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Redefining Accountability: An Urgent Priority For The Wynne/Hoskins/Bell Team

By Ted Ball

"Accountability" is a word that is loaded with meanings that strike fear in the heart and soul of our health care system. That's because it has come to mean: "*Who is to blame*?" And, "*how should they be punished*?"

So why are we surprised when the outcome of this approach is blame-avoidance, blame-shifting, cover-ups, in-fighting, defensive behaviors, anti-learning dynamics and the cause of even further dysfunction in a health system that has already been diagnosed as being among "the least healthy work environments in the country".

When things are not going well, the first question seems to be: **who is to blame**?

We already know the "unintended consequences" of these types of systems, structures and processes. The whole focus is on blame and blame-avoidance – rather than on accountability for achieving measurable outcomes that may be perfectly reasonable and very desirable.

Accountability is very different than blaming – which means: "to find fault with, to censure, revile, reproach." Blaming is an emotional process that seeks to discredit the blamed.

But when people work in an atmosphere of blame, they naturally engage in defensive routines – covering up their errors, and hiding the real issues that need to be dealt with – if the performance of our health system is to actually improve over the next few years.

When our energies are focused on finger-pointing, scapegoating, and denying responsibility, the effectiveness of our entire health care system – and the organizations and people who work in it – suffers.

Marilyn Paul, a scholar in the field of organizational accountability says that a blaming culture causes organizations to become dysfunctional because "where there is blame, open minds close, inquiry tends to cease, and the desire to understand the whole problem diminishes."

Within the healthcare delivery system, our existing blaming culture generates fear and destroys trust. When we blame, we attempt to prove that others must have had bad intentions, or lack ability. The qualities of blame are "judgment, anger, fear, punishment and self-righteousness", according to Paul.

In contrast, accountability emphasizes keeping agreements and performing tasks in a respectful manner. It is all about learning, truth and continuous improvement. Is that not what we really need in our health care system today? Are we now ready to learn from our past mistakes? Are we really prepared to change?

Experts like **Marilyn Paul** advise us that "a focus on accountability recognizes that everyone may make mistakes or fall short of commitments. Becoming aware of our own errors or shortfalls, and viewing them as opportunities for learning and growth, enables us to be more successful in the future."

Errors, shortfalls and mistakes can of course take place at any point in the system: how provincial public servants designed a particular policy or program; how operational managers implemented a program; how teams of health professionals were organized within systems, structures and processes to deliver the services; or, whether or not service provider organizations are aligned at the service delivery level.

Paul says that "accountability creates conditions for ongoing constructive conversations in which our awareness of current reality is sharpened, and in which we work to seek root causes, understand the system better, and identify new actions." She lists the true qualities of accountability as: "respect, trust, inquiry, moderation, curiosity and mutuality."

In my practice as an *Organizational Transformation Coach*, here are the **SIX PRINCIPLES OF ACCOUNTABILITY** that we use for our best practice toolkit/accountability process:

1. You can't be accountable for anything over which you have no control.

An *Accountability Agreement* must be a "fair business bargain". It is a personal promise to achieve measurable results. But a person can't keep their promise if circumstances beyond their control change.

That makes sense, doesn't it? If a CEO is being held accountable for improving staff/physician moral, and their provincial government is engaged in highly emotional disputes with unions and physician organizations, how can the CEO be held accountable for the results that such an atmosphere will produce?

However, the CEO should certainly be accountable for demonstrating improved outcomes with their own organization's unions, staff and physicians that they are able to achieve from the processes that they put in place to achieve their measurable results locally.

If a manager is being held accountable for an outcome that can only be achieved if a certain barrier is removed – like the lack of a skills development program, or the lack of equipment or specialized technology – and nobody removes the barrier, why should they be expected to be accountable?

How can they possibly deliver on their promise if they are not given the support they require to succeed? Best practice *Accountability Agreements* list the "**supports required**" to achieve the outcomes for which a person is willingly accountable. If they don't get the support they need, they can't be held accountable. It's that simple.

That's where this concept of "*mutual accountabilities*" comes into play.

At the operating level, a manager with an *Accountability Agreement* must be able to hold his or her boss accountable for providing the "*supports*" they mutually agree are required to successfully achieve their outcomes.

An *Accountability Agreement* is therefore a tool for people to mobilize the support they need to make them successful. It's a manager's best friend, not their worst enemy! Between the provincial governments and the agencies and institutions they fund, there also needs to be an explicit and "fair business bargain".

In Ontario, it starts with a "worst practice" **Accountability Agreement** between the MOHLTC, and each of the 14 LHINs. It is "worst practice" because it holds the LHINs accountable for outcomes over which they have no control. However, many LHINs then hold HSPs accountable for outcomes over which they also have no control either. This begins the "blame-avoidance shuffle" -- a dance that every health executive learns in order to survive.

So we either keep up the advanced "gaming skills" of our senior healthcare executives, or we change how the game is played -- by redefining "*accountability*".

"*Accountability*" holds a prominent place in the ***Health Minister's Mandate Letter***. If the **Wynne/Hoskins/Bell Team** redefine "accountability" for the health sector, we'll end the "blame-game" – and, we will shift our cultures towards the way true *Learning Organizations* think and behave. The second key principle for best practice approaches to accountability:

2. Accountability for outcomes means that activities/efforts and processes are not enough.

Think of the mindset shift required here. Our health care system is characterized by a complex set of rigid bureaucratic processes designed in separate silos holding different assumptions.

The truth is that our fragmented health care system is the product of isolated silos within our Health Ministry. The real focus of the existing system is on the rules, regulations and bureaucratic processes – not on achieving outcomes. That is what bureaucratic organization do: they focus on process, not on outcomes.

Best practices would suggest that "holding people accountable" should only be done in the context of clearly defined outcomes or results. These outcomes must be understood and adjusted

regularly to reflect new realities as they emerge in a constantly changing and chaotic environment.

Not only must everyone understand what is expected of them and why, they must also have the necessary resources, conditions and skills to achieve the outcomes for which they are being held accountable. Is that not a reasonable and "*fair business bargain*?"

In a best practice accountability process, no one is given points for "following the process". The only thing that counts is getting the results -- bottom-line measurable results.

If the *process design* does not produce the results required, we need to change the process. Better yet, we need to design processes that are focused on achieving the results that are required – right from the start!

The third principle:

3. Accountability for results requires real empowerment -- as well as room for personal discretion and judgment.

This principle would require another paradigm shift for the health sector: the principle is about the reality of "balancing empowerment and accountability". Not the empty rhetoric that has contributed to the growing cynicism of our front-line health care providers, but real empowerment.

While the health care sector is clearly part of the knowledge economy, many continue to live with industrial-age assumptions about the "need for command and control".

The assumption in other modern knowledge-based industries that rely on skilled professionals is that the solutions to their most complex and perplexing problems are within the hearts and minds of the people who work in the system.

Smart organizations that are thriving in the knowledge economy invest between 1% and 5% of their payroll budgets on developing the skills of their people to work in high performance teams solving organizational problems and dilemmas by tapping into the collective intelligence of the people in their system.

The fourth best practice principle on accountability design is:

4. Accountability must be dynamic: outcomes and targets change as circumstances change.

While most people would agree that this seems perfectly reasonable, the existing rigid bureaucratic culture of health care – from the Premiers on down to the front-line nurse – is about inflexibility.

In the existing system, we are given every incentive to focus on the process, rather than the outcomes. Indeed, Queen's Park and most LHIN have created a very *Process/Project Management Culture* in the health sector; rather than an *Innovation/Results-Focused Culture*. The **Wynne/Hoskins/Bell Team** can change this by redefining accountability.

Best practice *Accountability Agreements* are flexible. When circumstances change, accountabilities change. The focus is on what needs to be done to ensure that a person is successful.

The fifth key principle for accountability system design is:

5. Accountability and stewardship for the organization belongs to everyone.

Management guru **Tom Peters** has said that health care systems, structures and processes are the most complex organizational designs ever conceived by humans. But most of our core design assumptions are rooted in the old industrial model.

Systems thinking, chaos theory and quantum physics\ have all contributed greatly to our emerging understanding of the health care sector as a complex adaptive system. Each part of the system impacts on the performance of the other parts of the system. We know that.

When there is insufficient home care services within a community, elderly people get trapped in acute care beds – and then we get back-ups in our emergency departments.

When that happens, the resulting headlines seem to compel many of our politicians to invest even more money in hospital emergency services, rather than on the root cause of the key system design problem: an under-investment in community care.

Despite the fact that all parts of the health care system are "inter-connected", we've organized ourselves into rigid silos and departments which we attempt to "manage" through traditional bureaucrat control mechanisms – where we solve issues within each silo – often without any apparent concern about its impact on the other parts of the system.

So when government leaps in to "fix" *Health Links*, or "fix the CCACs and home care", if they have not thought through the "unintended consequences" of their actions, many people could pay a very high cost for poor public policy.

Best practice accountability processes include integrating the Accountability Agreements cross-functionally – across the organization, and across the delivery system. That way people truly understand how their actions impact on others; and why we need to ensure that we are working synergistically together within our organizations, and with all parts of the system.

At the front-line of the delivery system, care providers are very good at integrating across the delivery system when they are focused on serving the best interests of the family and patient. It's higher up that needs a more strategic approach.

Having line-managers from each of the *Health Link* partners integrating their *Accountability Agreements* cross-functionally can lead to the creation of the collaborative work plan to make the agreed-upon system changes and process redesigns happen.

The sixth and final principle for designing accountability systems is:

6. Accountability is meaningless without fair and appropriate consequences.

For all the fear and anxiety that our existing hierarchical, command-and-control accountability processes produce in people, the truth is that there really isn't much of a focus on the actuall *consequences* – just the "threat" that maybe "something bad" could happen.

In their book, ***Accountability: Getting a Grip on Results*** authors **Klatt**, **Murphy** and **Irvine** point out that "Accountability is not about assigning after-the-fact blame. Rather, it's about providing before-the-fact incentives for success -- and room for decision-making, risk-taking and growth."

They state that "consequences may be positive or, negative, but either way they need to be fair. They are not punishing or under-handed. Finding out what went wrong in a situation is essential for preventing the recurrence of problems."

As the **Wynne/Hoskins/Bell Team** approach the 6-month mark of their four-year mandate to transform our healthcare delivery system, they will very shortly be making *leveraged changes* that will begin to shift the DNA of the system. Their commitment to changing the status quo will require them to make deep and meaningful changes to the existing system.

Among the most leveraged shifts that they could make is to: **redefine accountability**!

NEXT WEEK MY BLOG IS: "THE CEO-LED/BOTTOM-UP HEALTHCARE TRANSFORMATION".