

# **Reversing performance in the UK National Health Service: from targets to teams**

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## ***Introduction***

The UK's 2010 and 2013 public inquiries into the Mid Staffordshire hospital scandal estimated that between 400 and 1200 people died unnecessarily in just a four year period<sup>1</sup>. The inquiries, carried out by Robert Francis QC, identified a range of performance management problems within the NHS stemming from a widespread preoccupation with nationally set targets, emphasising 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 front line staff worked within an "endemic culture of bullying" (Francis, 2010: Vol 1. B.38), forced to prioritise targets over patient welfare for fear of victimization and job loss which incentivised short cuts and "unacceptable standards of performance" (Francis, 2013: 111). Virtually no organisation emerges from the inquiries with credit except the local campaign set up by the relatives of the victims.

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 organisation, our proposal is that an important aspect of reform should be a reorientation away from targets and top down management towards a model of inter-disciplinary and inter-organisational 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), introducing private finance to reduce the taxpayer's burden. Although the financial gains of this strategy are highly contested (NAO, 2006), these reforms were maintained by successive Labour governments.

In order 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 re-admission 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 front line 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 because they are unable to deviate from the targets and rules and act on individual discretion. One consequence is a high reported level of bullying by staff and managers of 24% in 2012 (NHS Staff Survey 2012) which is likely to undermine effective team working.

### ***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 is a model of performance management which 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 organisational learning that needs to take place within the NHS. Effective team construction can also provide a much needed space for genuine concerns to be raised by staff and explored fully to

avoid superficial learning and 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 multi-disciplinary 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 (Alimo-Metcalf and Alban-Metcalf, 2005) demonstrated from her studies on middle managers within the NHS that transformational change models requiring a model of 'distributive leadership' (West, 2006) where a range of staff are given decision making responsibilities. This not only raises the level of collective responsibility for performance, 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 're-engineering' 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 Ophthalmology 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 where surgical error was reduced and patient satisfaction increased by 20% 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 organisations and allow teams to challenge traditional medical practice and ways of working. They did this in part by embracing technological development which served to drive new techniques into service. For example, a simple quality technique has been to introduce a check-off procedure to avoid wrong site surgery eliminating operations performed on a wrong limb, organ or person. In 2010 Sir Peter Carr, then Chairman of the NHS North East gave a paper to the Prato Conference on “the Toyota Production System in Healthcare” documenting the radical improvement in healthcare outcomes within the North East due to their adoption of ‘Japanese’ quality approaches as practised by the Virginia Mason Medical Center and by Intermountain Healthcare Facility both in the US. Culturally, Sir Peter asserted that the norm in the NHS is that services are organised around clinicians, procedures and hospital administration, but not around the patient. NHS North East found that to achieve the necessary change they had to challenge the inbuilt professional resistance to improving standardisation in traditional medical practice. They found that resistance to standardisation prevents engagement of front line staff in the improvement of their service; further, technological development has the capacity to drive standardisation techniques into service against professional resistance. A simple quality technique, for example, has been to introduce a check-off procedure to avoid wrong-site surgery. In 2009-10 there were 57 reports of errors where an operation took place on a wrong limb, organ or person.

In both cases, effective team construction provided the opportunity to incubate and practice knowledge creation (Nonaka and Takeuchi, 1996). Importantly they also provided a mechanism for staff to be in charge of quality care, rather than having their caring priorities distorted by ‘top down’ targets which often do not have relevance to specific local organisational and individual patient needs. 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. Although both examples above were applauded nationally and awarded for their innovation and excellence, the methodology was not adopted more widely within the NHS. 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-organisational teams provides us with a model that addresses a number of the drivers of quality performance in healthcare, including organisational learning, staff engagement and performance management. Where front line 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 prioritised.

The implications for performance management are firstly to re-orientate performance targets so that they are locally set. Rather than appealing to nationally, and often politically set targets biased towards financial drivers, one implication of a team-based model of performance is to allow for local teams to set appropriate standards, reflecting local diversity and situational differences. This would require a radical devolution of powers to set NHS targets, requiring major buy in of political and regulatory bodies. A team-based model also implies that the monitoring and reviewing of performance should similarly be devolved to interdisciplinary teams, with an emphasis on adaptation to local realities and collective problem solving. This requires developing team working practices which allow for concerns and collective problem solving rather than triggering punitive responses where targets have not been met. Although not a magic solution to the inherent tensions between budgets and quality care, interdisciplinary teams that hold the responsibility for setting and managing performance targets goes some way to redress the balance away from purely financial arguments towards inclusion of clinical ones. To respond to the important issues raised by Francis and avoid another Mid Staffordshire disaster, will require a re-orientation of NHS performance management culture away from targets towards a team-based model.

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<sup>i</sup>Witness statement of Professor Sir Brian Jarman to Mid Staff9ordshire NHS Foundation Trust Public Inquiry. Monday 13th June 2011. Exhibits BJ1-BH56.