performance in this area. A focus on narrow outcomes diverts attention from building organisational excellence.

Related to this is the curious fact that although the NHS Plan placed very great emphasis on improving the patient experience and the value of staff, the measurement of these been neglected until recently. While access and treatment times and cleaning are important, the essence of the patient experience is much more than improved performance on this narrow selection of measures and may miss what the patients really want. There is a danger that we could implement all 365 targets in the NHS Plan and still find patients and the public dissatisfied with the NHS.

The fourth potential contradiction is in our attitude to inspection. Although this is seen as a guarantee of standards and is rightly viewed by many of the inspectors as part of a wider developmental process it is very easy for this view to be subverted, unintentionally, by the language used to describe it or the perceptions of those on the receiving end. We know that the real key to high quality and continuous improvement is to ensure that it is internalised rather than a periodic activity in response to, or expectation of inspection. This is not to argue that inspection is not important, it is and the service may not be ready to do without it, but we need to ensure that it does not inhibit the development of a culture of continuous improvement.

Despite the collection of large amounts of information, there seems to be a reluctance to tell it how it is and transmit unwelcome news up the organisation.

Improving the performance management system

Perhaps the most surprising contradiction in the approach to performance management is that although we are all aware of the problems we seem to do so little to change it. *Rethinking the system (Leading Edge 3)* looks at how we might recast the system to improve the link between performance management and performance improvement.

'There seems to be a reluctance to tell it how it is and transmit unwelcome news up the organisation'

NHS Confederation *Leading Edge* briefings are designed to reflect and stimulate new thinking. If you would like to share your views, or would like more information about our work on Rethinking Performance Management, please contact Nigel Edwards, Policy Director at the Confederation at nigel.edwards@nhsconfed.co.uk

To obtain further copies of this *Leading Edge* briefing contact Joanne McManus, NHS Confederation publications sales and enquiries
DSI NE, Enterprise House, Rolling Mill Road,
Jarrow, South Tyneside NE32 3DP
Tel: 0870 444 5841 Fax: 0870 444 5842
E-mail: publications@nhsconfed.co.uk

NHS Confederation
1 Warwick Row, London SW1E 5ER
Tel: 020 7959 7272 Fax: 020 7959 7273
Internet: www.nhsconfed.net E-mail: enquiries@nhsconfed.co.uk

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2 Aligning what we say and how we behave

The NHS Confederation is producing a series of *Leading Edge* briefings to launch a debate on Rethinking Performance Management across the UK's health services. This *Leading Edge* is published together with *Why won't the NHS do as it is told - and what might we do about it?* and *Rethinking the system*. The current system appears to fail both the performance managers and those they manage; neither does it directly connect to front-line clinicians or their patients. This briefing examines some striking contradictions between what we know about the NHS and how the performance management system has been set up.

Introduction

We know that the NHS is not a machine, and that many of our levers are disconnected, but this does not stop us using many machine-type interventions. There are a number of other quite fundamental contradictions in other aspects of NHS performance management. These contradictions undermine the effectiveness of the system and increase the probability that we will produce unintended consequences and perverse effects.

For the sake of contrast the contradictions are stated baldly but this hides many nuances and local variations. It is also worth pointing out that there is progress and increasing coherence – however, it is for behaviour to slip back to old patterns.

Messages about redesign

The NHS Plan makes it very clear that much of the change that is required in the system needs to come

Messages about redesign

What we say	How we behave
Focus on redesign	Focus on capacity
Redesign takes time and is emergent	Set short-term milestones
Expect 'J-curve' shaped progress	Set linear targets
Redesign produces local solutions	Issue detailed instructions
Invest to change	Must have national consistency Annual allocations
More change means more management	Tight management cost targets

from the redesign of services around the patient. Redesign methodology relies on large numbers of small cycle changes which together can produce step changes in performance. This takes time and commitment and will not produce immediate large-scale change, indeed in some cases performance may describe a 'J' curve with an initial drop as new systems are developed. Where greater change is required which needs up-front investment, the capacity for doing this is limited by the process of annual allocations and the requirement for financial balance each year. It is not clear that these two important insights have informed the development of performance management.

'The problems with risk and innovation are compounded by our attitude to failure'

Innovation and risk

There are similar tensions in the approach to risk and innovation. Government policy stresses the need for radical redesign, risk-taking and social entrepreneurship, and indeed many of the more ambitious aspects of the plan are dependent on this. Unfortunately the approach to performance management is often risk-averse and tends to increase the level of prescription to try and control risk – this discourages risk-taking and innovation. The larger the number of targets the less likely it is that there will be high levels of creativity and risk-taking.

There is a further problem in the approach to innovation and social entrepreneurship as a result of a failure to describe the difference between good and unacceptable diversity. The current system seems to regard all diversity as bad rather than the natural and inevitable result of innovation, user-focus and local ownership. The Governments consultation document *Shifting the Balance of Power* talks about the NHS being uniformly excellent and innovative without apparently noticing the contradiction. This conjures up the fascinating prospect of one million people being struck by the same thought while they shower!

The problems with risk and innovation are compounded by our attitude to failure. Although it is now widely accepted that failure is generally a systems characteristic and that seeking to apportion blame is a major obstacle to learning and development, this is not always carried through into performance management. There have been improvements in this recently and the Department of Health initiative as part of the work on the chief executive community is welcome. Nevertheless much of this mindset remains. This seems to reflect the remnants of an outdated model of heroic leadership.

Innovation and risk

What we say	How we behave
Be innovative and entrepreneurial	Don't fail
Take risks and set innovators free	Prescribe details and minimise risk
Develop new ways of working	Avoid diversity
Heroic failure is allowed	But needs a lot of explaining
Failure is a systems characteristic	Individuals pay the price

Managing change

What we say	How we behave
Change needs to be bottom up	Drive, push from the centre
Engage local stakeholders in change	Follow national policy
Connect with the front line managerially	Set targets
There are five priorities	There are over 400 targets
Trade-offs are needed	Insist on everything
Different starting points for change	Standardised targets for bed numbers
Targets need to be locally valid	Assume local targets naturally drop out of national targets
Policy has unintended consequences	Behave as though they don't exist

Replacing the chief executive of a failing organisation may allow a new start or deal with individual performance, but it will not guarantee organisational turnaround.

Managing change

We understand that the traditional top-down method of change is not appropriate. It is a slow and a passive process that at best engenders a low level of commitment to change, and at worst active resistance. It is also poor when dealing with complexity, promoting learning, and fails to encourage people to work across existing organisational boundaries. We also understand that policy driven in this way frequently produces unintended or perverse effects.

There is a widely held belief that change is produced by challenging targets and the language used by Government makes reference to driving, pushing and a number of other verbs that imply that change is something that you make other people do and that works from the top downwards. The logical extension of this is that lots of change must mean lots of targets. While up to a point targets do create change, it is at the stage that they start to multiply that the system starts to falter. Firstly, there are only so many targets that an organisation can focus on and secondly, where there are limited resources there need to be trade-offs between the different targets.

'Top-down change frequently produces unintended or perverse effects'

Silo-based policy-making provides incentives for policy leads and performance managers to create new and competing targets. These targets are created to demonstrate and monitor the implementation of national policy and it is automatically assumed that targets and measurements that make sense at a

national level easily convert into meaningful local targets. This is not a safe assumption because of different local circumstances, starting points and other competing needs. There are few incentives to consider the need for trade-offs until the policy is handed over to those responsible for performance management. In the recent SaFF round this led to the phenomenon of imperative, must, must do and must do targets, and to situations where organisations were asked to reinstate priorities that they had previously agreed with the regional office to demote.

A top-down approach has a malign effect on the ability of local organisations to get the full engagement of all local stakeholders and front-line staff that the NHS Plan requires. The engagement of front-line clinical staff is of particular importance given the emphasis on redesigning care around the patient. Many previous reforms have failed to touch most front-line staff or the details of patient care and the problem has been compounded by the NHS' 'disconnected hierarchy', where the top of the organisation is not effectively connected to the front line and may not even share the same objectives and priorities. The Modernisation Agency's work makes a point of addressing this and this in part explains the success of many of the collaboratives.

Whole-systems solutions

'Why won't the NHS do as it is told – and what might we do about it?' (Leading Edge 1) rightly stresses the importance of developing collective approaches to problem solving and performance improvement, and gives a number of examples of where the pursuit of individual organisational targets can produce sub-optimal outcomes even when all of the individual boxes have been ticked. Increasingly, it is understood that solving complex problems requires whole-system responses. For example, dealing with A&E trolley waits may require interventions in primary, intermediate and social care as well as efficiency improvements in the hospital. We also understand the dysfunctional behaviours that can emerge from measuring individual organisations. All this makes a simplistic assessment of individual organisations unhelpful unless it includes a sophisticated understanding of their role in the local health community.

'Increasingly, it is understood that solving complex problems requires whole-system responses'

Whole-systems solutions combined with a wish to develop primary care and to shift resources, creates a further contradiction in an

Whole-systems solutions

What we say	How we behave
Work collectively to solve problems	Measure individuals
Complex problems need whole system solutions	Concentrate on line accountability and single organisational performance
Invest to change and shift resources to primary care	Annual financial balance for all organisations

Measurement and information

What we say	How we behave
Measure for improvement	Measure for selection
Measure for local use	Measure for national tracking
Valid information is important	Ignore lessons about the production of valid information
People, process, structures and outcomes are key	Measure outputs and ignore issues about sustainability
Staff and patient views are crucial	Fail to collect these systematically
Build quality into the process	Enforce by inspection
Tell it how it is upwards	Reluctance to do this

'The widespread use of measurement for selection is a major obstacle to developing performance improvement'

environment when all organisations are held to account for short-term targets and in particular, annual financial balance.

Measurement and information

The way that performance is measured may be more important than the number of targets. A key rule of performance improvement is that where possible, measurement should be to inform improvement, not for selection or punishment. Information collected for a third party is likely to be less reliable than information collected for improvement and where it is used to make judgements there are strong incentives to game the system. It has already been noted that much of the measurement that is required is to allow the implementation of policy to be tracked at a national level. The widespread use of measurement for selection is a major obstacle to developing performance improvement.

Until recently the service has not been particularly good at using information for service improvement and does not have the capacity to identify what information it needs. There are good examples such as the risk-adjusted outcomes audit run by the British Association of Cardiothoracic Surgeons (Icnarc) which collects vast amounts of patient-related data from individual members. But these are relatively rare and, interestingly, voluntary.

The second difficulty with the measurement regime is that it pays very little attention to the way that performance is achieved. The focus on outcomes provides no real information about the robustness of the processes, the capabilities of the management team and the culture of the organisation. Any system that wants to devolve and decentralise must be confident that the organisations it is placing its trust in are mature and robust and capable of sustainable change. This sort of explicit and objective comparison of the enablers of performance is needed most of all by the organisations that are being performance managed. They should be constantly comparing and challenging their own