

The dawn of the era of systems and creativity. An essay by Nick Black

Nick Black argues that despite the successes of centrally driven assessment and public accountability of health services over the past 30 years, health care remains beset with difficulties. Improvement requires us to recognise that health services are human systems that must encourage and embrace the creativity of staff.

After 70 years of progress, challenges abound

In 1988 Arnold Relman, editor of the *New England Journal of Medicine*, described how the universal goal of "an equitable health care system, of satisfactory quality, at a price we can afford" was struggling against the countervailing interests of both the medical-industrial complex and unfettered professional autonomy. (1) The latter was apparent in geographical variations in clinical practice, reflecting inconsistency in professional judgements. Relman suggested that a new era of health care was dawning that would address these challenges through rigorous assessment of clinical practice together with greater public accountability of doctors and services.

That new era of assessment and accountability dominated the next 30 years. The gains can be seen not only in improved outcomes and greater adherence to guidelines but also greater productivity. (2) Underlying these has been considerable success in challenging medical paternalism and undue professional autonomy.

And yet health systems are still beset with problems. In England, regulators judge the quality of many providers as inadequate, the productivity of services varies widely, administrative complexity bewilders patients and staff alike, lack of integration across sectors persists, staff are dispirited, and progress in developing patient centred care has been disappointing.

Why is this? The widely held view is insufficient funding. While additional funds would no doubt provide some welcome relief, any benefit would be short-term and propping up the existing system might further delay the need to address the underlying causes. Instead, what is needed is a new era to supplement the earlier ones which sought solutions through technology, cost containment, and assessment and accountability.

Shortcomings of the era of assessment and accountability

The approach was based on the market-oriented tools of new public management which in turn depended on management solutions developed in the early 20th century to improve manufacturing. These broke down production into the constituent parts and then sought to control variation by standardising processes. These were then centrally driven by means of incentives, targets and sanctions, all of which was predicated on the assumption that patients (seen as customers) act rationally in their own self-interest in response to provider choice.

It should be of little surprise that when applied to health care there have been unintended consequences. Regulation has become not only a bureaucratic burden but also an intellectual and emotional burden. A low trust system has been created which discourages risk taking and threatens the job security of managers. Staff initiative has been discouraged and organisational silos have been perpetuated, limiting the development of relationships between components.

So what is needed?

Health and care services must be able to adapt to complexity, uncertainty and nonlinearity. To achieve this, the new era needs to encompass two features that may seem incompatible: systems and creativity. We need to supplement existing achievements by introducing a greater recognition that health and care services are 'human systems', in which the focus should be on the relationships between constituent parts (primary care, hospitals, social care etc). At the same time we need to accommodate and support social entrepreneurs, the creative disruptors who will instigate innovation.

Given that systems thinking has been around for years, how can it be portrayed as something novel? In the past the approach focused on the organisational components of systems. Solutions were then sought through trying to get each part to do better. This inevitably perpetuated existing ways of delivering care and, when improvements didn't occur, the organisations were blamed (such as by sacking the manager). But health and care services are human or living systems in which the connections and relationships between components are fundamental to its success. These may be between departments, wards, hospitals or whole sectors. A shift of focus away from organisations and to the inter-connecting links requires exploiting the resourcefulness of staff and being truly responsive to the health care needs of

patients and social care of clients. It also needs the development of systems leaders, people who recognise that problems cannot be solved by single organisations but by building relationships based on deep listening. (3) Leaders must encourage and allow creativity to emerge by drawing together relevant people to address any given issue. This takes courage and insight as it may not involve those in formal positions, such as medical directors, but staff who in the past have had no voice. This is vital as creative solutions will reflect who is involved and the space they are afforded to think afresh.

Leaders of systems don't have to feel they must solve problems themselves. The solutions will come from the social entrepreneurs among the workforce, of which there are potentially many. They are motivated by altruism (rather than profit-making), with ideas that traditionally have had little opportunity to be realised. The system needs such entrepreneurs to create necessary disruption given the intrinsic intransigence to change. The challenge is how to release the creativity that lies dormant within the system and then channel the best ideas into practice. We need all involved in health and care services to 'think like a system and act like an entrepreneur'. (4)

The era of systems and creativity is already here

This may sound too demanding and unrealistically ambitious but the era of systems and creativity has already dawned. Brilliant examples abound in many countries, not least in the NHS in England where the essence of the Five Year Forward View and the emerging integrated care systems is a shift in emphasis towards focusing on the relationships between component parts of the system and encouraging local creativity to transform services.

In Lambeth (London), Denis O'Rourke has brought together patients, carers, primary care, commissioners, hospitals and social care to transform mental health services. The Living Well Network they created supports 400 people a month and has led to improved patient experiences plus a 43% reduction in referrals to specialist care and less need for admission to residential care. (5) Meanwhile, in Frome (Wiltshire), the devastating impact of loneliness (which increases the risk of early death by 20%) inspired Helen Kingston, a GP, and Jenny Hartnoll, a health trainer, to bring together general practice, social services, charities and the community hospital to develop the

Compassionate Frome Project. Encouraging use of existing organisations and developing new ones, such as Talking Cafes, residents' quality of life has improved and a 17% reduction in emergency admissions has been observed in a county with a 29% increase. (6) Reductions in the need for hospital emergency care has also been seen in Nottingham. Almost 14% of 999 calls are for falls in the elderly of whom half are taken to overcrowded A&E departments struggling to cope. Working with adult social services enabled paramedics to introduce a Falls Rapid Response Team that integrated health and social care assessments. Greater confidence in managing risk meant the proportion needing to be transferred to hospital fell to 28% and patient and carer satisfaction increased (7).

Meanwhile, in Gateshead, a large general practice introduced specialist community nursing for older people which reduced emergency admissions by 54%. (8) A similarly dramatic reduction of 36% has been achieved among care home residents in east London. Improved GP support reduced the risk averse behaviour of care home staff who had tended to call ambulances all too readily. (9) Local creativity can also be seen in hospitals. In Wrightington, Wigan and Leigh Trust the incidence of severe Acute Kidney Injury has fallen by 28% and mortality by 57% following the appointment of Suzanne Wilson, a specialist nurse, who raised awareness of AKI among ward staff. (10) She organised regular one hour drop-in sessions, sometimes involving a patient speaker, to help staff understand the urgency of detecting AKI early. These are just a few illustrative examples.

There is also much that can and is being learnt from other countries. 'Shared dialysis', in which patients take much greater control of their clinic treatment resulting in improvements in outcomes, efficiency and patients' experience, was initiated in Sweden not by staff but by an enterprising patient. This is currently being piloted in England. (11) So is a radical new way of organising and managing district nursing, based on the Dutch experience with Buurtzorg, with benefits for patients and staff. (12) And the carers of people with Parkinson's disease and with other long term conditions could learn much from ParkinsonNet, an interactive website shared by patients and staff in the Netherlands that has shifted the focus from clinicians to patients' concerns and halved the rate of hip fractures and the overall cost of care. (13)

Implications for government, staff and the public

Like all health care systems, the NHS has relied heavily on national strategies and central mechanisms in its quest to achieve universal, high quality services that meet the needs and expectations of the public at a reasonable cost. Despite notable successes, relying principally on central guidance, rigorous assessment and public accountability are not sufficient. Inadvertently this approach has tended to suppress and discourage one of the NHS's great assets, the creativity and commitment of its staff and patients. By releasing their energy and recognising the importance of the relationships between organisational components, the health and care system can flourish. The changes needed do, however, pose profound challenges for government, staff and the public. As with any paradigm shift, people will find it difficult and even uncomfortable.

First, government and other national and regional organisations (commissioners, regulators etc) may struggle to cope with accommodating the new era as it will be essential that central authorities relinquish some control to enable local creativity to redesign local systems.

Second, after years of seeking consistency in service provision across the country, the new era will result in more not less diversity. That is inevitable if changes to improve care are going to emerge from local initiatives. Government must have the courage to welcome, support and defend changes even if they result in greater variation between places. Government's concern must be with areas that are standing still rather than those creating increased variation.

Third, staff will face the challenge of adapting to a world in which the focus is on systems. That requires the ability to think across health care sectors and social care. Narrow sectarian interests must be relinquished. While this is essential for those in formal managerial positions, orientation towards the whole health care system and what is best for the public needs to be adopted by all staff. In practice, staff may find this less challenging than managers.

Fourth, proponents of change in previous era have advocated national dissemination or 'roll-out' of good ideas. Frequent disappointment at the lack of success of such an approach turns to frustration and bewilderment. The problem is that approach ignores the importance of context, not only local history, personalities and

experiences but also the crucial contribution of individual entrepreneurs. Straightforward adoption of what worked elsewhere rarely replicates the earlier success. For deep and sustainable change, there has to be local ownership and that requires local learning (including local mistakes). However much national policy-makers entreat people to transform in a particular way, it will be more productive to encourage and enable local innovation even if that increases the extent of geographical variation in provision. The examples of brilliant innovations cited above should act as exemplars to stimulate and encourage others but not be taken as blueprints.

And finally, the greatest challenge might be for the public. Long-held and cherished visions of what health care looks like and how it functions - doctors, nurses, hospitals, general practice surgeries - will be challenged. Fear of loss of the familiar needs to be understood and addressed as part of the new era. Given that a feature of the new vision is greater involvement and engagement of patients and the public, from shaping services to self-management of conditions, addressing the public's concerns about emerging changes is a vital undertaking.

Concluding thoughts

Heralding the dawn of the era of assessment and accountability in the 1980s, Relman warned that "No one should underestimate the size and difficulty of the task. However, the logical necessity of this new initiative seems clear." (1) Over the past thirty years those difficulties were overcome and many benefits resulted. But it hasn't proved to be sufficient. The same warning applies to the new era, as does clarity about the need for it. The new era offers the opportunity to supplement past successes in ways that will reinvigorate services and ensure they meet the aspirations and needs of the public and of staff over the next few decades.

References

1. Relman AS. Assessment and accountability. NEJM 1988;319:1220-2

2. Black N. Declining health-care productivity in England: the making of a myth. *Lancet* 2012;379:1167-9
3. Senge P, Hamilton H, Kania J. The dawn of system leadership. *Stanford Social Innovation Review* 2015 (Winter); 27-33
4. Burbidge I. Altered states. *Royal Society of Arts Journal* 2017;1:10-15
5. O'Rourke D. How lessons from the building industry are transforming mental health services. *Guardian* 2015 (15 April)
<https://www.theguardian.com/society/2015/apr/15/new-alliance-contract-for-mental-health-services-transformed-in-lambeth> (accessed 2 May 2018)
6. Brown M. Compassionate community project. *Resurgence & Ecologist*.
<https://www.resurgence.org/magazine/article5039-compassionate-community-project.html> (accessed 2 May 2018)
7. Foster C, Khendek U. Falls Rapid Response Team: the integrated ambulance and urgent care service model in Nottingham.
<https://www.kingsfund.org.uk/sites/default/files/media/Falls%20Rapid%20Response%20team.pdf> (accessed 2 May 2018)
8. Stansfield S. 2 May 2015
<http://fabnhsstuff.net/2015/05/02/oxford-terrace-rawling-road-medical-groupmanaging-frailty-community-though-personalised/> (accessed 2 May 2018)
9. Sherlaw-Johnson C, Crump H, Curry N, Paddison C, Meaker R. Transforming health care in nursing homes. An evaluation of a dedicated primary care service in outer east London. *Nuffield Trust* 2018 (April)
10. Moore A. Investment in quality saves NHS Trust millions. *Nursing Standard* 2017;32(12):23-4
11. Yorkshire & The Humber Shared Haemodialysis Care. Shared haemodialysis care. Improving outcomes. <https://www.shreddialysis-care.org.uk/> (accessed 2 May 2018)
12. de Blok J. Buurtzorg Nederland: a new perspective on elder care in the Netherlands. *AARP The Journal* 2011(Summer):82-86.

http://omahasystem.org/AARPTTheJournal_Summer2011_deBlok.pdf (accessed 2 May 2018)

13. Gray BH, Sarnak DO, Tanke M. ParkinsonNet: an innovative Dutch approach to patient-centred care for a degenerative disease. Commonwealth Fund 2016 pub 1921. http://www.commonwealthfund.org/publications/case-studies/2016/dec/~/_media/files/publications/case-study/2016/dec/1921_gray_parkinsonnet_case_study (accessed 2 May 2018)

I have read and understood the BMJ Group policy on declaration of interests and declare the following interests: none

The Corresponding Author has the right to grant on behalf of all authors and does grant on behalf of all authors, a worldwide licence (<http://www.bmj.com/sites/default/files/BMJ%20Author%20Licence%20March%202013.doc>) to the Publishers and its licensees in perpetuity, in all forms, formats and media (whether known now or created in the future), to i) publish, reproduce, distribute, display and store the Contribution, ii) translate the Contribution into other languages, create adaptations, reprints, include within collections and create summaries, extracts and/or, abstracts of the Contribution and convert or allow conversion into any format including without limitation audio, iii) create any other derivative work(s) based in whole or part on the on the Contribution, iv) to exploit all subsidiary rights to exploit all subsidiary rights that currently exist or as may exist in the future in the Contribution, v) the inclusion of electronic links from the Contribution to third party material where-ever it may be located; and, vi) licence any third party to do any or all of the above. All research articles will be made available on an Open Access basis (with authors being asked to pay an open access fee—see <http://www.bmj.com/about-bmj/resources-authors/forms-policies-and-checklists/copyright-open-access-and-permission-reuse>). The terms of such Open Access shall be governed by a [Creative Commons](#) licence—details as to which Creative Commons licence will apply to the research article are set out in our worldwide licence referred to above.

We attest that we have obtained appropriate permissions and paid any required fees for use of copyright protected materials