

REPORT

MANY TO MANY

HOW THE RELATIONAL STATE WILL
TRANSFORM PUBLIC SERVICES

Rick Muir and
Imogen Parker

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ABOUT IPPR

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The purpose of our work is to assist all those who want to create a society where every citizen lives a decent and fulfilled life, in reciprocal relationships with the people they care about. We believe that a society of this sort cannot be legislated for or guaranteed by the state. And it certainly won't be achieved by markets alone. It requires people to act together and take responsibility for themselves and each other.

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EXECUTIVE SUMMARY

We need to radically reconfigure our public services so they are better able to tackle the complex challenges we face, and meet changing public expectations. Public service reform has relied too heavily on the use of bureaucratic and market-based tools that are ill-equipped to deal with a growing range of complex problems, from chronic disease to long-term unemployment. This report sets out a new agenda for public service reform – one that is better able to deal with this complexity, by devolving power, connecting services and deepening relationships.

In this report we make two arguments for change in the way we run our public services.

First, public services are failing to tackle many of the big social problems we face. Since the 1980s, the ‘new public management’ reforms have sought to improve the efficiency and effectiveness of public services. This has led to much greater performance management from above, and increased competition from outside.

The two predominant methods by which government has sought to run public services – bureaucracy and markets – are both predicated on assumptions of a relatively simple world in which most problems have a small number of causes which interact in a linear fashion. Such problems – how to collect the bins, for example, or reduce hospital waiting times – can be very effectively tackled by top-down plans and simple market incentives.

The difficulty is that public services are increasingly expected to tackle a growing range of ‘complex problems’ – examples of which include antisocial behaviour, chronic ill-health, large numbers of young people not in education employment or training (NEETs), and long-term unemployment. Such problems consume a growing proportion of public expenditure. They have multiple, non-linear and interconnected causes that feed off one another in unpredictable ways, and are precisely the problems that the governments of all the advanced economies struggle to address effectively.

For example, to get a person who has been out of work for many years into sustained employment often means tackling a range of problems that cut across traditional government silos, such as mental health problems, low self-confidence, lack of skills or a history with the criminal justice system. Simply contracting out a silo of provision to a private provider on a ‘payment by results’ basis will not deal effectively with this kind of problem – as has been demonstrated by the dire record of the Work Programme in getting the sick and disabled into work.

To give another example, in the 1950s the NHS predominantly had to deal with acute ailments such as broken limbs or communicable diseases such as measles. These problems can be dealt with effectively by simple medical treatments administered episodically by hospitals or GPs. However, today 70 per cent of all NHS funding is spent on dealing with chronic diseases, such as dementia and heart disease, which require ongoing care. Moreover, a growing number of people suffer from multiple chronic diseases, which require personalised treatment and self-management by patients themselves. Health care has become more complex, and the old models of care in hospitals will not do.

To deal with complex problems we require a more relational state. The 'relational state' is better suited to tackling complexity for two reasons:

1. It creates public service systems that are more interconnected, allowing problems to be addressed holistically.
2. It forges deeper relationships at the frontline, which allows for more intensive and personalised engagement.

Our second argument for change is that, in addition to the greater efficacy of the relational state in tackling complex problems, citizens themselves are demanding more relational forms of provision. As part of our research we spoke to women with recent experience of using maternity, early years and adult care services. We found that these women wanted services to provide deeper relationships, rather than shallow transactions. They wanted more personalised services, which meant greater consistency of personnel, staff with stronger interpersonal skills, and the provision of one-to-one guidance to help them to navigate fragmented systems. They wanted their relationships with services to be empowering, both individually and collectively. They supported having the ability to 'exit' as a last resort when services fail, but they also wanted to see services provided through shared institutions, so that neighbours could develop stronger relationships with each other.

Having first presented the case for the relational state, this report then sets out how we can build a more relational state in practice. There are already hundreds of examples, from around the country and around the world, of services being provided in ways that strengthen relationships. Our task here has been to consider how the lessons offered by these cutting-edge examples at the margins of current provision can be spread across mainstream services.

This can be achieved through two big reform moves which we call 'connect' and 'deepen'.

First, at the system level, the relational state means managing public services as interconnected systems. This, in turn, means taking five big steps:

- A decentralisation of budgets to local authorities and city-regions to unlock innovation, improve responsiveness and break down silos.
- Allowing greater pooling of funding, so that services can take a 'whole person' or 'whole area' view.
- Enabling greater integration of professionals into multi-disciplinary teams.
- Greater frontline autonomy combined with accountability for outcomes achieved, such as through the publication of performance tables that rank providers.
- Expanding new collaborative infrastructures such as school chains, so that providers can share knowledge and learn from innovation.

The relational state means that government is an enabler rather than the manager, steering an interconnected system in which a diverse range of actors and institutions take the lead. It means a smaller Whitehall, and a bigger role for our towns and cities.

Second, at the individual and community level, the relational state means deep relationships instead of shallow transactions. In practice, this means:

- Linking service users with lead professionals with whom they can develop a relationship over time. Successful examples of this approach include the way in which children with emotional disturbances are supported in Milwaukee, and the way successful Youth Offending Teams in England allocate a key worker to each young offender (see case studies 3.6 and 3.1 in section 3.3). This would mean that in social care, for example, every elderly or disabled person is visited by the same care worker in their home, so that they can develop an ongoing relationship over time.
- Allocating professionals to neighbourhood-based patches. If applied to social care, this would mean that a neighbourhood care co-ordinator would be a single point of contact for all those with care needs in a given area. This approach has been shown to deliver better outcomes at lower cost in Western Australia (see case study 3.9).
- Designing institutions that strengthen relationships between citizens and enable them to tackle shared problems together. Successful examples of this include neighbourhood justice panels in Swindon, which bring offenders and victims of low-level offences together to tackle the causes of offending behaviour in order to prevent minor disputes escalating into the costly criminal justice system (see case study 3.10). Another example is provided by Casserole Club, which operates in Barnet, Tower Hamlets and Reigate. It offers an alternative to traditional 'meals on wheels', with a Facebook-style website where residents sign up to cook an extra portion of food and deliver it to an elderly person in the local area who would benefit from it (see case study 3.11).

Of course there are barriers to change: whenever change is meaningful there always are. In particular, the relational state requires a shift in our political culture away from centralism and day-to-day ministerial intervention. It needs to be combined with a sustained push for greater efficiency and lower head-counts on the transactional side. It also requires citizens to come forward and take part.

None of this will be easy – but if we are to provide public services that are fit for the more complex times that we live in, and that meet the expectations of the modern public, then we have little choice. We should remember that the prize from this effort will be great: a renewed role for government, services capable of tackling the great challenges of our age, and more empowered and connected citizens.

INTRODUCTION

Why is government so bad at tackling problems such as obesity, long-term unemployment and antisocial behaviour? Why does nobody know why crime is falling, nor whether it has anything to do with government policy? And why, despite improvements in outcomes – from reduced mortality rates in hospitals to better GCSE results in schools – do the public often remain dissatisfied with the services they receive?

Our answer to these questions is that public services are not equipped for the challenges of a complex world, nor to meet the expectations of the modern public. We want public services to do two things. First, we want them to help tackle the big social problems we face – in other words, we want them to be effective. Second, we want them to provide a high-quality service to their users. This report argues that public services are still failing to do either of these things as well as they should.

Our public services require far-reaching reforms if they are to meet public expectations and successfully address the complex problems of modern society. The two predominant methods by which government has sought to run public services – bureaucracy and markets – no longer offer convincing paths to public service improvement. While these ‘new public management’ methods can be effective at tackling so-called ‘tame problems’, which can be dealt with in ‘silos’ and have a small number of linear causes, they are less effective at tackling complex problems. These problems – which include antisocial behaviour, chronic ill-health, large numbers of young people not in education, employment or training (NEETs), and long-term unemployment – are consuming a growing proportion of public service expenditure, and have multiple, non-linear and interconnected causes that feed off one another in unpredictable ways. They cannot be properly tackled by top-down interventions from government, or by market incentives.

In addition to struggling with complexity, many of our public services are not providing the quality of experience their users want. In our previous report, *The relational state: How focusing on relationships could revolutionise the role of the state* (Cooke and Muir eds 2012), IPPR argued that this is because providers have focused too much on their performance indicators and not enough on the quality of their relationships with the public. In that earlier report we described a new model for organising public services, one that would respond more effectively to these concerns, which has become known as ‘the relational state’ (Mulgan 2012).

This paper is divided into two parts. In part 1 we set out the case for the relational state, deepening the arguments made in our previous paper (Cooke and Muir eds 2012). In chapter 1 we explain why orthodox 'new public management' methods are ill-suited to tackling complex problems and managing complex systems. We make it clear that while bureaucracy and competition should play an important role in public service systems, they are generally best suited to dealing with problems that have simple, linear causes and which can be dealt with within departmental or contractual silos. To deal with a growing range of complex problems we require a more relational state. At the macro level this means more interconnected public service systems, and at the micro level it means deep relationships taking the place of shallow transactions.

In chapter 2 we argue that not only is the relational state best-placed to tackle complex problems, but citizens are increasingly demanding more relational forms of service provision. We spoke to women with recent experience of using maternity, early years and adult care services and found that they wanted more personalised services, entailing greater consistency of personnel, staff with stronger interpersonal skills, and one-to-one guidance through fragmented systems. They wanted their relationships with services to be empowering, both individually and collectively. They supported having the ability to 'exit' (choose a different provider) as a last resort when services fail, but they also wanted to see services provided through shared institutions to enable neighbours to develop stronger relationships with each other.

Part 2 of the paper sets out how we can build a more relational state in practice. This involves two big reform moves. First, at the macro level, the relational state means managing public services as interconnected systems. This in turn means taking five big steps.

- A decentralisation of budgets to local authorities and city-regions to unlock innovation, improve responsiveness and break down silos.
- Allowing greater pooling of funding, so that services can take a 'whole person' or 'whole area' view.
- Enabling much greater integration of professionals into multi-disciplinary teams.
- Granting greater frontline autonomy combined with accountability for outcomes achieved, such as through the publication of performance tables that rank providers.
- Expanding new collaborative infrastructures such as school chains, so that providers can share knowledge and learn from innovation. Collaboration should be considered compatible with managed competition: together they can raise performance.

In this model, government is an enabler rather than a manager, steering an interconnected system in which a diverse range of actors and institutions take the lead.

Second, at the micro level – where we are concerned with individual cases – the relational state means cultivating deep relationships in place of shallow transactions. In practice, this means:

- linking service users with lead professionals with whom they can develop relationships over time
- allocating professionals to neighbourhood-based patches
- designing institutions that strengthen relationships between citizens and enable them to tackle shared problems together.

Taken as whole, this paper provides a framework for reconfiguring our public services so that they can deal with complexity, better meet the needs of their users, and enable our communities to come together to overcome the challenges they face.

PART 1

THE CASE FOR THE
RELATIONAL STATE

1. PUBLIC SERVICES IN A COMPLEX WORLD

In this chapter we explore why public services struggle to tackle a growing range of problems, from chronic disease to nuisance neighbours, and from long-term worklessness to the rehabilitation of offenders. We argue that these are examples of ‘complex problems’, which have multiple, interconnected and non-linear causes that interact in unpredictable ways. Such problems account for a growing proportion of public spending, and need to be tackled differently if we are to avoid rising costs and improve outcomes in the future. We show how orthodox ‘new public management’ methods – while reasonably effective at tackling ‘tame problems’, the causes of which are fewer in number, linear in nature and can be tackled within service silos – struggle to cope with the demands of growing social complexity. To deal with complex problems, we need to reconfigure the way in which our public services are organised.

1.1 The rise of complexity

1.1.1 Tame and complex problems

A distinction can be drawn between social problems that are ‘tame’ and those that are ‘complex’ or ‘wicked’. Whereas with former can be dealt with by following discoverable and reliable procedures, the latter are inherently unpredictable and there are no standard procedures whose success can be relied upon in advance. Tame problems are characterised by smaller numbers of linear causal relationships, while complex problems are characterised by multiple non-linear and interconnected causes that feed off of one another in unpredictable ways.

A further distinction can be drawn within the category of ‘tame problems’ between those that are simple and those that are complicated (see table 1.1). Dealing with simple problems is like following a recipe: once one understands the recipe and knows how to use the tools required, following the recipe is very likely to lead to a successful outcome. Complicated problems are made up of a number of simple problems, although they are not simply reducible to them. Their complexity arises not only from their scale, but also from the fact that solving them requires co-ordination, management and specialist expertise.

Complex problems are distinct from these two types of ‘tame problem’. They are made up of both simple and complicated problems, though again they are not simply reducible to them. They require a deep understanding of local conditions and the capacity to adapt to ongoing change. The factors that contribute to complex problems are interdependent, and their

variables are non-linear – doing one thing does not simply lead to another. Complex problems do not have certain or predictable outcomes.

Glouberman and Zimmerman (2002) illustrate the difference between these three types of problems by using the analogies of following a recipe, sending a rocket to the moon and raising a child (see table 1.2 below).

Tame problems		Complex problems
Simple problem: Following a recipe	Complicated problem: Sending a rocket to the moon	Complex problem: Raising a child
The recipe is essential	Formulae are critical and necessary	Formulae have a limited application
Recipes are tested to assure easy replication	Sending one rocket increases assurance that the next will be OK	Raising one child provides experience but no assurance of success with the next
No particular expertise is required, but cooking expertise increases success rate	High levels of expertise in a variety of fields is necessary for success	Expertise can contribute, but is neither necessary nor sufficient to assure success
Recipes produce standardised products	Rockets are similar in critical ways	Every child is unique and must be understood as an individual
The best recipes give good results every time	There is a high degree of certainty of outcome	Uncertainty of outcome remains
An optimistic approach to the problem is possible	An optimistic approach to the problem is possible	An optimistic approach to the problem is possible

Table 1.1
Examples of 'tame' and 'complex' problems

Source: Adapted from Glouberman and Zimmerman 2002: 2

Examples of 'tame' public policy problems might include how to improve basic levels of literacy and numeracy and reduce hospital waiting times. Solutions to these problems require skill and expertise, but if procedures that have previously been successful are followed then there is a high likelihood of success: for example, ensuring that schools spend more time each day focusing on basic literacy and numeracy can be expected to produce improvements; bringing in extra staff and prioritising critical cases have been shown to be successful methods for reducing hospital waiting times.

Examples of 'wicked' or 'complex' public policy problems include tackling antisocial behaviour, reducing reoffending and getting the long-term unemployed into work. Each of these problems have multiple causes that interact with one another in ways that vary radically at the individual level (such as mental illness, family breakdown, unemployment, low educational attainment, and drug and alcohol problems). Standardised approaches are unlikely to be very fruitful, and so in-depth knowledge of personal circumstances is required. Solving these problems will take time and deep individual and neighbourhood engagement, and there is no guarantee that any particular approach will work.

1.1.2 Complexity theory

'Delivery state' models of public management have become untenable: it is no longer credible to view government as a machine in which levers can be pulled at the centre and predicted outputs produced. As a result, scholars of public administration have started to look to 'complexity theory' in order to understand how complex systems work (Klijn 2008, Bourgon et al 2010).

Complexity theory has started to have an impact on a range of disciplines, most notably biology, physics, chemistry and economics. Klijn (2008) defines complexity theory as:

'the idea that the whole (the system) is more than the sum of its parts (the individual agents) while at the same time developments of the whole stem from the (interaction of the) parts. Complexity theories stress that systems tend to develop non-linearly and are subject to various feedback mechanisms. They are also dominated by self-organisation and usually co-evolve with other systems.'

Klijn 2008: 301

Complexity theory has become increasingly prominent in a number of scientific fields, including:

- **Biology:** where molecules, cells, organisms and species are known to interact in ways that trend towards disequilibrium or multiple potential points of equilibrium, and where ecological systems go through different adaptive or maladaptive cycles.
- **Chemistry and physics:** where non-equilibrium thermodynamic theory describes how open systems exchange energy, matter and information with their environment and which, when pushed 'far from equilibrium', create wholly new structures and order, and where non-linearity means that relatively small changes are able to affect whole systems in major and unpredictable ways.
- **Economics:** where conventional thinking about rational economic agents with perfect information has been overturned by growing evidence of non-rational behaviour in many markets, and where notions of predictable equilibria in response to changes in key variables (such as prices) are no longer seen to hold.
- **Chaos theory:** where small random and non-linear events result in large effects on complex systems.

The main concepts within 'complexity theory' that are useful to our understanding of how societies and organisations work are:

- **Connectivity and interdependence:** in an increasingly networked society the actual or anticipated decisions of one actor, organisation or system can have major and unpredicted impacts on other actors and systems. So, for example, the decision taken by policymakers

to reduce the amount of lead in petrol on environmental grounds is now recognised as having played an important role in reducing crime because of its impact on child development and the behaviour of young men.

- **Adaptation and co-evolution:** complex social systems are able to adapt and evolve, and adaptations by actors or organisations are dependent on adaptations by other actors or organisations. So managers and organisations do not simply adapt to their external environment, but their actions also impact on the wider system.
- **Self-organisation:** actors and organisations do not simply act according to prescribed roles and rules, but also act of their own accord in ways that create new relationships and new structures. So, for example, older people have been found to subvert new ‘telecare’ technologies in their homes, triggering alarms not to report falls but to have conversations with people in order to overcome loneliness (Dempsey 2013). Similarly, frontline workers or so-called ‘street-level bureaucrats’ have been found to play a major role in shaping policy as it is implemented, often in ways that were not predicted by policymakers (Sabel 2012).
- **Emergence:** the process by which new patterns or structures emerge out of the seemingly random interaction of individual elements of a complex system. These ‘emergent properties’ are only observable at system level, but have their roots in the micro-behaviours of individual actors and organisations. So, for example, crime has fallen dramatically over the last 30 years across all developed societies, but very few people can explain why – it seems likely that a range of micro-changes, at one level unrelated, came together to produce a transformative impact in aggregate.
- **Feedback processes:** in classical economics, feedback processes are linear: with positive feedback, more leads to more and less to less, whereas with negative feedback more leads to less and vice versa. In complex systems, feedback is non-linear, with contingent factors affecting the strength and direction of feedback loops in ways that are not predictable in advance. In managing such systems there is a premium on looking at the ‘whole system’ and seeking to understand its dynamics, and on pilot experiments that probe how particular feedback loops work (see Klijn 2008 and Bourgon et al 2010).

1.1.3 The rise of complex problems

Across a number of scientific disciplines, these theoretical insights are enabling scholars to achieve a better understanding of how complex systems work, both in the natural world and society. They have started to have an impact on public administration, as it has become apparent that many of the problems policymakers are grappling with are complex and/or embedded in complex systems. Indeed, economic, social and

demographic changes – including ageing, material affluence, globalisation and the shift towards post-industrial economies – mean that developed societies are characterised by greater complexity. In this section we illustrate this by looking at the big, complex problems facing different public services. It is important to note that these problems exist both at the micro level (personal cases and particular communities), and at the system level, where these problems are manifested in aggregate.

The rise of chronic health conditions

Demands on the NHS have changed dramatically over recent decades. Once a system that predominantly dealt with episodic and acute problems such as communicable diseases and broken limbs, it now has to care mainly for people with long-term chronic conditions such as diabetes, heart disease and hypertension. People with long-term health conditions now account for 50 per cent of all GP visits, 70 per cent of in-patient bed days and 70 per cent of the primary and acute care budget in England (Department of Health 2012).

Unlike a broken leg or a bout of measles, these chronic conditions cannot be dealt with by a visit to hospital or a GP – they require ongoing management, most of which is conducted by the patient themselves, or their carer, rather than by clinicians. In fact, patients with chronic conditions often know more about their condition than qualified experts. Many people are living with a number of chronic conditions at the same time, particularly as they get older, with complicating interactions between different conditions and treatments. For example, 30 per cent of people with a long-term physical health condition also have a mental health problem (Naylor et al 2012). Managing these conditions is a complicated business, and requires highly personalised ongoing care that varies from patient to patient.

In addition to managing these conditions, however, there is the need to prevent them from emerging in the first place. In order to achieve this, the health system needs to shift its focus away from clinical interventions in hospitals and towards the less predictable world of behavioural and lifestyle change.

Changing patterns of crime

One of the most important emergent and unexplained trends in recent times has been the fall in crime across most developed countries since the mid-1990s. In England and Wales this includes both crimes reported to the police and those picked up in the Crime Survey for England and Wales.

Criminologists have so far struggled to explain this trend, with the long list of suggestions that have been put forward including:

- reduced levels of lead in petrol resulting in lower levels of male aggression

- cheaper household goods reducing the gains from burglary
- better locks on doors and windows preventing theft
- the rise of a more educated population with an aversion to physical violence
- new and cheaper hand-held technologies distracting young people from other activities (Economist 2013).

It is notable that very few observers have ascribed the falling crime rate to the work of the government or police. This is because crime has fallen across all developed countries, independently of how much they have spent on their criminal justice systems or their approach to policing. With no single change that can account for this shift, it seems that a number of smaller changes – often unintended and unseen by policymakers – have had a very significant impact on crime across the system as a whole. The implication is that crime reduction is a complex and non-linear process that requires ongoing experimentation and innovation.

Antisocial behaviour

The other main role of the police – maintaining order – has also become increasingly demanding and complex. Although perceived levels of antisocial behaviour have fallen in recent years, they remain worrying: 13 per cent of adults perceived anti-social behaviour to be high in their area according to the 2012/13 Crime Survey for England and Wales, and 2.2 million incidents were recorded by the police in the year to June 2013 (ONS 2013a).

In recent years a tremendous amount of pressure has been put on the police to deal with a wide range of order maintenance problems that were previously dealt with by communities themselves. Shapland and Vagg (1988) have shown how in close-knit communities, such as those in more rural areas, citizens feel more confident to intervene with young people when they misbehave because they know both the young people and their parents. By contrast, in more anonymous urban areas where few people know each other, citizens are much less likely to intervene when trouble occurs, and are therefore much more likely to call the police at the first sign of trouble. Growing urbanisation and social atomisation have therefore increased the demands placed on the police (Brodeur 2010).¹

Greater concern about antisocial behaviour has not just increased demands on police time – it has also made their job more complicated. There is no blueprint for reducing antisocial behaviour: every community has its own cluster of complex interacting factors that need to be understood, and effective responses need to be designed at the neighbourhood level. Tackling the causes of antisocial behaviour requires deep knowledge, highly personal interventions and more collaborative working across professional boundaries.

¹ Brodeur (2010) reviewed 51 studies based on various sources. Of these studies, 46 showed that the percentage of police work devoted to crime was 50 per cent or less, and two-thirds of them concluded that this figure was 33 per cent or less.

NEETs

Britain now has 640,000 young people (aged 16–24) who have never had a job – a number which has doubled since 1998 (Thompson 2013). These young people suffer from multiple barriers to work: they generally lack decent qualifications, they often lack the social and interpersonal skills that employers look for, and some have been in and out of the criminal justice system. The transition from education to employment, and from youth to adulthood, has simply broken down for these young people. Tackling these problems is not easy: they may not be able to successfully re-take qualifications they originally failed to gain, convincing employers to give them a chance is hard, and they may lack the motivation to engage with the system. These young people require highly personalised support if they are to re-engage with the education system and the labour market.

Long-term unemployment

Long-term unemployment is a problem that affects most post-industrial societies. In Britain the number of non-working non-pensioner households has risen over time (from 8 per cent of non-pensioner households with no adult working in the late 1970s to 17 per cent today) (Gregg 2010, ONS 2013b).

Governments have introduced a number of programmes to tackle this issue, but these have enjoyed limited success, particularly when it comes to more complex cases involving sickness and disability. Between April and June 2013 fewer than 7 per cent of those who had an illness and disability and were enrolled on the Work Programme (claiming employment and support allowance) were found a job. Although the programme has recently improved its performance among jobseeker's allowance claimants, over its lifetime only 168,000 out of 1.3 million people have been found work (Worrall 2013). These figures mask the even greater number of people who are not enrolled on the programme but are economically inactive, often because of long-term sickness.

Clearly, some of the difficulties of the Work Programme are caused by a very weak labour market. Indeed, in the six months after the Work Programme went live its referral volumes increased from 2.5 to 3.3 million due to higher unemployment (Lane et al 2013).

However, tackling long-term unemployment means addressing multiple factors that affect an individual's capability for work. These can include poor physical and mental health, disabilities, low self-confidence, a lack of qualifications, a poor work history, drug and alcohol dependency, caring responsibilities, benefit disincentives and an offender history.

Getting those who are least 'work-ready' into work cannot be achieved by the standard high-churn approach, whereby Job Centre Plus advisors try to match people's skills to locally available jobs. That sort

of ‘across the counter’ approach might work for matching ‘work-ready’ people to appropriate jobs, but these complex cases involve very personal situations which have prevented people from accessing the labour market, sometimes for decades. They require active brokerage by third parties and deep personal engagement.

1.1.4 The growing complexity of the public service landscape

Since the onset of the ‘new public management’ reforms in the 1980s, public service systems themselves have become much more complex. Market reforms in particular have fractured public service systems into a multiplicity of commissioners and providers. Waves of privatisation, contracting out, decentralisation, and the setting up of arm’s-length agencies have made the public service landscape more fragmented than it once was. Increasingly, achieving results in these overlapping complex systems is more likely to involve ‘steering’ through networks rather than directing ‘down the line’ (Bovaird 2008, Rhodes and MacKechnie 2003, Sabel 2004).

Recent reforms under the current government have only added to this complexity. The Coalition has introduced policies that advanced greater decentralisation, autonomy and competition, which it believes will unleash innovation and improve results. These include the following.

- Introducing free schools and turning more schools into academies. There are now 174 free schools and 3,304 academies, which together make up the majority of English secondary schools (Department for Education 2013a and 2013b).
- Handing policing powers to 41 directly elected police and crime commissioners, and substantially reducing the role of the Home Office in local policing policy.
- Abolishing primary care trusts and strategic health authorities, and transferring healthcare services budgets to 212 GP-led clinical commissioning groups, while promoting greater competition between providers.
- Breaking up the probation service into 21 ‘package areas’, where private and third-sector providers will be able to bid for contracts to take on probation work on a payment-by-results basis.
- Outsourcing welfare-to-work services to 18 prime contractors (and their sub-contractors) through the Work Programme on a payment-by-results basis.
- Abolishing regional development agencies and replacing some of their functions through 39 voluntary local enterprise partnerships.

Securing national goals through this more complex ecology of commissioners and providers will require a very different set of strategies to those deployed by governments in the past.

1.2 Bureaucracy, markets and relationships

There are three models for organising public services: bureaucracy, markets and relationships. At different times one of the former two models has been hegemonic, and has been predicted to sweep away its rivals. Max Weber, writing in the early 20th century, argued that ‘bureaucracy’ – or rule-bound hierarchical governance – was to become dominant, because of its technical and rational superiority as a means of organising complicated societies. By contrast, the New Right of the 1970s came to regard bureaucracy as a creature of state socialism, whose internal processes and furtherance of public sector vested interests had made it lethargic, inefficient and unresponsive. It was to be swept aside in favour of introducing market forces into public services, empowering users as consumers and exposing public servants to the rigours of competition.

Our argument in this chapter is that more interconnected forms of horizontal organisation and governance are becoming increasingly necessary in order to cope with the growing complexity of social problems and public service systems.² Nevertheless, it would be a mistake to argue that bureaucracy and markets should have no place in this new configuration. Every public service contains elements of all three models: in the health service, for example, bureaucracy provides for minimum waiting times, competition gives you a choice of hospital, and your relationship with your GP provides you with the support and guidance you need to make the best decisions.

Moreover, if one organisational principle were to be made dominant across all services this would represent a failure to appreciate crucial differences in the purpose and context of particular services. As Johan P. Olsen argues:

‘Bureaucratic-, market- and network organization are usually portrayed as alternatives, based respectively on hierarchical authority, competition and cooperation. From an analytical point of view, these are different mechanisms for achieving rationality, accountability and control, mobilizing resources and compliance, and organizing feedback from society. In modern, pluralistic societies with a variety of criteria of success and different causal understandings, it is, however, unlikely that public administration can be organized on the basis of one principle alone. An administration that simultaneously has to cope with contradictory demands and standards and balance system coordination and legitimate diversity organizationally... and technologically... is likely to require more complexity than a single principle can provide.’

Olsen 2005: 23

2 For a similar argument see Sabel 2004 and Dunleavy et al 2005.

In this section we describe these three models of public administration, their underlying assumptions, the tools they deploy, the purposes for which they are most suited, and the conditions under which they are most effective. Our argument is summarised in table 1.2 below.

	The delivery state		The relational state
	Bureaucracy	Markets	Relationships
Assumptions	Desired outcomes can be achieved through the implementation of rational plans developed by a technocratic elite and imposed through the exercise of hierarchical authority.	Optimal equilibria will be arrived at through the exercise of consumer choice in a context of competition between different providers.	Outcomes cannot be directly planned for in complex systems where phenomena have multiple and non-linear causes that interact in unpredictable ways.
Tools	Rewards and sanctions are set at the top and imposed down the management line, through the use of performance indicators, targets, performance-related pay, ranking and reputation mechanisms and external audits.	Either: 1) quasi-markets in which providers are motivated by a desire to increase market share and consumers can choose between different providers, or 2) in cases of natural monopolies, the whole market can be 'contracted out' on a contestable basis to an external provider.	1) At the macro level, an interconnected system: silos broken down and budgets devolved; government acting as an enabler rather than a manager; change achieved through incremental trial and error; and infrastructures created for generating new knowledge and sharing learning. 2) At the micro level, complex problems are tackled through deep relationships among citizens, and between citizens and professionals.
Suitable problems	'Tame' problems for which policymakers know what works and the challenge is to scale up and transfer.	'Tame' problems where consumers and providers respond predictably to market incentives.	'Complex' problems where no standard strategy or market incentive can be relied upon in advance to achieve an outcome, and where causes are multiple, interconnected and non-linear.
Ideal conditions	Workforce is low on skill and motivation; user engagement is not essential; a small basket of outcomes can be identified that will unlock wider improvement; technocrats have reliable and useful information; problems can be tackled within service silos.	There is genuine choice and competition; consumers have reliable and useful information; good providers are able to expand and weak providers exit; an intrinsic public service ethos is non-essential; problems can be tackled within service silos.	Complex systems; a skilled and motivated workforce (or an infrastructure in place to achieve one); high levels of user and professional engagement; reasonably strong levels of trust and social capital.

Table 1.2
Three models of public administration and the conditions under which they are most effective

Before discussing each model in detail, it is worth making two points clear at the outset.

- These are ideal typical models, and in reality public services will only approximate them.
- The models can complement each other: each of these categories may contain sub-sets of the others. Indeed, as is made clear below, complex problems and complex systems will generally contain 'tame' elements which may be dealt with using appropriate bureaucratic or market techniques. In addition, different approaches may be more or less appropriate at different 'stages'. For example, education systems are thought to develop through different phases, with more top-down bureaucratic solutions proving efficacious in the early phases of the 'improvement journey', but with more relational approaches becoming more appropriate once a system has matured and the challenges facing it have grown more complex (Mourshed et al 2010).

1.2.1 Bureaucracy

'Bureaucracy can be seen as a rational tool for executing the commands of elected leaders. In this perspective it is an organizational apparatus for getting things done, to be assessed on the basis of its effectiveness and efficiency in achieving pre-determined purposes. Bureaucratic structure determines what authority and resources can be legitimately used, how, when, where and by whom. Commands and rules are followed because they are given by office-holders as trustees of an impersonal rational-legal order. Administrative legitimacy is based on the idea that the tasks are technical in nature – to identify a logically correct solution by interpreting rules and facts or applying expert causal knowledge. Administrative dynamics are subject to deliberate design and reform by legislation through procedurally correct methods.'

Olsen 2005: 5

Those who favour bureaucracy as an organisational model do so on the assumption that expert elites are best placed to make decisions about how to achieve governmental objectives. Under this model, there is a strict separation between policymaking, which is done at the centre, and implementation, which is carried out by staff following detailed plans handed down from above.

Bureaucratic models have been utilised under both traditional public management and the 'new public management' (NPM) approach that replaced it. The distinction between the two is that whereas under the former there was much greater trust that the frontline would follow centrally determined plans, the rise of NPM brought with it much more rigorous regimes of performance management. This involved targets being set for actors lower down in system hierarchies, with processes

for providing feedback and audits back to the centre to monitor compliance. Fear of dismissal or public shame drive managers at all levels to ensure that targets are met and regulations followed.

Bureaucracy is well suited to so-called 'tame' public policy problems, where there is already a strong body of evidence regarding what works and the task of management is to make sure that more people are doing it. This is not a straightforward task, and requires considerable expertise in how to manage complicated organisations and ensure the adoption of standardised processes.

For example, as we have already described, there is strong cross-national evidence that standardised approaches to improving basic levels of numeracy and literacy have been effective. To take a specific example, a literacy hour was introduced into in all primary schools in England in 1998. The policy involved a framework for teaching which set out termly teaching objectives for children aged 5–11 and provided a structure of time and class management for the daily literacy hour. This included 10–15 minutes of whole-class teaching, 10–15 minutes on phonics and spelling, 25–30 minutes of group activities, and a final plenary session for children to reflect on what they learned. An independent evaluation of its pilot phase concluded that a large increase in attainment in reading and English could be directly attributed to the policy (Machin and McNally 2004).

Another example of a bureaucratic approach tackling a 'tame' problem effectively is the introduction of waiting times targets in the English NHS. The reduction of waiting times is a tame problem in that there are replicable procedures that have proven efficacious, including increasing staff levels, bringing in external capacity and prioritising critical cases. The results of the policy in England were impressive: by 2010, 93 per cent of admitted patients and 97 per cent of non-admitted patients were treated within 18 weeks (which was the referral-to-treatment target). The King's Fund found that the average waiting time for inpatient care fell from 13.2 weeks in March 1997 to 4.0 weeks in March 2009, and that the average wait for outpatient care fell from 4.8 weeks in March 2005 to 2.4 weeks in March 2009 (King's Fund 2010).³

However, targets do also produce negative effects which in many ways reflect some of the wider problems with bureaucratic governance. One of these is that targets tend to encourage 'gaming'. For example, in order to meet the A&E waiting times targets, patients were sometimes kept in ambulances before being admitted into hospital. Another example of 'gaming' is that, in order to meet waiting times targets for GP appointments, many GP surgeries simply stopped allowing patients

³ It is important to note that other parts of the UK that did not impose targets at the same time fell behind as a result. Indeed, immediately after 2000, Wales, Scotland and Northern Ireland saw increases in their waiting times compared to falls in England (Bevan and Hood 2006).

to book appointments more than four days in advance (Bevan and Hood 2006). Similarly, in the police service, officers were instructed to bring a certain number of offences to justice – incentivising them to focus on ‘easy wins’ such as searching youngsters to find small quantities of drugs rather than prioritising more serious crimes (Fitzgerald et al 2002). Schools were told to ensure that at least 30 per cent of their pupils gain five A*–C grades at GCSEs, which incentivised teachers to focus their efforts on young people on the C/D grade borderline rather than those who were even further behind (Burgess 2013).

Another problem with targets is that they can instill rigidity in public services. Rather than responding to local needs and circumstances, providers instead look upwards to central government. This inhibits innovation, which is critical to improving public service productivity. Targets can also demoralise public sector workers, who find themselves taking a ‘tick box’ approach rather than exercising their professional judgment regarding what is best for the service user (Fitzgerald et al 2002).

These concerns can be addressed in a number of ways. One is to limit the use of targets to those services in which performance is poor and the workforce lacks the capability to improve on its own – in these cases, a system of rewards and sanctions may be required. In a study of the 20 most improved school systems around the world, Mourshed et al (2010) found that school improvement moves through different phases, during which different levels of central prescription are appropriate. In the early phases, with low workforce capability, central prescription is effective at raising schools’ performance to an adequate level; however, getting schools from there to excellence requires that government step back and let a more capable workforce innovate.

Where targets are deemed suitable, the negative externalities can be addressed to some extent by minimising the number of goals set and ensuring that those goals that are set will unlock improvement in the most important areas. Problems can also be mitigated by creating outcomes frameworks that are broad enough to enable those who are monitoring overall performance to change the metric of focus and thus ensure that managers maintain a holistic view (Bevan and Hood 2006).

Returning to the question of tame and complex problems, there are two reasons why bureaucratic methods are less effective at tackling complex problems. First, where problems have non-linear causal relationships, standardised approaches are unlikely to be effective. The bureaucratic blueprint assumes linearity – and so in non-linear cases the predicted outcomes do not materialise (Hallsworth 2011). For example, there is no successful standard approach to preventing someone from reoffending. Each case needs to be understood individually; no single lever can be pulled that will lead to success in all cases.

Second, bureaucratic approaches generally fail to deal with the interconnectedness that is inherent in complex problems – that is, problems with causes that cut across departmental silos. For example, reducing the number of NEETs requires not just efforts within the school system, but collaborative initiatives involving employers, the criminal justice system, social workers and so forth. Similarly, reducing reoffending necessitates that ex-offenders receive support from probation, housing and health services and the police. As we shall see, market models suffer from a similar flaw in that they tend to fragment the delivery landscape.

1.2.2 Markets

Recent governments have sought to expose public sector organisations to greater competition. This arose in part as a counter-reaction to traditional bureaucratic models of public administration which were thought to be costly and unresponsive to users. The thinking behind it is that where consumers or commissioners of services are offered a choice between different providers, those providers will offer the best possible service at the lowest possible cost in order to increase their market share.

Markets have been introduced in two different forms. First, where customers can choose between different providers of a particular good, quasi-markets have been created which attempt to replicate the conditions that exist in markets for private goods. The main difference between private and public service markets is that in private markets consumers pay individually for goods and so can distinguish between them based on price. Public services are generally collectively funded, so there is no price mechanism to inform consumer choice. Instead, policymakers have developed proxies (generally quality measures) that allow consumers to make educated choices between better or worse providers. These include, for example, the league table position of schools, or ‘star ratings’ for hospitals.

Second, in the case of ‘natural monopolies’, or where consumers cannot be offered a choice between different providers, a whole market can be contracted out to an external provider. In these cases – such as local authority refuse collection or welfare-to-work services – commissioners choose between competitive bids.

We should note that these two market models are not the only forms of competition that exist in public service systems. Another type of competitive dynamic is created where services are publicly ranked, and providers are thereby motivated on reputational grounds to out-perform their rivals (Bevan and Wilson 2013, Gash et al 2013). This is not a market mechanism, because providers are not motivated by a desire to increase market share and consumer choice is not the main driver of performance. We will discuss the role that reputational competition can play in driving improvement in the third chapter of this report.

A distinction also needs to be drawn between the introduction of markets and the introduction of profit-making private providers. While the latter is dependent on the former, it is possible for markets to be introduced to create competition between public sector providers without allowing in new entrants, or while restricting new entrants to those with a non-profit motivation (as with free schools in England, for example).

So what type of problems can markets help us to solve? In some ways, market reforms can be seen as the New Right's answer to the complexity challenge. Hayekian thinking rests on the assumption that because one person's knowledge is only partial, a decentralised system for acting upon information and making decisions is always more optimal than a centrally planned system. For the New Right, this meant that markets offered a means of resolving complex problems.

However, market models suffer from the same two problems as bureaucratic ones: they struggle with complex non-linear relationships, and they often serve to fragment systems – whereas what is required to tackle complex problems is greater connectedness.

The assumption of linear relationships that lies behind neoclassical economics is similar to that which underpins the bureaucratic model. Just as the rational planner, in the bureaucratic approach, can be expected to come up with the best solution and then implement it with predictable results, neoclassical theory assumes that the market has a rationality of its own that can be depended upon to achieve optimal outcomes. This kind of economic thinking assumes rational self-interested actors operating in a world of perfect information. Causal relationships and feedback mechanisms are simple and linear in this model: for example, prices rise and consumers go elsewhere. Points of optimal equilibria are reached naturally through the interaction of these variables.

However, these linear relationships are not always present in the real world. Some markets are relatively simple and the relationship within them between price and demand is predictable: for example, in the market for basic groceries, where the goods involved are simple and similar, consumers are able to make straightforward choices based on price signals, and shops can easily interpret changes in demand. But goods such as health and education are more complex, and in reality do not work in the ways predicted by neoclassical economic theory. There are a number of reasons for this.

- Consumers do not always respond predictably. For example, in New York, the publication of data on mortality rates from heart attacks at different hospitals did not cause more consumers to choose better-performing hospitals – indeed, despite the availability of this data, former President Bill Clinton famously chose one of the worst-performing hospitals in the city for his heart bypass (Hibbard et al

2005). The influence that such data has depends, of course, on the patient. Evidence on the effects of the recent English healthcare reforms appears to show that patients with more serious conditions are more likely to choose based on quality measures than those with less serious conditions (Gaynor et al 2012). Patients do not act on official quality data alone (or perhaps at all in many cases), but also on other motivations or sources of information – such as habit, hunches or word of mouth – that are not accounted for in the narrow model of rationality deployed in neoclassical theory.

- Providers do not always respond predictably to changes in demand. This is in part because, for complex multi-dimensional goods like healthcare and education, it is not always clear why users are making choices. For example, it is not easy for GPs to interpret why a patient has left their surgery – they may have moved house, or been dissatisfied with an aspect of service delivery. It is for this reason that choice mechanisms need to be buttressed by ‘voice’ mechanisms, such as individual feedback or user forums, so that providers gain a richer account of consumer opinion (Dowding and John 2012: 140).
- Good providers do not simply expand, and poor providers exit, as neoclassical theory predicts. Good providers often face financial limits on their expansion because they are publicly funded; if they are non-profit providers, they may not wish to expand simply because they are not motivated by a desire to increase market share. Conversely, unlike in private markets, poor providers generally do not exit public service markets, for the simple reason that public services are lifelines that their users and communities depend upon. It is politically inconceivable that any British government would simply let a town lose its university, for example, and hospital closures are similarly very difficult in reality even if they might be clinically justified. This is not to say that the provider cannot be changed in cases of underperformance – but even in these cases the process is difficult. The Institute for Government identifies the absence of proper failure regimes as a major problem in public service markets, and has found that there is lack of confidence within government about managing transitions to new providers (Gash et al 2013).
- There are barriers to genuine competition in many markets, which means that the mechanisms set out in neoclassical theory do not operate as might be predicted. Sometimes this is because there is not enough funding to offer genuine choice, as we shall see when we discuss the social care market in the next chapter. Public resources need to be committed to ensure the provision of ‘surplus places’, so that citizens can exercise choice between different providers. However, this might not be considered an efficient use of scarce resources. Sometimes there are not enough potential providers to enable real competition – for example, in cases where

very large contracts are put out to tender, only a small number of firms can afford to take them on. Dunleavy and Carrera (2013) argue that the main reason why contracts to provide big government IT systems go wrong is because the sums involved are very large, and relatively few providers are able to bear the attendant risk. This limits competition and drives up costs, with government becoming dependent on a single provider with high exit costs.

- For competition to work in an optimal way, providers need to compete on the desired dimensions of competition. However, just as with targets, numerous examples have arisen of providers in public service markets ‘gaming’ the system. In welfare-to-work programmes, for example, there have been clear cases of providers maximising their profits by ‘creaming’ users who are easier to support, and ‘parking’ those with more complex needs (Gash et al 2013).

The second reason why markets struggle with complexity is that the causal factors of complex problems are generally highly interconnected. As we have seen, complex problems typically require collaboration between providers, and across silos, and integration around users – but these are made harder by both forms of market reform described above. Quasi-markets can fragment systems into competing autonomous providers, undermining collaboration between them. They also struggle to tackle problems that transcend the scope of the particular market in question.

Similarly ‘contracting out’ tends to fragment provision into separate contractual arrangements, which inhibits co-ordination and integration. One response to this issue has been to package together larger contracts encompassing more and more aspects of a service – for example, the outcomes-based ‘black box’ commissioning of welfare-to-work and probation services. However, as a solution to the problem of fragmentation, this approach has its own negative effects.

- Fewer actors can take on the risk of these large contracts, which reduces the very competition the policy is intended to encourage.
- It gives rise to huge trust issues, particularly when the profit motive is combined with the fact that private providers are not subject to the same transparency requirements as public bodies. A number of examples have recently come to light not just of ‘gaming’ by private providers but also of alleged fraudulent activity in outsourced welfare-to-work and criminal justice services.

None of this is to say that there is no role for markets in complex public service systems. They can help to drive down costs – for example, the introduction of compulsory competitive tendering in local government in 1988 reduced costs by about 20 per cent on average in the first year, although there is little evidence that it improved

quality.⁴ International evidence supports the claim that, in general, the contestability of contracts reduces costs – for example, in 1996 the Australia Industry Commission found that contestability reduced costs internationally by between 10 and 30 per cent (Julius 2008). This is likely to be because, among other things, the private sector can benefit from economies of scale where it can centralise back office functions, it is more experienced in efficient business processes, and it tends to be an early adopter of new technologies.

Markets can also improve service quality, but their impact depends on how particular markets are structured and regulated. For example, the 1991–99 Conservative reforms to the NHS introduced price competition between hospitals, which ended up reducing service quality because of the resultant focus on cost cutting. By contrast, the Labour government's 2006 reforms to the NHS, which allowed competition on quality (with a fixed tariff per operation), successfully improved outcomes as measured by the length of hospital stays and number of deaths from heart attacks (Propper et al 2004, Gaynor et al 2011). In its study of the English social care market, the Institute for Government found that experts widely regarded markets to be good at driving down costs but poor at delivering on quality, because resource scarcity causes local commissioners to focus on price (Gash et al 2013). Cross-national studies of school systems show that outcomes from the introduction of competition vary widely depending on the specific context and the type of regulation in place (Allen and Burgess 2010).

However, it should be noted that quasi-markets in public services seem to work best when competition is balanced by countervailing forces for co-ordination and collaboration between providers. For example, cross-national studies of successful school systems have found that those that excel have supportive 'middle tiers', such as local commissioners and chains, that help to provide for co-ordination between schools and pool specialist support functions (Mourshed et al 2010, O'Shaunessy 2012, Fullan 2012). So, while there is an important role for markets within complex systems, it is a major conceptual mistake to make competition the organising principle for public service systems.

1.2.3 Relationships

The final paradigm of public administration is the 'relational state' – a state that does things *with* its people rather than simply *for* or *to* its people (Mulgan 2012). The rationale for this model is that many of the problems that society faces are so complex that narrow 'new public management' frameworks will simply not suffice. To tackle complex problems we need public services that are more interconnected at the macro level, and that provide for deeper relationships at the micro level.

⁴ The record of market reforms in improving quality is unclear in part because government has done little to systematically evaluate the impact of competition on outcomes in complex areas like health and education (see Gash et al 2013).

At the macro level, the relational state means managing public services as elements of interconnected systems – systems in which actors and institutions interact in multiple and unpredictable ways, in which there are complicated feedback loops, and in which big effects can be generated by unplanned micro-behaviours.

In these complex systems it is impossible for the state to guarantee particular outcomes, and so the role of government changes from that of a manager to one of an enabler. Rather than setting out detailed plans to achieve specific outcomes, government should set high-level goals and then enable actors and institutions to find their own ways of achieving them. Government should establish the basic rules of the game by which actors and institutions should go about achieving those goals, including aligning incentives for competition and collaboration. Government should sustain healthy feedback loops so that the system is constantly learning, and put infrastructures in place for the development of new knowledge which can then be shared. It should ensure that the workforce has the capabilities to innovate and excel through robust systems for recruitment, training and continuous professional development. It should monitor the overall health and performance of the system, and retain a suite of backstop responses to cases of failure and chronic underperformance (see Hallsworth 2011, Sabel 2004).

The relational state in practice, as an interconnected system, would entail a number of things.

- A radical devolution of budgets to the local level to unlock innovation and improve responsiveness.
- The pooling of devolved budgets in areas like housing, offender management and welfare-to-work so that complex problems can be tackled in a holistic way.
- Allowing local public service commissioners to recoup the savings made from their innovations to incentivise upstream preventative investment.
- The closer integration of policy and practice, so that approaches can be adapted through ‘trial and error’ at the coalface.
- The development of collaborative backbone organisations in public services, including provider chains, specialist institutions, research bodies and agencies for professional learning and development, to ensure that the system is constantly learning.
- Robust bottom-up accountability systems that include both choice mechanisms, through which people can choose an alternative provider as a backstop, and voice mechanisms whereby citizens, both individually and collectively, can challenge poor provision and help shape the design of the service.
- Full data transparency, with all providers having a responsibility to ‘feed the field’ so that the system can learn and providers be

held accountable. Data transparency is critical both to enabling consumers to hold services to account, and to facilitating the reputational competition that is proven to be a driver of improved performance (see Bevan and Wilson 2013).

At the micro level of individuals, institutions and communities, the relational state is characterised by 'deep relationships' rather than shallow transactions. Where individuals and communities suffer from complex problems – such as chronic health conditions, poor educational attainment, long-term unemployment, crime and antisocial behaviour – we require much more intensive and personalised engagement between professionals and service users, and between citizens themselves. Some examples of how this could be put into practice include the following.

- In social care, home care workers could be paid and incentivised to develop sustained relationships with the people in their care, and care co-ordinators could act as both single points of contact and brokers for users and carers in a fragmented system.
- In schools, underachieving pupils could be allocated an adult mentor to help provide them with more personal support and encouragement between the ages of 14 and 18.
- In the criminal justice system, adult offenders could be provided with the same kind of key worker support that is more routinely made available to young offenders.

Three points of qualification should be made at this point. First, just as with the bureaucratic and market models, a relational approach is likely to be most successful only under certain circumstances. For example, relationships depend on trust, and are most likely to be fostered in conditions where community participation and social trust are already reasonably strong. Furthermore, the degree of decentralisation and frontline autonomy that we envisage will only be tolerated by central government, and by the public, if the workforce is sufficiently incentivised, willing and able to improve services without micromanagement from on-high. Finally, a more decentralised approach to public service decision-making requires a political culture in which blame does not automatically fall on national government, thereby incentivising it to continually intervene to put things right (Lodge 2010). We explore these challenges in greater detail in chapter 4.

Second, an interconnected system approach does not preclude but rather encompasses the deployment of bureaucratic and market tools. However, these should be tasked with tackling 'tame problems' within the system – in other words, where problems are rooted in a small number of linear causal relationships and can therefore be tackled within departmental or contractual silos. It would be a mistake to govern a whole complex system based on bureaucratic or market principles.

Finally, it should be noted that at the micro level, deep relationships are not always necessary or appropriate. In many service areas, what users want is a 'shallow transaction' with as little friction as possible – renewing prescriptions, paying council tax, and having routine hospital operations like a hip replacement or cataract surgery might fall into this category. In these areas, automation and technology can help us deliver services in ever more speedy and cost-effective ways which require fewer staff. In a fiscally constrained environment, saving money through automation in transactional areas can help to sustain investment in those areas where we require deep relationships.

1.3 Conclusions

In this chapter we have argued that a range of complex problems have arisen that traditional public services have so far failed to tackle effectively, including reoffending, antisocial behaviour, long-term unemployment and chronic illness. These problems are driven by multiple, non-linear causal interactions that cannot be predicted in advance, and they cannot be effectively tackled, either individually or in aggregate, by simply relying on top-down planning or market incentives. Rather, at both the system and the individual levels, these problems require a major change in the way we organise public services.

This vital shift towards the relational state can be summarised in two words: connect and deepen. At the macro level we need systems that are more interconnected, so that we can manage their complexity more effectively. At the micro level, complex problems require deep relationships: intensive and ongoing engagement between professionals and citizens characterised by detailed knowledge of individual cases, personalised responses, and the creative brokerage of solutions.

We have argued that the relational state is the best way to tackle a growing range of complex social problems. In the next chapter we demonstrate that citizens themselves are demanding more relational and less transactional public services.

2. FROM TRANSACTIONS TO RELATIONSHIPS

At the start of this paper we argued that there are two things that we generally want from our public services: we want them to be effective at tackling the major problems we face as a country, and we want them to provide a high quality service to their users. Chapter 1 described why our public services are poorly equipped to deal with complex problems, and argued for a shift towards a more relational approach. That chapter looked at public services very much from the point of view of the policymaker surveying the major challenges we face. This chapter looks at public services from the other end of the telescope: the perspectives of the people who use public services.

To gain a greater understanding of user experiences, we spoke to women using three important public services: maternity, early years and adult social care services. We asked our participants what aspects of service provision they wanted to see changed, and gauged their reactions to a number of possible remedies. As we will see, the women we spoke to wanted to see deeper relationships both between frontline staff and service users, and among service users themselves. They wanted a greater level of personalisation, with more consistent relationships with staff, who should have stronger interpersonal skills. They wanted services to be empowering, but did not view 'empowerment' as being solely about consumer choice. Finally, they wanted services to help them to build relationships in their local communities, and to do much more to include their families.

Our argument is that there are too many examples of public services where what people want is a deep relationship, but what they get is a shallow transaction. Although quick and efficient exchanges are desirable in areas such as refuse or tax collection, many services are inherently relational in that the quality of the service as experienced by the user depends on the depth of the relationships formed. We conclude that a more relational state is desirable not only because it would be better at tackling complex problems, but because it would also provide a more personal and empowering experience for the citizen, and enable them to share, much more than they do at present, in a common life with others.

2.1 Transactions and relationships

Citizens want different things from different public services. For example, we want our bins to be collected properly at roughly the same time each week, but we do not generally want to be involved in the decision-making around how to design the refuse service, nor do we necessarily want to see the same bin men on every collection. We want the job

done, and want it done as cheaply as possible without undermining basic quality. Refuse collection is, in this sense, a classic ‘transactional’ service. Such services are standardised across an area, have low levels of personalisation, and are provided to the individual household without any need for wider community involvement. With services such as refuse collection, tax collection or paying for parking permits, the consumer usually wants a quick, frictionless transaction with the state: an efficient exchange, in and out.

However, there are other services where this transactional approach is not appropriate. These are relational services, where the quality of the service crucially depends on the relationships among users, and between users and professionals. For example, what a user of home care services generally wants is a good-quality relationship with a carer who they can get to know, enjoy a conversation with, and who will become knowledgeable about their needs and condition. In other words, what is required is a deep relationship, not a shallow transaction. Table 2.1 below summarises the distinctions between transactional and relational services from the point of view of the service user.

Table 2.1
The differences between transactional and relational services.

	Transactional services	Relational services
Degree of personalisation	Standardised service applied across the whole population, with limited differentiation	Highly personalised service that caters to individual needs and is capable of understanding the ‘whole person’
Degree of user empowerment	Passive consumption, with low levels of participation in the design and delivery of the service	High levels of citizen participation in service design and production
Degree of collective participation	Service delivered to individuals without reference to social networks	Collective action by citizens is a core means by which the service achieves its goals

There are clearly important roles for both transactional and relational modes of service provision. Indeed, as we will argue in the final chapter, the key to improving public service productivity in the years ahead will be to find those areas that are inherently transactional and make them more efficient – for example, through time-saving technologies. Reductions in staff overheads on the transactional side could help to sustain investment in those areas where time, people and deep relationships are essential.

The argument that we will develop in the remainder of this chapter is that too many essentially relational services are currently being provided in a transactional fashion.

2.2 Relationships in maternity, early years and adult social care services

In the following sections we will explore the attitudes of women who use three highly relational services: maternity care, early-years services and adult social care. We asked women using these services what they thought of the quality of service they received, and what they would

like to see done differently. It was soon clear that the women we spoke to were too often experiencing a shallow, transactional service when what they wanted were deep relationships. Below we discuss how they deemed these services to be performing in relation to the three dimensions of service provision set out in table 2.1: personalisation, empowerment and collective participation.

Methodology

This chapter is based on findings from in-depth, original qualitative work with women with experience of three public services: maternity, early years education and childcare, and elderly care.

For those respondents using maternity and early-years services, we recruited women who had had a child in the previous 18 months and had used NHS or local authority services, and who currently had at least one child using some form of publicly-funded childcare or early years education.

For groups of elderly-care service users we recruited women who were responsible for making decisions for a friend or relative receiving some form of care on (at least) a daily basis, either in their home or in a care home.

We spoke to women from across a range of socioeconomic backgrounds, from the long-term unemployed to high-earners in the City.

The groups were held in September 2012 in Newcastle, Brighton and Hove, London and Coventry. All quotations in the report are verbatim, and have only been modified for sense or anonymity; where used for clarity, names have been changed.

2.2.1 Personalisation

A service is 'personalised' if it is focused on meeting the particular needs of the user, and if it treats them as a whole person – understanding their needs 'in the round' rather than simply from the functional perspective of the service. Personalisation is the opposite of the standardised, pro-forma approach to service provision whereby everyone receives the same service within certain parameters, and where there is little attempt to think outside the functional box. In our conversations with female service users, three factors were emphasised, each of which are preconditions for a more personalised service:

- the need for consistent relationships with professionals
- the need for strong interpersonal skills among frontline staff
- the need for much better information and guidance to help users navigate the fragmented local service landscape.

Consistency of personnel

Consistency of personnel was highly prized by the women we spoke to: in maternity services, for example, consistency in the midwife–mother relationship is crucial. It is difficult to build a relationship if each appointment is with a different professional. The Royal College of Midwives has found that in London the majority of women always see a different midwife (RCM 2012). One of the women we spoke to said:

‘Mine was never there... if I’d had the same midwife and health visitor it would have given me more confidence and meant [that] I didn’t need to explain everything every time.’

The current division between community health and hospital services makes it difficult to build consistent relationships, because it means that community and hospital midwives are usually different teams. Consistent relationships during the antenatal period and during labour can only be realised if community health and hospital care are more integrated.

Similar concerns were expressed when it came to adult care workers. In practice, elderly vulnerable adults in receipt of home care see different care workers (who often have a limited grasp of English) each day for a quick and functional delivery of care provision.

‘You’re getting different carers. There’s no relationship and no consistency.’

What was wanted, above almost anything else, was a deeper relationship: a warm, friendly and caring individual to spend time with the service user, talk to them like a person in their own right, and develop and sustain a relationship with them.

Failing to recognise and act on the importance of consistency in the service model has created other direct negative impacts on the quality of care. A common story was that carers from the same agency arrived each day with no background in or understanding of the needs of the care user. Lucy’s uncle is paralysed from the neck down, but has to deal with carers repeatedly missing appointments because they arrive without knowledge of his disability.

‘You get a report saying, “We came round but you didn’t answer the door.” My uncle’s paralysed, so he can’t answer the door. That’s why he has a carer... It’s so fundamental that before you visit there [should be] a note saying, “This person is incapacitated, so you need to contact this family member”. [Carers] should have their records with them and right in front of them.’

The fact that carers vary so frequently puts added pressure on family members, who often have to become the gatekeepers of background information on medication and care:

‘You go to one appointment, and you find yourself having to convey all the medication, all the history, all the background.’

This is a particular problem with elderly individuals and those suffering from dementia (sufferers of which are predicted to number more than one million by 2021⁵), who are often not able to recall and convey accurate information about their needs and history.

Having a succession of different carers means that no single individual takes responsibility for the long-term needs of the patient. Each carer is only involved for their allotted few minutes – making lunch and cleaning up on Wednesday afternoons, perhaps – rather than considering the service user’s ongoing physical and mental needs.

In extreme cases, this leads to neglect, starvation and misdiagnosis. Yet almost as distressing was the resultant dependence of service users on their family members, their loss of individuality and independence, and the ensuing loneliness and depression that many of our respondents watched develop in their parents.

‘Nurses wouldn’t turn up... sometimes for two weeks, and they wouldn’t call or anything... so I had to [go over and] give [my dad] his injections, and that wasn’t nice. He was in his seventies, and he was quite a proud man, and he didn’t want his kids doing that.’

‘When my auntie died, the [carers] hadn’t turned up. And on the day she died she hadn’t eaten for three days. [Each carer] had put out corned beef sandwiches on the table, but she doesn’t eat corned beef. And the sandwiches were just sitting there, so each one had come in, put down another plate and walked out, but no one had looked or spoke to her. It’s so awful – there are too many gaps, no bodies or individuals communicate or take responsibility, so you have to. And you think, What about the people that don’t have anyone? Some people don’t see anyone week-to-week, and when it comes to public services, unless you’ve got a voice shouting in your corner, you’re finished.’

Interpersonal skills

Personalisation also involves frontline staff having the interpersonal skills required to relate to service users in depth. The women we spoke to stressed the importance of services being provided with a ‘human touch’ – they valued midwives, for instance, who behaved like ‘real people’. What this meant was staff not being overly formal, and not treating individuals as patients to cross off a list, but rather seeing each of them as a ‘whole person’.

5 http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=341

‘It’s nice when they just talk to you normally – it really relaxes you when they act like real people.’

‘I think it’s nice when you get a more natural feeling – they’re not just doing their job, they want to be there, and they’re being natural and normal, not ticking boxes. Not saying, “I have to do x, y and z,” but... not putting their heart into it.’

Similar views were expressed when we asked mothers about how to define ‘good quality’ in an early-years setting. Formal qualifications were not always prized, because they were not seen as a clear indication of being good with children. Parents valued their own interaction with staff more highly: having regular conversations is important because of the level of trust involved in placing a young child in care, and the speed at which young children develop.

‘[It’s important that] they communicate with you – my little boy at nursery, when you go in to pick him up, someone always comes over and they say, ‘He’s done this today, he’s done that today’. And it’s just nice that they can tell you something your child’s done, and you can have a personal conversation with them, because they know them a little bit more. And you think, They’ve done stuff that they wouldn’t have done at home, and [that’s] great.’

In home care for elderly people, because there are often no ongoing relationships, care tasks can become purely functional: a transactional activity to be executed in a small window of time. In many instances, carers don’t have an adequate level of English to make conversation. Care needs are often incredibly intimate, and our respondents described how the way in which local authorities commission providers drives down both costs and quality, meaning that carers have little time (and often lack the language skills) to treat service users with dignity and respect.

‘They treat them like they’re animals. And there’s no communication – they just strip them and wash them and don’t even talk. There’s no dignity.’

‘Can you imagine being disabled and having a stranger in to wash you? And the next day having a different stranger? And the next day another one, and it might even be a man. Can you imagine how you’d feel? You’d want the same person every day. [The agencies] humiliate them and take their lives away from them.’

Several women painted a picture of loneliness and depression for their ageing relatives – despite daily contact with carers, they suffered from a lack of human interaction and even conversation.

Even when carers might want to interact at a more relational level, time constraints squeeze out any opportunities for forming deeper relationships.

‘When you’re working for that agency, you’re only given a certain amount of time with the person and then you’ve got to move on. It’s down to the agency, not the carer. So if I come to your house, I’m told I’ve got to clean the patient, sweep up, get them some food. It might be a bad morning when I go in, and she’s soiled herself. But I run out of time because I’ve got another patient waiting... And they’ve cut all the care in half. Now it’s gone to just half an hour to give a shower – and if you’re really immobile it’s hard to do it in half an hour.’

This testimony is backed up by the findings of a recent survey of professionals who deliver care in the home, 79 per cent of whom found that their schedules meant they had to leave client appointments early to get to the next, rush their work, or work extra time without pay (Unison 2012).

Information and guidance

The fragmentation of public services into departmental and contractual silos means that users must interact with a bewildering range of agencies – repeating conversations, duplicating information, and making sure that these agencies are speaking to each other. Using some services can be like taking on an assault course.

The fact that elderly and vulnerable adults need a care package which is split across hospitals, social services, GPs, NGOs, agencies, housing associations, local authorities, private contractors and informal family care makes the system extremely difficult to navigate. There is no central point of contact that oversees and understands the needs of individuals. Patients are sent back and forth between different service providers, which means that they (or others on their behalf) have to ‘battle the system’ to avoid falling through the gaps.

Sarah’s account typifies the difficulties of organising and co-ordinating care across services:

‘[The hospital] told me with my mum... just before she went home, [that] they’d sorted out a commode so she wouldn’t have to be going up and down stairs, and... it would be put in on Monday, with some bedding pads, and everything was in place – this is what they’re going to do to send her home. I came back on Saturday to pick her up, and there was this foreigner who couldn’t really speak English, and she said, ‘I need you to sign’... I asked about the commode and everything, and she said, ‘There’s a letter for GP’, so I signed it... But nothing came on the Monday. I rang the hospital and they didn’t know anything about it, and said it wasn’t arranged, and [that] it was

down to the GP. So I got an appointment with the GP, and the GP said it was the hospital... So I sat there and said I wasn't leaving until I saw the doctor I knew. I sat there for an hour and a half, and I managed to see him. He was disgusted – he said it wasn't down to him, it was down to the hospital, and what they're doing is that is if they discharge people to get the bed, and [then] say it's the GP, then the funding has to come from the GP. It's another way for them to pass the buck. But the doctor managed to resolve it by kicking up a big fuss. The delay didn't annoy me, because I could make do, but it was the confusion – I'm ringing here and there and no one is taking responsibility. And you don't know where to go.'

The women we spoke to had to take on responsibility for unpicking the system, often spending huge amounts of time researching options and medical diagnoses and relaying information between different parties. Tanya talked about the difficulty of having to keep sneaking out of the office to make calls (all to numbers which seemed out of date, and to organisations that were only open during her working hours), trying to insist on a local authority home visit. As well as the practical difficulties involved, these processes were both stressful and emotionally draining, often taking place while a relative was seriously ill, recently diagnosed or quickly deteriorating.

'The information and communication is abysmal, and it's heart-breaking. Not just between the medical [team] and the family, but with all the different groups of people... the doctors aren't informing the family, or the GPs... or the social services.'

'I always ring up and get a new person, and I have to explain the situation again and again and again. It's really upsetting to have to go through it all every time.'

Compounding these difficulties was the fact that the patient was often not able to remember or have a clear picture of their own needs or medical history; and in many cases, their needs were changing rapidly due to recovery or decline.

Services can also be poor at providing information and advice. Mums-to-be told us that they wanted better professional guidance both throughout and after pregnancy. Midwives are the main gatekeepers of information about options in the local area – meaning that the information and guidance that was given depended on the individual midwife and the classes available. Several women did not attend antenatal classes, or were only eligible or offered antenatal classes for their first child (and so found that the processes and available options had changed since).

Women also wanted more advice and guidance post-birth. Especially with first children, most of the focus was put on a healthy pregnancies and deliveries: after leaving hospital, many new mums felt quite unprepared for caring for a newborn.

‘When I went home with my baby I didn’t know what I was doing, and I ended up phoning up the NHS because I couldn’t get him to stop crying. It sounds so silly now, but at the time it was really scary.’

2.2.2 Empowerment

Broadly speaking, there are two ways of empowering citizens in relation to public services. According to the economist Albert O. Hirschmann, when a customer is unhappy with a service they can either go elsewhere (‘exit’) or stay where they are and complain (‘voice’) (Hirschmann 1970). One of the variables that influences the likelihood of an individual either exiting or complaining is loyalty. A service user is less likely to vote with her feet if she feels a sense of loyalty to the service provider; she is more likely to raise her concerns either individually in the form of a complaint (individual voice), or collectively, through some form of collective action with fellow dissatisfied service users (collective voice).

Recent governments, including that of Tony Blair and the current Coalition government, have focused on the former, seeking to expand the individual consumer’s ability to ‘exit’ services by increasing choice. For this reason, in our conversations with users we focused on the concept of extending individual choice.

While the women we spoke to supported choice between different providers, they saw it as a last resort – a means of exiting a poor local service. Their preference was for the most conveniently accessible local service to be of a high quality, mitigating the need for ‘exit’. As we show below, they also valued opportunities to develop relationships with others in their community through their use of public services. Exit would disrupt those relationships, and so was not to be used lightly.

Our respondents were sceptical about some aspects of the ‘choice agenda’. Some felt that choice was more theoretical than actual. In maternity services, for example, birth plans were felt to be ineffective because they were not taken seriously in the event, and because the resources required to make choices real were not available:

‘I don’t see why they make you make a birth plan – it’s a complete waste of time. They don’t look at it; they don’t read it; they don’t ask you questions about it: you just have to get on with it. And they don’t really care what you want, they just want to get you in and out of there as quickly as possible.’

In some parts of the country, women were given unpleasant choices: for example, a choice between a birthing centre with midwives but no doctors (and therefore limited pain relief) where partners were allowed to stay overnight, or a hospital with full access to anaesthetists and emergency services, but where partners were only admitted during visiting hours.

In early years services and schools, choices were often not real due to a lack of places. For example, two mums from Newcastle didn't get any places on a shortlist of five services, and so were having to travel large distances for childcare.

'I put five choices on my form, all local, all within two miles, and I didn't get one of them. I've now got a 30 minute travel to get my boy to school and... I don't even know the area at all.'

There are also real barriers to exiting services even in cases where users are unhappy with them. When it came to early years, unless the standards were appalling or the child was unhappy, parents were reluctant to move them even if better provision became available. This was because they valued the continuity of relationships the child had formed with other children and care providers more than they valued a place at a better-quality provider.

'You do want them to build their own community... I make a lot of effort to make sure my son has friends, and take him to groups and things like that... So then it would be awful if he had to move. And you get to know the other mums.'

We specifically asked about the use of personal budgets as a means of giving users much greater choice in and control over the sort of service they receive. A personal budget is a pot of money which is paid directly to a service user so that they can spend it on purchasing a service themselves, rather than using the standard service – which, in the case of personal care, is offered by the local authority. We asked our participants about the idea of extending the use of personal budgets to maternity services. They generally had a negative reaction: despite the limited nature of the choices on offer in maternity services, many women believed that personal budgets impose an additional burden of responsibility at an already stressful and emotional time.

'It's really stressful – as if you don't have enough to worry about when you're pregnant! You just want to know you're being looked after by someone good. You don't want to think, Oh, now I've got to sort that out.'

Similarly, the women we spoke to in our social care groups welcomed personal budgets as empowering for disabled adults, but were also suspicious that they might represent a means for the government to devolve responsibility without offering the support and guidance that could make it genuinely empowering for families.

‘I think the word “empowerment” is trying to conjure up a utopia of us being able to do our own thing, but it’s just a smokescreen for cuts.’

Respondents also respected professional opinion. In the maternity groups, many preferred having a health professional make the best choices for them (albeit while taking their input and opinions into account) because of their expertise, and were wary of being made responsible for decisions they felt ill-equipped to make.

‘It’s unfair, because there are some people that might not have time to do the research. We’re not experts, and you’re asking us to make the decisions, but [we] might not make the right ones.’

So while choice and control were considered important, personal budgets were only thought to be desirable where people really wanted them, and choice was seen only as a ‘last resort’ mechanism when a local service had failed.

One implication of this is that, beyond choice, public services ought to be buttressed by strong voice mechanisms as well. These can take the form of both individual complaint mechanisms and collective opportunities for user voice to be heard, such as user forums, participatory governance structures or peer support communities. However, collective voice bodies such as these suffer from their reliance on civic enthusiasm, and require more extensive commitment than individual choice or complaints mechanisms do. A rounded approach to user empowerment ought, therefore, to encompass all these forms of engagement (Dowding and John 2012).

2.2.3 Collective participation

It is not just deeper relationships between professionals and users that are prized, but also stronger citizen-to-citizen relationships as well. As well as having a relationship with midwives, participants felt that maternity services should also strengthen users’ relationships with other local parents. This is particularly valuable during the period of time immediately after pregnancy, when parents are most in need of a network of support and advice. Many new mothers felt isolated and worried post-birth, unable to determine what behaviour or maladies were ‘normal’, particularly with first-borns. They would be troubled by questions like, ‘What does a “bad cough” sound like?’

Women wanted both pre- and post-birth meetings with midwives to take place in community settings. Some centres administered injections and weigh-ins as drop-in group sessions, with opportunities for one-on-one time if it was wanted. Parents appreciated these opportunities to meet others, build supportive networks, and facilitate information-sharing about services and practicalities.

In early-years settings, interactions between children were felt to be crucial to their development, and the importance of the continuity of peer groups and relationships through guaranteed provision at primary schools was emphasised. Parents wanted guarantees of school places attached to early years services – in part because of how highly relationships are valued in this context, particularly within children’s peer groups.

‘It takes kids a really long time to settle. Mine cried every day, and now he’s settled because he finally made friends with his playgroup. Then they all went to the same nursery, so he’s still settled much more and it’s been so good for him.’

‘She was in playgroup there, [but] then she couldn’t get into the nursery reception class, so she couldn’t go with all her friends [and] had to move to a different school... It’s terrible... because it’s the kids that are suffering. It’s awful, because I don’t think they care about it.’

The women we spoke to also felt that services tended to undervalue family relationships. In terms of maternity services, a high priority for mothers was that their partners were allowed to stay overnight post-birth, both to support them and to encourage bonding with the baby. Excluding partners after birth not only puts added pressure on the mothers (and on nurses or midwives to provide non-medical support), it also makes the mother the immediate primary carer for the baby.

‘There was nothing worse than when I had my little girl, and by 8pm [my partner] had to go home. And then he came in the next day, but had to go between 12 and two because it was no visiting then. [Whereas in the birthing centre for my little boy, my partner] was able to stay with us for the whole night. It was lovely. That’s how you want your first night – being all relaxed and having someone else to support you. It meant all the other midwives just pop in and out as they’re needed, and don’t need to do as much because you’ve got your husband there.’

While space clearly presents practical issues, particularly in hospital settings, some providers have thought creatively about how to better include fathers and support mothers. For example, the Princess Anne wing at the Royal United Hospital in Bath has reclining chairs, which allow all partners to stay overnight after birth (GWH 2012).

Similarly, because many pregnant women’s partners were unable to attend appointments due to work commitments – combined with the fact that the majority of information is directed at the mother – men often feel excluded or unsure of their role.

‘I remember just after I had my second [baby], I had to go into theatre, and they just gave my baby to my boyfriend and said, “Here you go”. He’d never held a baby or anything, and was like, “What do I do?”, and they left him to do it without any help between eight and 12 at night... and he was by himself.’

This imbalance can not only place too much responsibility on mothers as primary carers, but also can exclude fathers from becoming involved for fear that they might ‘get it wrong’. Small changes – like including the father at the six-week check-up to ask questions about the baby – could send strong signals of their inclusion in the wider process.

In health and social care, services are not well enough set up to ensure that family members are involved. In some instances this means that vital information is not conveyed, either to the individual making decisions about care and treatment, or to other professionals involved in it. One respondent described how a frail grandmother was informed that she had terminal cancer when she was alone, and was left distressed and without company for hours because her family hadn’t been informed. Another told us of a man suffering from dementia who was diagnosed with a brain tumour, but whose diagnosis wasn’t shared with his family, meaning that neither they, nor his GP, nor his carers knew of it.

2.3 Conclusion

In chapter 1 we drew a distinction between ‘delivery state’ methods of tackling social problems, which utilise bureaucratic or market techniques, and the relational state approach, which involves much greater integration of public service systems and deeper relationships both between professionals and citizens and among citizens themselves. We argued that the relational state is, or could be, much more effective than the delivery state at tackling a growing range of complex problems.

In this chapter we looked at public services from the perspective of the citizen. From this perspective, the ‘delivery state’ is often experienced in the form of transactional services – which sometimes work very effectively from the user’s point of view, particularly those services from which the user wants limited personalisation and low levels of participation. However, it is too often the case that where service users want a deep relationship they instead experience a shallow transaction.

The women we spoke to argued that in maternity, early years and adult social care services the degree of personalisation was too limited. To address this, they wanted to see much greater consistency of personnel, a more ‘human touch’ at the frontline, and much more support and guidance with their efforts to navigate fragmented systems. They supported user empowerment, but thought that personal budgets should only be for those who want them. They saw ‘exit’ as a useful last resort in the case of a failing service, but also prized the relationships developed in shared local services.

They wanted to see services delivered in community settings that strengthen support networks, and they wanted families to be included much more in the decision-making process and in care itself.

Taken together, this chapter presents an argument for shifting towards the relational state. This involves a movement away from a 'one-to-one' approach in the case of individual consumer choice, and from a 'one-to-many' approach in the case of bureaucratic standardisation, and towards a 'many-to-many' model that is personalised and empowering, and which better enables citizens to build a shared life together.

PART 2

BUILDING THE RELATIONAL STATE

3. CONNECTED SYSTEMS AND DEEP RELATIONSHIPS

FROM THEORY TO PRACTICE

So far in this paper we have made a two-part argument in favour of the relational state. First, we have argued that public services must be reformed to enable them to tackle a growing number of complex problems. Over the last 30 years policymakers have deployed bureaucracy and markets in efforts to make public services more efficient and effective. We have argued that these tools are best suited to tackling so-called 'tame problems' with linear causes, and which can be dealt with within functional silos. These include problems such as reducing hospital waiting lists and improving basic literacy.

While these 'tame problems' are often difficult to resolve, they are distinct from a further set of problems which we have categorised as 'complex'. Complex problems are characterised by multiple causes that are interconnected across functional silos, and by non-linear relationships between those causal factors which mean that standardised blueprints and simple market incentives are unlikely to work. Examples of complex problems include long-term unemployment, large numbers of young people not in education, employment or training (NEETs), reoffending, antisocial behaviour and chronic disease. Dealing with complex problems requires much greater integration of public service systems, and the fostering of deep relationships both among citizens and between service users and frontline professionals.

Second, we have argued that public service users themselves are demanding more relational forms of service provision. Too often, when a service user expects a relationship they experience a transaction – such as when an elderly person is washed and dressed in 15 minutes, when an unemployed person with complex needs is given a brief 'job-focused' interview, or when an expectant mother has to retell her story repeatedly to different midwives. Moreover, citizens want their relationships with public services to be empowering and to connect them with others around them. This argument is summarised in table 3.1 below.

Having established the case for a more relational state, this chapter turns to how we can create one in practice. We do this in two ways. First, we explore two public services currently being run along 'delivery state' lines, explain why they are not functioning as well as they should, and set out what relational state alternatives would look like. Second, we describe the main practical steps required to create more relational services, illustrating these with international and domestic examples.

Table 3.1
Three models for organising public services, their effectiveness and the service they offer to the citizen

	The 'delivery state'		The 'relational state'
	Bureaucracy	Markets	Relationships
Assumptions	Desired outcomes can be achieved through the implementation of rational plans developed by a technocratic elite and imposed through the exercise of hierarchical authority.	Optimal equilibria will be arrived at through the exercise of consumer choice in a context of competition between different providers.	Outcomes cannot be directly planned for in complex systems where phenomena have multiple and non-linear causes that interact in unpredictable ways.
Tools	Rewards and sanctions are set at the top and imposed down the management line, through the use of performance indicators, targets, performance related pay, ranking and reputation mechanisms and external audit.	Either: 1) quasi-markets in which providers are motivated by a desire to increase market share and consumers can choose between different providers or 2) in cases of natural monopolies the whole market can be 'contracted out' on a contestable basis to an external provider.	1) At the macro level, <i>an interconnected system</i> : silos broken down and budgets devolved; government acting as an enabler rather than a manager; change achieved through incremental trial and error; and infrastructures created for generating new knowledge and sharing learning. 2) At the micro level, complex problems are tackled through <i>deep relationships</i> among citizens, and between citizens and professionals.
Effectiveness			
Problems the model is best suited to solve	'Tame' problems for which policymakers know what works and the challenge is to scale up and transfer.	'Tame' problems where consumers and providers will respond predictably to market incentives.	'Complex' problems where no standard strategy or market incentive can be relied upon in advance to achieve an outcome, and where causes are multiple, interconnected and non-linear.
Ideal conditions	Workforce is low on skill and motivation; user engagement is not essential; a small basket of outcomes can be identified that will unlock wider improvement; technocrats have reliable and useful information; problems can be tackled within silos.	There is genuine choice and competition; consumers have reliable and useful information; good providers are able to expand and weak providers exit; an intrinsic public service ethos is non-essential; problems can be tackled within silos.	Complex systems; decentralisation of power; a skilled and motivated workforce (or an infrastructure in place to quickly achieve one); high levels of user and professional engagement; reasonably strong levels of trust and social capital.

Type of service offered to the citizen			
Degree of personalisation	Standardised services with limited tailoring to individual consumer needs.	Standardised and personalised services, although degree of personalisation limited by silo-based delivery.	High levels of personalisation and a whole-person view of need through more integrated services.
Degree of citizen empowerment	Low levels of user empowerment.	In quasi-markets, consumers are empowered through individual choice and voice. In contracted-out monopoly services there are low levels of user empowerment.	Individual choice and voice mechanisms supplemented by stronger collective voice mechanisms.
Degree of collective participation	Low levels of community involvement.	Individualised provision, with emphasis on strengthening 'exit' options which limits community-building through shared local institutions.	A bias towards provision through shared local institutions which can strengthen social networks.

3.1 The Work Programme

The Work Programme (WP) is an active labour market programme provided mainly by private companies on behalf of the Department for Work and Pensions (DWP). People over the age of 25 on jobseeker's allowance (JSA) are referred to the programme after being unemployed for 12 months; younger JSA claimants are referred after nine months, and those claiming employment and support allowance (ESA) can be referred at any time. The WP operates on a 'prime provider' model whereby the country is divided into 18 'contract package areas', and with two or three prime providers within each area. Top tier providers win the contracts, and can then subcontract work to a larger number of smaller providers.

Providers are 'paid by results': they receive an upfront 'attachment fee' to help with set-up and running costs in the first few years, a 'job outcome fee' if they can show that a client has been in work for a certain period (normally six months for most client groups), and a 'sustainment fee' for keeping that person in work every few weeks beyond that period. Higher fees are payable for the hardest-to-reach groups, the intention of which is to prevent providers from concentrating on the easier cases (so-called 'creaming') and neglecting the harder cases ('parking').

The WP is an example of 'black box commissioning', in that the government does not prescribe how providers should do their work: the intention is that they should be able to innovate to achieve set outcomes. In most respects the programme is very similar to the Flexible New Deal programme it replaced, although it is operating on a lower budget.

The WP has been heavily criticised for its poor performance in getting the long-term unemployed back to work. In the programme's first two years, providers failed to hit their targets for all three client groups: 18–24 year olds on JSA, older JSA claimants and ESA claimants. In its first year, the WP got just 1 per cent of its JSA claimants (of all ages) into work, and just 0.6 per cent of its ESA claimants (compared to targets of 44 per cent for 18–24 year olds, 33 per cent for older JSA claimants, and 17 per cent of ESA claimants). While things picked up in year two (hitting 38, 30 and 5.7 per cent for the three groups respectively) they remained below target. By year three there was better news: between April and June 2013 the WP had a 58 per cent success rate for 18–24 year olds, and one of 46 per cent for over-25s. However, the WP is still woefully failing to help the sick and disabled into work: just 5 per cent of those referred were found work in the latest period, against a 17 per cent target (Worrall 2013, Davies 2013).

What explains the problems experienced by the Work Programme? There are a number of technical reasons why it has struggled. The targets were probably too ambitious in the first two years, particularly given the weakness of the labour market at this time. The incentive payments do not appear to be high enough to discourage the 'creaming' of easier clients and the 'parking' of harder cases. There were also transition costs, particularly for those companies that had to establish entirely new relationships in local areas where they had no previous presence, and the programme as a whole was less well-resourced than the Flexible New Deal, which has put added pressure on providers to cream and park clients and has probably held back innovation. Lastly, the segmentation of claimants into different groups is probably too crude, and there is a need for better diagnostics (Gash et al 2013).

These are the sort of technical problems that could be dealt with without altering the basic structure of the WP. However, there are more fundamental flaws which prevent the WP from being effective, especially when it comes to the most complex cases. First, the programme has pushed out many small voluntary sector providers with the specialist skills required to deal with the most complex cases. This is because the contracts are too large: they last for five years, cover large geographical areas, and come with a £20 million capital requirement that most third-sector providers cannot meet. As a result, just five out of the 40 prime provider contracts went to non-private-sector organisations. The big winners from the WP were large companies like A4E (which secured five contracts) and Ingeus Deloitte (which won seven). Even taking voluntary sector involvement in the wider supply chain into account, third sector organisations will deliver just 20 per cent of WP operations, compared to 30 per cent of equivalent welfare-to-work services in the late 2000s (CESI 2012).

Second, the private providers running the WP do not hold the levers that are responsible for the job outcomes they are paid to deliver. In particular, these providers are being held to account for a weak labour market that they can do nothing about – and even in a more buoyant labour market, it is unclear what value they would be adding to employment outcomes that might have happened anyway. This difficulty in attributing cause means that we do not understand whether providers are being paid too much or too little for what they do.

A third, related point is that complex problems require co-ordinated solutions that the WP cannot deliver. Those ESA claimants that the WP is failing to get into work require a holistic and personalised approach which attends to all of the barriers that stand between them and the labour market, including physical and mental health problems, lack of confidence, poor interpersonal skills and lack of qualifications. These barriers cannot be adequately overcome by WP providers who do not have existing local relationships that enable them to bring together interventions across different services. Indeed, most assessments indicate that the WP remains a narrow, job-focused programme that is therefore unable to deliver the kind of connected and deeper interventions that are necessary (Gash et al 2013, Davies 2013).

The WP is a classic ‘delivery state’ approach to tackling a complex problem: a silo of state provision is contracted out on the basis of competitive bids which set out how providers will achieve targets for a given price. However, complex problems with multiple and interconnected causes are not susceptible to this kind of linear approach.

So what would a relational alternative to the Work Programme look like?

First, welfare-to-work programmes for the long-term unemployed should be commissioned locally rather than nationally. As in countries like Spain and Germany, national government could retain control of the administration of and eligibility criteria for out-of-work benefits, but active programmes for the long-term unemployed could be devolved to local government. Local government enjoys long-standing relationships with all the relevant service providers. Because local councils have a responsibility to a place rather than to a government department (in this case the DWP) they can configure a range of interventions around a person, having first sought an understanding of that person’s problems ‘in the round’. It might make sense to devolve welfare-to-work programme budgets to a ‘functional economic area’ such as a city-region, alongside economic development, transport and skills budgets. Greater Manchester and parts of the North East have already come together to create ‘combined authorities’ to more effectively manage local economic development.

Second, any active labour-market programme for the long-term unemployed should put the community and voluntary sector in the driving seat. The third sector is particularly well-suited to delivering

these kind of relational services: they are driven by intrinsic motivation, which helps to build trust; they are rooted in local communities with a deep knowledge and understanding of the area; they tend to have strong existing relationships that can help to make things happen; and they generally have more expertise when it comes to working with people with complex needs. The private sector and state bureaucracies are arguably better equipped to deal with those who are basically ready to work but who need to be matched with the right vacancies – their greater ability to do things like pooling back-office functions, automating delivery and implementing effective business processes make them better suited to the high-churn and transactional aspects of employment services.

In order to put the third sector in the driving seat, we need a programme based on a larger number of smaller contracts. Instead of having 18 contract package areas, devolving commissioning to the city-regional level would produce smaller, lower-risk contracts that the community and voluntary sector could bid for with confidence.

3.2 The probation service

‘Probation’ refers to a range of services intended to both punish and rehabilitate offenders in the community rather than in prison. These include assessing and managing risk, advising courts, implementing court orders in the community and delivering rehabilitative programmes to prevent reoffending.

Ever since the 2003 Carter review, governments of both parties have attempted to introduce greater competition into the probation service. The 2007 Offender Management Act led to the establishment of probation trusts, whose role is to both provide and commission probation services in their areas. The Home Office set a target for more services provided by trusts to be contracted out, although only limited progress was made in this regard.

The Coalition government has accelerated the pace of reform by setting out proposals to contract out services for the majority of ‘low-’ and ‘medium-risk’ offenders in the community. Under these proposals, the country has been divided into 20 contract package areas, and private and voluntary sector providers have been invited to put in bids. As with the Work Programme, providers will be paid at least partly ‘by results’, which in this case means their success in preventing reconvictions. The remaining, slimmed-down public probation service will be tasked with risk assessment, court advice, advice to the Parole Board, allocation of all offenders on community sentences, sentence enforcement and supervision, and the management of high-risk offenders.

There are a number of reasons for believing that these reforms are misconceived. First, they will fragment services between a public probation service, which retains various enforcement functions, and contracted-out providers which have responsibility for the case management of most offenders. There is a risk that parcelling up probation services in this way will inhibit the exchange of information between the different local agencies, causing oversights and increasing the risk of harm.

Second, the contracts are too big. It is likely that they will push out voluntary sector providers, who might be the most appropriate, and instead lead to the concentration of services in the hands of a few large private companies. This concentration would be likely to limit competition and innovation rather than promoting them (which is supposed to be key aim of the proposed reforms). Large, nationally-commissioned contracts are also likely to be unresponsive to local needs and circumstances, as was found recently with contracts for the electronic monitoring of offenders (Gash et al 2013).

Third, providers will lack influence over most of the factors that affect whether or not somebody reoffends (which include their family life, employment status, health and housing situation). Contracting-out service silos on a national basis, as with the Work Programme, will undermine the ability of local providers to integrate and co-ordinate provision around the individual user, which is essential for tackling complex problems like reoffending.

If we were instead to base reform plans for probation on the principles of 'connect' and 'deepen' set out earlier in this paper, the service would be structured entirely differently. National commissioning of services for low- and medium-risk offenders would be replaced by local commissioning. This is hardly a revolutionary act: it was only in 2001 that the probation service became a national agency, and in Scotland probation functions are carried out by the social service departments of local councils (see Loader et al 2011).

Local delivery units within probation trusts are already coterminous with local authority boundaries, and so could be transferred into local government in much the same way that public health has been. This move would confer a number of advantages: probation officers responsible for overseeing community sentences could be fully integrated into the work of local youth services, drug and alcohol treatment services and mental health services; probation officers could co-ordinate holistic efforts to tackle offending behaviour; and community service work would be more closely linked to local people's priorities for the area, and could be subject to public input via a democratic body. In fact, probation services for adult offenders could learn a great deal from the experience of Youth Offending Teams, which have been based in local authorities for the last 15 years (see case study 3.1 below).

This does not mean, however, that local councils should dominate the provision of probation services. Rather, there could be contestability in the commissioning of focused interventions to reduce reoffending. A larger number of smaller contracts for delivering rehabilitative services is much more likely to produce greater innovation than the national commissioning process that the government is pursuing.

3.3 Steps towards relational public services

The relational state entails the creation of more interconnected systems and deeper relationships at the frontline. In this section we break down these two processes into a number of reform steps, and illustrate them with reference to domestic and international examples.

3.3.1 Connected systems

At the macro level, the challenge is to design and manage public services in a way that gives recognition to the fact that they are complex systems. This means enabling greater connectedness between actors and institutions within those systems so that they are able to respond, innovate, adapt and learn in a way that is self-improving. If done right, this negates the need for continual micro management from the centre.

Decentralise

The first step towards the relational state is decentralisation. The centralised nature of the British (or, more precisely, the English) state is the biggest obstacle to more relational modes of provision. The key decisions about funding and priorities across a whole range of areas – including transport, skills, housing, economic development, employment support, schools, health and the criminal justice system – are still largely taken in Whitehall. This is a case of English exceptionalism: most European countries of our size devolve many of these matters to regional and municipal governments.

Two major consequences of centralisation are relevant to our argument for the relational state. One is that services are funded in silos, which means that they are unable to take a ‘whole person’ or ‘whole place’ view. This is particularly problematic when attempting to solve complex problems with interconnected causes, such as crime, reoffending and long-term unemployment. The other major consequence is that service providers are too often held to account upwards to Whitehall rather than outwards to the citizen, which undermines flexibility, responsiveness and innovation.

The solution must be to devolve decisions, which crucially means budgets, to a more local level. In some areas this could mean existing local authorities, although there are cases in which a larger area would make more functional sense. In areas such as transport, economic development, housing and skills the government should ask for combined authorities to be created from below in return for a significant devolution of funding. Two such bodies have already been formed in the North East and Greater Manchester.

Such a radical step involves a major challenge to the way England is governed, comparable in scale to the devolution reforms of the late 1990s. This entails a significant change in our political culture, where blame and accountability traditionally gravitate towards London. We discuss how these challenges can be overcome in the next chapter.

Pool funding

Local authorities and combined city regional authorities should be able to pool devolved budgets across silos, enabling local areas to reduce duplication, focus holistically on high-cost areas such as ‘problem families’, and invest in upstream prevention.

Pooling funds across a number of areas will be essential for the next spending review: if we continue to ‘salami slice’ departmental budgets nationally, public services are likely to be eviscerated. A more sensible approach to making the further savings required in the next parliament would be to devolve funding to city-regional or local authority level, and to give those bodies time to reconfigure local services across silos. Taking a place-based approach is likely to encourage preventative investment and avoid salami-slicing, so long as it is combined with a long-term (five-year) funding settlement, and so long as local areas can retain the savings they make.

Integrate

As well as pooling funds, tackling complex problems requires service integration too. This can mean professionals from different sectors working together to take a ‘whole person’ or ‘whole place’ approach to a problem. One pioneering example of integrated service delivery from the last 15 years has been the Youth Offending Teams (YOTs) based in local government. It is true that much of the recent fall in first-time entrants into the youth justice system has been down to the end of the previous Labour government’s ‘offences brought to justice’ target, which had the effect of encouraging police officers to make excessive numbers of arrests for relatively trivial matters. However, the continued falls in both the numbers of young people entering the youth justice system and the numbers in youth custody over the last three years is thought by many experts to be attributable to the integrated preventative work of the YOTs (see case study 3.1 opposite).⁶

6 We should note that integration through mixed teams is not without its difficulties. While it appears to have worked in the case of YOTs, IPPR has found problems in Community Mental Health Teams – particularly regarding social workers feeling undervalued and sidelined by medical professionals. There is also, therefore, a need for a change in professional mindsets in order to make these arrangements work. (This research will be published in a forthcoming IPPR report on the mental health social work profession.)

Case study 3.1: Youth Offending Teams

The local administration of the youth justice system is overseen by Youth Offending Teams (YOTs), which are composed of representatives from various agencies, with at least one representative each from the probation, social, educational, and health services and the local police. As of September 2013 there were 158 YOTs across England and Wales. While the structure and work of the teams varies from one area to another, their 'key tasks' include:

- assessing risks and the needs of young offenders
- making recommendations to sentencers about the type and content of sentences
- delivering community-based sentences and ensuring compliance
- undertaking preventive work to reduce the number of first-time entrants.

Recent years have seen big falls in the number of first-time entrants to the youth justice system. The number of first-time entrants rose until 2007, but then fell by 67 per cent between 2007 and 2011/12. The peak in the number of first-time entrants occurred in 2006/07, and is likely to have reflected the Labour government's target of increasing the number of offences brought to justice (receiving formal sanctions) by 2007/08. The number of youths in custody also fell by 30.6 per cent between 2005/06 and 2011/12 – a period in which the number of adult offenders in custody actually grew by 12.2 per cent. The YOTs have also had some success at reducing reoffending, from 3.32 offences per reoffender in 2000 to 2.87 in 2010/11 (Muir and Armitage 2014 forthcoming).

The fact that the government dropped the 'offences brought to justice' targets for the police clearly played an important role in reduced 'through-put'. However, since 2010 there have been three further years of continuing reductions in both the number of first-time entrants to the youth justice system and the number of youths held in custody, and it is believed by many in the criminal justice system that the youth justice system itself has contributed to these successes (Justice Committee 2013).

There has been little evaluation of the different interventions deployed by YOTs, so any conclusions about 'what worked' must be tentative. However, as part of research for a forthcoming report IPPR interviewed YOT managers in those parts of the country where outcomes had most improved (Muir and Armitage 2014 forthcoming). These managers identified a number of things that

they felt were critical to their success.

- The relationship between a young person and their key worker. In all of the YOTs we looked at, each young person had a lead caseworker, plus other specialist staff who could become involved depending on the assessment of the young person's needs.
- The fact that their partner agencies seconded their staff into the YOT, meaning that staff focusing on health issues sat alongside staff specialising in other areas within the YOT. They were effectively full-time employees of the team, under one line manager. This enabled more co-ordinated and effective interventions.
- Reducing first-time entrants by working with partner agencies to adopt different approaches, and encouraging diversionary actions to stop young people getting sucked into the system.

Greater autonomy for frontline staff, combined with data transparency and accountability for outcomes achieved

Complex public service systems are increasingly thought to work best where the traditional distinction in public administration between 'principal' and 'agent' is broken down (Sabel 2012, Seddon 2008, Hallsworth 2011). This means that instead of a sharp distinction between the decision-maker and those implementing the policy, frontline workers are given flexibility to adapt policy in practice in order to respond to complex local needs and demands.

The private sector has for many years considered front-line autonomy to be key to innovation. The so-called Toyota Production System, for example, sought to move away from Taylorist and Fordist models of management and mass production, and instead give frontline workers the capacity to adapt the production process as they learn and improve (Seddon 2008).

New public management emerged in part as a means of reducing frontline autonomy: professionals were not trusted by politicians, and were seen as neither skilled nor motivated enough to improve services. They therefore had to be monitored and more sharply incentivised to work hard and deliver.

The key improvement challenge for public services is finding a way to combine the frontline autonomy that is necessary for innovation and improved productivity with the accountability required to incentivise improvement. The way to square this circle is through the publication

of comparable outcomes data. This would ensure that professionals are motivated on reputational grounds to continually improve the performance of services, and that they are held to account by each other, by government and by the public.

There is good evidence that ‘reputational competition’, whereby results are published and providers publicly ranked, can incentivise improvements in performance (Bevan and Wilson 2013). It tends to drive public service leaders to seek to do better in order to enhance their reputation. For example, when data on survival from cardiac surgery performed by providers across the state of New York was published, it had little impact on consumer choices about which hospitals to use, but it was found to push hospital managers to improve and therefore resulted in fewer deaths (Hibbard et al 2005). Similar improvements have been associated with the publication of school league tables and hospital star ratings in England (Bevan and Wilson 2013).

By contrast, there is strong evidence that reducing transparency can lead to poorer outcomes. For example, after Wales stopped publishing school league tables educational attainment fell markedly in Welsh schools (Bevan and Wilson 2013).

Case study 3.2 demonstrates how, in the case of the Finnish school system, frontline autonomy has been successfully combined with accountability. There are strong grounds for concluding that Finland’s educational success is linked to three factors.

1. Ongoing learning and innovation to adapt provision to the needs of pupils.
2. Extensive collaborative support for those with special educational needs.
3. The close monitoring of data to hold providers to account and allow the system as a whole to learn without the need for disruptive interventions by the centre.

Case study 3.2: Supporting special educational needs in Finland

For many years, Finnish 15-year-olds have outperformed their peers in other advanced countries in the PISA test of reading, mathematics, problem-solving and scientific knowledge. The key to this is a relatively narrow attainment gap between children from richer and poorer families in Finland relative to those in other comparable countries. This greater level of educational equality is the key driver behind the country’s better overall results.

A number of factors have been presented as explanations for these outcomes, including Finland’s higher levels of social solidarity, the

value the country places on education, and its high-calibre teaching profession. However, as Charles Sabel (2012) points out, many of these factors (a homogenous, relatively egalitarian society, for example, and a cultural premium on education) are also present in other Scandinavian countries – yet Finland consistently outperforms its neighbours. Moreover, Finland has not always been top of the league: prior to its shift to a comprehensive school system in the 1970s, the country performed poorly in terms of attainment and test repetitions (Sabel 2012).

Instead, Sabel singles out the following factors as the keys to Finland's success:

- Diagnostic testing for emergent cognitive problems, starting at the age of two and a half and continuing frequently throughout formal schooling. These are low-stakes tests, in the sense that they do not imply rewards or sanctions – they are diagnostic and formative, intended to identify problems early and design personalised responses. The tests are designed in consultation with teachers by institutes that specialise in cognitive development.
- Expansive and intensive support for pupils with special educational needs. Thirty per cent of Finnish students receive special education services – a much higher rate than in other OECD countries. These students receive tailored support to address learning problems.
- Ongoing monitoring, learning and adaptation. Special education provision is monitored by student welfare groups (SWGs) which involve the school principal, a psychologist, the school nurse and teachers. SWGs review the performance of each class in their school at least once a year. This allows the identification and tracking of students in need of remedial, part-time special education. Nationally, the National Board of Education 'provides the school system as a whole with some capacity for self-reflection and correction' (Sabel 2012). This body monitors outcomes across the country, and provides funding and training for special education services.

3.3.2 Establish collaborative infrastructures

The debate about how to run public services too often gets bogged down in a binary debate between the merits of competition versus collaboration. The fact is that self-improving complex systems have elements of both.

As we have seen, public ranking of actors and institutions facilitates reputational competition, which has been found to raise performance. However, successful systems also possess collaborative backbone institutions that can track data, enable adaptation, disseminate knowledge and improve motivation and morale among all participants.

Particular attention needs to be paid to how knowledge regarding what works is generated and shared around the system, in order to facilitate ongoing learning and informed innovation. Much greater emphasis must be put on research and development. While this is common in medicine, in other public services such as teaching and policing there is far too little awareness of properly evaluated effective practice. We cannot expect these services to improve if professionals are not exposed to proper and relevant research.

A responsibility should be put on all providers of public services to 'feed the field'. The need for the whole system to improve through the sharing of successful practice should override any concerns among private providers about commercial confidentiality. It is also vital that we understand how public money is being spent: a commitment should be made to 'open book accounting' across all public service providers, and private companies delivering public services should be subject to the same transparency requirements as public bodies.

Finally, for knowledge to be generated and transferred around the system, we also need collaborative backbone organisations that are tasked with disseminating knowledge and offering opportunities for ongoing professional development. Such collaborative organisations can act as clearing houses for innovative practice and allow the system as a whole to learn.

Case studies 3.3 and 3.4 illustrate this point with two examples from effective school systems which have combined competition with collaborative infrastructures: Ontario's successful school reforms, and the London Challenge.

Case study 3.3: Ontario's school reforms

From 2003, Ontario state premier Dalton McGuinty introduced a number of reforms to the province's school system. As a result, the province went from having a poorly performing school system to one of the most improved systems in the world. High school graduation rates increased from 68 per cent (2003/04) to 82 per cent (2010/11), while reading, writing, and maths results increased by 15 percentage points across its elementary schools over the same period. There was a drop in the number of teachers leaving the profession, and attainment gaps between students from different backgrounds were substantially reduced (Fullan 2012).

McGuinty's education advisor Michael Fullan has identified a number of factors behind this success (Fullan 2012). First, they reduced the number of centrally imposed targets. Instead of having a large number of priorities, Ontario selected three – literacy, maths and high school graduation rates – and committed to raising the bar for all students, while narrowing gaps. These objectives took precedence over all others, partly because they were thought to leverage so many other learning goals. This strategy gave school leaders and teachers greater autonomy to innovate and experiment in order to achieve the three goals.

Second, the province invested significantly in enhancing the professional development of teachers. Ontario combined accountability and competition through transparent publication of school results with a philosophy of 'non-judgmentalism'. This meant that instead of assigning blame, support was provided to help struggling teachers improve.

The final element of their approach was to ensure that best practice was properly disseminated around the school system through greater communication, the cataloguing and sharing of best practice, and by fostering a culture of teamwork. The central ministry offered guidance for districts to promote collaborative professional environments, while also acting as a clearing-house for the best innovations. A commission was also created, which involved unions, principals and superintendents, to resolve disputes and avoid confrontation.

Case study 3.4: The London Challenge

In May 2003 the Labour government established the London Challenge with the aim of improving educational attainment in London schools under the newly-created posts of a dedicated minister and a commissioner for London schools. The programme provided improvement support for 70 schools, led by a school improvement advisor. Overall, three-quarters of London's schools were involved, either as providers or recipients of support.

The initiative also involved a city-wide programme aimed at boosting teacher recruitment, the creation of the London Centre for Leadership and Learning to disseminate the best research evidence on improving teaching and school leadership, and a new data system enabling schools to benchmark themselves against, and share learning with, demographically similar schools.

CASE STUDY 3.4 CONTINUED

The programme was accompanied by the introduction of new sponsored academies and specialist schools.

By 2010, London had moved from being the region with the lowest proportion of pupils getting five A*–C grades at GCSE to being the highest, and Ofsted found that 30 per cent of London's local-authority-controlled secondary schools were 'outstanding', compared to 17.5 per cent across England as a whole.

3.3.3 Deep relationships

How can we create conditions in which relationships among citizens, and between citizens and professionals, can be deepened? Effective relationships between people who do not know each other, and who may have very different perspectives, take time to develop. As Marc Stears has commented:

'The sense of an openness of time is especially essential for the attentive listening to others that is a core component of full relationships. It is the listening that opens up new possibilities of understanding, appreciation and commitment.'

Stears 2012

If our interactions are highly time-constrained, and if there is a high churn of frontline staff within services, then relationships are more likely to be transactional and perfunctory in nature. In order for 'time-expansive' relationships to develop, we need much greater consistency of personnel in frontline services, but we also need to design institutions that bring people together so that sustained relationships can be formed.

Lead professionals

One way to provide consistency is to allocate a lead worker to individual service users who can develop an ongoing relationship and help plan holistic approaches to addressing those users' needs. Case studies 3.5, 3.6 and 3.7 show how this has worked effectively in the case of Family Nurse Partnerships, which were trialled in the US, the provision wraparound services for children with emotional difficulties in Milwaukee, and the 'open dialogue' model for supporting young people with mental health problems which was developed in Finland.

Case study 3.5: Family Nurse Partnerships

Family Nurse Partnerships is a programme of prenatal and early-childhood home visits by nurses, targeted at low-income mothers, which originated in the US. The visits were intended to promote healthy lifestyles (such as by reducing drug, alcohol and tobacco consumption), to help develop supportive relationships with family members and friends, and to link mothers and their families to other services.

Randomised trials in Elmira (in 1977), Memphis (in 1988) and Denver (in 1994) found that, compared to similar families without home visits, the programme led to improvements in parental behaviours (including reduced smoking and improved diet), healthier baby weights, improvements in parenting styles and reductions in child abuse. Fifteen years later, the single mothers in Elmira who had received visits were found to have had fewer pregnancies, spent fewer months on welfare or food stamps, and had fewer interactions with the criminal justice system than mothers who had not received visits. The children of lone mothers who had received visits were also found to be doing better in terms of offending and behaviour than the children of mothers who had not received visits (Olds 2006).

This model has now been rolled out by the Department of Health in England, aimed at 16,000 disadvantaged parents under the age of 20.

Case study 3.6: Wraparound Milwaukee

Aimed at children with serious emotional disturbance, this initiative pools budgets from agencies that were formerly in non-collaborative silos. These agencies have been replaced by a sole provider – Wraparound Milwaukee – through which a lead professional coordinates a package of services for each child, and which operates a 24-hour crisis service. Since Wraparound Milwaukee was set up in 1995, psychiatric hospitalisation of children has dropped from 5,000 inpatient days to 300, and at a cost of £3,850 per month per child the service represents good value for money compared with the previous high costs of funding various agencies and inpatient care. Wraparound Milwaukee also now serves three times as many children as before, with improved outcomes (Cabinet Office 2009).

Case study 3.7: Open Dialogue, Finland

Open Dialogue is both an innovative approach to assisting individuals and families experiencing mental health crises, and a system of care. It was developed in Finland, and is currently the standard psychiatric service offered in its Western Lapland region. It works with families and their social networks, and is delivered in the home where possible.

The aim of this model is early intervention in the first stages of psychosis, to ensure that cases do not become chronic. The model is based around open family or network meetings, and it involves whole networks in providing help. It also ensures continuity of personnel: the same social worker stays with a family throughout the intervention, so that trust, knowledge and relationships can deepen.

The service has achieved very high recovery rates – around 75 per cent of those who experienced psychosis have returned to work or study within two years, and only around 20 per cent are still taking antipsychotic medication at the two-year follow-up. These results are among the best in the developed world.

Neighbourhood-based working

Another, often overlapping, way of deepening relationships is to make professionals responsible for a particular neighbourhood within which they can develop relationships with local residents. Case studies 3.8 and 3.9 look at the examples of neighbourhood policing in England and Wales, and local area co-ordination in social care services in Western Australia.

Case study 3.8: Neighbourhood policing in England and Wales

Neighbourhood policing was rolled out in England and Wales in 2008, and involves two or three officers being tied to a particular council ward. These neighbourhood officers could not be ‘abstracted’ onto response work, and only under exceptional circumstances could they be ‘pulled’ to work in other geographical areas. Between 2008/09 and 2010/11, the proportion of people who said that the police do a ‘good’ or ‘excellent’ job rose from 53 per cent to 59 per cent, and the proportion who expressed overall confidence in the police rose from 67 to 72 per cent (Chaplin et al 2011: 97). Unfortunately, due to budget cuts many forces are now allowing neighbourhood officers to be abstracted onto response work again, which risks a return to the so-called ‘fire brigade policing’ of the past (BBC News 2013).

Case study 3.9: Local area co-ordination in social care in Western Australia

Local area co-ordination was developed in Western Australia from the late 1980s, with the aim of strengthening the independence and self-sufficiency of people with learning disabilities so that they could live with their families at home or in the community. In practice this meant embedding local area co-ordinators (LACs) in a specific area, and making them responsible for around 60 individuals and their families. The LAC's role is to offer a single point of contact to help people sustain a good life and solve their problems in the community. It aims to turn the orthodox approach to social care on its head: it does not respond to need and crises, but rather seeks to build capacity and independence, thereby preventing problems before they become crises. It aims to help people to become as strong and as connected as possible (Broad 2012).

National benchmark data, as reported in the Disability Services Commission Annual Reports (1999/2000 and 2000/01) shows that overall, and across all outputs, Western Australia compares very favourably with other states on key benchmarks related to learning disabilities services uptake, cost and consumer satisfaction: 77 per cent of customers in Western Australia were found to be satisfied, compared to 65 per cent across Australia as a whole. The per capita cost of LACs (AU\$3,316) is lower than the non-residential (\$3,899) and residential (\$61,944) alternatives, and the system has managed to stabilise social care costs over time compared with the country as a whole (Disability Services Commission 2003).

Institutions that deepen relationships

In order to strengthen communities' capacity to solve complex problems, we need to design public service institutions that strengthen rather than dissipate relationships between citizens. Case studies 3.10 and 3.11 describe two examples of new institutions in Britain that have been introduced to strengthen horizontal relationships between citizens: neighbourhood justice panels, and a social media alternative to 'meals on wheels' called Casserole Club.

Case study 3.10: Neighbourhood justice panels

Neighbourhood justice panels are resident-led institutions to which the police and local authorities can refer cases of antisocial behaviour, neighbour disputes and low-level crime, so that they can be dealt with outside the formal criminal justice system. Whereas the criminal justice system is focused on determining

CASE STUDY 3.10 CONTINUED

guilt or innocence and is adversarial, neighbourhood justice panels are focused on solving problems. They deploy restorative justice techniques that emphasise everyone putting their side of the story across, and encourage the parties to empathise with each other.

Neighbourhood justice panels are intended to stop petty and low-level matters entering the courts, where costs are higher and problems have been allowed to reach a crisis point. Very often with issues like neighbour disputes – which take up a huge amount of police and council time – the problem is a breakdown of relationships; these panels make efforts to restore them.

A number of test areas are currently being piloted around the country. Swindon, one of the leading test areas, has a 70 per cent success rate in terms of acceptable behavioural contracts (agreements that the panels draw up to resolve cases brought before them) being adhered to.

Case study 3.11: Casserole Club

Casserole Club is a website that connects people who like to cook with people in their local community who might benefit from a good home-cooked meal. It was developed in the UK by FutureGov with the support of Surrey county council and Reigate and Banstead borough council.

The club acts as a relational alternative to standard council 'meals on wheels' services. 'Cooks' are encouraged to cook and share an extra portion of food with someone who lives locally ('diners') who would benefit from it.

Casserole Club is currently active in Barnet, Tower Hamlets and Reigate. The service has 2,633 signed-up cooks, aged between 20 and 75; 80 per cent of diners are over 80 years old. The longest-running pair-up of cook and diner have been exchanging meals for 16 months. In the initial pilot the average meal-share occurred every 1.5 weeks, and the average distance between cooks and diners was 0.8 miles.

By connecting members of a local community through the meaningful action of sharing food, Casserole Club has the potential to improve community and personal wellbeing, as well as contributing to the growing demand for social care and support among the UK's ageing population (Bickerstaffe 2013a).

3.4 Conclusion

This chapter has illustrated how a more relational state can be delivered in practice, and outlined a number of key steps that should be taken in order to achieve this.

- Decentralise much more service funding to city-region and local authority level. This would represent a constitutional reform in England similar in magnitude to the devolution settlements made across the United Kingdom in the late 1990s.
- Pool budgets locally so that services can take a 'whole person' or 'whole place' view.
- Integrate service provision, for example by bringing together mixed teams of professionals which are given responsibility for dealing with complex problems.
- Allow for much greater frontline autonomy to encourage innovation, combined with the publication of rankings to hold providers to account for what they do and encourage reputational competition.
- Establish collaborative infrastructures to generate and share knowledge, and to support continuous professional learning and development.
- Allocate lead professionals to individual cases.
- Allocate workers to neighbourhood patches.
- Design institutions that strengthen citizen-to-citizen relationships.

4. POLITICS, MONEY AND AGENCY

There are three potential obstacles to the relational state. First, is our politics mature enough for the kind of ‘letting go’ required? Second, can we afford to pay for labour-intensive relational services during a fiscal squeeze? And third, does the public have the appetite for the kind of civic activism that is at the heart of more relational services? This chapter explores each of these challenges in turn.

4.1 Politics

Is our politics mature enough for the relational state? A precondition for the reforms set out in this paper is that central government has to ‘let go’. This is because complex challenges are not susceptible to standardised, one-size-fits-all blueprints; because services delivered in functional silos from Whitehall are unable to get a grip on the interconnected causes of complex problems; and because greater professional autonomy is required to allow for more innovative and relational approaches at the frontline.

Three aspects of our political culture militate against ‘letting go’. First, national politicians tend to mistrust public service workers and local government. This mistrust means that, for many politicians, ‘letting go’ in relation to public services is analogous to ‘letting go’ in one’s personal life: providers will become lazy and services will become slow and sclerotic, captured by the producer interest.

Second, national politicians know that when things go wrong locally it is they who tend to get the blame. The UK is such a centralised country that when services fail, blame invariably gravitates towards Whitehall, directed both by a London-based media and by a public accustomed to ministerial responsibility. As a consequence, politicians are reluctant to ‘let go’ because they believe that they would still be held to account when things go wrong.

Third, politicians are rewarded in the media – and, indirectly, by public opinion – for being seen to be acting directly to address problems. This explains two pathologies of British public policy: the ‘eye-catching initiative’ and the top-down structural reorganisation. In the year 2000, then prime minister Tony Blair asked his advisors for a steady stream of ‘eye-catching initiatives’ to create an impression of energy and purpose (Blair 2000). Subsequent prime ministers have followed suit, and the result has been a blizzard of pilots, task forces, tsars and so forth across a range of politically salient areas. Many of these are never followed up, and neither has there been much evaluation of their effectiveness. They serve a political purpose far more than they improve services.

The second of these two pathologies is that public services undergo almost continuous structural reorganisation. For example, the NHS has spent three years undertaking a vast and expensive restructure, which has wasted time and distracted professional and managerial energy that should have been focused on improving services. This is only the latest in a series of four whole-system reorganisations since the early 1990s, some of which largely represented attempts to reverse mistakes made in previous reorganisations. Very few people would claim that these structural reforms drove improvements in clinical outcomes.

Top-down initiatives and restructures tend not to work because, as complexity theory teaches us, the most effective change in a complex system comes about endogenously and incrementally, rather than externally and suddenly. Innovation comes about through learning over time, and most evidence indicates that major reorganisations lead to big falls in productivity because they distract the public service workforce from their core purpose (Dunleavy and Carrera 2013). Indeed, one of Labour's most renowned public service reformers, Lord Adonis, has argued that the best reforms start small and grow out across systems over time, citing the examples of the Teach First programme and academy schools (Adonis 2010).

The political problem is that incremental change appears to have few political attractions: it lacks the muscularity and sense of agency and authority that is projected by new initiatives and structural reforms. Its gains are less visible in the short term, and only become more so in the long term – and as we know, democratic politics, driven by electoral cycles, is not very good at taking the longer view.

Are these barriers insuperable? We do not believe they are: on the contrary, we can identify four reasons for optimism. First, the fiscal pressures on the British state, arising from both the need to reduce the deficit and the need to meet the longer-term costs of ageing, are forcing Whitehall to consider substantial decentralisation. Another round of departmental 'salami slicing' is likely to be increasingly damaging for public services; instead, a 'new deal' with city regions is being considered across the political spectrum as a way of allowing local areas to pool budgets, reduce duplication and invest in prevention. The most pressing challenge here is to work out how a spending review can be carried out on such a basis.

Second, the 'who is to blame' problem can be overcome, so long as central leadership is replaced with strong local leadership. Devolution to Scotland, Wales and Northern Ireland, and the creation of the London mayoralty, show that if decentralisation is combined with the devolution of accountability to a highly visible local figure or body, the public's understanding of who is accountable shifts (IPPR and PwC 2009). Government should agree to devolve powers to city regions in the first instance, and in return those areas should produce clear and visible

system of local leadership and accountability, such as a city-regional mayor along London lines.

Third, national politicians' fear that the performance of services will suffer if they 'let go' of the reins can be mitigated by ensuring that local providers of services are properly held to account for the outcomes they achieve. Rather than directing them through a plethora of targets, a core basket of outcomes should be agreed for services, and providers ranked on their performance. As we demonstrated in chapter 3, data transparency and public ranking on performance encourages reputational competition, which helps drive improvement.

Finally, none of these changes would leave national government without a role, which is clearly a fear of those who are opposed to decentralisation.

- Westminster would continue to set high-level goals for public services; however, it would refrain from setting out how those are to be achieved on the ground.
- The government would retain backstop powers of intervention if the system fails to improve, or if particular providers fail.
- On equity grounds, national government would set the eligibility criteria in areas like social care, health, education and benefits – for example, IPPR has argued that housing benefit should be devolved to the local level to enable councils to borrow to invest in house-building, but under this reform eligibility criteria for entitlement to housing benefit would still be set nationally.⁷
- There are many programmes and initiatives that can best, or only, be delivered by central government: defence and policing procurement, major infrastructure projects, tackling serious, organised and online crime, and major national programmes – such as the literacy and numeracy hours – which involve the recruitment of specialist staff.

Overall, Whitehall will still have a vital job to do, but it will be smaller and more strategic.

4.2 Money

Relational services are generally labour-intensive, requiring highly skilled and relatively well-paid staff, including doctors, nurses, teachers, social workers and police officers. Can we afford an extension of the relational side of services at a time when we have to pay down the deficit and meet the long-term costs of ageing?

It is vital that we make our public services more productive in the years ahead – and, rather than adding to our deficit, we argue that the relational state is part of the solution to the fiscal squeeze.

⁷ <http://www.ippr.org/publication/55/9279/together-at-home-a-new-strategy-for-housing>

First, not all services are relational. In high-churn, routine transactional services from which the public wants an efficient exchange, there is scope for services to become ever more efficient through automation and the consequent reductions in staff numbers. As Dunleavy and Carrera (2013) argue, the services that have seen the largest productivity gains over the last two decades have been those such as HMRC and the DVLA which switched to online provision, allowing them to shed staff numbers. There is still scope for more provision and data to move online, particularly in the benefits system and the NHS (ibid).

There is also a role for more efficient time-saving approaches for routine interactions, such as high-churn medical procedures. For example, surgeons at Narayana Hrudalaya facilities in India provided 3,174 cardiac bypass operations in 2008 – double the number performed by the leading Cleveland Clinic in the US, with a 1.4 per cent mortality rate in comparison with Cleveland's rate of 1.9 per cent, and at a cost of £1,250 compared to £12,500–£85,000 in US and £3,000 in Indian private hospitals. These hospitals now offer operations to Britons at one-twelfth of their cost in the UK. Narayana Hrudalaya achieves these lower costs through procedure specialisation, a mass-production ethos, and a relentless drive for efficiency (Anand 2009).

India provides another example in the form of the Aravind Eye Care System, which aims to provide affordable eye-care to all in a country with the highest number of blind people in the world. It examines more than 2.5 million patients, and operates on about 300,000, every year. Low costs are achieved by operating 24 hours a day, and by allowing pre- and post-operative care to be handled by nurses. Each surgeon performs an average of 2,000 operations annually, compared with an average of 125 among ophthalmic surgeons in the US (Ydste 2011).

Looking to Europe, Vejle hospital in Denmark doubled the number of knee and hip operations it performed between 2002 and 2008, with staff hours increasing by just 15 per cent. It reduced the average length of hospital stays for knee operations from 6.5 days in 2005 to 3.9 days in 2008. The number of patients who were out of bed on the same day as their operation went from 61 per cent in 2005 to 95 per cent in 2008, with patient satisfaction with the programme also running at 95 per cent. The Vejle example demonstrates how reforms can blend relational elements with a major productivity drive: the hospital treats patients in groups to provide support and reassurance, and patients meet together both before and after surgery to make sure they are prepared and can support each other post-procedure. As with the Indian examples, the patients are operated on in a 'conveyor belt' system, which helps to reduce costs (Cabinet Office 2009).

So, by saving money through automation, reducing staff costs and saving time on the transactional side, we can help to sustain funding on the inherently more labour-intensive relational services.

Second, decentralisation coupled with integration can bring down costs by incentivising upstream investment in prevention. For example, work by YOTs to prevent and divert first-time entrants into the youth justice system has contributed in part to falling numbers in the system and in custody, which is saving the government money. Another example is that greater integration of social care and health in Torbay has led to a fall in the number of elderly people being admitted to hospital, because efforts have been made through home care provision to prevent falls and other avoidable accidents.

If we are to incentivise this investment in money-saving preventative approaches, we also need both to ensure that local areas can keep the money they save from such investments, and to provide local areas with longer (five-year) spending allocations so that they can bring forward investment now in the knowledge that they will save money later (Bickerstaffe 2013b).

The third way in which the relational state can contribute to the productivity challenge is by expecting more from citizens.

For example, the neighbourhood justice panels described in the previous chapter are relatively low-cost: all they require is co-ordination through a local authority's antisocial behaviour team, a room, a police or council referral, the presence of relevant officers at the hearing, and some basic administration. The critical ingredient is the recruitment of volunteers from the community who are willing to give their time to serve. We should note that the Ministry of Justice's current test areas were established without any additional funding.

These panels are an example of communities, facilitated by the local council and police, seeking to resolve problems before they get sucked into expensive formal systems. In the area of criminal justice, a 'restorative resolution first' approach should mean that low-level crimes, and issues such as neighbour disputes, do not escalate to the point of entering the formal criminal justice system, which involves enormous amounts of process, administration and lawyers. The central issue here is whether there is enough public appetite for getting involved, and it is to this question we now turn.

4.3 Agency

The relational state involves a greater level of civic participation by the public: relational services require an investment of time by the citizen as well as the state. In cases of deeply personal provision – such as care for the elderly or disabled, or in cases of chronic illness – the user is necessarily highly engaged with the service. In other areas, particularly

those which require collective mobilisation, greater agency is required from ordinary citizens to make things happen without any prodding by agencies of the state.

The difficulties facing David Cameron's 'big society' agenda are salutary here. While it is true that levels of volunteering have increased in the last few years, they have just returned to the same levels that were reached in 2007 (Mohan 2013). Moreover, the NCVO estimates that over the course of the current parliament there will have been a withdrawal of third-sector funding amounting to £3.3 billion. Surveys of community and voluntary sector organisations have found that, as a consequence of these cuts, the majority are reducing the services they offer (NCVO 2012).

The failure of the big society agenda lay in its apparent belief that there is a zero-sum relationship between state and civic activity – in other words, if you cut back the state then voluntarism will flourish. In fact, reductions in public funding have unquestionably undermined the work of the community and voluntary sector. But this is not just an issue about funding: it is also one of public authorities needing to play a more active role in shaping opportunities for civic activity.

The role of government at all levels should be to help mobilise civil society, and to actively support institutions and intermediaries through which community capacity can grow. For example, in the case of neighbourhood justice panels, government – in this case, local government – takes the first step of creating an institution which provides a space in which relationships can develop, thereby increasing the community's capacity to resolve its own problems.

Another example is youth mentoring. In 2010, IPPR asked members of the public which voluntary activities they found most appealing, and found that mentoring young people who are underachieving was one of the most popular options (IPPR and PwC 2010). There are a number of mentoring initiatives around the country, such as Think Forward in Shoreditch, which already match underachieving young people between the ages of 14 and 19 with an adult mentor who provides support and advice. The aim of these schemes is to help raise attainment and provide better advice on work, education and training. If we wanted to achieve a step-change in voluntarism then this fertile area would be a good place to start. Crucially, though, it is likely that an intermediary is required to achieve it.

Instead of simply stepping back, government should strategically consider where we need greater civic activism, and then support the institutions and intermediaries that can achieve it.

4.4 Conclusion

There are three major questions which challenge the relational state: Is it politically naïve? Can we afford it? And, finally, are the public up for it? The relational state clearly represents a challenge to our political culture, but it requires a shift along the spectrum, rather than an end to politics as we know it. Fiscal pressures are already pushing Whitehall towards giving greater recognition to the need for further decentralisation, in order to find more rational ways of saving money through local, place-based integration. National politicians can be persuaded to 'let go' so long as the right system of accountability for outcomes is put in place, with full data transparency, and provided that we have strong local governance.

Relational state thinking can also help public services to become more productive: integration can unlock savings and enable preventative approaches to costly problems. Necessarily labour-intensive relational services can also be supported by delivering transactional services in a much more efficient fashion, through time-saving 'mass production' techniques and automation.

We must be realistic about the amount of untapped civic energy that is out there, particularly given the other pressures on people's time. The key, however, is not to imagine that greater civic participation will simply appear: it will need to be promoted and organised, and this involves an active role for the state.

5. CONCLUSION

In this paper we have argued that, despite improvements in many outcomes and years of reform, our public services are failing to tackle a growing range of complex problems, and still do not provide their users with the type of service that they want.

Since the 1980s, 'delivery state' reforms have made public services more efficient and, in a number of areas, more effective. However, exclusively bureaucratic and market-based approaches are ill-suited to the demands of growing social complexity. To tackle problems such as youth disengagement, long-term unemployment, chronic ill-health and antisocial behaviour, we need a different approach. Moreover, in many areas citizens are demanding deep relationships rather than shallow transactions from their public services.

We have argued that the shift towards a more relational state must take place at two levels. First, at the level of public service systems, there is a need for greater connectedness. This requires the decentralisation of service budgets to the local level; the integration of budgets and, sometimes, of organisations; greater frontline autonomy combined with transparency about outcomes; and the establishment of collaborative infrastructures so that actors and institutions can learn and improve. Second, at the micro level, we need to foster deep relationships, both among citizens and between users and professionals. In practice, this is likely to take the form of lead professionals taking responsibility for individual cases, greater neighbourhood-based working, and the proactive creation of institutions that bring users together and increase their capacity to help themselves.

There are, of course, barriers to change: whenever change is meaningful there always are. In particular, the relational state requires a shift in our political culture away from centralism and day-to-day ministerial intervention. It needs to be combined with a sustained push for greater efficiency and lower head-counts on the transactional side. It also requires citizens to come forward and take part.

None of this will be easy – but if we are to provide public services that are fit for the more complex times that we live in, and that meet the expectations of the modern public, then we have little choice. We should remember that the prize from this effort will be great: a renewed role for government, services capable of tackling the great challenges of our age, and more empowered and connected citizens.

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