Instead of more inspections and regulation, the NHS needs to adopt a ‘bottom-up’ improvement model

blogs.lse.ac.uk/politicsandpolicy/support-for-healthcare-improvement-the-missing-piece-in-the-partnership-working-jigsaw/

7/13/2015

*The evidence base for improving public health services by top-down regulation is thin. An alternative approach is the ‘bottom-up’ rather than the ‘top-down’ perspective. But what are the ingredients of a bottom-up service improvement model? In this article, **Bob Hudson** suggests three essential components: people, context and complexity.*

With the new UK Government seemingly wedded to enduring reductions in public expenditure, there is now a clearer focus on getting the best value for money out of every ‘public pound’ spent on healthcare – securing both efficiency and improvement. The key to doing so is said to be collaboration across organisational and professional boundaries, but what is less clear is how to achieve this. The superficially attractive approach is regulation – governments issue top-down edicts to service delivery bodies informing them what is expected and how it will be measured.

Tighter regulation and inspection is the dominant improvement paradigm in the NHS. The Chief Executive of NHS England has, for example, recently announced the introduction of ‘success regimes’ for ‘failing’ localities. A briefing paper from NHS England describes the targeted localities as having ‘deep-rooted and long-standing’ difficulties that are in need of ‘transformation’. The ‘health and care economies’ of these places will find themselves ‘overseen’ by a bevy of regulators – NHS England, Monitor and the NHS Trust Development Authority plus others when deemed appropriate. The new model does also offer ‘support’ but this is ‘offered’ in traditional top-down NHS style . The threat of punishment simmers away beneath the pleasantries – for example, localities will be placed under the control of an appointed ‘Programme Director’ and will be held to account for meeting ‘a clear and agreed timeline’.

The evidence base for improving public services by top-down regulation is thin. The alternative policy implementation paradigm is the ‘bottom-up’ rather than the ‘top-down’ perspective but what are the ingredients of a bottom-up service improvement model? The academic literature suggests three essential components: people; context; and complexity.

People

A defining characteristic of the literature on collaboration is that it favours an organisational and institutional focus at the expense of ‘micro-level’ examination. Hence much attention is given to issues such as legislation, governance and budgets and much less to the role and behaviour of individuals who operate across professional and organisational boundaries and seek to coordinate the different domains – in other words, ‘boundary spanners’.

Typically this concept is used to refer to practitioners, managers and leaders who undertake boundary-spanning activities as part of their ‘day job’ within service delivery organisations. However there is a second – much smaller – category of boundary spanners consisting of those who have a dedicated responsibility to work in multi-organisational and multi-sectoral settings and whose task is to create and sustain a range of complex connections.

Acceptance of the role and contribution of boundary spanners will largely depend on their ability to establish a personal reputation and ‘soft’ skills – knowing when to engage in bargaining, persuasive or confrontational models; knowing how to move between different levels of strategic and tactical exploration; and displaying sophisticated appreciation of the loci of power. This involves working in groups, building social capital and joint problem-solving around a whole range of personal, professional and organisational concerns. Some of this will be done in public forums but much will be done in private; some will be undertaken in groups but much might be undertaken in one-to-one sessions. None of it is easily susceptible to observation and measurement, and this makes assessing their

'impact' methodologically treacherous.

The crucial implication of this is the need for the boundary spanner to be perceived as a 'critical friend' rather than a regulator or external scrutineer – someone who will help rather than simply judge, demand improvement and withdraw. Finding this combination of experience and skill in one person will be challenging and in any case not all organisational forms could tolerate the high degree of flexibility, autonomy and sheer unconventionality that characterise successful boundary-spanning activity. There are also questions about ensuring a supply of effective boundary spanners – too much reliance on an existing cadre without a strategy on succession planning could leave the model dangerously exposed. None of these issues appear to have been seriously explored in relation to the NHS.

Context

In everyday talk it is often said that things should not be 'taken out of context'. This similarly applies to service improvement activity since there is now a growing body of evidence that an intervention that is successful in one location does not deliver the same results elsewhere. This is in direct contrast to the strictures of the top-down model where all localities tend to be directed to a handful of ' exemplars' and instructed to 'do it like them'. The implication here is that service improvement cannot be effective without local presence. Geographically remote support – typically at national level – in the form of guidance, toolkits and information-giving events can only be expected to deliver marginal results.

The importance of an improvement support presence in a local context is about more than accessibility however; it is also about accessing and understanding local 'narratives'. This is not about purely personal phenomena. Such processes also operate at a collective level when individuals confronted with organisational change attempt to knit together personal and organisational actions into a consistent sequence of events – a 'narrative direction'. Accessing 'the story' is the key to understanding how individuals and groups make sense of policy implementation imperatives and it is the task of those working in service improvement contexts to access and understand the stories of individuals and groups as a prelude to improvement. The *quid pro quo* for access to narrative revelation is that it is kept 'indoors' – it would be considered a betrayal of confidence to report on the detail of the 'stories' to external regulators.

Complexity

Traditional analyses have concentrated on separating out individual parts of the system and seeking to improve them, often without reference to one another – a linear one-way process in which knowledge, guidance, toolkits and so forth are disseminated to end users and are then in turn smoothly incorporated into local policy and practice. There is only limited evidence that models such as Total Quality Management, Continuous Quality Improvement, Business Process Reengineering and others are effective. The new policy imperative around 'whole system working' requires a focus on the relationships between the various parts of the environment to ensure that 'the system' is more than the sum of the parts. In this social world, causation is complex, outcomes are determined by multiple causes and these usually interact in a non-additive fashion.

Dealing with this sort of complexity requires a completely different approach to service improvement, one that draws upon all three of the components identified in this analysis. Indeed the key overarching message is the inter-dependency between the three components of people, context and complexity. The absence of any one of these components would undermine – even destroy – the model:

- If the 'people' component was not present, the context would not be fully understood and the complexity could go unchallenged
- If the 'context' component was not present the people would have limited access to local narratives and the complexity could go unchallenged

- If the ‘complexity’ was not appreciated the contextual narratives would be attenuated and the people skills would not be effectively utilised.

It might appear trite to conclude that what is required is the right people working in *local contexts* who can make *complex interventions* work, but this is indeed the task.

Bizarrely, the NHS in England does not possess a cadre of skilled, locally based improvement support specialists. Two of the bodies that might have developed into such a role – the Care Services Improvement Partnership and the Integrated Care Network – were summarily killed off in the Coalition’s 2010 ‘quango cull’. Those left – NHS Improving Quality, the NHS Leadership Academy, clinical senates, clinical networks and academic health science networks – tend to have a narrow, even clinical, NHS focus, and are themselves about to be ‘rationalised’. The one beacon of good practice to be found elsewhere in the UK is in Scotland with the Joint Improvement Team.

NHS commissioners and providers in England are facing huge challenges – a financial deficit without precedent, rising demand from a demographic time bomb and a simultaneous requirement to radically ‘transform’ the nature of service delivery in line with the recent Five Year Forward View. Rather than pouring ever more effort and expenditure into inspection and regulation, the Department of Health and NHS England could reap a much bigger dividend from investing in a robust national service improvement agency.

About the Author

Bob Hudson is Visiting Professor in Public Policy at the University of Durham.