

# NHS Reform

# White Paper

# Analysis

**March 2021**

**February 2016**

Rt Hon Matt Hancock MP

Secretary of State for Health & Social Care  
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Dear Rt Hon Matt Hancock MP

**NPC NHS Reform White Paper Analysis**

**Introduction:**

There are more questions than answers in this paper. We are faced with the biggest ever shake-up of our NHS as we start to come out of the impact of the pandemic.

The obvious answer to why the NHS found itself so unprepared for the pandemic lies with the political decisions made back in 2016. Exercise Cygnus – designed to test the level of response the NHS could give to any given crisis (including a pandemic) – showed very clearly that its resources and equipment were so severely depleted, it would not be able to safely respond and/or cope with a pandemic that would impact right across society.

Why was this so? Decades of chronic underfunding and ‘tinkering’ with services has meant that staff vacancies are at an all-time high; services being quietly filtered out to the private sector and contracts awarded to profit-making companies all add to the fact that we were so unprepared for what happened. In 2020, 52% of our NHS beds had disappeared.

The Cygnus report recommendations to seek to enhance and improve stocks of PPE, and other equipment were ignored. The report remained unpublished for 3 years, and in the meantime no action was taken (it was deemed too costly) and the government continued its pursuit of their agenda of austerity, making year on year cuts to councils and the NHS.

The response to the pandemic was large scale contracting out of services that should be delivered by the NHS and public health services. Billions have been spent on a supply chain that is at the very least suspect (a Jeweller in USA; a pub landlord)! and in many cases delivered faulty PPE and equipment that just could not be used.

Does it matter who delivers health and care services? Yes, it does.  Privatisation of services means that the provider of those services are in business first and foremost to make a profit for their shareholders and providing the services to public/patients is the means to do that. Providing health and care services is therefore a secondary matter. They get paid a lot of money from government, by way of our taxes in order to make that profit. Zero hour contracts are abundant in the care environment which means workers have less protection and struggle to earn enough for their family needs.

There’s also an intrinsic difference between the NHS using private sector provision to meet shortfalls (mainly due to cuts in beds and loss of essential expertise) and the increasing takeover of NHS services.

It is important to remember services like dental care, audiology, eye care etc are taken for granted and affect older people disproportionately are being lost as ‘free’ NHS services.

**Will the expected Bill change anything?**

**What will the Bill be about?:**

According to the white paper, the Bill expects to improve ‘joined up’ thinking in the NHS. It will do this by establishing Integrated Care Services (ICS’s). ICS’s are in place in some parts of the country but currently do not have statutory powers.

ICS’s will have fixed annual budgets to deliver a wide range of health and social care services. Delivery will be based on area-wide targets not specifically on the needs of the population. ICS NHS bodies will have no power to direct service providers but will have a new duty to compel providers to have regard to the financial objectives. This leads us to believe that controls will be financial - not about the amount and quality of services delivered.

The proposal mentions pooling of budgets by NHS England and ICS’s but does not include Local Authorities. This implies that no funding will be coming via LA’s into these arrangements.

The NPC has consistently highlighted health inequalities (or as we call them ‘post code lotteries’). The pandemic again brought these to the fore very sharply with poorer councils not able to respond as quickly as they would want. The instating of statutory ICS’s is not guaranteed to improve these inequalities and there is a concern they could get even worse under the management of ICS’s.

The white paper is different from the NHS England proposals that have recently been consulted upon. Instead of one ICS board, the bill proposes two in each area. One board would be for commissioning (NHS and Local Authorities); the second an over-arching ICS Health & Care Partnership board. This board could include anyone as a ‘partner’ – the phrase used is ‘voluntary’ or ‘independent’ partners.

The inevitable concern here is that Local Authorities will have a diminished role with the NHS making commissioning decisions about social care services, and that there is a clear pathway for private corporations to have seats on the Partnership board and influence commissioning. In effect, the ICS’s themselves will not be ‘integrated’

The proposal is to give ICS’s legal status; i.e. they would become a statutory body with power over health and care services in all areas of the country. The NPC has rejected this in its submission to NHS England as local needs for services can either be ignored or changed without recourse other than a judicial review. ‘In the name of the law’ can have disastrous consequences.

It is not clear what the social care system will be like, nor how the current problems of insufficient provision and mix of quality; the mis-match between the status and pay of care workers set against their responsibilities and care homes closing will be addressed.

The funding system for integrated services is unclear, particularly how funds will be allocated at local level between health and social care and whether local authorities will have any role in that.

Social care does not feature in the white paper, so we are left assuming one of two things. That it will be subsumed into the NHS with no extra funding, or there will be no real improvement in the way social care is funded. Either way, this does not deal with the chronic crisis in care. The government have said they will reform social care later this year.

**Accountability:**

The proposals here are a merger of NHS England and NHS Improvement with the potential to devolve some responsibilities down to the ICS’s. NHS England is the largest quango in the world and by devolving responsibility down could, in effect, create 42 smaller quangos.

In addition, the Secretary of State for Health and Social Care (SOS) will have new powers to intervene in the NHS. Currently, the SOS can only intervene after a referral from a Local Authority’s Health Overview & Scrutiny Committee and then commission an Independent Reconfiguration Panel to examine the referral and make recommendations.

Under the new proposals, the SOS will have powers to intervene at any point in the reconfiguration process to close an A&E or any other service. It is interesting that the Independent Reconfiguration Panel will be abolished with new arrangements yet to be determined. It also appears that the current Local Authority referral powers will be removed until the new system (whatever that ends up being) is created.

This proposal effectively puts the management of the NHS in the hands of politicians. We strongly believe they are not the best people to manage the NHS – their track record speaks for itself.

**Competition Rules and Commissioning:**

The Health & Social Care Act 2012 (or the Lansley Bill as we often refer to it), made competitiveness in the NHS a reality by setting targets for private provision. Within this section, there is also a monitoring function that ensures procurement of contracts are done according to due process. The proposal to remove commissioning of healthcare services from the Public Contracts Regulations 2015 and the Health & Social Care Act would at first glance seem to be all that we have fought for.

However, we believe that scrapping competition rules will work in the opposite way. There is no limit on ICS’s as commissioners or on NHS Foundation Trusts opting to put more services out to tender

if they wish. With an approved list of over 80 providers – 25% of them American, it is increasingly easy and relatively quick to procure private companies to take the work that should be delivered by the NHS. Marketisation means that plans are made on the basis of cost rather than local health needs.

Corporate seats on ICS Health & Care Partnership boards has the potential to make the process even quicker. The Bill does not state that the NHS is the preferred provider. Remembering that scrapping competition rules also takes away the monitoring function, we should take a cautious view.

There is a lack of clarity about how contracts with providers will be negotiated and managed. Direct payments to providers will remove the ability to deal with problems with contracted out services. There is less control by Commissioners than with the current system.

**Interaction with the Public:**

Words like ‘collaboration’ and ‘involvement’ abound in the white paper, but there is no real indication that the public will have a say in what they wish to see. Also in frequent use ‘co-production’ which for the NPC means that patients contribute to the provision of health services as partners of professional providers. Interpretations of co-production vary depending on who you are talking to with varying methods being sold as co-production. With the uncertainty around public involvement, this is an area of concern.

‘*Patient choice is a powerful tool for delivering improved waiting times and patient experiences of care’* is a line that we would all think is a huge improvement. However, resource funding is unclear in the paper and under-resourcing will significantly undermine patient choice. There are areas of the country where choice of GP practices and hospitals is not possible because of the distances between alternatives.

More worrying is that if a patient/service user changes their GP or hospital provider through dissatisfaction with the service, the patient/service user does not have access to reports from the provider they have left. This is because of the exclusion with access to their records from third parties in the Data Protection legislation.

**Digital/Data:**

Increased reliance is being placed on digital and data systems. £700 million already contracted out to set up and manage ICS’s. Most of this work goes to private companies and the NPC has major concerns around:

* Compatibility of systems across the NHS. It is still not possible for computers to ‘talk’ to each other and between the GP and NHS systems.
* Data security, particularly sensitive data that may be damaging to individuals in one way or another.
* Exclusion of those who do not have access to technology. Appointments and treatments may not be available to those who cannot use technology, or there will be a convoluted route to take to get them.
* Even when patients have technology it can go wrong. An example of this is an individual being locked out of online access to GP records and not able to get the access reinstated. This led to difficulties in getting an essential prescription.
* More and more access to meta-data to target private companies, opening the health market to mammoth insurance companies, reducing accountability, transparency and democracy.
* Local/National outages that render system inoperable.

**Community Nursing Services/Mental Health:**

Mental Health services have been underfunded for decades to such an extent that many patients requiring treatment or hospitalisation find themselves miles away from home. The waiting time for access to beds has increased. In 2000 there were 54,117 beds available; in 2018 there were 24,523. With the increase in need for support for the mental health needs of the population as a result of the pandemic, there is nothing offered in the bill which in reality demonstrates that there is no understanding of what people have suffered.

The reinstatement of Community Nursing services managed and directed at local level would enable local authorities to pass over some responsibilities for preventative and health care services allowing them to concentrate their funding on other equally important priorities in their communities.

There are Local Authority Social Care Teams which specialise in working with each user group, older people, people with physical disabilities, etc.  They are staffed by qualified Social Workers who carry out assessments of the needs of users and of carers (with those people free to choose whether to have assessments), and put services in place. Most of those services are contracted out; i.e. domiciliary care (personal care, shopping and some light housework, respite care, day centres, residential care, supported housing and meals on wheels where this still exists. They often have links with local voluntary organisations in areas where these exist, and they will provide information about those.

We believe that combining these teams with a Community Nursing Service would ensure a whole package of services being available to be delivered locally by the relevant provider.

**Public Health:**

The government axed Public Health England in favour of a National Institute for Health Protection. Details of how this reorganisation will impact on councils’ public health functions do not form part of the white paper.

Public health services run by councils have more than proven their worth through the pandemic, as part of the tremendous local response. Centralisation of public health powers is a concern.

Many Public Health experts say this move has the potential to diminish councils’ public health role. They are worried about the white paper's measures alongside the axing of PHE will mean that whereas public health should face outwards… the whole system will turn inwards to the NHS. It would seem there are significant attempts to turn public health into something that supports the NHS.

Public health should remain with Local Authorities who are best placed to understand the needs of their local population and can target services very quickly to a specific area.

**Why Now?**

Many health professionals and others involved in campaigning are of the opinion that this reform is the wrong thing at the wrong time. The NPC takes much the same view. We know that the NHS needs some reform and this would be better done through the Reinstatement of the NHS Bill which the NPC has supported since its inception. It would take the NHS back into public ownership; empower patients to say what they want and how it should be delivered. It would value the work of NHS staff and compliment the NPC’s own policy for a National Care Service which puts the individual at the heart of service delivery.

**Conclusion:**

We believe this white paper and the Bill that will arise from it is a dangerous piece of legislation that will strengthen the role of private companies and over time erode the ‘free at the point of need’ system currently in place.

We only have to look at the latest outrage in London where the UK arm of a large US healthcare insurance firm is set to take over 49 GP surgeries in the capital. Operose Health - a subsidiary of the Centene Corporation has acquired AT Medics run by six GP directors operating primary care services for 370,000 patients. Operose Health run other primary care and GP services in other parts of the country. They have merged or closed surgeries, leaving some patients without a GP within a 40-mile radius of home.

Some commentators are very clear that hidden within the recent budget is a cut to the NHS amongst other things. Therefore, it follows that this ‘reform’ is another cover for further funding cuts to the NHS and opening the back door a lot wider to privatisation.

**Questions/Concerns:**

As said at the beginning, there are critical questions to be asked and these are:

1. The document promises that lessons will be learned from COVID, but in itself it shows that the government have no understanding of the needs of the population. Lessons do need to be learned but putting our NHS in the hands of politicians is not the answer.
2. There are several demands for an independent inquiry into actions and omissions that led to so many deaths; the poor PPE; test and trace; the procurement process; breach of human rights of older people and much more. Therefore, if there is a genuine wish to learn, then the inquiry should take precedence and learning applied thereafter.
3. The consultation window for the NHS England Integrated Care Services paper was inadequate, being held over the Christmas period in a short timescale. The outcomes of that consultation are yet to be published.
4. With this in mind, is not the publication of the NHS Reform White Paper pre-empting that outcome, or, more importantly, is it intended to ignore the outcome, particularly if responses are not in a positive vein.
5. The reform of social care is nowhere on the horizon and this should be dealt with before any reform of the NHS. The two services are inextricably linked but funded differently.
6. How will NHS England’s role differ from that of the CQC?
7. How would providers receiving direct payments be managed and accountable?
8. The Welsh model remains publicly funded, publicly delivered and publicly accountable and should be adopted by England.

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**March 2021**