From competition to collaboration: can the NHS White Paper deliver?

Bob Hudson *identifies a number of defects and omissions from the new NHS White Paper, and explains why the policy lacks conviction in relation to its key principles.*

As an example of stealing your political opponent's clothes, the new NHS White Paper takes some beating. From market to state, from competition to collaboration, from silos to systems thinking, it could easily pass for a Labour Party document – it even name-checks Nye Bevan. The proposals are draped around three organising principles: working together and supporting integration; stripping out needless bureaucracy; and enhancing public confidence and accountability. It sounds good, but what does it mean and will it deliver?

Working together and supporting integration

The proposals are said to be formulated 'with the whole of the health and care system in mind', including 'formally recognising the need to bring together NHS organisations, local government and wider partners'. This is announced as if it was a new idea. An integration timeline bizarrely only commences from 2014, when in reality there have been attempts to join these services up since at least the 1980s. There is a plentiful literature on why they have largely been unsuccessful and on how the obstacles can be addressed, but the White Paper displays little apparent interest in policy learning. Meanwhile, old strategies with an indifferent track record like joint commissioning, joint committees, and joint appointments are dusted down and portrayed as innovations.

An indispensable starting point here would be to define 'integrated care'. This is a complex concept, but the best the White Paper offers is to claim there are two forms: integration within the NHS and integration between the NHS and other parties. This shallow interpretation is then institutionalised in the proposal to divide up the new integrating agencies – the 42 Integrated Care Systems (ICS) – into two parts: an ICS NHS body focusing on running the NHS, and an ICS Health and Care Partnership looking at wider systems. This distinction goes against the grain of 'systems thinking' and positions other partners as add-ons to the priorities of the NHS. Much the same goes for the aspirations around 'place' as the venue for a system-led approach, a concept which remains unclear, undefined, and will not be a matter for legislative provision.

Stripping out needless bureaucracy

There is much talk of 'bureaucracy busting' in the White Paper. Normally the term would be expected to refer to some form of state bureaucracy, but in this case it is largely about liberation from the market bureaucracy created by the Lansley White Paper of 2010. The removal of the obligation to tender and of the role of the Competition and Markets Authority (CMA) in the NHS, for example, will be welcomed, as will changes to tariff payments in order to smooth the process of flexible working.

Obstacles to closer working across organisational boundaries will still, however, be far from removed. Firstly, although the White Paper proposes dismantling much of the market bureaucracy in the NHS, it leaves these arrangements intact within the main partner sector of adult social care. Here there will still be an expectation of service tendering, still be a role for the CMA, and still be no change to the biggest financial barrier to integration of all – the means-tested basis of social care as compared with an NHS free at the point of use. There will inevitably be limits to the compatibility of a state-led and a market-led model. Despite the emphasis on integrated care, the White Paper is an NHS document, not a system-focused administrative revolution.

Secondly, the market bureaucracy is to be replaced by an ever more convoluted state bureaucracy. Although over 130 clinical commissioning groups are to be abolished and replaced by the 42 ISCs, their functions will still have to be reflected somewhere in the new arrangements. A place also has to be found in the new structures for the nascent 1,300 primary care networks and at the same time, NHS Trusts will be getting reorganised into complex 'provider collaboratives'. The NHS will be consumed by this turbulence for several years.

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The relationship between the NHS and its wider partners is even more byzantine, with new arrangements simply heaped on top of existing ones. The ICS (Health and Care Partnership) will be tasked with producing new 'system plans'; ICS (NHS) and local authorities should then 'have regard' (yes that old chestnut) to these plans. ICSs, in turn, will be required to relate these system plans to those of local authority-led Health and Wellbeing Boards, which will continue to produce their own Joint Strategic Needs Assessments and Joint Health and Wellbeing Plans. Local authorities will also continue to have responsibility for producing their own plans for shaping social care markets and ICSs will in some way be subject to scrutiny by 150 local authority Overview and Scrutiny Committees. Meanwhile, some way has to be found to engage the social care provider market (20,000 independent organisations) and a voluntary and community sector that is fragmented and teetering on bankruptcy. This situation could have many descriptors but 'bureaucracy busting' is unlikely to be one of them.

Enhancing public confidence and accountability

The White Paper states that 'we need a legislative framework that builds on the trust we have for those within systems to understand and deliver what their populations need'. This implies the need to engage robustly with patients, users, carers and citizens to better understand these needs and respond to them, yet there no proposals whatsoever to ensure this happens. Co-production, the popular concept within social care for involvement in the planning, development, and delivery of services, fails to even get a mention, while HealthWatch and Overview and Scrutiny Committees get only a passing nod of recognition. The existing weak engagement channels of Foundation Trust Governors, token representation on clinical commissioning groups' boards and Patient Participation Groups within GP practices are totally ignored.

Accountability to the centre is another matter. The White Paper proposes an amazing raft of new powers for the Secretary of State:

- the imposition of capital limits on NHS Foundation Trusts;
- control over NHS England and over local service reconfigurations;
- the power to define and require a new 'duty to collaborate';
- a power to create new integrated care trusts and to transfer functions to and from arms-length bodies;
- a power to intervene where local authorities are deemed to be failing to adequately deliver their adult social care duties;
- a power to bypass local authorities and make payments directly to social care providers;
- a power to require NHS England to take over local authority public health functions; and a new power to remove a profession from regulation.

If there is to be accountability, the White Paper is clear that it is only in one direction – upwards.

Where now?

The dilemma is that, although the White Paper lacks conviction in relation to its three key principles, it will soon be the only show in town. Local partners will have to make the best of it they can. The defects and omissions identified above will need to be raised and hopefully addressed during the passage of the Bill. Meanwhile local partners will need to construct the new architecture of reform and try to develop a shared vision for their localities. Creating and nurturing the ties that bind – trust and mutual respect – will be much harder than setting up committees. A new report from the King's Fund on London's five non-statutory ISCs suggests that even after five years of working together, much remains to be done in this respect. And in all of this, local partners will have to reckon with the potential whims of an overweening Secretary of State. There may well be some decent opportunities lurking in this policy thicket, but capitalising upon them will take statecraft of the highest order.

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