

# BRISTOL ROYAL INFIRMARY INQUIRY

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## PHASE TWO

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### **Determinants of Performance**

#### **Summary Report**

This is a summary report of the key points emerging from the seminar discussion on the *Determinants of Performance* which took place in London on 26 January 2000.

The following were points put to the Panel in discussion; they do not necessarily reflect the views of the Panel.

#### **Summary of the discussion**

The purpose of the seminar was to explore the factors which determine the level of performance of organisations in general and the National Health Service (NHS) in particular. The seminar included participants with experience of a wide range of public sector organisations (including the NHS, social services, education and the courts) as well as organisations in the voluntary and private sectors. Discussion focused on identifying generic factors which influence performance in organisations and thinking about how these factors operate in the specific context of the NHS. Consideration was given to defining and measuring success and to analysing the characteristics of successful organisations and those that do less well. Barriers to improving performance were discussed and attention given to identifying appropriate and effective interventions to overcome them. The key points emerging in each of these areas of analysis are summarised below. The report begins by drawing attention to particular characteristics of the NHS which may influence its performance and exploring the similarities and differences between it and other organisations in the public and the private sectors.

## **1. Defining characteristics of the NHS**

(i) Key features of the NHS were identified by seminar participants as important to bear in mind when thinking about problems and opportunities in relation to performance. These included:

- \* *complexity and size* (the NHS is a large employer with a very wide “product range”);
- \* *staffing mix* (the NHS involves powerful groups of clinical professionals with significant external power bases);
- \* *central-local relations* (the 'head office' of the NHS is comprised of people from the NHS and the Civil Service, working in a political milieu with values that may differ from those of the NHS) and
- \* *public expectations* (the NHS, like other public sector organisations, operates with limited funding in an environment of high and rising public expectations).

It was also pointed out, however, that there are many pressures and constraints which are common to organisations in all sectors. It was suggested that the similarities between the NHS and other organisations are as important to remember as the differences.

## **2. Factors influencing levels of performance**

(i) The following factors were identified as important in determining levels of performance in organisations. These were:

- \* *leadership* (includes both the qualities and behaviour of the individual leader and the make-up and behaviour of the 'top team');
- \* *vision* (includes the clarity and consistency of the vision and the ability to communicate it and build commitment to it throughout the organisation);
- \* *culture* (includes both style and process in areas such as: how decisions are made and who influences those decisions, how information is communicated, how problems or complaints are dealt with and how staff are treated and expected to behave);
- \* *organisation* (includes the quality and appropriateness of facilities, staff and systems, and how they interact);

- \* *engagement* (includes the capacity to take account of and learn from the external environment, to assess threats and to manage pressures) and
- \* *renewal* (includes the capacity to learn and develop in response to change).

### **3. Nature and operation of these factors in the NHS**

#### *(i) Leadership*

A number of questions were raised about leadership: Who are the leaders in the NHS - clinicians, managers or politicians? Where do the public fit in? What is the relationship between leadership of the wider organisation and of individual institutions? What is the relationship between management and control within the institution? Key issues of leadership identified included:

#### \* *the role of the Board*

NHS organisations at every level (Health Authority, Trust and Primary Care Group) have boards which are in charge; non-executives on those boards have a key role in linking the accountability of the organisation to the wider community. When boards work well they can be very effective. If a board becomes dysfunctional this may take a while to identify. At present there is a cultural reluctance for non-executives to get engaged in key clinical issues. Possible reasons include inadequate training, insufficient knowledge, or information flowing from within the organisation, uncertainty about how to judge the information they receive and uncertainty as to whether their role is to rubber-stamp decisions or to become engaged. It is important to define the role, purpose and authority of the board in the organisation.

#### \* *the clinical interface between managers and clinicians*

Achieving a satisfactory fusion of managerial and clinical leadership is essential, though not easy. Problems include clinicians' reluctance to participate in management and managers' reluctance to release sufficient clinical time for clinical managers to fulfill their management role. Clinicians' ability and willingness to get involved with management needs to be developed early in their careers through building it into their basic education and post registration development.

\* *working relationships*

Effective partnerships are essential at the top between the chief executive and medical and nursing directors. However, if these become too close there is a risk of 'vertical divorce', where the clinicians are seen as having crossed sides. There is a need for some degree of creative tension, with senior staff retaining an advocacy role for others in the organisation and ensuring good relationships up and down as well as across the organisation.

\* *empowering front line clinicians*

Front line clinicians, especially nursing staff, have the most acute awareness of the impact of the organisation on its patients and are a key source of intelligence about possible improvements. It is important both to give them time to reflect, to listen to them and to empower them to act.

(ii) *Vision*

There was discussion about the lack of clarity of vision in the NHS and possible reasons for this. Reasons suggested to the Panel included:

\* *multiple agendas*

The NHS involves a wide range of stakeholders with very different and sometimes conflicting values and agendas. Examples of significant tensions include those which exist: between the needs of individual patients and the population as a whole; between a focus on health care delivery or on wider health improvement; between the values of equity and efficiency; between political pressures at the centre and local patient care; between providers and users of the service.

\* *over-simplification*

There is a tendency for politicians and the media to favour simplification and spin, rather than acknowledging and dealing with complexity.

\* *external pressures*

It is difficult to maintain and pursue a clear vision across a huge spectrum of concerns in the context of insufficient resources, continuous pressure from the centre to respond to new agendas and directives and the continuing drive for efficiency and effectiveness.

Against this background it was suggested that building commitment to a coherent programme requires, among other things: major efforts to create a synergy of values between the different partners and to ensure that participants on every level including the public, feel engaged; the setting of realistic aspirations, whereby morale is maintained by setting stretching but achievable objectives; coherent 'system' leadership to forge links flexibly across organisation boundaries with NHS and non NHS bodies involved in delivering and improving healthcare.

(iii) *Culture*

There was considerable agreement among participants about the type of organisational culture needed in the NHS. Desirable attributes identified included a culture which:

- \* *is open and transparent* (encourages information sharing);
- \* *listens* (is willing to listen to concerns and regards unwelcome news as an opportunity rather than a threat);
- \* *supports learning* (provides time and encouragement to reflect on aims, strategies and processes and share mental models and ideas within and between teams and across organisational boundaries) and
- \* *shows respect* (respects the needs and interests of individual patients, carers and staff ; a successful organisation lives the values it expresses).

(iv) *Organisation*

Important attributes of organisational structures, processes and resourcing identified included:

- \* *clear roles, responsibilities and accountability* (for example: knowing how to act in the face of competing objectives; knowing what to do if something goes wrong and when to take further action);

- \* *good people management practices* (for example: well-planned procedures for recruitment and placement of staff; fostering acquisition and development of skills, good teamworking and responsible roles) and
- \* *appropriate incentives and rewards* (rewards and sanctions systems which are lined up with the organisational objectives, and which recognise the individual contribution of employees. It was suggested that the reward for success in public sector organisations could be an increase in pressure to perform without an appropriate increase in resources resulting in difficulty in maintaining quality).

(v) *Engagement*

Participants discussed the need for engagement with the world beyond the organisation in terms both of making good links and managing external pressures. Features of such engagement which were identified as important in the context of the NHS included:

- \* *relations between periphery and centre* (the capacity to assess the significance of pressure from the centre and manage the impact of external demands, in the context of local needs);
- \* *relations with peers and other local organisations* (commitment to learning what happens elsewhere, for example through consideration of external benchmarks, use of comparative data, and sharing best practice) and
- \* *relations with the public* (ensuring that the local community, including both regular users and the public as a whole feel involved and valued. This means providing good and timely information, and a responsive approach, inviting comment and giving time and attention to those who wish to voice concerns. Conversely it means, avoiding tokenistic consultation, defensiveness at public meetings and behaviour which implies marginalisation of people's views).

(vi) *Renewal*

There was discussion of the need for flexibility, creativeness and a constructive attitude to change. This is both to avoid becoming stale and to ensure that the organisation remains attuned

and responsive to changing user expectations and developments in the wider policy environment.

#### **4. Defining, measuring and identifying success**

(i) Discussion centred on how success is defined and measured and on ways of identifying success or failure within organisations. Participants suggested that for organisations such as the NHS with many stakeholders and multiple objectives there is no single answer to what constitutes success, nor will the answer stay constant over time.

(ii) A number of examples were discussed as to how assessments of success and failure are often made in practice. Suggestions for sensitive areas to look at included: the chief executive's behaviour, skills and relationships with staff; the extent to which an organisation is outward looking or introspective; the views, knowledge and influence of those on the ground floor about and upon the values, objectives and processes of the organisation as a whole. However, a degree of caution was urged about relying on anecdotes or reputation to make evaluative judgements. The example was given of organisations that are viewed positively simply because they do not cause trouble to others around them, even though they may not be performing well internally. It was acknowledged that, while 'soft' evidence may sometimes be most telling and should not be ignored, it needs to be underpinned wherever possible by sound and systematic measures and information. Seminar participants anticipated failure within organisations that:

- \* turn in on themselves, with professional and managerial isolation and no external benchmarks;
- \* are out of touch with customers or users and are defensive or unwilling to engage with their concerns;
- \* have a culture of short termism and lack of investment which discourages innovation;
- \* are under stress (due to deprivation, poor facilities, external pressures);
- \* are without clear objectives;

- \* have a poor management/clinical interface, where there is excessive compartmentalisation;
- \* have a top team which is unable or unwilling to lead or intervene;
- \* are run by fear and bullying, which do not show respect or value their staff or customers;
- \* lack transparency and
- \* lack a critical mass to work efficiently, have insufficient resources or skilled staff.

(iii) If success is a multi-dimensional and dynamic concept, then it requires a variety of measures. There were various suggestions as to what components might be included in a meaningful and well-balanced portfolio to assess performance. These included measures:

- \* relevant to both short and longer term objectives;
- \* that relate to core organisational values;
- \* capable of tracking change in positive or negative directions of all dimensions within the service including culture as well as activity;
- \* of all perspectives on the service, but particularly those of patients and the wider public;
- \* for routine aspects of the service as well as priority areas;
- \* that go right through the whole organisation;
- \* that take account of an organisation's impact beyond its own domain (eg the effect on community services of developments in secondary and tertiary care)
- \* that do not distort priorities or generate perverse incentives, and
- \* that help distinguish between sub-optimal and unacceptable performance.

## **5. Strategies to improve performance**

(i) There was extensive discussion of possible interventions to improve performance, what they are and how they are best used. Participants also considered potential obstacles to effective intervention and the hazards of intervening inappropriately. It was acknowledged that even successful interventions may cause some difficulties for those involved. It was also acknowledged that all organisations, whatever their level of performance, need to be stretched, but the package of interventions will need to differ according to how well or badly an

organisation is doing. A number of principles were suggested to be of critical importance. These included the need to:

\* *define and understand the problem*

Problems arise for different reasons and at different levels (individual, system or environment) requiring different approaches. It is important to understand and take account of the reasons for poor performance in devising solutions.

\* *customise the intervention*

Different organisations have differing needs and respond to interventions differently. There is no universal template for change which will suit all circumstances. It is essential to understand the organisational context and culture and to customise the intervention accordingly.

\* *ensure ownership*

External intervention risks making an example of the organisation and alienating those involved. It is important to avoid a punitive culture and to engage people within the organisation as observers and participants in identifying and analysing problems and suggesting and negotiating action plans to deal with them.

\* *be supportive*

Punitive approaches can inhibit learning. Support and encouragement to help work things out will elicit a more constructive response from those involved.

\* *combine and coordinate interventions flexibly*

There is a well-recognised menu of interventions for change, both soft and hard in style, but no standard template as to how they should be used. Organisations within the NHS vary in culture and style, and should not be regarded as machines which need mechanical solutions. Change is a dynamic and organic process. Isolated, one-off changes may dissipate energy, raise barriers and produce negative effects in other areas. Sustained improvement needs sensitive, responsive and coordinated action over time across a variety of areas.

\* *encourage excellence*

If success is defined as avoidance of failure, there is a risk of aspirations being set too low and intervention being limited to those organisations that are clearly failing. There is a need to encourage and reward improvement positively for organisations at every level of performance. The best should be celebrated, the striving encouraged and the average challenged to avoid complacency.

\* *identify and disseminate good practice*

More sound evidence is needed on the effectiveness of interventions to improve performance and better dissemination of what is already known (notwithstanding the already good initiatives to spread best practice such as the NHS Learning Network), it is important to encourage people actively to seek out relevant knowledge.

**Inquiry Secretariat, February 2000**