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CONFERENCE ABSTRACT

The Dominant Models of Health and Care Service Improvement: Commonalities and Divergences

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Introduction: Despite health and care services being performed by similarly skilled professionals, using largely the same technology and with similar levels of governance, there are few specialisms where there is an exclusive 'dominant' model of high performance or high reliability unlike other sector models (e.g. automotive lean production or six sigma for the electronics sector). Competition and confusion exists in the health and care setting which obscures the benefits of one approach over another.

Aim and Objectives: Adopting an improvement methodology can generate an absolute denial that any other approach is legitimate or worthy of use. This methodological fanaticism is concerning and often based on highlighting differences with other models and approaches to the detriment of staff learning. This paper presents a review of the competing approaches and methodologies employed by health and care organisations as the medium through which improvement interventions are undertaken and how there are significant gaps within and between the logic, application and potential for change offered by each approach. The study draws from 9 case studies of teams and organisations employing the lean, the theory of constraints, Value-Based Health Care, service improvement and Bevan Prudent Principles approaches to change. The case study service reviews were conducted over a 4-year period using interviews and secondary data collection.

Results: The cases show how, over time, some approaches have endured only a short lifecycle of improvement and reached a 'ceiling' or stall point before either being stopped or moving towards another of the approaches. The study supports the view that there is a mastery process which underpins the journey of improvement teams and also that selecting an ineffective improvement approach can have detrimental impact on learning as well as staff willingness to engage in change in the future. The results clearly indicate without an essential model then implementation of change achieves some benefits but these are largely from 're-engineering' processes rather than from a process of continual learning. In addition, some methods are clearly confused in terms of their promotion of value generation yet their focus on cost savings.

Conclusions: Improvement approaches are not the same. They have different logics, focus and lifecycles. Incorrectly selecting a method can therefore fail to deliver the benefits sought. Further, if every improvement methodology promotes the important feature of staff learning then it is illogical that organisations and teams "lock themselves" into a single model which lacks an essential logic to learning rather than emulation. Emulation involves copying others who are perceived as successful and involves "borrowing methods" from other sectors to ground the health and care approach. This paper shows how decisions are not binary and why emulated methods

tend to fail because a contingent and integrated care systems approach is ignored in favour of ‘point improvements” within a system.

Implications for applicability/transferability: The Toyota Motor Corporation does not just make cars and its divisions operate a bespoke ‘Toyota Production System’. At the heart of the system are significant skills investments “To make good products – we must first make good people”. These “dialects” of improvement are seldom understood by healthcare professionals who instead emulate without contextualising the sustainability of improvement processes and how they need to be ‘contextualised to the health and care setting. Only staff can innovate and locking into a single improvement solution is found to be unwise and constraining.