executive of NHS Improvement, who had returned to be 'back on the ground' so to speak, as Chief Executive of his trust just in time for the winter of 2017/18, repeated his view that despite the best efforts of all concerned to date, at a local level the system remained "incredibly chaotic".

He said:

"[There are] quite simply endless demands for information and far too much focus on assurance. It is not so much CQC, because the inspection system is working quite well now. The problem is that it is not just what NHS Improvement and NHS England are demanding. It is the clinical commissioning groups, the commissioning support units, urgent care networks, the local accident and emergency delivery board, etcetera. In addition, local health and wellbeing boards and scrutiny committees also, quite rightly, want to understand what is happening locally.

"You have five or six people – all good people trying to do good things – repeatedly calling to ask for the essentially the same thing, or to tell you things you already know. It just gets in the way of what needs to be done. I've seen examples of very hard-working people in the architecture trying to hold this back, and shelter providers from it. But it is clearly very hard. When we do get to simplify the system, we need to get rid of as much cost and assurance as possible to free up time and money." [50]

It was clearly hoped that bringing both the boards and the operations of NHS Improvement and NHS England closer together would help. But it was also clear that, in this 'non-merger', NHS England was becoming a very different independent board – a much more unified, corporate body – to the one that Andrew Lansley had envisaged and for which he had legislated, and that the NHS was operating in a very different way to the one that the Act intended.

Analysis and conclusion

"Administration is going to be the chief headache for many years to come."
Aneurin Bevan
speech to the Royal College of Nursing, June 1946[1]

"The overarching conclusion that I've come to after more than 30 years in the NHS is that the models are always dictated by the personalities, the relationships, the behaviours, and the trust between individuals or lack of it."
David Flory
former Deputy Chief Executive of the NHS and Chief Executive of the Trust Development Authority[2]

"If the purpose of setting this all out in legislation, as Andrew has said, was to make it permanent, so that it could not be changed... well, it hasn't been changed. It's just been ignored!"
David Bennett
former Chair and Chief Executive of Monitor[3]

"Together we make our own history, but not under circumstances of our own choosing."
Simon Stevens
paraphrasing Karl Marx on the current regulatory and legal framework, at a Nuffield Trust summit on 1 March 2018[4]

"Reorganisation is the thing that you absolutely should do, but only when everything else has failed."
Sir Roy Griffiths
author of the Griffiths inquiry into NHS management[5]

"We have been trying to undo the reforms by behavioural collaboration. It is a bloody sight harder to pull off than people think."
Ed Smith
former Chair of NHS Improvement[6]

"There is the inherent difficulty of the whole thing. Is it possible, in any business or in any organisation, truly to separate policy from execution?"
William Waldegrave
Secretary of State for Health, 1990–92, and former aide to Arnold Weinstock at GEC[7]

"You separate yourself from the operations, and deal with the strategic. That is the theory. The only thing that buggers it is the practice!"
Alan Milburn
Secretary of State for Health, 1999–2003[8]

"If the problem is the way politicians behave, then why don't politicians just change their behaviour?"
John Appleby
Chief Economist, The King's Fund, in 2006[9]

"The big problem facing the service now, apart from resources, is the rapidly changing nature of demand with the ageing population... Among the hospital, GP, community care, local authorities and social services, you have to devise a system to bring them together based on individual patient needs, and then actually deliver. That is an enormous problem. I can see that purchaser/provider is being pushed aside [as a result], because it does not fit that very easily at all."
Kenneth Clarke
Secretary of State for Health, 1988–90, who introduced the purchaser/provider split[10]

"We have to recognise that we are a democracy. And people want to hold people like me, rightly, accountable, for over £100bn of public money. So there are always going to be times when the Health Secretary has to involve themselves in operational issues."
Jeremy Hunt
Secretary of State for Health, 2012–present, at a Nuffield Trust summit in 2014

Analysis

Five years after the establishment of NHS England – "the world's biggest quango" – and six years after the Act that created it, what might the analysis and conclusions be?

The Health and Social Care Act was a monumental distraction

The first thing to note is that the Act proved – as it felt at the time to be – a monumental distraction to what the NHS needed to be doing.

The parliamentary time it took, the political capital it consumed, and the sheer organisational effort involved in putting the new dispensation in place, all meant that key issues that the health service was already pursuing, even if less effectively than it should have been – namely the move to integrate better hospital, primary and community services, and align them better with social care – lost focus. *Our Health, Our Care, Our Say*[11] in 2006 and *High Quality Care for All*[12] in 2008 had, for example, been pursuing these. Sir David Nicholson is far from alone in judging that "if we had simply carried on pursuing those agendas, the NHS would be in a far better place than it is now".[13]

It took the interest of Norman Lamb, as the Liberal Democrat minister in the Coalition Government from late 2012, and more substantively the *Five Year Forward View* [14] in 2014, to restart the integration agenda, and Jeremy Hunt to renew the focus on 'quality and safety'.

But what were the Act's aims?

The second thing to note is the lament of Simon Burns, the Minister of State for Health, who guided much of the Act through the House of Commons. "You cannot", he declared, "encapsulate in one or two sentences the main thrust of this."[15] It was – and is – all immensely complicated. It is more than just a joke to say that it is now impossible to draw an organogram that tells you, with any truth, how the superstructure of the NHS now operates. But the complexity of it does not make any nuanced assessment easy.

In its own terms, however, there were three essential aims behind the biggest reorganisation that the NHS had been subjected to since at least 1974.

The first aim was to move the NHS, in the words of the white paper *Liberating the NHS*, to "a system of control based on quality and economic regulation, commissioning and payments by results, rather than national and regional management".[16] It was to respond to quasi-market pressures, rather than be a managed system.

The second aim – the intended consequence of the first – was that the quasi-market approach with an independent commissioning board would end "political micromanagement" of the service, and "political interference" in it. Ministers would merely set the broad objectives for the NHS through a rolling mandate, leaving the commissioning board, the quasi-market and its regulation to deliver.

The third aim was that, by setting this all down in detailed legislation, the change would, in Lansley's words, be "permanent". It would no longer be possible for a health secretary, or anybody else for that matter, to alter the way the NHS functioned simply by a ministerial direction or change of course. Primary legislation would be required to do that.

Has the Act succeeded? No, but...

On all three of those goals, the Act must be judged either a failure, or at best only a partial success, and then in ways that its originators had not entirely envisaged. Take them in reverse order.

Well the Act has proved 'permanent' – at least to date – in the sense that it has not been amended. Indeed, if it does not get rewritten until the end of this Parliament or the start of the next, it will have provided one of the longest periods since 1974 without a reorganisation of the NHS. Only it won't have done, because it has been endlessly and repeatedly worked around.

The current NHS Improvement is the result of a *de facto* merger – but not a legal merger – of Monitor and the Trust Development Authority. But it retains the conflicting duties of not just overseeing the provider side of the NHS but also acting as the market regulator: ensuring that procurement and competition law apply within the NHS.

But if NHS Improvement is an awkward compromise with the Act, that is nothing compared to the efforts now being made to bring NHS England – strictly the 'commissioning board' under Lansley's legislation – together with NHS Improvement (the body that oversees the provider side). The Act makes a formal merger between the two impossible, and a *de facto* merger even more difficult than the one between Monitor and the Trust Development Authority. But, slowly but surely, if not a merger, much greater integration of the two is happening, in the face of the legislation. And that is turning NHS England into a very different sort of independent board to the one the Act envisaged – a point to which we will return.

In other words, as David Bennett, the former Chair and Chief Executive of Monitor recently put it: "If the purpose of setting this all out in legislation, as Andrew has said, was to make it permanent, so that it could not be changed... well, it hasn't been changed. It's just been ignored!"[17]

Has the Act ended 'political micromanagement' of the NHS? Clearly, at one level, it hasn't. Jeremy Hunt, the Secretary of State for Health, tracks endlessly, and seeks to affect, the details of NHS performance – not least its many waiting-time targets. He is intimately involved in the plans for dealing with winter pressures. The relationship between him and the chief executive of the commissioning board – now NHS England – has clearly not been the one that the Act envisaged – namely that a three-year rolling mandate for the NHS would be negotiated and agreed, with the commissioning board then largely allowed to get on with it, while being held accountable to the Secretary of State for Health and Parliament.

And does the NHS now have "a system of control based on quality and economic regulation, commissioning and payments by results" rather than one of "national and regional management"? Again the answer has to be no. As the money has tightened and the spending on social care that helps the NHS to function has been cut hugely, there has, perhaps inevitably, been a return to 'command and control' – on a scale that has seen NHS foundation trusts in practice lose many of the freedoms they were meant to enjoy under Labour's legislation, let alone Lansley's. Furthermore, and more than somewhat ironically, the Act proved to be the high-water mark in faith in the 'choice and competition' agenda that underlies the quasi-market approach. So that part of the Act turned out to be a victory in yesterday's war.

The overall verdict, however, needs to be appreciably more nuanced than a headline stating that the Act has failed in all three of its principal aims. This is because it has succeeded in some ways – just not in ways that its originators entirely envisaged. But before exploring that, it is worth trying to understand the factors that have affected the outcome of the Act.

So what did affect the Act's outcome?

Policy and operational management have proved inseparable: behaviour trumps legislation: and personalities matter

These three elements interact. But they need to be dealt with in turn.

Policy and operational management have proved inseparable

The idea that politicians would set the policy and objectives for the NHS and that the commissioning board would then deliver them – thus removing politicians from the day-to-day micromanagement of the NHS – was central to the concept of Lansley's reforms.

But, in the real world, it turns out that the organogram does not work. Policy cannot neatly be separated from operations, or perhaps more accurately from operational management and oversight – as quotes from former health secretaries displayed on the first few pages of this report illustrate. Or, at the very least, that has not proved possible in health – it has recurred time and again in the first five years of NHS England.

The division hits definitional difficulties. These operate at the relatively trivial level. Are food standards in hospitals, car parking rules or the precise questions and sampling methods of the Friends and Family Test, matters for national politicians to decide (policy), or, in large measure, operational issues? On a larger level, the Cancer

Drugs Fund was originally the political and policy creation of David Cameron as Prime Minister. But its demise – or rather its re-engineering into something that is decidedly different after it repeatedly bust its budget – was devised and implemented by NHS England, the operational part of the NHS. The Better Care Fund, which transferred NHS cash to social care, was a ministerial initiative – a policy. But NHS England's profound scepticism about its value and impact has seen it largely run into the sand.

Having an 18-week waiting-time target for elective procedures is a policy decision; indeed it is written into the NHS Constitution. The decision to ease it – in order to fit the money available – was clearly taken by NHS England, the operational manager.

NHS England and NICE have agreed that where a new technology – usually a pharmaceutical – will cost more than £20m a year in any of its first three years, NHS England can ask NICE, even though NICE has judged the product to be cost-effective, to recommend how its introduction should be phased in. That is clearly a policy decision. It turned NICE from a cost-effectiveness body into a rationing one. But it was engineered by two arm's-length bodies, with Jeremy Hunt, the Health Secretary, entirely silent on the issue, at least in public. NHS England has subsequently made it clear that it will only fund new guidelines from NICE if they are accompanied by a clear affordability and workforce assessment.[18] All these are clearly issues of policy, not just operations. But it has been NHS England instigating them, along with the move towards integrated care providers in place of the all-too-often siloed activities of hospitals, general practice, community services and social care.

Indeed, when Simon Stevens told the House of Commons Public Accounts Committee in 2017 that in some parts of the country the purchaser/provider split would effectively cease,[19] that was remarkable given that the creation and enhancement of the purchaser/provider split had been the subject of three of the biggest parliamentary rows on health in the previous 30 years.* Here was its demise, or partial demise, being announced by the Chief Executive of NHS England, not the Secretary of State for Health. If anything was a matter of policy, this was.

Yet, the Secretary of State's Monday morning meetings regularly focus on what are clearly operational issues – waiting times and winter planning, for example – with Hunt demanding action, and still on occasion insisting that hospital chief executives' heads roll, according to one interviewee. On one occasion there was an entire Cabinet committee assembled to pore over the operational details of individual hospitals' performance. There is a question – to which we will return – about how much this reflected the operational style of the only Secretary of State for Health to have held office since NHS England was created. But a pure separation has proved impossible, and often-times there has been role reversal. Not just in the *Five Year Forward View*, which set the service's strategic direction, it has been NHS England that has been the policy instigator.

* These were the original introduction of the purchaser/split in 1991; Labour's reinforcement of it through the creation of foundation trusts in 2000; and the Health and Social Care Act 2012.

Behaviour trumps legislation

That behaviour trumps legislation is clearly visible both before and after the creation of NHS England. An example is Alan Johnson's insistence that both the chair and chief executive of Mid Staffordshire NHS Foundation Trust be removed, when legally the power to do that lay with Monitor, the foundation trust regulator. In practice, the niceties were observed and Monitor formally took the action. But it was clear whose ultimate decision this was. Likewise, when Andy Burnham wanted the interim appointments replaced by permanent ones, action was taken through the formal mechanisms. But in practice, behaviour – political decisions – trumped the legislation, despite Monitor being a statutorily independent regulator.

That, of course, has occurred in other sectors from time to time when the political heat has got too high, and sometimes without the legal niceties being observed – for example when Michael Howard, as Home Secretary, sacked Derek Lewis as head of the prison service in 1995, and when Ed Balls, as Secretary of State for Education, dismissed Sharon Shoesmith in 2008 as head of Haringey social services in the wake of the Baby P scandal.

In NHS England's time, 'behaviour trumps legislation' has also operated the other way around. Indeed there were periods where it felt as though Simon Stevens, the NHS Chief Executive, was behaving like the Secretary of State for Health – setting the policies intended to lead to accountable care organisations and integrated care systems, while declaring that the purchaser/provider split in such places was effectively dead – while Jeremy Hunt, the Secretary of State for Health, was acting more as the chief operating officer: pouring over individual hospital performance and seeking to create new 'dashboards' and other measures of how well the NHS was doing.

Even more dramatically, as has already been noted, far from being implemented as intended, large parts of the Health and Social Act are in fact being circumvented. The Trust Development Authority and Monitor have been merged into NHS Improvement, and both the governance and operations of NHS Improvement and NHS England are gradually being merged to overcome some of the fragmentation that the Act introduced. How far that can go, while staying within the law, remains to be seen.

As Ed Smith, former Chair of NHS Improvement, has put it: "We are skating way, way over the formal structures. The best way of running this is not as prescribed in the legislation."[20]

Personalities matter

Both the above points also play in to personalities – an issue often avoided in studies like these, but one that is unavoidable. Sir David Nicholson, for example, always understood the political weather. But Simon Stevens, with his much more political background, could, at least on occasion, make it. And Jeremy Hunt is not Andrew Lansley.

Richard Douglas, the Department of Health's longstanding Director General of Finance until 2015, says:

"Jeremy's approach of weekly meetings on everything was totally not what Andrew wanted from this. Andrew genuinely wanted to do it in a hands-off way. Jeremy was the exact opposite.

"Jeremy never recognised the distinct roles of any organisation in the system. So to him, whatever the rhetoric, NHS England was the headquarters of the NHS in England, not the commissioning board, which had been designed not even to be primus inter pares. *He didn't recognise what the Trust Development Authority was, or what Monitor was, or the distinctions between the two. This was not Jeremy's way of working. These were all people who were there to deliver the things he wanted. So it was a complete contrast of world views.*

"If you think of the world view from Lansley, it was that there are these very clear, legal structures. Each organisation with a clearly defined responsibility, and Jeremy just did not recognise that at all. So that bit never had the chance to work. It has been a little like socialism. We never really tried it." [21]

In an ideal world, this study would have embraced not just two chief executives of NHS England but two secretaries of state – in order to illustrate how far the system might in practice operate differently with a different secretary of state at its head. It may be a point that only those with a long memory of previous health secretaries will get, but one only has to imagine what it would have been like with, say, Alan Johnson or Stephen Dorrell as Secretary of State for Health (both of whom behaved more like board rather than executive chairs) and Simon Stevens as chief executive, to understand that who does these jobs, and how they behave, makes a real difference.

David Nicholson, way back in 2014, said: "This" – by which he meant the concept of an independent board, not the whole of the reform – "would work fantastically well with Andrew Lansley as Secretary of State. It would work fantastically well with someone like Alan Johnson as Secretary of State. People who do not want to get right down into the detail. When you have someone who does [Hunt], it becomes very tense."[22]

> It has been a little like socialism. We never really tried it

David Flory's view on this is as follows. Having held increasingly senior posts since the earlier days of the so-called 'internal market' in the 1990s, and having been through at least half-a-dozen reorganisations of the NHS's superstructure, before finishing as Chief Executive of the Trust Development Authority, he says: "The overarching conclusion that I've come to after more than 30 years in the NHS, is that the models are always dictated by the personalities, the relationships, the behaviours, and the trust between individuals or lack of it."[23]

Hunt's own take on this is clear. The famous Monday morning meetings are, he says, his way of operating:

"I did exactly the same thing at DCMS [the Department for Culture, Media and Sport] when I was Culture Secretary. The only difference is that of my four priorities – culture, media, sport and the Olympics – I had one meeting on each of them a day: on Monday, Tuesday, Wednesday and Thursday.

"But when I came to health the parliamentary scrutiny was so huge – Andy Burnham was going for me hammer and tongs – that I had to do all the meetings on the Mondays to get them out of the way. Parliament doesn't sit until 14.30 on a Monday afternoon, and the first moment you can have an urgent question is 3.30. So if the meetings start at 8.30 in the morning you can get most of them out of the way before Parliament can call on you.

"You can discuss your longer-term strategy. But it also means you know what is going on. And it is right to say that my business background told me that if you want to change something you have to get everyone around the table and have a discussion.

"I didn't realise when I started them that this was quite a revolutionary thing in an NHS that had just been Balkanised into all these different fiefdoms. And there is an argument that the 2012 Act would have fallen flat on its face if I had not done that.

"Because what it basically did was create a discipline where every Monday round the table would be the head of NHS England, Monitor, the Trust Development Authority, the Care Quality Commission, the Department of Health and various other people. The NHS is the fifth largest organisation in the world. And if you have NHS England that is constitutionally independent, you have NHS Improvement and the CQC that are legally independent, and you want to do something – for example we have just launched a big campaign to reduce medication error – how can you possibly do that unless you get everyone together on a fairly regular basis and have a good discussion and shared sense of objective?

"The big issue is accountability, and something that Simon Stevens often talks about, which is that although he is legally accountable for the money, he can't hire and fire trust chief executives, and they are able to incur big deficits. And the meetings bring that together.

"OK, it inserts me into the process. But the really important thing is that it brings NHS Improvement and NHS England together. It creates a discipline where NHS England and NHS Improvement feel they have to come to me with a common NHS position on every issue. And given the structures that I inherited, that is pretty important. I really need to know what the NHS thinks.

"So if you have a £1bn trust sector deficit, what is the cause of it, and what is the solution? If we were not sitting together every week with a group of people who broadly trust each other and get on together, we would not have a hope in hell's chance of cracking that sort of problem.

"On things like getting financial balance, or preparing for winter, I am not sure you can do those things, with the legal structures as they are, without having some way of bringing people together. I think it has proved its worth in gold.

"My demise in this job has been oft predicted. But I am quite confident that the civil service would brief any successor of mine that it is absolutely essential to have those Monday meetings." [24]

The Act was a victory in yesterday's war
Under the Blair Government, there had been a gradual extension – indeed restoration – of patient choice along with the introduction of increasing elements of competition between the public, private and voluntary providers of care, the object being to produce a 'self-improving NHS' that would require much less ministerial involvement.

> [Without the Monday morning meetings] there is an argument that the 2012 Act would have fallen flat on its face

There is room for debate about how far that was responsible for the big improvements to the NHS over the 2000s, not least the massive reduction in waiting times. Many would argue that the defining features were in fact 'targets and terror' – the absolute imposition, from the centre, of waiting-time targets on NHS organisations – plus a large amount of extra cash. Others would acknowledge that choice and competition played a part.

But accepting that choice and competition had – and still have – a part to play, the quasi-market agenda was not the sole defining force for change. It was part of a wide-ranging – and far from consistent – armoury of tools that Labour used. The single most powerful tool in the 'choice and competition' agenda was the NHS tariff – the price list for procedures. That ensured that hospitals which did more got paid more: the 'click of the turnstile' approach that helped to drive down waiting times. But that could have been used to drive activity up without all the other elements of the quasi-market.

What Lansley's Act sought to do was nail down the quasi-market – a useful tool – in detailed legislation in order to make it *the* key shaper – indeed virtually the *only* shaper – of how the NHS was to function. And that may have been its biggest single mistake, not least because of the following.

It proved, ironically, to be the high-water mark of faith in 'competition and choice' as the key drivers of NHS reform; the language now is all about 'integration'
As the bill was going through, many of its critics saw it as likely to lead to mass privatisation of NHS services – given the way that it apparently set in stone the 'choice and competition' agenda. Andy Burnham, the former Labour Health Secretary and by then opposition health spokesperson, spoke for many when he argued that Lansley's bill provided "the green light to let market forces rip right through the system with no checks or balances" and that Lansley was "removing public accountability and opening the door to unchecked privatisation".[25]

It is true that – partly as a result of the Act – private provision of NHS services has increased. The calculations are not easy to do. But over the eight years since 2010, it looks to have risen from around 8% of all clinical activity when Labour left office to perhaps 12%, or from 4.4% to 7.7% of expenditure, according to Department of

Health figures.[26] It has occurred much more visibly in community services than in hospital ones.

So if this is 'creeping privatisation', it is still pretty creeping, and, perhaps surprisingly, there have been relatively few legal challenges. Virgin Care did sue six Surrey clinical commissioning groups over the way they put an £82m contract for children's services out to tender and received an undisclosed settlement to which one of the clinical commissioning groups contributed £382,000. But there have been less than half a dozen complaints to Monitor over five years about breaches of the competition or procurement rules, and at least one of those was a complaint by an NHS organisation rather than the private sector.

More fundamentally, however, faith in the 'purchaser/provider split' and in 'choice and competition', as key drivers of NHS reform, has been dissolving since the day the Act became law. Indeed, the NHS is not alone in that, with less trust being placed in choice, competition and outsourcing in other parts of the public sector.[27]

Elements of 'choice', of course, remain. Patients retain a choice of GP and over which hospital they are referred to for secondary treatment – though relatively few exercise the latter. Choice also remains, and has indeed been growing, in the sense that there is more consultation than in the past between clinicians and patients over the alternatives for treating their condition.

But the idea that patients actively choosing where to go for their hospital or community care would be a key driver of quality and efficiency is increasingly moribund as the service seeks to integrate services better. It is clearly not seen – and never was seen – as central to NHS improvement by the current Secretary of State for Health.

Within three months of taking office, Hunt was acknowledging that the NHS tariff – the price list for treatments – "works very well for people who have curable illnesses, someone who needs a new hip, a new knee or a cataract operation... [where] the problem is solved and the person goes home". But it is, he said, "much less good at dealing with people who have a long-term condition, that needs long-term support", where " a more integrated service" is needed.[28]

By June 2013, Nicholson was promising a strategy review in which "we're very interested in thinking about the integration of commissioning and provision... [and] about whether the straightforward commissioner-provider split is the right thing for all communities".[29] Hunt added the following month that "we need to make sure that, while we respect the principle of the purchaser/provider split, it doesn't get in the way of joined up services".[30]

By 2014 he was declaring that "there are natural monopolies in healthcare, where patient choice is never going to drive change". Market forces were not going to deliver the integrated care that the service needed. "The market will never be able to deliver" on that priority, he said.[31]

Those comments came close on the heels of the *Five Year Forward View*,[32] which provided the clearest signal yet that 'competition and choice' were no longer the driving force.

The white paper *Liberating the NHS* refers to 'competition' a dozen times and to 'choice' – mostly in the context of choice of provider – more than 70 times.[33] The *Five Year Forward View* has no reference to competition and it mentions choice just half-a-dozen times and only once in the context of provider choice, where the document merely promises to "make good on the NHS's longstanding promise to give patients choice over where and how they receive care".[34]

And then, of course, as the *Five Year Forward View's* 'new models of care' were being developed, Stevens declared that in some parts of the country that would "effectively end" the purchaser/provider split as the service moved to "integrated funding and delivery for a given geographical population".[35]

> there are natural monopolies in healthcare, where patient choice is never going to drive change

The quasi-market cannot be driven to its logical conclusion

There was always a fundamental challenge to the quasi-market approach, which applied as much in Labour's time as since, namely that – however well it may or may not work in other sectors – it has never been possible to drive it to its ultimate conclusion in health.

Behind the theory of markets is that it is possible for providers to go bust, close down and be replaced – being either taken over or displaced by new entrants whose competition may have led to the original provider's financial failure in the first place.

There are areas where public money is involved where that has worked. Insolvent housing associations, for example, have been sold to another for entirely nominal sums, with that working because there is capital value in the housing and a pretty much guaranteed rental income, at least some of it from Housing Benefit. Although it has never happened, it is just about possible to conceive of a university going bust and closing. The would be incredibly tough on the students, who would presumably be absorbed elsewhere, and on the staff and on the location, given that universities, like hospitals, are frequently core local employers and drivers of a local economy. But it turns out that both politically and practically – not just after Lansley's Act but also before it – it has not proved possible to close acute hospitals simply because they are financially failing.

Over the decades since 1948, the NHS in England has closed, quite literally, hundreds of what were once small acute hospitals, many for good reasons, for example they were too tiny, too ill-equipped or too impossible to staff on the scale needed to provide high-quality care. But England has now closed so many that – community hospitals aside, which fulfil a rather different function – even the small acute hospitals that remain are of significant size: 300 to 400 beds plus.

Closing them down would involve taking out huge chunks of a community's health provision. And there does not appear to be a market of private providers willing to take them over – at least on the terms available.* So instead they get reshaped – as has always happened – in terms of what activity takes place within them. They are not closed – save where the closures are the result of a new replacement hospital being built.

So even in the case of the Mid Staffordshire NHS Foundation Trust, which was financially as well as clinically challenged, the eventual solution was a £250m investment in Stafford and its surrounding hospitals, which, in practice, continued to run a deficit. In other words, the market is not followed through to its local conclusion. Instead, the system – the politicians and the managers – intervene. So the quasi-market can only be *a* tool, not *the* tool. But that is what the Health and Social Care Act sought to create.

The Act failed to recognise that, for good or ill, the NHS remains a system

There is a minority view, held by some former civil servants and others, that in a period of growth, Lansley's nailed-down-in-legislation choice and competition model – "a system of control based on quality and economic regulation, commissioning and payments by results"[36] – might have worked. Growth might have allowed the degree of spare capacity needed for patients all to be able to choose.

But a number of things put paid to that. Hunt's way of working may have been one of them. But others included the money – or lack of it – and the failure to recognise that, in the end, the NHS remains a system and a cash-limited one at that. It has to operate within the money that Parliament votes for it. And the only place that the money finally comes together is in the Department of Health, and thus ultimately in the Secretary of State for Health's office.

That was true, of course, ahead of the 2012 legislation. But it proved to be even truer after it. Ahead of the legislation, Monitor was responsible for the licensing and oversight of the foundation trusts, holding them individually to account for their financial performance. It was not, however, responsible for the foundation trust sector as a whole balancing its books. And that remained the case after Lansley's Act.

The NHS Executive, operating through the strategic health authorities, was, before the Act, responsible for the finances of the rest of the service – for its overspends and underspends. The strategic health authorities traded those off within their areas, and if a strategic health authority overspent, the NHS Executive sought to balance that with underspends elsewhere. The Department of Health then had to balance the overall health budget – including making any trade-offs against things that the department funded directly such as public health, training and research – if the NHS itself overspent, as happened in 2005.

After the 2012 legislation, however, those intermediate levels of financial control largely disappeared with the abolition of the strategic health authorities. NHS England was purely a commissioning board, not the NHS headquarters. As a result, the responsibility

* The one time this was tried – by Circle at Hinchingbrooke Hospital in Cambridgeshire – it ended in failure, with Circle handing the contract back.

for balancing the books became much more fragmented. It remained, however, as one civil servant put it in 2015, "the department's job to balance the budget".

He said:

"To do that, we cannot simply rely on the commissioners breaking even. The commissioners can balance their budget. But if the income the providers receive is not sufficient to cover their expenditure, and they go way into deficit, we will end up busting our departmental expenditure limit. Part of the job of the strategic health authorities in the old world was to make sure that did not happen.

"But in the new world, there is nobody below the Secretary of State and the Department of Health who is responsible for balancing the books. There are lots of independent organisations, none of whose job it is to balance the money overall. So Monitor, for example, is responsible for the oversight of foundation trust finances, but because they are freestanding organisations it is not responsible for ensuring that the foundation trust sector as a whole balances. So it comes back to the department and the Secretary of State. With the disappearance of SHAs it has almost become essential that the Department of Health becomes the system manager again."

And from that comes the view that the continued central oversight and involvement from ministers was not just down to Hunt's way of doing business. As one of David Cameron's former advisers puts it about the Monday morning meetings: "I am not sure how else you would do it. The fundamental accountability lies with the Secretary of State. So they have to know what is going on."

And from that comes an understanding of Hunt's mounting frustration with the fragmentation of the system that he had inherited. No one appeared responsible for balancing the books. This helps to explain his desire for Monitor and the Trust Development Authority to merge into NHS Improvement, and why NHS Improvement and NHS England are – as far as the law allows – slowly becoming a single body, even as that steadily dilutes the purchaser/provider split. This leads to the following question.

How far can a quasi-market drive improvement in the NHS?

There is some academic evidence[37] and plenty of anecdote to illustrate that, during the 2000s, competition and choice played a part in driving down waiting times, and perhaps enhancing quality – although, as already noted, that ran alongside targets, and much more cash. But even some of the earlier advocates of the choice and competition model now question how far the quasi-market can drive improvement, certainly in the current circumstances.

David Bennett, the former Chair and Chief Executive of Monitor says:

"In retrospect, if in 2010 one had asked the question what is the right thing to do in order to best prepare the NHS for 10 years of austerity, the answer would probably not have been the introduction of more market-like mechanisms. In that sense one has some sympathy for Jeremy because he inherited something that was not fit for the circumstances.

"At the time, I did believe that, over time, a steady increase in the use of choice of various sorts would drive improvement. It would help patients not only get a better result, but they would feel better about it. Because there is plenty of academic research to show that if you give people a choice they feel better about it.

"But what I didn't know then – what we didn't know then – was that the NHS was going to go into 10 years of austerity, and in that context the gain from any additional application of market forces was always going to take too long and need too much money.

"And even without the financial squeeze, I would say, with the benefit of hindsight, that the potential for driving economic improvement in the NHS through the use of market forces and autonomous entities such as foundation trusts, is only ever going to be limited." [38]

Or indeed, as Rudolf Klein has shrewdly noted, the introduction of market notions in the early 1990s "was a response to fiscal stress [that is, too little money], so now fiscal stress is prompting a retreat from those notions".[39]

So where has the Act succeeded? Has it depoliticised the NHS?

To be fair to Andrew Lansley, he never said that the Act would depoliticise the NHS – although that is the way many people interpreted the *Liberating the NHS* white paper's claims that it would end "political micromanagement", "political interference" and "excessive bureaucratic and political control".[40] As Lansley put it in a 2015 interview: "It is not removing politicians. It is at least restricting them – trying to hamstring the politicians a bit."[41] But if it has not removed politicians from all engagement with the management of the service, it has, undoubtedly, changed the political dynamic.

> with the benefit of hindsight... the potential for driving economic improvement in the NHS through the use of market forces... is only ever going to be limited

It would, for example, have been impossible for any previous chief executive of the NHS to publish, independently, the *Five Year Forward View* complete with its bid for cash. It would have had to be cleared with ministers – and no doubt amended by them – when in practice they barely saw it before publication. Hunt's view is that he agreed with it.[42] So that was not a problem. Even so, the Act has given the NHS its own, statutorily independent, voice.

It would have been equally impossible for a previous NHS chief executive – and probably for David Nicholson in quite the same way (which is where personalities again enter) – to debate so publicly, and so confrontationally, whether the Government had in fact delivered the money it promised. The board of NHS England has also mattered – standing alongside Stevens as his employer. Statements by Stevens – and by the board of NHS England – that it would have to restrict what the NHS offers in the wake of the 2017 Budget settlement, might have been aired obliquely by previous chief executives after a tough settlement, but not so transparently. Whether this second shift – the ability to argue publicly about the money and its consequences – proves to be a good thing or a bad thing for the service and its patients, only time will tell.

To put it another way, the creation of NHS England means there is now a public official, possibly a slightly unique form of public official, who is neither a civil servant, nor merely a manager, able to speak on the service's behalf and fundamentally to shape it. How far that will prove lasting, and how far it is a function of Simon Stevens' presence as Chief Executive, and Jeremy Hunt's willingness as Secretary of State to work that way (a future health secretary might seek much greater control), remains to be seen.

Those are pretty incontestable facts about how the political dynamic has changed. Equally, a number of key changes have gone through with arguably less controversy than would have been generated in the past, when they would have been ministerial announcements, or decisions that would have inevitably ended up on the minister's desk. These include the changed role of NICE, the creation of trauma centres and a fairer distribution of NHS cash around the country by NHS England.

But if the Act has indeed created a more independent NHS voice, and more independent action, there have been changes on the political side of the equation as well, although in the absence of a counterfactual, these are harder to prove.

There is a strong case that the Act allowed Hunt to become much more outspokenly 'the patient's advocate' – a direct critic of the service rather than merely its defender. And some, at least, would see that as a positive. Hunt's own view on being the patient's advocate is that:

"It may be a product of the Act. But I would have done it anyway. Because politicians curiously have a dual role. You are both responsible for large bureaucracies but you are on the side of the voters who are getting services from those bureaucracies. So I think that when I first faced up to the horrors of Mid Staffs I thought I had to be on the side of patients and families who suffered. In a democracy that is where the Health Secretary has to be... So whatever the structures of the 2012 Act I would have done that." [43]

The Act has also arguably diluted some of the more traditional political responsibility. For example, the winter of 2016/17 saw hospitals under acute pressure, particularly in A&E departments, with, literally, weeks of awful headlines about missed waiting-time targets. Those headlines had followed a summer in which there had also been weeks of headlines about 80% of NHS trusts being in deficit to the tune of £2.5bn. The Department of Health had only been able to balance the books by cutting public health and other elements of expenditure.

But in that winter of 2016/17 – and again in 2017/18 – Hunt was able to go on BBC Radio 4's *Today* programme and other media outlets to say that it was all "unacceptable" and that it was "my responsibility" but that he and the NHS were doing their best – without either the media or the Opposition in Parliament able ultimately to pin the responsibility on him. The first time that happened was ahead of the 2017 general election, when Theresa May still had a 12-seat majority in the House of Commons and a greater ability to sack ministers than she later enjoyed. The second time came after she was sufficiently weak for Hunt to decline to move from this post in a January 2018 reshuffle that came amid that 'winter crisis'.

Alan Milburn, who was Secretary of State for Health over the politically terrible winter of 1999/2000, which led to Tony Blair's big spending pledge, has acknowledged that had he not been newly appointed he might well not have survived that winter. But having spent the previous 18 months as Chief Secretary to the Treasury, outside the department, he had, so to speak, clean hands. Equally, Patricia Hewitt, who arrived in 2005 as Secretary of State for Health to discover that the NHS had managed to overspend at a time of record growth, has said that had she not been new, she might not have survived that piece of financial turmoil. In 2017 and 2018, Hunt had been Health Secretary first for more than four years and then for more than five, but appeared to survive that crisis almost effortlessly. That may have been due solely to a mix of Hunt's own political skills, and the weakness of the Prime Minister of the day. But perhaps it was also due to the Health and Social Care Act.

Hunt's view is that:

"You are on a hiding to nothing if you try to pretend that the Secretary of State is not in the end responsible for everything. It is not a political dodge when I say that I am responsible for the problems that the NHS goes through in the winter period and I apologise to patients, and I also say it is unacceptable... I think the only way you can square that circle is basically being honest with the public. You take responsibility. It is down to you. But you do not have a perfect 'command and control' structure..." [44]

So on both sides of the equation, the political dynamic clearly has changed, even if political involvement in elements of the operations, including firefighting winter pressures, remains.

> **You take responsibility. It is down to you. But you do not have a perfect 'command and control' structure**

It also looks likely – though again there is no counterfactual – that the existence of the mandate to which NHS England operates may have reduced the number of ministerial initiatives. Significant ones, in year, can only be introduced with the agreement of NHS England, which can insist – unless the Secretary of State chooses to issue a direction that he then has to explain to Parliament – that they will not take them on unless additional resources are found. Richard Douglas, who was Director General of Finance at the Department of Health for more than a decade to 2015, says:

"I do think the mandate helped, certainly through my time, in that we did not add a lot of other pressures to the system that we might otherwise have done. It is difficult to prove a negative like that. But the mandate did say that 'we can't just keep adding burden after burden, without providing the capacity to do it'. And that was a discipline. It may not be recognised out there in the NHS because it feels like they are repeatedly being asked to do more things. But my view is that it would have been an awful lot worse without the mandate." [45]

And that is a view shared by some current figures in NHS England.

The mandate, of course, was always going to be a subject for negotiation between NHS England and ministers. But it is notable that, in more recent years, it has become less a document that sets out the marching orders for the NHS and more one that confirms what NHS England judges can be delivered for the money.

"Looking for the next best thing" or *"You can't always get what you want"*

So five years after NHS England started operations, what are the conclusions about "the world's biggest quango" and the impact of Andrew Lansley's Act?

Has it depoliticised the management of the NHS? No, by no means. But it has changed the political dynamic.

Has the creation of NHS England and the other arm's-length bodies created "a system of control based on quality and economic regulation, commissioning and payments by results, rather than national and regional management"? No. Instead, something very different – indeed remarkably different – has been, and still is, happening. The Act turned out to be the high-water mark of faith in choice and competition and in the purchaser/provider split. The direction of travel has instead been towards an entirely different destination.

Hunt puts it this way: "The purchaser/provider split, or the internal market, creates accountability by separating the commissioning of care from its provision. Unfortunately, most health economists now say we need to integrate care to get to population health. Which means joining up the purchaser and the provider to get to whole-person care."[46]

So everything from the 'new models of care' outlined in the *Five Year Forward View*, to the sustainability and transformation plans, and on to accountable care organisations and integrated care providers has been about the planned integration of services, not competition (although in the case of social care, with its very different funding system, and its location in local government, it is a case more of improved collaboration than of integration).

The purchaser/provider split, *the* core organising principle of the NHS in England since 1991, is dissolving, and in large measure, the Act, if not being ignored, is being worked around.

Monitor and the Trust Development Authority have been merged in practice, although not legally. And their replacement body, NHS Improvement, has started to make a growing range of joint appointments, both operationally and at board level, with NHS England. The destination may not be reached, but the direction of travel is clear: an eventual merger of the two – perhaps one day legally, but if not in practice, as far as the law allows in practice.

Despite the legislation having set up NHS England not to be *primus inter pares*, it is progressively becoming so. Or rather it and NHS Improvement are transforming into what

the name NHS England has always suggested – the headquarters of the NHS – as the two bodies increasingly merge their activities. In other words, the system is heading towards a very different sort of independent board to the one that Lansley envisaged.

It is becoming less 'a commissioning board', and much more a corporate one, or a return to a statutory version of the sort of management board that Roy Griffiths recommended. And it is becoming a more managed system, with a model of statutory independence closer to that of the post-war nationalised industries, rather than a commissioning model operating with a purchaser/provider split – pretty much the opposite of what Andrew Lansley intended.

As Humpty Dumpty is put back together again to overcome the fragmentation that the Act created, inspection looks likely still to sit to one side in the Care Quality Commission – rightly in this author's view. But questions of what happens to other parts of the architecture, most notably NHS Digital and Health Education England, will inevitably arise, while the market-regulation part of NHS Improvement will still have to sit separately with NHS Improvement, however much the rest of their activities are merged.

Under these approaches, it is important to understand that 'commissioning' does not entirely disappear. NHS England will still be commissioning the work of accountable care organisations or integrated care providers, or whatever they finally end up being called. Within those, some services will doubtless continue to be put out to tender. At a micro level, elements of competition will remain. But the traditional 'purchaser/provider' split will have been hugely diluted.

That, of course, will raise questions about how these new providers will be held to account – with the question about how NHS organisations *should* be held to account being a very longstanding one, and one to which the purchaser/provider split was in part seen as the answer.

Hunt's answer is a further extension of Ofsted-style ratings combined with transparent publication of performance and outcome data:

"I think the only way you can do that is through transparency of data on performance and outcomes. So I think the model that we are moving to is that we will allow the sustainability and transformation partnerships [STPs] to blur the purchaser/provider split but they will be wholly and publicly accountable for their performance on cancer, and on mental health and so on.

"Simon Stevens has already introduced Ofsted-style ratings for clinical commissioning groups on mental health, on diabetes and dementia and a whole range of other areas. But they would need to be independent Ofsted-style inspections, so that the STPs can't mark their own homework. It would need to be rigorous, and we are still at the very early stages of how we get the STPs to work."[47]

If the endgame is the creation of a more corporate version of an independent board, then at some point fresh legislation will be needed, as it may be anyway, and separately from merging NHS Improvement and NHS England, in order to allow integrated care providers to operate effectively – rather than everyone muddling through and around the existing law and the existing regulation in ways that have already produced legal challenges, and may in future.

Were that more corporate board to emerge, however, the clearer accountability that that would provide – a single organisation responsible for NHS finances and performance, answerable to ministers – might indeed allow something a little closer to the reduced ministerial involvement in the operations of the NHS that many have long desired but which Lansley's Act has not, in practice, permitted.

It most certainly would not take all of the politics out of the NHS. It would depend on the circumstances and on the behaviour of the secretary of state of the day. But it might make it a little easier for her or him to act a little more like the chair of the board.

Lessons for policy makers

But if that is to happen, and fresh legislation would at some point almost certainly be required, then key lessons that the Institute for Government drew from *Never Again?* should be borne in mind.[48]

- There never was 'a story to tell' – a narrative which explained why this piece of legislation was necessary.
- Over-hasty negotiations within the Coalition Government turned what would have been a big shift of power and responsibility – GPs doing most of the commissioning of NHS care, operating beneath a new, and statutorily independent, commissioning board – into a massive structural upheaval.
- The lack of a strong centre in Number 10, drawing on external expertise to understand what was being proposed, proved lastingly damaging.
- Legislation should be, as Stephen Dorrell, the former Health Secretary, put it about Lansley's Act, "an accurately targeted rifle shot, not a carpet bombing".[49]
- Evolution tends to be better than revolution, unless revolution is unavoidable.

And those are worth recalling if or as and when the Act is amended or replaced, as indeed are lessons from the Institute for Government's other work on successful policy making – *Making Policy Better*[50] and *The 'S' Factors*.[51]

There appear to be three main candidates for legal change:

- a formal merger of NHS England and NHS Improvement to create something very different from the body that the Act envisaged
- a legal underpinning for the sustainability and transformation partnerships, and their planned successors, integrated care systems
- amendments to the procurement rules that are driving unnecessary cost into the system.

There is, as yet, however, no consensus on which of those are needed or precisely how they should be done.

> the independence of NHS England is the bit [of the Act] that has worked best

And other questions will need to be answered. Should foundation trusts regain the operational independence that they have lost? And if so, what happens to those hospitals and services that are never going to attain foundation trust status? If the operational parts of NHS Improvement are merged with those of NHS England, what happens to the regulatory parts of NHS Improvement? Does it retain its duties to prevent anti-competitive behaviour? In other words, just how much of the quasi-market gets undone in such a round of legislative reform? Before any attempt at legislation, those questions, and no doubt others, will have to be answered.

So to make any future legislation a success, at a minimum there should be:

- an understanding of the past that learns from failure
- clarity on the goals
- an open, and ideally evidence-based, generation of ideas on what should change
- thorough appraisal
- clarity, as far as possible, on central government's role and accountabilities, and
- the creation of a constituency of support.

Perhaps the final reflection – though not the final verdict, that is for readers – should come from the current Secretary of State for Health, Jeremy Hunt. His view is that:

"You want as much independence as possible in the operations of the NHS, and the one thing I would not have done differently in the Act is the creation of NHS England as an independent board. The independence of NHS England is the bit that has worked best.

"But you are kidding yourself if you think that something that is of such interest to the public and Parliament will ever be something that a health secretary cannot involve themselves in.

"So right now there is massive interest in accident and emergency, and relatively less interest in stroke care and heart attacks where there have been huge improvements and where NHS England has been quietly getting on with that job. They keep me posted, but they are doing a good job.

"But I do get involved in trying to understand what we are doing to try to improve the resilience of our A&Es. Parliament expects that. The public expects that. I cannot possibly go onto the media and say: 'A&E is nothing to do with me; it is the responsibility of NHS England.' That just would not work.

"So we all have to understand that when there is parliamentary and media interest the Secretary of State will have to get involved. But you want to have a structure where broadly speaking as much as possible is kept at arm's length." [52]

That is a view that many former health secretaries would endorse. Virtually all of them recognise that it is not a good idea if they seek to run the NHS personally.[53] Several, once out of office, say that they could see advantages in an independent board of some sort.[54] And some took steps to run the service more 'at arm's length' – creating management and policy boards, NICE, an independent inspectorate, a competition panel and foundation trusts, to name a few. Achieving the goal of 'keeping as much as possible at arm's length' remains, however, a challenge.

Timeline

May 2010

A Conservative and Liberal Democrat Coalition Government is formed. David Cameron becomes Prime Minister and George Osborne becomes Chancellor. Andrew Lansley is made Secretary of State for Health after six-and-a-half years as opposition spokesperson.

A marriage of the two parties' manifestos produces an approach to NHS reform that everyone, including Andrew Lansley, regards as "crazy", along with the promise of "no more top-down reorganisations".

Jul 2010

After that is unpacked, the white paper *Equity and Excellence: Liberating the NHS* is published.

Jan 2011

The Health and Social Care Bill is published. Political opposition takes off.

Apr 2011

The bill is 'paused'...

Autumn 2011

House of Lords' amendments take place.

Dec 2011

The NHS Commissioning Board is set up as a special health authority, prior to statutory independence.

Mar 2012

The Health and Social Care Bill is given Royal Assent.

Sep 2012

Jeremy Hunt replaces Andrew Lansley as Secretary of State for Health.

Feb 2013

The report of the Francis public inquiry into Mid Staffordshire NHS Foundation Trust is published.

Apr 2013

NHS England, the Trust Development Authority, Public Health England, Health Education England, Monitor and HealthWatch all come formally into existence.

Jul 2013

A constellation of the new and some existing NHS national bodies, plus local government, publish *A Call to Action.*

Mar 2014

Sir David Nicholson retires as Chief Executive of NHS England.

Apr 2014

Simon Stevens takes over.

Oct 2014

The *Five Year Forward View* is published.

Dec 2014

The NHS gets a £2bn 'down payment' on the *Five Year Forward View* plan.

May 2015

The Conservatives win the general election with a promise of "at least" £8bn for the *Five Year Forward View*.

Jul 2015

Amid big spending cuts elsewhere, the post-election Budget sees the NHS get more money.

Nov 2015

Monitor and the Trust Development Authority are merged.

Dec 2015

Local 'sustainability and transformation plans' are announced.

Apr 2016

NHS providers overspend by £2.5bn. The Care Quality Commission says that adult social care is "approaching a tipping point".

Jun 2016

The UK votes to leave the European Union. David Cameron quits and Theresa May becomes Prime Minister. Philip Hammond replaces George Osborne as Chancellor.

Mar 2017

Simon Stevens says that "some waiting times will grow".

Apr 2017

Stevens tells the Public Accounts Committee that accountable care organisations will "effectively end the purchaser/provider split".

Jun 2017

A general election takes place. Theresa May loses her majority.

Jul 2017

NHS England and NHS Improvement appoint joint directors for part of the country in the first sign of a potential merger.

Autumn 2017

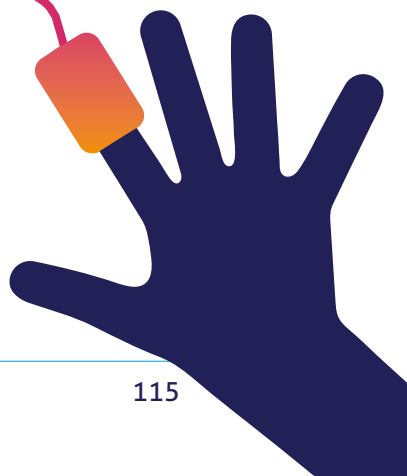
Two judicial reviews of 'accountable care' are launched.

Jan 2018

Cross-representation on the boards of NHS England and NHS Improvement is put in place. The NHS has a second seriously bad winter in succession.

Mar 2018

Theresa May promises a 'multi-year funding settlement'. NHS England and NHS Improvement announce the merger of further elements of their operations.



Glossary

Accountable care organisations – a model of care that takes different forms in different countries, but essentially sees one organisation charged with (and paid for) delivering fully integrated care for patients across hospital, primary and community care services, ideally with close ties to social care.

Clinical commissioning groups – groupings of family doctors (more than 200 of them) set up to purchase or commission care on behalf of their patients.

Elective operations – non-emergency procedures, or 'waiting list' operations.

General practitioners – family doctors.

Integrated care providers – see accountable care organisations (above).

Internal market – the somewhat misleading 1990s' shorthand for the 'purchaser/provider split' (see below), which saw health authorities and GP fundholders purchase care on behalf of their patients. The term is misleading because, even back then, limited proportions of care were purchased from private and voluntary sector suppliers.

Monitor – originally just the regulator of NHS foundation trusts (see below). It licensed them after they passed tests that included financial sustainability, with the ability to intervene by removing chairs and boards when things went awry. Under the Health and Social Act 2012, Monitor became a full economic regulator, charged with "preventing anti-competitive behaviour" as the Act made clear that procurement and competition law applied to the NHS. In addition, it gained a hand in setting the NHS tariff (see below), or price list, used to pay NHS organisations for much, although not all, of their work. There were, and are, conflicting responsibilities in these roles. Monitor is now part of NHS Improvement.

NHS England – the statutorily independent commissioning board established by the Health and Social Care Act 2012.

NHS foundation trusts – created in 2003, foundation trusts are NHS organisations, including hospitals, ambulance services, and community and mental health services, that nominally have more operational independence than ordinary NHS trusts. They are not-for-profit public benefit corporations with a membership of staff and patients who elect governors, who in turn appoint the trust chair and its non-executive directors. Foundation trusts remain part of the NHS but technically they are not subject to ministerial direction and are meant to have greater freedoms than ordinary NHS trusts, including the ability to retain surpluses, own and dispose of land, borrow, and launch joint ventures.

NHS Improvement – the body that oversees NHS providers. It is also responsible for ensuring that procurement law and much of competition law are applied in the NHS. NHS Improvement was created by the de facto merger of Monitor and the Trust Development Authority.

NHS tariff – the 'price list' for NHS procedures, through which hospitals, both public and private, are paid. It does not cover all activity – it does not apply to ambulance services or, in the main, to community and mental health services. The proportion of a typical hospital's income that comes via the tariff can vary widely, but around 60% would not be atypical.

NHS trusts – those hospitals and other services that have yet to attain NHS foundation trust status.

Primary care trusts – the commissioning bodies for health care in Labour's day, with additional responsibilities including public health. They were abolished by the Health and Social Care Act 2012.

Purchaser/provider split – originally established in 1991, its core idea is that the purchasers or commissioners of care should decide which services to buy from providers – whether NHS organisations or private and voluntary sector organisations. In other words, the NHS should operate as a 'quasi-market'. The precise details have varied over the years.

Quasi-market – see purchaser/provider split (above).

Strategic health authority – the organisation that oversaw primary care trusts (see above) and those hospitals and services yet to become NHS foundation trusts (see above). Strategic health authorities were abolished by the Health and Social Care Act 2012.

Sustainability and transformation plans and – later – sustainability and transformation partnerships – the corralling together of all NHS services, local government social care and the voluntary sector in, initially, 44 parts of the country to develop plans for more integrated care.

Trust Development Authority – an organisation originally set up under the Health and Social Care Act 2012 to oversee the 'pipeline' of potential applicants for foundation trust status. It has now merged into NHS Improvement (see above).

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Facing contents page

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Nicholas has one piece of involvement in this story that some might regard as a potential conflict of interest: he had a very small, and unpaid, hand in some of the drafting for the *Five Year Forward View*.

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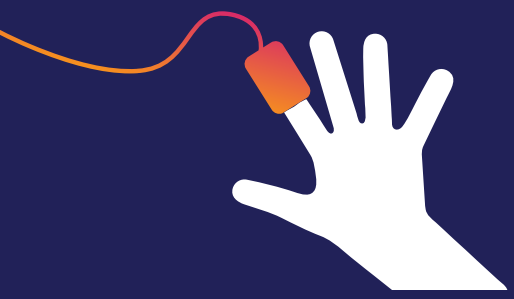

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