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The UK's 2010 and 2013 public inquiries into the Mid Staffordshire hospital scandal estimated that between 400 and 1,200 people died unnecessarily in just a four-year period. The inquiries, carried out by Robert Francis QC, identified a range of performance management problems within the National Health Service (NHS) stemming from a widespread preoccupation with nationally set targets, emphasizing an organizing principle of reducing costs rather than delivering quality patient care. The inquiries conclude that there had been a systemic failure at Mid Staffs; including a culture of bullying and secrecy regarding patient care, a focus on achieving externally set targets and budgeting, and low staff morale. This was explained, in part, by the performance culture in place where frontline staff worked within an "endemic culture of bullying" (Francis, 2010: Vol 1. B.38), forced to prioritize targets over patient welfare for fear of victimization and job loss which incentivized short cuts and "unacceptable standards of performance" (Francis, 2013: 111). Virtually no organization emerges from the inquiries with credit except the local campaign set up by the relatives of the victims.

Reversing Performance in the UK National Health Service

From Targets to Teams

By Elizabeth Cotton, Roger Kline and Clive Morton

Despite there being great emphasis and some specific proposals on how to improve patient care and patient involvement the reports provide few concrete recommendations to improve performance despite an emphasis within the Francis report on the urgent need for the NHS to reform its performance management. Although we offer no magic solutions to the structural problems across the organization, our proposal is that an important aspect of reform should be a reorientation away from targets and top-down management toward a model of inter-disciplinary and inter-organizational team working.

Performance Management in the NHS

Each successive UK government since 1948 has grappled with the tension between NHS funding and health targets for an increasingly aged population. The NHS has undergone three major periods of restructuring since the 1980s, involving the introduction of quasi-market systems and decentralization of budgets including the creation of hospital trusts with boards of executive and non-executive directors and the introduction of the Public Finance Initiative (PFI), to reduce the taxpayer's burden. Although the financial gains of this strategy are contested highly (NAO, 2006), these reforms were maintained by successive labor governments.

To increase levers and accountability to justify this vastly increased health expenditure, there has been an inevitable increased use of nationally set productivity targets to measure NHS performance (NAO, 2011). This performance is overseen in a top-down fashion, cascaded within trusts and have become vastly more important than the traditional clinical outputs. This has led directly to a culture of gaming within the NHS to avoid missing targets; patients parked on trolleys in hospital corridors to avoid falling foul of waiting time targets, early discharge of patients followed by readmission going unreported; in extremis mortality rates not accurately reported.

One consequence of this has been the establishment of a hierarchical command and control system of management from national to local levels (Ghoshal and Bartlett, 2002; NHS Staff Survey, 2012). Research indicates that managers under pressure to deliver targets typically default to a command and control style, become insensitive and defensive, putting a downward pressure on quality of care (Alimo-Metcalfe and Alban-Metcalfe, 2005). Additionally, work has intensified for frontline staff, spending increasing time and resources measuring and reporting outcomes against targets (RCN, 2012). Combined, they militate against NHS staff being able to work flexibly in response to individual patient's needs. One consequence is a high reported level of bullying by staff and managers of 24 percent in 2012 (NHS Staff Survey 2012).

Responding to the Francis Report: From Targets to Teams

In response to the Francis reports, our proposal is to adopt the reverse of relying on targets and inspections, rather to give staff the responsibility, scope and resources to produce good quality care. This model of performance management requires quality to be "built in" rather than "inspected out." To do this, we propose that priority be placed on creating and reinforcing inter-disciplinary non-hierarchical teams, to support the necessary organizational learning that needs to take place within the NHS. Effective team construction can also provide a much needed space for staff to raise and explore genuine concerns to avoid remedial action (Nonaka and Takeuchi, 1996; Dunleavy and Carrera, 2013). The research indicates that a well-structured team environment with clear goals, a supportive line management, good training, learning and development are all good predictors of patient satisfaction, patient mortality and staff absenteeism and turnover (Kings Fund, 2012; West and Dawson, 2011). Other research has evidenced that within multidisciplinary team working environments staff are significantly more satisfied, less likely to make mistakes and provide safer patient care (Gittell, 2009).

A team-based model also has implications for performance management. Alimo-Metcalf (2005) demonstrated from her studies on middle managers within the NHS that transformational change models requiring a model of "distributive leadership" where a range of staff are given decision-making responsibilities. This not only raises the level of collective responsibility for performance, but also accountability where team performance is understood and measured routinely. Evidence from studies in other sectors, such as those carried out by Ghoshal and Bartlett (1995), indicate that long-term highly performing companies followed policies of "support and stretch" as opposed to a focus on "control and constrain." A support and stretch culture rests on learning, particularly emphasising cross-boundary working, an approach linked to high clinical results (Gittell, 2009; West, 2012).

There are examples of how this has already been done within the NHS. One case is at the Peterborough and Stamford Foundation Hospitals Trust where between 1996 and 2003 the Peterborough Transformation Team ran a series of interdisciplinary reengineering projects the methodology of which was adopted nationally by the then NHS Modernisation Agency (Morton, 2003). The methodology was based on the Nonaka and Takeuchi model of creating non-hierarchical cross-functional, and often, cross-employer teams to think through more effective processes using well-tried and tested quality techniques, honed from manufacturing experience. The outcomes were often stunning, such as in Opthalmology where the typical waiting times for cataract operations fell from 2 years to 6 weeks by successive implementation of the recommendations of that specific cross-functional team.

A second experience in the NHS North East is where surgical error was reduced and patient satisfaction increased by 20 percent through the introduction of team working. The experience was that to achieve the necessary changes in improving performance, the organization had to challenge the inbuilt professional resistance to working across disciplines and organizations and allow teams to challenge traditional medical practice and ways of working. They did this in part by embracing technological development that served to drive new techniques into service.

In both cases, effective team construction provided the opportunity to incubate and practice knowledge creation (Nonaka and Takeuchi, 1996). They provide a model of performance management which, unlike command and control management, does not militate against learning.

What remains, however, is a deep-rooted cultural resistance to working in a different way within the NHS, across senior and middle management. These examples are a microcosm of the larger issues relating to how embedded the current top-down system of target setting has become, reinforced during a period of economic crisis where demand outstrips supply.

Conclusion

Working within inter-disciplinary and inter-organizational teams provides us with a model that addresses a number of the drivers of quality performance in healthcare, including organizational learning, staff engagement and performance management. Where frontline staff are put in charge of quality, rather than having their caring priorities distorted by top-down targets it is more likely that the real issues of patient care will be prioritized.

The implications for performance management are firstly to reorientate performance targets so that they are locally set. The inevitable tendency within a centrally run national health system is to aim for total consistency and employ a series of checks and balances to ensure money is well-spent and that performance locally is defensible nationally. This leads to the top-down, regulatory, often remedial approach that stifles locally driven quality, care standards and innovation. Our solution is a team-based model of performance to allow setting of appropriate standards, reflecting local diversity and situational differences. This requires developing team working practices that allow for concerns and collective problem solving rather than triggering punitive responses where targets have not been met. This is the difference between transactional change and transformational change, where it is the latter that the healthcare system needs. Interdisciplinary teams that hold the responsibility for setting and managing performance targets go some way to redressing the balance away from purely financial arguments toward inclusion of clinical ones. To respond to the important issues raised by Francis and avoid another Mid Staffordshire disaster, will require a reorientation of NHS performance management culture away from targets toward a team-based model.

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Elizabeth Cotton is senior lecturer at Middlesex University Business School, co-author of Global Unions Global Business and Director of The Resilience Space.

Roger Kline is research fellow at Middlesex University Business School, co-author of Professional Accountability in Social Care and Health: Challenging unacceptable practice and its management (2012), Director of Patients First.

Clive Morton OBE is associate professor of Corporate Governance and Business Development at Middlesex University Business School.