



HPO White Paper by Rob Peddle and Ian Rosam

For most of the 20th Century, Business Schools, management training and Quality have promoted a method of management that seeks to exert control by believing you can predict future events and what people will do. Based on this assumption you can, in theory, control this by putting in place objectives, targets, work methods, controls, regulations and standards, etc. and check it is happening as you predict it should, through the deployment of KPIs, conformance/compliance auditing and other traditional ‘top-down’ approaches.

This method of management was driven following the initial success in Ford, then others, to manage their production lines more effectively through control at the task level, hence the term the **Mechanistic Management System** (1). The phenomenon of “*when the going gets tough, the tough gets going*” (2) is the manifestation of the mechanistic approach, a leap for the ‘fix-by-control’ lever to sort out the problem. In quality management terms we can see this approach in the way Standards are written and the ubiquitous use of statistical techniques, such as six-sigma(4). These display a belief that we can exert control through this mechanistic approach, and hence creates a desire to define precisely what is to happen.

However, the prevailing business discourse is increasingly recognising that this approach is flawed (3). Recent problems such the Financial Markets Meltdown, hospital errors, Deepwater Horizon, the Fukushima nuclear power plant disaster and the more recent breast implant failures demonstrate a wide range of every day organisational systems and processes where the current approaches have disastrously failed. Of course the subsequent investigations invariably show that something wasn't done correctly! To explain the reasons for and then rectify the failure, managers are asked to ‘fix’ what people do through increased control, so that there isn't a repeat - a reaction that tries to predict events and exert control through a mechanistic solution. But, from the evidence we all experience:

- Is this really working?
- Is the mantra that ‘*the tough get going*’ really delivering the results Society or the organisations concerned need?
- Are people really robots like ‘cogs in a machine’ - will they always work in predictable mechanistic ways?

The mechanistic approach has clearly worked in parts of an organisation that are mechanistic in nature. These tend to be where the system is relatively stable, where the focus is on the ‘means’, or the ‘control of inputs’, which are managed top down and where individual parts can be analysed and audited in isolation of the rest. But if you look in other areas, or the organisation as a whole, these are **Organic Management Systems**. They are ever changing adapting to the business environment in which they sit, not running along some predictable path. Such a management system must learn what is changing in that external environment and then adapt what they do and how they behave, sometimes very quickly, in order to survive. These are open systems (6) (9). In contrast, a Mechanistic Management System is closed, i.e. non-adaptive to the external environment and exerting predictive control - just think about the demise of Kodak (5) and its ‘closed’ approach to its changing business environment.

Far from managing in a stable environment, most managers are now faced with managing within an ever changing business environment (2) where the focus is on the outcomes, requiring a more consultative approach to management. It is now much more about understanding that results and capability are delivered through complex patterns of behaviour. It is implicit in this thinking that maps, procedures, documents, graphs and records are just pictures of the real world to help understand them, but they aren't the real world (7).

The essential difference between robots (the mechanical 'cogs in a machine' approach) and an organic approach is the degree of involvement and variability in behaviour of people. But, why is this so? It is because people make choices all the time. People at all levels make decisions that effect performance and capability that cannot be predicted. Just think about a few everyday situations;

- "shall I progress that order or this one",
- "should I go to this meeting or do that work",
- "shall I fill in that form or get on with next piece of work",
- "shall I answer that phone or do that paperwork",
- "shall I make this decision or that one given the evidence in front of me",
- "should we launch this new product or not",
- "shall I start the car or not" (1).

This happens all the time as part of the 'business as normal'. It is the natural way things happen and it is impossible, indeed illogical, to make the assumption that such things can be so tightly controlled that we can eliminate these types of decisions being made as part of normal working live. More importantly, as we move from manufacturing to service economies, we both need people to take decisions themselves and we all increasingly expect to be able to do so. Of equal importance, the rapid growth of communications technologies, Social media, etc creates an environment where there are increasing amounts of external stimuli that drive such decision-making.

That is not to say that the Mechanistic Management System is bad or that the Organic Management System is good, just that they are at different ends of a continuum. The reality for any organisation is somewhere in between these extremes and consequently managers need to understand this and adopt the right tools, techniques and approaches in the right places. For example the manufacturing lean techniques developed by Toyota are being promoted by the British NHS (11), and whilst this may appear to work at a detailed level, can the decisions required and the real needs of individual patients, their families, nurses, and doctors really be predicted, as if they were robots? Or, in reality, do all of these 'participants' in the system make choices all the time that effect the quality of medical outcomes? Perhaps this is why in launching the public hearing into the deaths at Staffordshire Hospital there was a call for a '*Move from process-driven targets to a focus on patient outcomes*' (8). In other words, a move away from trying to manage an Organic Management System as if it were a Mechanistic one! This is a clear case where there has been, and possibly still is, confusion as to what management tools and techniques are appropriate to apply to what type of system or individual parts of it.

The truth is that organisations, and parts of them, are all at different positions on the continuum from Organic / open management systems at one end of the scale to Mechanistic / closed management systems at the other. There is no one-size-fits-all that describes the best way to manage because, as soon as any one 'way' has been applied, then the external environment changes and the organisation has to adapt to these changes. As the adaption takes place, the position in the continuum and hence the appropriate management system and culture also adapt to better reflect the changing environment (10).

As all organisations, by definition, operate to a greater or lesser extent in an ever-changing business environment, this requires at least a partial organic / open management system – some more so than others. It would therefore seem that the underlying assumption that predictive control can always be applied is illogical, because people often do have choices or need to make decisions that cannot be predicted. Indeed such an assumption can be very dangerous and counter productive, as in the case of Staffordshire hospital. These types of situations lead to managers, who have been encouraged by the currently accepted approaches, driving through the use of inappropriate Mechanistic Management System techniques. There is hence a real need for **strategic quality thinking**, not just the blind application of existing tools.

Quite naturally, as a consequence of so many system and process failures, the effectiveness of the audit function has also been questioned. This is true of both internal and external audits. Traditional auditing has focused on the review of tangible objective evidence produced by the mechanistic approach, i.e. a focus on what the individual does or what they record, hence the use of terms such as “show me.” But such an approach is virtually blind to the impact of the multitude of everyday experiences that take place all the time inside the ‘business as normal’. These may be boring, exciting or interesting; they may be good or bad, or disruptive or evil; they may build or destroy relationships. However, it is the interaction of these experiences and their impact at a local and global business level (or beyond) that produces the organisational capability, their results and the overall outcomes. *'All of these aspects of experience are relevant for understanding the reality of organisational life' (3).*

Auditing, therefore, needs to build on its past Mechanistic Management System roots and stop just looking at what people say they do to comply with a process map or procedure or what they decide to record. If auditing is to add the true value it can and should do to meet the demands of those who rely on them, it also needs to adopt behavioural based techniques to understand the reality of organisational life and its impact on organisational capability and risk to outcomes. We need strategic quality audit thinking not just the blind application of existing tools.

'instead of the tough getting going by continually reaching for the application of mechanistic control levers, perhaps they should reach more for the organic understanding levers.'

For further information or access to tools and techniques that apply this thinking, contact The High Performance Organisation Group

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- (4) PDCA (plan–do–check–act) is an iterative four-step management method used in business for the control and continuous improvement of processes and products. It is also known as the Deming circle/cycle/wheel, Shewhart cycle, control circle/cycle, or plan–do–study–act (PDSA)
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