White Paper: power grab, sea change or cementing in the status quo?

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Some of the headlines and reports on the leaked draft White Paper outlining plans for a new top-down reorganisation of the NHS are quite remarkable. The Times and the BBC, clearly following a steer from Downing Street both heralded the plans as a step to "scrap forced privatisation and competition within the NHS".

In the Daily Telegraph an article by Theresa May's former chief of staff Nick Timothy also proclaims a sea-change in government policy, headlined "*Covid exposed the folly of turning the NHS into an unaccountable quango*" – and as if that were not enough to have Torygraph readers spluttering over their porridge, a sub-headline apparently questioning Margaret Thatcher's political legacy:

"*Years of market-based reforms have ended up increasing bureaucracy, waste and inefficiency.*"

There seems to be a consensus among the media reports that the new draft represents a substantial shift of policy: but is this really the case?

Sometimes the real clues to a statement lie in what is left out rather than the words it uses. Most of the 40 pages of the leaked draft are giving retrospective recognition and legal status to a fait accompli.

The mainstream media reports highlight new powers for the Secretary of State to intervene in and 'take back control' over – and responsibility for – the NHS, which were technically sacrificed in Andrew Lansley's disastrous Health and Social Care Act in 2012. They all agree that the proposals would move decisively away from the fragmentation and competition entrenched in Lansley's Act to a new focus on collaboration and "integration."

Are they finally giving way to pressure from NHS England to ditch some of the broken structures of the 2012 Act

However while key sections of the Act are already being publicly flouted, much of it would remain in place.

NHS England is already three quarters of the way through its plan to force through mergers of the local Clinical Commissioning

Groups set up under the Act, to lay the basis for just 42 "Integrated Care Systems" which it aims to put in charge.

The remaining 13 areas have been told to complete their CCG mergers by April, or face intervention, despite grumbling from Leeds CCG chiefs and warnings from one of the pioneer ICSs, Bedford Luton and Milton Keynes that the new set-up is far from the promised smoothly integrated system, and little more than a fractious stooge body following NHS England's every whim.

And while the latest reports allude darkly to ministers' "frustration" at the "independence" of NHS England boss Simon Stevens, there are no clear examples of what ministers have wanted to do that has not been done. Successive Health Secretaries Hunt and Hancock have repeatedly responded as if they were still in full charge of the NHS.

Giving the Health Secretary back powers to intervene earlier in controversial hospital closure plans and reconfigurations simply highlights the failure of Hunt or Hancock to block half-baked schemes – such as Shropshire, Huddersfield, and South West London – that have been referred to them by disgruntled local councils.

It's when it comes to the issue of contracting and the private sector that the silences and omissions shout louder than the weasel words in the leaked draft.

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It's clear that a government that has looked first to private contractors and consultants for test and trace, laboratory services and procurement of PPE, and is planning to spend up to £10 billion on private hospital care for the next four years rather than invest in the NHS is not by any means calling time on privatisation.

There is no plan to scrap the historic Kenneth Clarke, Margaret Thatcher division of England's NHS into a "market" separating purchasers (commissioners) from providers, and as experience in Bedford Luton and Milton Keynes shows, these divisions are still alive and well in "integrated" care systems.

There is no plan to roll back of contracted out clinical or support services – or even a commitment to bring these back in-house as contracts end.

Nick Timothy points out that the end of the fixed tariff payment system for clinical services could actually result in more privatisation – allowing private hospitals to under-cut NHS trusts, and cherry pick low-cost simple elective cases, leaving the NHS remains saddled with more complex cases.

Removing the requirement for competitive tendering on contracts is also

rather more contentious now we have had 12 months in which contracts worth billions awarded without competition for supply of PPE have yielded questionable results and triggered widespread complaints of cronyism – and criticism from the National Audit Office.

Significantly, the new rules that will offer ICSs discretion on whether or not to put contracts out to tender do not apply to "professional services" – effectively exempting the gamut of number-crunching back office services needed to deliver the Long Term Plan's focus on "digital" systems and "population health management".

The draft makes no mention of the £700m Health System Support Framework already established by NHS England to fast-track the outsourcing of such contracts to a pre-approved list of over 80 mainly private companies, more than a quarter of them US-owned.

Meanwhile there is an eloquent silence on whether the statutory ICSs would be accountable downwards to local communities as well as upwards to NHS England and ministers, and no promise they would meet in public or publish board papers.

While there will be "a duty placed on the ICS NHS Board to meet the system financial objectives which require financial balance to be delivered," there seems to be no provision to ensure an ICS allocates the "single pot" of funding for the health system fairly and with regard to health inequalities – or what would be done if they failed to do so.

Strangely, the leaked proposals would not even integrate the leadership of ICSs: while there are new powers to curb capital spending by foundation trusts, not only do NHS trusts and foundation trusts "remain separate statutory bodies with their functions and duties broadly as they are," but each ICS would require two boards.

The main ICS Board, with commissioning powers, would include NHS 'partners' and local government. The second, subordinate, ICS Health Partnership would effectively act as an enlarged Health and Wellbeing Board, also involving local government, alongside voluntary sector and, notably private ("independent") providers. This is admitted to be a concession to complaints from the Local Government Association that councils were being left on the sidelines of ICSs – but in practice institutionalises the subordinate role of local government.

There is much more in the draft – but nothing to explain the biggest riddle of all: why ministers have decided now is the time

There is little discussion of the role of GPs in the new set-up: they were (falsely)

claimed to be put “in the driving seat” when CCGs were established in the 2012 Act, but they would have even less influence in the new ICS bodies covering much wider areas and dominated by the big acute hospital trusts.

There are only fleeting references to mental health, which would also be further marginalised by the proposals.

There is much more in the draft – but nothing to explain the biggest riddle of all: why ministers have decided now is the time, in the middle of a pandemic, to focus on another reorganisation of the NHS.

If ministers simply wanted to scrap the requirement to put contracts out to tender they could do so at any point by simply revoking the regulations that followed the 2012 Act.

So why now? Are they finally giving way to pressure from NHS England to ditch some of the broken structures of the 2012 Act?

Or is this maybe a convenient ‘dead cat’ to divert attention and discussion from the urgent need for a big increase in NHS revenue and capital funding as we run up to the March budget?

Funding, including the dire shortage of capital as the NHS maintenance backlog has soared to £9 billion, is the other missing link in the draft. No matter what reorganisation the White Paper finally ushers in, after a decade of real terms cuts and austerity, the NHS cannot go forward and cope without an extra injection of cash.
