High Quality Care for All?

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A Simple Question

Is the aim of the NHS to provide:

> The best possible quality of care – and then control for the best cost of that provision; or,
>
> The lowest possible cost of provision – and then control for the best quality care it can afford?

Whilst it is accepted that this is a naive dichotomy, especially in the current climate, it is one that throws the problems identified in the paper "The Next Leg of the Journey" (**TNL**, Bevan, Ham and Plsek, 2009) into stark relief.

In a resource constrained environment giving the former answer will result in an outward facing and adaptive approach to change – where the focus of activity will be on organizing internal structures, processes and practices to deliver desirable outcomes that is, it will tend to innovate; whereas giving the latter will result in a conservative stance – the focus of activity will be on reducing the cost of provision rather than the value of the outcome and will tend, at best, to conservatism more likely contraction.

To give the first answer puts professional management expertise *at the service of healthcare provision* whilst to give the second puts *healthcare provision under the control* of accountants and their managerial masters.

An Adaptive System View

Consider this paraphrase of von Neumann:

> *A simple system is more complicated than its behaviour,*
>
> *A complex system is more simple than its behaviour.*

It is not too difficult to extrapolate from this that *adaptive systems are necessarily complex* and that, for all practical purposes, *complex systems are adaptive*.

The clear lesson from this is that it is not possible to fully determine the behaviour of a complex system *within the terms of the system* (which is, of course, Goedel's incompleteness theorem) and that any attempt at the complete determination of allowable behaviour (i.e., unreflected proceduralization) will fail or, if successful, necessarily lead to the creation of a simple system.

Reading this alongside Ashby's "picturesque" version of his "Law of Requisite Variety" (noting that, for this purpose, "variety" is equivalent to "complexity") that "... only variety can destroy variety" leads to the conclusion that simple (i.e., rule → behaviour based) models cannot be successfully

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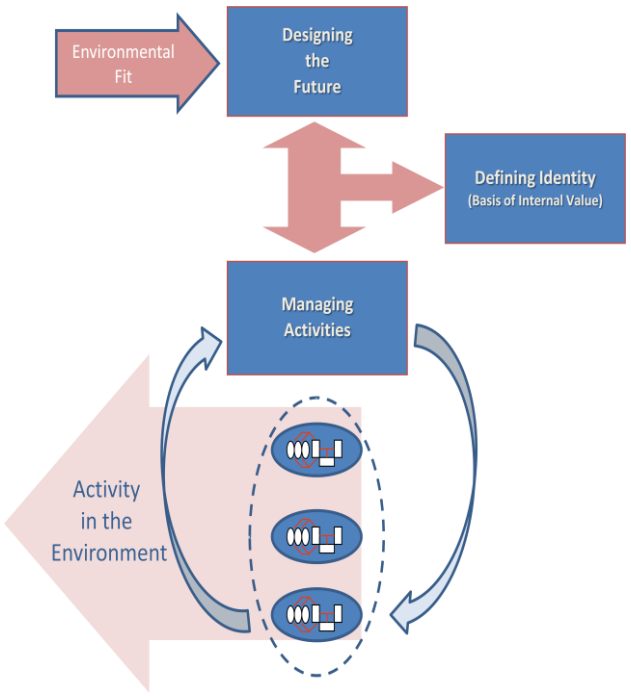
used to *manage* complex systems. This is, of course, because the relationship between the output states (behaviours) of the simple system, its structural complexity (complicatedness) and its hierarchical nature means that at each higher level the complexity to be dealt with in the system grows - and there will of necessity come a point at which the system is no longer (if it ever was) competent to the task.

Adaptive systems constrain this complexity growth by using the notion of 'completion from outside', which is a consequence of Goedel's theorem, recursive (defined here as structural similarity between levels of complexity) embeddedness (i.e., that adaptive systems both contain and are contained within other adaptive systems) and systemic identity.

In consequence the management of an adaptive system uses three internal languages: a language of environmental fit; a language of internal value; and, a language of defining and controlling activity. When these languages operate together they suggest three key elements of the management task, as in the figure below.



Key elements of an adaptive management model

The integrating mechanism for these three elements, the arrow between the boxes, is a three way 'strategic' conversation (or trialogue) that balances environmental demands against internal capabilities and capacities using the prevalent internal definition of identity.

The adaptive driver is the stress created in the 'identity ↔environment' relationship (caused by an environmental mis-fit) that stimulates a change in the definition of the output goals or the definition of the activities undertaken. And, because of the recursive structure, the upward proliferation of complexity is controlled by redefining the performance parameters of the embedded tasks to reflect the new 'reality' and allow change as an adaptive response at that level. By defining performance in terms of outcomes the complexity of the detailed management of tasks is removed.

The key factors to achieving adaptive contextualization are:

The definition of systemic identity as outward facing and adaptive – that is contribution focused – not inward facing and mechanistic;

Rich links to the performance environment to ensure that messages regarding mismatches are received and understood;

Clear definition of the internal tasks as direct contributions to the desired outcomes in the environment and the ability to communicate them as such to those responsible for delivery;

An active approach to aligning capability, capacity and output to environmental demands within the definition of identity; and,

An information system (formal or informal) that is designed to verify and report outcome performance.

Beer (e.g., 1985), in his work defining the Viable System Model (VSM) states that the competent management of systems at lower levels of recursion (i.e., internal tasks) requires four primary types of information:

Performance control – information relating to the resourcing and output performance of the individual tasks;

Co-ordinating – information relating to the interaction of the individual tasks such that they combine to create whole system outcomes;

Compliance – information providing confirmation that the individual tasks have been undertaken according to agreed rules and therefore that reported performance is legitimate; and,

Danger – in effect an organizational 'reflex action' that over-rides conventional reporting channels to warn of potentially damaging occurrences.

When this information structure is overlaid on the model above it creates a general model of an adaptive organization and the information architecture needed to support it (see below).

A Simple Demonstration

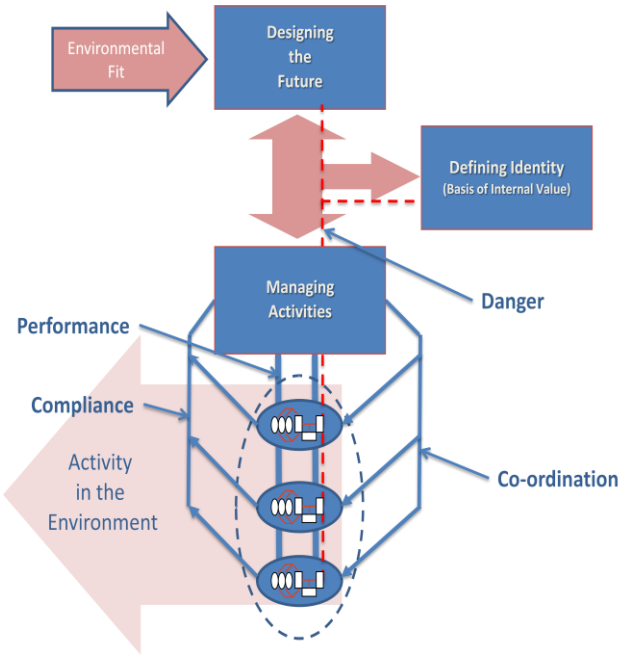
Accepting that the environment for healthcare provision is becoming increasingly complex and interactive and that the boundaries for provision are becoming blurred, supports a restatement of the original question as:

Is it my role to:

Provide the best/most appropriate healthcare in this circumstance; or,

Manage the tasks that make up this area of healthcare provision?

Looking at this question using the adaptive model shows that giving the first answer implies the second whereas giving the second precludes the first – the organization is cut off from its environment and is able only to focus on the tasks for their own sake – which brings the very real danger that it will make process efficiency gains at the cost of organizational effectiveness.



Information Channels
TheTrialogue embedded in Beer's Viable System Model

Subordinating the tasks to be undertaken to the outcome to be achieved means that performance is defined in relation to outcome effectiveness rather than process or task efficiency and, because these outcomes are tested against environmental demands, the organization becomes adaptive – able to change its activities and processes to improve its performance. It also means that the lower level activities (or organizational units) that contribute to this outcome must be 'primary performance elements', that is, they directly and necessarily contribute to the realization or delivery of the primary purpose of the organization.

Contribution Alignment vs Task Management

> "... front-line staff in the NHS are much more motivated by the needs of the members of the public ... than they are by senior leaders ..." (TNL)

A profound consequence of the adoption of the adaptive model is the explicit alignment of activity with the primary purpose of the organization – activities (including efficiency improvements) do not have value in isolation but only to the extent to which they enhance the achievement of the purpose. In an organization where the "front-line" has a large emotional investment in the core organizational values this alignment can mean that significant discretionary capability is released – a process cost reduction that is perceived as a contribution to satisfying "… the needs of the members

of the public …" is likely to be sought out and embraced, whereas one that is perceived as serving only the needs of "senior leaders" to the detriment of the of the primary purpose is not.

Mid Staffordshire Foundation Trust

The Mid Staffs NHS FT see today's (25th Feb 2010) "scandal" headlines is only the most prominent example of what can happen when task and local optimality management is the dominant feature of the assessment of performance.

> "We noted that much of the board's time was taken with the process of the application to become a foundation trust … issues such as business development and marketing."
>
> "Members of the trust's board were adamant that the quality of care had always been a top priority for the trust. They were not however, able to point to evidence of any significant scrutiny of standards of care of patients that they had undertaken. "
>
> "Many members of staff at all levels and in different professions told us that the trust's priorities had been finance and achieving foundation trust status."

These extracts, taken from an official review (Healthcare Commission, 2009) demonstrate that this was the case and, that the current media frenzy was to be expected at some time. And that, when the report is read through the lens of the adaptive model, similar "scandals" are to be expected in the future as the lessons needing to be learned to prevent them are clearly are not being learned.

The System is Broken – we can all see that it is broken

This is because:

- The absence of a strong statement of primary purpose has allowed a situation where "patient care" has become "one amongst many";
- Process performance indicators are used as proxies for organizational performance but, because there is no integral focus on the environment, there is no way of telling when they cease to be effective as such.
- Because it is inward (process *efficiency*) focused rather than outward (organizational contribution) focused performance improvement can only be achieved by *getting better at what we do* – rather than *making sure that what we do is relevant*.
- This means that over time a mis-match between process performance and organizational performance can occur (i.e., all the process indicators will be 'good' but organizational performance will deteriorate).
- Managers (or other legitimate controllers) then use ad-hoc initiatives to 'bring the organization up to date' and, as timelines shorten and initiatives come closer together, the organization will come to suffer a form of ataxia.

And it will only get worse in the future.

- Because "patient care'" is now one amongst many indicators, managers and/or other controllers can legitimately select different indicators to address financial or political circumstances and, therefore set "improvement agenda" that are designed to suit their, rather than the patients', purposes.

– Because the process efficiency indicators have ceased to be proxies and are accepted as *the* indicators of organizational performance the failure of the organization to perform will be assumed to be because the process performance targets are not stringent enough – and they will be tightened further.

This is not to say that the move to explicit contribution management will be easy – all organizations have some form of cultural legacy that will impact any attempt at such a transition. The recursive nature of the adaptive model requires that there is both a top down and bottom up exchange of meaningful information and that performance is recognized as emergent rather than additive – dependent on context rather more than procedure – both of which may present challenges to current managerial attitudes.

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