The jigsaw of public service reform
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Reform’s ten years of campaigning have coincided with ten years of sustained attempts by government to reform public services; from Tony Blair’s “Principles of Public Service Reform” – standards, devolution, workforce reform and consumer choice, to David Cameron’s “Big Society”. Yet, despite the effort, the political capital and Reform’s contribution, public services remain largely unreformed – consider how many people still see the NHS as a monopoly provider with much of the public committed to the defence of real-estate and buildings rather than the quality of services provided. Indeed, in most parts of the country, parents have a “choice” between their nearest school and the private sector; and local authorities are often still elected on the basis of national party popularity, rather than the quality of local services delivered by the incumbents in office.

There are lessons to be learned for the reform of all public services by looking at the attempts to reform the NHS over the past ten years. Many commentators believe that reform has foundered on three things:

- A compelling reason to persuade the public and staff, who are overwhelmingly committed to the founding vision of the NHS, of the need for radical change.
- A coherent set of reforms that can be seen to match the future model proposed.
- A capable implementation approach.

Politicians and NHS leaders have struggled to make the case for change because the NHS’s successes and failures are not clearly understood by the public. The public has not had the widespread variations in the quality of care between the best and worst NHS services explained to it, and therefore believe most services to be of an equal standard. When news of failures does get out, the tragic stories that appear in the media are viewed as aberrations and local management failures, rather than systemic problems requiring radical change. Consequently, politicians who want to sell change find themselves having to describe improvement to an already “great” service. This is bound to lead to suspicion amongst the public and ultimate disappointment.

I liken the last ten years of attempted reform to a jigsaw puzzle where the picture on the box resembles a Rorschach ink blot, where everyone sees a different image. Reform pieces are often provided a handful at a time to make part of the picture without being sure that the different pieces can be made to fit together; and the people building the puzzle have different ideas about how the pieces are supposed to fit together, disagree about what the picture is, and don’t have all the pieces! As a result, there has never been a clear, consistent and publicly compelling story.

The boldest and most comprehensive reforms were those created by Health Secretary, Alan Milburn, and his principal advisor, Simon Stevens. The Milburn reforms provided a set of jigsaw pieces for provision (Foundation Trust freedoms, payment by results, independent sector treatment centres), a second set for quality (National Service Frameworks, NICE and the Commission for Health Improvement (CHI)), and a third set for rapid improvement (targets and performance monitoring); and they also provided far more money.

The Prime Minister, Tony Blair, believed he was creating a self-sustaining NHS that was structured to drive quality and productivity with autonomy and accountability, whilst the financial flows would reward successful institutions and poor providers would fail and be replaced by new entrants.

Unfortunately, that’s not what happened. Some say the NHS and Department of Health didn’t see the same picture. In the end, the pieces were put together to create a system that dramatically reduced waiting lists, but increased activity and used the new money provided to grow bigger, newer hospitals, but based on the old model. Competition was not used as a mechanism for driving quality and productivity, but a tactical mechanism to increase capacity. Furthermore, targets, whilst proving highly effective at driving specific outcomes, became a mechanism for top-down dominance, allowing Whitehall to reach into local institutions, rather than a framework within which to devolve authority. In addition, NICE and CHI mutated into publishers of advice rather than drivers of change, albeit it is important to acknowledge CHI’s ground-breaking Star Ratings, NICE’s world leading medicines evaluation and the quality transformations brought about by the NSFs in areas like cancer. Finally, payment by results has barely evolved from its original prototype, market entry and exit have never been solved, the blunt instrument of Star Ratings has not turned into the surgical knife of transparency and NICE’s dominance of the drug arena has yet to become a broader engine to drive evidence-based medicine.

When John Reid became Secretary of State for Health, he inherited a set of workforce reform pieces from Milburn that were intended to create an NHS pay structure that challenged old working practices, and created the tools for managers to redesign NHS services. These pieces were hard to fit into place, so he reshaped them as “pay rises for hard working NHS staff”. Success in implementing the pay reforms was too often measured as being the speed at which the pieces...
could be put together, rather than whether the picture made any sense!

When Patricia Hewitt took over from Reid, her first question was: “Where’s the box lid with the picture on it?” After a couple of months, she created her own picture of what the reforms were designed to achieve, drew a narrative of how the pieces were supposed to fit together and gave instructions to complete the policy work required to make the picture coherent. However, just as work was starting, she discovered that whilst, on the whole, the NHS and the public recognised the need for the new picture, many of them did not accept the shape of the pieces that were intended to make it up.

With the change of Government in 2010, Andrew Lansley started on reform again and had a similar diagnosis to Hewitt – no picture, not enough pieces, and more focus on delivering change, albeit he had a variant of the picture and created differently shaped policy pieces to those of Hewitt. He has also faced the recurring problem of creating a public desire for change.

Despite many attempts by both the major political parties over decades, many of the public still don’t see the need for change within the NHS. If pushed, opinion polls point to a public thinking that the answer to NHS improvement relies upon better management delivered by fewer managers – a problem exacerbated by every Opposition when they attack management costs and fight the closure of poorly performing hospitals.

If the NHS is going to be truly reformed into a productive, self-improving institution that can give the nation another 60 years of affordable comprehensive health service, government needs to create a strategy that addresses the three key parts of the puzzle:

- The picture needs to reflect reality, which means telling the public the truth about where the NHS does well and where it does badly. Transparency over the performance of public services and public servants is the key to changing the public from defenders of the status quo to campaigners clamouring for improvement.

- The reform pieces need to be simple enough to put together; be cut in a way that allows them to be used without blocking each other; and, when all are used, produces the intended picture. Single issue campaigners for reform do the NHS little favours, and statements along the lines of “it’s all about competition”, “it’s all about integration”, “it’s all about better commissioning” or “it’s all about fewer hospitals” miss the point – the NHS, like all public services, is a highly complex ecosystem of shared values, embedded culture and market behaviours; if we dumb the question down to something that’s simple enough to solve with a catch phrase we do it an injustice.

- Finally, implementation needs to be driven by the service with structures and incentives designed to “make doing the right thing the right thing to do”. A set of reforms that lead back to the centre and that are so complex that only a very few will understand them will never create a self-improving NHS.

The challenge for present and future NHS leaders who care enough about the NHS to want it to change is to align these three elements to create a visionary picture of a future NHS that is understood and believed in, and made up of a set of reform pieces that both protect the core values and create the conditions for radical change where this is needed, so that the patients and the NHS can create a 21st-century health service that learns from the past but isn’t bound by it.