5 People-centred services

In our initial assignments with public services, we helped leaders transform individual service streams – council tax, benefits, homelessness, housing, social care, among others. Working also with police and fire and rescue teams, we began to realise that many of the people presenting to them were already known to the authorities through transactions with other services. In other words, a disproportionate volume of services was being consumed by the same relatively small group of people, whose lives for one reason or another had gone off track. From this realisation grew the idea of designing services that were what we thought of as "citizen-shaped". As this work developed, we came to label them "people-centred services".

People's lives fall off the rails in a variety of ways. The public services provided to respond to their needs are wide-ranging, potentially involving one or more of police, fire and rescue, health, mental health, care and voluntary services, attending to needs of many types. Sitting atop their inherent expertise-based organisations, and beginning in Margaret Thatcher's reign as Prime Minister, successive governments imposed command-and-control management practices in the name of "New Public Management". These had the aim of increasing efficiency and lowering costs. Instead, as illustrated in previous examples, the interventions caused massive unintended consequences through the imposition of dysfunctional means of control. *

In the face of abundant and continuing evidence of failing services and rising costs, successive governments have demonstrated the strength of their unswerving faith in command-and-control ideas by demanding that providers do more of the same, only faster and better. As Russ Ackoff taught us, like all attempts to do "the wrong thing righter", this only makes them wronger. As we have seen, conventional controls provide no indication of, or even window on,

* Seddon, J., (2014). *The Whitehall Effect*. Axminster: Triarchy Press.

the way the controls themselves sub-optimise performance. Instead politicians, who believe things are as tight as a drum, are beguiled by the way, over time, services become reported as "on target", whereas the time taken to get "on target" is actually a reflection of the time it took public-sector managers' ingenuity to work out how to at least appear to be on target by gaming the system. *

Take targets for carrying out assessments in care services, for example. An assessment takes place every time a patient or client is referred to a different service or department, which can be multiple times for reasons we explain shortly. In these circumstances, meeting targets for assessments simply covers up the terrible truth: the extraordinary time it actually takes for people to get through the red tape, the mind-boggling number of people involved, the forms, assessments, administration, reminders, means testing and, most insulting of all, the "friends and family test" – would you recommend this service to your friends and family? – do nothing to turn around the life of a person in need. But it is the stuff of the command-and-control regime, which blinds it to the dysfunction it causes.

When leaders study their service through the eyes of the customer or citizen, this is what they find. If your life comes apart and you approach your local authority for help, you may be seen by a dozen or more people, each of them dutifully meeting their activity targets for conducting assessments, considering your needs through their own specialist lens, being encouraged to refer you elsewhere so they can class your case as "closed", protecting their stretched budgets by imposing "thresholds" to weed out those judged insufficiently needy, and each asking questions you have already answered several times already. If after all that you do qualify for a service, it is likely to be an offering that doesn't meet your needs. Many services are commissioned, the idea being that putting the service out to the market will drive down costs. For suppliers to quote a price

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* Seddon, J., (2008). See Chapter 8: 'Deliverology': *Systems Thinking in the Public Sector*. Axminster: Triarchy Press

in their tender, a specification is required, so the service is usually standardised. But standardised services inevitably fail to match the variety of people's needs, providing some things that don't help and others that go further than necessary, both of which having to be paid for even if they are not value work. If, having been provided with help that didn't, you take your problem back again (failure demand) you will be subjected to the same labyrinthine treatment. Any semblance of a relationship having evaporated, you will likely be treated as a new case and quite frequently offered the same service that failed to help the first time. If you have the temerity to turn it down, you risk being labelled difficult or recalcitrant.

(To return for a moment to our discussion on the nature of this change, many leaders of public services might read the paragraph above and be outraged. Our plea to them is go study.)

The backbone of the control system is the management of activity and cost, which is what the bureaucracy demands must be measured and accounted. When people come back, as they do, to get their unsolved problem fixed, it is not recognised as failure demand; it is counted as new activity to be processed though the same insensitive machine. Even while the system can show it meets its targets, its purpose of putting a life back on track is lost and undermined. While it proudly reports meeting its budget, it wastes enormous sums of public money. While commissioners can show control of commissioned services by pointing to suppliers' adherence to Key Performance Indicators, having lost sight of their purpose they have no idea of the real effectiveness of the services they pay for.

The first clue, as ever, is the volume of failure demand entering the system. But, as you will now be aware, the only way to eradicate it is to alter the system to prevent it occurring in the first place. The best case for changing the system comes from studying people-centred services – not least because of all the services described in this book, people-centred services turn out to be the easiest to study.

Paradoxically, it is the bureaucracy developed over recent years

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that is to thank for that, in the shape of the records it maintains of transactions between public services and the public they serve. We have helped leaders study many cases, and virtually all of them display the same features: inordinate numbers of assessments, referrals, rationing/refusal of support by threshold, and, after all that – or more accurately, because of all that – a stunning failure to meet the purpose of helping people to get themselves back on track. Study graphically shows how most services fail to meet their first and most important test – responding effectively to the variety of customer demands. When extensive maps of transactions are posted around a room and one asks the question, "At what point did we understand this person, what happened to them, what context it occurred in and what mattered to them?", the answer most often is never.

> *Paul's life fell off the rails. Over a period of 10 months, he was the subject of 179 activity records by public servants, involving 91 staff from 20 different teams. He experienced 12 assessments and 11 referrals, leading to six hospital admissions with total stays of 81 days, while staff generated seven support plans. At no point did anyone spend time with Paul to understand what mattered and what "success" might mean to him.*

Bureaucracy imposes unnecessary cost. Yet this pales into insignificance compared with the costs of providing services that are ineffective. The political narrative is driven by the unquestioned assumption that demand is rising and someone has to pay – this is the whole basis for austerity, for example. Yet the evidence suggests that demand – at least the original "my-life-has-fallen-off-the-rails" demand – is stable. It is failure demand that is growing inexorably. The truer narrative is that services are ineffective and thus waste massive amounts of public funds. But failure demand can be eliminated. Doing so increases capacity as it strips out fake demand and unnecessary cost. Effective service costs less.

Budget management is at the heart of the current dysfunction. It

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forces service provision to be constrained by allocating monies to specified services. Domiciliary Care, Day Services, Respite Care, Residential, Nursing, Learning Disability, Children's Mental Health, Adult Mental Health, Sheltered Housing, Physical Disability, Carer Services, Drug Therapies, Obesity Services, Smoking Cessation, Sexual Health and so on – the labels vary around the country – each has its own individual "pot" of money and accompanying budget, against which the management bureaucracy will be held to account. In effect, budget management determines the offerings that each service can and cannot provide.

Budget management is exercised through commissioning, with sometimes dysfunctional results as budgets for some services are spread over a number of commissioners. This is the case, for example, with the budgets for sexual and reproductive health.

> *A coil (long-acting reversible contraceptive device) can be fitted by a GP, but he or she must identify whether the fit is to stop bleeding or to prevent pregnancy in order to decide who to invoice for the fit. The answer is invariably that it is for both, and the commissioner who pays the most receives the bill.*
>
> *A person suffering from a genital dermatology problem who first presents at a sexual health clinic, unaware their condition is not sexually transmitted, may be turned away or referred on to dermatology services, despite the fact that the sexual health clinic has the expertise to manage the condition.*

In sum, what drives behaviour are rules on commissioning, not patient demand.

The problem – as by now you will probably have figured out – is that the "pots" don't fit people. They are a constraint on the delivery of services; budget management and the way it is allocated to commissioning responsibilities enshrines the fragmentation of services, ensuring that decisions about provision are budget-based

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(what we can spend money on) not person-based (what someone needs). Many people who are judged as having "insufficient needs" will be left for the condition to get worse, ensuring greater consumption of resources later. Others will "over-consume" resources, unnecessarily spent because they fail to help. Managing costs *causes* costs.

Meanwhile, assessment of management's performance will be based on achievement of activity and cost (numbers of citizens seen, assessed and/or closed, and provided with services, and costs compared to the budget) rather than how well the services worked for recipients. These two primary system conditions, activity management and budget management, are the control mechanisms that have the reverse effect, driving the system out of control.

To address the purported crisis in health and care services, government has adopted two general strategies: commissioning – as mentioned earlier, using the market to drive costs down – and "strategic reviews", a euphemism for cutting services back.

Commissioning services

Government guidance advises commissioners to adopt a "commissioning cycle" in which it will "identify the benefit, decide how to achieve it, commission services and monitor them". This sounds reasonable on the surface, but does it constitute a sound method? How do commissioners identify the benefit? What commissioners don't do is study demand in the way we describe it here. They often tell us their work is solidly based on demand, but on investigation it always turns out that they mean *historical provision* (for example, the number of drug-treatment programmes provided last year), assuming, wrongly, that that tells us something about demand. Commissioners have no knowledge of the effectiveness of their service, and how ineffectiveness drives failure demand.

Government insists commissioners should focus on "outcomes". Despite this, the "performance data" (KPIs) are typically the usual

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activity statistics. How many people have been assessed? Were assessments completed in target times? How many services were provided? Was the budget adhered to? By this sleight of hand "outcomes" come to be represented by the output of providers, not results experienced by those receiving the services.

Commissioners see their challenge as purchasing services while staying in budget. This means that price frequently becomes a determining factor in the choice of provider. In practice, the focus on price has two perverse consequences: mass-produced, standardised services that fail to meet the variety of needs, which also rules out a "thermostatic" approach (so you get 30 minutes regardless of whether 10 or 40 might have been better); and unnecessary volumes of activity (since that is how providers are paid).

Another factor reinforcing the status quo is that in a previous life many commissioners were local-authority leaders who ran the services they are now buying, in traditional command-and-control manner. Some authorities have seized on the opportunity to outsource all their services, retaining only the managers who used to run them in the role of commissioners. The results are as we might expect. Brought up, as they have been, on the principles of New Public Management, such commissioners have no new ideas to bring to the design of services or the activity and service-level measures that they judge suppliers by.

Meanwhile, the commissioner / provider split might have been designed to make any collaborative focus on effective design near impossible. Providers are obliged to comply with the performance measures commissioners specify, and use that ("we give you the performance data you ask for") as a defence against commissioners taking a closer look at real outcomes for the customer. At worst, the focus on price and meeting the budget gives both commissioners and providers a shared incentive to cast a discreet veil over what is actually happening to people who need help. Moreover, in many areas providers are large and have no competition, leaving authorities with no choice about whom to commission. This again

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discourages closer cooperation.

Operationally, providers under pressure of rising costs are frequently on the phone to commissioners to ask for greater provision – more time to give to tasks, and/or more tasks to be provided to individuals. Recourse to the "safeguarding team" becomes an option when the gap between what they are commissioned to provide and the needs of vulnerable individuals gets too wide. Managers in provider organisations spend 90% of their time on the bureaucracy of time sheets, expenses claims, checking attendance, tracking down social workers, progress-chasing requests for changes to provision with commissioners, and the like. Fire-fighting to meet KPIs means that stress levels are high and morale low, exacerbated by the knowledge that continuity of support is poor and outcomes for the recipients of service less than satisfactory. Indeed, complaints are frequent.

The fact is that the way services are commissioned makes it almost impossible to do the job properly. The focus on price leads to services being commissioned on a time and task basis – a specified amount of time for a specified service. But commissioning specified services means telling providers what they *won't* be paid for – things like cleaning, taking out the rubbish, shopping, lighting the fire, help with making friends, overcoming loneliness, improving the quality of life – since these are not care needs as defined in the contract. The providers' rotas and specifications drive what care staff are allowed to do, taking away autonomy, judgement and initiative, having an adverse impact on morale. In many cases care staff do do what matters, but "under the radar". Providers feel they put huge effort into providing the service but are dismayed by the feelings of failure and of not being able to truly help.

The dysfunction is evidenced by many absurdities.

> *A man being cared for had grown very long toenails. The care provider had to tell the commissioner (rather than cut the nails). It took three months to arrange a visit by a chiropodist. The one thing you can predict is that toenails*

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will continue to grow, but the commissioning regime makes it impossible to plan ahead. The next time the nails need cutting, the referral process has to start again.

A quadriplegic man was discharged from hospital. He was entitled to adaptations to his home, most of which had been installed. The remaining problem was his use of the kitchen. The local authority offered to either renew the kitchen or help him move house, since it had budgets for these activities. What the man actually needed was a hydraulic lift for his chair. But for that there was no budget.

When the whole system – commissioners and providers – is studied it is clear that all parties share the conviction that demand is rising. They believe demand is greater than the ability to supply. Commissioners are blamed for not providing enough money, commissioners blame government for not providing enough money. All parties assume that the only thing worth discussing is who will have to pay.

Meanwhile providers are also often perversely incentivised to do the wrong thing. For example, a GP practice manager, when asked to take part in the National Diabetes Prevention programme aimed at reducing the prevalence of diabetes amongst their at-risk patients, refused to refer patients to the programme because the practice would receive less money for prevention than for treating a patient who had developed the condition. We have seen the same in hospitals, with patients being prioritised for treatment according to the monies their condition attracts. These are not bad people. These are bad systems.

Strategic reviews

The second means government uses to tackle the "care crisis" is "strategic review", aka cost-cutting. The (false) starting assumption here is that resources are already stretched as tight as possible. The big budget numbers comprising staff and service provision

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costs, the response to what's described as the "austerity agenda" is either to restrict access to services, or reduce services, or both. Thresholds for service are increased, recruitment halted, allocation panels delayed or stopped, and some services discontinued. In choosing the latter, government requires health-service leaders to create two lists, one comprising services that could in all likelihood be discontinued without causing a local outcry, the second services whose loss would be more controversial, decisions about which would be made by the government. If ministers had an inkling of how these services use money, understanding the distinction between productive and unproductive use, they would be in a position to make more constructive decisions.

> *A local authority decided to save money by closing day-centres for people with learning disabilities, replacing them with lower-cost services in the community. But the service users hadn't suddenly lost their needs; meeting them in a different way required greater provision of day-services in their homes (paid from a different budget), which turned out to be more expensive than the day-centres.*

When considering budget cuts, local-authority managers start from the view that they are more or less locked in to services already contracted, so opportunities for cuts must be sought in contracts viewed as "discretionary".

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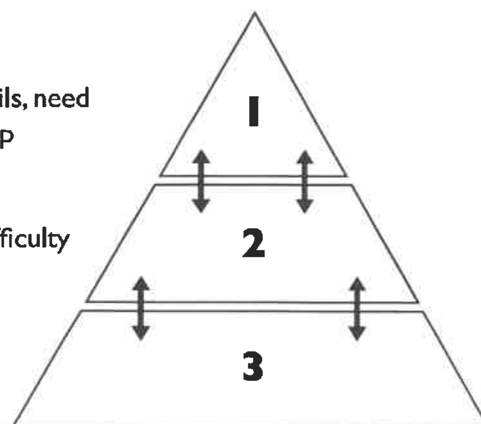
Triangle of needs



Commissioners, particularly those who were previously managers in local authorities, like to talk about people's "triangle of needs" (see figure). Those at the bottom – the vast majority – are assumed to be capable of taking a do-it-yourself approach to care service needs. Those "experiencing difficulty" in the middle tier are acknowledged to be in need of some help but in view of budget constraints are ineligible for commissioned services, which are reserved for those at the top whose lives are in serious disarray.

In practice, what happens is that those in the middle are left to get worse.

We also conceptualise the hierarchy of needs as a triangle, but with a different interpretation of the relationship between the tiers. Living relatively normal lives, most of us at the bottom of the triangle have little need for state support, and when we do seek a service we expect it to work. In the middle, some individuals or families run into difficulties of various kinds – which current commanded-and-controlled service methods are likely to make worse, driving them into the neediest band at the apex of the triangle where they really do require help. Instead, the focus should be on helping them to get back to normal as quickly as possible, as they would want. Greater effectiveness, better outcomes, lower costs.

After commissioning and strategic reviews, as a last resort there is a third and even cruder method managers use to cut costs. This is labelled "managing demand", in essence rationing by another name: limiting services, finding excuses to turn people away and second-guessing professional decisions – reviewing GP referrals to hospital, for instance. For a fuller discussion of the folly of managing demand see chapter 20 of *The Whitehall Effect.** The bottom line: we don't need to "manage" demand, we need to understand it. Understanding demand is management treasure: a lever for improvement that is simply out of reach to command-and-

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* Seddon, J., (2014). *The Whitehall Effect*. Axminster: Triarchy Press, 2014

control management teams: if followed through, it leads logically to what any manager, commissioner or government department would die for, a close fit of provision to need, the frugal use of resources to maximum effect.

People in difficulty want choice, involvement, relationships, consistency and continuity; in general they don't want to go into a home, which is the last (and most expensive) resort. In short, they want these services to respond to what matters to them.

Surprising as it may seem to some, this is perfectly possible – if we go beyond command and control. To design an effective service that meets these predictable, ordinary needs, we return to our three primary controls: the understanding of demand, the value work and achievement of purpose. Recall first that study of the system almost always shows that at no point are those in need asked what they are actually in need of. Because of the system conditions under which they operate, the focus of service providers is what's right for us as opposed to what's right for you. And recall that demand is the greatest lever in transactional services. So understanding demand in citizen terms is crucial to an effective design. The expertise required is, to put it simply, the competence to listen, understand and help the citizen be clear about what matters to them.

In these more effective designs, all demand – people putting their hand up for help – is met by someone going directly out to meet them. No forms, no signposting, no remote contact, no standardised assessment, and no denial of service. The focus of the meeting is to establish what has happened to the citizen, the context – what is going on in his/her life – in the family, the community, or whatever it is that's relevant to the presenting demand. Having understood the need and context, the next step is to help the citizen to establish what, for them, would be a good result. What do you need to live a good life in your terms? Or, it sometimes may be, what do you need to die a good death? The third step is to determine what the citizen can do to take responsibility in achieving that end. Then, and only then, the helper can determine what further support they need

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from family, from community, from the voluntary sector, or from the state, to get there. The provision of specialist expertise is only applied where it is needed and where it is proportionate to actual needs – meeting the recipient's definition of a "better" life.

In a command-and-control perspective, such a simple approach is frighteningly open-ended; where is the control? In real life, what happens is nothing short of amazing. Lives get put back on the rails, often quickly once the real need is identified. The cost of services provided falls dramatically – listening doesn't cost much – and, the greatest prize of all, as individuals and families are straightened out and stop coming to the notice of the police, education authorities or social services, overall demand begins to fall away. Does this sound too good to be true? It is the result of using effective controls; a thorough understanding of demand, a focus on doing only the value work and achievement of purpose in the care recipients' terms.

Julie, head of adult services in a county council, describes the change as moving from asking "What's the matter with you?" to "What matters to you?" Asking the former leads a service down the path of prescribing a set of predetermined service-driven solutions to a problem. The latter leads to a conversation about what a good life looks like to an individual citizen. That conversation may require two hours, two weeks or even two years to answer fully, but the important thing is to get a complete picture of the citizen and his or her requirements in their own context. Asking different questions is just the start; combining the answers with a system redesigned to cope with the inevitable variety of responses leads to a profoundly different set of outcomes. It delivers bespoke, personalised solutions that put back – as far as is possible – independence and resilience into people's lives. Proof of the pudding: the authority has underspent its adult services budget in successive years, and there has been a concomitant drop in demand into the service from 8000 to 3000 cases a year.

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In a municipality in the north of Sweden, care-service leaders wanted to solve the problem of continuity, a critical issue for so many people receiving care. They had already redesigned the services to be "thermostatic", adjusting to the urgency or "temperature" of the presenting conditions on the spot. That made availability less predictable – so how could continuity in the caring relationship be ensured? It appears a difficult problem, but one quickly solved by understanding how to measure and manage variation – as we described with the housing repairs case in the last chapter.

Overcoming the usual stand-off with care providers, a commissioner in Wales launched a joint initiative to study their common system. Faced with clear evidence of its ineffectiveness, the parties developed a commissioning strategy based on analysis of demand in a geographic area that gave discretion to care workers to do what mattered for individuals on a thermostatic basis. Care quality improved and costs fell. Both parties understood the importance of controlling the services by understanding demand and capacity.

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Summary:

People-centred services represent a huge opportunity to go beyond command-and-control to offer a much closer fit between public-service provision and users' real needs, getting both lives and public services back on track

Budget management is the primary cause of sub-optimisation in people-centred services. It drives up ineffectiveness and thus costs.

Demand for people-centred services is stable, failure demand grows like yeast.

Three same primary controls drive up effectiveness and capacity, reduce costs and get more lives back on the rails.

Shouldn't that be the purpose of people-centred services?