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Liberating the NHS: orders of change?

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Introduction

There have been a number of responses and reactions to the new White Paper (DH 2010a) and the Health and Social Care Bill (DH, 2011). While some describe this policy programme as the 'most radical pro-market shake up' in the history of the NHS, others have suggested it is 'a natural continuation of structural reforms that have been running, at various speeds, for two decades' (BMJ 2011: 342; Guardian 2010).

In the following HSMC policy paper we aim to develop current discussions and thinking about the new reform programme by presenting a policy analysis of the change and continuity associated with its key proposals. To understand this change and continuity we draw on an approach put forward by Hall (1993) that suggests policy change can be broken down into three subtypes or orders. 'First order' change suggests policy is likely to be an incremental adjustment of previous policy. This suggests a large degree of continuity in terms of the goals and techniques of policy. 'Second order' change moves one step beyond incremental adjustments in creating a new strategic direction. This order of change introduces new or altered policy instruments but it does not radically alter the goals behind the policy. 'Third order' change is likely to reflect radical changes in the overarching terms of policy. This introduces a new 'framework of ideas and standards' that specifies new policy goals and instruments but also new problems the policy is meant to be addressing (Hall, 1993: 279).

Based on our analysis of the reform proposals we suggest that rather than radical 'third order' change, the *Liberating the NHS* reform programme combines incremental changes to previous policies with the creation of new policy mechanisms aiming to create a new strategic direction in reform efforts. It points to a large degree of policy continuity in relation to NHS reform but also raises the point that the combined impact of the reforms when implemented may bring about radical 'third order' change as the scale and speed of the proposed changes take effect. We conclude with a critical reflection of the contextual factors likely to affect the implementation of the reform proposals and raise some practical implications that will be addressed by forthcoming HSMC policy papers.

1. Putting patients and the public first: the government view

A policy goal contained in the *Liberating the NHS* reform proposals calls for 'putting patients and the public first' so that 'shared decision making' becomes the norm (DH, 2010a: 13). To achieve this goal, the policy proposes an 'NHS information revolution' that will replace the existing 'closed', 'bureaucratic' system with new information technology providing up-to-date healthcare records, improved online communication and support for self care. The reform of patient information also looks to extend patient recorded outcome measures (PROMS), patient experience surveys and create 'professionally endorsed' information systems. Alongside this reform of patient information, proposals for patient choice aim to move beyond the current focus on 'choice of provider' towards 'fundamental control' of patient choice in the circumstances of treatment and

care. These measures include the extension of Choose and Book, further personal health budget pilots and a Health and Social Care Information Centre focused on professional and patient engagement (DH, 2010a: 18). Proposals to create local HealthWatch groups will aim to improve the quality of patient experience and ensure feedback and complaints form part of the commissioning process. Increasing patient voice also calls for an enhanced role for Local Authorities in promoting choice and public engagement (DH, 2010a: 20).

Putting Patients and the Public First: analysing ‘orders of change’

Putting Patients and the Public First aims to resolve the weaknesses of previous policies with proposals to provide a more systematic approach to patient information, choice and involvement. A notable example of this is proposals for an ‘information revolution’ in making information systems more accessible, relevant and well-structured. The aim to create new professionally endorsed information systems and new national information standards suggest a series of second order changes aiming to introduce new or altered policy instruments to achieve the goal of ‘shared decision making’.

In contrast with the second order change associated with the reform of patient information systems, the reform of patient choice suggests a large degree of first order change in building on previous policy arrangements. The proposals to support the choice of any willing provider, maximise choose and book technology and extend personal health budgets can all be associated with New Labour reform policies. They appear to go with the grain of previous policy expressed in *High Quality Care for All* (DH, 2008) and *From Good to Great* calling for ‘more power in hands of patients’ (DH, 2009a: 7). As we see in later sections, the reform of patient voice does introduce new instruments (i.e. the HealthWatch body); however it is unclear whether these new arrangements will change or improve the ‘collective’ voice of patients.

Patient information, patient choice and patient voice: what's the evidence?

Patient choice

- Research suggests patient choice and choice of provider contributes to reductions in waiting times and improved satisfaction with care quality (Jones and Mays, 2009).
- Patients want to be involved in decisions about their own treatment. However they are likely to rely on a trusted health practitioner to choose their treatment (Fotaki et al, 2008). Most GPs make choices on the patient's behalf (Rosen et al, 2007).
- Choosing between hospitals or primary care providers is not a high priority for the public, except where local services are poor and where individual patients' circumstances do not limit their ability to travel (Greener, 2007).
- Choice tends to vary geographically (Dixon et al, 2010). Referral patterns within the local area are strongly ingrained due to historical patterns and brand loyalty (Powell et al, 2010).
- Choose and Book did not enable choice as intended but has been used as an additional technological tool for administrative purposes (Rashid et al, 2007; BMA, 2009). For GPs, Choose and Book allowed for immediate appointment making, improved attendance at outpatient appointments and enabled referral tracking. However, it also increased workload, created technical difficulties, and led to an uneven distribution of hospital appointment placements (Rosen et al, 2007)

Patient information

- Educated populations make greater use of information and are more likely to exercise choice (Fotaki et al, 2008). However patient choice was found not to harm equity in waiting times for elective care (Cooper et al, 2009).
- Research found most GPs distrusted official sources of information (e.g. waiting list data). Research has found a lack of consensus on the type of information GPs wanted to support patient choice or about how it should be presented (Rosen et al, 2007).
- The absence of detailed comparative clinical information means patients make choices based on other factors (Greener and Mannion, 2009).

Patient voice

- Patient voice has been hampered by changing patient and public involvement (PPI) policies and broader regulatory frameworks (Hughes et al, 2009)
- Policies have tended to move towards a focus on consumer choice and economic regulation with collective voice and citizen participation playing a subordinate part. These reforms may increase responsiveness, but the overall effect potentially weakens the foundations of democratic decision making (Vincent-Jones & Mullen, 2009). Whether voice results in greater equity and a real shift in power away from professionals to citizens and patients remains to be seen (Forster and Gabe, 2008).
- Patient voice initiatives require greater capacity and capability in relation to leadership, support, and responsiveness (Anderson et al, 2006).

2. Improving healthcare outcomes: the government view

Reform proposals outlined in *Liberating the NHS* call for a move from 'the focus on nationally determined process targets' (DH, 2010f: 3) to the improvement of healthcare outcomes in relation to mortality, morbidity, safety and patient experience. They build on Lord Darzi's reform agenda by proposing that the current 'performance regime' will be replaced with an NHS Outcomes Framework providing clear and unambiguous accountability.

Published after the consultation on the White Paper in December 2010 (Department of Health, 2010i), the Framework will evolve in terms of the levels of ambition to be set. What we do know is that it will span three elements of quality: the effectiveness of the treatment and care provided measured by clinical and patient reported outcomes; the safety of the treatment and care provided to patients; and the broader experience patients have of the treatment and care they receive. Within these three elements there are five domains. Underpinned by the model of quality assurance put forward by Donabedian (Donabedian, 1966, 2003), each of the domains has a small number (the maximum is three in the safety element) of overarching indicators, and a number of 'improvement areas' with outcome measures. These area indicators will be developed into a set of publicly available indicators reflecting NICE quality standards (DH, 2010a: 22). The new Public Health Service will set local authorities national objectives for improving population health outcomes. A summary of the framework is presented in Table 1.

Table 1. The NHS Outcomes Framework (DH 2010f)

Elements of Quality	Domain	The overarching indicators	Examples of Outcome measures for improvement areas
Effectiveness	Preventing people from dying prematurely	<ul style="list-style-type: none"> Mortality from causes considered amenable to healthcare Life expectancy at age 75 	<ul style="list-style-type: none"> Condition specific mortality Infant mortality
Effectiveness	Enhancing quality of life for people with long-term conditions	<ul style="list-style-type: none"> Health-related quality of life for people with long term conditions (EQ-5D) 	<ul style="list-style-type: none"> Employment of people with long term conditions Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
Effectiveness	Helping people to recover from episodes of ill-health or following injury	<ul style="list-style-type: none"> Emergency admissions for acute conditions that should not usually require hospital admission Emergency readmission within 28 days of discharge from hospital 	<ul style="list-style-type: none"> The proportion of patients recovering to their previous levels of mobility/walking ability at 30 days and 120 days PROMs for elective procedures
Patient experience	Ensuring that people have a positive experience of care	<ul style="list-style-type: none"> Patient experience of primary care Patient experience of hospitals care 	<ul style="list-style-type: none"> Patient experience of A&E services Women's experience of maternity services
Safety	Treating and caring for people in a safe environment and protecting them from avoidable harm	<ul style="list-style-type: none"> Patient safety incident reporting Severity of harm Number of similar incidents 	<ul style="list-style-type: none"> Incidence of healthcare-associated infection Admission of full term babies to neonatal care

The White Paper suggests these reform proposals for assessing healthcare outcomes will not only increase accountability but will also create further incentives for quality improvement. It states that where New Labour made progress in developing Payment by Results for acute trusts it did not incentivise results throughout the system in terms of quality and outcomes. *Liberating the NHS* therefore looks to accelerate the development of currencies and tariffs for commissioners and community services. Payments and currencies will draw on best practice tariffs and will develop benchmarking approaches with greater local flexibility to include local marginal rates (DH, 2010a: 25). The scope of CQUIN payment framework will also be extended to support local quality improvement goals and quality standards (DH, 2010a: 26).

Improving healthcare outcomes: analysing ‘orders of change’

The reform proposals to improve healthcare outcomes aim to replace existing process targets and performance management. Where targets and heavy performance management came to represent Labour’s approach, certainly in the ‘targets and terror’ period which followed the publication of the *NHS Plan* in 2000 (Bevan and Hood, 2006; Propper et al, 2008a), *Liberating the NHS* will remove targets from national monitoring – a process that was started very soon after the election with amendments to the current operating framework (DH, 2010g). Rather than ‘a tool to performance manage providers of NHS Care’, the new Outcomes Framework will be flexible in allowing the NHS Commissioning Board to decide how to ‘operationalise’ the framework through the commissioning process (DH, 2010a:8).

On the one hand, the reform proposals to move from process targets and indicators to outcome measurement potentially create a third order change in suggesting a radical overhaul of policy with a new ‘framework of ideas and standards’ specifying new policy goals. Removing government from the process of setting and monitoring targets is a key change in policy. However, this emphasis on outcomes is limited by acknowledgement in the White Paper that suggests the continuation of a number of process based performance measurements at a local level. For example, over the next five years NICE will produce a library of approximately 150 quality standards based on process indicators of care. At the time of writing, there are four – for stroke, dementia, specialist neonatal care and venous thromboembolism (VTE) prevention, with another nine in development (NICE, 2010).

Despite the suggestion of a shift towards outcomes rather than processes, reform proposals to improve healthcare outcomes are more suggestive of second order change. They introduce new policy instruments but ‘national performance management’ is likely to continue. Some process targets are likely to be maintained, as existing targets that were not removed from national management in the revision of the Operating Framework may remain in regulatory regimes or be incorporated into Quality standards. Alongside reform of the means through which healthcare outcomes are assessed, reform proposals to incentivise quality improvement using new currencies, tariffs and benchmarking to local quality goals also represent further development of the Payment by Results system that characterised the previous government. Although there is evidence of second order change in the way transactions will be monitored by the NHS Commissioning Board (see following section), the White Paper continues the implementation of currencies that were already being developed, for example the implementation of ‘best practice’ tariffs in mental health. The promotion of the CQUIN framework also builds on previous policy that focused on rewarding quality.

Improving healthcare outcomes: what's the evidence?

- In calling for a greater emphasis on the outcomes of care, the House of Commons Health Committee criticised the regulatory methods of the Healthcare Commission for being based on 'processes and procedures rather than actual outcomes' (House of Commons Health Committee, 2009:84). It recommended that the Care Quality Commission's registration system must focus on the outcomes being achieved by NHS organisations rather than formal governance processes.
- Despite the White Paper emphasis on outcomes, research evidence suggests that process indicators can be effective in some contexts. Mant and Hicks (1995) give the example of comparing hospital performance in treating heart attacks through assessment of mortality outcomes. They suggest that measuring process indicators based on evidence-based interventions is more effective in spotting significant differences between hospitals than outcome measurements. Rubin et al (2001) identified the advantages and disadvantages of process-based measures of health care quality. From the providers' point of view, outcome measures may be influenced by factors outside their control.
- Donabedian's model was originally designed for Quality Assurance of Clinical Care to relate process causes to outcomes effects. It suggests that if the evidence-base is strong that a process will lead to an outcome, then assessing quality through measuring elements of process indicators is effective, particularly at levels where data sets are relatively small.
- Evidence about the effectiveness of financial incentives for primary care and preventative services suggests that incentives can be effective, although the effects are small (Christianson et al, 2007). The impact of the Quality Outcomes Framework (QOF) suggested that QOF financial incentives improved quality of care recording and improved the standards as measured by process indicators and all major intermediate outcome measures. However, the translation of improved QOF measures into actual improved outcomes for people with diabetes was not clear (Khunti et al, 2007; Hughes, 2007).

3. Autonomy, accountability and democratic legitimacy: the government view

The *Liberating the NHS* reform programme puts forward a number of proposals aiming to remove the 'top down control' of professionals and providers. One of the more eye catching and controversial elements in achieving this goal is the reform of commissioning. A proposed consortia based model will give GPs overall control of NHS budgets to commission services. The White Paper suggests that whereas Practice Based Commissioning 'never became a real transfer of responsibility' and World Class Commissioning focused on the 'capacity of staff' at the expense of deeper 'weaknesses in the system', the proposed consortia model 'learns from history'. It builds on the role GPs 'already play in committing NHS resources' and asserts that 'primary care professionals'

are best placed to coordinate the commissioning and pathway of care (DH, 2010a: 27). The financial consequences of clinical decisions will be aligned through 'effective dialogue and partnerships with hospital specialists' (DH, 2010d: 3).

A national NHS Commissioning Board will hold consortia to account against agreed outcome indicators for performance and quality. This 'lean and expert organisation' will be a Special Health Authority but with 'limited power to micro manage and intervene' (DH, 2010a: 30). It will provide 'leadership for quality improvement' through the provision of commissioning guidelines, designing good practice, financial incentives, setting quality standards and tackling health inequalities. The Board will also promote partnership working with Local Authorities in the promotion of patient and carer involvement through personalisation and patient choice (DH, 2010a: 33).

Alongside greater autonomy, increased accountability will be achieved by building on the power of Local Authorities to promote local well being and bring greater local democratic legitimacy. They will lead health improvement and prevention, including Joint Strategic Needs Assessments (JSNAs) and the promotion of joined-up commissioning. Health and Well-being Boards (HWB) will provide strategic overview with members drawn from GP consortia, the NHS Commissioning Board, HealthWatch organisations and community representatives. HealthWatch organisations will replace Local Involvement Networks (LINKs). As 'citizen's advice bureaus' for health and social care services, they will take on the NHS complaints advocacy services and support people to exercise 'choice' (DH, 2010e: 4).

Autonomy, accountability and democratic legitimacy: analysing 'orders of change'

The proposed reforms to autonomy, accountability and democratic legitimacy suggest they will increase service responsiveness to patients, reduce costs through management restructuring and liberate providers as the policies join together 'to create a social market within health where good providers thrive and poor providers can fail' (DH, 2010d: 9). The reform of commissioning suggests a significant change of strategy. While the goals of commissioning remain the same, the proposed reforms demonstrate second order change as new policy instruments give power and autonomy to the system of General Practice. With consortia 'free from top-down managerial control', they will potentially have the freedom to decide which aspects of commissioning activity they undertake fully themselves and which aspects require external support or collaboration across several consortia.

This second order change is also evident in relation to changes in the governance of commissioning. There is evidence of new policy instruments with the creation of an NHS Commissioning Board to ensure transparency, fairness and the promotion of competition. Within the decentralising ethos of these new arrangements we find that this new policy instrument will continue to provide 'arms length' control in holding consortia to account for the outcomes they achieve. The policy instrument changes but the performance management of consortia will not be far away. For example, the Board will have a 'reserve power' to assign practices to consortia if necessary and intervene in the event that a consortium is unable to fulfil its duties effectively or where there is a

significant risk of failure. The Secretary of State will also have a statutory role as 'arbiter of last resort' in disputes that arise between NHS commissioners and Local Authorities, for example in relation to major service changes (DH 2010a: 33).

Proposals for a new and enhanced role for local government to implement health improvement and ensure service integration also suggest second order change in its creation of new relationships and terms of engagement with the NHS. Health and social care responsibilities for Local Authorities is not new. For example, the Joint Strategic Needs Assessment has been a statutory duty since 2007 and Local Authorities have already had power to scrutinise the delivery and planning of services through Overview and Scrutiny Committees. Despite this, the proposals for an enhanced role for Local Authorities in the transferral of Public Health responsibilities could represent a significant shift from the NHS being a health and sickness service into one focused only on sickness. With Local Government involvement increased, it may be able to make a dramatic contribution to public health. In this sense, reform proposals may not only represent a change in strategy but may well introduce a new framework of ideas and standards similar to third order change.

Despite these decentralising and empowering intentions, reform proposals to increase local democratic legitimacy suggest the continuation of first order change with the potential to weaken patient voice. Although it is unclear exactly how these new arrangements will unfold, further structural change to local involvement and collective voice arrangements potentially weakens these very aspects. For example, Local Improvement Networks were only established in 2008. In relation to commissioning, consortia will be asked to work closely with local populations via HealthWatch bodies. However these commissioning proposals may create a further limited role for patient voice. Rather than patients empowered to make decisions, it is 'the system of general practice' that will represent and support patients on their behalf. Faith will be placed in patients' advocates to support patients in their healthcare choices (DH, 2010d: 2-4).

Commissioning: what's the evidence?

- Research suggests that PCT commissioning did not bring about the beneficial change intended. Some have suggested this has been due to weak incentives and inadequate management capacity to drive aggressive bargains with hospitals (Cookson et al, 2010). PCTs struggled to develop care pathway models (Goodwin, 2007).
- The impact of Practice Based Commissioning was also limited. Despite some evidence that PBC 'worked' (Coleman et al, 2010), these initiatives were few and impact limited in terms of better patient services, more efficient use of resources, lower elective referral/admission rates and improved coordination (Dusheiko et al, 2008; Curry et al, 2008). The factors that seemed to undermine PBC were bureaucratic processes, financial infrastructure, incentives and governance arrangements (Audit Commission, 2006). It was also limited by GP's unwillingness to engage in organisational development and to think more widely about the nature of PBC (Coleman et al, 2010).

- Research suggests that a lack of information necessary for effective commissioning limited population needs assessments and restricted the ability to set and manage virtual budgets and develop commissioning ideas (Lewis et al, 2009; Audit Commission, 2006; Curry et al, 2008).
- Despite the criticism of PCT commissioning, recent data suggested PCTs were improving against the Word Class Commissioning framework just as the announcement of their abolition came (HSJ, 2010).

Accountability and Democratic Legitimacy: what's the evidence?

- Partnerships are likely to encounter tensions between democratic legitimacy and accountability as the delivery of outcomes designed by the centre assume precedence over local democratic processes. This chain of command means sharing goals between partnerships horizontally and empowering effective partnership working is greatly reduced (Sullivan and Skelcher, 2002; Glendinning et al, 2002).
- Until very recently, it was the Local Strategic Partnership's responsibility to draw up a statement of local priority targets (known as a Local Area Agreement (LAA)) against which Local Authorities and its partners are performance managed. However, many of the targets are, by default, national targets, determined by central government. As an example, Birmingham's LAA for 2008-2011 contained 51 nationally designated targets and only 25 local targets (Birmingham City Council, 2008).
- 'Lay' involvement in partnerships at the individual level tends to be problematic as it is unlikely that such individuals are able to wield as much influence as senior organisational members. They may feel increasingly marginalised and disillusioned with the process (Sullivan and Skelcher, 2002).
- Foundation Trusts (FTs) were introduced to allow greater freedoms to 'high performing' Hospital Trusts to be more innovative, locally accountable and more responsive by involving local people as Governors and members. Although membership numbers have increased steadily, elections to governor posts do not appear to have always caught the public's imagination. Figures reported in response to a parliamentary question and reported in the Health Service Journal in October 2009 revealed that up to a third of elections for Governors were uncontested, leading, it was suggested, to a clique of well-connected people involved in the management of FTs rather than the open and inclusive arrangements envisaged (HSJ, 2009).

4. Freeing providers and economic regulation: the government view

The *Liberating the NHS* reform programme proposes to create 'the largest and most vibrant social enterprise sector in the world'. In doing so it gives Foundation Trusts (FT) freedom to innovate by removing the 'controls imposed' on them by Whitehall (DH 2010a: 35). Options for increasing Foundation Trust freedoms include abolishing the cap on income earned from private activity, encouraging the widening of health and social care provision, and enabling trusts to merge or tailor to local circumstances. As all NHS trusts become Foundation Trusts, staff within particular FTs (such as those only providing community services) will have an opportunity to transform their organisations into employee-led social enterprises. By freeing providers 'to use their front-line experience to structure services around what works best for patients', this employee-owned model will lead to higher productivity, greater innovation, better care and greater job satisfaction.

Reform proposals for economic regulation sees the Care Quality Commission (CQC) continue as a quality inspectorate across health and social care and Monitor becoming the economic regulator responsible for all providers. In its new role, Monitor will promote competition, regulate prices, and support continuity of services in times of service reconfiguration. It will also license all providers of health care to ensure organisations are 'fit and proper' to provide NHS services, and take over DH responsibility for fixing prices for services that are subject to national tariffs (DH, 2010c: 13). The NHS Commissioning Board will have primary responsibility for setting the tariff structure. However, Monitor will regulate the overall affordability of setting prices (DH, 2010a: 36; DH, 2010c). These proposals also set out how Monitor's relationship with FTs change as their 'oversight role' is removed as part of measures to strengthen the internal governance of Foundation Trusts.

Freeing providers and economic regulation: analysing 'orders of change'

The White Paper suggests that freeing providers and economic regulation will promote patient choice and competition by stimulating innovation, improvement and productivity. The proposals for economic regulation suggest second and possible third order change as Monitor gains a new strategy in regulating competition. Although competition has been a central feature of recent NHS policy, the proposals for possible de-merging and special licence conditions on providers with high local market power suggests a decisive shift towards the promotion of competition using regulatory instruments. The reform represents second order change as Monitor gains "ex ante" powers to protect essential services and help open up the social market to competition as well as taking "ex post" enforcement action reactively. The "ex ante" powers may require monopoly providers to grant access to their facilities to third parties (DH, 2010a: 39). The proposed changes to the 'governance' of economic regulation do suggest more radical change. Of particular note, Monitor's application of competition law to NHS contracts has the potential for far reaching change. In addition, proposals for Foundation Trusts that move from collective

to individual liability for Directors potentially mean Board members are faced with personal liability for decisions made. The role of Governors is also significant here with new duties to hold Non-Executive Directors and Board members individually and collectively to account for performance.

In freeing providers, we find first order change in the proposals that all NHS Trusts will become Foundation Trusts within three years. These proposals are largely consistent with the previous policy, where NHS Trusts were expected to have a clear 'trajectory' to become Foundation Trusts by the end of 2013/14 (DH, 2010h). Alongside this first order change, we do find second order policy change in the reform proposals calling for acceleration towards employee owned models of organisation. Although the interest in a social enterprise model builds on previous government ideas promoted in the Darzi Review (DH 2008) and Transforming Community Services (DH, 2009), reform proposals to create 'the largest and most vibrant social enterprise sector in the world' is likely to introduce second and may even bring third order change in bringing new models of organising into health care delivery.

Freeing providers and economic regulation: what's the evidence?

- Quantitative research on competition in the NHS found that quality improved quicker in hospitals where there were more hospitals competing than elsewhere (Cooper et al, 2010; Gaynor et al, 2010; Bloom et al, 2010). Although the association between competition and quality (usually measured by a measure of mortality) was statistically significant, the magnitude of the effect was 'relatively modest' (Gaynor et al, 2010: 23).
- Earlier research on the health care market in the early 1990s, where Health Authorities and GP Fundholders made market decisions, and price was determined locally, suggested that flexible prices caused quality to reduce (Propper et al, 2008).
- Although there has been significant recent attention to the benefits of collaboration, evidence of competition between providers of community based services is not clear. Ham and Smith, (2010) reporting on case studies of integrated care organisations identified that policy on choice and competition was a key barrier to integration. They conclude that policy-makers should explicitly recognise the need for competition in some areas and for collaboration in other areas and should develop competition rules to reflect this need (Ham and Smith, 2010:14).
- There is some evidence that there may be benefits in terms of productivity and quality for NHS organisations adopting some elements of 'mutual' organisation (Ellins and Ham, 2009). Community services may draw on this form of organisation within a market, either as social enterprises, or as Foundation Trusts, but it is not clear that a competitive environment is necessary to support this form of organisation. A recent review of third sector organisations as providers of funded health and social care concluded that the literature does not support the policy of a larger role for the third sector in healthcare, let alone a switch to a market-based system (Heins et al, 2010).

5. Cutting bureaucracy and improving efficiency: the government view

The *Liberating the NHS* reform programme suggests that the result of implementing its proposals will cut waste and transform productivity. The combined savings of reform will amount to a major delayering as the NHS can no longer 'afford to support the costs of the existing bureaucracy'. The notable highlight of these proposals will be the reduction of management costs by 45% over 4 years. Despite the significant disruption, loss of jobs and transitional costs this will cause, *Liberating the NHS* suggests it is a 'moral obligation' to release as much money to support front line care. Proposed reform to increase productivity and efficiency is necessary (DH, 2010a: 45).

Cutting bureaucracy and improving efficiency: analysing 'orders of change'

The proposals to cut bureaucracy and improve efficiency are likely to be highly significant. Although similar to *'From Good to Great'* (DH 2009) which set out a five year plan of £15-20 billion efficiency savings, the introduction of 45% management cuts over four years is likely to result in a number of significant changes to NHS systems and processes. On this basis, the pressing need to make efficiency and productivity changes may lead to third order change as new ideas and standards are required to resolve pressing problems. As yet it is unclear how the efficiency and productivity drive will work out. The reform proposals may achieve third order change, however there may be a number of barriers and tensions to achieving this type of change. One such tension to third order change can be found in the commitment of *Liberating the NHS* in pursuing an 'any willing provider' policy. Dixon (2010) suggests the 'any willing provider' policy has the capacity to reduce the ability of purchasers to use contracts that limit the volume of services, negotiate favourable deals and establish integrated pathways for more effective management of patients (Dixon 2010: 3). A lack of system information and demand management skills may also inhibit the ability to improve productivity and efficiency (Smith et al, 2004).

Cutting bureaucracy and improving efficiency: what's the evidence?

- In recent research on the combined impact of health reform, Powell et al (2010) found that the economic downturn had brought a change in mindset towards cost improvements, productivity and efficiency. Systems were in agreement that the economic situation required collective action between acute sector, PCT services and clinical groups. However the situation also created local dilemmas about how to improve systems with less money whilst improving quality of service.

- The National Audit Office report *Reorganising Central Government* (NAO 2010) examined over 90 reorganisations of central government departments and their arm's length bodies which occurred between May 2005 and June 2009. They identified key issues that included the lack of business cases or budgets for reorganisations, weak identification of the benefits of reorganisation and poor project management. The report's key recommendations included specific identification and presentation of the costs of significant reorganisations, and separate management and reporting of such costs within departments' financial accounting systems.

Discussion

Our analysis of the proposals contained in the *Liberating the NHS* reform programme suggest significant change and continuity with previous policy agendas. By using an 'orders of change' approach (Hall, 1993) we find that the reforms contain a variety of first, second and third order change (see Table 2). Evidence of first order change can be found in the incremental adjustments to previous policies such as Choose and Book, personal health budgets and proposals for the creation of quality incentives. Alongside this first order change suggesting a large degree of continuity with previous arrangements, the reform programme also contains second order changes in creating a new strategic direction. The most controversial of these new policy instruments can be found in proposals to introduce a GP led consortia approach to commissioning. These, along with the national Commissioning Board present a significant change in strategy to achieving the goals of commissioning.

On the evidence presented here, *Liberating the NHS* appears build on a combination of new policy instruments and incremental changes to previous policy ideas and approaches. In this sense, our findings support those who suggest that the proposed reforms are evolutionary rather than revolutionary. They can be seen as an extension of New Labour reforms and the internal market reforms put forward by the previous Conservative government (Le Grand 2011; BBC 2011). Despite this, our analysis does find some possible evidence of third order radical change. The reform proposals to free providers and accelerate the introduction of new models of organisation has the potential for third order change. The proposed changes to the governance of Foundation Trusts also suggest more radical change. Furthermore, the proposal to implement 45% management cuts also has the potential for third order change as it suggests that new ideas and standards are required that 'delay' the NHS in order to stimulate innovation and responsiveness in service delivery.

Table 2. Analysing Liberating the NHS as orders of change

	'First order' change	'Second order' change	'Third order' change
Putting patients and the public first	Incremental reform of patient choice policies (choose and book, personal health budgets)	New policy instruments in relation to patient information systems and information standards	
Improving quality and healthcare outcomes	Incremental reform of quality incentives	New policy instruments emphasise outcomes but process indicators and targets continue	
Increasing accountability and democratic legitimacy	Incremental adjustment to existing strategic partnerships (Health and Well Being Board) and existing patient and public involvement policies (HealthWatch)	New policy instruments with a commissioning consortia model and NHS commissioning board Transfer of public health functions to Local Authority suggests a strategic shift	
Freeing providers and economic regulation		New policy instruments in relation to Monitor gaining new economic and 'licensing' powers. FTs also given new powers to create new organisational forms	Opening up of provider market/acceleration of new models of organisation Changes to the 'governance' of economic regulation
Cutting bureaucracy and improving efficiency			A new framework of ideas and standards required in the context of 45% management cuts

Employing an ‘orders of change’ approach allows us to illuminate the variation in the proposed reforms - from incremental to substantial change. Despite the apparent strengths of the framework in illuminating change and continuity, we are aware that taking such a perspective does have its limitations. Our analysis of the proposals contained in *Liberating the NHS* suggest a combination of first and second order change, however a weakness of the approach is in the way it reduces the effects of change into three subtypes. This may detract from the bigger picture in relation to the combined impact of the reform proposals. For example, a weakness of the Hall perspective is its apparent silence in relation to a view of third order paradigm change built on a series of rapid incremental changes. On the face of it, our analysis suggests there appears to be little third order change associated with the reforms; however the combined effects of these ideas and the pace with which they are implemented may increase the chances of third order change. As the policy develops and emerges during implementation, the *Liberating the NHS* agenda has the potential to introduce radical change as its ideas, standards and frameworks become articulated and understood at the local level.

Implementing Liberating the NHS: implications for policy and practice

Liberating the NHS proposes a policy programme built on a series of ‘interconnected and mutually reinforcing’ reforms aiming to improve the use of available resources and create freedoms and incentives for staff and organisations (DH, 2010a: 2, 9). We wait to see what the final results will be in relation to the possible changes and refinements to these proposals as they go through the legislative process. However, our experience of research and practice suggests that the extent to which the reform programme achieves these policy goals will depend on its implementation. When we look at the research evidence generated about the implementation of reform under New Labour, this suggests that rather than being implemented as a coherent policy framework, implementation was complex and contingent on a range of factors. Despite some evidence of an overall positive effect associated with these reforms, implementation created an imbalance of incentives across demand and supply. The resulting imbalance meant that some local health systems struggled to engage and break historical patterns and pathways (Brereton and Vasoodaven, 2010; House of Commons Health Committee, 2008; Powell et al, 2010).

The implementation of *Liberating the NHS* is likely to come up against similar internal and external dynamics that will affect and challenge its mutually reinforcing nature. Of particular note, local economic constraints and the potential turmoil brought about by local organisational restructuring will potentially limit the interconnected nature of the reform programme (Walshe 2010; Edwards 2010). Such contextual circumstances are likely to create uncertainty and resistance in some parts of the service. When we analyse some of the published responses to the reform proposals they do provide a number of concerns. Of particular note, the BMA recently voted against the reforms based on the view that the proposals represented ‘unmandated’, ‘damaging’ and ‘unjustified’ top down reorganisation of the NHS (Guardian, 2011). Such views have been echoed by other trade union and professional group representatives. Wider concerns

have been raised about the pace and scale of the proposed changes with the King's Fund in particular suggesting some of the reforms go 'too far too fast' (Iacobucci, 2010). Uncertainty remains about achieving the 'balance' between service reconfiguration on the one hand and system efficiency and stability on the other (Foundation Trust Network, 2010). Furthermore, issues related to the governance and accountability of the proposals still need further clarification (Local Government Group, 2010; Faculty of Public Health, 2010).

The Health Services Management Centre (HSMC) has extensive experience of research, policy and practice in relation to the key proposals outlined in *Liberating the NHS*. A notable highlight is its current work on commissioning. Here, HSMC is currently engaged in a number of innovative projects and exercises that will work with and support practitioners in light of the commissioning reform proposals contained in *Liberating the NHS*. As well as this current work, it will also draw on its extensive experience of research and practice in relation to, priority setting and strategic commissioning in the context of local health systems.

Connected to commissioning and the wider challenges and opportunities brought about by *Liberating the NHS*, HSMC's experience of leadership and organisational development will also be crucial. Important areas for future development will be building and nurturing clinical leadership, particularly in the context of primary care. Other areas will include the need to continue to work with practitioners on how to develop solutions in the context of the productivity and efficiency challenge. The expressed interest in freeing providers and generating new models of organisation will also tie in with existing HSMC work exploring the role of social enterprise and the wider third sector in the delivery of health and social care services.

Forthcoming policy papers will carry out further in depth analysis of the practical implications of *Liberating the NHS*. These will reflect on the delivery of these objectives and how HSMC can support and enable practitioners to realise these goals.

Liberating the NHS: implications for policy and practice

- *Liberating the NHS* will herald in new organisations, localities and geographical boundaries. In this context, it will be essential for all NHS staff to proactively develop and nurture new relationships between primary, community and secondary care and between Local Government and the NHS.
- The context of organisational change, transition and uncertainty brought about by *Liberating the NHS* means the role and importance of leadership cannot be overstated. Leadership in such contexts is likely to mean engaging with resistance and steering organisations in coming to terms with the new environment. It is likely to be made more challenging by the discontinuity of leadership positions at PCT and SHA levels. With the potential vacuum created it will mean clinical leadership becomes increasingly important and will also mean that greater emphasis might be needed on distributed forms of leadership. Local leadership in building team work, collaboration and communication will become increasingly important in the contexts and scenarios likely to be brought about by *Liberating the NHS*.

- Loss of jobs and organisational restructuring may create conditions for organisation memory loss. Ensuring the prevention of organisational memory loss is not easy but in such contexts it is crucial that information and knowledge is appropriately managed and diffused across organisational settings.
- Research evidence suggests that local service improvement efforts are put back by re-organisations. Because of this it will be important for the newly established commissioner and provider services to be given time to make sense of the new landscape and to formulate and deliver services. Time and patience will also be needed to develop the necessary system relationships for the proposed improvements to happen.
- The importance of evaluation and feedback about the impact of the proposed changes will be crucial. Future research and dissemination of best practice will be of increasing importance if the NHS is to reap the benefits of the proposed reform. It will require all researchers and practitioners to look at ways of sharing knowledge and information about how the reforms have impacted. Research about the impact of *Liberating the NHS* will be particularly important in relation to the newly established commissioning consortia. Feedback to policy and practice about these new commissioning arrangements will be essential.

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