Short on detail but not on ambition: four problems with the new NHS white paper

Bob Hudson *writes that, on the face of it, the new NHS white paper's recoiling from the primacy of competition and markets warrants a warm welcome. Yet reactions have been underwhelming because there is remarkably little detail on how this ambitious mission is going to work.*

White Paper titles are rarely short on ambition; those concerned with the NHS never so. In 2010 there was '*Equity and Excellence: Liberating the NHS*' and now its successor is provisionally entitled '*Integration and Innovation: working together to improve health and social care*'. The 2010 White paper failed notably to live up to its billing – indeed the new White Paper constitutes a direct assault upon it – but will this new version fare any better?

It would be harsh to fault it on ambition and good intentions, certainly few people will be unfavourably disposed towards innovation and integration. The market system is to be dismantled and collaboration is to take precedence over competition, though there is no proposal to make the NHS the preferred provider of NHS services. In its place there will be new NHS 'provider collaboratives' operating at scale and overseen by strategic commissioning groups that will replace the current multitude of local clinical commissioning groups.

These new 'Integrated Care Systems' (ICS) will aim to join up the NHS, primary care, local government and the voluntary sector in order to promote system-working at 'place' level, probably a local government footprint. Moreover, there will be a 'duty to collaborate' placed upon these local partners. New legislation will establish ICSs as statutory bodies and although a consultation on legislative options only closed in January, the die is cast. Several parts of England already have non-statutory ICSs in situ and the intention is that all of England will be covered by the new arrangements.

On the face of it, this recoiling from the primacy of competition and markets along with a rehabilitation of the role of the state might seem to warrant a warm welcome. Yet reactions have been underwhelming. The explanation for this lies in the detail, or lack of it, on how this ambitious mission is going to work. Four particular problems are evident.

Rewriting national-local balance

The 2010 White Paper, in its pursuit of 'liberation', provided a degree of independence to NHS Foundation Trusts, and established NHS England as an independent body. Now, these powers (and more) are reverting to the Secretary of State for Health who will also be in charge of every ICS, as well as acquiring new powers to take over public health functions from local government and transfer functions to and from specified arms-length bodies. Quite how the balance is to be struck between allowing local partners to act flexibly 'in place' and this arrogation of control to the centre is unclear and unsettling.

Failing to learn from experience

The White Paper takes a traditional view within central government that organisational restructuring can solve problems. This flies in the face of evidence that past attempts to do so have underestimated the associated costs and disruption. The 2012 Health and Social Care Act abolished strategic health authorities and primary care trusts, created clinical commissioning groups and NHS England, and cost an estimated £3 billion. Now, it's all change again despite having little to show for the previous exercise.

There is a similar failure to learn from experience with the legislative 'duty to collaborate' between the NHS and local government. There have been decades of such 'mandated collaboration' imperatives with little to show for the endeavours. The reasons for these failures – differences in funding, accountability, staffing and incentives – are well known but the White Paper has no suggestions for addressing them. Similarly, all other parts of the UK have already adopted their own versions of the ICS model and have messages to share that could warn of pitfalls for England, but the White Paper content suggests little interest in comparative policy learning.

Lack of transparency, accountability, and engagement

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Placing ICSs on a legislative footing should offer some clarity on accountability, but bringing organisations together into joint decision-making forums always renders them remote from public gaze. The White Paper offers few clues on how clarity will be brought into the new arrangements. It remains unclear what powers an ICS would have over an NHS Foundation Trust and even less so in relation to local authorities holding their own line of democratic accountability. Provider collaboratives between NHS providers might make sense but there is no word about how the relationship with providers of social care (almost entirely independent companies) or the voluntary sector will fit in to any arrangements. Indeed, it is not even clear what is meant by the key organising concepts of 'place' and 'integrated care'. Even murkier is where patients, users, carers and the public fit into this grand scheme – something with which the NHS has always been notoriously weak.

Lack of understanding of social care

Given the recognition of 'care' in the White Paper title and the emphasis on 'integrated care' throughout, there is remarkably little recognition or understanding of the sector. There are some minor proposals that are helpful, notably giving the Care Quality Commission new powers to assess the commissioning of social care, collecting new data on those who fund their own care and new obligations on assessment after hospital discharge, but these are small beer. Notwithstanding the award of a seat round the ICS table for local government, there is little to dispel the fear that social care is simply perceived as a handmaiden to the priorities of the NHS, especially the reduction of hospital costs. Not only will the local government voice be relatively weak, but the powers given to the Secretary of State could see councils losing control of their social care and public health services to the priorities of the ICSs. In such circumstances, it would no longer be clear what the purpose of democratic local government might be. Meanwhile the long-promised root and branch reform of social care has been yet again kicked into the long grass.

What needs to be addressed going forward

Given the political reality that the government will press ahead with the changes, there needs to be some attention paid to these dilemmas. First of all, the hidden wiring (if it exists) need to be brought into view. It is these practicalities that can make the difference between a successful shared endeavour and an acrimonious shouting match.

Secondly, all of the parties need to have collaborative capacity – the ability to enter into, develop, and sustain robust partnership working. NHS partners might have this but local government and the voluntary sector have been pared back to survival mode. Joint working has no qualities of spontaneous growth or self-perpetuation; it needs perpetual attention and support.

Thirdly, explicit measures need to be put in place to ensure ICSs have some accountability to those who use services and to the wider public. The most influential discourse in adult social care right now is around co-production – developing more equal partnerships between people who use services, carers and professionals – but this seems like a foreign land to the White Paper. Some way has to be found to invest in building the voice of users, patients, carers and citizens into these new arrangements. And finally, given the enormity and complexity of the exercise, there needs to be a smart and accessible policy support function, possibly along the lines that were developed for the Care Act 2014.

Finally, the government needs to snap out of the idea that a policy lever can be pulled in Whitehall and things will magically happen across the length and breadth of the country. Shared endeavours work best when there is a negotiated relationship between all of the local stakeholders based upon a high level of trust and mutual respect. This alchemy is built locally from the bottom-up, not by edict from the top-down. The policy landscape is littered with the corpses of failed top-down experiments; this organisational re-set of the NHS is at serious risk of adding to the number.

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