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HEALTHY PERFORMANCE - A CASE STUDY ON PERFORMANCE MANAGEMENT

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HEALTHY PERFORMANCE

A CASE STUDY ON PERFORMANCE MANAGEMENT WITHIN THE ENGLISH NATIONAL HEALTH SERVICE

EDITED VERSION

By

JEREMY WALDING

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Authors Declaration

At no time during the registration for the degree of Master of Philosophy has the author been registered for any other University award without prior agreement of the Graduate Sub-Committee.

Work submitted for this research degree at the Plymouth University has not formed part of any other degree either at Plymouth University or at another establishment.

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ABSTRACT

JEREMY WALDING

HEALTHY PERFORMANCE
A CASE STUDY ON PERFORMANCE MANAGEMENT
WITHIN THE ENGLISH NATIONAL HEALTH SERVICE

The following thesis has set out to identify the current gaps in knowledge, literature and research surrounding performance management within the English National Health Service (NHS). A literature review and qualitative case study were conducted on the factors associated with organisational and strategic performance management within the English NHS. The study sets out to close the gaps in knowledge surrounding performance management to identify an alternative approach towards delivery. Current literature indicates that performance management frameworks within the NHS that may have been influenced by the impact of New Public Management movement approaches are very much based on a 'command and control' accountability structure. Past literature has highlighted that 'command and control' may not be the most effective approach to adopt (Seddon, 2003) by the NHS and may have the potential to lead to dysfunctional behaviours (Grizzle, 2002), such as, gaming, cheating or chasing perverse incentives (Marr, 2008). To explore the phenomena further the thesis has conducted qualitative ethnographical research on the perspectives and realities of English NHS staff to uncover the factors surrounding performance management. As a result of the investigation, a proposed new model and a set of recommendations emerged to support the future design and approach of performance management, therefore, providing a valuable contribution to the creation of knowledge in the chosen field.

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1. Introduction

In England, health care services and treatment provided by the public sector is resourced from a nationally subscribed system that funds the English National Health Service (NHS). The English NHS commissions a system of healthcare organisations to provide services free at the point of delivery and is the oldest and largest single payer healthcare institution in the world (OECD, 2011).

As a large complex institution, there is a need for the English NHS to maintain sustainability and delivery by adopting a number of performance management frameworks and approaches to manage its strategy, operations and service delivery. Due to public and political interest, the sustainability of the NHS and those factors and determinants that impact upon it is a very debatable subject (Pym, 2015). NHS sustainability may be dependent for a number of reasons (Raith, 2008) however there is an on-going necessity for the NHS to continually satisfy the public and the electorate, although this may be dependent on its management and delivery of performance and policy objectives (Mackie, 2008).

Comprehensive monitoring, review, reporting, governance, scrutiny and strategic direction are all essential business management functions expected of the NHS that would be contained within their organisational performance management frameworks (Mackie, 2008), but what are the factors, determinants and pervasive characteristics that surround these frameworks and approaches (Pettigrew et al, 1999)?

The following study sets out on a journey of discovery to explore and investigate these factors, determinants and approaches surrounding performance management in the English NHS today and in doing so looks to uncover whether an alternative approach to performance management could be adopted to support greater sustainability of the English NHS (Raith, 2008) and therefore lead to greater outputs from the resources invested.

The chosen field of the study will be performance management a strategic organisational tool that has been claimed as a valid method to manage healthcare performance (Dwivedi, 2008) which has now become of great interest within the business management community as a field of academia (Busi & Bitici, 2006). There is now a rapidly growing interest in academia regarding performance management across both commercial and public sectors, this is evident amongst a number of authors that have emerged from the academic texts from the 1980s onwards such as, Johnson & Kaplan (1987), Kaplan & Norton, (1992) Neely (2007) Marr (2006), Seddon, (2005), Michelli (2009) just to name a few.

Literature within the field of performance management is extensive in fact Neely (1999) claimed that in 1996 a publication had appeared on the chosen field every two weeks in the USA. De Waal et al (2008) commented on the available literature associated with performance management claiming that it tended to be no older than 1996 and mainly consisted of scientific articles when they looked at studies related to the problems of performance management system implementation.

Performance management frameworks and approaches in the NHS have been specifically placed central and at the very core of this study alongside the impact it may have on staff operating within an English NHS context, so there is an expectation that the volume of literature may or may not be limited. There are a number of extensive studies that have been conducted on the NHS that have investigated the impact and determinants such as, Pettigrew et al (1999) who observed that there has been much-published research on performance measurement in the NHS but less concerning overall performance management. Mannion & Davies (2003) conducted studies on the impact of NHS star ratings and performance that may indicate the effectiveness of the established performance management frameworks; although these studies were limited and were over ten years old and since their publication there has been significant organisational restructuring of the NHS as a result of the *Health and Social Care Act* (2012).

The literature indicates that the current embedded NHS performance management system has been designed and shaped from a range of imposed frameworks set by the UK Government Secretary of State via independent related regulatory authorities, see *Standards for Better Health* (Healthcare Commission, 2004), *Annual Health Check* (Healthcare Commission, 2009), *Developing the Performance Regime*, (2008). The thesis will set out to hold a reflective mirror up against these frameworks and practices and in doing so identify the approaches that have been adopted by NHS organisations to address any potential gaps in the literature.

Despite the legislative policies highlighted above produced by the Department of Health a large body of literature from academic sources such as, Marr & Schuima (2003), Santos et al (2007) indicates that the term 'performance management' when applied to an organisational and strategic application can potentially run the risk of being misinterpreted by individuals and organisations operating within the NHS. The thesis sets out to explore this further at a strategic level as the very perception and purpose of the term may be acting as a barrier towards the delivery of its intended benefits. For example, performance management may be perceived as having the potential as a business management tool to be implemented as a means of controlling or commanding people within a large chaotic institutionalised system (Seddon, 2005). Or it may be perceived as a means to support an organisation to learn and adapt to its changing circumstances (Marr, 2008b).

The literature also indicates that performance management may be perceived as a limited means of measurement (Lebas, 1995 & Lebas, 2007, Lynch & Cross, 1991) or could be perceived as a strategic planning tool (Kaplan & Norton, 2001, 2004) or even both combined (Gates, 1999 & Marr, 2006). A divergence of views that may be prevalent in the literature and in the field surrounding performance management within the NHS may provide a lack of focus on the specific barriers surrounding performance management, not having this understanding amongst the individuals and teams operating within may provide a challenge for the NHS to address, if they were looking at strategic alignment (Gates, 1999). The study will set out to define exactly what the 'performance management' term is within an organisational and strategic NHS context to enable an analysis to be

conducted on the impact the term may have on staff and individuals and in doing so enable a new alternative perspective, practice or approach to emerge.

Whilst previous studies have explored performance management and its effects on public sector performance (Pettigrew et al 1999, Mannion & Davies, 2003) these contributions have tended to focus primarily on organisational aspects rather than the effects surrounding the individual from an internal perspective. Therefore, there is a gap in knowledge to identify and explore how staff understand and perceives performance management.

These first few paragraphs of the introduction have established the importance of performance management for the NHS, however, there are early signs that there is a gap in the knowledge within the literature regarding the term alongside the potential barriers towards delivery. Before proceeding towards the aims and outcomes and the beneficiaries of the research there is a requirement to place in more detail the current background and the sustainability environment the NHS (Raith, 2008) is operating within that concerns the chosen field of research.

2.   Background

The next section provides an outline of the sustainability dilemma (Raith, 2008) that the NHS may be facing and the concerns regarding its measurement highlighting a need for the NHS to adopt a more robust effective performance management framework of measures and approaches.

It has been reported in the media that austerity reforms implemented since 2010 by the British Government have placed UK public services and the English National Health Service into a significantly challenging position (Pym, 2015), (Crump & Adil, 2009). The BBC reported in Pym (2015) that for 2014/15 a deficit of up to £1bn was likely to be incurred by NHS trusts and major hospitals. This deficit is likely to continue to rise in 2015/16, therefore, creating a potential problem for the British Government in ensuring that increased quality of care and productivity is achieved for the future (Pym, 2015). The increased financial pressures that the NHS is facing indicates that it is potentially expected to remain operating within a smaller financial envelope in the future, however, having to maintain current and increased levels of productivity output.

Sustainability of the NHS (Raith, 2008) has also attracted ministerial and political interest as the media has reported a number of concerns from political parties, Ed Milliband the Leader of the Opposition in 2014 claimed the numbers of people that were waiting on trolleys in hospital wards had increased from 62,000 to 167,000, while accident and emergency patients that were waiting longer than the four-hour target had risen to 939,000 (BBC, 2014). The media report went on to claim that it was later disputed by David Cameron the UK Prime Minister who

claimed at the time that the British Government had invested an extra £12.7 billion into the NHS to improve performance and that waiting times in A&E, cancer treatment and trolley waits had decreased significantly (BBC, 2014). These statements may not necessarily be based on scientific evidence however they do highlight the political concerns surrounding NHS performance and sustainability (Raith, 2008) and raises the importance of establishing the right measure of productivity output against the financial investment.

In 2012 Professor Nick Black (2012) disputed accusations of there being a true decline in NHS productivity over the last ten years as a result of significant investment in the NHS from the UK Government. Professor Black (2012) claimed that figures which were produced by the Office for National Statistics (ONS) may have underestimated improvements that were delivered by the NHS in outcomes. Black (2012) claimed that health outcomes as a measure of effective performance and value for money may be realised by the public in the longer term and may be more important to patients than quantitative process-based productivity measures that the ONS was using at the time. Black (2012) stressed the importance of outcome-based measures of performance to indicate improvements in the NHS this has been highlighted in **Table 2.1** below

Table 2.1: **NHS Productivity in England has been removed due to copyright restrictions**

Source: Black (2012) extracted online Feb 2013.

Black (2012) challenged the validity of the performance measures the Department of Health were historically using to evidence sustainability (Raith,2008) and performance and questioned whether the NHS performance measurement system may be measuring the wrong aspect of productivity. Concerns surrounding using the right measures have also been raised by Seddon (2003) & Marr, (2008), which we will be discussed later within the literature review.

Looking at productivity as a measure is a very debatable area as highlighted within the *Atkinson Review* (ONS, 2005), *The Gershon Review* (TSO, 2004),

Wanless et al (2002, 2004) and Black (2012), but it is important when considering performance whether there is a correlation or relationship between the levels of expenditure against productivity output. From 2003 -2009 there has been a significant investment in the UK NHS, this is evident looking at the level of investment as a percentage gross domestic product from the UK Government that has risen from 7.8% in 2003 to 8.4% in 2007 (OECD, 2011), see **Table 2.2** below:

	2003	2004	2005	2006	2007
Australia	8.3	8.5	8.4	8.5	8.5
Austria	10.3	10.4	10.4	10.3	10.3
Belgium	10.0 (b,d)	10.2 (d)	10.1 (d)	9.6 (d)	9.7 (d)
Canada	9.8	9.8	9.8	10.0	10.0
Chile	7.5	7.1	6.9	6.6	6.9
Czech Republic	7.4 (b)	7.2	7.2	7.0	6.8
Denmark	9.5	9.7	9.8	9.9	10.0
Estonia	5.0	5.1	5.0	5.0	5.2
Finland	8.2	8.2	8.4	8.4	8.1
France	10.9	11.0	11.1	11.0	11.0
Italy	8.3	8.7	8.9	9.0	8.7
Japan	8.1	8.1	8.2	8.2	8.2
Korea	5.2	5.3	5.7	6.0	6.3
Luxembourg	7.7	8.2	7.9	7.7	7.1
Mexico	5.8	6.0	5.9	5.7	5.8
Netherlands	9.8	10.0	9.8	9.7	9.7
New Zealand	7.9	8.3	8.7	9.1	8.8
Norway	10.0	9.7	9.1	8.6	8.9
Poland	6.2	6.2	6.2	6.2	6.4
Portugal	9.8	10.1	10.4	10.1	10.0
Slovak Republic	5.8	7.2	7.0	7.3	7.7
Slovenia	8.6	8.4	8.4	8.3	7.8
Spain	8.2	8.2	8.3	8.4	8.5
Sweden	9.3	9.1	9.1	8.9	8.9
Switzerland	11.3	11.3	11.2	10.8	10.6
Turkey	5.3	5.4	5.4	5.8	6.0
United Kingdom	**7.8**	**8.0**	**8.2**	**8.5**	**8.4**
United States	15.7	15.7	15.7	15.8	16.0

**Table 2.2: Investment into global health
% of Gross Domestic Product**

Source: OECD (2011) extracted online Feb 2013

This increased investment can also be seen as a percentage of total expenditure on health, see **Table 2.3** below:

	2003	2004	2005	2006	2007	2008	2009	2010
Australia	66.1	66.7	66.9	66.6	67.5	68.0	..	..
Austria	75.5	75.7	76.1	76.0	76.4	77.2	77.7	..
Belgium	74.8	76.0	75.9	73.9	73.5	75.0	75.1	..
Canada	70.2	70.2	70.2	69.8	70.2	70.5	70.6	70.5 (e)
Chile	38.8	39.9	40.0	42.1	43.2	44.0	47.4	..
Czech Republic	89.8 (b)	89.2	87.3	86.7	85.2	82.5	84.0	..
Denmark	84.5	84.3	84.5	84.6	84.4	84.7	85.0	..
Estonia	77.0	75.5	76.7	73.3	75.6	77.8	75.3	..
Finland	74.6	75.0	75.4	74.8	74.4	74.4	74.7	75.1(e)
France	78.9	78.8	78.8	78.7	78.3	77.7	77.9	..
Germany	78.4	76.7	76.6	76.4	76.4	76.6	76.9	..
Greece	59.8	59.1	60.1	62.0	60.3	..	..	..
Hungary	72.8	72.4	72.3	72.5	70.3	71.0	69.7	..
Iceland	81.7	81.2	81.4	82.0	82.5	82.6	82.0	80.5 (e)
Ireland	76.5	77.4	77.0	76.8	76.9	76.7	75.0	..
Israel (1)	61.7	60.9	59.3	59.0	58.3	58.4	58.5	..
Italy	74.5	76.0	76.2	76.6	76.6	77.5	77.9	77.6
Japan	80.4	80.8	81.6	79.4	80.4	80.8	..	..
Korea	52.4	52.6	52.9	55.3	55.8	55.9	58.2	58.3 (e)
Luxembourg	84.2	84.8	84.9	85.1	84.1	84.1	84.0	..
Mexico	44.2	45.2	45.0	45.2	45.4	46.9	48.3	47.3
Netherlands	..	..	..	..	..	..	..	..
New Zealand	78.3	76.9	77.1	77.5	79.8	80.3	80.5	..
Norway	83.7	83.6	83.5	83.8	84.1	84.3 (e)	84.1(e)	..
Poland	69.9	68.6	69.3	69.9	70.8	72.2	72.2	..
Portugal	68.0	67.1	67.1	66.1	65.7	65.1	..	..
Slovak Republic	88.3	73.8	74.4	68.3	66.8	67.8	65.7	..
Slovenia	71.9	73.1	72.1	72.3	72.3	73.4	73.4	..
Spain	70.3	70.4	70.6	71.3	71.5	72.6	73.6	..
Sweden	82.0	81.4	81.2	81.1	81.4	81.5	81.5	..
Switzerland	58.3	58.4	59.5	59.1	59.1	59.5	59.7	59.0 (e)
Turkey	71.9	71.2	67.8	68.3	67.8	73.0	..	..
United Kingdom	**80.0**	**81.3**	**81.9**	**81.3**	**81.3**	**82.4**	**84.1**	**..**
United States	43.6	44.0	44.1	44.9	45.1	46.0	47.7	..

Table 2.3: International expenditure on health

Source: OECD (2011) extracted online Feb 2013

Table 2.3 above highlights that the UK has increased its expenditure on health by 4.1% over a six-year period from 2003 to 2010, however, remaining stable from 2006-2009. If we were to look at this in more detail within five-year

averages from 1976 to 2009, it can be seen that 4% growth has been the average since NHS inception (Harker, 2012).

Figure 2.1 NHS Expenditure from 1975/76 to 2008/09 has been removed due to copyright restrictions

Source: Harker, R, (2012) extracted online April 2012

Figure 2.1 above highlights that Harker (2012) reported to the UK Government that expenditure on the NHS had risen considerably since it was established in 1948, with an estimated spend of £11.4bn per annum rising to £121bn per annum in 2011. **Figure 2.1** indicates a significant investment in 4% growth on average from 1950/51 to 2010/11, the largest five-year moving average (+7.6%) occurred over the period 1999/2000 to 2003/04; therefore, it may have been this period where there were increased productivity outputs.

However, Lester (2004) had a number of concerns regarding NHS performance as a result of this increased investment claiming that in 2002 when the NHS

performance target regime was implemented, (*Performance Assessment Framework*, NHS Exec, 1999) the NHS had received a 20 percent funding increase, (*NHS Plan, A Plan for investment a Plan for Reform*, DOH, 2000 & 2000b). Lester (2004) claimed two years later this resulted in output that only increased by a further 4 percent.

It is apparent from the literature that to measure return on investment and value for money is not an easy task is as it may be dependent on whether the correct measures are in place; this was highlighted earlier by Black (2012) and Marr (2008). Performance targets imposed at the time of the Lester (2004) study may have required a much longer run effect to evidence their value as proposed by Black (2012), additional measures may be required to look at the longer term outcome and financial gains that may be achieved over a longer period.

Radnor & McGuire (2004) also when looking at expenditure and value for money supported Black (2012) claiming that it was far too dependent on the design of the measures and the collected data. The Lester (2004) study may have led to the production of misleading data and intelligence, therefore, this study questions its validity to understand whether the NHS is operating from a high performing sustainable baseline.

Performance measurement is key to understanding whether the NHS is operating from a sustainable position (NHS Institute for Innovation & Improvement, 2008) and there has been much debate concerning measurement design. Seddon (2003) preferred the measurement of systems instead of the traditional target

setting quantitative based targets, Marr (2008) highlighted similar problems regarding measurement by coining the term, 'measurement trap' where public sector organisations find themselves in situations where they only measure what is imposed or easy to acquire. Marr, (2008) stressed that measures may not necessarily provide the most valid information to interpret performance and therefore may have an impact on the decision-making process and as a result on organisational performance.

Over the last 15 years it is evident from Department of Health literature that the NHS has been continually subject to new designs of its performance management framework, this can be found within the following documents, *The New NHS Modern & Dependable* (DOH, 1997), *Performance Assessment Framework* (NHS Exec, 1999), *Developing the Performance Management Regime* (DOH, 2008), *Equity & Excellence* (DOH, 2010) *NHS White Paper 'Liberating Excellence* (2010).

Interestingly as a result of the study reviewing the above performance frameworks, a majority of the performance measures within the frameworks have remained consistent throughout as quantitative measures, for example, waiting times, numbers in treatment and cases all predominately based on productivity output rather than quality and patient outcomes. Outcomes are now a part of the new NHS performance management frameworks and are in contrast to the previous performance management regimes as they look more towards health inequalities, life expectancy, mortality rates, and patient satisfaction as set out in *NHS Outcomes Framework 2011/2012* (2010). However, the study has found

limited empirical studies on the impact these new frameworks may have had on staff regarding the consistent redesign of performance frameworks over the last 15 years or their perspectives regarding the measures used, this will need to be tested later.

Other impacts on staff that may affect performance and productivity also include major reorganizational changes that have been imposed on the NHS from the Department of Health such as, the *Shifting the Balance of Power* (DOH, 2001 & 2002) and *Health and Social Care Act* (DOH, 2012). It is evident from the available NHS literature that NHS staff may have been placed within an ever changing environment of reorganisation and redesign over the last 15 years due to changing these reforms, therefore it would be of interest to identify what impact this may have had on the implementation of adopted performance frameworks and approaches.

Another factor that may have impacted on NHS performance and sustainability (Raith, 2008) and the individual staff is the developing neo-market system of healthcare commissioning, purchasing and providing (see *Shifting the Balance of Power*, DOH, 2001 & *Developing the Performance Regime*, DOH, 2008). The use of performance management/measurement being used as a contractual tool for commissioning alongside its use as a strategic planning, governance, and regulation tool is not new, Atkinson et al, (1997) proposed its use for contracting in the commercial sector, see statement below:

'Our approach to performance measurement focuses on one output of strategic planning, senior management's choice of nature and the scope of the contracts

it negotiates both explicitly and implicitly with its stakeholders. A performance measurement system is a tool the company uses to monitor these contractual relationships'.

Source: Atkinson et al, (1997) Page 26

Although performance management and measurement have been used in both the commercial and public sectors there has been reported problems concerning the use and role of performance management/measurement and the approaches and measures that have been used, see below:

- Public organisations are too fixated with measurement (Michelli & Pavlov 2008)

- Behaviours of command & control adopted for performance management may result in negative accountability (Marr, 2009, Neely, 2007, Michelli & Pavlov 2008)

- Performance management approaches based on command and control can act as a barrier towards a performance driven culture (Marr, 2009 & Neely 2007)

- From imposed measures, performance management may create dysfunctional behaviours such as, gaming & cheating (Marr, 2008) (Neely, 2007) (Grizzle, 2002)

The above claims from the literature highlight some of the concerns, problems and issues that have arisen from the adoption of performance management/measurement. Seddon (2003) claimed that performance management approaches that involved quantitative target based measures within the English NHS were flawed. Seddon (2003) urged the English NHS and public sector to adopt a much better form of measurement than the traditional measures that could be based on system measurement as opposed to command and control accountability.

Seddon's (2003) work was very much based on an organisations ability to redesign operational processes, similar to the work of Taiichi Ohno (Lu.J, 1989) who pioneered 'Kanban' within the lean movement, (Lu.J, 1989) focused on the Japanese commercial car industry with Toyota. Moulin (2002) argued that performance management has become something of an industry in recent years; organisations now are required to look at a myriad of top-down measures and approaches making it more difficult than ever to select the ones that really matter and add value. Seddon (2003) claimed that poor measurement and approaches may have a negative impact on the performance of the organisation and proposed a system based thinking as the solution to revolutionise performance management in the future, this will be looked at later within the literature review.

Taking into consideration numerous studies that have already been conducted in the field of performance management/measurement, leading authors such as, Marr (2006), Neely (2007), Kaplan & Norton (!994), Seddon (2005) and Mackie (2008) are becoming increasingly interested in the structure, design and

development of performance management, however empirical studies within an NHS context are fairly limited. Without a full review of the literature, the factors surrounding performance management in the NHS may be less known creating a gap in knowledge. For example, Marr & Schiuma, (2003) claimed when conducting an extensive literature review on performance management they were very concerned with, see below:

'The increasing lack of there being a cohesive body of knowledge.'

Marr & Schiuma (2003) page 680

To achieve the adoption of an alternative approach there may be a requirement for a change in culture, behaviour and working practices (Taylor & Pierce, 1999). This will require the study to explore the social science dimension of performance management, de Waal (2002) found that performance is an outcome of both organisational and human activities and is not necessarily just a result of a process or a procedure, Symon (2004) also looked at the difficulties of organisations measuring performance and the overall cynicism and resistance to change that was being performed by individuals operating within the NHS. This highlights the potential complexities of behaviour surrounding performance management and the individual.

Another area that may require investigating for the study is whether performance has improved in the NHS over a given timeline as result of the imposed frameworks. This would require comparing and contrasting past and current performance management frameworks in the NHS. The NHS reforms set out in

Equity and Excellence (DOH, 2010) may provide a set baseline or a point in time from which to measure.

Chapter Summary

The background has raised a number of concerns and has identified a number of gaps in knowledge surrounding performance management and sustainability (Raith, 2008). Political concerns were raised regarding the sustainability of the NHS within the public domain as set out by Pym (2015), there were a number of concerns raised regarding NHS productivity output and investment concerning the accuracy and relevance of the productivity measures (Black, 2012). The study noted that there was consistent change in the NHS regarding performance management frameworks and structure where the impacts on staff are less known although the measures over the last 15 years have remained consistent as quantitative measures.

A number of behaviours have been identified within the literature from both the commercial and public sectors as a result of performance management implementation including, gaming (Marr, 2006, Neely, 1998) fixation with measurement (Michelli & Pavlov, 2008) (Neely, A. Michelli, P. Martinez, V, 2006) and behaviours of command & control (Seddon, 2005) that may result in negative unintended consequences for staff and senior management. The study will be required to look at alternative approaches however to achieve this there will be a need to explore the social dimension (Symon, 2004) (de Waal, 2002).

The above summary of the background section provides a baseline for further study the next section looks at the key aims of the thesis and a guide to enable the reader to navigate through.

3. Aims and Outcomes

3.1 The key aims

This study is concerned with the factors and impacts surrounding performance management frameworks and approaches within the English National Health Service.

The proposed aim of this study is;

"To explore what factors are surrounding English National Health Service performance management frameworks and to explore its impact on the organisation and individuals in order to allow an alternative performance management approach to emerge"

The above aim provides a purpose for the study to specifically identify the internal impact of performance management on the organisation and the individual by understanding the nature, environment and social context of the phenomena.

From the proposed aims of the study, key objectives have been formulated to help define the scope of the thesis and to support the narrowing of the available literature. The study is fully aware that the literature field is substantial (See, Santos et al, 2007) at this initial stage it is expected that the findings from the literature review will provide further detail to produce more specific detailed targeted research questions.

To guide the literature, review a set of initial key objectives have been listed below:

- Identify via the current literature what alternative approaches are available to support performance management frameworks

- From the literature map out or baseline which performance frameworks and approaches are in existence and note their impacts and effects

- Via the literature explore and compare factors and impacts of previous and current performance management frameworks

The aspirational goal of the study is to provide a model or a suitable number of recommendations to support the performance management development of the case study organisation, these may be sufficiently broad or generalizable to support other NHS organisations and in doing so this may provide an original contribution towards the creation of knowledge.

The following initial key questions will be used as a guide to focus the literature review and to support the study objectives:

1.   Can performance management be defined?

2.   What is performance management?

3.   What is the performance management approach in the NHS?

4.   What are the tools for performance management?

5.   What are the problems and culture surrounding performance management in the NHS?

6.   What are the potential gaps and barriers in knowledge regarding performance management frameworks in the NHS?

7.   Can recommendations be developed for a new performance management framework or approach via the literature?

By using the above questions as markers and guides within the literature review there will be an opportunity for the study to establish the breadth and depth of the available literature to aid the design of a rigorous methodology for further investigation.

The study will need to contest any formed assumptions and biases that may be present from the researcher's perspective regarding performance management by using the literature as an evidence base it can support the triangulation of data and be used as a reference point for future primary research (Denscombe, 2003).

At this stage of the study, it is not possible to assume whether a model or framework could be proposed from the literature review but the thesis will have this in mind as a possible outcome to be shared with the relevant beneficiaries of the research and case study organisation.

3.2 Beneficiaries of the Research

Fieldwork will focus on a real world NHS organisation, Plymouth Primary Care Trust (client organisation) that was operating at the time of the imposed performance management frameworks; an initial exploratory search on available internal secondary data in the form of documents and policies was performed on the case study organisation whilst conducting the literature review. This allowed the researcher to baseline the case study organisation position regarding performance management and the findings were later fed back.

It is envisaged that any completed work obtained from the exploratory study, literature review, and primary research may provide added benefits to the case study organisation, NHS and wider public sector before the thesis will be complete.

The exploratory study will be a documented snapshot in time for the case study organisation providing a reference point for further policy development and academic study in the future. It is also envisaged that the thesis would provide practical relevance for other postgraduate students within the selected and related business management fields potentially leading to a training and workshop programme or included within relevant future journals and conferences.

3.3 A Guide to the Thesis

The thesis is designed to ensure the reader is able to follow the journey of the study this will require a sequential process that starts with placing the subject area and potential dilemmas into context by proposing the why, what, where and how questions, see **figure 3.1** below.

The introduction and background earlier have already partially answered the questions although not in any sufficient detail, however, there still remains a gap in the knowledge, therefore, the study has been chunked down into the following phases for further investigation:

Phase 1: Aims and objectives setting,

Phase 2: Secondary research stage literature review

Phase 3: Fieldwork primary research investigation

Phase 4: Analysis and Conclusions

The results of all the above stages of study should filter into a model or a set of recommendations that will ultimately provide a contribution to the chosen field. See **figure 3.1** below;
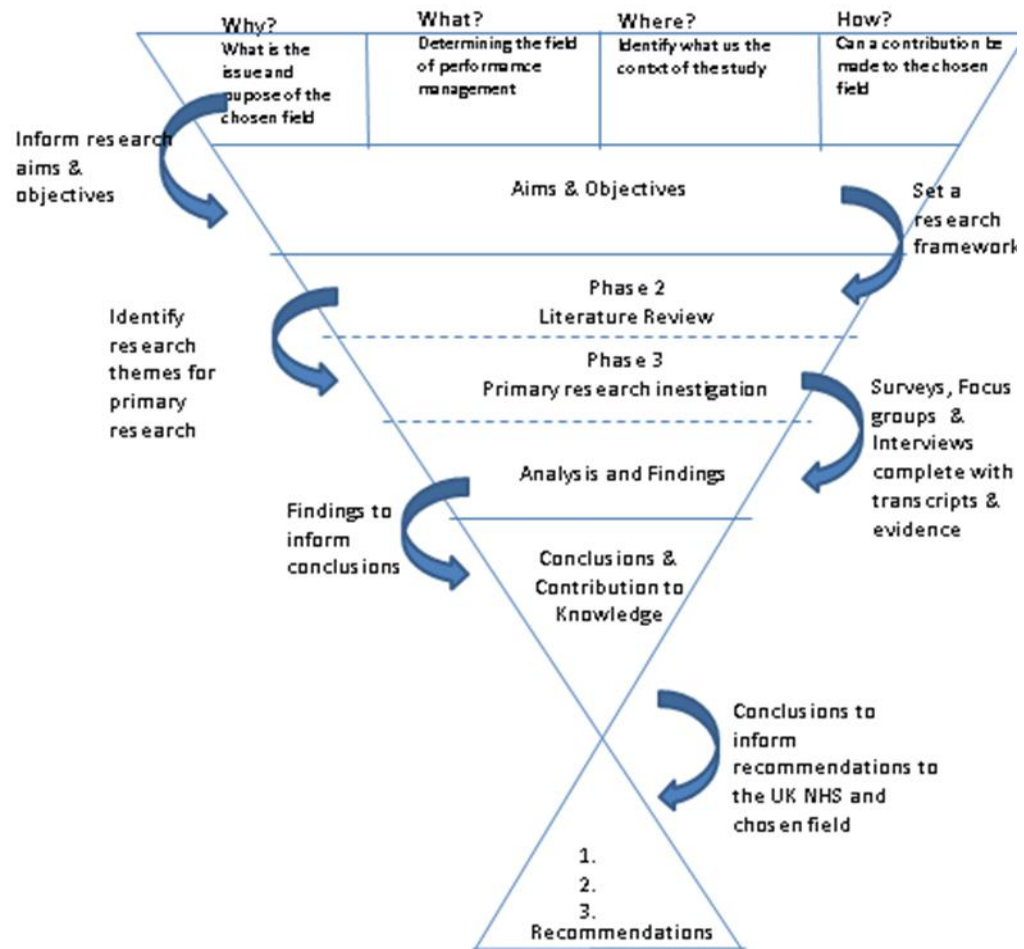
Figure 3.1 A Guide to the Thesis

The literature review will be a key part of the next stage of the thesis it will identify currently what is known about performance management approaches and frameworks. The review will also incorporate findings from available policy documents and local plans obtained from the operating case study organisation.

A more detailed exploratory study will be performed to gain an understanding of the structure of performance management, how it operates within a local NHS organisation and how it fits within its wider external environment. Key gaps and areas will be identified that will inform the wider review and support the establishment of a baseline position for a future primary research investigation,

the exploratory study and review will provide an aid to understanding the key concepts within a real life NHS context.

The literature review will explore how issues and factors concerning performance management could be resolved whilst looking at other alternative methods that have been used in the past that may be implemented in the future. The literature review will summarise and collate arguments and opinions that have been documented from leading authors from within the field of performance management. The literature review will aim to assure the reader further whether there may or may not be an established credible body or gap of knowledge within the field and discipline of performance management.

The methodology will explain how the researcher arrived at the research questions and will provide the research philosophy, approaches and the design. The section will cover any expected limitations that the primary investigation may encounter and will test the validity of the research. A theoretical framework will be proposed that will forward the most appropriate theory to describe the experimental techniques that will be implemented.

The findings and analysis section will look at what was found and what is understood, the purpose of this section is to provide a discussion to tease out any emerging themes and common trends from the data and to discuss interesting points of comparative analysis. The division of the results and discussion material will present according to subject matter the factors associated with performance management. The conditions and the limiting factors obtained for each set of

results will be provided; all data will be presented within a summary form and where possible into relevant graphs and diagrams. The discussion will attempt to question what was found, what does it mean and how does it fit into the existing body of knowledge using an iterative approach with existing literature and can it present new learning within the field.

The last section conclusion and contribution to knowledge will aim to identify a set of recommendations to provide the NHS with a conceptual model, design or approach towards performance management. The section will also outline what is still outstanding and left to be discovered and will aim to provide a contribution to the existing academic knowledge but may also consider proposing further areas of investigation beyond what has been provided within this body of work.

4.   Literature Review

The aim of the literature review was to establish what is known regarding the factors surrounding performance management, to narrow the broad scope of the performance management literature due to the problem or business dilemma not being defined, an exploratory study was concurrently run alongside the review. The exploratory study obtained related secondary data via organisational policy documents internally within the case study organisation and from online sources such as the Department of Health website (www.gov.uk/government/department-of-health). The documents from the exploratory study supported a number of preliminary discussions with staff from within the case study organisation. By conducting preliminary discussions, it supported the guidance of the literature search into categories that were relevant to the study.

The study also conducted a systematic review of the literature available from other public and commercial sector journals, texts and documents, past studies, theories, measurement instruments, findings etc. in doing so this ensured nothing had been left out or ignored and allowed potential gaps in current knowledge to emerge. The main intention was to look at the most relevant literature that contained empirical research concerning the chosen field that had been published and made available across both the private and public sectors beyond the 1990's, taking into account the comment that was provided earlier by Neely (1999) that in 1996 a publication had appeared on the chosen field every two weeks in the USA.

The first stage of the literature review was to gather as much secondary data as possible by implementing a scatter gun approach to the following key search words:

Performance management + performance measurement + NHS

Much of the previous texts already collated referred to 'measurement' as opposed to 'management' therefore it was essential to ensure that both terms were covered to capture all relevant work, 'NHS' will need to be added to provide the context. When the keyword 'NHS' began to limit the search it was excluded as a search word to yield more texts from the private and commercial sector.

Keywords were searched utilising the following online databases systems.

- Google Scholar

- Metalib

- Voyager

- Emerald

- Proquest

- ISIS Web of Knowledge

- Blackwell

- Ebsco

- Athens

- NHS Evidence

Once a bibliographic index was compiled a critical review was conducted on the texts extracting what was pertinent or peripheral to factors concerning the field of study. A thematic or content analysis (Denscombe, 2003) was then conducted extracting common issues and notes were taken in the related areas and assigned to emerging themes and variables. A comprehensive chronological review was then undertaken on UK Department of Health policy documents before searching related literature within industry and commerce, concurrent to this a related search was applied to academic and trade journals.

A search was later conducted on documents and texts that were authored by the emerging leading academics within the field of performance management along with existing scientific research papers from the academic institutions. The methodology for the literature review ensured that no variable identified within the subject area was ignored to provide a steer for further investigation.

4.1 The Scope of the Study

In order to provide a useful contribution to the selected field, it was important to ensure that the review maintained a clear focus, therefore, it was important to follow a set systematic method. The literature that was sourced within the background section earlier indicated that there was a risk of multiple interpretations of the role of and purpose of performance management (Pettigrew et al, 1999) therefore it was important at the initial stages to define what 'performance management' actually is.

Without establishing a definition of the term it was unlikely that the study will be able to achieve its aims and objectives or robustly answer the posed questions. Gaster (1995) supported the necessity to define terms claiming that definitions provide an opportunity to drive the whole implementation process. Initially, this thesis has indicated there is a form of inherent complexity within the chosen field (Neely, 2005, Moulin, 2003, 2005a) regarding its term and approach, this may create further problems if this is not defined appropriately. The following section will attempt to provide a working definition for the study by identifying how it is currently applied within the field

4.2 What is 'Performance Management' defining the term

The literature review has been able to establish that performance management has been created from a number of diverse origins these range from financial accounting (Parmenter, 2007) (Cokins, 2004), (Kaplan & Norton 1984), HR (Becker et al, 2001) strategic planning (Kaplan & Norton, 2001), etc. This multi-professional use has resulted in a number of differing variations of role and purpose that can be found in the following texts (Austin, 1996), (Cotton & Hart, 2003) (Bamford & Cooper, 1997), (Spitzer, 2007) & (Cokins, 2009). Santos et al, (2007), Pettigrew et al, (1999) and De Waal (2008) have all claimed that there are multiple perspectives, determinants and factors regarding performance management purpose and role therefore for the literature review to establish a definitive definition, meaning or interpretation it is going to be difficult.

A number of the leading authors in the academic texts, for example, Marr (2006) & Neely (2007) have applied the term towards the development of organisational

strategic planning and measurement providing well-documented approaches and interpretations from within the public, commercial and academic communities.

It is evident from the literature that multiple uses could be applied to the term that may lead to varying perceptions as to its implementation and delivery; this creates a responsibility for the organisation to communicate the purpose of performance management. For example, Neely (1998) placed a great emphasis on the fact that to ensure it can be adopted it needs to be communicated effectively to ensure motivation and interaction are achieved at all levels of the organisation to achieve desired outcomes. Therefore, its application cannot just be for accountability and control but also as a tool for learning across all levels of the organisation.

The performance management term has also been generally applied as a tool for human resources and personnel management looking at the individual management of staff (Rowden, 2001) (Becker et al, 2001) (OPM, 2014), the requirement to apply the term to the individual is important to organisational performance and are very much interrelated. For example, Armstrong and Baron (1998) claimed that performance management is a strategic integrated approach providing real purpose and value that results in increased effectiveness for companies, claiming that this cannot be achieved without improving the performance of the individuals who operate within organisations.

Armstrong & Baron (1998) claimed there was a direct relationship or correlation from applied human resource methods on individuals, such as performance

appraisal and had an impact on the overall strategic performance of the organisation.

The UK Treasury looked at the broad use of term 'performance management' by focusing both on the performance of the organisation and the individual (HM Treasury, 2001). This would indicate that future research in performance management cannot discount or discard the impact of the individual on the overall performance of the organisation. Therefore, it would be important to ensure that the term refers to the individual and the organisation. For the purpose of this study, the term will focus primarily on overall strategic and organisational performance and its impact on the individual.

The literature also provided a number of texts that focused on its purpose as an essential reporting tool to provide sound decision making (Cokins, 2004) (Marr, 2006) (Kaplan & Norton, 2001). Moulin (2002) looked at performance management as a tool to evaluate how organisations identify what value they can provide to their customers and its stakeholders a notion shared by (Cokins, 2004) (Marr, 2006) (Kaplan & Norton, 2001. Moulin (2002) explored the connections between performance measurement and organisational excellence looking at value for customers primarily from a quantifiable as opposed to a qualitative perspective.

To apply this within an NHS context we may need to confirm what quantitative value performance management supports NHS organisations to deliver value for patients and the public. This may have to be measured by identifying a value for

money benefit that can be defined as efficiency, effectiveness and productivity (Bevan, 2009) (Keller & Price, 2011) (HM Treasury, 2004). This application was also supported by Neely (2005) who stated a preference for Moulin's (2002) approach, as it had a direct association that was of benefit for stakeholders, Neely (2005) later declared that this approach is essential to the success of any organisation. Moulin (2005b) later supported this notion of performance management as it encouraged organisations to measure what value was actually being provided.

Moulin's (2002) discourse regarding the term correlated with the balanced scorecard approach that was originally founded by Kaplan & Norton (1992, 1996, 1996b). Kaplan & Norton (1992) proposed that performance of an organisation could be effectively managed if dimensions, such as financial, customer, internal processes, innovation and learning were balanced and continually evaluated and monitored. Moulin's (2002) definition was predominately concerned with the delivery of value from a financial perspective for customers and stakeholders' claiming that they are the real key to ensuring performance is effective rather than the individuals that operate within it.

Neely et al (2002) also viewed the term 'performance management' initially from an efficiency perspective, proposing that performance management is about looking at the process of quantifying efficiency and effectiveness of past actions. One of the major criticisms from Moulin (2002) with regards to Neely et al (2002) position was that it inferred that past actions to plan and make improvements were more important to measure than looking at prospective future planning and

forecasting. Moulin (2002) supported that it is important to look at historical common trends to identify the insights from the past but equally important for the organisation to predict the future where there is a potential risk for uncertainty and to be ready for changing adapting environments (Bevan, 2009).

Cokins (2008) took this a step further looking at the potential of performance management tools that could develop better processes and benefits through applications such as, predictive analytics. Cokins (2008) identified a dynamic aspect to support the delivery of organisational objectives and his work was a significant step forward from Kaplan & Norton (1992, 1996, 1996b) and Neely et al (2002). By using performance management to look at the past, current and future performance of an organisation it could support the organisation to develop, improve and survive similar to the organisational health approach proposed by Bevan (2009) and Keller & Price, (2011).

The literature, in general, indicates that the term 'performance management' could be applied for two main purposes. The first application involves quantifiable measurement and reporting where productivity and value for money is key (Neely et al, 2002) (Spitzer, 2007), authors such as, Deming (1982, 1986, 1996, 2000) & Drucker (1954, 1959) may have influenced this discourse due to the rise of the European Foundation for Quality Management (EFQM, 1999) excellence model of measurement that has provided a background to measuring performance (Bocci, 2004).

The term performance management from a number of authors such as, Moulin (2002) and Neely (2002) refers performance management towards the measurement of quantitative efficiency, (Spitzer, 2007) (Austin, 1996), (Ammons, 1995, 2002) & (Brignall et al, 2000) focused primarily on measurement and reporting tool, looking at the statistical measurement of variation however providing limited scope as to the individual social dimension of its application.

The literature found that there were a number of other academics within the field who were applying the term towards the organisational strategic planning process to support delivery of results. Examples of looking at a more balanced strategic perspective can be found in the work of Axson (2007), Marr (2006), Kaplan & Norton (1992, 1996, 1996b) & Cokins (2004). Performance management is applied to the overall strategic planning process regardless of whether it is quantitative or qualitative providing it delivers value to its stakeholders, more recent interpretations go beyond mere retrospective quantitative measurement to incorporate both forward planning and strategy Cokins (2004).

The application of mere measurement has been challenged by two prominent authors in the field, Marr (2006) & Axson (2007), they have specifically defined and conceptualised the term beyond mere measurement reporting taking the opportunity to expand the performance management application further. Marr (2006) & Axson (2007) added 'business' and 'strategic' to performance management term and in doing so expanding both its purpose, process, role and function by focusing on the continuous need for an organisation to improve via a collective strategic planning approach. Axson, (2007) primarily based

performance management within a commercial setting titled, 'business performance management' as opposed to just 'performance management', see below:

'Business performance management encompasses all the processes, information and systems used by managers to set strategy, develop plans, monitor execution, forecast performance and report results with a view to achieving sustainable success no matter how services may be defined.

Source: Axson (2007), pp 78

Axson's, (2007) statement above provided a much broader perspective than Neely et al, (2002), Bocci (2004), Spitzer (2007) & Austin (1996). Axson (2007) placed the business processes as a major factor in the strategy at the very heart of the performance management process. Axson (2007) also proposed that there needs to be a cyclical process in place that is consistently improving through a self-perpetuating process of change, see **figure 4.2**, ensuring that the most effective performance gains can be achieved. Axson (2007) placed a real importance for performance management on the business planning function of the organisation to set the strategic direction.
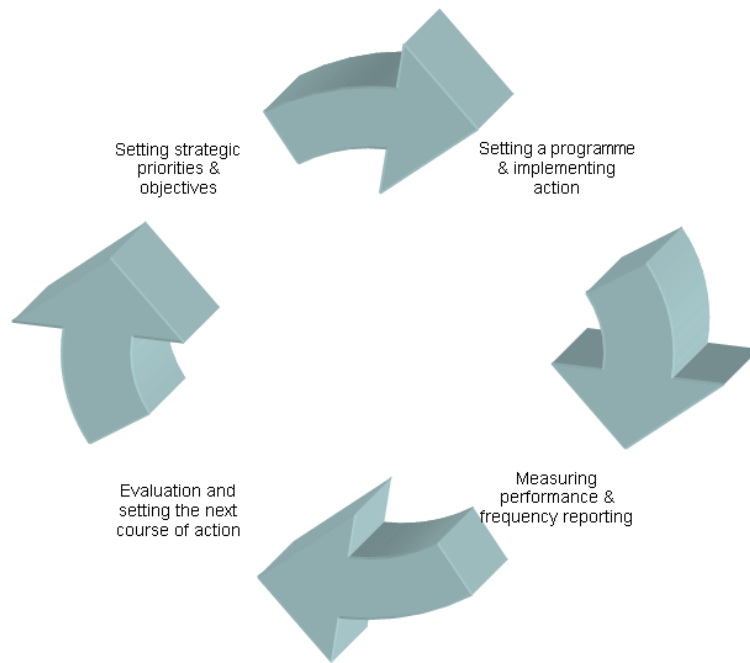
Figure 4.2: A cyclical performance management process

Marr (2006) supported this proposal and took it a step further by coining, 'strategic performance management' as opposed to 'business performance management.' Marr (2006) placed the importance of performance management from a strategic perspective by focusing on the organisation's ability to continually refine, assess and implement via an on-going cyclical process similar to Axson (2007). By placing more emphasis on the strategic application of performance management and aligning to the overall business process, Marr (2006) claimed that it could enable a high-performance culture (Reid & Hubbell, 2005) and environment where effective decision making, strategic direction and forward thinking could be adopted by everyone within the organisation at every level.

Marr (2006) perceived that the effectiveness of performance management was very much dependent on an aligned or accepted responsibility amongst individuals operating within the organisation. Marr's (2006) proposition would

infer that there is a real need for an understanding of the behavioural social world of individuals, to identify their beliefs and realities on how they operate within particular organisational structures.

Seddon (2005) supported Marr's (2006) discourse with regards to requiring an aligned collective value claiming that performance managing should be conducted via 'systematic based thinking' that requires the whole system to be included as opposed to just its independent or component parts. Seddon's (2003) work will be important later within the study when looking at the systematic complexity of the NHS to identify the interdependencies that have been built upon relationships formed within the social world. Taking into consideration the work of Seddon (2005) & Marr (2006) this would indicate that there is a real need for the study to carry out further investigation from a qualitative social science perspective.

By attempting to define 'performance management' Axson (2007) Marr (2006) & Seddon (2005) have proposed that the process of strategy design and the business process is an important factor to consider. Therefore, an organisation's ability to set a vision and prioritise its objectives at every level is an important function of the performance management process and not just its ability to measure and report.

However, in support of measurement and reporting, Cotton & Hart (2003) & Bamford & Cooper (1997) had highlighted that the process of measuring whether better outcomes had been achieved was an important element of the

performance management process, as it balanced any exclusively forming 'top-down' intentions that may have been advocated by the Department of Health. Cotton & Hart (2003) & Bamford & Cooper (1997) placed real importance on the performance management approach for the purpose of collating evidence and knowledge against standards to challenge and contest good, bad or indifferent performance.

Ammons (1995, 2002), Brignall et al, (2000), Axson (2007), Marr (2006, 2007 & 2009), Cotton & Hart (2003) & Bamford & Cooper (1997) Seddon (2005), Spitzer (2007) & Austin (1996) have all attempted to define 'performance management' and identify its purpose and role from various perspectives. Taking their discourses into account the study on the basis of the literature available has formed a working definition that may be used for further investigation:

'Performance management is a systematic and strategic based approach that incorporates, evidence, learning and knowledge alongside the continued cyclical refinement of its strategic, business planning, reporting and decision-making processes. Performance management identifies that success and results are achieved by enhancing the individual value of its employees'

Source: Healthy Performance Study

Although the study has presented the above definition from reviewing the literature it still remains a scientifically untested empirical field. The intrinsic value of employees and staff alignment to the frameworks that was raised by Marr (2006) may be too broad and difficult to measure along with the motivation of individual employees.

The first part of the review section has proposed a working definition of performance management by attempting to briefly review its role and purpose amongst the leading authors, but this is yet to be established within an NHS context. To identify what performance management actually is and how it is applied within a public sector healthcare setting the following part will aim to establish its application and the differing approaches available.

Current literature concerning performance management has indicated that the concept is by no means new; in fact, the literature review found that a high volume of commercial organisations was adopting a number of performance management tools and approaches utilising a wide range of organisational theory. Commercial texts were very dominant using performance as a specific tool for corporate planning and strategic development (Parmenter, 2007), (Cokins, 2007) (Kaplan & Norton, 1996). The earliest reference regarding its application within the public sector application can be traced back to the 1960's when it was used by Coventry Council to monitor the performance of their regeneration programme (see Friend & Jessop, 1969, cited in Mackie, 2008). The earliest reference found within the searches where there was a need to monitor performance and ration healthcare in the NHS can be found in the document, *A Hospital Plan for England and Wales* (HMSO, 1962). This was just a form of performance management introducing a level of efficiency into the NHS.

There is a risk like other business management tools that performance management could be a fashion or fad or indeed another management consultancy term, however considering, *A Hospital Plan for England and Wales*

(HMSO, (1962) and a significant volume of text this may not necessarily be the case (Neely, 2007). It is evident in the literature that performance management frameworks have been around for a number of years and have been adopted commercially and extensively within the public sector (Marr, 2000a), therefore there must be some perceived merit or value in applying it as an approach however the study needed to focus specifically on its application within an NHS context and this is what will be covered next.

4.3 Performance Management within an NHS context

The review found that the UK Department of Health first mooted the term 'performance management' as a part of the adoption of a new *Performance Assessment Framework* (DOH, 1998). It could be debated that the policy was implemented as a means to control NHS productivity levels as a significant investment was expected two years later, see **figure 2.1** (Harker, 2012) or as a means of managing the extra level of investment that was provided through the *NHS Plan* (DOH, 2000).

Since the publication of *Performance Assessment Framework* (DOH, 1998) & the NHS reforms document, *Shifting the Balance of Power* (DoH, 2001) there has been a continual regime of target based frameworks that have been implemented such as, the *Performance Assessment Framework* (DOH, 1998), *Developing the Performance Regime* (DOH, 2008) and the new *NHS Outcomes Framework 2011/12* (2010).

The target and indicator-based approach have provided a platform for these policy-driven frameworks that have been set through national guidance via top-down approaches (See *The NHS Plan: A technical supplement on target setting for health improvement,* DOH, 2000b). There is no evidence from within the literature that these frameworks have been locally determined by individuals from within NHS organisations, indicating that a centralistic system of control may have been adopted by the Department of Health, we will look at this in more detail later within the exploratory studies.

4.4 New Public Management & its impact within the English NHS

It has been well noted within the literature that over the last three decades the origins of performance management that have been adopted in the NHS may have been influenced by a theoretical and ideological public management concept. The New Public Management (NPM) concept was first coined by Hood (1991) as a means for governments to modernise and create a paradigmatic shift in public management and policy.

This section of the thesis sets out to explore and investigate the relationship between the adoption of NPM and its impact on performance management in the English NHS. The section will review the available literature within UK government policy publications and from leading academic authors from within the field of NPM such as Hood (1991), Politt (2011) and Dunleavy (2005).

This section will identify any notable criticisms and evaluations of the NPM movement and search for any documented evidence of efficacy and effectiveness. The literature review had drawn upon public policy implemented by the UK government but had also looked at the global and international

adoption of NPM from other governments to identify whether an effective or positive paradigmatic shift to modernise public services had occurred within public management.

In the last thirty years, NPM has been used as a term by the UK government as a movement, concept, paradigm shift or a set of ideas to manage public services and bureaucracy. NPM has provided a template to modernise government and the public sector in the UK and has been implemented as an approach by the English NHS via a number of reforms that have been set out by the Department of Health (Jan-Erik Lane, 2000) promoting the universal usage and practice of audit, governance, standards monitoring and performance management. This section will focus particularly on the emergence of NPM on performance management although its concept is much wider.

It is fair to claim that within the literature that NPM has been loosely applied by the UK government as a paradigm, concept and or set of ideas for public management that can be utilised as a means to reverse government growth and spending (Dunshire & Hood, 1989 & Hood, 1995) and to cut back and reduce where possible public sector bureaucracies. For this to occur there would be a necessity for adopting governments to impose greater market-based approaches that are more in line with the operating environment of the private sector. It has been criticised that this market-based approach on the English NHS has generally focused on patients and the public as customers or citizens and the need wrap services around their needs (Drewry,2005) rather than focusing on the English NHS ability to deliver a provision of services. Although it could be argued that market-based provision has been strengthened by the UK government as a means to decentralise, develop and advocate privatisation or quasi-privatisation.

The literature had applied the term beyond marketization as a means to reduce internal process and bureaucracy with a purpose to support greater governance, efficiencies and performance (Dunleavy, 2005).

The literature had highlighted that the term NPM was broadly adopted but was not necessarily referred to within public policy documents although was applied by a number of leading academics in the field (Hood, 1991, Pollitt, 2011& Dunleavy, 2005).

To identify better clarity of the term and its impact on performance management in the English NHS it was important for the review to establish exactly what the origins were of a theoretical model. Hood (1991) claimed that NPM had its origins from post-World War II public management developments that had emerged from a number of public management theories to reduce the size of the public sector and government, this was supported by Cutler (2007) who had made reference to the fact that NPM concepts associated with health management may have been developed back in the 1950s when there was an attempt by the UK government to improve acute hospital throughput by changing the traditional Weberian (Max Weber) hierarchal view of public management that relied heavily on bureaucracy and structure.

Leading up to the 1960's in the UK similar challenges to public management models and theories were challenged; Arrow (1963) had proposed a model that was based on public management to have a greater focus on public choice and viewing the public as citizens or customers. Further challenges were later presented requiring the UK government to modernise and to reduce existing structures of bureaucracy that were in place, Niskanen (1971) proposed that the

UK government achieve better public management needed to move away from traditional Taylorist (Frederick Taylor, 1912) scientific principles of management by adopting a more flexible private sector market-based approach towards the delivery of public services. Arrow (1963) & Niskanen (1971) theoretical models were at the time just proposals and implementation of these principles of early NPM was yet to adopt in whole or part by the UK government.

It was not until the Thatcher government in the UK during the early 1980's when there was a major shift in challenging the bureaucracy and size of the state and a requirement for a step change to reduce the reliance on the state. UK government at the time looked at the need for the English NHS to decentralise their providers of services from the Department of Health into NHS Trusts allowing Health Authorities to be created to perform a contractual role with providers, governance and performance and also creating a number of arm's length agencies to introduce a market-based system to manage services.

During the 1980's and Thatcherism, it was very much advocated in the UK that NPM was the new movement towards a more efficient government that was more customer focused and this was increased by subsequent UK governments leading into the 1990's and to date. Hood (1991) & Politt (2011) both made the case that NPM has its early origins from the UK but it had expanded to a variety of other countries in the 1990s. NPM was adopted by other governments in Australia, US, Africa, Asia and New Zealand and then later to Scandinavia and Continental Europe (Jan-Erik Lane, 2000 & Hood, 1995). It was reported by Politt (2011) that New Zealand had advocated and adopted NPM in public services more so than the other countries and had provided the most documented evaluations as to its usage.

Returning back to the UK performance management as an NPM related product or method was further increased within the English NHS when the New Labour government came to power in 1997. The UK government at the time had set out new performance management and governance frameworks (*The Performance Assessment Framework*, Dept of Health, 1997) that had been built upon the ideology set out by the previous UK Thatcher and Major governments in the 1980's and 1990's (Hood, 1990). During the 1990's and up until 2013 it was fair to claim that the UK Government had imposed a number of NPM related reforms on the English NHS that looked at radically decentralising and breaking up the existing monopoly and monolithic position, these reforms included, Shifting the Balance of Power (Dept of Health, 2001), NHS Plan (Dept of Health, 2000), Equity & Excellence (Dept of Health, 2010). The range of white papers and guidance that was published almost every three years by the Department of Health clearly had highlighted that there was a requirement for the English NHS to progressively and incrementally shift towards a market-based approach that had a plurality of providers.

The Health & Social Care Act reforms in 2013 was a large part of the Equity & Excellence (2010) white paper that advocated a requirement for a plurality of providers within the English NHS where NHS providers would not necessarily be deemed as the 'preferred provider' up and above private sector entrants to gain market advantage, this was a means to level the playing field.

The impact and development of NPM by the UK government on the English NHS was very much focused on the requirement for NHS trusts and commissioning agencies to adopt performance management and contractual methods as an adjunct towards a more market-based, decentralised public sector to aim to

manage resources more efficiently and effectively to provide better value for money for the customer or citizen. As an NPM related concept, performance management and standards-based approaches required the delivery of targets that could be related to a specific program or priority as a means of decentralised control. This would ensure a market-based commissioner or contracted service provider was effective in generating the expected outputs and outcomes that would be delivered by its activities that may promote economic rationalism as a means to achieve an efficiency gain.

We have very much broadly looked at the origins of NPM and how it has impacted on the English NHS and the development of its performance management agenda but what is the broad theoretical model of New Public Management? Hood (1991, 1990) & Pollitt (2011) were able to describe theoretically how the UK government over the last three decades has been able to take private sector marketization and management to reform the English NHS. However, an emerging trend within the literature as indicated by Cutler (2007), Hood (1991), Pollitt (2011) and Dunleavy (2005) had highlighted that NPM could fall foul of being a mere topical fad or fashion that may lose favour over time. To evaluate this, you would need to observe this in more detail longitudinally and you would need to separate the very doctrine of NPM to see whether the legacy of its adoption in the UK government still filters into subsequent public management policy.

Hood (1991) conducted extensive research on the literature available surrounding NPM allowing him to break down NPM into separate component parts that would provide a level of meaning and justification towards the concept. Hood (1991) proposed seven overlapping doctrines that could be identified as

being more likely to be a part of NPM ideology; these can be seen in Table 4.1
below.

Table 4.1: The Doctrinal components of new public management

No	Doctrine	Meaning	Typical Justification
1.	*'Hands-on professional management' in the public sector*	Active, visible. discretionary control of organizations from named persons at the top, 'free to manage'	Accountability requires clear assignment of responsibility for action not diffusion of power
2.	*Explicit standards and measures of performance*	Definition of goals. targets, indicators of success, preferably expressed in quantitative terms	Accountability requires a clear statement of goals efficiency requires 'hard look' at objectives
3.	*Greater emphasis on output controls*	Resource allocation and rewards linked to measured performance the breakup of centralised bureaucracy-wide personnel management	Need to stress results rather than procedures
4.	*Shift to disaggregation of units in the public sector*	Break up of formerly 'Monolithic' units. unbundling of U-form management systems into corporatized units around products, operating on decentralized 'one-line' budgets and dealing with one another on an 'arm's length' basis	Need to create 'Manageable' units. separate provision and production interests, gain efficiency advantages of the use of contract or franchise arrangements inside as well as outside the public sector
5.	*Shift to greater competition in public sector*	Move to term contracts and public tendering procedures	Rivalry as the key to lower costs and better standards

6.	**Stress on private sector styles of management practice**	Move away from military-style 'public service ethic', greater flexibility in hiring and rewards; greater use of PR techniques	Need to use 'proven' private sector management tools in the public sector
7.	**Stress on greater discipline and parsimony in resource use**	Cutting direct costs, raising labour discipline, resisting union demands. limiting 'compliance costs' to business	Need to check resource demands of public sector and 'do more with less'

Source: Hood, C (1991) A Public Management for all Seasons? Royal Institute of Public Administration, Public Administration Vol. 69 Spring 1991 (3-19)

Table 4.1 above highlights clearly that the NPM concept is about adopting market-based management ideas into government and public services that can be influenced by approaches developed within the private sector, this appeared as a common theme within NHS reform literature.

By observing NPM components in more detail from Table 4.1 above and relating them to historical performance management development in the English NHS the review was able to identify the significant emergence of the commissioning role for primary care trusts that was outlined in the *NHS Plan* (Dept of Health, 2000). The reforms can be deemed as pivotal to the adoption of NPM and performance management (see *Developing the Performance Regime*, Dept of Health, 2007), NHS Trusts were provided with the flexibility of earned autonomy and incentives as rewards for clinical team's dependant on their performance objectives.

Primary care trusts were being provided greater operational freedoms and were being rewarded with less frequent monitoring from arm's length regulatory agencies such as the Healthcare Commission and Care Quality Commission with

fewer inspections being performed. This was very much due to the implementation of the *Standards for Better Health Framework* (Dept of Health, 2004). The performance/governance framework *Standards for Better Health* was a set of measures and indicators for English NHS trusts to declare a level of compliance and performance against.

The performance was measured by the Healthcare Commission annually as part of the Healthcare Commission's "Annual Health Check". These standards were later replaced from 2009/10 by registration criteria that were set out by the Care Quality Commission that had succeeded the Healthcare Commission in 2009. Good performing trusts were expected to be held up as pilot sites for new initiatives such as team bonuses for staff and rewards for good performance. As an NPM concept accountability on quality was decentralised from the Department of Health to the Healthcare Commission whilst allowing services to be 'free to manage', although this was very much dependent on a performance management approach being imposed that required a clear statement of goals via the use of targets and standards. It was debatable whether the Department of Health had imposed radical shifts of decentralisation and autonomy on English NHS trusts as rewards were still very much dependent on measured performance.

It may be claimed that similar performance management frameworks previously imposed had a fundamental and pivotal role in supporting the UK government to develop their NPM ideologies to further break up the monolithic units of the Department of Health with a common move to decentralise civil service departments. Whether this created more 'manageable' units to separate provision and production interests to gain efficiency advantages perhaps still needs to be

evaluated. A number of arm's length regulatory authorities had to be created to enable a purchaser-provider split (see *Shifting the Balance of Power*, Dept of Health,2004), Pollitt (2011) had identified that 130 new agencies were set up during the 1980's employing 70% of the previous UK civil servants. The Blair government in the UK had recognised that by multiplying the number of arm's length agencies had brought a number of improvements towards performance, governance and standards in the English NHS but had also created problems of increased distance between ministries and operational management with the loss of policy coordination

Politt (2011) had recognised that as a result of NPM the UK government had further decentralised the English NHS from the late 1990's introducing more central control and coordination from 1997-2010. Services were further rewarded and incentivised on their performance via the adoption of targets and standards monitored through contractual arrangements to increase levels of transparency and contestability.

A good example of NPM where the English NHS was provided with the opportunity to be 'free to manage' could be observed during the term of the UK Coalition government in 2011. The UK government at the time via reform set out to further strengthen the use of competition based procurement rules by transferring the commissioning and the performance management responsibilities on to General practitioners within primary care (Equity & Excellence, Dept of Health, 2010).

By doing this the UK Coalition government was able to disband existing primary care trusts in 2013 due to the legislation set out by the Health & Social Care Act

although they needed to create a number of redesigned related arm's length agencies to monitor the English NHS with a more relaxed approach to performance management. They were able to do this by introducing outcome based measures that were not necessarily designed to look at the quantitative output or process but were able to measure success by evaluating the outcome. As a result of the reforms General Practitioners were provided new commissioning responsibilities and were considered by the UK government to be 'free to manage' but this calls into question whether they were 'free to choose' if a level market of providers were not established and there was an imposed outcomes framework in place, this is perhaps debatable (Hood,1991).

The UK Coalition government (*Equity & Excellence*, Dept of Health,2010) was very much intent on maintaining NPM methods by assertively promoting a plurality or market of service providers from both private and public sector to both compete to attain the same product or service (Jan-Erik Lane, 2000) although they had shifted away from the requirement to retain an output based performance management approach.

During the period when NPM had been adopted, public policy in general had highlighted that the UK government approach from 2001 towards performance management in the English NHS had swung from moderate to intense and then from 2007 the UK government had begun distancing themselves from imposing central targets on the NHS to allow greater freedom for services to make their own decisions and to set their own targets (Cabinet Office, 2008), however it could be argued it was not entirely clear within English NHS Trusts whether they had less or more upwards performance reporting to do as a result of imposed *NHS Outcomes Frameworks* (Dept of Health, 2014).

Jan-Erik Lane (2000) claimed that the theoretical background of NPM can be traced back to the mid-1960s from the Chicago School Economics as a result of the practice of criticising large government states and their interference in public sector management. A key important concept of NPM that had a large impact on the English NHS is the need to promote public choice of service provider where citizens can be perceived as customers (Niskanen, 1971) as opposed to users of public services.

An example of where citizens were viewed as customers of public services in the UK can be identified during John Mayor's term of office as UK prime minister in the early 1990's. The UK government had implemented a number of policies such as the Next Steps Initiative, Citizens Charter, Competing for Quality, Resource Accounting and Budgeting, and the Private Finance Initiative. These were subsequently followed by policies adopted by John Major's successor Tony Blair's whose administration implemented in the English NHS 'Patient Choice' that was introduced in 1997, choice was later strengthened further as a means to for the public choose service provider by the implementation of the '*Choose and Book*' Programme & *Payment by Results* (Department of Health, 2004) that set a national tariff to enable commissioners to procure care from a market of NHS Trusts that was not necessarily place or locality based.

Another aspect of NPM the English NHS had adopted for a number of years was to focus on user involvement basing services around patient needs; this was introduced as a means to drive improvements and quality of services by allowing the user of the service to become the evaluator to influence commissioners. To support this approach a range of service performance measures such as annual user surveys and patient satisfaction were implemented on service providers by

the Commission for Health Improvement and the Healthcare Commission from 2003 and later strengthened as a part of the *Annual Health Check* (Healthcare Commission, 2007).

As an NPM concept public choice and the need to performance measure was not necessarily a priority when New Labour first came to power to the UK government in 1997 (Robertson & Thorlby, 2008). Competition and contractualism and the need to introduce the private sector into an English NHS market were not necessarily supported, as highlighted in *The NHS Plan,* (Dept of Health, 2000). It could be argued that New Labour had initially rejected competition as an effective change management approach in the hospital sector and had initially made limited reference to 'patient choice' (see *The NHS Plan*, Department of Health 2000) within their performance management frameworks, most of the measures consisted of service outputs rather than subjective measurement. However, 'choice' as a means of public management had subsequently evolved from 2007 under Gordon Brown's leadership with the continuation of the 'Payment by Results programme' (see *NHS Reform in England*, Dept of Health, 2006) further strengthening the performance management agenda.

It could be argued that choice as an NPM concept had directly impacted on the development and emergence of performance management, for example, a greater need to measure and publish waiting times and the quality of services were used as indicators to influence patient choice (NHS Improvement Plan, Department of Health, 2004). However, The Kings Fund reported that Lord Darzi had stated in an article about the reforms at the time that *patient choice* and *Payment by Results* had become controversial and sat 'uncomfortable' with some English NHS staff in the past (Robertson & Thorlby, 2008). It would be interesting

to explore whether patients who had an opportunity to choose their care from multiple providers shared the same discourse as NHS staff.

Jan-Erik Lane (2000) claimed that the radical nature of NPM and its concepts may have served well the politics of the new right or neo-conservatism in the 1980s and may have allowed the resurgence of neoliberalism in a globalised world economy in the 1990s and beyond. NPM was a one size fits all concept that could be utilised in all UK government departments, not just the English NHS. The politics at the time and the need for change management through reform may have allowed its adoption to flourish and other countries were keen to learn from the UK experience.

The US government had adopted NPM concepts to support economic rationalism but perhaps not so assertively than the UK government during the Ronald Reagan administration in the 1980's. NPM was adopted in the US to promote a more entrepreneurial decentralised approach to promote less reliance on the state. This may have paved the way for the Clinton administration in the 1990's to incorporate more performance management-based approaches within public management, this was very much evident within legislated policy, the National Partnership for Reinventing Government (1993) had signed into law the *Government Performance and Results Act* (Whitehouse, 1993). The Act focused on the need for federal agencies to modernise US Government and public services by strengthening NPM adoption through the direct implementation of performance measurement and other initiatives (Ewoh, 2011).

The literature review found that the *US Government Performance and Results Act* (1993) evidenced a strong correlation between NPM theory and performance

management. The act was very much built upon NPM principles requiring US government departments to deliver on performance management approaches (see below).

In carrying out the provisions of section 1105(a)(29), the Director of the Office of Management and Budget shall require each agency to prepare an annual performance plan covering each program activity set forth in the budget of such agency. Such plan shall-

(1) establish performance goals to define the level of performance to be achieved by a program activity;

(2) express such goals in an objective, quantifiable, and measurable form unless authorised to be in an alternative form under subsection (b);

(3) briefly describe the operational processes, skills and technology, and the human, capital, information, or other resources required to meet the performance goals;

"(4) establish performance indicators to be used in measuring or assessing the relevant outputs, service levels, and outcomes of each program activity;

(5) provide a basis for comparing actual program results with the established performance goals; and

(6) describe the means to be used to verify and validate measured values.

Source: *US Whitehouse (1993) Government Performance and Results Act, Whitehouse. Gov, Extracted online 1/2/16*

The above quote highlights that internationally other governments other than the UK were also adopting performance management as a result of NPM (Ewoh, 2011).

The literature exposed a number of criticisms against NPM mainly that there was a lack of evaluation conducted by the Department of Health on historical NHS reforms from the 1980's and whether it was evident that there was a paradigmatic shift in change that may have occurred (Hood, 1991, Politt, 2011 & Dunleavy, 2005). Politt (2011) and Dunleavey (2005) both commented that NHS Reforms

that were built on NPM ideology were consistently layered over time not allowing any identifiable evidence-based design to emerge that could influence future ideas and approaches of subsequent reforms. It was not clear whether the UK government utilising NPM concepts such as performance management was more or less effective in comparison to the elder traditional Weberian (Max Weber) and Taylorist (Frederick Taylor, 1912) principals and models of hierarchy, bureaucracy and public management. NPM appeared to be based on the political ideological of its time and not necessarily free from political interference, therefore, proving problematic in isolating NPM from political influence.

The literature had not provided any single accepted explanation or interpretation of why NPM coalesced in the UK let alone globally and internationally other than it was a close fit to the political direction of the government at the time, or there is no real start point as to when it truly 'caught on' (Hood 1990, 1990 & Jackson 1991). Hood (1991) heavily criticised NPM as a subject area that lacked the ability to pin a specific concept to it and therefore this created insufficient enthusiastic commitment within the public sector. Could NPM be merely a novel programme 'fashion' or 'fad' of public sector management (Hood, 1991) with performance management becoming its by-product even though techniques that had been tried and tested within the private sector long before the arrival of NPM (Cutler, 2007)? What is not clear is the impact of NPM and whether it had provided expected economic rationalism, reduced bureaucracy reduced state reliance and delivered real efficiency gains to the public sector, UK government and the English NHS. Hood (1991) claimed that the public may have been 'sold' NPM concepts such as performance management by being provided shallow case

studies functioning as 'success stories'. It is not fully clear whether unintended consequences had emerged as a result of NPM, however, Hood (1991) & Politt, (2011) were very much concerned with the growth of the 'performance indicator industry' within the UK public sector that had determined the overall costs and benefits of the system.

Can a one size fits all universal approach to public management and policy be replicable across all government departments or could this just be ideological posturing being advocated based in different political values and beliefs of those that were elected at the time in government? NPM has been questioned in academia as to whether it is merely a sellable concept for successive governments in the UK to cut costs rather than the bureaucracy itself (Jackson, 1989 & Cutler, 2007). The field of NPM and its impact and influence on performance management on the English NHS is very much evident in the literature although it was perceived as a complex means to manage public services. Cutler (2007) identified a number of complexities within NPM including the difficulties of comparing performance across different public sector units even though NPM was considered as a truly universal concept that could be utilised across government.

Within the literature there appeared to be a shared discourse from leading academics in the field of public management and policy that NPM as a concept and a paradigm may have come to the end of its road or shelf life, however new advances in a range of digital based technology and social media may have breathed new life into NPM.

Dunleavy (2005) had highlighted the need for the public sector to herald in a new NPM concept by embracing the new digital era as a means of providing customers and citizens with greater choice and enabling governments with more decentralising opportunities whilst strengthening the connection with patients and the public.

Internationally and globally countries other than the UK and the US, such as New Zealand and Australia are still adopting NPM concepts, therefore, it can still be regarded as an evolving field and still growing and spreading. NPM and exploring the new 'Digital Era' is being regarded as the next step for governments to modernise to reintegrate or take back public management control and accountability although now placing it with the customer or citizen, similar to the principles set out in the Citizens Charter in the 1990s that were highlighted earlier.

An example of this digital approach being adopted in the English NHS is the development of place-based hubs and the reorganising of services with the technology to become more needs based around distinct groups of patients. These digital tools now provide open reporting with real-time performance to enable the public to performance manage the services and to promote public choice via the booking of appointments. Dunleavey (2005) outlines the potential of a new NPM approach that fully exploits digital storage, Internet communication and social media as a means to allow greater performance and governance so public services can get closer to the public. Re-integration of services, as opposed to decentralisation, is now more of a common theme by having the technology available old traditional thinking of NPM is now being challenged and becoming a fast outdated concept. Technology has the potential to make services more accurate, prompt and has the potential to remove most barriers of process

and bureaucracy, however, this was very much the original concept of NPM that was highlighted earlier back in the 1960s and 1970' by Arrow (1963) & Niskanen (1971).

NPM has been applied by successive governments in the UK and its impact on the English NHS has been driven by the political ideology of reform over time. Performance management that can be perceived as a product of NPM has been a widely used approach to support economic rationalism, the decentralisation of government and to reduce bureaucracy. However, NPM has been criticised within the literature as being a public management fashion or fad (Cutler, 2007, Hood, 1991& Pollitt, 2011) that may have been based on the political ideology of its time with little or no evaluation conducted on its effectiveness. No doubt NPM has taken root in the English NHS via the implementation of performance management and marketization and it is envisaged that future reform within the English NHS is likely to adapt or modify some aspects of NPM as part of the new digital era (Dunleavy (2005) that may impact on performance management implementation and many of the NPM core themes such as, patient choice is likely to remain for the foreseeable future.

4.5 Performance management and its traditional link to accountancy

The literature has already indicated that the purpose of performance management is strong in supporting the delivery of strategy development; however, within earlier texts performance management frameworks were identified as being used for more traditional financial accounting purposes. Kaplan & Norton (2000) proposed that performance management should be applied not just for control but also to enhance strategic development to release

the financial value of the organisation. Johnson & Kaplan (1987, 1984) used performance management as an accountancy tool for activity based cost management, this was supported by Armstrong (2003), Cokins (2004), Cleland (2004), Cooper (1998), Kaplan, & Anderson (2004) & Sandison et al. (2003).

There is a wealth of literature in the commercial sector that looks at the links in setting budgets and strategy and performance management moving away from its application as a pure accountancy tool, however, there is still an important financial role. Parmenter (2007) conducted a survey on Chief Financial Officers internationally and found 90% were dissatisfied with their budget process due to the annual budget not necessary linking to their organisational strategy and performance frameworks. In contrast, Hope & Fraser (2003) proposed that the budget process could be moved altogether from the performance management agenda, as it is too costly and generates little value as it limits the performance of the organisation. This should not discount the importance of budgets but Hope & Fraser (2003) did highlight that there was not a performance link not necessarily inferring that financial reporting was not necessary. In contrast, Cokins (2004) supported a budget link and developed the, *'beyond budgeting management model'* claiming that this freed the organisation from traditional accountancy performance management approaches.

The review identified a number of leading authors that were proposing a move away from the traditional financial reporting systems for performance management, this was suggested by Kaplan & Norton (2004, 2000, 2001) via the development of the *'balanced scorecard concept'* although management

accountancy was still very dominant within commercial performance management literature, Lingle & Shieman, (1996), Frigo & Krumwiede, (1999) & Griffel, (1994) proposed that Performance measurement should be used as a tool for management before it is used as a budgeting evaluation tool (Griffel, 1994).

The literature was limited from within the NHS concerning the relationship between performance management and accountancy, the Healthcare Commission's *'Annual Health Check'* (2007) was part assessed on financial performance via *Key Lines of Enquiry* (Audit Commission, 2008) but was balanced with a number of other dimensions similar to the balanced scorecard pioneered by Kaplan & Norton (2004, 2000, 2001).

It could be debated that the primary purpose of performance management in the commercial sector is to support the sustainability of financial values for shareholders, hence its association within the literature concerning budgeting and finance (Cokins, 2004; Kaplan & Norton, 2004, 2000, 2001). However, with the absence of shareholders within an NHS, it may be fair to assume this may not apply, however, the NHS is subject to the delivery of healthcare services for the benefit of stakeholders who may also be concerned with reducing cost and the financial efficiency of the organisation (Balachandran et al, 2005).

Therefore, finance is an important dimension of performance management but may not be its main purpose. Bourne et al (2003a & b) were able to report on the current trends in relation to the purpose of implementing a performance management framework by conducting empirical studies on a number of leading

commercial executives. He found that organisations were still looking for pure financial performance measures although this was now decreasing and they were utilising more strategy based performance management frameworks to understand their performance. A more recent tool has been developed in the performance management field, titled the '*Performance Prism'* (Neely et al, 2002, 2001) however it still places an emphasis on financial performance.

The literature has highlighted there has been a significant shift for performance management to move away from traditional accountancy but the links are still there.

4.6 Performance management and the standards based approach

Within the NHS more recently the standards-based approach regarding public satisfaction and waiting times has become more prominent measures and indicators to measure both quality and value. *Standards for Better Health* (DOH, 2004) produced a set of standards that was set out by the Department of Health requiring NHS trusts to declare their level of compliance to the Healthcare Commission (Healthcare Commission, 2006), these standards were later replaced from 2009/10 by a registration criteria established by the Care Quality Commission.

The literature has indicated that the English NHS has been adopting standards-based performance management frameworks for a number of years. The Healthcare Commission in 2006 joined forces with the Audit Commission to implement an 'Annual Health Check' on NHS organisations (See Audit

Commission & Healthcare Commission, 2008). This brought together a standards-based requirement for an NHS organisation for the first time to balance financial performance (Key Lines of Enquiry, Audit Commission, 2008) against service quality standards, the results of these assessments provided a publicly owned performance-based standards rating system (Audit Commission & Healthcare Commission, 2008).

The standards-based approaches were expected to encourage organisations to benchmark their performance against national datasets (Ammons et al, 1995, 2002) supported the need for standards-based monitoring as Ammons claimed that strategy could also be boosted in the public sector if standard national measures could be developed to evidence progress comparatively across similar organisations.

Comparisons could be made nationally by benchmarking an organisation's performance against the English average; this, in turn, could also provide a very powerful learning tool for local organisations. Ammons et al (1995) later went on to claim this approach could support *'Best Value'* (DoE, 1997) (Stephen, 2001), (Newchurch & DETR Partnership, 1999) principles providing an opportunity for accountability and transparency to existing amongst citizens and government to participate if performance was not being delivered. Local authorities and NHS organisations now have to publicly publish not just their financial performance but also the standards they are expected to achieve within their business plans (Darzi, 2007).

The impact these above standards-based approaches had on individuals operating within the NHS is very much undocumented within the literature, there will be a need to establish whether standards monitoring transformed the performance management approach for organisation or was it deemed as an addition to the existing performance requirements expected by the Department of Health.

4.7 Performance management or measurement?

The Literature review had recognised that there was much debate regarding the application of the term 'performance 'measurement' as opposed to 'management'. Pollitt (1986) was the earliest reference within the literature that raised a concern that performance management may be being applied purely for the purposes of measurement. This notion that measurement can become a fixation as a means to an end is an interesting (Seddon, 2003) one and whether naming the performance system to reflect its purpose could be an indication of the organisations' perception of its primary role. There have been concerns in the past that the public sector has too many measures and targets (Symmons,2004) and measurement should not be the sole purpose of the framework.

Bolton (2003) had primarily supported the need to use the term for performance measurement for public accountability, due to increased public expectations of public services. Berman (2000) referred extensively to the term performance measurement claiming it had a positive relationship to evaluate and manage strategy. Boland (2000) proposed that performance measurement is a key part of a systematic perspective. Seddon (2005) suggested that the measurement

term should be used to provide a feedback control system for performance management strategy. This would suggest the term performance measurement can be applied beyond mere measurement (Michelli, 2009) but can also be associated with the application of strategic development; the term management defines an all-encompassing role.

Marr (2008) raised concerns regarding a fixation public sector organisations have on measurement proposing that there is a risk of 'measurement bias' where there may be an initial desire from the organisation to measure valid outcomes however in the long term they may become more difficult to measure. Marr (2008) suggested that as time sets in there become a natural progression to only measure the quantitative units of measure rather than outcomes that may be more difficult.

The NHS is now looking specifically at health inequality outcomes as measures *NHS Outcomes Framework 2011/12* (DOH, 2010) where there may not necessarily be one all-encompassing measure as there would need to be in place a number of sub-indicators to contribute towards the overall outcome. Measuring performance where the data may not be collected could prove difficult and challenging, measuring what is easy and what is already collected may also provide an inaccurate interpretation of the performance output.

In summary, there was much debate on the use of the term 'performance measurement' as opposed to management. There did not appear to be any robust evidence within the literature that would determine whether this would detract

from performance management's main purpose or role other than it could be perceived as a mere measurement tool (Michelli, 2009) and not encompass the full application of strategic planning, development and improvement.

4.8 Placing the individual at the centre

The literature predominantly referenced its application as a strategic tool for management (Marr, 2006) (Kaplan & Norton, 2001) but there was also a wealth of texts that supported its application placing the very individual at the centre of attention to improve strategic outcomes of the organisation. We have already established that the term, 'performance management' can be applied to workforce or human resource management as well as organisational performance. This can be evidenced by the number of human resources and personnel management texts that have referred to its application (Rowden, 2001), (Becker et al, 2001), (OPM, 2014) and (Armstrong & Baron, 1998).

Armstrong & Baron (2003, 1997, and 1998) placed the performance management application towards a human resources environment not necessarily just within an individual context but by also placing its use as a strategic human resources management tool. Armstrong & Baron (2003, 1997, and 1998) claimed that performance management could be applied functionally, vertically and integrated with the individual's needs to support the overall collective 'strategic' improvement of the organisation. Armstrong & Baron (2003, 1997, and 1998) have clearly highlighted that it may have an individual application but performance management also enables the individual within an organisation to contribute to a much broader strategic performance management agenda.

The strategic benefit of the individual has also been supported by Cederblom & Permerl (2002) and Soltani et al (2003). Cederblom & Permerl (2002) supported the notion that strategic intentions could be incorporated into individual core competencies within appraisals or work plans that may support the organisation's performance and strategic plan to deliver its outcomes. This was also supported by Soltani et al (2003) who recognised that people were the key to success by creating employee involvement and engagement in performance evaluation; this would deliver better performance outcomes and as a result achieve better employee satisfaction.

Armstrong and Baron (1997, 1998 & 2005) found there was general consensus that the term performance management encompassed a range of activities to manage individual performance, but these activities were clustered around the areas of development, reward and incentive and had little association with overall organisational strategy development. Becker et al (2001) identified that the balanced scorecard as a performance reporting tool had an importance of integrating individual learning and development, similar to Agyris (1978) double-loop learning model where individuals can play a part directly feeding back into strategic planning and development. Becker et al (2001) supported the notion that individual performance could be improved by aligning human resource strategy alongside business strategy via the design of a human resource scorecard by looking at a cost-benefit analysis alongside individual performance drivers.

Other leading authors identified a positive relationship between human resource management and organisational performance. For example, Kapel et al (2002) identified the important role Human Resource practitioners have in helping managers deliver team performance through their employees although this would be very much dependent on the performance management system that was adopted and the perception of the individuals. Kapel et al, (2002) proposed that it may produce a good performance management system although if it was not adopted with the appropriate training and support supplied from management then it would ultimately be ineffective.

Pfeffer (1994) looked at how the company manages its people to increase the competitive advantage of the organisation. He claimed that successful companies could overcome competitive advantage barriers by not investing in the mechanical aspects but the humanistic or the organic emotional intelligence element of the company. Gill (2004) placed emphasis on culture, we will explore this in more detail later in the chapter, and was of the opinion that if performance management systems did not work it was due to the organisation not creating the right culture for the people who operate within it.

It is evident from the literature there is now a need to ensure a healthy balance between the mechanical and the humanistic elements of the organisation by placing the individual at the very centre of an organisation to realise expected performance improvements. Intrinsic motivation and staff alignment are important factors (Marr, 2006) in delivering effective performance highlighting a real need

to establish how individuals define and perceive performance management frameworks and approaches.

4.9 The individual & organisational health

The performance management literature indicated there was a potential for organisations to increase their performance by looking at the impact on the wellbeing of the individual, see (Marr, 2002), (Pfeffer, 1994), (Armstrong and Baron, 1997, 1998 & 2005) (Seddon, 2005) and as a result this could affect overall performance outputs.

Dodge et al (2012) made attempts to define health and well-being by focusing on an equilibrium theory or balance that can affect individuals by life events along with the challenges that people experience in everyday life within their social worlds and environments. Looking at it from an organisational perspective public sector organisations, in general, can be subject to a multitude of challenges, changing environment's, increasing fluctuating demands, economic pressures and political interference, these may have the potential to impact on the organisation and the individual that may affect performance and productivity outputs.

In support of the above Boorman (2009) published an influential report on health and well-being after conducting an investigation into NHS staff claiming there could be a direct correlation between the well-being of the individual and productivity output. He sourced the data from electronic staff records that were extracted from the NHS Central Electronic Staff Record (ESR) system. Boorman

(2009) claimed that staff were convinced their health and well-being was not taken seriously enough to improve organisational performance. In contrast NHS Employers and Zeal Solution Ltd (NHS Employers, 2014) conducted a yearlong research programme and found that the NHS had implemented a number of policies over many years to support staff well-being, however there were concerns that financial pressures may have reduced the funding for such projects and in doing so had impacted negatively on performance (NHS Employers, 2014). Boorman's (2009) research did have limitations; for example, there were marked variations between NHS organisations this may have been due to incorrect coding and the quality of the data collected. What is important for the study is that the report indicated that there may be a possible link between wellbeing and performance that cannot be ignored.

The literature exposed that the health of the individual is an important factor for organisational performance. The health of an organisation was also considered an important aspect to propel organisational performance forward indicating a strong requirement for the organisation to build capacity to learn and to keep changing to adapted external environments,(Keller & Price, (2011).

Bevan (2009) supported Keller & Price's (2011) notion of resilience and sustainability and proposed a new performance management perspective for the NHS that was very much based on the need to deliver 'organisational health'. Bevan (2009) considered the importance of employee wellbeing that was proposed by Boorman (2009) see **Figure 4.3** that illustrates this:

Figure 4.3: Two-stage model for organisational health performance

Adapted from: Bevan (2009) Page 24

Interestingly Bevan (2009) & Keller & Price (2011) both focused on the requirement to achieve a state of health or resilience through the learning organisation (Senge, 1990) and supported the notion that the health and well-being of individuals and the organisation is crucial to its strategic success.

Keller & Price (2011) evidenced via an empirical study that consisted of a survey of over 600,000 employees and over 500 organisations across a number of sectors that there was a correlation between the health of the organisation and performance. The findings showed that companies in the top performing quartile within their industry had adopted organisational health approaches and were twice as likely to have above median growth. Keller & Price (2011) compared organisations with others that were looking at traditional process-driven performance management approaches as a control group against an experimental group of organisations that were using an 'organisational health'

perspective over an 18 – 24-month period. Keller & Price (2011) claimed the results were staggering, see **Table 4.2** below:

Table 4.2 Organisational health study has been removed due to Copyright restrictions

Source: Keller & Price (2011) Extracted online 30/6/15

As can be seen from **Table 4.2** above, Keller & Price (2011) provided statistical scientific evidence that showed that an organisation that was incorporating organisational health dimensions could align, execute and renew itself and had the potential to sustain performance much faster than its competitors and in doing so increased performance output. De Smart et al (2006) & Keller & Price (2011) presented an organisational health model that provided a commercially based concept that looked at the relationships and capabilities of the organisation (Bevan, 2009) focusing on five dimensions:

- Complementary – different things complement each other to create additional value

- Renewal – the institution drives change to adapt to a shifting market

- Alignment – people are aligned to what they are trying to do and why

- Execution – decision-making and tasks are performed effectively

- Resilience – Institution has a robust strategy and whether the risks and shocks

Source: Keller & Price (2011) Extracted online 30/6/15

Bevan (2009) also provided a model that consisted of four dimensions for organisational health that was very similar that which Keller & Price (2011) outlined as a proposed model, see below:

- Interrelation – communicating information to enhance openness, transparency and fairness, viewing the organisation as a change agent that balances its parts through an equilibrium or homoeostasis.

- Identity – This again relates to relationships but requires a level of cohesiveness and honesty and shared values across the parts of the organisation, this is very dependent on how the organisation is structured. The structure needs to promote a strong level of alignment and clarity of purpose, having the right fit culture is important to ensure identity across all parts of the organisation.

- Autonomy – This is very much about how the organisation operates from the external environment and how it relates to its changing landscape. This

allows the organisation to take risks when required to achieve better outcomes free from external command and control.

- Resilience- Similar to autonomy it refers to how a robust organisation can adapt to a changing world and deal with incoming challenges. Innovation and problem solving are key functions of resilience to deal with any fluctuations or turbulence an organisation may encounter.

Bevan's (2009) four dimensions above can be illustrated in **figure 4.4** below:
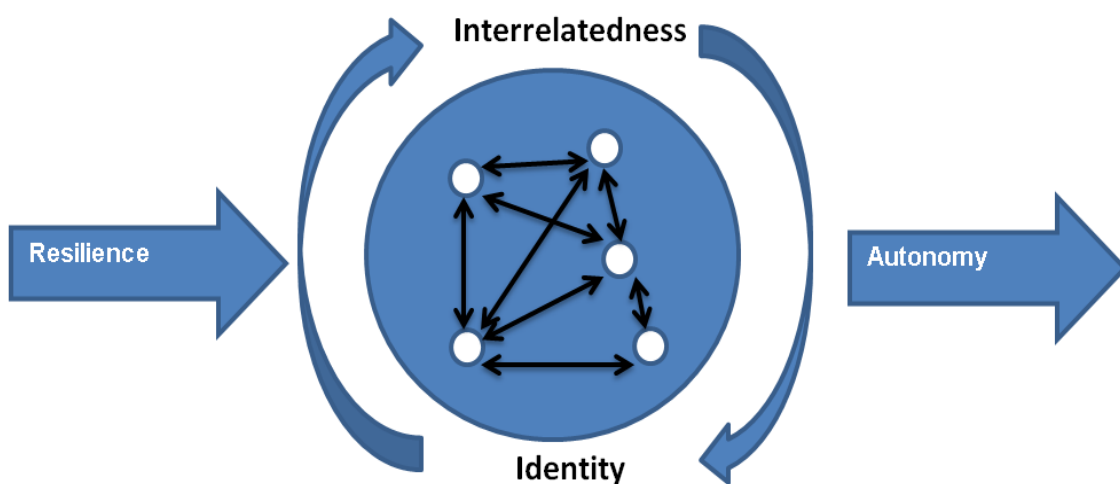
Figure 4.4: The four dimensions of organisational health

Source: Bevan (2009) Page 9

Figure 4.4 above highlights interrelatedness and identity as a cyclical process that binds the parts of an organisation together cohesively, whilst resilience and autonomy keeps directing the organisation forward, with resilience providing assurance that the organisation can robustly change and adapt to its environment whilst autonomy is consistently moving forward to seek out new opportunities and challenges.

4.10 Learning organisation

Learning was highlighted within the literature as an effective approach to improve performance; Keller & Price (2011) perceived that to sustain performance, organisations must build the capacity to learn. Davies (2000) raised a debate within the literature claiming that other alternatives to the traditional methods of performance management could be adopted to increase performance in all areas, such as the building of learning organisations. Senge (1990) supported the learning enabled organisation by proposing a form of loop learning where learning can occur through an iterative process such as **figure 4.5** below:
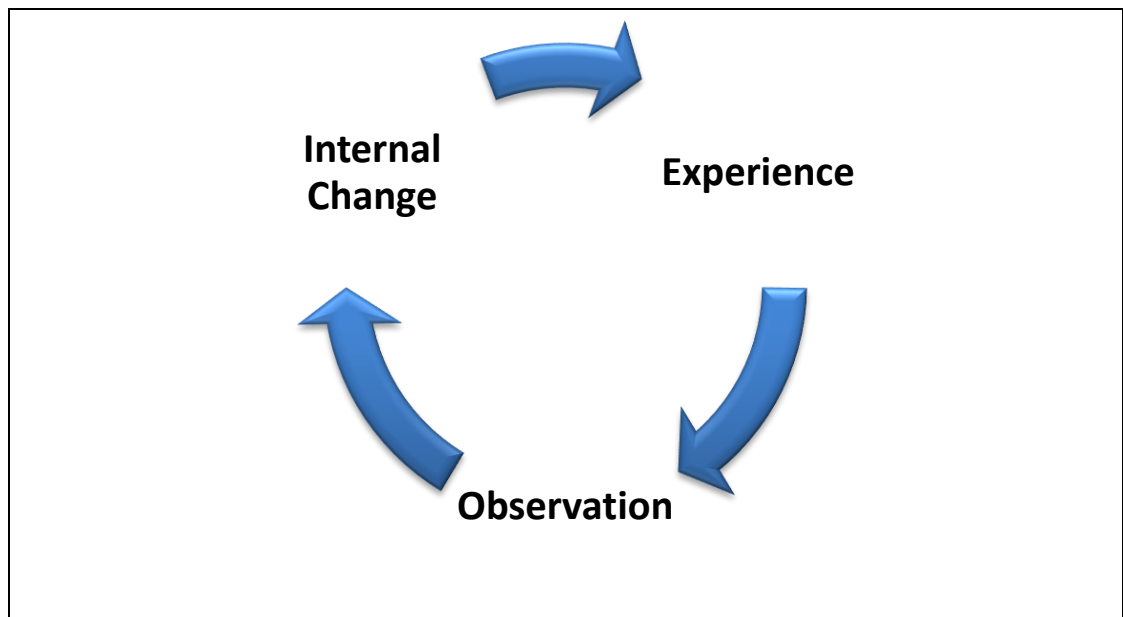
Figure 4.5: A learning process

As a result of the learning process highlighted in **figure 4.5** there is an opportunity for the individual or organisation to experience and observe to create an internal change and acquire knowledge or 'know how'. For example, observing

performance intelligence collated from the experience or action of a decision-making process can occur that can allow the organisation and the individuals operating within it to change and adapt to produce improved or better outcomes.

This cyclical process requires assimilation by the individual and absorption to establish what the intelligence is trying to indicate (Senge, 1990). Within the case study organisation from the exploratory discussions, it was important for the information generated by the organisation to be converted from raw data into information and on to knowledge to make improvements and to identify new ways of working to improve performance outcomes.

Agyris (1978) proposed both a single and double loop learning process that he considered to be far more transformational than the traditional cyclical learning process outlined in **figure 4.5** above. Agyris (1978) associated single loop learning with traditional linear production processes, making decisions on solving problems as and when they occurred, not questioning existing ways of working or learning unless a problem arose, this was very much the thinking of efficiency and productivity models set out by Taylor (1912).

This single loop learning may have been effective in productive industry utilising existing practices but it does not challenge what is being performed, so the requirement for an organisation to change and adapt their approach is fairly limited, therefore Agyris (1978) proposed a double loop learning process that could provide the organisation with a new perspective, an ability to learn how to

learn with a stronger level of innovativeness and creativity that potentially exposes waste in the system or ineffective processes at any given time.

This performance management approach to continually challenge and adapt (Seddon, 2005) (Keller & Price, 2011) (Bevan, 2009) is a step development from a number of traditional efficiency models such as, Six Sigma (Deming, 1986, 2000) & Total Quality Management (Lynch & Cross,1991) that are based on a linear single loop model. The single loop does not place the organisation within a dynamic position to self-learn unless a problem arises, organisations need to constantly learn and transform to seek new opportunities, structures, process and ways of working (Seddon, 2005). Double loop learning transforms this process by taking assumptions from the action that may require a level of risk and courage (Bevan, 2009) and then measures the consequences of the action from the single loop learning process. This was very much supported by Cooperider et al (2005) when proposing the appreciative inquiry approach, this has been illustrated in **figure 4.6** below:
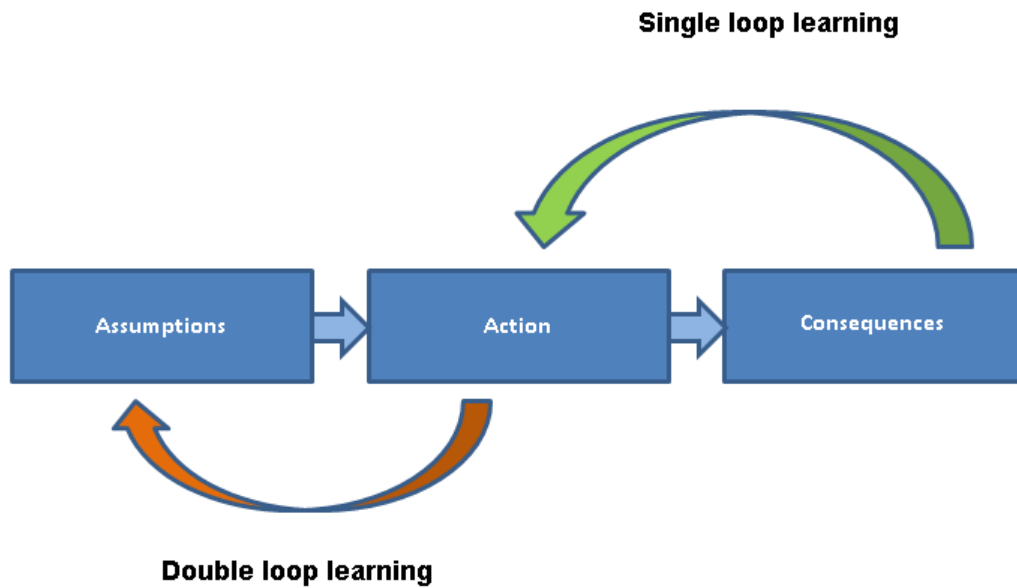
Figure 4.6: The single loop & double loop learning model

Adapted from: Cooperider et al (2005)

The need to develop a learning enabled approach will be investigated further within the study although to support learning there will need to be a commitment from the leadership of the organisation as well as the individual, the next section looks at what elements of leadership can support performance by looking at organisational health (Bevan, 2009) (Keller & Price, 2011).

4.11 Leadership & performance

The next section looks at the impact leadership has on performance as an important factor. It has been identified within the previous section that double loop learning has the potential to be transformational allowing a learning organisation to continuously adapt and therefore improve performance (Bevan, 2009). Within the literature, leadership may be an impact for the study to consider on performance management and its adoption (Collins, 2001).

Baker (2011) produced a paper commissioned by the Kings Fund that looked at the roles of leaders in high performing healthcare systems. Baker (2011) looked at five systems that he deemed as high performing health care systems and identified key themes that underpinned these and found that leadership embraces the common goals and aligns activities throughout the organisation. Baker (2011) claimed this would require leaders to be more involved in the development of strategy and implementing new performance systems.

This was also supported by Bevan (2009) who saw the importance of the leader within organisational health although claimed that at a 'top down' command and control style of leadership was ineffective; this will be covered later in the review section. Bevan (2009) proposed that leaders need to shape and inspire the actions of other members of the organisation to drive performance forward and identified nine elements below in **Table 4.3** that may be delivered to achieve organisational health.

Table 4.3: Nine elements towards Organisational Health has been removed due to Copyright restrictions

Source: Bevan (2009) Page 24

The nine elements that Bevan (2009) has proposed in **Table 4.3** above highlights the necessity to incorporate not just leadership but a number of balanced elements. These may be interdependent and may require looking at the total package or system to ensure all these elements can be incorporated. The next section looks at the potential of system based thinking that may support leaders and individuals (Bevan, 2009).

4.12 System based learning approach

The literature review found that Seddon (2005) Davies (2000) & Senge, (1990) all claimed that large organisations have the potential to increase performance by adopting a system based learning approach towards performance management.

The review identified that 'system based' thinking that was originally proposed by Seddon (2005) had the potential to address performance within the complex chaotic interdependent system such as the NHS. System based thinking presented an opportunity to look at performance issues from a multitude of factors that may be interrelated or connected. Seddon (2005) claimed this approach connected to the laws of nature, engineering and modern ecosystems in the way they function within their environment as a collective to create and adapt organically.

System based thinking was also supported by Bevan (2009) who looked at how whole system redesign may be adopted to improve performance, see *World Class Commissioning* (DOH, 2008). This requires the organisation to gauge how patients are managed and how they experience care and treatment through a care pathway healthcare system where a multitude of agencies may contribute towards the ultimate outcome for the patient. This would indicate that to improve performance the patient needs to share their experiences to create continuous organisational learning and knowledge, similar to the double loop model proposed by Agyris (1978).

Senge (1990) and Seddon (2005) claimed by taking an approach to adapt, redesigning and improve the organisation needs to take into consideration the interrelated functioning of the component parts of the system, claiming this would enable an understanding of the system of an organisation unless you contemplate the whole. This approach advocates the use of outcome indicators as opposed to function based productivity measures to measure the whole system, although Seddon (2003) did not discount targets all together but did not consider it as a basis for a system.

Seddon (2005) was of the opinion that system based thinking was the key for the NHS to deliver better performance improvement highlighting that outdated Taylorist mechanistic principles (Taylor, 1912) were becoming a failing management approach for the NHS. Seddon (2005) proposed that it would be far more productive for organisations if the managers could adopt learning based practices by identifying and understanding the underlying causes of performance failure identifying performance outliers with the intent to smooth out any potential variations (Rightcare, 2010).

The learning based performance approach recognises that the NHS is a complex system that could be improved, Senge (2006) also referred to the fact that structural design in itself has the potential to influence individual behaviour within an organisation, but it is the tools applied that may create an alternative shift of mind for the workforce. The communicative action that was proposed by Habermas (1984) very much links with the internal exchanges that occur within the organisation but it is also about how the organisation interacts with the

external environment that may have a significant impact on the organisation's ability to perform.

Burgoyne (1999) proposed for an organisation to continually learn and improve the workforce needs to be aware of the internal politics and to be able to locate where there are knowledge hubs within the system. Burgoyne (1999) stressed to achieve these relationships between external organisations it was essentially important to reflect on learning. This may be perceived as adopting tools such as, benchmarking, (Bogan, & English,1994) or communities of practice (Wenger & Snyder, 2000)

The exploratory discussions found that the NHS is by no means an island. There is a multitude of suppliers and providers from the private, voluntary and independent sectors that make up the whole patient care pathways. All these other organisations may have a differing decision-making process that could impact on the patient journey. If the aim is to improve the performance of the organisation there may need to be an opportunity to embrace these learning enabled approaches working internally and externally amongst a system of stakeholders.

The need to learn within this complex system was also supported by Bevan (2009) who proposed the concept of 'organisational health' to the NHS. Bevan (2009) by focusing on the need for the NHS to foster a culture of learning within the NHS that was required to be adopted and established directly by NHS leaders and senior management. Bevan (2009) expected leaders within the NHS to break

away from previous command and control based performance management approaches and to adopt a learning enabled environment that would be sufficiently adaptable within a system that the organisation is operating within.

Pisek & Wilson, (2001) claimed that complexity theory has the means to take abstract ideas of learning to a more conceptual model of performance management. The theory may allow a future design for the NHS to be developed from a basis of not isolating the organisation but instead perceiving its functions as a product of its internal and external environment that is subject to interrelationships and interdependencies. This supports the learning based thinking approach proposed by Seddon (2005), Senge (2006) & Reynolds & Ablett (1998).

The study will consider later the approach of organisational health set out by Bevan (2009) and systems based thinking proposed by Seddon (2005) and its impact on the individual's well-being and the potential impact it may have on a future performance management approach.

4.13 A theoretical perspective on performance management

The literature has identified a number of proposed and adopted approaches for performance management and common themes have emerged that will support the development of a conceptualised framework. It is now important for the study to review the literature to explore a theoretical and philosophical perspective.

Since the release of Frederick Taylor's seminal text, '*Principles of Scientific Management* (Taylor, 1912) it could be argued that performance management has consistently been advocated or used as a tool for the linear process of production and manufacturing within industry and commerce and to manage and measure productivity and efficiency.

The literature indicates that this approach towards productivity outlined by Taylor (1912) has taken the NHS and the public sector along a similar journey, as highlighted within *The Gershon Review* (The Stationery Office, 2004), an influential report that highlighted the need for public sector efficiencies. By looking at the need to deliver productivity and efficiencies this could be perceived as the organisation as a rational entity or machine that can be scientifically measured (Deming, 1982, 1986).

The need to economically evaluate through efficiency measures is important to the rational mechanistic organisation to yield better productivity, claiming this can be easily replicated by other organisations with a similar design (Deming, 1982, 1986).

The literature indicates that Taylor's (1912) work concerning productivity is prevalent today (see Spitzer, 2007 & Deming, 1986) and has been adopted within the NHS see *Healthcare output & productivity* (DOH, 2005).

Taylorism proposes that performance can be a predictable rational entity, however Cooperider et al, (2005) criticised that Taylorism omits the

unpredictability of the emotional social humanistic element of the organisation, for example, De Waal (2002) discovered there was a human tendency in the NHS to resist change and claimed it had a direct impact on the organisations ability to produce better performance.

Deming (1986, 2000) the pioneer of 'Six Sigma' is a good example where the philosophy of Frederick Taylor was further adapted to look at quality as the overriding indicator of good performance. He proposed quality could be achieved by calculating the ratio of work divided by total costs as the denominator, although this did not look at the humanistic elements of staff and patient satisfaction etc.

Taylor's (1912) discourse perceived the organisation as a machine where change could be controlled and predicted, however more post modernistic authors, such as, Seddon (2005) Marr (2008) & Senge (1990) argued that performance was dependent on the individual within the organisation to learn to address any unwanted variation in the system and to manage unpredictability by placing control back with the individual rather than from a position of control and power hierarchy.

The review found this was also supported by many of the current influential post modernistic authors in the field of performance management today, such as, Michelli, (2009) Neely, Adams & Kennerley (2002), Marr (2008) and Axson (2007) who over the last fifteen years based their models on more humanistic forms performance management on organisational learning, balanced score carding and strategy mapping concepts.

Many of the tools Taylor (1912) proposed were about shifting the responsibility and power back on to a manager and away from the individual, therefore, creating a 'command and control' dynamic (Cooperider et al, 2005). More texts such as, Michelli, (2009) Neely, Adams & Kennerley (2002), Marr (2008), Axson (2007), Kaplan & Norton (1984, 1992) de Waal (2002) all focused on the more post-modern concept of performance management strategy development and the ability to self-learn in order to create organisational health (Bevan, 2009) whilst providing a resilience in adapting to its changing external and internal environments from a greater humanistic organic perspective.

4.14 Tools for performance management

Since the early 1980's there has been a wealth of literature that has focused primarily on the private commercial sector's ability to adopt performance management-based approaches, this has been heavily influenced by the work of Kaplan & Norton (1992).

A multitude of performance management based tools has emerged on the commercial market that has set out to enable organisations to balance their financial metrics with non-financial measures, to monitor quality improvement, and deliver stakeholder satisfaction. Activity-based costing (Cokins, 2004) and the balanced scorecards (Kaplan & Norton, 1992) are two such influential tools that have been developed over the last fifteen years. Other models have also emerged including dashboarding such as, *Key Performance Indicator's* (Parmenter, 2007), *Predictive Analytics* (Cokins, 2007) *Performance Prism*

(Neely & Adams, 2001) (Neely et al, 2002) *Value Creation and Strategy Mapping* (Kaplan & Norton, 2004, Marr, 2006), *Mission-Orientated Scorecard* (Michelli & Bocci, 2009) and looking at organisations on basis of *systems learning* (Seddon, 2003).

The review found the above concepts and models were generally finance and strategy based and were all heralded by the proposing authors as key tools for any organisation's success towards better performance, although with little challenge from academic texts. However, Wicks et al (2007) identified that the balanced scorecard model is not a sufficient performance management tool on its own. Wicks et al (2007) proposed the need for a balanced mix of tools and approaches with the balanced scorecard (Kaplan & Norton, 2004) that also focus on the individual recognising the human cultural dimension alongside performance measures.

In support of this Marr et al (2004) proposed that there is a need to have a common understanding or taxonomy of the assets of an organisation that not only includes physical and financial, but also human, culture and intellectual property.

Other issues that have emerged concerning performance management tools such as the balanced scorecard has been time lag problems, Kocakulah et al, (2007) noted that when healthcare institutions adopt balanced scorecard approaches measurement, for example, it can take anything up to two years to implement,

This should not deter from the success of the balanced scorecard as a popular tool (Kaplan & Norton, 2004), research was conducted by Silk (1998) on the adoption of the balanced scorecard and highlighted that 60% of Fortune 1000 companies have tested the balanced scorecard, although successful implementation out of the 60% was not very documented by Silk (1998). Marr & Schiuma, (2003) found that Kaplan and Norton were cited along with the balanced scorecard out of 2000 papers within the field of business performance measurement, as the most cited authors from 1998 to 2002. The journals that Marr & Schiuma, (2003) most frequently cited were the *Harvard Business Review*, followed by the *International Journal of Operation & Production Management.*

The balanced scorecard (Kaplan & Norton, 2004), over the last few years, has emerged beyond just being a tool for measurement but also has provided a conceptual approach to management as a whole, although its effectiveness and adoption is still out for debate.

The business performance management software developer market has grown in parallel over the last fifteen years with a number of leading corporate suppliers already providing business intelligence solutions to the NHS and local government. Major corporate brand names such as *Microsoft Performance Manager*, *SAS, QPR, Performance Accelerator* and *Business Objects*, just to name a few. It would be easy to assume that the implementation of these 'off the shelf' packages would provide a one size fits all solution, however, there is little to no academic literature or empirical evidence on the effectiveness, impact or

adoption of these packages by individuals. The review found they are very much viewed as strategic tools and primarily for strategic management and executive decision making. There is no doubt that the field of performance measurement is an emerging area for research, however, the simplistic view of software developers just applying a technical solution to strategic management potential does not address a multitude of intrinsic factors that may be prevalent within the individual.

4.15 Control vs. learning

The review noted earlier that a pure 'top down' 'command and control' style of leadership was an ineffective approach towards managing performance (Bevan, 2009). The literature highlighted previously that there were potentially a number of behaviours surrounding performance management and command and control approaches that may be prevalent. Seddon (2005), Marr (2008) & Neely (2007) had made reference to a 'command and control' culture approach that was associated with the adoption of performance management within the public sector.

The need to control contractual relationships through 'top down' governance was evidenced by the policy document, *'Developing the Performance Management Regime'* (DOH, 2008), this highlighted that potentially a command and control approach may be exercised within the NHS. The review had found a shared discourse amongst leading performance management authors having major concerns regarding the implementation of 'command and control' approaches and the relationship with performance management, claiming it had a negative

impact on an organisation's ability to perform. This was well documented by Seddon, (2005), Marr, (2008), Neely (2007), Bird et al, (2003) & Bevan (2009).

In contrast to command and control Marr (2008) conducted an extensive national survey of cross-government and public sector organisations and he claimed that organisations that adopted a less controlling style based more on a learning approach to performance management were more likely to outperform others. Marr (2008) claimed that command and control dynamics are more likely to have a negative impact on the individual and in doing so potentially reducing the morale and motivation.

Marr (2008) concluded from his analysis that the 'top down' approach may cause strategic alignment problems, target fixation and gaming, claiming that these were behaviours that were being displayed and were more likely to be dysfunctional (Grizzle, 2002), running a risk of individuals within the organisation losing the intent to deliver on strategic ambitions and reducing the opportunity for the organisation to improve performance. The literature infers that the 'top down' regime within the NHS may be acting as a barrier towards performance delivery. Graham (2004) claimed that the command and control dynamic may be providing a barrier towards the alignment of staff to the strategic intentions of the organisation.

In contrast, Mackie (2008) proposed that organisational performance within a government context should place a focus on the control of managerial activity to improve performance, in particular relating to financial performance and

government policy cycles. Mackie (2008) proposed that the introduction of performance management is to provide systematic controls to regulate public sector organisations activities ensuring they conform to plans and strategy. However, Mackie (2008) provided little reference as to the impact on individuals operating within a command and control regime.

Van Dooren et al (2010) looked at the requirement to balance command and control with learning based approaches. Van Dooren et al (2010) proposed that for performance to be effective it may be a necessity for the individuals that operate within that system to adopt a more balanced approach that provides accountability and learning. An interesting concept as the NHS may need to balance both approaches

In contrast to the command and control dynamic Franco & Bourne (2003) identified a number of factors to support balancing a learning based approach. They claimed that corporate culture was a significant factor towards managing organisational performance and proposed that there was a need to encourage team working, ownership of problems that arise and the requirement and motivation to continuously improve and align the workforce to the organisational strategy. Franco & Bourne (2003) encouraged more motivational methods to improve performance as opposed to a controlling behaviour. This may be achieved through joint working on individual goals and strategies. Involvement and participation of individuals were important to promoting the understanding of corporate strategy and performance, by involving members of staff in the review process or jointly in the formulation of corrective action plans.

Drucker (1959) claimed that business consists of the knowledge of individuals, therefore, knowledge and learning cannot be excluded from any development of a high performance driven culture.

The review found that that the relationship between knowledge, organisational learning and how it affected performance was significant as an alternative means to enhance performance delivery. This was supported by Mintzberg, & Heyden (1999), Senge (1990), Lassey (1998), Clarke (2001), Huber (1991), Nonaka (1991), Fiol & Lyles (1985), Stata (1989), Gladstone (2000), Gamble & Blackwell (2001), Wenger et al (2000) & Marr (2009).

Within an NHS context, the review found related policy literature that supported this claim, for example, Bevan (2009) proposed the NHS needs to be free from control approaches to adopt more learning based practices. Darzi (2007, 2008) conducted a constitutional review on the NHS, *'Our NHS Our Future'* (Darzi, 2007) proposing that learning and knowledge creation could be the key to delivering effective performance management. He called for clinicians to be provided with the opportunity to be directly involved in the management of performance by pulling from a range of knowledge and evidence bases.

Seddon (2003) & Schang (2011) supported learning based approaches specifically where there was a need for an organisation to reduce unwanted variation in activity, spending and outcomes. Schang (2011) promoted the distribution of intelligence to prompt better learning that could allow individuals

within the organisation to make decisions much closer to the action as opposed to waiting to be guided.

Davies & Nutley (2000) claimed that the NHS could improve its performance by building learning organisations from a basis of knowledge to enhance evidence-based decision making and accused the NHS of only trying to improve performance centrally by imposing structural change. Davies & Nutley (2000) were of the opinion that this provided little intrinsic value to employees and resulted in a sceptical workforce towards performance management that may have provided less effective outcomes in the past.

4.16 Intrinsic value and motivation

Within the literature, the review found a number of post modernistic philosophers and business theorists that had perceived knowledge and learning as a positive force for power. Foucault (1975, 1954) proposed that knowledge and learning could be achieved through shared ownership; his discourse was also shared by Drucker (1959) who claimed that knowledge needs to flow if performance was to improve, although claiming this to be dependent on the need to motivate the individual within the organisation and to enhance their level of internal intrinsic value.

This was also supported by Marr, (2008) and Reynolds & Ablett (1998), however Lebas & Euske (2007) noted that the description of performance whether it's simple or complex may have no intrinsic value on the individual but may have

potential value if it is used by a number of individuals for decision-making purposes.

It was evident from the current literature that there were limited empirical studies regarding the relationship between performance and intrinsic value amongst the NHS workforce. The most related study was produced by Scott et al (2003a & 2003b) when researching organisational culture in the NHS. Scott et al (2003a & 2003b) provided little evidence to identify what impact intrinsic value performance management had on the individual indicating this will need to be explored further.

4.17 The relationship between culture and performance

Fostering a positive culture towards performance and continuous improvement has been identified already as an essential factor outlined by Michelli (2009). Micheli (2009) took stock of the reasons why public sector organisations were required to performance manage and conducted several empirical research studies that had indicated a number of reasons why organisations should introduce a performance management system, these included the need to implement strategy, align behaviours and support decision making.

The above points implicate a potential impact on culture, both Michelli (2009) and Marr (2006) proposed that to attain a high performing culture it will be dependent on the internal intrinsic motivating factors of the individuals from a social dimensional perspective. To achieve this there is a requirement for the organisation to promote, facilitate learning and improvement and a requirement

to foster a more positive culture towards performance and continuous improvement Micheli (2009).

The next section reviews the literature to establish whether there is a correlated relationship between culture and performance (Kotter & Heskett, 1992) (Scott, 2003). There were a number of studies that focused on the diagnosis of organisational culture that included, *Cultures for Performance in Health Care,* (Mannion et al, 2005) that was the most detailed and concise empirical study that related to the *Competing Values Framework* that was outlined by Cameron & Quinn, (1999) (Cameron, 2006) we will look at this in more detail later.

A number of studies have been conducted to look at how an organisation can deliver a high-performance culture (Reid et al, 2005) (Atkinson, 2004). Collins & Porras (1995) claimed this can be achieved by having a visionary organisation that can translate its core ideology into goals and strategies. Cook (2001) proposed that to achieve the right culture for the organisation to perform well was for employees to offer feedback to reinforce the positive behaviours. Graham (2004) was concerned with the need to integrate staff and align them with strategy development to ensure that staff and employees were pulling in the right direction. This was supported by Juechter et al (1998) who also believed that the organisation required a strategic focus and proposed five conditions for high-performance culture to emerge.

- A relevant focus
- Driven from the top but at every level

- Leadership commitment

- Comprehensive involvement

- External coaches with the skills to facilitate

Source: Juechter et al (1998:63)

Rowden (2001) conducted a number of empirical studies to identify what a high-performance culture could be by observing the human resource characteristics of thirty-one small successful companies. He found there was a strong correlation between companies that he considered were high performing and that had a relatively low turnover and who had provided fair treatment to its workforce.

It has been well documented that there are limitations measuring organisational culture as it has been considered as a field of study that may be too broad to measure, although Cameron & Quinn (1993) had proposed a measurable framework that could be utilised by organisations such as the Competing Values Framework that we will discuss in more detail later in the chapter.

The review found that the most relevant empirical study that looked at the culture performance link and was conducted on the NHS was the work of Mannion, Scott, Davies & Jacobs (2005). They found when looking at previous studies concerning the culture performance link associated with healthcare there were 1700 bibliographical records and 69 full articles from North America and only one empirical study was found that was conducted within an NHS context.

Mannion, Scott, Davies & Jacobs (2005) conducted extensive quantitative and qualitative analysis on the association between senior management and performance. Associations between the Trust cultures and objective measures of performance were assessed using a variety of multivariate analytical methods. They conducted qualitative studies on six Acute Trusts and six Primary Care Trusts by comparing, one – zero performance rated star trusts with three-star trusts utilising the competing values framework (CVF) that was proposed by Cameron et al (1999) (Cameron, 2006). The star ratings were an imposed national performance measurement system implemented by the Healthcare Commission to inform patients and the public of current performance and quality and standards of care.

It was noted by Mannion et al (2005) that the star rating system is far from being a perfect measure but was at the time the most up to date national system that could have been used. Schang (2011) claimed that the system of star ratings had created improvements in reported performance notably reductions in waiting times, this was also supported by Bevan (2006). Quantitative performance measurement systems such as the star ratings were by no means new at the time for the NHS, the *Performance Assessment Framework (1999)* a major performance management driver for trusts was implemented previously to the star rating system that used similar measures and a balanced scorecard methodology (Kaplan & Norton 1991). Mannion et al (2005) claimed that the need to impose a rating system on the NHS potentially could have contributed to the major preoccupation of national health care policy It could be argued whether the rating system imposed at the time was able to measure what constituted true

good or better 'performance' or 'quality' however there is little evidence to the perceptions of NHS staff and the public (Mannion & Goodard, 2002).

The Healthcare Commission (2007) considered the star rating system as important in evidencing NHS organisations performance if an NHS organisation was rated 'excellent' by the Healthcare Commission they were granted 'earned autonomy' providing the organisation with an opportunity to qualify for independent foundation status from the Secretary of State. Foundation status provided the organisation with a number of flexibilities in particular financial freedoms; see *Key Lines of Enquiry* (Audit Commission (2008). Mannion et al (2005) claimed that these rating systems had the potential to shape organisational behaviour, however other measurable systems of performance such as clinical governance reviews, audits and annual heath checks (Healthcare Commission, 2007) were also a part of the national performance monitoring system set out by the Healthcare Commission. They conducted their studies on cultural characteristics selecting 'high' and 'low' performing hospitals initially using the star rating system to identify which trusts were performing better than others. Mannion et al (2005) found that each trust reviewed had its own unique character similar to a typology set out by Handy (1985) but there were key points of divergence identified across high and low performing see **Table 4.4** below:

The **table 4.4** below highlights the distinctive characters between high and low performing trusts that Mannion et al (2005) considered as a style of leadership and management that was having an impact.

Table 4.4: Key points of divergence in NHS cultures has been removed due to Copyright restrictions

<div align="right">Source: Mannion et al (2005: 435)</div>

From the table above high performing, trusts were seen to be more likely to have a transactional as opposed to a transformational leadership approach where

management was focused on integration and empowered to deliver performance, as opposed to allowing professional cliques to form. Information systems were important to ensure that good data and intelligence can support good decision making but more interestingly the big taboo was about not hitting targets.

Leadership and management orientation was the key to the findings, Schein (1985) supported this notion describing leadership as an essential function as it had the ability to manipulate culture and have a strong correlation between hospital leadership and performance.

Interestingly the study concluded that high performing trusts were more likely to be implementing a more directional and command and control style of leadership. It has been already documented that a command and control approach is more likely to foster dysfunctional behaviours towards the delivery of performance management, (Seddon, 2005), (Marr, 2008), (Neely, 2007), (Bird et al, 2003) (Bevan, 2009) (Grizzle, 2002). It would appear from the study that Chief Executives in a high performing trust were more likely to be motivated to deliver the measured performance set by national agencies such as, the Healthcare Commission and the Department of Health and in doing so had developed local performance systems to deliver as the culture was to hit top down targets.

The review does question whether the measurement system and performance management framework that was used to define high and low performance for this study had included the measurement of quality standards of care that is expected more today (see NHS Outcomes Framework, 2011). If today's system

of measurement was applied to the Mannion et al (2005) study this may have produced different results and outcomes, therefore a high performing trust today in 2015 may have required an alternative style of character and leadership to achieve high performing status.

Another criticism of the study's methodology was that it only captured the views of middle and senior managers and not the wider staff perhaps this may have included the views, beliefs and perceptions of back office and practitioner staff to ensure there was no risk of management bias.

The study found accountability and information systems to be an essential element of a high performing NHS Trust, top down and upward accountability and the evidence of meeting of targets needed to be supported at each level of the organisation. Formal reporting and proactive development of databases for the performance management agenda in high performing organisations were very much in contrast to low-performing where fragmented systems of accountability were found to be in existence.

In contrast, the high performing trust according to the study needed to focus on the development of staff to deliver the performance agenda, staff need to be recruited that could be aligned to the corporate agenda rather than staff who focus primarily on their professional group. The study had identified the need for high performing trusts to adopt a proactive approach to looking at the wider system of the local health economy to manage its performance and its environment. Relationships with other external agencies affecting the whole

system was an essential factor, low performing trusts tended to have poor external relationship with other stakeholders.

The case studies analysed highlighted the need for a high performing NHS organisation to operate within an environment where leadership and accountability were required to be strong where there was need for an investment in the individual to develop high-performance behaviours that needed to be aligned to the national performance agenda.

This raises a question as to whether the relaxation of the national performance agenda by making the NHS less target orientated and imposing less control from the centre does create a high performing culture. Therefore, would the environment and culture need to change in the NHS to achieve high performing status? The study had proposed there was a clear link between culture and performance (Kotter, & Heskett, 1992) that could be generalised however the findings were analysed at a particular point in time pre-NHS *Health and Social Care Reforms* (2013) and the performance agenda has now moved towards an *NHS Outcomes Framework* (2011) which is less target orientated. It would appear that the complexity of culture and performance is inextricably linked although may be likely to change as a result of demand, financial pressures and differing accountabilities.

The study had speculated within the key findings of a previous study that an organisation's culture may impact on the organisations performance from a number of directions, Mannion et al (2004) claimed that culture may be driven by financial efficiency, shared values and the internalised norms within the

organisation and these factors may impact on the way individuals will engage to deliver performance, however according to Mannion et al (2005) working conditions of the individual may become more important than the financial efficiency goals of the organisation.

The Mannion et al (2004) study utilised a measurement framework based on Competing Values Framework (CVF) developed by Cameron et al (1999) (Cameron, 2006). The frameworks have provided a tool to assess and diagnose the culture of NHS organisations from an empirical scientific perspective. Cameron et al (1999) set out the CVF framework and typology to identify relevant identifiable measurable cultural dimensions and behaviour. The CVF diagnostic tool has been applied across the private, commercial and public sectors.

So we have looked at what constitutes a high or low performing NHS organisation but can a culture type be established? Cameron & Quinn (1999) when developing the CVF also were able to identify four culture types that were used in the study see **figure 4.7** below:

Figure 4.7: The Competing Values Framework has been removed due to Copyright restrictions

Source: Cameron & Quinn (1999: 14)

Figure 4.7 above highlights the four types of culture outlined by Cameron & Quinn (1999), clan is very much focused on the need to work cohesively within an integrated system, developmental looks at entrepreneurship and the need to creatively innovate. Hierarchal provides a type that requires rules, governance and policy appear a very top-down controlled culture, whereas the rational type focused on the individual and in competition this could be potentially viewed in more profit based healthcare organisations.

The study also looked at the processes that were being implemented with the four types that were more likely to be organic or mechanistic; these evolutionary and rationalistic approaches have already been highlighted earlier looking at Taylorist (Taylor, 1912) and learning based approaches (Senge, 1990). See **figure 4.8** below:

Figure 4.8: CVF culture positioning and processes has been removed due to Copyright restrictions

Source: Mannion et al (2005)

The study found that the valued aspects of the clan culture involved tradition, cohesion, commitment, morale, an internal culture focus and a relational cultural orientation where staff could share more interpersonal, bonded and shared experiences. The expected performance with the clan type favoured good staffing levels, a higher degree of specialisation and was more likely to provide a named doctor or nurse although were more likely to have more cancelled operations and

poorer star ratings than non-clan trusts. Processes were more likely to be organic where there was a greater focus on the internal organisation and its integration focussing more on staff morale.

Developmental types preferred innovation, dynamism, growth and entrepreneurship, where there is a need to focus on the external relationship working with other stakeholders and a relational culture orientation focused on staff interpersonal relationships. The study found the trusts with this dominant type to be better at achieving waiting times targets and therefore was more likely to achieve better performing star ratings.

The more mechanistic process was provided by the hierarchal type and was very much based on order; procedures, stability, predictability, and assuming a strong focus on performance and governance. The study found these trusts were more likely to have good data quality and financial balance although much higher costs associated with bureaucracy.

The last type-rationale looked at external competitiveness and achievement where waiting times, star ratings and other formal performance indicators such as low-level complaints are usually rapidly dealt with. This type is very mechanistic and considers rationality, rules and ordered decision making is important to their success.

From the findings of the research the study was able to identify the dominant type for individuals within the NHS see **figure 4.9** below:
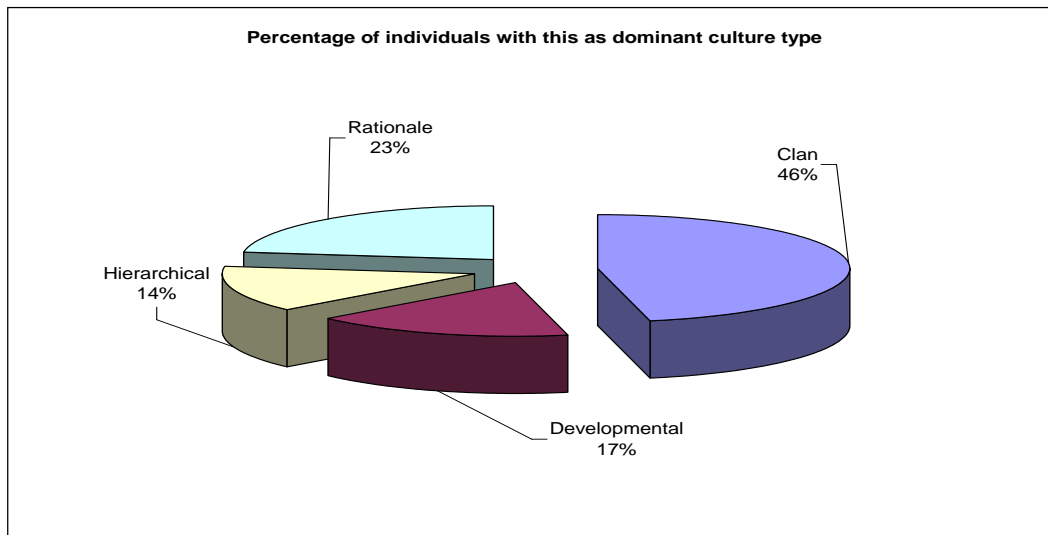
Figure 4.9: NHS dominant culture types

Source: Mannion et al (2005)

Clan and rationale were the most dominant types indicating that the culture in the NHS is both organic and mechanistic in nature. The study results highlight that individuals are not so positioned on the developmental types that lean more towards organic dynamism, growth and entrepreneurship staff are also low in Hierarchal type that requires stability, predictability and a strong focus on performance and governance where a mechanistic approach according to the study is more likely to achieve waiting time's targets and better-performing star ratings, however, he claimed that good data quality and financial balance is required to underpin them.

The study had observed the frequency distribution of culture types across all the trust that participated in the study Mannion et al (2005) found by group that clan culture had the largest percentage of 53% and hierarchical had the lowest share with 5.9%. See **figure 4.10** below:
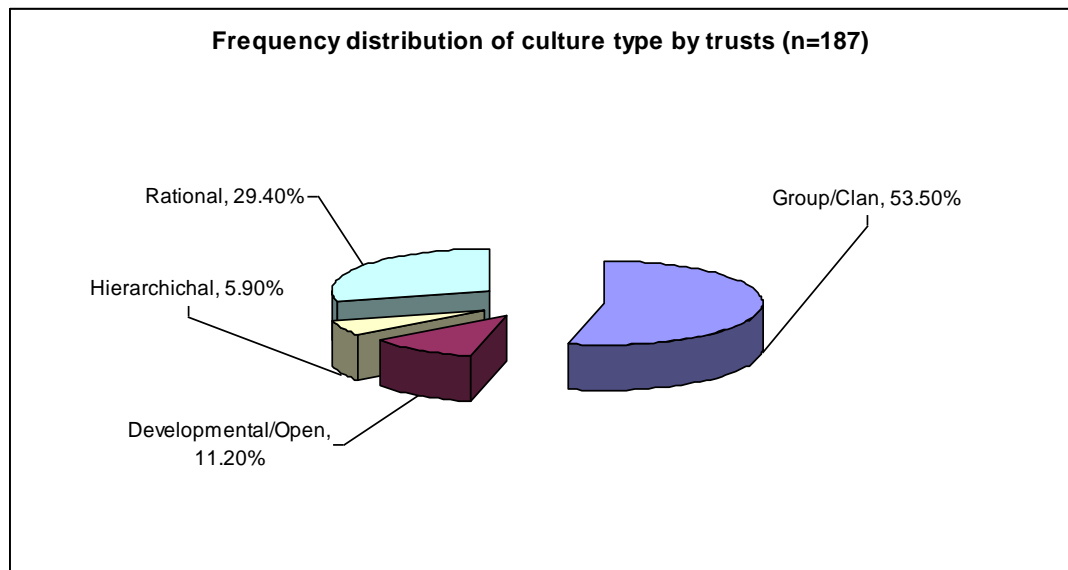
Figure 4.10: Frequency distribution of Cultures by trust

Source: Mannion et al (2005)

From the study findings, it produced some interesting comments concerning the dominant clan type. Clan trusts were more likely to have fewer complaints from staff and better staff satisfaction. When observing performance associated with process measures such as episodes, attendances and waiting time's clan trusts were more likely to have less activity and shorter waiting times. Trusts with dominant clan cultures were structurally smaller and generally less involved in teaching and research and were less likely to have been merged or integrated.

The findings are revealing, however, the validity can be challenged as there is a risk of bias as the study only measured top senior management teams, not the wider staff group. A similar study was conducted by Gerowitz et al (1996) who looked at a comparative study whilst implementing an assessment on the identified values of senior managers, such as, employment loyalty and commitment. The Mannion et al (2005) study criticised the methodology

employed by Gerowitz et al (1996) as he had focused on the generalisation of individuals although both of their studies did not include perspectives from wider staff, clinicians or patients.

Mannion et al (2005) then later went on to conduct case studies on Primary Care Trusts this was very much different to the acute setting that he had focused on previously. Mannion et al (2005) concluded that the fundamental difference between PCT managers and acute trust managers is the definition of 'performance'. Acute trusts were focused on the targets that were set by the Department of Health, whereas PCT managers were very much focussed on cultural change.

4.18 Chapter Summary

The study set a number of questions to guide the literature review and will now act as a basis for the following summary.

The first question was whether the available literature could define what performance management is. It has been well noted within the literature that over the last three decades the origins of performance management that have been adopted in the NHS may have been influenced by a theoretical and ideological public management concept such as, New Public Management (NPM). The review explored and investigated the relationship between the adoption of NPM and its impact on performance management in the English NHS by reviewing the available literature within UK government policy publications and from leading academic authors from within the field of NPM such as, Hood (1991), Politt (2011)

and Dunleavy (2005). The literature highlighted that NPM had been applied by successive governments in the UK and had been primarily driven by the political ideology of reform over time. Performance management was considered a perceived product of NPM as a tool to support economic rationalism, the decentralisation of government and to reduce bureaucracy and being criticised within the literature of being a public management fashion or fad.

It was evident from within the literature that the term 'performance management' is being broadly applied for a multitude of applications (Pettigrew et al 1999) such as financial accounting, human resources, strategic planning and measurement. From the literature, the study has been able to propose a working definition for performance management that looks at the role of supporting the total business planning process whilst recognising its strategic application and its impact on the individual. The literature had identified the importance of performance management as a strategic business management planning tool that looks at the past, current and future performance and not just as a means of pure measurement (Marr, 2006) (Axson, 2007).

The literature found the role and purpose of performance management are strong in supporting the delivery of strategic development, however within earlier texts performance management frameworks were identified as being predominantly used for a traditional financial accounting purpose (Kaplan & Norton, 1994). It would appear there has been a significant shift away from the traditional accountancy approach although the strong links to finance are still potentially there within an NHS context. There is now a range of performance management

tools are in existence that is predominately cited within the commercial sector with the balanced scorecard (Kaplan & Norton, 1991) being the most dominant. It appears the balanced scorecard has acted as the basis for a number of other tools that have been developed by other leading academics in the field such as, Parmenter, (2007), Cokins (2007) Neely & Adams, (2001) Michelli & Bocci, (2009), unfortunately the effectiveness of these tools are less well documented within the literature.

Another question was to identify what is the performance management approach within the NHS. A further exploratory study will need to investigate this further, however, within the literature it was evident within a number of policy documents such as, '*Developing the Performance Management Regime'* (DOH, 2008) that there was a need for the Department of Health to control the performance of the NHS. It was claimed within a number of texts that these controlling approaches that were potentially adopted by the Department of Health may provide a number of problems (Seddon,2005), Neely (2007), (Bird et al, 2003) (Bevan, 2009) and have the potential to create a number of problems such as, strategic alignment issues, target fixation and gaming (Marr, 2008).

In addition, it was claimed that these behaviours may have the potential to create a real barrier towards staff alignment and towards the organisation's strategic intentions (Michelli, 2009), therefore this may have a potential impact on the performance of the organisation and its productivity outputs (Graham, 2004). It was not clear from the literature how this impacted on individuals within the NHS

as there appeared to be little empirical evidence to establish what were the staff beliefs and perceptions concerning performance management.

The literature review found there was a need for organisations to place the individual at the centre or core of the performance management and strategic process with a need to understand the behavioural social world of the individuals involved (Marr, 2006). In addition, the literature found potential correlation between the well-being of the individual and the organisation's productivity output (Boorman, 2009), (Armstrong & Baron, 2003, 1997, 1998). The health of the organisation and its individuals was considered by the literature as an important factor to propel the organisation's performance forward, potentially achieved by enabling a learning process to occur, allowing the organisation to adapt towards its changing external environment (Bevan, 2009) (Keller & Price (2011).

There was a set question posed regarding the culture surrounding performance management in the NHS, the literature had identified a number of studies that had focused on the diagnosis of organisational culture in the NHS that was conducted utilising the Competing Values Framework (Cameron & Quinn, 1999). Mannion et al, (2005) concluded that the NHS is very strong within a clan culture where an organisation is more likely to consider tradition, loyalty and a strong emphasis on morale as being important.

The literature looked at a potential link between performance and culture and recognised that to attain a high performing culture it could be potentially dependent on the internal intrinsic motivation of the individual concerning

performance management (Marr, 2006). To foster a more positive culture towards performance and continuous improvement it was proposed there is a need for the organisation to facilitate an approach towards learning (Micheli, 2009), (Marr, 2006) (Seddon, 2003) (Bevan, 2006) (Keller & Price, 2011).

To investigate the issues raised by the literature there would be a necessity for the study to further explore the phenomena from a social dimensional perspective. The posed questions that were applied to the literature have exposed a number of gaps concerning the role and perception of performance management within an NHS context. Other gaps from the literature also include not being able to establish sufficient empirical research on staff beliefs and perceptions surrounding performance management and no evidence regarding the effectiveness of the current NHS frameworks and approaches.

From conducting the literature review there is now a real need for the study to carry out an exploratory investigation within the NHS looking at the secondary data available regarding performance management structures, designs and relevant processes both external to an NHS organisation and internal. There is also an opportunity to look at the effectiveness of performance frameworks within the NHS by comparing or benchmarking performance across a number of NHS organisations with a purpose to identify best practice; this will be covered in the next chapter.

5.   The Exploratory Study

As a result of the above literature review, it was important for the study to observe the real world and establish the current structure of performance management frameworks within the NHS both externally and internally within a specific NHS organisation. Findings from the literature have identified that performance frameworks set by the Department of Health via nationally implemented policy may have an effect on organisational and staff behaviour and culture (Mannion et al, 2005).

The next section outlines the performance management environment from which the NHS operates both internally and externally and follows a three set stage process that includes,

Exploratory Study Stages

1. **Performance Frameworks:** Looking at the wider performance management structure, design and the accountable agencies that shape and operate it.

2. **Comparative Evaluation:** Economic comparative analysis conducted on secondary data

3. **The Case Study Organisation:** An internal exploratory study within the case study reviewing secondary data

The study will look at the feasibility of conducting a comparative evaluation of past, current and existing frameworks and then the study will focus internally in

greater detail on a specific NHS primary care trust organisation that will be known as the case study organisation that will be operational within the chosen performance management environment.

The exploratory study was carried out ethnographically whilst employed by the chosen case study organisation providing a real life experience of the phenomena and the factors surrounding performance management. The exploratory stage was a literature based study although preliminary discussions were conducted to enrich the details of the findings.

5.1 Exploratory Stage 1: Performance frameworks in the NHS

It will now be important to consider the current performance management structures within the NHS to set out the scope and context for the study.

Within its history, the Department of Health has implemented a number of major transitional reforms on the NHS (Robinson & Le Grand, 1994) as a result of adopting legislation set out in the *Health & Social Care Act* (DOH, 2013). The legislation has required the NHS to reform its operating structure and required the English NHS to adopt a new performance management framework based on outcomes rather than predominant process based targets, see *'The NHS Outcomes Framework 2011/12* (DOH, 2010)*'*. The Department of Health claimed that by implementing outcomes based systems it would allow the relaxation of targets that were being made on the NHS and provide a better opportunity for the NHS to have greater control and autonomy.

The legislation *Equity and Excellence* (DOH, 2010) allowed the NHS to reduce the volume of quantitative based targets and allowed them to look at other key performance indicators to measure such as health inequalities, life expectancy and prevalence of conditions etc. The new legislation placed a greater focus on a need to deliver value for money and quality assurance to increase the effectiveness, efficiency and productivity of the NHS, to improve service for patients, public and the taxpayer (*Equity and Excellence* DOH, 2010) this was also outlined in the *NHS Performance Framework Implementation Guidance* (DOH, 2009).

Back in April 1999, the Department of Health released *NHS Performance Assessment Framework* (NHS Exec, 1999) which first referenced the introduction of the NHS and laid down the foundations for a target driven performance management NHS. The framework highlighted six areas of performance that the English NHS was expected to be performance managed against see **figure 5.1** below:

Figure 5.1 Performance assessment framework dimensions has been removed due to copyright restrictions

Taken from: NHS Performance Assessment Framework (NHS Exec, 1999)

It was evident that the Department of Health had designed the new Performance Assessment Framework on the balanced scorecard approach that was pioneered by Kaplan & Norton (2007), and set out to propose standardised benchmarking nationally across the NHS. It is debatable as to whether the scorecard was appropriately balanced looking at the basket of indicators that were set as the exploratory study found that the majority of the measures were process driven and less based on learning and development outcomes within a fair share quartile structure. Quality was alongside the need to deliver good patient/carer experience. It is difficult to establish from within the literature whether it was evident that the *Performance Assessment Framework* (NHS Exec, 1999) was effective or not, but it had provided the NHS with a nationalised performance

management reporting structure and implementation framework to enhance accountability against public investment whilst utilising commercially based tools.

The new framework supported the implementation of *The NHS Plan: a plan for investment, a plan for reform* (DOH, 2000) that had been published by the Department of Health heralding a new investment and a new beginning welcoming a new performance management framework for the NHS. A technical report was later published *'Target Setting for Health Improvement'* (DOH, 2000b) and for the first time this set out a target-based performance management system for the NHS.

Key performance indicators were mainly based on productivity wait times and targets, this approach was further enhanced by a performance rating system that was later adopted by the Commission for Health Improvement (CHI) that later became the Healthcare Commission in 2004 and then became the Care Quality Commission[1] in 2009. Trusts were performance measured against a balanced scorecard (Kaplan & Norton, 2001) and low-performing trusts were expected to provide a corrective performance action plan.

Better performing three-star trusts were granted earned autonomy (star ratings were covered within the literature review) with the opportunity to apply for foundation trust status. The Healthcare Commission was expected to provide autonomy for high performing trusts by providing less monitoring, fewer

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[1] The Care Quality Commission is currently the independent regulator of health and social care in England.

inspections which establish private companies and retain more of the proceeds of local land sales for reinvestment in local services (Healthcare Commission, 2008). It was reported by Snelling (2003) that a three-star trust could be awarded capital payments up to £1million and a range of management freedoms so it was important to ensure the measurement system reflected good performance.

The literature lacked empirical evidence and research as to whether star ratings had overall incentivised and encouraged NHS trusts to deliver better performance, other initiatives implemented such as, the promotion of a performance fund, although this had relied heavily on the performance ratings that were being monitored by the Commission for Health Improvement. Snelling (2003) had concerns regarding the methodology that was used for the star ratings and looked at developing an alternative performance rating system using the same data and concluded that only 41% of hospitals would have received the same number of stars as their official rating.

In 2008 Anna Walker the CEO of the Healthcare Commission claimed that the NHS performance was getting better as a whole using and managing resources and performing better against national targets and life expectancy, however information to measure outcomes needed to be improved particularly within the areas a patient experience (Healthcare Commission, 2008).

Since the adoption of *The Performance Assessment Framework* (NHS Exec, 1999) it has been evident that the NHS has been subject to a continued raft of centralised controlled performance management structures. These have been

imposed by the Department of Health more recently from 2005 onwards through policy set out through, *'Commissioning a Patient-Led NHS*, (DOH, 2006), '*Developing the Performance Regime* (DOH, 2008) & *How to Achieve World Class Commissioning Competencies* (DOH, 2008).

More recently *'Developing the Performance Regime* (DOH, 2008) was implemented to monitor the overall performance of the NHS through a hierarchal system of organisations utilising a set of measures see **figure 5.2**. The system was performance managed via the strategic and operational planning process implemented by the Department of Health and the Strategic Health Authorities. These strategic organisations had a purpose of making the system accountable via local commissioning bodies such as, Primary Care Trusts (PCT), that were authorised to monitor the strategic performance of the local NHS. The PCTs expected to achieve this via the establishment of contracts or service level agreements as a commissioner with the NHS provider services and trusts (*Commissioning a Patient-Led NHS*, DOH, 2006) (*Developing the Performance Regime*, DOH, 2008).

Figure 5.2: The NHS Accountability Structure has been removed due to Copyright restrictions

Taken from: Developing the Performance Regime (DOH, 2008)

The Primary Care Trusts were expected to monitor the quality and governance standards by contracting and commissioning whilst holding NHS provider trusts to account. If required when performance was not up to the required standard primary care trusts were expected to contest NHS Trusts performance via a contractual, purchasing and procurement process that would be measured against a set of indicators identified within Primary Care Trust's local delivery plans. Running in parallel to these process external regulatory bodies such as the Care Quality Commission and Monitor[2] were also implementing performance management approaches scrutinising standards via inspection, reviews and conducting annual health checks that were measured against quality and productivity measures.

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[2] Monitor is the sector regulator for health services and foundation trusts in England
https://www.gov.uk/government/organisations/monitor

The regulatory bodies were able to exercise legislative authority and provided a legal registration system for NHS providers to operate from (Healthcare Commission, 2008). All tiers of the system were monitoring and setting performance targets and key performance indicators that were expected to be achieved at every level. It was fair to state that NHS staff who was delivering the provision of services were presented with a high volume of performance targets to be provided that were cascaded from external agencies. Potentially it could have been perceived by staff within the NHS that the performance framework or regime imposed consisted of a very complex 'top down' 'command and control' structure designed to hold all NHS organisations legally to account, the resulting behaviours of staff are less well documented within the literature apart from a number of empirical studies that were conducted on organisational culture as previously highlighted by Mannion et al (2005).

It was claimed within the *Developing the Performance Management Regime* (DOH, 2008) document that by developing the set structure outlined in **figure 5.2** there was an opportunity for the Department of Health to devolve or cascade target based systems located at the top of the hierarchy down towards organisations that were lower down the structure to provide greater freedom and autonomy. It could be debated as to whether there was a true reduction of targets and indicators at a primary care trust level bearing in mind national minimum quality standards were being adopted by the NHS at the same time set by *National Institute for Clinical Excellence[3]* (The National Institute for Clinical

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[3] The National Institute for Health and Care Excellence (NICE) is an executive non-departmental public body of the Department of Health in the United Kingdom (NICE, 2009)

Excellence, 1999) that would require the on-going delivery of plans that would hold a number of performance targets expected to be delivered.

The regional NHS strategic health authorities were also producing performance target based documents that would monitor primary care trusts on an annual basis via the development of the primary care trusts strategic and local delivery planning framework that would cascade performance requirements to commissioned provider trusts. Primary care trusts would set out their performance requirements from NHS provider trusts aligned to their medium-term financial plans via the development of service agreements and local operating plans (See *NHS Operating Plan,* DOH, 2011). The strategic planning process of primary care trusts was significant as to the setting of the performance management framework as it set out all the performance measures and commissioning priorities that were required to be delivered from NHS provider trusts.

In 2010 the Department of Health challenged the established performance management approach and published the *NHS Outcomes Framework* (DOH, 2010). The new framework was very much based on a previously published White Paper produced by the Department of Health, *'Equity and Excellence, Liberating the NHS'* (DoH, 2010). The influential White Paper again claimed to be freeing the NHS from a target based system, therefore, ushering in a new performance management framework system more focused on outcome measurement (*NHS Outcomes Framework,* DOH, 2010). The need to emphasise patient outcomes and quality was stated in the *Performance Assessment Framework* back in 1999.

The White Paper (*Equity & Excellence*, DoH, 2010) proposed that there will be the support that would promote greater autonomy and empowerment for patients and staff. As can be seen in **figure 5.3** the outcomes based approach claimed that it expected to allow a new system to emerge that will become more transparent by informing patients more regarding the performance of NHS trust, enabling patients to exercise more choice and to empower professionals to become more autonomous

Figure 5.3 NHS outcomes based approach has been removed due to Copyright restrictions

Taken from: Equity and Excellence (DOH, 2010)

The exploratory study found a potential dichotomy in that a robust performance management system will also need to be in place to provide the expected performance information. This may not necessarily release professionals from the burden of a target/indicator based system as internal performance systems would need to be created.

The White Paper (2010) proposals may be interpreted as a significant move from the *Developing the Performance Management Regime* (DoH, 2008), however *Developing the Performance Management Regime* (DoH, 2008) had claimed it also wanted to devolve accountability down to patients to release the centre from imposing performance targets, although a regime based system structure of control from external regulatory bodies had emerged.

It was not clear within the literature whether there were any empirical studies conducted that evidenced that, *Developing the Performance Management Regime* (DoH, 2008) or *Equity and Excellence: Liberating the NHS* (DOH, 2010) had released professionals from the burden or volume of performance targets and whether patients were better able to hold the NHS to account than previously. Running alongside the two policy documents there was still a requirement for robust regulation to be conducted on primary care trusts and NHS trusts.

The new *NHS Outcomes Framework* (DoH, 2011/12) claimed it was very much in contrast to the previous frameworks as commissioning was expected to be shifted away from current senior and executive management and handed over to medical and clinical staff (Darzi, 2007). *Equity & Excellence* (DoH, 2010), indicated that costs would be saved on centralised data collection as this was perceived as too time-consuming and was feeding the previous performance management regimes. It is interesting to see that there was a need for greater patient and public transparency although it could be debated this may require a performance framework with a robust intelligence base in place to feed the

information to the public and may require more measures and targets to evidence performance.

The *NHS Outcomes Framework* (2011/12) provided the NHS with a set of outcome measures and quality standards that were set by the then Secretary of State for Health Andrew Lansley Member of Parliament to monitor the performance of the NHS. It was evident within *Equity & Excellence* (DOH, 2010) that it was the Secretary of State's intention for the new framework to support the legislation with regards to the delivery of reforms. General Practitioners were now in the driving seat forming new Clinical Commissioning Groups taking on the performance management responsibility in holding NHS Health trusts to account. So it could be argued there was a shift to an alternative 'top down' performance accountability structure as highlighted in **figure 5.4** below:

Figure 5.4 NHS Accountability Structure has been removed due to Copyright restrictions

Taken from: Equity and Excellence (DOH, 2010)

The Department of Health claimed that the new *NHS Outcomes* Framework 2011/12 (2010) provided another opportunity to move away from previous regimes and approaches and frameworks that may have been consistently based on process-driven targets, such as; waiting times and patient volumes. However, a number of these process-driven targets had been rolled over into the new frameworks.

It is evident from the document that the *NHS Outcomes Framework 2011/12* (DOH, 2010) had set out to combine three main performance frameworks across the NHS and local authorities see **figure 5.5** below:

Figure 5.5: Overlapping NHS Performance Frameworks has been removed due to Copyright restrictions

Source: NHS Outcomes Framework 2011/12 (DOH, 2010)

Local Authorities were expected to lead to public health and social care and the new clinical commissioning groups led by general practitioners were expected to

monitor NHS trust providers. The Venn diagram above in **figure 5.5** indicates how the expected measures were expected to overlap across, NHS, public health and adult social care services, however it may be criticised that the measures were still very much based on quantitative process driven indicators not performance outcomes and there was a strong similarity to the existing measures used for *Developing the Performance Management Regime* (DOH, 2008) as the basis for the scorecard with little additional measures.

The NHS Outcomes Framework (2011/12) spans three domains of quality:

- the effectiveness of the treatment and care provided to patients

- the safety of the treatment and care provided to patients; and

- the broader experience patients have the treatment and care they receive.

Source: NHS Outcomes Framework 2011/12 (DOH, 2010)

The above is measured by monitoring both clinical outcomes and patient-reported outcomes (aka PROMS), PROMS were used by acute care commissioners for contracting purposes to evidence whether the quality of care was being delivered. The expectation from primary care trusts that used these performance measures was to develop an incentivised performance approach to NHS Trusts to deliver quality, as a significant move away from the traditional waiting list based measures that were required within the previous set framework and it was not evident in the literature whether the *Developing a Performance Regime* (DoH, 2008) performance approach had been effective.

5.2 Exploratory Stage 2: Comparative evaluation

With exploratory stage 1 completed the study is now more aware of the external NHS performance management environment in which the case study organisation operates. It is now important to conduct a comparative evaluation (Ragin, 1987) to perceive through an external lens whether the imposed frameworks, *Performance Assessment Framework* (DOH, 1999) and *Developing the Performance Regime* (DOH, 2008) had produced, increased or improved performance outcomes as a result of their implementation

For stage two of the exploratory study, a comparative analysis was conducted on secondary data made available to the study that was extracted from existing NHS data sources.

Systems accessed included:

- The Spend & Outcomes Tool
- Programme Budgeting Benchmarking Tool
- Atlas of Variation
- NHS Comparators
- Health Investment Packs

The assessment was conducted internally within the case study organisation with a purpose to expose any potential relationships between cost, policy implementation and any resulting performance outcomes.

A mixed economic evaluation methodology was implemented; this was considered important by Right care (2010). Drummond et al (2005) had reported

that it was important to look at a range of economic evaluation tools to identify variation in performance outcomes from a point in time along a chronological path to enable the development and redesign of processes and services to improve healthcare delivery, this view was also shared by Seddon (2005).

Drummond et al, (2005) defined economic evaluation as the comparative assessment of costs and benefits of alternative health care interventions. This approach was supported by Gold et al (1996) who claimed that economic evaluation would be a growing interest due to the increasing and ongoing scarcity, affordability and demand for healthcare in the NHS.

The raw data was collated via Department of Health national data systems as already highlighted above and was accessed from available economic evaluation based tools. The study used predominately the *Spend and Outcomes Tool* (SPOT) (Right care, 2010) an already established Department of Health benchmarking tool that compares and contrasts primary care trusts and NHS Trusts against comparable peer cluster groups.

Benchmarking was an essential part of the comparability assessment process, Bogan & English, (1994) claimed that benchmarking provides an opportunity to motivate comparable organisations to learn from the best to achieve better results.

The chosen benchmarking tool analyzed estimated gross expenditure by programme budgets that consisted of twenty-two programme categories ranging from mental health disorders to infectious diseases see **Table 5.1** below:

Table 5.1 Programme Budget categories by gross expenditure has been removed due to Copyright restrictions

Source: Extracted online 1/11/13 from SPOT tool, www.rightcare.uk

Table 5.1 above provides a list in the second column that consists of a basket of conditions that can be measured against a set time period 2003 – 2011 within the subsequent columns that provides the gross costs per head of population for each programme and subcategory area. There were limitations to the data presented as it is not possible to cannot delve deeper into the detail beyond this

level of granularity, this made it more difficult to identify whether a process impact had influenced the cost and any resulting performance.

Costs are bundled into one subcategory that may have multiple variables influencing the performance outcome, this created a problem identifying whether there was a correlation between cost and outcomes. The analysis then proceeded to a second stage to benchmark performance against a comparable peer cluster group. The cluster group had already been selected by the Office for National Statistics (ONS) who had previously identified statistically comparable NHS organisations by measuring via a Squared Euclidean Distance formula (right care, 2010).

The organisation selected for the case study was Plymouth Primary Care Trust (PCT) that yielded a comparable cluster group of the following:

- Portsmouth City Teaching PCT
- Newcastle PCT
- Salford PCT
- Southampton City PCT
- Brighton and Hove City PCT
- Leeds PCT
- Bristol PCT
- Bournemouth and Poole PCT
- Liverpool PCT

An assessment was later conducted using the NHS Benchmarking tool to measure performance outcomes against the cost to identify the better performing

NHS organisations. The need to use cost against outcomes as a measure has been validated as an appropriate method by Rightcare (2010) who claimed that value and good performance to the patient, public and taxpayer can be established by the relationship between outcome and cost.

There were a high volume of categories that were analysed against the peer group to illustrate this further see **Table 5.2** that highlights the sub-indicators that related to infectious disease outcomes, www.ypho.org.uk/resource/view

Table 5.2 Infectious Diseases Sub-indicator has been removed due to Copyright restrictions

Source: data extracted online 1/11/13 from SPOT tool

www.ypho.org.uk/resource/view

Table 5.2 above provides the comparable performance outcome data that provides an indicative score calculated from the raw data against a negative or positive Z score, where 0 is measured closer to the national average. If a PCT was to receive +2 above the mean, there was a need to investigate as an outlier. **Table 5.3** also provides a national rank highlighting the lower figure as the better performing PCT.

Table 5.3 Infectious diseases expenditure measures has been removed due to Copyright restrictions

Source: Extracted online 1/11/13 from SPOT tool,

www.ypho.org.uk/resource/view

The analysis was then later compared looking at cost data shown in **Table 5.3** above, the sub-indicators in **Table 5.3** were bundled into one cost area: infectious diseases providing a national rank position alongside a cost per head of the procedure or treatment.

Figure 5.6 Expenditure by cluster group for infectious diseases has been removed due to Copyright restrictions

Source: Extracted online 1/11/13 from SPOT tool, www.yhpho.org.uk,

Figure 5.6 above highlights the spend and ranking for the case study and its cluster group where spend was much lower on infectious diseases per 100,000 populations, although Brighton & Hove PCT was much higher, but when analysis was conducted on the cluster group Brighton & Hove had a positive Z score of 3.01 and was ranked 11th nationally and Plymouth was ranked 67th, only spending £22per head in comparison to Brighton who was investing £68 per head. The Z-score had indicated that Brighton & Hove PCT was an outlier and required investigation.

The expenditures and outcomes measured against the Z-score[4], for every PCT spend was later analysed using the SPOT Tool on a spend and outcomes quadrant see **figure 5.7** below:

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[4] A z-score essentially measure the distance of a value from the mean (average) in units of standard deviations. A positive z-score indicates that the value is above the mean, whereas a negative z-score indicates that the value is below the mean. A Z-score below -2 or above +2 may indicate the need to investigate further. Each dot represents a programme budget category (SPOT Tool, 2011) www.yhpho.org.uk.

Lower spend Better outcomes	Higher outcome Better outcomes
Lower spend Worse outcome	Higher spend Worse outcomes

Figure 5.7: SPOT Tool spend and outcomes quadrant

All the programme categories for each PCT within the peer cluster group were analysed using the quadrant to look for better performance, for specific areas see the SPOT tool quadrant in **figure 5.8** below:

Figure 5.8 Plymouth SPOT Tool Quadrant 2011 spend has been removed due to Copyright restrictions

Source: SPOT Quadrant Extracted online 4/4/15

www.ypho.org.uk/resource/view

From **figure 5.8** above the lower spend and better outcomes are within endocrine, respiratory systems and circulation conditions this may indicate where good performance may have been delivered therefore there may be a relationship or link between outcomes and cost. The peer cluster group may be used to benchmark against the study organisation as there may be an opportunity to compare with other areas based on cost and outcomes, by identifying the better performing PCT's it would be interesting to explore whether there was a variation in the approach towards their performance management framework that study

organisation could learn from. For example, high spend worse outcomes for the case study organisation is within mental health, trauma and injury, there may be an opportunity to assess how other areas are producing even better results on similar measures and assess their performance management frameworks.

A full assessment was conducted on the case study organisation and its peer group however there did not appear to be any common trends emerging from the analysis and there was not a significant variation within the data.

On a number of occasions, the researcher was advised by the business intelligence Unit from the case study organisation to be cautious regarding the data quality, as a number of the indicators were found to have time lag and were being reported through a manual system, as opposed to automated data collection, this had the potential for the findings to be contaminated by bias, human interpretation and lacked generalizability and validity,

The tool found the worst performing programme area for the case study organisation was mental health promotion as it emerged with lower investment providing worse outcomes for the population. The researcher later assessed the case study organisation's internal budgets and found that spending in mental health promotion was being reported as being invested in other mental health sub-categories. Part of the problem to provide robust performance returns may have been due to the structure and design of Plymouth PCT having been a commissioner and provider of mental health services and was not in a position to extract from a number of budgets a specific budget for mental health promotion,

even though activity was being delivered from other parts of the organisation and was being reported as a surplus in another. This indicated to the study that the tool lacked sufficient rigour and validity to identify good or worse performing areas within the peer cluster group.

As the economic evaluation exercise was not sufficiently robust the study ceased to proceed with the economic evaluation and comparing and contrasting performance management frameworks on secondary data. An assessment was measured on secondary data against a basket of indicators that were set by the Office for National Statistics Health Profiles Assessment www.fingertips.phe.org.uk/health-profiles that included, life expectancy, healthy lifestyles and community health, just to name a few.

This provided an opportunity to compare and contrast two performance frameworks imposed by the Department of Health, *Developing the Performance Regime* (2008) that was predominately processed target based and the *NHS Outcomes Framework,* (2010).
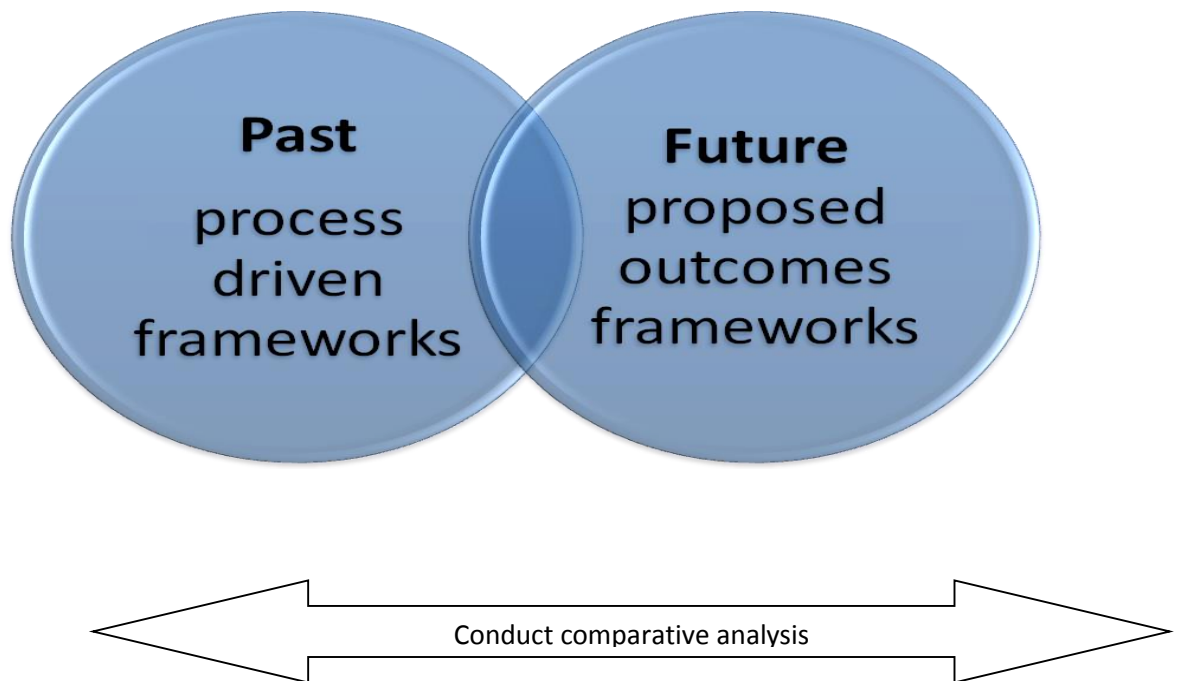
Figure 5.9: Comparing Frameworks

By conducting a comparative analysis utilising health profiles assessment the study hoped to expose what elements were more effective from both frameworks by conducting further investigation on localised performance frameworks and approaches. Unfortunately, due to the reforms imposed by the Department of Health, *Equity & Excellence* (DOH, 2010) the structure of the NHS changed significantly. The lead in time for the new *NHS Outcomes Framework 2011/12* (DOH, 2010) and the redesign of measures and data sources did not allow for the continuity of a like for like measurement and had significant implementation issues, therefore it became difficult for the study to conduct a robust comparable data collection, as too many variables had emerged to be considered that may have influenced the outcomes.

The comparative study based on the reported economic evaluation had identified a range of data sources although it was producing differing outcomes across the cluster group. An economic evaluation exercise conducted on secondary data had identified to the study that there are a set of statistical-based tools and techniques that can match spend/cost against outcomes.

Another factor came to light within the case study organisation as a result of the imposed NHS reforms. *Equity & Excellence* (DOH, 2010) Clearly the majority of the national data sources and agencies that were established to collect the data were disbanded. Significant changes had been made to the population boundaries for NHS organisations, in particular, primary care trusts moved towards new Clinical Commissioning Group populations that were straddling local authority populations. This made baseline measurement more complex and more difficult to track and as a result would have affected the rigor and validity of the results and findings.

The economic evaluation and comparative exercise were by no means free from criticism as it was statistical and deterministic in nature and the values of the variables were far too limited to be measured probabilistically. Cause and effect regarding the implementation of these frameworks on the overall performance of the case study organisation within a cluster group may require further investigation later and therefore will not be discounted for future post-doctoral research at a time when the outcomes data sources have been established in the NHS.

5.3 Exploratory Stage 3: The case study organisation

An exploratory study was conducted on the case study organisation at the very early stages of the research in 2008, with a purpose to establish the operating background of Plymouth Primary Care Trust (PPCT) and to expose their adopted performance management framework and strategic planning structures before embarking on implementing detailed primary research.

It was decided that a review of the case study organisation's performance framework alongside its strategic planning processes was important due to the potential relationship performance management may have on the organisation's annual strategic planning cycle.

The exploratory study involved conducting informal discussions with a wide range of staff that included senior leaders within the organisation and this involved collating literature from a number of secondary data sources. The data from the literature will allow the researcher to define potential problem areas and gaps that may exist regarding the factors surrounding performance management and strategic planning.

The main reason and purpose for PPCT in expressing an interest in conducting research on their performance management structure in partnership with the Plymouth Business School was to identify whether new ways of working could be identified and incorporated into their existing performance management framework.

From 2001 to 2013 PPCT was constituted as a local statutory NHS commissioning and provider primary care trust and was accountable for the health needs within the geographical boundaries of Plymouth City Council. Since its inception in 2001 PPCT acted as the lead healthcare organisation in Plymouth with a primary purpose to commission and provide health services to a population circa 275,000 people. PPCT had a lead role in commissioning a range of NHS acute and community trusts and was uniquely placed by also having a role in the provision of community-based adults, children's, mental health and learning disability services.

PPCT was placed in a position to act as the commissioner and provider of services and required to adopt a responsibility of internal purchasing and contracting that was not necessarily the standard design of primary care trusts in England at the time, See *Commissioning a Patient-Led NHS* (DOH, 2006). As a result of its unique organisational structure in comparison to other primary care trusts, the performance management framework of PPCT would be difficult to compare with the peer cluster groups (identified within exploratory stage 2) where primary care trusts tended to be sole commissioners of services.

The PPCT consisted of circa 4,000 staff with a skill mix that included medical, clinical, executive, business and administrative staff, see **figure 5.10** below:

Figure 5.10: PPCT Skill Mix 2009 has been removed due to Copyright restrictions

Source: PPCT Workforce Development Plan (2009)

Figure 5.10 above shows the majority of the staff was graded at 5/6 agenda for change pay ranges (NHS Employers, 2013) see **Table 5.4** below for pay ranges:

Table 5.4 Table of agenda for change bands effective 1st April 2014 has been removed due to Copyright restrictions

Source: *Agenda for Change Terms and Conditions Handbook, extracted online April 2015* *http://www.rcn.org.uk*

Having a high volume of 5/6 grades may have been due to the grading being more associated with nursing professionals where there was a larger percentage of staff. Medical and Executive level posts would be at a higher 9 and above, although senior management would be generally at an 8D level. **Figure 5.10** above indicates only a small percentage of senior management posts within the organisation.

The number of staff that were more likely to be aware of adopted performance frameworks may have been more likely to be within grades 8a to 9 Senior to Executive management. Grades below 8a were more likely to be operational management where their role was to deliver performance but not necessarily monitoring or reporting for decision-making purposes.

The skill mix tree in **figure 5.10** indicates that the larger percentage of staff may not be involved in any kind of overall strategic performance management process, but may be subject to the decision-making activity of higher graded senior management and Executives. Lower graded staff may be required to report performance to populate the performance framework but may not be able to view performance overall or be enabled to be a part of the performance management or strategic planning processes.

Performance management frameworks and scorecards that PPCT developed had been nationally recognised. Boorman, (2009) conducted a number of studies on primary care trusts within 2008/9 claiming that there was a direct relationship between the wellbeing of primary care trust staff and performance management.

Boorman (2009) highlighted that PPCT had in place an effective workforce performance framework that provided a good practice model or benchmark for other NHS organisations to follow. He claimed it enhanced the wellbeing of its staff as it provided an opportunity for real involvement at every level within the organisation. Boorman (2009) presented PPCT Workforce Performance Scorecard as a performance reporting case study as he claimed it produced clear and accurate workforce and financial information to managers. This involved PPCT combining workforce data from the Electronic Staff Record (ESR) system alongside real-time financial information direct from the financial ledger. By bringing financial and workforce information together, Boorman (2009) claimed it enabled the production of clear workforce plans. PPCT workforce scorecard utilised twenty-one measures that were extracted from two automated workforce and financial systems, Oracle and ESR as highlighted above.

The exploratory study found that the workforce performance scorecard that was highlighted by Boorman (2009) was being utilised by a number of operational team leaders and managers within PPCT to deal with the most immediate operational and problematic issues. The study found that it did promote corrective action by using the existing intelligence systems, however, the scorecard could only be used for operational purposes within the provider arm of the organisation and it was not necessarily being utilised by staff at all levels. The scorecard was not clearly aligned to the overall organisational strategic priorities where themed objectives were expected to be achieved. Measures aligned to an organisation's strategic plan was a requirement for a performance management framework to be effective that was proposed by Marr (2006) and Gates (1999) who claimed

that an effective strategic measurement system needs to combine financial, strategic and operational measures to gauge how it can meet its targets.

The exploratory study found that PPCT workforce scorecard although being presented as a good practice model nationally by Boorman (2009) was creating a potential risk to the overall performance of the organisation, as it was being used as a decision-making tool in isolation from the organisation's strategic priorities and objectives. Marr (2006) indicated in his texts that this lack of strategic alignment adds minimal value to organisational performance if there is a disconnection between the strategic and operational elements as they have the potential to become two opposing sides.

Boorman (2009) claimed it did provide a real benefit and added value to the well-being of staff but he was not able to substantiate this through his empirical studies. The exploratory study did find that workforce reports were being consistently sent out on a monthly frequency to four hundred operational managers, who at the time were expected to contribute and deliver support to the strategic priorities as well. So it could be argued there was an indirect effect or relationship on strategic performance overall however it was not evident whether operational performance reporting was influencing commissioning and strategic decision making.

The exploratory study conducted a number of informal discussions with the 8a grades and above and took note of their observations as to what elements, factors and functions should be included within the PPCT performance

management framework. To bring this together visually the study mapped out the wider business and performance management framework see **figure 5.11** below:
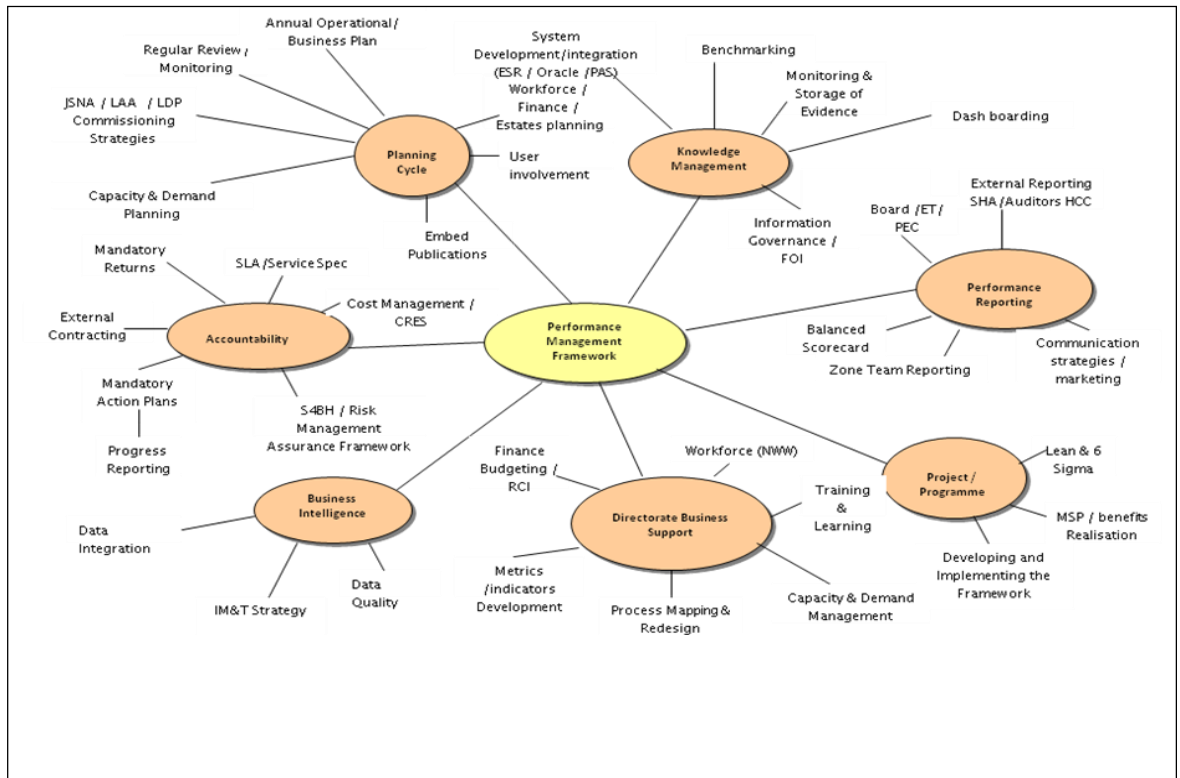
Figure 5.11: PCT Performance Management Frameworks

Source: Healthy Performance exploratory study

As can be seen from the mind map above in **figure 5.11** workforce and financial reporting is only a small but essential part of the framework providing business support to the Directorates of the organisation. It could be argued there should be weightings applied to the elements of the framework, however, this would create a larger number of variables that would be difficult to measure.

At any given time along the annual planning cycle see **figure 5.12** below: one element would need to carry a greater weighting, for example, business intelligence would have a higher level of priority during gateway 1 with the development of the strategic priorities bringing together the evidence bank and

finance would have a higher priority during the refreshing of the strategic framework and medium term financial plan in Gateway 2 & 3.

Figure 5.12 PPCT Annual Planning Cycle has been removed due to Copyright restrictions

Source: Strategic Framework for Plymouth 2010-15 (2009)

The exploratory study found it difficult to ascertain whether the framework was planned or designed or had organically emerged from the adoption of Department of Health policy implementation or the need for multiple systems and processes that had been created out of necessity.

The framework in **figure 5.11** highlights the sheer complexity of the existing system that is in place, the exploratory study found that the PPCT framework in 2008/9 consisted of a complex map of business support and planning activity to provide governance, accountability, reporting, scrutiny, business intelligence and

programme/project management to the organisation. This form of emerged organised complexity (Weaver, 1948) potentially contained many random and non-random correlated interactions and interdependencies that may have influenced the intrinsic motivating behaviour of the teams and individuals operating within all or parts of a whole complex adaptive system.

Individual's i.e. staff at any one time may not necessarily be aware of the whole framework or system, as the exploratory study found no one person had a whole or total coordinating role, the closest responsibility would be associated to the Director of Finance and the CEO. Performance management was not co-ordinated by one specific team or department even though there was a specifically titled performance management team that was located within the finance department. The performance management team was closely aligned with a business intelligence team of analysts and had the potential to carry an association with finance as opposed to a role of independent assurance.

The exploratory study found that performance reporting was not necessarily joined up between operational (providers) and commissioners, for example; the operational quality governance framework was reported separately within the provider arm of the organisation, whereas the strategic priorities were reported via the finance team at the Executive Management Team and Board meetings. This lack of alignment as a concern to performance was identified by Marr, (2006) and Michelli (2009).

The strategic reporting function did not focus on key operational areas such as, quality outcomes, patient satisfaction and clinical risk this was conducted by the operational provider service, the performance reporting function was focused on external accountable requirements, however this may not be as unusual as Kerssens-Van Dronglen et al (2003) proposed that there are two levels to performance reporting, the company reporting to external organisations such as, strategic health authorities and internally within the company between managers and subordinates.

As PPCT was both a commissioner and provider within the same organisation there may have been a potential issue although this would need to be tested for the provider may have perceived the commissioner as an external stakeholder within. This raised a question for the exploratory study as to whether PPCT performance management framework was sufficiently co-ordinated across commissioner and operational (provider) and whether it was able to capture and manage the performance of such a complex adaptive system (Johnson, 2009). Operating within this complex environment there was the potential for differing perspectives from staff regarding the primary purpose and function of performance management as to whether it was a support or hindrance to their role and work; this will need to be investigated internally within the primary research stage of the thesis.

5.4 Exploratory Study 3a the strategic planning process

The strategic planning process is essential for any organisation with regards to performance management as it provides a real platform from where an organisation can prioritise, manage, shape and develop its business and services within its given resources (Marr, 2007) (Kaplan & Norton, 1997). The next part of the exploratory study was to investigate the PPCT strategic planning approach, processes and methodology to observe its impact on overall performance management delivery.

From a local PPCT publication *A Strategic Framework for Plymouth 2010-15* (NHS Plymouth, 2009) it was well documented that the strategic planning process began with the setting of a vision agreed by the Executive Board of the organisation. The published strategic vision, *'Healthy people, living healthy lives in healthy communities'* (NHS Plymouth, 2009) was stated within the strategic framework document and was aligned to Plymouth City Council's ambition to become one of Europe's healthiest vibrant city and cited within, *Plymouth Joint Strategic Needs Assessment 2008/09 (*NHS Plymouth & Plymouth City Council, 2008).

The exploratory study found by conducting informal discussions and observations PPCT's annual strategic and business planning cycle had a direct relationship to the strategic performance management requirements. The priorities that are identified within the strategic plan are developed into performance targets and indicators that are a mix of national and locally defined measures, the measures form the basis of the performance reporting framework for the Executive Team

and Board outlined within a local delivery plan. Performance reporting and assurance is supported by the PPCT Performance Management Team located with the Business Intelligence Team.

PPCT Performance Management Team consisted of five senior managers who supported and directly reported to the PPCT Executive Team who brought together national and local priorities into the PPCT Business Plan, (NHS Plymouth, 2009). The Performance Management Team holds regular monthly performance monitoring meetings with related executives and operational senior managers to establish whether expected or planned performance is going off track from the plan. If the plans were off track the Performance Management Team were expected to support and guide the executives and senior managers into developing mitigating action plans that would assure the Board of delivery and that corrective action was taking place. The performance was also externally monitored against national targets and priorities that were set by the Department of Health and monitored via the South West Strategic Health Authority (*Developing the Performance Regime,* DOH, 2008).

The strategic and performance management framework for PPCT (NHS Plymouth, 2009) was aligned and incorporated with the requirements of national priorities set out by the Department of Health within, *NHS Operating Framework* (2010/11) and *NHS Business Plan 2011-2015* (DOH, 2010). Priorities were influenced by the strategic ambitions set by the local South West Strategic Health Authority within the document*, Improving health: ambitions for the South West* (SWSHA, 2008). Another document that helped to shape national and PPCT

performance requirements was published Lord Darzi, (O*ur NHS, our future* Lord,

Darzi, 2007, 2008) who had recently conducted a constitutional review on the

NHS and set out a number of recommendations requesting more patient-led

measures and clinical involvement.

The PPCT Strategic Framework (NHS Plymouth, 2009) was required initially to

establish a local strategic plan based on available evidence and the local

population's health needs as identified in the *Plymouth Director of Public Health*

Report (2009). PPCT conducted an extensive review from an evidence bank on

the retrospective performance results obtained from previous PPCT performance

and national reports. The evidence bank identified common trends and outliers

to set the performance baseline position for the PPCT. This was aligned to

operational performance and public health population-based needs

assessments, the evidence bank identified the future strategic improvement

priorities through the priority setting process that is outlined in **figure 5.13** below:

Figure 5.13: Stages of the priority setting process has been removed due to Copyright restrictions

As can be seen from **figure 5.13** above the first stage of the process provided the evidence to agree on the priorities and work streams for the organisation. The second stage took it a step further by developing ideas or projects to achieve performance. The programme of projects influenced the design of PPCT performance management framework. In 2009 the evidence bank was based around nine programme areas, see **figure 5.14** below:

Figure 5.14: PPCT Nine Health Programme Areas has been removed due to Copyright restrictions

Source: NHS Plymouth (2009) Strategic Framework for Plymouth 2010-15

As can be seen from **figure 5.14** above there were nine areas selected from, end of life care on the right to staying healthy on the left. To support and enable delivery, the health programmes were underpinned by IT, finance and HR, all health programmes fed into the PPCT Board and the Corporate Executive Team via a performance reporting framework. The exploratory study was interested in establishing whether there was an equal weighting towards local priorities identified within the evidence bank in comparison to national target requirements, the following explores the process in more detail.

The prioritisation process for PPCT was very much based on a Programme Budgeting and Marginal Analysis, (PBMA) methodology (Gray & Pierce-Smith, 2014) (Ruta et al, 2008), (Yorkshire & Humber Public Health Observatory, 2012) which was considered by PPCT as an established approved Department of Health systematic priority-setting methodology.

The evidence bank was summarised into a number of health programmes, the main aim of the evidence bank was to explore whether PPCT varied significantly from other primary care trusts as a form of benchmarking (Bogan & English,1994) (NHS Atlas of Variation, DOH, 2010) and (Rightcare, 2010). The performance was measured from targets and measures over time to look for emerging trends in the following areas:

- Needs Analysis- Incidence /prevalence and mortality
- Activity - including acute and primary care data

- Finance - programme budgeting, prescribing costs & productivity metrics (NHS Institute, 2009)

- Outcomes & performance from PPCT performance summaries

- Quality- patient survey results, feedback from stakeholders & complaints

- Reviews & inspections – *World Class Commissioning* (DOH, 2008) & Care Quality Commission reports

The evidence bank was analysed against a set criterion that looked at variation in activity, expenditure, value for money etc. This was quite ambitious as the only economic evaluation tools available were the SPOT tool and the programme budgeting tools (*NHS Atlas of Variation*, DOH, 2010) as highlighted in exploratory study 2 previously; the study has previously found a number of issues regarding timeliness, data quality and lag. Each health programme area was provided with a summary performance sheet for the Corporate Executive Team.

A wide range of measures were used against a red, amber, and green coded performance risk assessment to establish the priority areas, to support the identification of the priorities PPCT utilised a Programme Budgeting Marginal Analysis (PBMA) methodology that utilised economic and financial principles, Ruta et al, (2008) claimed that PBMA is very effective in focusing on how public resources are spent.

PBMA consists of two economic concepts 'opportunity cost' and the 'margin' (Donaldson et al, 2010) (Ruta et al, 2008), the opportunity cost supports allocative

decision making from the limited resources. By analysing the cost and effectiveness there is a potential to forgo other areas that may be creating little value towards the achievement of the strategic improvement priorities. By identifying cost opportunities, it allowed PPCT to decide strategically on what areas can be maximised within its budget envelope to obtain a better return on investment.

Ruta et al, (2008) claimed a marginal effect could be gained by looking at the cost of a number of disease condition areas by assessing their weighting and return on investment as comparable indicators. For example, if there was variation in the cost of hip replacement surgery against cancer treatment, cancer may be more weighted as it may have higher associated care costs than hips. By identifying the benefits and outcomes within the evidence base at the financial margin PPCT may have an evidence-based case to do fewer hips and more cancer treatment (Donaldson et al, 2010) in order to achieve a more economical level of rationalisation.

It was evident within the exploratory study that the PPCT baseline or platform developed for the strategic prioritisation process needed to consist of a comprehensive evidence base, not just financial opportunities gained but needed to include patient wellbeing and gain through the delivery of health inequalities as outlined in, *Plymouth Director of Public Health Report* (PPCT, 2009), this may not require such a financial rationalisation based approach such as PBMA. The study found within the available literature regarding PBMA reports that it had been used in over sixty health organisations in Australia, New Zealand and Canada but its sustained use had been limited as it required the adoption and acceptance of staff to be aware of resource scarcity (Ruta et al, 2008).

Ruta et al, (2008) claimed it did have the potential to align to the goals of doctors and managers to achieve economic aims and it had been viewed as useful in pulling together different views under one framework (Donaldson et al, 2010). The study found that PBMA is primarily concerned with identifying economic opportunities in cost rather than treatment and healthcare outcomes that may have supported the required efficiencies further in long run costs. The study found that there was a necessity for PPCT to support the specific programme budgets by incorporating actual service activity data and intelligence on needs, demand and quality alongside user experience presented as a form of balanced scored methodology as outlined by Kaplan & Norton (1997) rather than past performance reporting on historical measures that may not have been meaningful to service teams (Marr, 2009).

Although the advantages of the PBMA process may be its simplistic systematic evidence-based methodology, PBMA is based on agreed set criteria that provide a clear rationale and accountability for decision-making for senior management and corporate executive teams. When the PBMA strategic prioritisation process was complete the improvement priorities were agreed by executive/senior management/medical/clinicians and were then subsequently integrated within PPCT planning and project management methodology and principles as shown in **figure 5.15** below:

Figure 5.15: PPCT PBMA prioritisation process has been removed due to Copyright restrictions

Just before the NHS Reforms (*Equity and Excellence*, DoH, 2010) were implemented a new strategic framework was proposed for PPCT by the newly established GP Consortia. The system was titled, 'Sentinnel' which was a newly designed performance framework that replaced the previous PBMA evidence-based approach by adopting evidence from a demand on the referral system. Data was produced from GP referrals and was expected to evidence need and demand to act as a point of measure. Sentinel claimed that the health population's needs could be identified from the referrals of patients and therefore act as the baseline to set the strategic priorities proposing that patients will have more choice on referral, improved access, reduced waiting times and as a result may reduce costs for PPCT.

Figure 5.16: Proposed PPCT Healthy System has been removed due to Copyright restrictions

This system was never fully implemented and was not evaluated or reviewed at any time and therefore could not be empirically tested to establish whether it was

a more effective alternative to the PBMA based strategic planning system. The study found that the Sentinel system may be a suitable framework to measure demand and capacity from patient activity, although its limitations were measuring the wider population's health needs and outcomes that do not necessarily enter a GP/primary care referral system. The Sentinel system in **figure 5.16** was based purely on the demands of one part of an operational service and did not include the needs identified to improve overall public health outcomes to prevent ill health for the total population as outlined in, *Plymouth Director of Public Health Report,* (PPCT, 2009).

The study subsequently found there was an expectation from the GP Consortia that GP and IT capability had the ability to purely drive the rationalisation and decision-making process for PPCT, this indicated a 'designed effort' approach (Lohman et al, 2002) as opposed to utilising intelligence and knowledge, learning and understanding by the whole organisation through PBMA. PBMA may have been more in tune with the value and rationalisation of care based on needs incorporating the dynamics of an overall evidence-based system and its impact, recognising it more as a 'coordinated effort' on population and patient well-being (Lohman et al, 2002).

5.5 Chapter Summary

In summary, the exploratory study chapter has investigated a number of areas that has involved reviewing performance management frameworks internally within the NHS and has looked at its design alongside taking account of its external accountable agencies.

The Department of Health within its history has implemented a number of major transitional reforms on the NHS (Robinson & Le Grand, 1994) *Performance Assessment Framework* (NHS Executive, 1999) *Equity & Excellence* (DOH, 2010) as a result the subsequent imposed frameworks may have had an impact on staff and the perceptions surrounding performance management. The NHS performance management frameworks are based primarily on contractual relationships within a system of organisations that have adopted a top-down governance approach. This may indicate that a dominant command and control performance management approach may have been adopted by the NHS, to evidence this and to identify a possible alternative approach a primary research stage would need to be conducted.

The study found that a number of new frameworks have been implemented (*NHS Outcomes Framework 2011/2012,* DOH, 2010) that is expected to release the burden of targets on NHS professionals, this will require the development of a number of internal indicators and measures to populate the information system. This, however, may potentially increase not decrease the burden on staff if an effective performance management system is not in place.

The chapter went on to conduct an economic comparative analysis by utilising a range of tools and using the secondary data available, unfortunately, due to data quality issues the tools were not sufficiently reliable or robust to conduct a valid analysis, however a methodology has been identified that could be utilised for further study when the data quality improves in the future.

The study went on to explore the case study organisation via an internal review of the secondary data available this was conducted ethnographically (Denscombe, 2003). The study was able to identify the current internal performance management framework where a best practice workforce scorecard was being implemented (Boorman, 2009). However, the scorecard was only being used for operational service based purposes and it lacked the strategic alignment necessary that was outlined by Marr (2006) previously within the literature review.

The exploratory study went on to investigate the case study organisation's strategic planning processes and methodology looking at the evidence bank and the adopted strategic planning PBMA process (Gray & Pierce-Smith, 2014) (Ruta et al, 2008), (YHPO, 2012). It was difficult to identify the effectiveness of the process and whether it had improved performance and there was no documented evidence that highlighted the potential impact on staff that were subject to its implementation. Operating within this complex environment there may be the potential for differing perspectives from staff regarding the primary purpose and function of performance management as to whether it was a support or hindrance to their role and work; this will need to be investigated internally within the primary research stage of the thesis.

Overall the exploratory studies did not close the gaps in knowledge that were identified from the literature review but had provided a more detailed description as to the environment, structures and process from which the NHS was operating within that concerned performance management. The exploratory studies

provided further evidence and information to support the development of the research questions that will be covered in **Chapter 6** next.

6. Methodology & Methods

To test the research questions and the posed conceptual model set out in the previous chapter that was identified from the literature review there was a necessity for a primary research investigation to commence to further explore the common themes and the phenomena surrounding performance management in greater detail.

6.1 A guide to the methodology

The following section sets out a guide to the methodology chapter to support the reader at the initial stages and to enable them to navigate through.

The first section provides a brief background and outline with relevant points to introduce the reader to the chosen methodology, further details will be provided in the subsequent sections this will support the readers thinking before identifying the required research philosophy and philosophical framework. The chapter then moves on to consider two research traditions, positivism and social constructivism (Denscombe, 2003) and then reviews the most appropriate research tradition by ensuring that the approach that is adopted meets the overall requirements to test the realities of the individuals.

After selecting the most appropriate research tradition a philosophical framework will be chosen that will be expected to underpin the methodology throughout the primary research stage, the philosophical approach will be selected by taking into consideration the observed and experienced phenomena alongside the work of the relevant philosophers. As a result of the research philosophy and the

philosophical framework having been established the methodology will then move onto to consider whether to adopt post- modernist or modernist approaches, this will be achieved by placing into context the nature of the participant's world within the chosen field.

The chapter will move on to reviewing the existing traditional command and control mechanistic approaches towards performance management that were originally set out by Taylor (1912), and look at the feasibility of this approach against the more postmodern organic approach that was highlighted by Cooperider et al, (2005). The research approach will be selected by evaluating whether it is more appropriate for the methodology to choose between inductive or deductive reasoning or logic (Locke, 2007) (Kervin, 1992) (Bryman and Bell (2007) (Seekran, 2003) (Denscombe, 2003). The chapter will outline how the methodology can move away from the traditional problem-solving approach towards a more dynamic model to test the conceptual framework and the posed research questions set out in **section 6.11.**

The methodology chapter will then move on to the proposed research design that will have been supported by the formulation of the underlying research philosophies and the theoretical framework, the research design will set out the qualitative data collection methods and highlight how it can connect to the overarching research questions to support the credibility of the study.

The position of the researcher will be an important factor for the study due to the requirement to analyse the social world of the participants, therefore the

methodology chapter will set out a rationale for choosing the ethnographical approach and will seek to place the researcher into a position to observe the behaviours of the participants within the context of the NHS.

The chapter will outline a range of qualitative research techniques and tools that will be implemented consisting of surveys, focus groups and semi-structured interviews, presenting the methods used and the profiles of the participants selected and explaining how relevant available documentation within the field will be analysed.

The research plan will provide a roadmap that will present how it can test the research questions and will outline the required method of testing at the various stages to ensure the study can arrive at the required outcome. Without implementing a robust plan there may be a risk presented that may create a difficulty in obtaining the right data and intelligence. The chapter will then highlight the steps that have been taken by the researcher to address the potential ethical issues that may be prevalent, in particular issues surrounding the position of the researcher and recognising the influence they may have on the study participants and the risk of bias. The methodology chapter will then finally close with a brief summary picking up all the relevant points to enable the reader, to move onto the findings and analysis.

6.2 Background to the methodology

The methodology required sufficient rigour and validity to provide the coherent answers to the chosen research questions, however, there was a need to investigate the 'reality' of the individuals, delegates, participants or actors within the phenomena. This required a common mutual understanding between researcher and participant whilst working within their realities that were partially external to the researcher as they were employed within the case study organisation.

The methodology needed to ensure that the researcher was positioned to deliver a level of independence and impartiality whilst exercising a level of unconditional positive regard (Rogers, 1951 & 1961), ensuring that all points of view provided from the delegates were considered valid. Knowledge captured, acquired, obtained and documenting these realities took into account ontological and epistemological considerations (Bryman & Bell, 2007, Creswell, 2007, 2003).

The data collated a considerable volume of narrative and thick descriptions (Hammersly, 1990) (Gerttz, 1973) from the participants that needed to be analysed based primarily from within the participant minds as a perspective on the environment. The reality of the delegates or their truth was fundamental in understanding the factors surrounding performance management, therefore a robust methodology was essential in minimising the risk of bias.

Due to the ontological nature of the knowledge it was sensible to base the methodology within the relativist school of thought as all statements provided

were relative in some way to the truth of the participants (Easterby-Smith et al, 2008). Taking a relativist concept provided an opportunity to consider that there was no absolute truth surrounding the chosen field due to the potential prevalence of multiple variables and the broad nature of performance management that had been highlighted in the literature review. Perception of the individual from the delegate's frame of reference was considered to be of great value, providing an opportunity to incorporate used language, symbols and culture (Easterby-Smith et al, 2008). The data was collected directly from the individuals that required direct and indirect researcher interaction, however, the study utilised a multiple methods approach to ensure that triangulation supported the validity of the findings, see **figure 6.3** below
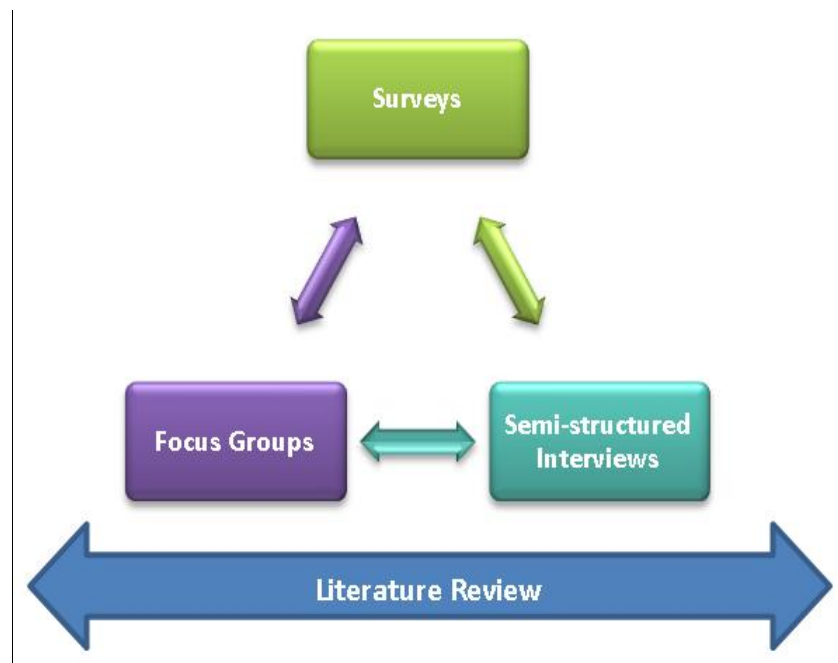
Figure 6.3 Triangulation of mixed qualitative methods used

The data above in **figure 6.3** was collected as a snapshot at the time of the participant's reality; unfortunately, it was not possible to collate data and

information on all their thought processes and mental frameworks and the broader determinants. As all the truths within their realities were difficult to obtain it was decided that a representationalist[5] view needed to be implemented. This was achieved by taking into consideration the perspective that people potentially have the ability to perceive the world differently and that their conscious experience may not necessarily be the real world but formed from representations acquired from an internal mindset formed from their sensory input (Bandler & Grindler, 1981, 1975).

First-hand knowledge was not considered as a coherent concept as knowledge may have been acquired from a multitude of experiences that may not have been obtained from their existing environment. The methodology, therefore, needed to ensure that the primary research phase prioritised the search for common trends, emerging issues and understandings obtained directly from the delegates.

The literature review had already uncovered differing viewpoints regarding the purpose of performance management presenting an issue with regards to associated multiple realities, arguably this may have been due to the socially constructed world of the individuals involved therefore it necessitated a phenomenological approach to be adopted (Denscombe, 2003). Whatever counted as truth to the persons involved was deemed more important than any facts as the truth was within the realities of the participants as the delegates may

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[5] '*The doctrine that the immediate object of knowledge is an idea in the mind distinct from the external object which is the occasion of perception*' http://www.merriam-webster.com/dictionary/representationalism, Extracted online22/08/15

have been naïve to the facts when formulating perceptions and beliefs (Bandler & Grinder, 1975, 1981).

The methodology took into consideration the need to be aware of potential discourses and bias of the researcher, to ensure participant truths were not contaminated the researcher kept a personal journal log (Breakwell el al, 1997) and when dealing with the participants the researcher exercised sufficient mutual understanding and unconditional positive regard (Rogers, 1951, 1961). This was further reinforced by obtaining a sufficient number of perspectives from a wide sample utilising a range of qualitative tools and implementing the triangulation method outlined in **figure 6.3** above.

By adopting a qualitative ethnographical approach, the researcher was able to immerse themselves into the world of the individuals to delve deeper to understand the nature and scope of their knowledge and to identify epistemologically what was regarded as acceptable within the field of performance management (Denscombe, 1983). It was not expected that quantitative scientific empirical methodologies would have yielded such high volumes of truths from the individuals in comparison to the qualitative based social science methodologies that were implemented by the study, as it was considered that the knowledge that was obtained was socially constructed via the delegate's personal meanings and interpretations from within their internal world. The purpose of primary research at this stage of the study was to examine the phenomena in more detail by yielding data from accessible sources within a local NHS organisation. By conducting the primary research, the intention was

to obtain a number of coherent answers to the set research questions set out in **section 6.3** and to test the conceptual model set out in **section 6.2** within a robust qualitative methodology. It was more appropriate to conduct inductive approaches as it ensured that relevant contextual information and data could have been better captured, allowing the appropriate rigour and validity to be achieved. A qualitative post modernistic ethnographical social science methodology was chosen as the most relevant application to the investigation's aims and objectives.

The methodological design was primarily influenced by the philosophical work of Descartes (1641) see **Section 7.2** taking into consideration the phenomena of dualism where mind and body could be considered separate by studying the "subject" (the observer) and the "object" (the observed) through perceived truths. The study utilised a theoretical framework based on 'appreciative inquiry' methodology that was originally founded by David Cooperider (Cooperider et al, 2005) that supported the collaborative change management model (Busi & Bittici, 2006).

Forms of collaboration models in performance management have already emerged and have been adopted by a number of organisations in areas such as logistics management and HR. An example of a performance management model can be found in **Figure 6.4** below:

Figure 6.4: A collaborative performance management approach

Source: Busi & Bittici. (2006)

Figure 6.4 highlights a requirement to collaborate positively with a number of influencing factors that would be important towards performance management development, this very much is similar to having an appreciation of all elements that are interrelated within a whole system approach proposed by Seddon, (2003) and Bevan (2009).

Other theories that contributed towards the theoretical framework included John Seddon's (2003) work on *'system based theory'* where his discourse viewed organisations as developing organic living systems similar to Agyris (1978)

'double loop' learning model that promoted the adoption of the learning enabled organisation.

The requirement to adopt an ethnographical approach (Hammersley, 1990, Denscombe, 1983) was an opportunity as significant time was already being spent by the researcher within the chosen field and study environment; this allowed the researcher to gather real not virtual data as an employee, acting as both participant and observer providing accurate real life observations of the phenomena. The ethnographical approach allowed the researcher to understand all the relevant internal realities, cultures and behaviours of the individuals and groups and provider greater access to get into the minds of the subjects and experience from their discourse, worldview and perspective.

6.3 Research philosophy

Before a theoretical approach could be identified there was a need to look at the two research traditions of positivism and social constructionism (Denscombe, 2003). The positivist school of thought implied that research should only be concerned with the external, measurable, scientific empirical evidence (Denscombe, 2003). However, the reality that is to be measured by the study within the primary research stage was taken from internal realities such as, cultures, beliefs and intangible perceptions. The external reality of individuals was of importance but the internal was deemed essential in recognising the internal intrinsic world of individuals, therefore a positivist school of thought was discounted and a non-positivist approach was adopted

Social constructionism suggests that 'reality' should not be objective or exterior, but internally based and socially constructed along with the perceptions and meanings that people apply to it. Social constructionism focuses on how individuals make sense of the world through the sharing of experiences, this could be achieved by using approaches such as Appreciative Inquiry to open up the possibilities and considering how different groups and individuals can perceive realities differently (Denscombe, 2003).

Social constructionism provides a greater association with the theoretical framework that was based on a collaborative appreciative inquiry model (Cooperider et al, 2005) (Busi & Bittici, 2006). Social constructionism does not rely on scientific quantitative methodology, as the study needed to incorporate the realities and meanings of the delegates that were perceived to be socially

constructed (Denscombe, 2003). The methodology required socially constructed concepts and personal understandings to be identified to uncover the basis of the delegate's knowledge and understanding surrounding performance management.

The literature highlighted that social constructivism is from a postmodern school of thought very much is based on the work of Berger (1966) and Gergen (1973, 1982, 1985, 1994) who had both examined the communication of individuals and the assumed meanings that were developed by the individuals. Postmodernism proposes that language is of importance as this is how people construct their reality; therefore, the collection of the narrative via field notes transcripts, audio recordings etc. from delegates will be of significant importance to the findings very much supporting the relativist approach that was highlighted earlier and the philosophy of Descartes (1641), Marx (see Engels, 1975) & Habermas (1979, 1984).

6.4 The philosophical framework

The works of Descartes (1641) and 'dualism' was fundamental to the methodology of the study, as a philosophical thinker he focused on the mind and the individual having perspectives on the world that could be formed as a result of subjectivity rather than objectivity (Descartes, 1641). Cooperider et al (2005) supported this philosophical approach to support their work on *Appreciate Inquiry* that will be explained further.

Descartes (1641) presupposed the existence of the mind as non-physical although recognised that the mind and body are joined together but are not identical. Descartes (1641) proposed this notion as the phenomena of 'dualism' (Robinson, 2003), placing real importance on thought, perception and shared beliefs as being a major influence to shape individual behaviour from a non-physical world.

This philosophical framework placed great importance on dualism and the need to consider socially constructed concepts as a phenomenological approach (Denscombe, 2003). It emphasised the importance of understanding how individuals operated within a performance management environment within an NHS context and allowed the exposure to gauge how individuals made sense of the world around them (Denscombe, 2003).

It was essential to understand the essence of the experienced phenomenon directly from the delegates involved and to capture and assess the key perceptions and factors that underpin performance management. An advantage

of adopting the phenomenological approach was that there was no reliance on empirical measurements and statistics. However, by utilising a non-positivist method this could have been deemed as its weakness, the investigation could have been criticised as having a lack of scientific rigour and validity from the positivist camp as the methodology relied heavily upon subjective assessment (Denscombe, 2003). Other criticism that may have been applied was its reliance on the narrative description from a discrete number of participants rather than a quantitative statistical analysis that may have been taken from a larger sample. The phenomenological approach could have led to generalisations being taken from a smaller study sample in comparison to the scientifically based approach (Denscombe, 2003).

Adopting a phenomenological methodology provided a very rich detailed account that highlighted the complexity of the phenomena that may have only been achieved by understanding and observing their internal participant's social worlds. By providing a wide range of qualitative social science-based tools that described and interpreted the stories of the individuals involved based on their perceptions, beliefs and attitudes and by taking a more humanistic approach, the study was able to place human experience and social life at its very centre and core.

The literature review highlighted that established performance management frameworks had already been implemented within the NHS by the Department of Health; therefore, delegates involved in the investigation were abler to describe the past and real-time events and use their experience as a platform to predict,

test and forecast the effectiveness of future models or approaches. The nature of being in their world enabled the delegates to draw from their everyday life without their experience having been analysed or theorised in any way, free from any bias towards a preferred model or approach. Phenomenology has its roots from the founding father and philosophical thinker, Edmund Husserl (Husserl,1970; Smith & Smith; 1995) who aimed to understand the universal aspect of human behaviour and existence and broke away from the scientific traditions (Denscombe, 2003). By implementing the phenomenological ethnographical approach, the study ensured people were provided with a respect for their lived experience providing interesting primary data that will be covered in the findings and analysis, **section 7** later.

Another important aspect to consider for the philosophical framework on how people socially construct their world will be to observe the 'communicative action' (Habermas, 1979, 1984) of individuals by obtaining an understanding of their language, jargon and interpretations to enable them to self-reflect. Another influential thinker and philosopher that came from the German or Frankfurt school of philosophy and thought was Jurgen Habermas (1979, 1984). Habermas (1979, 1984). had observed the potential for individuals to dynamically change via their interpretations of the world, Habermas (1979, 1984) proposed his theory of *'communicative action'* that the individual has the potential to be liberated towards change and learning. Habermas (1979, 1984) believed that psychoanalysis was important in this area as it held the key to interpreting language and linguistics based on communicative competencies.

From the work of Habermas (1979, 1984) a number of psychoanalytical concepts were considered within the philosophical framework, the work of Carl Rogers (1951 , 1961) who placed the individual at the centre with total respect and trust, Bandler & Gindler (1981) who pioneered 'neuro-linguistic programming' (NLP) based on the work of Milton Erickson (Rossi & Ryan, 1985) where the individual via language, meaning and by reframing their interpretations and mindsets could be freed or liberated from limiting perceptions to seek their full potential.

Habermas (1979, 1984) & (Bandler & Gindler, 1981) focused on the potential of the individual to be liberated from existing traditional thought, proposing that individuals can go beyond their mere existence of just knowing. This was important when investigating the fixed limitations of the command and control dynamic (Seddon, 2005) and the potential move towards a more organic learning organisation. Habermas (1979, 1984) was in support of Marxian philosophy (Engels, 1975) where society did not have to remain static or fixed and where people can find a potential to discover an alternative way of thinking and working to create a different environment.

Another influential philosopher that looked at the liberation of the individual was Kant (1788), Kant (1788) proposed that a person can be free from the just knowing, similar to Habermas (1979, 1984) and proposed that knowledge needs, to begin with, experience of an individual's world and reality that can be generated from their actions and interactions.

Habermas's (1979, 1984) view on critical knowledge and self-reflection supported the notion that individuals could philosophically rather than behaviourally free themselves from imposed performance management regimes that may have been traditionally imposed by the Department of Health. To counteract these top-down command and control methods the work of Habermas (1979, 1984) will be considered regarding the potential of perceived learning, social thought and communicative action. The philosophical approaches identified will play a fundamental part of the philosophical framework of the methodology, to enable the potential for an alternative approach towards performance management to emerge.

6.5 Modernism Vs. postmodernism

Now the research philosophy and the philosophical framework have been established the methodology will need to consider whether to adopt a post-modernist and or modernist approach.

Modernism is very much based on the premise that knowledge can be sought through reason, logic and rationality (Denscombe, 2003). A traditional research approach that emerged from the 18th Century viewed the perspective of objective truth being determined by investigation through scientific rigour and validity. In contrast, the postmodernist approach leans more towards everybody's perspective being valid within the phenomena being investigated (Lewis et al, 2008) that does not require a scientific empirical methodology, therefore considering the theoretical framework highlighted earlier in **section 6.2** it would make sense for the study to adopt a more post-modernist methodology.

It could be debated that the scientific modernist approaches developed by the prominent statisticians, such as, Edwards Deming (1982, 1986, 2000) had influenced modern performance management approaches, this can be seen via the NHS value for money efficiency agenda where it was claimed it needed to adopt a number of tools to reduce unwanted variation (right care, 2010).

This necessity to plan and predict may have become an essential role for performance management as highlighted by Seddon (2003), however, Seddon (2003) looked at the need to reduce variation in systems rather than applying it towards quantitative based targets like Deming (1982, 1986) had proposed.

This modernist approach from Deming (1982) & Taylor (1912) has the potential to hold the NHS to a rigid mechanistic culture, this will be discussed further. If we apply more modernist approaches to the methodology, we may yield scientific data that may not fully expose the potential organic developmental approaches that the study is setting out to explore and discover.

In contrast, the post-modernist movement looks at a freer no right way of doing things as it is related to the organisation of people and human interactions. Postmodernism looks at the how we dynamically socially construct ourselves through our social and communicative action (Habermas, 1984, 1979) (Kant, 1788), whereas modernists perceive people as having a fixed identity where knowledge can be obtained through rational scientific research independent of the discourses outlined by Habermas (1984, 1979) & Kant (1788).

Postmodernists perceive truth in a multitude of ways more importantly from the beliefs & attitudes of the individual's subjective internal reality as opposed to external objective logic and reason. If you were to view organisations from a post-modernist perspective there would be an opportunity to identify an alternative freer performance management approach, perhaps a more locally determined framework based on the organisation's ability to adapt to the imposed environment (Bevan, 2009) (Keller & Price, 2011).

A number of postmodernist authors, Lewis (2008) Senge (1990), Morgan (1997), Wheatley (1999) & Cooperider et al (2005b, 1987) have all challenged this fixed modernist thinking, claiming that perceptions of the experience and the stories and narratives we provide as human beings are far more essential than independent scientific empirical measurement (Lewis et al, 2008).

Therefore, it was essential to base the investigation from a more post-modernist approach towards performance management on the premise that individuals have an ability to adapt to their changing circumstances (Bevan, 2009), (Keller & Price, 2011), (Marr, 2006) & (Lewin, 1946, 1951).

6.6 Mechanistic Vs. organic

It has been claimed in the literature by Seddon (2003) & Cooperider et al (2005) that organisations can be perceived by modernists as machines that only require intervention when they break down or do not have the capacity or ability to provide sufficient productivity (Lewis et al, 2008). This type of discourse or collective understanding leads to a notion that it is only when problems arise that

organisations need to change. This distancing from the human dimension and the social construct concerning an organisation's ability to change needed to be investigated further.

As noted in the literature review and methodology chapters earlier Taylorism and the *Principles of Scientific Management* (Taylor, 1912) gave rise to a need for organisations to performance manage from a scientific causal basis. It could be argued that Taylorism and his mechanistic approach to productivity and efficiency may have influenced the role and purpose of performance management (Cooperider et al, 2005) (Seddon, 2005) in the NHS today as a primary application for business management to support, manage and measure performance.

Within the literature it was evident that in the past the public sector alongside industry and commerce has applied an emphasis on production processes and procedures (Deming, 1982) that have been traditionally scientifically conceptualised from a discourse that the organisation should be perceived as a rational machine that can be scientifically measured (Deming, 1982, 1986, 2000).

By taking into consideration the mechanistic approach this would indicate that changes need to be made to the processes when there is a problem looking at productivity output measurement through targets (Seddon, 2005).

It could be generalised that Frederick Taylor (1912) gave birth to the modern productive organisation or business by applying a scientific mechanistic approach

towards business management, placing real importance on process rather than people and on the design of the organisational structure (Cooperider et al 2005). The researcher found from the high volume of texts available that succeeded the publication of '*Principles of Scientific Management*' (Taylor's 1912) that this mechanistic approach is still currently established as a recommended performance approach (see Spitzer, 2007, Austin, 1996 & Deming, 1986).

Performance management may not have been coined or termed during the birth of Taylorism but it could be argued that there are many parallels and criticisms that do exist regarding the Taylor (1912) approach. For example, productivity, job measurement, evaluation, target setting, standardisation, value for money & efficiency have been regarded as organisational virtues (Lewis et al, 2008) (HM Treasury, 2004) by the NHS.

As stated earlier Taylorism was based on the premise that organisations could become more predictable and to do this there was a necessity to promote a command and controlling dynamic to achieve the predictable outputs. The major criticism of the mechanistic approach is that it omits the unpredictable emotional human interactional element that may be key in producing better performance outcomes (Marr, 2006) (Cooperider et al, 2005). de Waal (2002) as a result of conducting empirical studies within the NHS claimed there existed a human tendency or dynamic for NHS staff to resist change that potentially may have been as a result of imposed controlling behaviours, this may cause the organisation to become less effective in producing better outcomes.

More recently amongst business management and organisational change texts there has been further development of performance management as a concept beyond Taylorism (Seddon, 2003, Cooperider et al, 2005) that has also been established amongst a number of other leading business management authors such as, Deming (1986, 2000) the pioneer of 'Six Sigma' who adapted the mechanistic approach of Taylor (1788) to look at quality, albeit from a scientific perspective not a humanistic dimension, claiming that the overriding indicator of good performance could be calculated from the ratio of work divided by total costs as the denominator.

Deming's (1986) discourse was that the business entity or organisation is not necessarily separate and could be interdependent and interrelated, Bevan, (2009) supported this notion see **section 4.8;** therefore, the study will need to measure the NHS as a whole system.

Bevan (2009), (Keller & Price, 2011), Michelli, (2009) Neely, Adams & Kennerley (2002), Marr (2008), Axson (2007), Kaplan & Norton (1984, 1992) & de Waal (2002) all looked at the ability of an organisation to generate increased performance outcomes through the enhancement of self-learning and the organisations ability to sustain and adapt to changing environments and market fluctuations and conditions. Therefore, perceiving the organisation as an organic self -learning entity as opposed to a mechanistic form was considered as a possibility for this investigation to answer the set research questions.

6.7 Research Approaches

The study found within the literature two broad research approaches that could have been adopted i.e. inductive or deductive reasoning or logic (Locke, 2007) (Kervin, 1992) (Bryman and Bell (2007) (Seekran, 2003) (Denscombe, 2003). Deductive research involves the testing of a hypothesis from collected data to test a theory which requires the need to evaluate deductive arguments to evidence its validity; a conclusion can then be formed from its status. Arguments can then only be valid or invalid; a good example of a deductive argument that can be applied to the chosen field can be viewed in **figure 7.1** below.
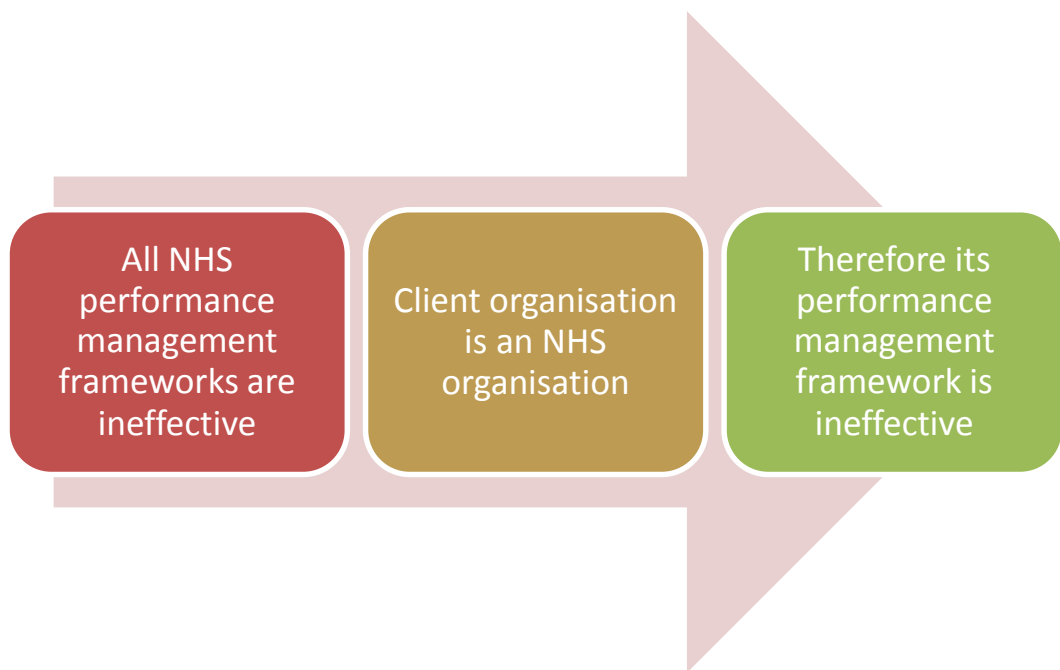
Figure 7.1 Deductive reasoning on NHS performance management

One advantage of the above deductive approach in **figure 7.1** is that it can provide a level of validity and reliability towards the results and findings as the methods adopted can be repeated; hence it can be argued that conclusions are

generalizable to other fields of business management (Guba & Lincoln, 1988, 1994), however a major disadvantage as an approach when applying deductive logic is that it may not fully capture the internal intrinsic aspects of performance management and all its factors (Bryman and Bell, 2007).

In contrast, inductive reasoning has the ability to construct and evaluate from abstracts, perceptions and observations, inductive reasoning suggests that truth can move away from generalisations and move more towards experiences that may not be replicable; an example of this can be highlighted in **figure 7.2** below:
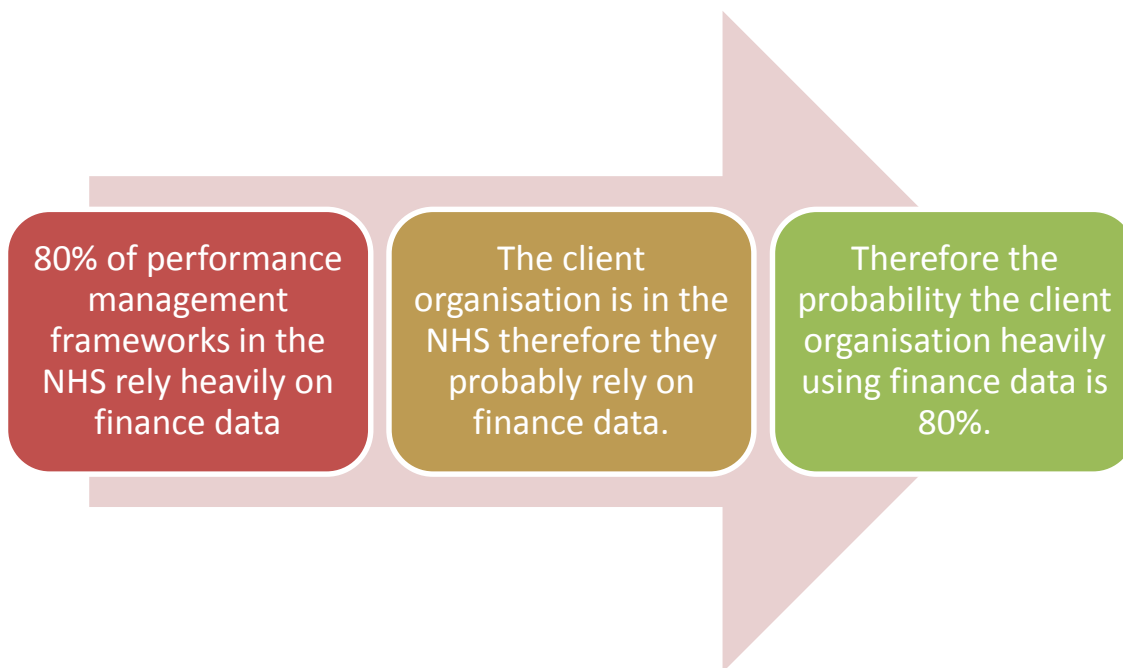
Figure 7.2 Inductive reasoning on NHS performance management

The inductive reasoning method set above in **figure 7.2** provides flexibility for social science as the conclusion of the research may be false but it may be based on the individual reality or perception. Inductive methods provide an opportunity to look at qualitative narrative methods whilst being able to exclude any form of

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mathematical statistical reasoning that would be deemed as deductive and generalizable.

The general principle of using inductive reasoning for the study is to base the research on observations that can identify the intrinsic internal world. Conclusions that were formed were based on educated probabilities and predictions from a position of the first-hand experience, although this was dependent on information that was readily accessible and available to the participants. The study set out to establish whether there may be some type of pattern or order regarding the factors surrounding performance management, it would have been more difficult to prove its existence unless a flexible form of inductive reasoning (Locke, 2007) could have been implemented.

6.8 Theoretical framework

The main emphasis for the theoretical framework was to move performance management from the traditional position to an alternative approach i.e. from a mechanistic (Cooperider et al, 2005) to an organic structure (Mannion et al, 2005), from a command & control (Marr, 2006) (Seddon, 2005) to a learning-based organisation (Senge, 1990) and to support a more collaborative (Busci & Bitti, 2006) way of working.

There were a number of approaches that could have been adopted however the best fit to achieve the above and to yield the most appropriate data was to base the theoretical framework of the appreciative inquiry model set out by Cooperider & Whitney (2005), see **figure 7.3** below that highlights four dimensions that will surround the affirmed topic of performance management.
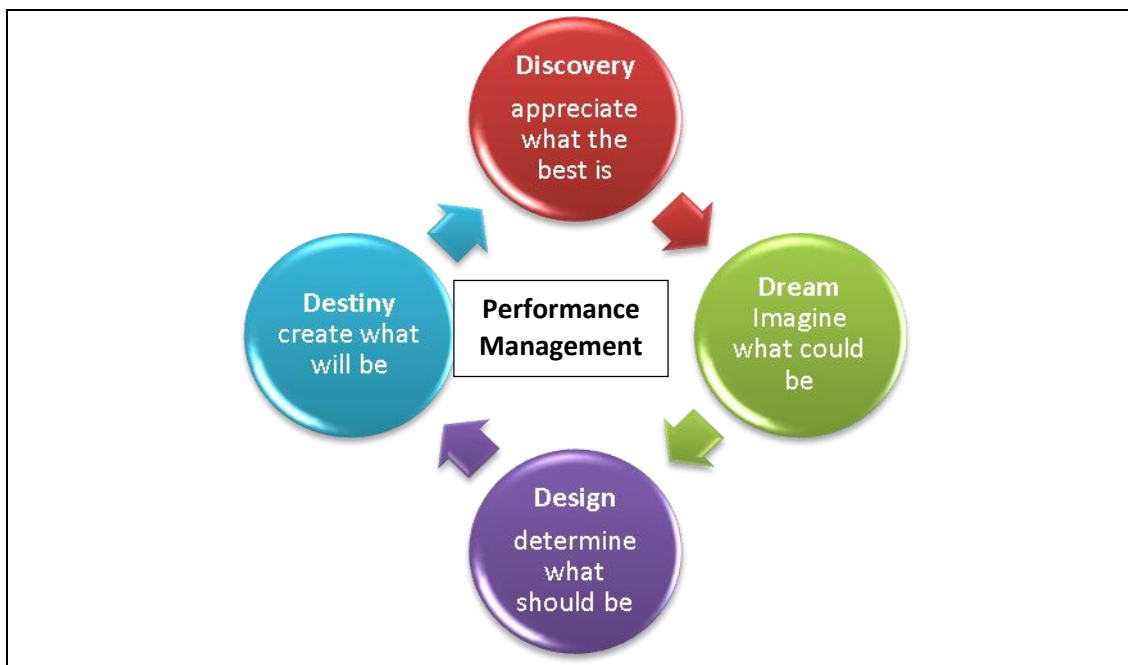
Figure 7.3: Appreciative Inquiry 4-D Cycle model

The appreciative inquiry model provides a dynamic tool to yield the primary data but also provides an opportunity by taking the participants into a future state and by reframing the changes and the emotional states surrounding the factors (Bandler & Grindler, 1981, 1975) allowing possibilities to emerge that the delegates may not have considered feasible in the past and within their current environment.

To establish future development for an organisation such as the NHS this may be achieved by looking at the four specific processes outlined in **figure 7.4** below, the organisation will need to work through these processes with a requirement of involving staff at all levels.

Discover
- The identification of organizational processes that work well

Dream
- The envisioning of processes that would work well in the futur

Design
- Planning and prioritizing processes that would work well.

Destiny
- The implementation (execution) of the proposed design
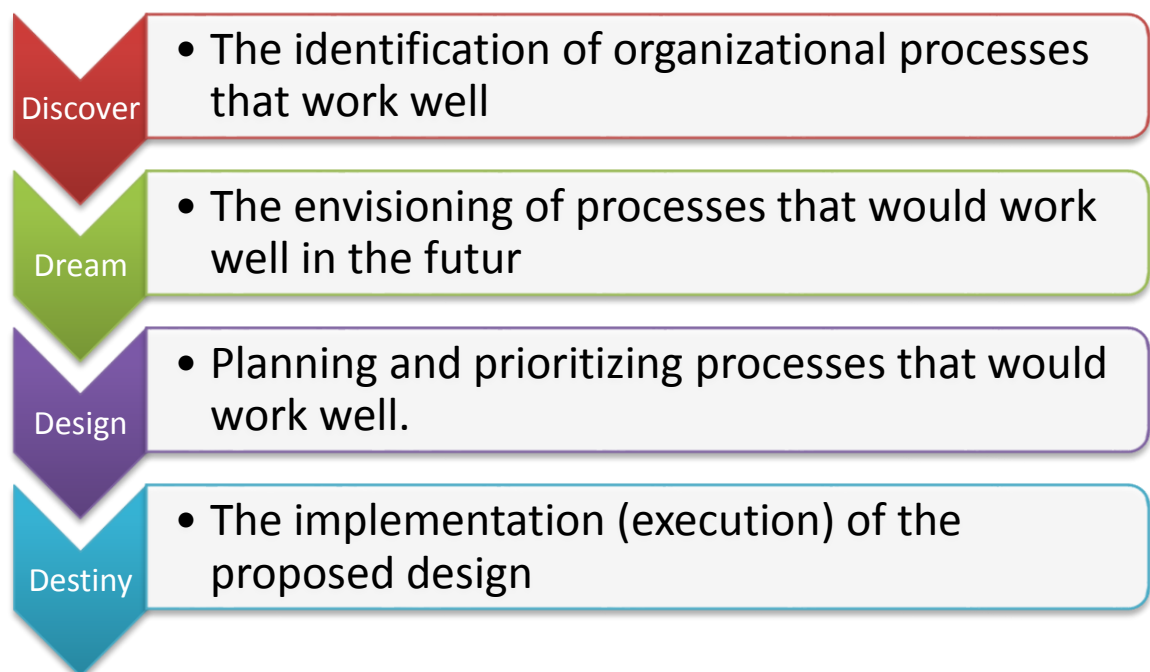
Figure 7.4: Appreciative Inquiry 4D process

Adapted from: Cooperider & Whitney (2005)

Appreciative inquiry was chosen as the most appropriate approach towards conducting the research as it focused on the organisation's ability to make significant changes that allowed participants to build on their achievements and strengths from an organic perspective as opposed to just trying to work on its problems and faults from a mechanistic approach (Cooperider et al, 2005).

To ensure the barriers towards performance management could be identified an initial survey on beliefs and attitudes were conducted to expose where the gaps and problems were using a standard qualitative 'Likert' scale preference based style questionnaire (Denscombe, 2003). The theoretical approach to administer the survey was very much based on a critical theory (Roderick,1986) foundation that required a critique on the current performance management approaches and barriers looking at the theoretical basis of Habermas (1979, 1984) with regards to his communicative action and Emmanuel Kant's work regarding, *'Critique of practical reason'* (Kant, 1788) looking at experiences being structured by our minds and his proposition that reason is purely subjective.

At a later stage of the study, an appreciative inquiry qualitative based methodology was implemented for three focus groups (Krueger & Casey, 2009) and four semi-structured interviews, as the gaps and barriers had already been identified providing an opportunity to direct the participants forward towards a desired future or state. The four dimensions' model outlined in **figure 7.3** provided a platform to guide the design of the interview questions and to steer the focus groups (Krueger & Casey, 2009) to work within the participant's truth or reality (Denscombe, 2003).

Appreciative Inquiry was first initiated from the publication, *Appreciative Inquiry into Organizational Life"* authored by Cooperrider and Srivastva, (1987) who were able to define exactly what the term meant, see below:

Ap-pre'ci-ate, v., 1. *valuing; the act of recognising the best in people or the world around us; affirming the past and present strengths, successes, and potentials; to perceive those things that give life (health, vitality, excellence) to living systems 2. to increase in value, e.g. the economy has appreciated in value. Synonyms: VALUING, PRIZING, ESTEEMING, and HONORING.*

In-quire' (kwir), v., 1. *the act of exploration and discovery. 2. To ask questions; to be open to seeing new potentials and possibilities. Synonyms: DISCOVERY, SEARCH, and SYSTEMATIC EXPLORATION, STUDY.*

'Appreciative Inquiry is about the coevolutionary search for the best in people, their organisations, and the relevant world around them. In its broadest focus, it involves systematic discovery of what gives "life" to a living system when it is most alive'

<div align="right">Source: Cooperider & Whitney (2001) page 2</div>

Later texts such as, the *Appreciative Inquiry Handbook* (Cooperider et al 2005) proposed the approach as a valid business management tool that could be implemented for a range of purposes to move organisations forward. The approach was supported by work of Berger (1966) and Gergen (1973, 1982,

1984, 1994, and 1999) who focused on the development of social constructionism as a major influence, see social constructionism in **section 6.1**.

Appreciative inquiry provides a theoretical framework to enable the study and the participants to seek a more aspirational performance management design and approach, providing a notion that there could be a right answer to the gaps and barriers presented within the initial survey. The appreciative inquiry focused on what was working well for the participants, moving them away from a limiting notion that they may be a part of a more controlled machine (Lewis et al, 2008). The approach focused participants more towards potential organic growth on enabling the case study organisation to adapt and change to its shifting environment (Bevan, 2009). Appreciative inquiry allowed the identification of statements from within the participant's experience to focus on success (Gergen, 1973) (Hammond, 2013), appreciative inquiry took the ideas of social construction and outlined it as a positive force (Berger, 1966, Gergen, 1973 & Cooperider & Whitney, 2001).

Appreciative inquiry (Cooperider & Whitney, 2001) provides a dynamic approach to identify and change the discourse of the organisation to enable the evaluation of group assumptions concerning performance management. Established assumptions that become the discourse for the case study organisation were challenged and contested as appreciative inquiry drew out new realities to change or reframe the perceptions (Bandler & Grinder, 1975 & 1981) (Rossi & Ryan,1985).

An appreciative inquiry theoretical framework (Cooperider & Whitney, 2001) enhanced the possibility for the organisation to become a learning enabled agent by utilising appreciation and respect by embracing the participant's statements and values (Rogers, 1951, 1961) as opposed to perceiving them to be a part of a rational mechanistic machine that merely requires problem solving (Lewis et al, 2008).

The **table 7.1** below illustrates the contrast between the traditional problem solving and compares it to the appreciative inquiry approach. **Table 7.1** highlights that there may be an alternative approach to performance management that is very much based on analysis, causes and the need to implement action planning for corrective action. The appreciative inquiry approach looks at the social construct and valuing what the best action may be through visioning, dialogue and social communicative action as outlined by Habermas (1979, 1984).

Table 7.1Traditional problem solving vs Appreciative Inquiry has been removed due to Copyright restrictions

<div align="right">Source: Cooperider & Whitney (2001) Page 27</div>

However, there may be limitations and risks adopting the proposed theoretical framework, appreciative inquiry considers assumptions important as a set of beliefs that may become the shared discourse of a group. Assumptions can be termed, perceived or understood as the following below:

- Statements or rules explaining what a group generally believes in
- The context of the group's choices and behaviours
- Not visible to or verbalised by the participants: rather they develop and often exist at an unconscious level
- Assumptions must be made visible and discussed before anyone can be sure of the group's beliefs or if they are still relevant and valid

<div align="right">Source: Hammond (2013) Page 10</div>

Dealing with assumptions may create a risk of bias with regards to groupthink (Janis, 1972). This may be deemed as a systematic error for an inductive process (Locke, 2007) that people may have a tendency to lean towards conformity creating a form of confirmation bias when brought into a group environment (Denscombe, 2003). However, the framework should not be discounted on this basis as there could be added advantages in recognising shared conformity and group think by participants if it can be recognised that they may become a part of the investigation and this could be part of an identified factor surrounding performance management. The key was to recognise when group think was being played out and to recognise and document how it impacts on the chosen field.

This notion of a group being able to change is central to appreciative inquiry, see statement below:

'Collective strengths do more than performing they transform'

Source: Cooperider et al (2005) page 7

Cooperider et al (2005) claimed that assumptions are the default behaviours that may become replicated and ingrained over a period of time at a subconscious level. It is when these assumptions are challenged and measured as to whether the current performance management frameworks for the organisation are the most effective when there may be an opportunity for the organisation to change by holding up a self-reflective conscious mirror to them.

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To support this mirror there will be a need to distill the literature from **sections 4 & 5** to arrive at a set of research questions which will be discussed in the following sections.

6.9 Distilling the literature

In order to begin distilling the literature within this section, it was important to capture the main points that were covered with some kind of clear understanding for the thesis to support the formation of a conceptual model. The literature was able to identify a number of factors that impacted generally on performance management but also included issues concerning definition and meaning, as well as organisational culture, this has been illustrated although not exhaustive in **figure 6.1** below:
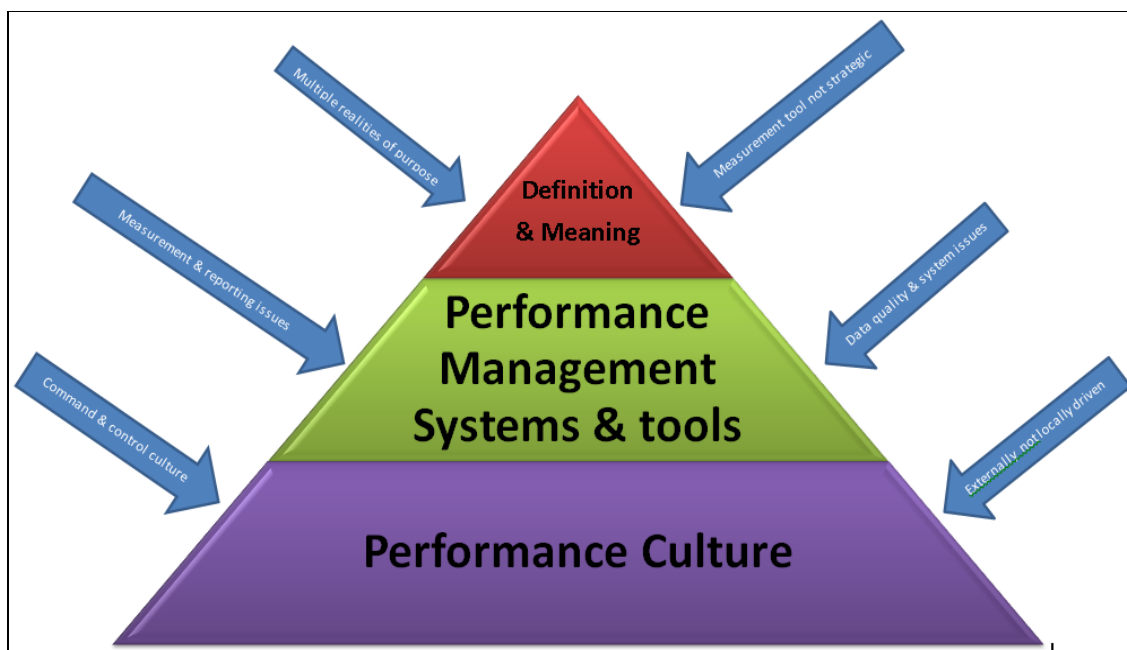
Figure 6.1 Literature reviews identified impacting factors on performance management

With this in mind the main themes from this chapter will be drawn together under the following three headings;

Tier 1: Definitions and Underlying Meanings

- Performance management can be defined due to its perceived purpose or role

- Performance management can be seen as a measurement and strategic tool

- Different schools of thought can influence its purpose that may be dependent on professional or group interpretations such as, finance or operations, HR etc.

- Definitions can focus on a number of specific areas, strategy, business & measurement

- Performance management has a traditional link to finance However modern applications focus more on the strategic development and overall business of the organisation

Tier 2: Performance Management systems & tools

- Balanced scorecard is a dominant performance tool

- Measurement systems have the potential to miss-interpret the information

- Measurement systems potentially may measure the wrong things

- There are a range of performance management tools with minimal empirical evidence to support their effectiveness

- Performance reporting systems in the NHS need to also focus on locally as well as externally driven measures

Tier 3: Performance Culture

- There are a number of factors that can influence the culture of performance management in the NHS

- There is a link between performance and culture in the NHS

- Command and control style approaches have been implemented by the Department of Health imposed on the NHS

- The NHS is predominantly a clan rational culture type that is focused on cohesiveness, morale and competitiveness

- Highly driven performance cultures can be driven by internal intrinsic motivation and wellbeing from the individual

- Organisational health can be increased as a result of implementing resilience and autonomy

- Leadership has an impact on performance delivery

- Learning culture based on systems and double loop learning may have the potential to improve output and make the organisation more resilient and sustainable

- Performance management can be part of smoothing out unwanted variation within a complex chaotic system

- Performance adoption must come from within the individual as well as the group or organisation

- Highly driven performance cultures need to be underpinned by a culture of learning

These above headings were chosen as they encapsulated the issues that emerged from the literature, no doubt they are very broad general areas that

require further investigation but at this stage it does allow a conceptual framework to be formulated and therefore cannot be set in stone as more issues and factors will emerge from the primary data. Therefore, the factors identified are fairly limited although they provide a baseline to initiate an investigation and enable the setting of research questions that will need to be answered.

6.10 Building a conceptual model

Having been able to distil the literature into the above key themes a conceptual model for a performance management framework can be formed and will be later tested via research questions that will be set out later in **section 6.11**.
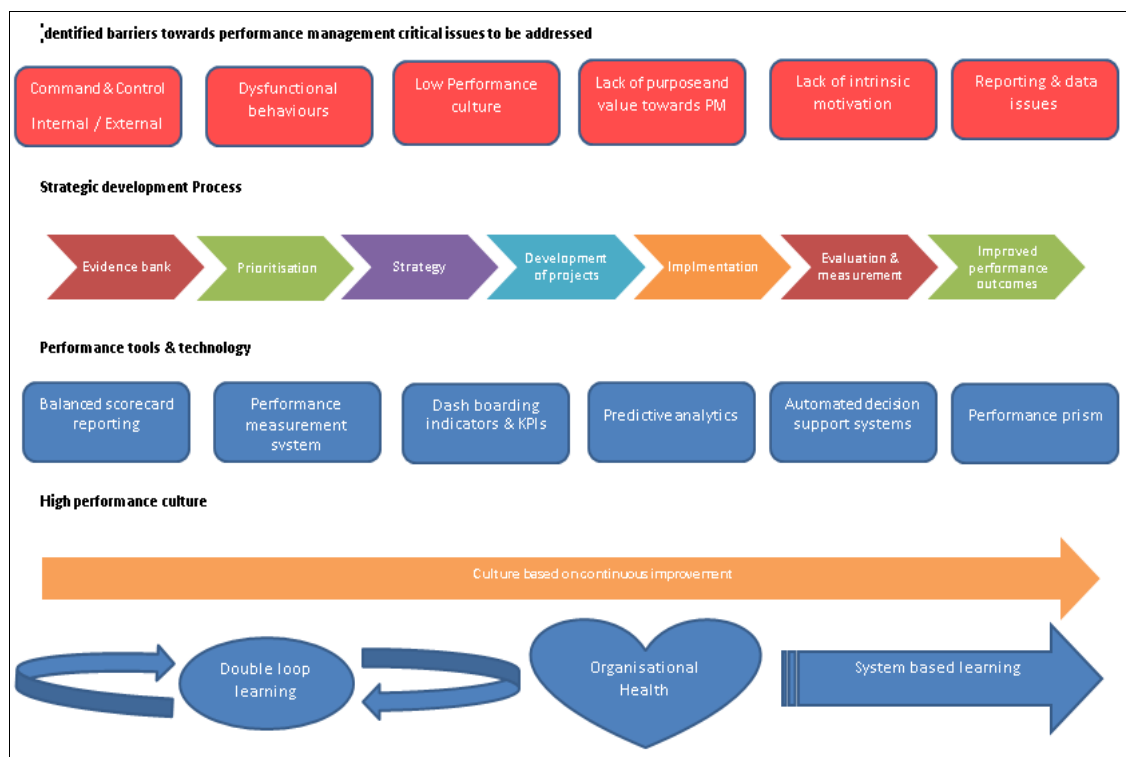
Figure 6.2 Conceptual models for performance management that emerged from the literature review

Figure 6.2 above and **Appendix I** highlight the barriers identified within the literature towards performance management which are in the boxes at the top. The boxes at the top highlight the potential barriers towards performance

management that were identified within the literature that can be linked to an NHS context; the research questions will have a strong relationship with the conceptual model, therefore, there will be a need to tease out the associated gaps in knowledge.

The conceptual model includes three main processes or strands towards effective performance management that may require future development. The research questions will aim to discover, probe and identify more details from the following areas:

1. Strategic development
2. Performance management systems and tools
3. Performance culture

The definition, meaning, role and purpose of performance management was highlighted within the distilled literature model and will be considered as a potential gap, a working definition of performance management has been proposed by the study. The main processes and strands run in parallel with each other alongside the red boxes impacting across the processes but not necessarily in a sequential linear order other than strategic development that was considered to be previously a cyclical process Axson (2007). Continuous improvement is an on-going process that underpins a high driven performance culture (Michelli, 2009) and utilises three main approaches that were identified within the literature, organisational health (Bevan, 2009) (Keller & Price, 2011), system based learning (Seddon, 2005) and double loop learning (Agyris, 1978).

The identified barriers and critical issues highlight that there are a number of areas that require further investigation hence the conceptual framework in **figure 6.2** above will need to be tested and reviewed against the proposed set of research questions that will be listed later in **section 6.11**. Therefore, a final revised conceptual model is expected to be complete at the end of the thesis that will incorporate the findings and analysis.

From the literature, another model emerged and that is a call or move away from the traditional to an alternative performance management approach that will also provide support in developing the proposed research questions, shown in **Table 6.1** below:

Element	Traditional Approach	Alternative Approach	Related Literature
Performance focus	Organisational	Individual wellbeing	Boorman (2009) Bevan (2009)
Purpose	Financial accountancy	Strategically balanced	Axson (2007), Marr (2007), Kaplan & Norton (1992, 1996, 1996b) & Cokins (2008)
Accountability	External scrutiny	Autonomy	Bevan(2009) Keller & Price (2011)
Focus	Target orientated	System based	Seddon(2005) Marr(2006)
Motivation	Externally driven	Intrinsic	Marr (2006) Michelli (2009) Reynolds & Ablett, (1998)
Measures	Productivity outputs	Outcomes	Neely et al (2007) Marr (2005)
Approach	Command & Control	Learning organisation	Senge (1990) Marr (2006) Agyris(1978) Nonaka (1991)
Benefits to the organisation	Value for money	Resilience & Sustainability	Bevan (2009) Keller & Price (2011)
Organisation	Mechanistic	Organic	Cooperider et al(2005) Mannion et al (2005)

Table 6.1: From traditional to the alternative model

Table 6.1 highlights a number of general elements that impact on performance management that was extracted from the literature. For example, the general approach to performance management has been to move from command and control to the learning organisation and from target orientated to a system based,

highlighted by Marr (2006) & Seddon (2005). Another example value for money (Kaplan & Norton, 1984, 1992) and efficiency (Deming, 1986, 2000) (Taylor, 1912) was considered the key benefit to the organisation, there has now been a call within the literature for a strong move towards resilience and sustainability (Keller & Price, 2011) (Bevan, 2009).

Table 6.1 will act as a future guide for the primary research stage to search out the reality within the case study organisation to explore and understand whether there has been a positive movement towards these alternative approaches or not and to explore whether there has been a change or impact as a result of the adoption.

Figure 6.2 and **Table 6.1** above provide a conceptual model that is by no means complete but provides the foundation for formulating the research questions to be tested.

6.11 The Research questions

To enable the formulation of the research questions we need to return to the aim of this study that was outlined previously within the introduction chapter; see below:

"To explore what factors surrounding performance management impact externally and internally on the organisation and the individual that will enable an alternative approach or model towards performance management to emerge, whilst uncovering the importance of these factors within an English National Health Service context"

There were a number of identified barriers towards effective approaches and frameworks surrounding performance management that was incomplete and unexplored that have been highlighted within the conceptual framework see **figure 6.2** in the previous section. There were also conflicting understandings regarding the term 'performance management' and its purpose within the literature. The study concluded that performance management was identified as a generalised term with a multi-purpose lacking a cohesive body of evidence or literature (Neely et al, 2007) associated with it.

The study found differing factors and impacts from multiple perspectives as to its purpose, there was a potential relationship or dependent link between performance and individual intrinsic motivation (Marr, 2008) (Reynolds & Ablett, 1998), (Lebas & Euske, 2007).

Contentions in the literature existed between those suggesting that too much command and control as an approach towards performance management may

lead to resulting dysfunctional behaviours, such as gaming and perverse incentives just to name two (Michelli, 2009) (Marr, 2006) (Neely et al, 2007) & (Grizzle, 2002) that may potentially lead to poor performance, while others in the field emphasised the importance of organisational learning (Senge, 1990), organisational culture (Mannion et al, 2005) (Michelli, 2009), organisational health (Bevan, 2009) (Keller & Price, 2011) and system based learning (Seddon, 2005) these will be the key areas to consider to support improved performance.

The exploratory study highlighted the downward pressure of command and control approaches from external bodies that was being exploited that may have a direct influence on local performance management design, concluding that local NHS organisations may need to find a balance between the external and internal performance management requirements within a complex chaotic system (Bevan, 2009) (Seddon, 2005). Although the policy literature only exposed the actual structures of the imposed performance management approach it did not provide concrete indications as to whether there was a positive move by the NHS towards alternative approaches that were highlighted within **table 6.1.**

Due to the literature lacking an academic body of evidence within an NHS context regarding performance management frameworks and approaches alongside the exploratory study not being able to provide an internal social science perspective from the individuals operating at all levels within the NHS, it would be therefore realistic and valid to proceed with conducting primary research from an ethnographical standpoint.

The research questions will be used as a qualitative tool to delve deeper into the internal world of its participants, to understand further the barriers and gaps and the specific factors surrounding performance management and will test the conceptual model set out in **figure 6.2**.

Therefore, as a result of the literature review and exploratory study, it was important at this stage of the study to recommend the implementation of a qualitative primary research programme or fieldwork that could bring into question the real actual issues surrounding performance management. Primary research will provide an opportunity to discover whether the understandings currently established within the literature actually reflects the reality of the individual and organisation and in doing so this may uncover further factors for investigation.

Taking the above into consideration the study will take forward the following questions:

1. **How do staff perceive the meaning, purpose and culture of performance management within the NHS?**

This first question will provide an opportunity to explore with individuals that are affected by the phenomena how performance management is perceived, what are the culture and barriers surrounding it and to identify what value it has to them and what impact it has to close the gap of knowledge that is inherent in the

literature; therefore, it will be essential for an assessment to be conducted on the role and relevance of performance management in their everyday working lives.

The above question may also provide further investigation to understand the relationship between the barriers that have already been identified in the literature review and to understand the local adoption of performance management. This link will be explored by conducting primary research on the beliefs and attitudes of staff at all levels, including a wide range of professional groups, to close the gap where previous empirical studies, such as, Mannion et al, (2005) and Davies (2000) had limited their investigations on the perspectives of senior management. The conceptual performance management framework in **figure 6.2** has provided a number of critical issues and barriers from an individual perspective surrounding the lack of purpose, value, motivation etc. It will be important to recognise from staff operating within the case study organisation whether these perceptions are shared from within an NHS context. The conceptual framework within **figure 6.2** takes into consideration the potential areas of development which relates to the strategic development process, tools and technology and high-performance culture. It will be important to establish whether staff perceptions correlate with the literature concerning these areas.

2. **What is the constructed reality of NHS staff surrounding performance management as a framework to support the organisational strategic development process?**

By assessing the constructed reality of surveyed and interviewed individuals across the organisation a better understanding potentially may be formed allowing the presentation of an alternative approach to emerging that may be adopted as a strategic development tool. Following the development of the conceptual model in **figure 6.2** and the literature review a number of factors such as, performance management has a beneficial role in supporting the strategic development of the organisation (Marr, 2006) but what is not clear yet without testing the above question is whether this is a shared reality of staff and whether this has an impact on staff at every level working within the NHS.

In addition to the constructed reality do they perceive identified factors surrounding strategic development as a real issue or an advantage, this would be considered as important to the study of the alternative approaches that move away from the traditional approaches that have already been proposed from within the conceptual framework leans more towards continuous learning consisting of double loop learning (Agyris, 1978) (Senge, 1990), system based learning (Seddon, 2005) and organisational health (Bevan, 2009) (Keller & Price, 2011). Future alternative approaches that may be connected to strategic development may not be perceived by staff as being functional or effective, if this was the case another approach may be required to be proposed.

3. **What is the relationship between NHS staff and the established performance management systems and tools?**

Command and control have been identified claimed via the literature as a common approach towards performance management in the public sector and the NHS (Marr, 2006) (Michelli, 2009) this is very much based on mechanistic principles outlined by Taylor (1912). A move towards adopting a range of performance management systems and tools rather than implementing a top-down framework that advocates a command and control approach may yet be tested but what would the response be from staff to adopt these tools positive or negative, would this change any of the identified factors that were identified within the literature review. This may require minimal effort if a quick win system or minor process tool was adopted or it may require a whole system change (Seddon, 2005). The above question will be teased out via the encouragement of discussion and debate from the participants involved in the primary research and focus group stage and may identify the feasibility of the conceptual model that was set out in **figure 6.2.**

4. **What steps can NHS organisations take to develop more effective approaches to the management of performance?**

The final question explores the adoption of an approach within the NHS away from traditional performance management design towards the alternative to explore whether this may lead to a higher performance culture amongst NHS staff or new realities within the case study organisation that may yield different

performance outcomes that could be investigated in the future as a result of further post-masters research. This would indicate as to whether the conceptual model in **figure 6.2** needs to remain, altered or to be further adapted to support a set of recommendations that may be implemented and tested.

It is fair to assume that the above questions are broad in nature the reason for this is to ensure as a much thick description can be yielded as possible, the guide for the questions will be its relationship to the proposed conceptual model set out in **figure 6.2.** It will be interesting to discover whether a new model needs to be proposed or whether the current conceptual may stand as it is.

The posed research questions are very much aimed at eliciting or capturing a broad amount of information to enable the researcher to later distill down to a number of potential findings or themed areas that may have already been identified within the conceptual model. It will also be important to consider any relevant variation from the conceptual model and current literature that the posed research questions may provide as this may present a further gap in knowledge that may not have been previously identified, this would also influence the redesign of the conceptual model.

As a result of the literature review and the exploratory study, there was a necessity to distill the literature first to capture the main points that were covered and to place them into a format that could be clearly understood to support the formation of a conceptual model.

The literature was later chunked down into three areas, definitions and meanings, performance management systems and finally performance culture. These were deemed essential headings for the study to take forward onto the primary research stage to investigate further the factors surrounding performance management and to close the prevalent gaps in knowledge.

Key themes were identified to form a conceptual model see **figure 6.2** exposing the potential gaps and barriers towards performance management that had emerged from the literature review and exploratory study. The conceptual model highlighted a potential process and alternative approach that could underpin the existing framework. **Table 6.1** proposed the potential move away from the traditional to an alternative approach towards performance management by citing the relevant literature that will act as a future guide for the primary research to be conducted.

To form the research questions a review was conducted on the aim of the study that was outlined previously within the introduction chapter, there were still a number of gaps within the aim of the study that still remains outstanding and will need to be addressed within the primary research stage.

6.12 Research design & Methods

The chosen research design has been supported by the formulation of the underlying research philosophies and the above theoretical framework that has been adopted. This allowed the data to connect to the overarching research questions to support the credibility of the study.

 The following research design was based on the need for the study to obtain qualitative primary data, therefore, the design did not take a primary quantitative form due to the need to obtain qualitative perceptions and statements from the participants, although numerical value based surveys were implemented (Cresswell, 2003). The qualitative design included a phenomenological approach as the study was concerned about participants lived real world experiences, their perceptions and how they observed the phenomena of performance management (Denscombe, 2003).

Performance management may be viewed as subjective in nature from the perspective of the individual, therefore, there was a requirement for an acceptance of their experiences, interviews, narratives and dialogues from the focus groups (Krueger & Casey, 2009) was very much essential in capturing these experiences. Data regarding notes and transcripts were later analysed by conducting a content analysis (Denscombe, 2003) and then the data was broken down into coded themes for an even deeper understanding.

As highlighted previously the phenomenological design was adopted due to the fact that the study was seeking to understand the 'essence of a lived

phenomenon and was seeking to capture and assess the related perceptions surrounding performance management.

6.13 An ethnographical approach

Alongside a phenomenological design, an ethnographical qualitative methodology (Denscombe, 2003, Breakwell et al, 1997, Hammersly, 1990, Creswell, 2007, 2003 & Werner & Schoepfle,1987) was implemented, as this was considered the most relevant social science approach to take as it best supported the interpretation and the patterns of behaviour regarding performance management with the researcher positioned internally within the field, phenomena and organisational culture.

The available literature has well documented that ethnography has been used as a qualitative method of research within the social sciences for a number of years (Breakwell et al, 1997) in fact some notable studies date back to the 1920's originating from the Chicago School of Human Ecology (Breakwell et al, 1997). Social scientists and anthropologists (Denscombe, 2007) have recognised that the ethnographical method does provides an opportunity to provide sufficient rigor, validity and reliability that would be expected from the quantitative empirical methods of science (Breakwell et al, 1997), although ethnography could be criticised as a valid methodology as it does not rely on quantitative statistical scientific measurement to evidence its reliability (Breakwell et al, 1997).

An ethnographical approach allowed the researcher to observe the human dynamic of the delegates alongside their own discourse, beliefs, attitudes and opinions this ensured the study was able to reduce the risk of bias.

The quote below best describes ethnography see below:

"Ethnography is directed towards producing what are referred to as theoretical, analytical or thick descriptions (whether of societies, small communities, organisations, spatial locations or social worlds). These descriptions must remain close to the concrete reality of particular events but at the same time reveal general features of human social life'.

Source: Hammersly, (1990) Page 598

Hammersly (1990) above highlighted the real value of ethnography in yielding the reality of the participants and the social dimension as the researcher had a direct opportunity to step inside the realities of the actors operating from within the phenomena and became immersed as an integral part of the study. The researcher was a direct employee of the case study organisation; therefore, they had already been exposed to the phenomena having obtained a direct understanding of meanings, symbols and significances that people had given to their behaviour free from the risk of jargon and misinterpretation.

Due to the researcher's current appointment within the case study organisation and the chosen field, these enabled the study to fully document and gauge the shared beliefs that had been displayed from within the potential subcultures that were present. Diverse influences upon the researcher had already been observed previously in the investigation as a result of ten years' experience within an English NHS setting. Perceptions and interpretations surrounding professional staff backgrounds and team dynamics had already been formed by the

researcher, although these were noted and were used for comparative purposes later to minimalize any researcher bias.

By adopting an ethnographical methodology and positioning the researcher there was an opportunity to distinguish between the external and internal influences, for example, external national policy imposed on the delegates may have had an indirect impact on the internal local performance frameworks processes and systems, it was an advantage for the study that this knowledge had already been acquired previously that had identified potential causes and effect.

The social world of the delegates could not necessarily be replicated or controlled in the future due to a number of factors such as performance management framework design, political interference and changing cultures. It would have been impossible to test all the potential external and internal variables and influences surrounding performance management. It would have been difficult to isolate the delegates for independent testing, for example, Seddon (2007) claimed when looking at systems based thinking you could not control, isolate or expose all the variables that are associated or interwoven within the performance management field.

An ethnographical approach allowed the study to observe the daily interactions and behaviours and documented a chronological path capturing the social issues of the delegates whilst minimising the risk of an imposed theory on to the participants. By imposing an external theory to the participant's world it may have contaminated the delegate's social worlds, by taking an ethnographical approach

the existing knowledge of the chosen field was already established within the same social environment as the delegates, therefore the study was able to utilise the same language, semantics and jargon allowing differing perceptions and understandings to emerge.

In parallel to the delegate's observations that were captured, it was important for the study to document the experience of the investigator during the investigation to ensure the study was free from bias. A journal documented the investigation recording the investigator's perceptions, beliefs and attitudes, as suggested by Werner & Schoeplfe (1987). The journal was later used to compare and contrast with the delegates perspectives and by doing so minimised the risk of any insider knowledge influencing the data ensuring that no bias may have obscured the findings and results (Denscombe, 2007).

The everyday social behaviour of NHS staff may be potentially affected by a multitude of reasons being influenced by policies consistently implemented by Central Government this would be impossible to measure and test if by adopting a statistical, scientific methodology. There was a real need to conduct a contextual inquiry (Denscombe, 2003) to capture the detailed descriptions and the primary data, this was achieved by the researcher having the opportunity to work and operate within the same environment as the delegates forming an understanding as to why approaches are adopted and for what purpose in the normal context of their work.

The two designs of phenomenology and ethnography were adopted but were also used in conjunction with narrative research (Creswell, 2007). The advantage of adopting narrative techniques allowed the researcher to uncover via interview and focus group (Krueger & Casey, 2009) the personal meanings or understandings of events (Creswell, 2007). Therefore, ethnographical methods and tools, such as qualitative surveys, focus groups and interviews were all used to capture a narrative as necessary primary data. The ethnographical methodology yielded rich detailed descriptions that tested the research questions accurately.

6.14 The position of the researcher

The researcher was placed in a position where they were internal within the case study organisation and in doing so were also subjected to the implementation of the organisation's performance framework and the changes of policies that surrounded the strategic development of the organisation.

The primary goal of the study was to identify the factors and issues concerning individuals within the organisation regarding performance management frameworks. Perceptions and interpretation surrounding the phenomena were very much within the internal worlds of those involved; therefore, the position of the researcher was of great importance to observe these behaviours within the context of the organisation.

The qualitative research methodology provided the identification of the complex human and cultural dynamics (Creswell, 2007, Breakwell et al, 1997, Denzin & Lincoln, 1994, Silverman, 1985, Strauss & Corbin, 2008, Strauss, 1987) this

required the researcher to be operating internally within the organisation, therefore a positivistic design would not have been appropriate for the study taking into consideration researcher position.

Active researcher involvement was conducted during other stages of the study; it was important for the researcher to provide a number of training sessions see **Appendix E.** As a result of the survey it was immediately identified as businesses need for the case study organisation. The researcher was also active in other ways studying and reviewing policy literature, developing and piloting research questions for the surveys with the participants and collecting data for subsequent analysis. However, to minimise the potential risk of bias the surveys, focus groups and the semi-structured interviews remained separate from the taught programmes.

The researcher was employed within the organisation delivering leadership to the chosen field as a Performance Manager; this provided easy accessibility to the data and information both primary and secondary and with sufficient time to invest in the research on behalf of the case study organisation. There was a continual interaction between implementing new approaches, reading, reflection and data gathering (Strauss and Corbin, 2008).

It was fair to state that the chosen field was consistently changing and redesigning as a result of continued imposed Department of Health policy (Smith, 2006) requiring development of the NHS alongside the changing and shifting priorities of the organisation, this had a large impact on the future validity and

generalizability of the research, therefore this placed a greater need to adopt an inductive approach (Locke, 2007).

6.15 Sampling and access considerations

Due to the researcher having direct access to the participants they had an opportunity to acquire access to the most influential performance management heads and leaders in the field alongside the relevant professional groups in business management. Bryman and Bell (2007) highlighted this open access as being fundamental to the success of any study, the researcher adopted a number of strategies to sample the participants this was determined by the role and responsibility they had within the chosen field.

It was important to initially conduct a survey on all available staff and professional groups to obtain a wide net of beliefs and perceptions allowing for variation and difference to enter the sample (Denscombe, 2003). Subsequently, it was important for the focus groups to be more specific with a balance of staff and professional groups ensuring there was a balanced mix of views and interpretations. For the interviews it was more important to delve deeper within a smaller group of staff that had a major influence on the chosen field to obtain the thicker descriptions, the sample chosen had a greater understanding and experience of the performance management agenda.

It needs to be noted that the researcher could not feasibly collect data from everyone from within the chosen field and needed to rely on obtaining a representative portion of staff and professional groups, therefore the sample was

carefully selected and the balance of staff and professional groups were recorded. Probability sampling was chosen as an initial approach as the researcher had a notion of the probability that the staff chosen were a good cross representation of the population (Denscombe, 2003). The mix of professionals and staffing for all three qualitative methods can be found in **figure 7.5** below:
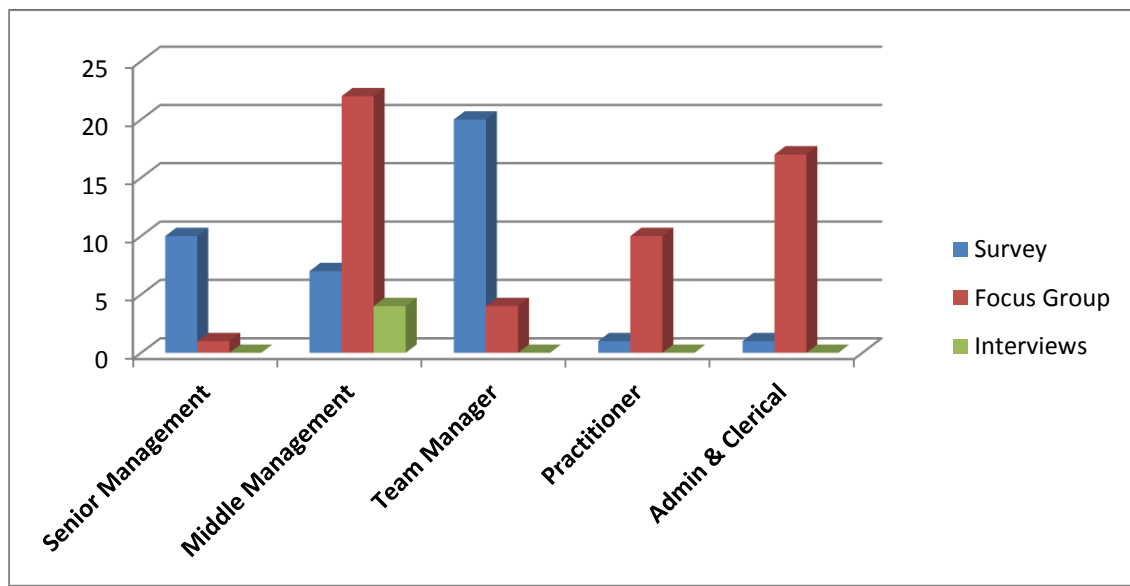
Figure 7.5: Participant profile

There are various methods of choosing a sample, see below:

- Quota sampling

- Stratified sampling

- Systematic sampling

- Cluster sampling

- Multi-stage sampling

- Non-probability sampling

- Probability sampling

- Purposive sampling

- Snowball sampling

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- Theoretical sampling

- Convenience sampling

Source: Denscombe, (2003) Page11

Internally it was easier for the researcher to identify what the relationships staff and professional groups had with existing and previous performance management frameworks and in doing so were able to select the most relevant participants. This was based on criteria which were pertinent to performance management and therefore a more non-probability and purposive sample method was implemented, non-probability as the study did not follow a random approach and purposive as the researcher knew the specific actors within the population that were more likely to provide the most valid information to answer the research questions (Denscombe, 2003).

The case study organisation employed approx. 4,500 staff, there were a high number of professional groups that consisted of medical, non-medical and administrative posts. The study had previously observed that in some way or another they were all affected directly or indirectly by performance management adoption imposed at differing levels. For example, a staff member working at a strategic level within administration would potentially perceive performance management from an overarching perspective. An operational provider or frontline staff group perspective may perceive the frameworks as numbers of cases or patients treated within their specific service area.

Therefore, there was a need for a clustering of professional staff groups and functions that required the adoption of a cluster sampling methodology, (Denscombe, 2003), the descriptions and coding's of the clusters became more apparent to the researcher after conducting the initial survey, please see sampling grid in **Table 7.2** below:

Sample Classification	Groups
Strategic	A Commissioners B Comm Administration C Finance D HR
Provider	E Medical F Non- medical practitioners G Provider administration

Table 7.2: The clustering sampling grid

For the surveys at the early stages staff were selected from a professional and group mix see **Table 7.2** above, before the annual performance review meetings, therefore, a more stratified random approach was adopted as the researcher asserted some control over the selection of the sample to ensure crucial people were involved (Denscombe, 2003).

The researcher had already identified a number of staff operating at differing levels, for example, senior managers, middle managers and frontline staff, a proportion of each was taken for the surveys as outlined in **figure 7.5**. The sample was later expanded during the focus groups and the interviews by looking at the hierarchy and then capturing the beliefs and perceptions at the differing levels.

Having highlighted the position of the researcher alongside sampling and access considerations we now look at the selection and design of the research techniques adopted.

6.16 Research techniques and methods

As the study was qualitative there were a number of research techniques and methods of data collection that were available that was identified within the business literature of Breakwell et al, (1997) Denscombe, (2003), Bryman and Bell (2007); Creswell (2007), Sekaran, (2003).

The following methods were implemented to yield the most accurate and relevant data, see list below:

- Participant observation

- Survey/questionnaire

- Focus groups

- Analysis of documentation and/or visual metaphors

- Semi-structured interviewing

Source: Denscombe (2003)

It was decided that an appropriate method according to the data required would be implemented at differing stages of the research; we will discuss the above methods and strategies in more detail later within this chapter.

6.17 Surveys & Questionnaires

As highlighted within the sampling section it was important to ensure there was a wide net of participants that could be covered, therefore a performance management survey was designed from the posed research questions. The survey focused on the perceptions and beliefs of staff, this was considered important as it was cheaper and faster to administer collecting preliminary data on selected days before a performance review session (Denscombe, 2003) (Bryman and Bell, 2007).

By conducting a survey at the initial stages the study was able to map out in detail the preferred performance management approaches of the participants from a wide group of staff providing a panoramic view of performance management within the organisation (Denscome, 2003), it was decided that the survey should be exploratory based to tease out common trends with a perspective of no right or wrong answers.

The survey template was based on a 'Likert' style questionnaire format, see **Appendix B**, focussing on themed areas with an average of eight questions requiring a tick for each statement from strongly agree to strongly disagree with an opportunity to provide further comment within in a box below.
The main questions included:

1. What is performance management?

2. What are the barriers towards the delivery of performance management?

3. What are the functions of performance management?

The questions then went on to investigate opportunities for involvement with the performance frameworks measured on a 0-10 scale with a further five questions inquiring about training, choice of measures etc. An information sheet accompanied the survey highlighting the study's purpose and why the participants had been chosen and how they were expected to participate. The survey was administered before an annual performance review meeting, only two people from forty-two participants declined conducting the survey due to late attendance at the review meeting. Participants were accompanied into a specific room to fill in the survey questionnaire on the site that was external from the room holding the performance review.

The aim of the survey as a research strategy was to identify immediately what was and what was not relevant for staff regarding performance management and how it impacted on them. This allowed the discounting of any areas that were not pertinent to the performance management field from within the internal realities of staff. By conducting the survey, it provided a real life interactive position for the study in getting out into the field across the organisation to a wider and more inclusive professional staff mix rather than just operating within the researchers own team and directorate. The skill mix is shown in **Table 7.3** below and the participant profiles for the survey are shown in **figure 7.6** below:

Professional Groups	
Senior Management	10
Middle Management	7
Team Manager	20
Practitioner	1
Admin & Clerical	1
Or Other…	1
Total Participants	40

Table 7.3: Survey participant profile
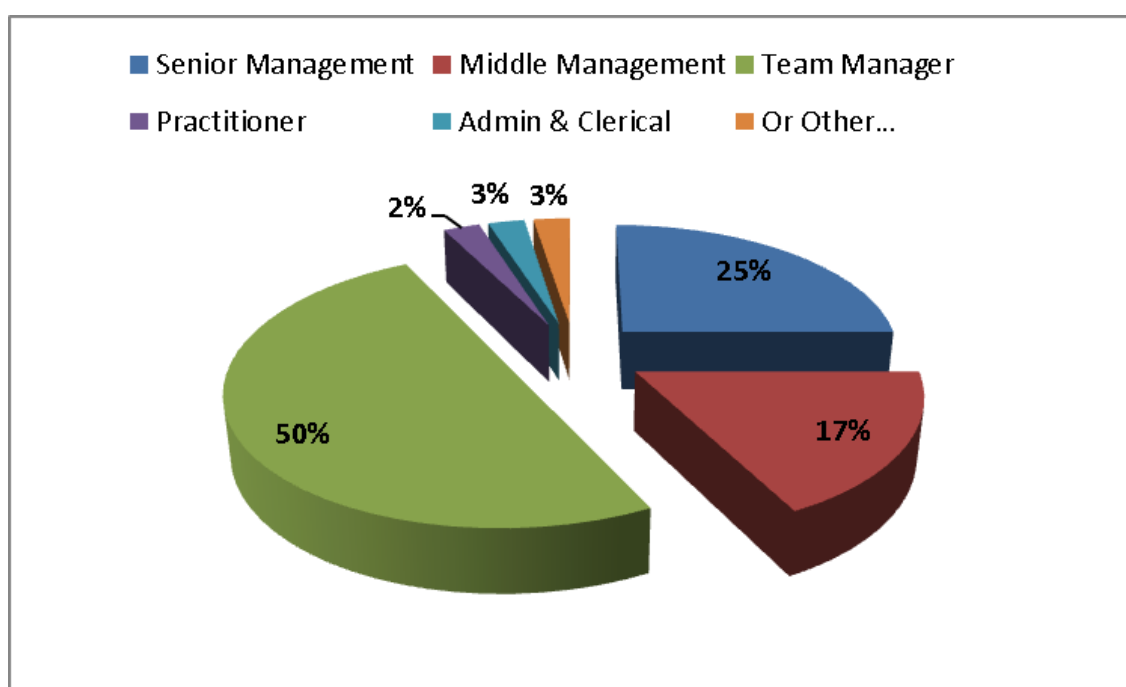
Figure 7.6: % of Professional Groups Involved in the survey

As shown in **figure 7.6** above the largest professional groups were team managers and senior managers, this may have been due to the attendance at the performance review meetings   The survey provided a good snapshot in time capturing the beliefs and preferences towards performance management, providing a baseline for measuring from for the next stage that required conducting focus groups.

6.18 Focus groups

When the survey had been completed and the data all coded the researcher was able to conduct a number of focus group workshops with interested staff, this ensured that perceptions and beliefs surrounding performance management could be shared within a safe comfortable and unthreatening environment (Krueger & Casey, 2009).

Focus groups have historically been implemented by market research companies and government departments. The NHS has used focus group techniques when developing services with users and patients. Focus groups are more naturalistic than structured interviews as the participants are allowed to confer as a group when producing the responses for the data. The reason for implementing the focus groups was to ensure performance management could be explored within a wide pool of participants rather than a one to one interview, therefore, making the focus group less time consuming than interviews. This form of interaction is better managed in a more controlled setting with the researcher observing the negotiation of the responses providing a much better power balance as a group.

However, focus groups do have their weaknesses, for example, it is very dependent on the social interaction of the participants and the influences within the groups there is a necessity to ensure that profession, status, gender and age is very much balanced as much as possible. The environment is not naturalistic in nature as it is created by the researcher and it is very much dependant on the skills and abilities of the facilitator to ensure the truth is exposed effectively.

Three focus groups were held over three sessions and were resourced by the organisation's training and development unit. There were approx. fifty-six participants in each group see participant profile in **Table 7.4** below:

Professional Groups	
Senior Management	1
Middle Management	22
Team Manager	4
Practitioner	10
Admin & Clerical	17
Or Other…	
Total Participants	56

Table 7.4: Focus group participant profile
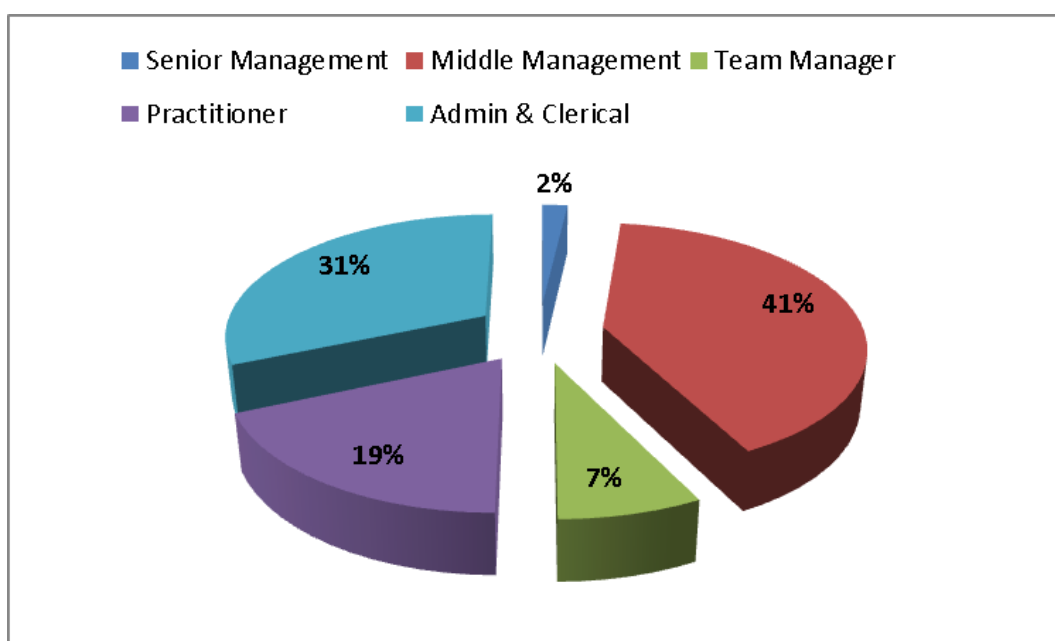
Figure 7.7: % of Professional Groups Involved in the focus groups

As shown in **figure 7.7** above the largest percentage of professional groups was middle management followed by admin and clerical this may have indicated the need from these professional groups for further interest in performance management. Focus group participants were recruited via a wide email communication sent to all staff within the case study organisation circa 4,000 inviting them to participate, 56 participants in total volunteered to take part with three sessions held therefore providing a 1.4% response of the total workforce.

The focus groups were held within the organisations training unit to ensure it was conducted on neutral territory for any given professional group; each session lasted no more than 45 minutes.

A number of semi -structured questions were posed to the group of participants and data was captured on flip charts, see questions below:

1. What is your current perception of performance management?
2. What do you perceive as the barriers to the delivery of performance management?
3. What are the opportunities for performance management in the NHS?

The data was then later analysed using a content analysis approach that required the identification of common themes from the group interaction as opposed to individual responses, overall the focus groups encouraged interaction and allowed discussion of performance management in general

6.19 Semi- structured interviewing

After the surveys and focus groups were conducted it was important to ensure that the data that was collated from a collective group could focus down towards an individual perspective, see **figure 3.1** in **section 3.3**, therefore the study looked at the three different types of interviews structured, semi-structured and unstructured (Denscombe, 2003) to support the interviews.

It could be argued that these three different types of interviews may have produced three different results or truths as a result of their designs; however, it was decided that there was a need for more open and more specific data to emerge, so the semi-structured design was chosen to best answer the research questions. The semi-structured one to one design provided the researcher with more flexibility with regards to the order of the questions that were chosen. With the questions being more open-ended, see **Appendix D** this provided an opportunity for the interviewer to develop ideas during the interviews and to encourage the participants to speak more openly. If this was purely an unstructured interview the train of thought for the interviewee may have become unmanageable yielding unnecessary data that may not be relevant to performance management and if the interviews were too structured, then it may narrow the responses and may not capture the participant's realities sufficiently.

Interviews need to involve a set of assumptions which are not associated with everyday conversations (Denscombe, 2003) (Silverman, 1985). These assumptions were taken from data collected from the surveys and the focus groups.

Four participants were recruited from the senior management professional group who had a direct role within the chosen field and had a significant influence on the implementation of the current performance management framework within the case study organisation, see participant profile in **Table 7.5** below:

Professional Groups	
Senior Management	4
Middle Management	0
Team Manager	0
Practitioner	0
Admin & Clerical	0
Or Other…	
Total Participants	4

Table 7.5: Semi-structured interviews participant profile

The above participants were invited to interview via letter, see **Appendix C** that provided a background to the study. As an appreciative inquiry theoretical framework has been adopted (Lewis et al, 2008, Cooperider et al, 2005) the structure and questions of the interviews were designed from the 4-D model (Cooperider et al, 2005) as outlined in **figure 7.3** in theoretical framework cited in **section 6.8**. The semi-structured interviews were conducted on a one to one basis for research ethics purposes consent was obtained before the interviews commenced. A consent form was provided to the participants, see **Appendix D** and the interviews were audio recorded and then transcribed onto paper-based transcripts, final copies of the transcriptions were made available and sent to the

interview participants at a later date, the same principles applied to all data gathering throughout the study.

6.20 Analysing the documentation

To support discussion during the focus groups and semi-structured interviews documents that were relevant to performance management were analysed from within the case study organisation and were considered as data in their own right as highlighted within the exploratory studies previously in **Section 5**.

The ethnographical position of the researcher allowed access to the internal organisational documentation that mainly consisted of strategic and developmental policies that were being produced by the executive board including relevant communications and briefings to staff. Some of these documents were previously used within the literature review and included the following;

- Government publications and performance statistics
- Performance reports
- Governance and quality briefings
- Staff newsletters and briefings
- Internal emails and minutes of meetings
- Organisational structure charts
- Formal policy documents and statements

The documentation evidenced the direction of travel regarding performance management for the local organisation providing a truth and structure to

performance management in the NHS establishing a point of reference to refer to alongside the emerging perceptions of staff. A content analysis was conducted on the documents to ensure they could be broken down into relevant themes to quantify the contexts of the text.

6.21 Coding and analysing the data

A qualitative ethnographical methodology was adopted for the study (Creswell, 2007) this produced a considerable amount of data required to be analysed. There will be a requirement for a process to be implemented that should move raw data to findings, this could have been supported by a computer aided analysis package (Denscombe, 2003) such as Ethnograph, NVivo or Atlas. NVivo was initially used to code the data but the researcher had found previously that the analysis that it had produced as a result of the pilot studies during the exploratory stage had found to be limited. The NVivo system had difficulty interpreting the data from narrative texts, therefore, creating an interpretative risk.

There are a number of new software packages on the market that may now assist this analysis process, but at the time there was a necessity for the study to be assured of the correct coding and storage of the data to support the survey responses, transcripts and field notes so they can be retrieved effectively. The experience of NVivo highlighted that using a software package to do this can create not miss-interpretation and not take into account the risk of jargon that may be prevalent within culture and reality of NHS staff.

To provide assurances the study will adopt a mix of Microsoft packages that will include, Excel, Word and Access with much of the analysis conducted manually by the researcher. Other software packages that will aid the analysis may include, Endnote that was used to store, code and retrieve the literature and documents allowing for a chronological content analysis to be performed.

To support the coding and planning of the data analysis the study will also use Tony Buzan's mind mapping software http://thinkbuzan.com/ to better organise the documents within a visual package. Mind mapping software will be used to collect a team and individual profiles within one visual map although this may be better performed using manual flip charts.

The study is very much concerned with the individual perspectives of NHS staff from a qualitative methodology by looking for the thick descriptions (Hammersly, 1990) (Gertz, 1973) where a lot of the interpretation and meaning may be potentially discarded by the researcher using a computer aided analysis. A software analysis package may render the data unreliable therefore there was a need to use the more laborious coding and analytical methods of manual analysis to mitigate against any potential risks of contaminating the findings.

To ensure common themes can be allowed to emerge from the data broad categories were identified as part of a manual coding system. So for example, if Balanced Scorecard (BSC) was highlighted by the participants as a performance management system or tool and emerged as a recurrent theme well-known to NHS staff this would need to be captured. BSC which is the acronym for Balanced

Scorecard was used as a code to group all statements related to balanced scorecard. A visual mind map was then scoped out to display the emerging themes and highlight the correlation or relationship with the other broad themes.

Subcategories and numerical codes were then identified that had a much more detailed granularity with the balanced scorecard and were coded, for example, as BSC1. This supported the researcher to discard any non-relevant data or noise from the analysis that may not have an identifiable relationship with the broad themes and enabling the researcher to accurately pinpoint common or relationships for interpretation into the relevant intelligence or information to support the findings.

6.22 Research Plan

The research questions and the methods of testing were identified, the next stage is to set out a primary research plan that maps out the various stages that would be required to ensure the study can arrive at the required outcome, without a robust plan in place there will be difficulty in obtaining the right data and intelligence to test and answer the posed questions.

Figure 7.8 below provides an outline plan that has been adapted from Sekaran (2003) that starts from a point that has already been conducted i.e. literature review, exploratory study, defining the problem area and setting the research questions. The researcher will be picking up the process by conducting the primary research by collecting the data and then proceeding to answer the posed research questions. If the research questions have not been sufficiently

answered the process is then redirected back to the literature review to reset the questions and to start the process again.

If the questions have been answered the research process can then proceed to write up the thesis, delivering the viva and then providing a final presentation and recommendations to the NHS, see **figure 7.8** below:
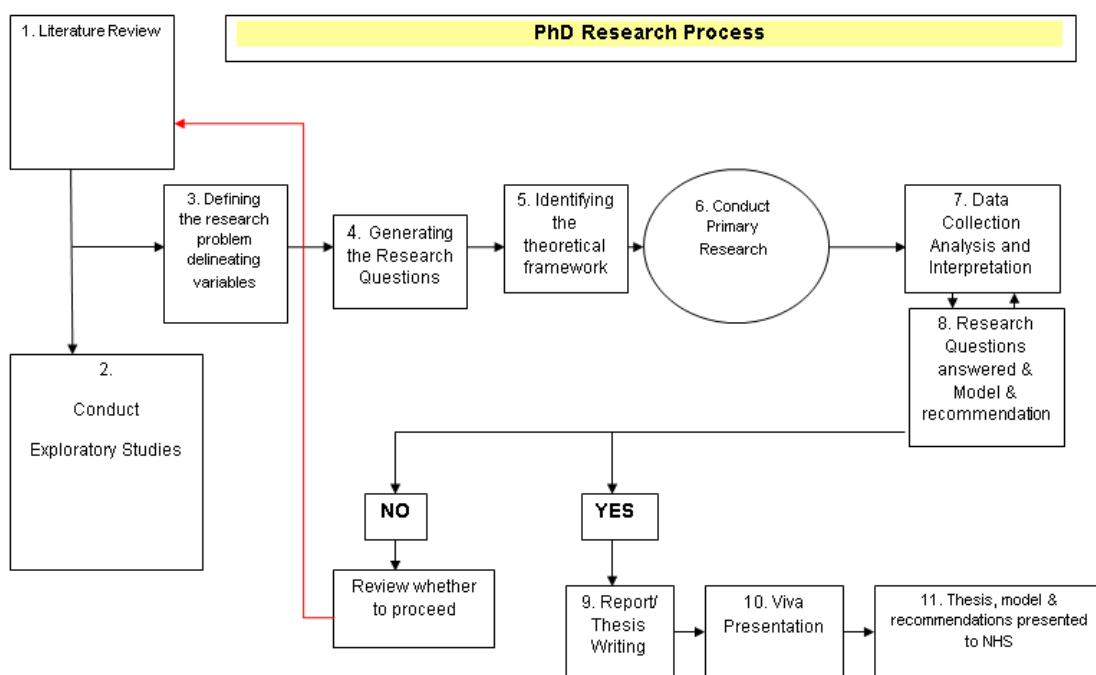
Figure 7.8: Healthy Performance Research Plan

The literature review and exploratory studies have already been able to identify the barriers and factors surrounding performance management, the next stage of the plan is to obtain the realities of the staff and senior managers who operate within the phenomenon. The surveys will not be sufficient to obtain all the data required therefore it will be necessary to capture all the narrative and thick descriptions (Hammersly, 1990) (Gerttz, 1973) that can be yielded from the semi-

structured interviews (Denscome, 2003), this will be conducted during stage six of the plan, see **figure 7.8** above.

Figure 7.8 is designed to ensure that the researcher can arrive at the report writing stage, this may require returning to the literature on a number of occasions to review the research questions further that may require the adjustment of the methodology if required.

6.23 Research Ethics

A big issue concerning ethnographic research is the explicit role it has within the organisation and the impact this may have on the research environment (Denscombe, 2003) (Hammersley, 1990), therefore it was important to ensure that ethical considerations were upheld throughout the research phase.

Ethical considerations began at the very start of the fieldwork (Creswell, 2007) it was decided at the very early stages that the research was required to provide meaning and value to the participants and that the studies should provide the participants with an opportunity to influence the future design of performance management in the NHS.

An ethical concern was that the researcher was an employee of the case study organisation who had unrestricted access to people, places and events and was able to use their informal status and relationship almost as a currency between the researcher and the subjects involved (Polsky, 1967). To minimise this risk the researcher ensured that full ethical clearance was sought from the Plymouth

Business School Ethics Committee and the NHS Ethics Committee, full approval was provided by both approving bodies, see **Appendix G.**

The contact details, names and roles of the potential survey, focus group and interview delegates were listed by the researcher from publicly accessible NHS websites. The researcher made it very clear to any potential participants that involvement is purely voluntary, separate from their normal duties and that they have a right to withdraw at any time. The participants were provided with a background to the study, the sponsoring and academic organisations involved and with a full explanation as to the research purpose. The researcher then sent out a written invitation with an information sheet attached explaining in writing the purpose of the study and the expected role of the participant and researcher. As highlighted in the previous section a written consent form was also sent to enable written confirmation of agreement before any interview was conducted see **Appendix D**.

The researcher approached potential delegates in their capacity as a post-graduate student from Plymouth University representing the sponsor, not as a staff member from within the case study organisation; however, it was important to make delegates aware that the researcher was currently employed as a senior manager conducting the research ethnographically from within the case study organisation. The researcher did not conduct any research on participants that they had previously appointed, employed or worked alongside from within the same directorate or team.

All final transcriptions, results and findings were made available to all delegates involved during pre and post publication stages of the research. The researcher had no issues raised from the delegates involved regarding any ethically sensitive aspects to the methods that had been employed and the researcher at no time required any access to patient or staff personnel records.

With regards to valid consent, the researcher explained to all potential participants the entire purpose of the project before consent was obtained. The researcher also informed potential participants in advance of any features of the research that might reasonably be expected to influence their willingness to take part in the study. Consent was obtained in writing.

No children participated during the research at any time, delegates for the semi-structured interviews, focus groups and the surveys only involved adults that were employed directly from within the NHS.

6.24 Chapter Summary

The methodology chapter has clearly outlined the adopted research approach and questions that will be implemented as a qualitative, non-positivist, post-modern ethnographical methodology, this is mainly due to the need for the researcher to step into the realities of the research participants to view the factors surrounding performance management from within their world and perspective.

Due to the ontological nature of the knowledge, the methodology will adopt the relativist school of thought as participant's statements are expected to be relative

in some way towards the chosen field (Easterby-Smith et al, 2008). A philosophical framework has been identified based on the work of Descartes (1641) with regards to dualism and social constructivism based on the work of Berger (1966) and Gergen (1973, 1982, 1985, 1994) and communicative action that was proposed by Habermas (1979, 1984).

The study deemed it to be important to adopt a post-modernist approach on the premise that individuals have the ability to adapt to their changing circumstances (Bevan, 2009, Keller & Price, 2011, Marr, 2006 & Lewin, 1946, 1951). The methodology will lean towards the potential organic developmental approaches such as, appreciative inquiry (Cooperider et al, 2005) and organisational health (Bevan, 2006) (Keller & Price, 2011) which will be a shift away from traditional mechanistic approaches that were previously proposed by Taylor (2012).

The research design, sampling, access considerations, research techniques and the qualitative tools were also outlined alongside the research plan (Cresswell, 2003).

7. Findings & Analysis

This next Chapter of the thesis looks at the findings and analysis that was specifically obtained from the primary data. A process of filtering the data into information and knowledge was required by conducting analysis on the raw data that was yielded from the surveys, observations, focus groups and semi-structured interviews. It is important to point out that the field notes taken from the researcher's observation were also included in the analysis but were notes from discussions with the research participants.

It was uncovering the complexity of the phenomena (Geertz, 1973) that was needed to be analysed as it held the potential gaps in knowledge that may have only been associated with an English NHS context that could have been lacking within the current literature. Conducting qualitative research, the study was able to disclose hidden aspects of performance management exposing any clues with a purpose to discover the deep-rooted messages that may have lay behind the descriptions presented (Denscombe, 2003). Qualitative research is very much dependent on descriptions when looking at meanings or patterns of behaviour, human activity can be seen as a product of symbols and meanings that have the potential to be analysed via the text (Denscombe, 2003). It was important to analyse these descriptions that included, relationships, activities and the language of the social groups and their feelings towards performance management.

Overall to start the analysis a process of funnelling the data was undertaken see **figure 8.1** below this required the breaking down of text into smaller components using single words, phrases or complete sentences.
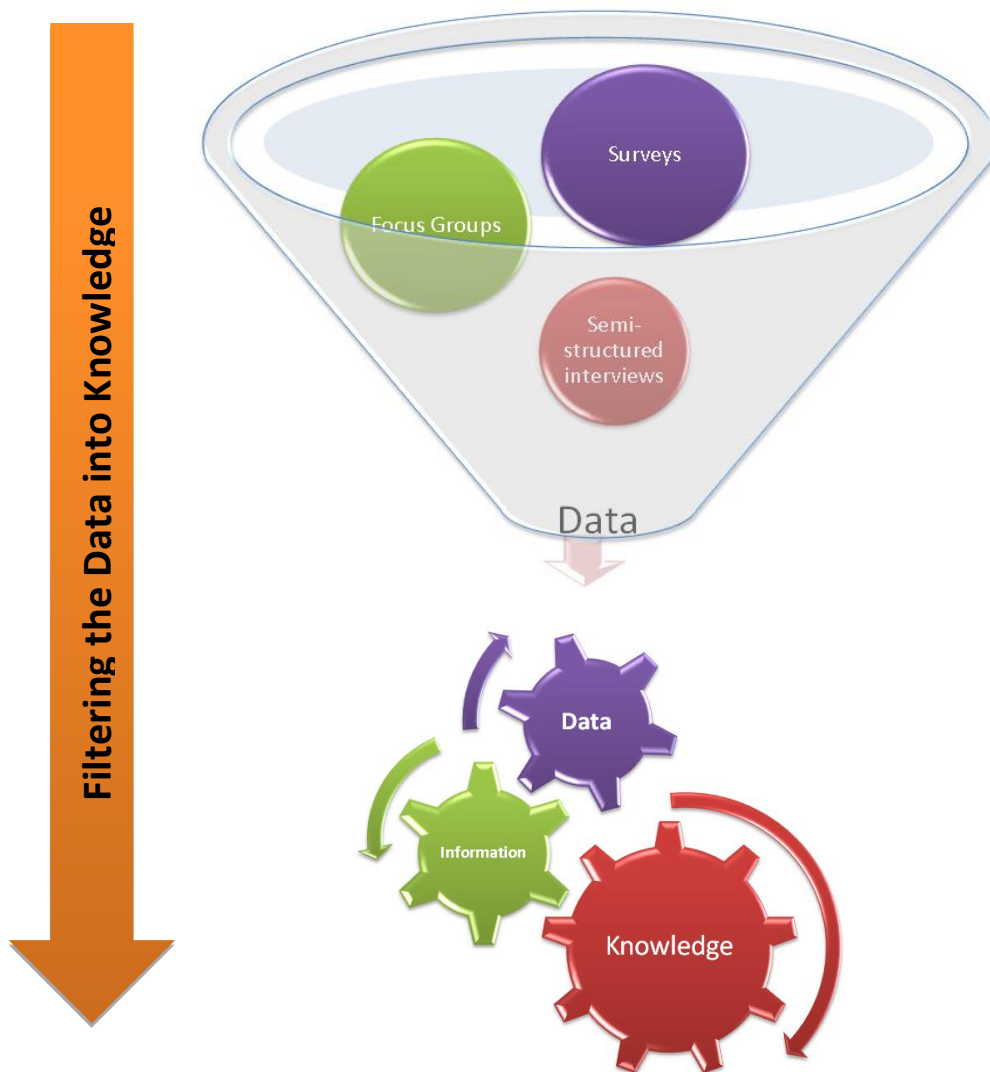
Figure 8.1 funnelling the data into information & knowledge

The next stage was to identify categories, interconnections, issues and ideas that were associated with a performance management theme or factor; this was made easier by the findings that were taken from within the literature review and the

research questions that had been set, the units of text were then later coded and their frequency taken as to when they occurred (Denscombe, 2003).

A number of common themes emerged from the evidence this has been mapped out in figure 8.2 below: and will form the structure of this section to present the findings to the reader.
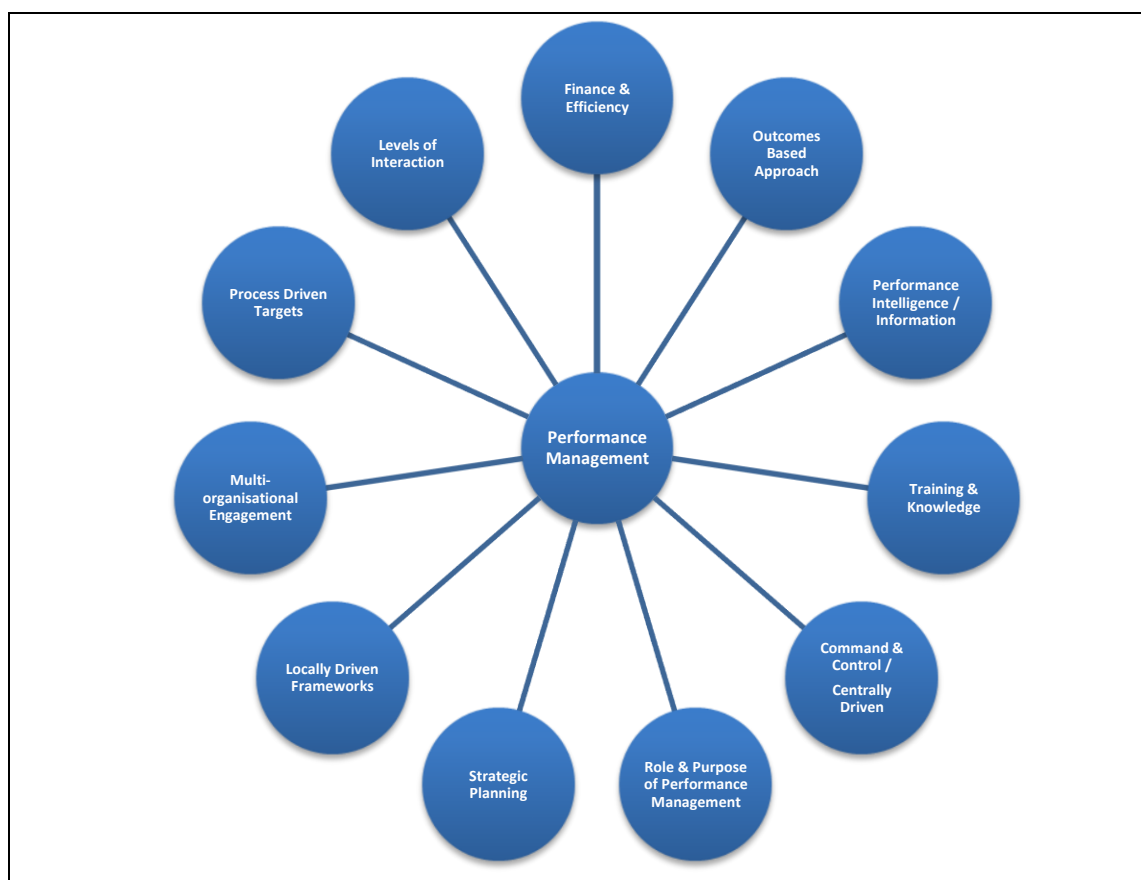
Figure 8.2 Common themes that emerged from the findings

7.1 The role, purpose & approach of performance management

From the literature review there were a number of multiple realities concerning the role of performance management, the perception of performance management was the main focus of the beliefs and attitudes survey, therefore this was naturally weighted towards its role, purpose and approach.

The primary research yielded the following findings:

- Performance management should be sited within senior management and not within the services

- Performance management is very time consuming for frontline services where there is insufficient capacity to support it

- Performance management should be perceived not as a waste of time but as an essential process although needs to be implemented at all levels for it to become effective.

- Current performance systems and frameworks can be over elaborate and can hit the target but miss the point.

The role of performance management appeared to be perceived differently by frontline staff and senior management; this was evident from the data obtained from the surveys, focus groups and interviews. There was recognition that it was shared amongst both groups of staff that performance management was an essential process that needed to be adopted by the NHS to ensure that improvements could be realised. Although the process of performance management in the NHS and how it is adopted was perceived as serving differing purposes, see the comment below:

'Performance management should be sited within senior management and not within the services'. (Delegate)

Taken from: Performance Management Survey

Senior management looking at the statement above was being referred to as corporate management that conducts strategic planning and decision making as opposed to service management that provides frontline delivery of services. The researcher was able to identify these perceptions via the professional groups that were involved. For example, senior managers in the interviews perceived performance management as really important and useful as it worked politically and managerially and provided an added benefit towards their leadership (Charlesworth et al, 2003) even though it was commented on that it was not so easy to qualify and quantify.

In contrast to the above statement, the perception from staff was there was a need for performance management to improve services for patients however there were also concerns that there was insufficient capacity to deliver it, referring to the intense work that was required to support performance management requirements on top of existing commitments.

'Performance management is very time-consuming for frontline services where there is insufficient capacity to support it'.

Taken from: Performance Management Survey

Other concerns regarding its purpose from the services were very much connected to the tick box nature of hitting targets (Marr, 2006, Seddon, 2005,

Symmons, 2004). This was perceived as having the potential to miss the point of what the services needed to deliver whether a number of cases or outcomes for patients, so there was potentially a value staff may have placed on the performance management process. (Marr, 2006, Michelli, 2009, Reynolds & Ablett, 1998). Marr (2008), Reynolds & Ablett, (1998), Lebas & Euske, (2007) found there was a potential relationship or dependent link between performance and individual intrinsic motivation.

The surveys found that the purpose of performance management was credible this was highlighted in the comment below:

'Performance management should be perceived not as a waste of time but as an essential process although needs to be implemented at all levels for it to become effective.
                                         Taken from: Performance Management Survey

It was found within the literature that there was a real need for performance management to be implemented at all levels, for example, Boorman (2009) claimed delivery at every level enhanced the wellbeing of staff. Manninon et al (2005) found that a high performing NHS trust required top down and upward accountability and the evidence of the meeting of targets was required to support each level of the organisation. Juechter et al (1998) believed that for a high-performance culture (Reid & Hubbell, 2005) to emerge performance needs to be driven from the top but at every level. Axson (2007) Marr (2006) & Seddon (2005) proposed that an organisation's ability to set a vision and prioritise its objectives is required at every level.

Senior managers within the interviews highlighted the differing approaches of performance management that were adopted over a set timeline. Pettigrew et al,

(1999) and De Waal (2008) both claimed there are multiple perspectives, determinants and factors regarding the performance management purpose and role. Target based approaches that were inherent in previous NHS reforms *Performance Assessment Framework* (NHS Executive, 1999), *Developing the Performance Regime* (2008) in 2013 were perceived very differently in comparison to *The NHS Outcomes Framework* (2010) and the *Health and Social Care Reforms* (2013). The relaxing of targets and the promotion from the Department of Health of greater organisational autonomy was seen both as an advantage and a disadvantage to performance manage the NHS. Bevan (2009) and Keller & Price (2011) saw autonomy as a real advantage as it supports how the organisation can operate from within their external environment and how it can change and adapt allowing the organisation to take risks when required from a greater level of freedom.

Senior managers from within the interviews commented that the whole performance management regime *The NHS Outcomes Framework* (DOH, 2010) had changed considerably over the last few years mainly to deal with the negative connotation of implementing previous targets based performance management regimes. This had created a relaxation of the performance agenda as a whole towards outcomes however it was not evident from within the interview descriptions whether this had produced any better performance. The literature had highlighted previously there were difficulties in measuring outcomes as a whole and potentially this may cause a risk for an organisation to move back towards quantitative units of measure (Marr, 2008). Senior managers within the interviews identified that there was a potential issue for the Department of Health

changing the regime from targets to outcomes and this may have created a misconception amongst staff that performance management may not now be required. A senior manager commented that there still is a requirement for quantitative based performance regimes as it provides an opportunity for the organisation to drill down into their performance data and identify potential cause and effects (Marr, 2006) (Seddon, 2005) rather than looking at the broad outcomes where there is a potential for multiple variables.

The role of performance management supported the need to maintain a consistent level of business intelligence to establish how the service is delivering and performing (Wilson, 2000). The senior manager interviews found that if the targets were to be relaxed the governance or management of performance may also be potentially affected, as the data may not necessarily be required to be collected locally or nationally and therefore removing a system of measurement to support decision making and strategic development.

Marr, (2008) stressed the importance of valid and correct measures to interpret performance highlighting this has a direct impact on the decision-making process of an organisation. Cokins, (2004), Marr (2006) Kaplan & Norton (2001) saw performance management as an essential reporting tool to provide a sound measurement for decision making. Davies & Nutley (2000) claimed that the NHS may improve its performance from a basis of evidence-based decision making providing the organisation is supported by the right measures. Mannion et al (2005) found that high performing trusts considered it important that good data

and intelligence supports good decision making we will look at this in more detail in **section 7.9**.

Within the interviews, senior management seemed conscious not to discuss performance management approaches in particular previous approaches before the implementation of the *Health and Social Care Reforms* (2013) and had recognised that four hour waits in A&E and quality and governance frameworks still had retained some level of Government ministerial interest. The need for performance management to retain targets for government use was also evident in the literature when discussing extra organisational performance management in a government context that was highlighted by Mackie (2008), who claimed that to ensure public accountability targets should be considered as useful information for the public. Bolton (2003) supported the need for performance management to be used for public accountability purposes due to the increased public expectations of public services.

Senior managers within the interviews claimed that the performance management approach should maintain an essential role within an organisation, regardless of the number of organisations that have displayed dysfunctional behaviours (Grizzle, 2002) as a result of performance management implementation. Marr (2008) had proposed in the literature that organisations were more likely to display dysfunctional behaviours (Grizzle, 2002) as a result of a 'top down' approach claiming this may create strategic alignment (Gates, 1999) problems, target fixation and gaming. A senior manager within the interviews used the Mid Staffordshire NHS Trust case claiming that the English

NHS Trust had failed to look at the bigger picture of its performance. A member of staff from the surveys commented on the value performance management can provide to an organisation

'It has the potential to paint the whole picture' (Delegate)

Taken from: Performance Management Survey

The senior manager who commented on the Mid Staffordshire case was advocating that to concentrate purely on target delivery was not necessarily enabling the organisation to see the bigger picture; this was supported by Symmons (2004) Bevan & Hamblin (2009) and Seddon (2005) who also saw a risk in pure target delivery that can allow organisations to hit the target but miss the point. This was also stated within the surveys, see below:

'The systems can be over elaborate and sometimes misdirected i.e. can hit the target but miss the point.' (Delegate)

Taken from: Performance Management Survey

Unfortunately, the data that was yielded regarding the role of performance management did not provide clear evidence as to whether any new performance management approach had produced any better performance measured against a standards-based framework. However, another senior manager during the interviews pointed out that its effective performance management framework did provide an essential role in identifying one of the largest negative performance slides nationally within the NHS. This was very much based on target

measurement although it was unclear as to what were the variables and factors that were accountable for the slide.

'Do you think that your previous performance management approach produced better results than your current performance management?' (Researcher)

'Well, it's difficult because if you look at where we are now and what has happened over the last eighteen months than we have seen in the XXX XXX (geographical area of England) one of the biggest performance slides nationally. We have adopted a different approach with different factors associated but I don't think the approach has led to that.' (Delegate)

<div align="right">Taken from: Interview 002</div>

The inability to identify whether the new outcomes approach post-reforms, *Equity and Excellence* (DOH, 2010) had produced better performance was also highlighted by another senior manager who claimed that the organisation was in too much of a state of change, see below:

'Do you think that the previous performance management system produced better results than the current system?' (Researcher)

'I think the jury is out probably out on that, the new system is very difficult to say what it would have achieved and you got to add into that a lot of the confusion of setting up a whole new organisation. Over that six months during the transition phase, we did not have much control over the whole performance as to what was happening we were focusing more internally.' (Delegate)

<div align="right">Taken from: Interview 004</div>

It was perceived that not having an effective intelligence system and having an over-elaborate system within the organisation to support performance management had made it difficult for staff to maintain a focus on the role and purpose of performance management.

The surveys and focus groups, in general, were concerned that there was insufficient time, capacity, knowledge and training to fully exploit the full capability of performance management and to realise its potential benefits. Staff not having the available time to engage with the performance management agenda may have been due to the increased service demands that were imposed. It was claimed that work had become unbearable having to deal with day to day frontline issues and as a result provided insufficient time to focus on performance management requirements. Staff not having the time for performance management may not necessarily have had a direct correlation or relevance as to the purpose of performance management and how it was perceived, but maybe by being provided the time or having a workshop or training course may have allowed staff to have an opportunity to fully understand its purpose and role. Another comment that was received from the survey suggested that the performance management system needs to begin from scratch and a review now needs be conducted to support the delivery of an excellence model, see below:

'Begin from scratch not that it is all bad, but a root and branch review would enable us to move to a model of excellence.' (Delegate)

Taken from: Performance Management Survey

It was the intention of the Department of Health to develop a number of excellence models (EFQM, 1999) within the NHS for a number of years (Bamford & Morton-Cooper, 1997). The need to move away from top-down approaches will be covered in more detail in **section 7.2**.

From the interviews, it appeared that senior management had utilised the role of performance management as a means to understand what is actually going

wrong from within the system, as a form of diagnosis to establish the true cause of problems this need to drill down was supported by Marr (2006). Within the interviews, it was commented that a CEO during pre-reforms in 2013 had utilised performance management as a means to establish who or what was causing the problems to identify how they can make the performance better. This provided a more interventionist approach in comparison to post reforms set out within *Equity and Excellence* (DOH, 2010) where targets were expected to be more relaxed in general. However, the purpose of performance management as a result of this adopted approach by the Chief Executive may have been perceived by frontline staff as a means for senior management to implement a mechanistic command and control based approach that was outlined by Marr (2008a), Seddon (2005) and Michelli (2009). This may have created a problem for the organisation with only being interested in identifying the problems from a mechanistic perspective as outlined by Taylor (1912) and not necessarily identifying what was working well from an organic learning based approach proposed by Cooperider et al (2005) and Bevan (2009) and how this could be shared or replicated in other areas via benchmarking (Neely, 1998).

In contrast to this one of the senior managers highlighted in the interviews that the performance management approach is about engaging staff (Taylor et al, 1999), having a conversation and providing an opportunity to offer a package of support to enable staff to meet local needs to basically work better and perform better having an effective intelligence support system may support this.

The senior management interviews highlighted that performance management should be regarded as an effective means of communication and a tool that lets everyone understand what is going on and what everyone can contribute to the overall vision of healthcare. Collins & Porras (1995) claimed that having a visionary organisation can translate core ideology into goals and strategies and Graham (2004) saw the importance for performance management to align with strategy development by ensuring that staff and employees could pull in the right direction.

The interview delegates placed a strong emphasis on the performance management role of supporting partnerships and with it having a role to influence within a system. System based thinking and learning were supported by Seddon (2005) and supported by Bevan (2009) when considering whole system redesign, see *World Class Commissioning* (DOH, 2008).

It appears that a perception regarding the role and purpose of performance management had established itself; it was evident from within the surveys that performance management did have a benefit for the organisation but it was not clear whether this was the same benefit for frontline staff in comparison to senior management. Perhaps the everyday practice of performance management from senior managers may have created a different perspective in comparison to staff that has the opportunity to decide on whether to adopt performance management or not.

A jointly agreed role between senior managers and staff may be missing but this does raise a question as to whether this is just internally within the case study organisation or does this exist externally with other organisations. The focus groups reinforced the need to establish the performance management role across professional groups indicating there is currently a potential risk for unnecessary duplication and that performance management could be conducted better if there was a greater understanding of its potential benefits that may align professional groups towards the same outcomes and goals (Taylor & Pierce, 1999).

It was fair to state that the role and purpose of performance management within an NHS context was exposed through the primary research stage of the study; however, it would appear this was dependent on the professional groups and the backgrounds of the delegates. This was supported by Pettigrew (1999) who observed multiple variable perspectives from NHS staff and proposed a need for a clearer understanding as to who does what that may come as a result of a well-defined framework. But it appears that for the right performance management approach to emerging for staff and senior managers it is more about finding the right reasons towards its application and that it should be about supporting the right things that provide real value and purpose for the individual, as highlighted within the focus group statement below:

'Performance management is about doing the right thing for the right reasons if you can achieve that you have adopted the right approach.' (Delegate)

Taken from: focus group flip chart notes

7.2 Centrally driven frameworks (command & control)

The main related themes concerning centrally driven frameworks that emerged as a result of the primary research are listed below:

- A top down centrally driven framework has been implemented by central government

- The centrally driven framework has been adopted by commissioners when purchasing services from providers

- Performance management has been perceived as an imposed framework to meet centrally driven processes

- Centrally driven frameworks have created a hierarchal process towards performance management

- There is a call from frontline staff there needs to be a more bottom-up approach

It is evident from the flip chart notes from the focus groups that a top-down centrally driven framework had been implemented by Central Government and had been realised by the delegates that had attended, see below:

Q 1 What is your current perception of performance management? (Researcher)

- *SHA / DoH – legal obligations, directives*
- *Checking up rather than being supportive*
- *Top down rather than bottom up*
- *Top down enforcement (another task in an already busy agenda)*
- *There is a 'fear' around what happens if we do not perform well*
- *Feels like a 'stick' rather than a helpful thing*
- *Feels separate – externally driven*
- *Commissioners – The influences of control*

- *Compliance with legal obligations*
- *'Top-down' approach*
- *Driven by government drivers*
  (Delegates)

Taken from: focus group flip chart notes

The top-down target based approach that was referred to by Seddon, (2003) Lester, (2004), Bevan & Hamblin, (2009) & Symmons (2004) indicated there were a number of problems with this approach caused by too many targets in place or being inappropriately applied externally from a position of hierarchy.

It was observed by the researcher during the primary research stage that staff and senior managers were very aware that there was in existence a defined national performance management agenda that had been prescribed and imposed, however more so from within senior management than staff. Much of the debate and discussion with senior management within the interviews focused on the organisation's requirement to deliver on the imposed 'top-down' centrally driven performance framework. Staff called for a more locally defined framework to support their operations as highlighted previously by Cooperider & Whitney (2001), Pettigrew et al (1999) this will be covered in more detail in **section 7.3**.

Senior managers within the interviews appeared to have a much stronger understanding and awareness regarding performance management relationship to policies and the positives that it can deliver. The command and control approach could be interpreted in both surveys and focus groups as being too unsupportive towards staff and senior managers. de Waal, (2002) claimed that command and control approaches can produce a dynamic for NHS staff to resist

change and potentially create a less effective performance. This was supported by Johnston et al (2001) who remarked that a huge issue is that targets are thrust upon staff without consultation or rewards; this increases the resistance from staff towards command and control approaches and has the potential to deteriorate the performance management framework that may be imposed.

Within the interviews a senior manager who was previously employed within one of the external scrutiny authorities highlighted that it was about identifying failing performance issues with organisations as highlighted in the statement below:

'So it wasn't that we were merely there to kick people around what we did do was we identified shortcomings and then put in support but in a very critical way, critical in a negative way about this entire deficit model, you're not doing this if you are doing this you need to do that and going as high as we could to achieve it.' (Delegate)

Taken from: Interview 002

This approach has been identified previously within the literature as a very Taylorist mechanistic perspective (see Talylor, 2012). In contrast, Cooperider et al (2005) supported a more organic approach allowing participants to build on their achievements and strengths from an organic perspective with the appreciative inquiry methodology. The senior manager above working for the external authority made it very clear to the people responsible that they were not working effectively, admitting it was a very ruthless approach to achieve the top down targets although claiming it had worked well and was very effective. For example, one of the senior managers's commented on what the attitude of one of the external authorities was very clearly, see below:

'I was saying to XXXX (Executive Director) there was an element whereby XXX (Executive Lead) at one stage I remember being at an all staff event and he got up on the stage and said looking at the audience and said, 'Nobody likes us and we don't care and that's what I told the Minister the other day. And at the moment that is absolutely true and I am quite happy to hear because I know that if nobody likes us and we don't care you are going out there and getting the job done you don't make friends, you are not there to make friends you are there to get the job done.' (Delegate)

To indicate the possible impact of the approach the same senior manager described in detail how the services were used to getting punished or penalised and that this had an effect on the way the organisation operated.

Leverage could be obtained by these external authorities from regional alliances as in the senior manager's perspective. This approach had real teeth, by using the performance management frameworks of their regional partners the approach was about exposing weaknesses of all the local delivery agencies. This is in contrast to Cooperider & Whitney (2001) who proposed to achieve a developing organic organisation you need to focus on the strengths and build upon them.

It can be interpreted that overall senior managers agreed with the staff that there is a lot of performance prescribed for the organisation and as a result of a centrally prescribed requirement targets were expected to be achieved as a priority as they do not want the Trust Board to be shocked that any target has come off track, as the Board ultimately would have been scrutinised by an external authority such as the case above.

The period of NHS history the senior managers and staff were referring to was pre-NHS Reforms Health & Social Care Act (2012) and not necessarily describing the approaches that may have emerged as a result of the *NHS Outcomes Framework 2011/12* (DOH, 2010). This highlights that the approach to providing more locally defined frameworks *NHS Outcomes Framework 2011/12* (DOH, 2010) for the latest framework may be required to be tested for a longer run effect.

Senior managers overall did have a critical approach towards the pre-reforms centrally driven frameworks compared to the latest approach and called for a balance as there are significant requirements for senior managers to submit returns to external authorities to an extent where it can also become too consuming this was identified by staff from within the surveys.

There was a criticism from the senior manager interviews that the new NHS Outcomes Framework due to the nature of working from an outcome measurement perspective will provide you with a performance position, but will not necessarily provide organisations with enough information to understand and manage the local healthcare economy. However, Seddon (2005) raised the issue that command and control targets was a failing paradigm and there was a greater need to understand the wider system and its processes not necessarily from a centrally driven framework based on targets.

Senior managers within the interviews quoted that by having nationally prescribed command and control frameworks they have the potential for a significant amount of clout within the organisation. There was an awareness that

they could be up for the external challenge, therefore there is a real need to attend to the indicators within the framework. The positives that were proposed by the senior managers regarding this was that there is a likelihood everyone will follow the same route which makes it easier for benchmarking purposes set out by Neely (1998). The senior manager who proposed this notion did have an external scrutiny background to the case study organisation and felt that the previous command and control approach would place the organisation in a position to require a certain area or national priority to be delivered then this would provide leverage for directorates and teams within the organisation to see improvement. This notion may be in conflict with the strategic alignment approach (Gates, 1999) to enhance intrinsic motivation of staff that was proposed by Marr (2006), Michelli (2009) & Reynolds & Ablett, (1998) who looked at the motivating factors of performance management coming from within the individual and not necessarily require to be controlled externally. This highlights a need to balance centrally driven frameworks alongside more locally defined less imposed frameworks this will be covered in **section 7.3**.

Observations from the researcher during the senior manager interviews noted the more simplistic culture that could be acquired adopting command and control from a senior manager's perspective. This highlights this role may have an impact on perspectives regarding performance management. Senior managers may have found it easier to manage and report on centrally driven frameworks rather than the more locally defined systems of performance. This may be due to centrally held information becoming much easier to collate allowing the organisation to be benchmarked (Bogan & English, 1994) (Rightcare, 2010)

(Neely, 1998) against other similar organisations to enable a level of self-awareness. These benchmarking benefits for the organisation may make centrally driven indicators and measures much easier to pull together than broader less detailed outcomes measurement if this was conducted nationally, as the majority of the work and thinking has already been provided. If we were to discount or discard the benefits of command and control based frameworks it may create a risk for the organisation not to benchmark and not provide awareness or a barometer as to its performance position within a system that may create a significant amount of work and duplication for individual organisations in the long term.

7.3 Locally defined frameworks

The main related themes concerning locally defined frameworks that emerged as a result of the primary research are listed below:

- Local systems need to be designed to capture quality

- Performance management needs to also support local clinical work

- Structures need to be flexible, not rigid

- The culture needs to support local systems

- It is about the balance between the central and the local requirements

What became interesting during the focus groups was that staff were requiring the NHS to look at more locally defined performance frameworks than the centrally nationally prescripted approach. It was requested within the discussions that performance management systems needed to capture quality measures.

It was noted within the focus groups facilitator's notes that staff were concerned that there was too much emphasis on finance measures rather than quality. The focus groups were very much referring to the quality outcomes of patients from a patient's perspective looking at the satisfaction levels of the service as opposed to the work of Deming (1986, 2000) with the 'Six Sigma' approach and Total Quality Management that was highlighted by Lynch & Cross (1991). These quality models proposed by (Deming, 1986, 2000) (Lynch & Cross, 1991) had an emphasis on quality to support productivity and efficiency; the staff at the time were very much referring to evidencing the value of their clinical work to commissioners. The setting of local measures and a framework may have provided greater meaning and value to staff and may evidence best practice, but the commissioners would need to measure quantitative based measures to contractually monitor the service.

However, measuring locally based quality may be more complex (Pisek & Wilson, 2001) due to not being centrally prescribed, this was an issue that was raised from the interviews as organisations potentially may run the risk of not focussing on the right measures (Seddon, 2005) and this may limit the opportunity to benchmark (Neely, 1998) in the future.

The researcher was made aware during the exploratory study stage that a number of national information dashboards had been withdrawn, this may have made it far more difficult for organisations to access consistent performance information that was also used for strategic planning on a more local level.

Financial measures would be consistent and quantifiable and would affect all organisations business operations.

The surveys and the interviews indicated there may be some advantages and disadvantages locally owning performance frameworks but this would require the right leadership and a good relationship system between commissioner and provider (Seddon, 2005) that would be required to deliver the requirements set out in, *Commissioning a Patient-Led NHS* (DOH, 2006). Pettigrew et al (1999) supported the need for good local ownership as a determinant of organisational performance that requires a clear understanding as to 'who does what', this may be achieved as a result of a well-defined local framework.

It was observed during the focus groups by the facilitator that a requirement to have a more locally based approach may provide a challenge to the senior managers. This would require them to think more operationally about how they do their business within this future scenario and would need them to design the most appropriate and meaningful measures (Marr, 2009), building a locally defined framework may have the potential to provide a level of freedom and autonomy for the organisation that was previously outlined by Bevan (2009).

It was noted within the senior manager interviews that it may be a much harder task in the long term to head towards more locally defined frameworks as there is a requirement to balance both national and local performance management expectations. It was noted in the focus groups flip charts that by taking out a level of accountability and allowing the organisation to define its own framework it may

have the potential to become very time consuming and add another perception of bureaucracy.

Staff recommended within the surveys that performance management needs to cite itself more locally within the services, this may provide the impetus and support required to balance both the local and the national expectations that were raised previously by the senior managers within the interviews. Although senior managers will need to support local staff in the development of local performance management frameworks to ensure it is not just for the preserve of the senior managers but to be aligned and focused on areas of value for staff so they can understand it as highlighted by Marr (2006), Michelli (2009) & Reynolds & Ablett, (1998) and the statement below:

'You can share policy documents there is no point trying to engage on a national agenda with the local environment if there is no pre-thinking about what does it mean for them. Otherwise, you are just handing something over saying this is a wonderful thing you might want to look at it or put it on a shelf; you have to make it real for people for them to be able to see it'.

Taken from: Interview 002

7.4 Process driven targets

The main related themes concerning process-driven targets that emerged as a result of the primary research are listed below:

- Process driven targets may primarily focus on the quantitative, not the qualitative outputs
- Targets can be used as a top-down tool for central government although may not provide the whole picture for frontline services

- There is a risk that chasing a target can focus resources on one element of the service

- There is a call for less of these targets however there is a desire from management to maintain them as they are more easily measurable than outcomes

It was stated within the surveys that the targets that had been set by senior management were sometimes misdirected in hitting the right target but also potentially can very much miss the point. Seddon (2003) very much remarked upon this calling for the nature of measurement regarding targets to change and in doing so requesting a review of the process-driven approach of the NHS.

This was reinforced by staff from the surveys who claimed that performance management is only effective if the target is real or of value to the practitioner, again this highlights that intrinsic motivation to adopt performance management is an important factor for the individual (Marr, 2006), (Michelli, 2009) & (Reynolds & Ablett,1998).

The focus groups remarked that performance management has the potential to paint a real picture and provide staff and managers with an opportunity to reflect on their performance that may lead to changing ways of working and processes. If the results that were being achieved were desirable highlighting that if the approach was more real, it may have a greater role and purpose towards the frontline.

One of the points made in the interview organisations were very performance driven and very target orientated systems were very much based on process and volume and not necessarily outcomes. This may be promoting a more mechanistic interventionist approach where there is a need to only intervene at times when the performance is moving off track or there is a problem, similar to Deming's (2000, 1986) approach that is in contrast to the learning enabled approach set out by Cooperider and Whitney (2005) who also looked at building on what is working. Ash (1992) looked at the need for organisations to deliver process-driven targets was a 'strategic control' issue that made sure that strategy was being implemented.

A strong statement was provided by one of the senior managers within the interviews that warned that performance management should not purely be about hitting targets and measuring every process but should be concerned with measures that provide the right information to support decision making, see below:

'If you want to absolutely destroy and undermine and obliterate creativity then the golden rule is to measure everything that could be measured so let's not do that let's look at things that are sensible.' (Delegate)

Taken from: Interview 003

It was highlighted that there is a difference between process-driven targets and process driven measures with a call from senior managers for there to be fewer targets but more measures regarding the process. With regards to process-driven targets what appears to be more important is the necessity to have a measurement that indicates what is needed to be achieved. There is a criticism

that if you want to achieve a quantitative number you could achieve that but it would not provide information and intelligence and a rounded view that would evidence how you got there and that would enable you to fully base a decision. The performance was being perceived as only being effective if targets are right in the first place, a strong focus on the process may not necessarily be all bad as it provides the opportunity to drill down but too much focus on the input may not be as effective as balancing this with the output.

To introduce a move to a new performance management system or approach that is more relaxed around process-driven targets, commissioned services were still in a fixated position on delivering targets, chasing numbers as opposed to focussing on operational services providing treatment and care to people, target fixation by organisations was an issue raised by Marr (2008) that created a number of problems alongside gaming and created a lack of strategic alignment (Gates, 1999).

There did appear to be a perverse incentive created by the implementation of these process based targets during the interviews. A senior manager made reference to the four-hour wait target in Accident & Emergency that was skewed towards everything that had happened in the last five or ten minutes before the four hours was up. The senior manager commented that from a performance perspective this may have allowed a trust to meet a target but it came at a cost of not balancing other performance requirements within the organisation. Marr (2008) conducted research on a number of public sector organisations highlighting this behaviour as dysfunctional (Grizzle, 2002) and a real issue and

created a real barrier to an organisation improving its performance. This would support Seddon's (2003) notion that targets are flawed; targets may provide direction numerically but can create problems within a system.

During the interviews it was noted that there was a frustration from senior managers due to there being an inability to have an influence on the negotiation of setting the targets this was also clear during the surveys where staff stated they had less influence on this process even though they were required to populate the systems to measure them. Although it was noted that quantifiable measures such as process-driven targets were not all negative, in fact, the senior managers remarked within the interviews that you need to have some kind of judgement to work from. What can be collected as a result of the process and is measurable and collected from the activities of staff may become a useful guide.

Mannion et al (2005) looked at the culture of high performing trusts and found that there was a cultural taboo within the better performing trusts of not hitting process based targets, however, the study defined a high performing trust as an organisation that would be achieving its star ratings anyway and this was being measured from a process based target perspective.

In summary not all process-driven targets are bad as they provide an opportunity to measure nationally and to drill down, however they need to be balanced alongside measures that provide information and the description regarding the input and the outputs that are meaningful for staff and this should not be about

the measurement of everything and less is required for the fixation of targets (Marr, 2009).

7.5 Outcomes-based approaches

The main related themes concerning outcomes based approaches that emerged as a result of the primary research are listed below:

- The government has now set centrally set outcomes frameworks

- The measurement of quality needs to be captured

- Outcome measures are not timely enough

- Lack of detailed drill down data makes it more difficult to measure outcomes

- Outcome measures may have the potential to support learning

- Outcome measures need to be meaningful for staff

As highlighted previously there were a number of comments from the interviews that highlighted a need to adopt more outcome-based measures and to support delivery of the performance agenda for the English NHS to move towards a greater focus on quality and outcomes (*NHS Outcomes Framework 2011/12, DOH, 2010*) as opposed to previous target based frameworks:

'There is certainly more that we can do, I would like to build in more outcomes into it partly as it is nationally driven but partly because it is the right thing to do. What you are trying to achieve is the best possible outcome with your resource.' (Delegate)

'Two years ago it (performance management) was nationally driven based on activity targets reducing waiting times, now with the overall economic problem the agenda has shifted to a more complex one actually we are trying to improve outcomes.' (Senior Manager)

Taken from Interview 001

It is fair to state that the English NHS has now completed a significant transitional phase as a result of the reforms set out within *Equity and Excellence* (DOH, 2010) moving the NHS further towards outcomes measurements. Criticisms of the new frameworks provided from the interviews have been that the measures used were not too dissimilar to previous process based frameworks as highlighted in the statement below:

'Now the transition entered the CCG (formally PCT) and now it has moved towards the outcomes framework certainly at a national level that is what is viewed by some, but internally they retained a lot of the old performance management frameworks.' (Delegate)

Taken from: Interview 004

This is a cause for concern as the measures that staffs were subject to internally are still target and process-based measures that may pose a risk of minimal staff involvement to support their design. Other issues that were raised by a senior manager within the interviews was that the measures were not timely enough and there was a significant lag almost taking up to a year to report and where there were deep-seated problems there was a need for drill down measures to be in place to expose the cause and effect. In contrast to this the business intelligence team were concerned during a focus group regarding the volume of data collection that was required to populate outcome measures and how it is perceived, see notes below:

'The measurement and delivery of performance information regarding quality outcomes are a potential challenge to the business intelligence team as existing cultural attitudes and beliefs were very much borne as a result that performance management focuses too much on data collation for the decision-making process.' (Delegates)

Taken from: Business Intelligence team focus group notes

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To avoid data collection overload this may require the organisation to design a set number of multi-layered or dimensional measures that reflects performance that is of importance and value to staff within the organisation, a great opportunity to look at utilising outcomes measures to support the development of a learning-based organisation, (Senge, 1990), (Marr, 2006), (Agyris, 1958) (Nonaka, 1991).

It was observed and noted by the focus groups and interviews that there appeared to be a level of acceptance regarding the use of outcome measures from both staff and senior management and was seen as the right move forward.

A senior manager highlighted in the interviews that outcome measures have the potential to mask the more detailed picture of the process if the outcome was the only measure, claiming that statistical confidence rules on outcomes are not as robust as they could be. Where there is a need to change the process to make improvements there may be potential difficulties with identifying what part of the process could be the problem and to monitor the on-going performance has been an issue when shifting towards the new framework as highlighted in the statement below:

'Trying to work to a new model rather than working to tried and tested model it was a new shift towards outcomes, the problem with outcomes is that they are very difficult to monitor.' (Delegate)

Taken from: Interview 004:

It appeared from the interviews as highlighted earlier there is a problem in drilling down into the detail with outcome measures, whilst at the same time not knowing

what is truly driving them, this inability to understand what is driving them may be the nature of outcomes measurement as it was remarked by one senior manager that they just become an overview. This highlights a need for the organisation to adopt more detailed granularity surrounding the outcome measures that may have been available with process-driven targets. A key requirement of this may be to standardise more detailed measures than the outcomes framework across organisations, however, this may require returning to a top-down approach although it was remarked that national measures cannot fully define everything, see statement below:

'It is all about the stability of the system and how you maintain that, so I think there is it sometimes not easy to translate that into a small set of national measures that actually fully define it, I can recognise the challenge and problems with that but I know they tried to solve that with the outcomes framework even though being slightly cynical it's not sensitive enough to identify the differences between organisations.' (Delegate)

Taken from: Interview 004

Interestingly a senior manager within the interviews highlighted that they would rather have produced fewer units of process based activity (numbers in treatment etc..) providing that customer satisfaction was higher, it was viewed as more important to measure the things that mattered to patients and the service. As highlighted in the statements below:

'Not the outcome as is what is monitored but the outcome as it what is best for the service that is ultimately where I want to get to I suppose.'

Taken from: Interview 004

'Include user satisfaction objective outcome measures e.g level of disability etc .reactive activities versus proactive activities to see if one influences the other.' (Delegate)

Taken from: Performance Management Survey

Delivering and providing lots of units may not always be a part of the public's agenda although it may be difficult to establish whether waiting times are either, this may be dependent on the patient's situation or on what part of the pathway the patient finds themselves. The perception of the patient may be more important to measure along the pathway and may provide the granularity of detail that sits under the broad outcome measure. The focus group notes highlighted when discussing the perceived barriers to the delivery of performance management there was now a need for the organisation to recognise client and patient perceptions and there was a greater need to focus on the patients and the service. This may not be achieved by just adopting a set of broad outcome measures from the Department of Health but may require more locally based set of measures to be designed, this would require staff and patient involvement to ensure the right measures are adopted.

'What are the opportunities for performance management in the NHS?' (Researcher)

'Performance management does have the potential to look at evidencing good quality services and identifying what quality actually is that may have gone unnoticed in the past.' (Delegates)

<div align="right">Taken from: focus group flip chart notes</div>

The interviews supported local design by taking the structured outcomes and relating to them locally so local decisions can be made to plan and commission services, no different to a process driven approach, the only difference is that formal top-down performance management may not necessarily be required to ensure that the outcomes can be met.

Outcome or process-based measures may need to be focused on the ultimate end point or objective and this may not change totally the beliefs and perceptions of staff towards performance management as specific attention may remain from the top down Central Government. There may, however, be an opportunity for the organisation to use performance management to engage and learn with staff and patients and look for the detail that may be missing that underpins these broad measures whilst still being able to balance with a top down requirements. The opportunities have been highlighted in the statement below:

What are the opportunities for performance management in the NHS? (Researcher)

- *Patient- good quality service at point of delivery*
- *Objective and proof of effectiveness*
- *Enhancing patient pathways*
- *Improved services – changes, clinical*
- *Outcomes – will be able to demonstrate*
- *Appreciation of quality issues throughout the NHS*
- *Less stressed patients*
- *Less complaints*

(Delegates)

'What are the opportunities for performance management in the NHS?' (Researcher)

'This would produce a more beneficial impact on less stressed patients and fewer complaints improving reputation management. Other positives included greater reflective learning, leaner working practice, more motivated and committed staff and a clearer vision and outcomes.' (Delegates)

Taken from: focus group flip chart notes

Outcomes measures in the future will need to have the detail to enable the flexibility for the organisation to change and adapt to future requirements as

highlighted by Bevan (2009) and Keller and Price (2011) when referring to organisational development.

7.6 Strategic planning

The main related themes concerning strategic planning that emerged as a result of the primary research are listed below:

- Difficult for frontline staff to engage with strategic planning

- Need to align staff with the organisation's strategic aims

- Strategy needs to provide the direction of travel using the performance framework to understand

- There is a necessity to develop a skilled network of champions to enhance and motivate staff

Staff had expressed during the surveys the difficulties of having the right people available who would know what the right direction of travel for the organisation is, this notion of alignment that was supported by Gates (1999) Marr (2006) and Michelli (2009) and can be highlighted by a statement provided by a senior manager, see below:

'I think there is an element of that to go in the strategic nature of the things we are trying to do and it understands the different behaviours that sort of underpin it. So when you know your direction of travel you then need your data systems to be aligned to that strategic framework and then your performance targets align to them data systems and then that will give you a greater clarity of what it is you are trying to achieve.' (Delegate)

Taken from: Interview 004

Further supporting this during the interviews, a broad question utilising an appreciative inquiry methodology was posed to a senior manager regarding performance management design, see below:

'If you were able to design your own performance management system without limitations or barriers what sort of design would it be or approach?' (Researcher)

'That is a very broad question I will need to ponder that for several weeks. I think for me it has got to try and find what direction you are trying to take it's all about strategic alignment as the NHS is facing these financial pressures with demand growing and essentially operating in a flat cash environment.' (Delegate)

Taken from: Interview 004:

The statement above clearly emphasises the importance of alignment (Marr, 2006, Michelli, 2009, Reynolds & Ablett, 1998, Gates,1999) so everything is moving in the same direction to achieve the same performance to meet the goals the survey results, see **Appendix B** showed that alignment was important for performance management and strategic planning, although staff had requested there was a need to have the right people in the right place to support this, see statement below:

'*It is sometimes difficult to access the right people to talk to- people who have an overview of the whole PCT service who can advise and support clear business planning e.g commissioners, people in their directorates.'* (Delegate)

Taken from: Performance Management Survey

This may require the organisation to work together at all levels and have the right skilled people in place who have the overview who can provide advice and

support on business planning, in other words, strategic champions from a multi-professional perspective. This would require a need for training and workshops to be developed to create an accessible network of skilled facilitators who could interact at all levels during the implementation of the strategic planning cycle.

It had emerged from the focus groups that there was a lack of flexible structures that was creating a problem amongst staff placing them in a position to be reactive; this can be highlighted in the statement below:

'What are the opportunities for performance management in the NHS?' (Researcher)

'Lack of flexible structures to allow teams on the ground to function more effectively, placing frontline staff in a position to deal with the day to day immediacy of the service and therefore placing the service in a more reactive rather than a learning, strategic planning or proactive approach.' (Delegates)

Taken from: focus group flip chart notes

The above note highlights that the lack of flexibility within the current structure does not allow the staff to engage fully with the strategic planning process potentially making it difficult for staff to operate in a proactive way. Communication was highlighted on numerous occasions as being a problem, see the statement below:

'Much stronger communication is required to ensure people are aware of the links to the strategic aims of the PCT.' (Delegate)

Taken from: Performance Management Survey

Staff were not aware of the strategic aims of the organisation therefore much stronger communication and awareness regarding performance management and strategic planning is required.

On a more positive note performance management was perceived within the focus groups as a means to address some of the issues regarding strategic planning, see delegate's flip chart notes below:

'What are the opportunities for performance management in the NHS?' (Researcher)

- *Clarity – Where we are? Where have we come from? Where do we need to go? & how do we get there?*
- *Identification of bottlenecks to improvement*
- *Identification of which services need more support*
- *Concrete evidence for planning which is understood by all stakeholders*
- *Answers the question, ''How are we doing?''*
- *Aid problem solving*
- *Trends*
- *Everyone (all staff patients and public) could see our performance level and how we are progressing*
- *Able to know where we are going*
- *Clear direction of travel*
- *Proactive – control forward planning, reflective learning, reflective learning = leaner working practice*
- *More motivated & committed staff, clearer vision.*
  (Delegate)

Taken from: focus group flip chart notes

In summary, there appears to be a number of issues and concerns regarding strategic planning and performance management that have a key role to play in supporting the delivery of the organisation's objectives. This requires the organisation to develop more flexible structures to allow the staff to align and to engage more fully with the process in the future and to be provided with the support from skilled individuals that can support training and awareness.

7.7 Finance & efficiencies

The main related themes concerning finance and efficiencies that emerged as a result of the primary research are listed below:

- Performance management is still used traditionally in the NHS for financial measurement

- Efficiency is shaping the performance management agenda

- Too much emphasis on financial targets rather than quality

- Performance management has the ability to support value for money

- Staff do not have an influence on setting service contracts

- True cost vs outcomes need to measured

- Performance management can be used to evidence true provider cost and value

The need for performance management to move away from traditional methods of accountancy has already been highlighted by Axson (2007), Marr (2007), & Cokins (2008). Kaplan & Norton (1992, 1996, 1996b) saw the strategic application of performance management to be of far more importance when finance is balanced against a number of other elements. The interviews had highlighted there was a potential return to using performance management for financial and efficiency purposes, see statement below:

'From my perspective, I do not see much of the outcomes framework, so I am in two minds as to what extent that is really the driver behind what it is that we do. My real sense is that it is shifting more towards the finance and Qipp side of it as that is where the greatest risks lie.' (Delegate)

<div align="right">Taken from: Interview 004</div>

Performance management's previous sole purpose as a financial tool needed to be measured alongside, learning and growth, patient satisfaction and quality/operational, similar to the balanced scorecard model that was highlighted in Kaplan & Norton (1992, 1996, 1996b). Chan (2003) suggested that balancing performance with a focus on vision and strategy was important for an organisation and recommended strategic evolution that complements financial measures, this was evident from the interviews, see statement below:

'Chasing individual targets is never a great thing we try to rebalance and reshape the whole system and I think that is the best model or tends to be that balanced scorecard system or having your different indicators all focusing on core issues and that way you can get, you have to try and triangulate.' (Delegate)

Taken from: Interview 001:

The surveys focus groups and interviews had all evidence that there was a strong relationship between performance management and finance and that it was being used as a tool for contracting and efficiencies. Atkinson et al (1997) proposed earlier within the study that a specific purpose and role for performance management was required to meet the contractual requirements of the organisation. The focus groups commented that performance management did not have the ability to identify quality in the delivery of frontline services as it was perceived as having too much of a primary purpose to measure for financial reasons. The need to use performance management as a financial contracting tool was also reflected earlier with the exploratory study within *Developing the Performance Regime* (DOH, 2008), see notes below:

'What is your current perception of performance management? (Researcher)

'Performance management does not have the ability to identify quality delivery in frontline services and only has a purpose to measure for financial purposes and requirements.' (Delegates)

Taken from: focus group notes

The interviews had highlighted that performance management was being utilised by commissioners to support the business planning process for *Payment by Results* which is a financial performance related measurement system that is used primarily within hospital acute based commissioning and contracting, this was referred to previously in the study, *Commissioning a Patient-Led NHS* (DOH, 2006). The focus groups perceived that performance management focused too heavily on financial data and its collation for senior managers to conduct the decision-making process focusing too much on the cost and volume of services rather than the quality output. The accountancy requirement for performance management is also very much evident within, *Healthcare Output & Productivity* (DOH, 2005) that uses finance as the basis of the primary measure.

The interviews highlighted that the case study organisation considers efficiency as a key deliverable to remain sustainable and solvent, therefore supporting performance management as a tool for finance, however Lingle & Shieman, (1996), Frigo & Krumwiede, (1999) & Griffel, (1994) proposed that Performance measurement should be used as a tool for management before it is used as a tool for finance, senior management's perception of performance management as an efficiency tool was indicated during the interviews, see below:

'Holding people to account to be achieving best value, looking for efficiencies and to be encouraging partnership and where people are performing to be making judgements may be looking at clauses to reduce funding.' (Delegate)

Taken from: Interview 002

Efficiency being used for performance frameworks for financial requirements is shaping performance frameworks. I don't think there is necessarily one perfect solution (framework approach/design) and I think that it's interesting how the 'Qipp will need to save a lot of money over a long period of time and how important that is shaping the framework.' (Delegate)

Taken from: Interview 001:

Axson (2007), Marr (2007), Kaplan & Norton (1992, 1996, 1996b) & Cokins (2008) proposed a more significant move away from the traditional dominant financial purpose for performance management by proposing that performance management should incorporate balanced learning across a number of elements.

It was commented earlier within the introduction chapter that in the past the English NHS has been placed in a situation where there was ever increasing resources and financial growth, see **figure 2.1** (Harker, 2012), therefore the investment within the NHS was expected to meet the demands imposed. It was stated by a senior manager within the interviews as a result of this investment the NHS was in a more flexible position to spend to a point that enabled them to meet a range of Department of Health set performance targets, see *Performance Assessment Framework* (NHS Executive, 1999*)*. A good example of this was the requirement to deliver a number of financial process-driven targets set out in, *A Plan for Investment, A Plan for Reform* (DOH, 2000), spending on more treatment output may have been the simpler linear decision-making approach that was

taken at the time. The need to deliver on targets and having the financial support

has been highlighted below:

'In the very early days, for example, the XXX intervention programmes or XX programmes just started so there was fresh Home Office money new clearly identified crime reduction money, it would get results at any cost these are the targets, go in and do it.' (Delegate)

Taken from: Interview 002

However, what may have occurred subsequently looking at the descriptions and

perceptions from staff and senior management there may have been an intention

from the Department of Health to shift away from these target based, process-

driven approaches to relax the targets and therefore the demands. This would

move NHS organisation towards efficiency and sustainability to meet the static or

lack of growth, that can be evidenced within, *How to Achieve World Class*

Commissioning Competencies (DOH, 2008) & *NHS Operating Plan,*

2010/11(DOH, 2010).

'About five years ago we had a situation where we basically had ever increasing resources, what the organisation tended to do where it had money is to decide what to do with it. Nationally performance frameworks you needed to reduce 18-week referral to treatments you addressed that by spending on more treatment the simple linear decision making, what we now got is we are not going to get any more money going up and therefore we need to think where are we going to take resources away to then shift from one bit of the system to another.' (Delegate)

Taken from; Interview 001

The impact of efficiencies and how this has affected staff behaviour during a

period of financial constraint was investigated via a longitudinal study that was

conducted by Collier (1997). Collier (1997) conducted research on the Police

force at the time where the control system that was being implemented was not fully aligned with the organisational culture. Collier (1997) concluded his research stating that the issue of communication and the sharing of knowledge or 'we are all in this together' approach is more important in ensuring that efficiencies can be achieved.

By making this shift towards efficiencies there would be a requirement to redesign the local performance framework accordingly to deliver and balance more in areas of quality and effectiveness. The study had found from the primary data that there may be a potential disjoint between staff and senior management regarding performance management purpose and presents a risk that the perception of it may become purely driven by the need to save money, rather than ensuring that quality of care and patient satisfaction can be delivered.

A senior manager discussed within the interviews an interesting situation when imposing a performance framework where the behaviour displayed was shaped by the need to deliver on financial results and priority targets. The Home Office had made funds available for specific intervention programmes and was being used as a performance incentive and as a result became a key driver to monitor financial performance. The behaviour of rewards and reprimands have been covered by Gleave (2008), the senior manager claimed performance management was achieved via the micro-management of finance and what it influenced. Drugs budgets were measured against performance targets using the process driven framework as opposed to an outcome based approach, performance management was used as a means to evidence delivery and

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provided an opportunity for the senior manager to raise some difficult questions as to why the organisation was investing in particular areas that were not necessarily a Home Office target or priority.

Quality improvement productivity and prevention (QiPP) (see *NHS Operating Plan, 2010/11* DOH, 2010) was referred to on a number of occasions during the focus groups. Within the interviews, it was perceived that QiPP had emerged as a dominant aspect of the framework evidencing that the application of strategic planning and performance management had been utilised as a means of creating efficiency savings.

'My real sense is that it is shifting more towards the finance and Qipp side of it as that is where the greatest risks lie.' (Delegate)

Taken from: Interview 004

The surveys that were conducted on frontline staff referenced that performance management was being utilised to primarily measure financial performance and indicated that contracting service level agreements was a major part of it to commission from a basis of value for money with the potential for performance management to provide transparency, greater accountability and evidence service effectiveness within the contracting relationship.

There were concerns from staff within the focus groups that service level agreements needed to reflect the reality of what a service should be delivering for patients in relation to budgets and staff allocations etc. it was noted that there needs to be an established true actual cost for activity, by breaking it down into

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its component parts along a pathway and then to measure against total patient outcomes to include, for example, the cost of services provided against the cost of savings made to the welfare state for e.g. in mental health services.

Kaplan & Porter (2011) supported this notion claiming that to solve the overall cost crisis in health there was a need to measure the right things and proposed that accurate costing of process improvement needs to be readily calculated, validated and compared. This was further supported by the following statement:

'When providers understand the total costs of treating patients over their complete cycle of care, they can contemplate innovative reimbursement approaches without fear of sacrificing their financial sustainability.'

Source: Kaplan & Porter (2011) page 6

The above statement supports the notion that to make improvement changes and to remain sustainable staff and senior management need to be aware of all costs; this would require collecting the relevant data and be provided with the relevant skilled individuals from within the organisation to calculate this within the service teams. Teams and individuals at all levels of the organisation would be required to learn the system, the measures, tools and procedures this would require engagement (Frigo & Krumwiede, 1999) (Kaplan & Norton, 2001) and this may bypass some of the causes of the dysfunctional behaviours outlined by Marr (2008).

Activity-based costing is an example that was proposed by Kaplan & Anderson (2004) where costs can be identified across a process or pathway of care. Another activity costing application that was referred to in the interviews to identify

the spend with regards to non-bed days as opposed to blocked bed days, performance is measured in these terms as there may be an opportunity to uncover financial savings opportunities. Staff within the surveys supported the notion that it is essential that the performance management framework should measure the true cost of providing hospital-based care in comparison to what is delivered in the community against the overall patient outcome. The focus groups highlighted that performance management can enhance the ability of a service to deliver more cost effective services; value for money could also be achieved by redirecting resources into more effective services and therefore creating a much greater return.

It would perhaps be more beneficial to frontline staff if there were an understanding and clarity about how the work of the service impacts on the case study organisation and its overall resources. Collier (1997) supported the notion of performance management having a financial and efficiency basis as a measure of service costs and overall patient outcomes. The focus groups appeared to support the notion that it may provide an opportunity for the public to scrutinise the services and to establish for themselves what value and quality of service NHS organisations are providing the resources and inputs invested.

7.8 Levels of interaction & multi-organisational engagement

The main related themes concerning levels of interaction and multi-organisational engagement that emerged as a result of the primary research are listed below:

- Performance information needs to be more open and transparent

- There is a cynicism around performance management with a lack of sign up on the frontline

- There are different levels of interaction therefore different perceptions of performance management

- Performance management may be seen as a senior execs and commissioners tool but not necessarily for frontline staff

- A multi-organisational system is both complex and adaptive and requires collaboration across stakeholders

- There should be a collective approach across organisations to gather performance information

Within the interviews, it was perceived that only the Executive Board and senior managers may place an emphasis on the need for a performance management system to interact at all levels of the organisation.

'I think for me there is a dangerous world with developing performance frameworks with only seeing them as a Board or senior executive framework when actually they are really designed to be for the whole organisation.' (Delegate)

Taken from: Interview 001

It was remarked during the focus groups that performance management had a particular corporate language that is far more in tune with senior managers that may not relate to clinical responsibilities. Perhaps there is a need now to build a sense of community or common purpose and the need for trusting relationships that incorporates staff at all levels into one single language, this may start from

creating and developing the learning enabled environment (Agyris, 1999) (Marr, 2006) & (Senge, 1990).

This could be developed in many innovative ways such as, developing communication through appreciative-based scrutiny reviews that brings together decision makers, practitioners and service users to look at creating and developing effective solutions (Turner, 2012), joint benchmarking (Ammons, 2002, Bogan, & English,1994) where the sharing of information across all levels and professions can provide a feeling of we are in this together (Collier, 1997). Introduce communities of practice (Wenger & Snyder, 2000) with a purpose to bring together informally a number of skilled individuals to share learning at all levels and to promote a shared understanding of performance management. The differing perceptions of performance management were raised as a risk during the literature review (Pettigrew et al, 1999) but its prevalence was also confirmed by a senior manager within the interviews, see comment below:

'People in the organisation have different levels of interactions with it (performance management); people have different views of performance management' (Delegate)

Taken from: Interview 001

The surveys and focus groups had highlighted that overall there was a necessity for frontline managers to become more aware of their service performance to understand how processes can be improved. Brignall (1993) proposed a multi-dimensional performance measurement system to support local authority service managers to encourage their involvement for greater service process redesign.

Building the right structure may appear to be an essential factor for better interaction but also the development of the right framework may be important to promote involvement, it was claimed that this has already been developed within the case study organisation, see comment below:

'You have to build a structure for the needs of all those groups and I think that is the way I built the performance framework to try and meet the needs of everybody at different layers but it is a multi-tiered structure now.' (Delegate)

Taken from: Interview 001

However, there was a level of cynicism noted towards performance management within the focus groups and the surveys amongst clinical staff who were potentially claiming it may be due to a lack of promotion and awareness of the existing performance frameworks at their level. A perceived barrier towards performance management was agreements at differing levels of the organisation, see comment below:

What do you perceive as the barriers to the delivery of performance management? (Researcher)

'Agreement between senior management teams & clinicians' (Delegate)

Taken from: focus group flip chart notes Q2

Interestingly it was proposed by a senior manager within the interviews that ownership needed to be initially claimed by the decision makers rather than the frontline deliverers, as he saw there was a necessity to feed the right information to the right senior exec committee to ensure they can see what is going on to

make the right decisions to cascade down to the operational layer supporting the notion of a top-down command and control approach (Seddon, 2003, Marr, 2006, Michelli, 2009) this was highlighted earlier within the literature review. It was perceived within the surveys that the performance management role was becoming a greater responsibility for frontline managers, see comment below:

'Historically in our service, this work has been done by senior managers (performance management), however, in the last 18 months there has been an increasing expectation that my level will have involvement.' (Delegate)

Taken from: Performance Management Survey

The statement above highlights the increasing performance management role that is being devolved down to providers, it was also noted within the focus groups that performance management may provide a level of support or a tool for providers to engage with their commissioners. Brignall & Modell (2000) highlighted the differing relationships between purchasers and providers and how it may be bridged to become more integrated and balanced by introducing a shared performance management system balancing the interests of both parties. This may require the development of an appreciative approach (Cooperider et al, 2005) from both parties to understand common interests, objectives and goals whilst respecting the differing roles required within the relationship.

Performance management may provide an opportunity for commissioners to engage with providers on an equal playing field this was very much reflected by the senior managers within the interviews. The need to create a better alignment (Gates, 1999) via shared performance management frameworks between staff,

senior managers and commissioners were a common theme within the primary data.

Concerning multi-organisational engagement, it was commented by a senior manager within the interviews that a performance framework provides an opportunity to engage the whole health community in a collaborative way or from a system based way of working (Busi & Bittici, 2006). Seddon (2005) has highlighted that the added benefits of viewing performance management from the perspective of a system as opposed to utilising targets claiming command and control are a failing paradigm. Senge (1990) called for a greater understanding of the wider system and its processes. To move forward on a collaborative performance management approach within a system there would be a requirement for the case study organisation to engage with a number of organisations.

A senior manager within the interviews called for the whole health community to work together to challenge any deep seated issues regarding performance but requested a performance framework that could operate within a set boundary so the performance is not getting lost nationally, see statement below:

'It is more difficult though with multiple providers and differing boundaries. Having a simple relationship enables better information sharing. Get a few areas where the outcomes are generally very good and others where we just seem to have deep seated problems and it is then how the whole health community works together to challenge those issues.' (Delegate)

'Those boundaries make a lot of performance sharing a lot easier than say a large county-wide place with a multiple of providers and those different boundary

debates by having that simple relationship with other providers it does make information sharing better.' (Delegate)

Taken from; Interview 001

Another factor that was raised within the interviews by senior managers was that by looking at the whole health community the case study organisation had the ability to view performance across a wider number of organisations. This may have the potential to support the shifting of care away across a pathway from acute hospital services into community-based settings with a purpose to realise efficiencies. However, it was also commented for this to work all the organisations would be required to sign up to a joint performance framework. Although, staff within the focus groups expressed that trust and the joined up approach was not necessarily occurring and was claimed to be providing duplication and acting as a potential barrier, see flip chart notes below:

What do you perceive as the barriers to the delivery of performance management? (Researcher)

- *Complex adaptive system*
- *Trust between organisations – duplication*
- *Perceived lack of joined up thinking – common sense*
- *Partners – outside influences*
- *Team working – internal & external = one NHS*
(Delegates)

Taken from: focus group flip chart notes Q2

However, looking at the notes that looked at the opportunities for performance management it was perceived within the focus groups that joint working may have an impact on performance management, see notes below:

What are the opportunities for performance management in the NHS?
(Researcher)

- *Guidance – inter-service cooperation*
- *Stop the blame culture*
- *Partnership across communities*
- *Support robust negotiating*
- *Appreciation of quality issues throughout the NHS*
(Delegates)

Taken from: focus group flip chart notes Q3

The above notes highlight the importance of joint working however from the interview transcripts communication is an important factor to consider when working within a larger system or community. Marr (2006) viewed the automated system as a means to enable organisations to communicate amongst stakeholders, Marr (2006) predominately utilised the value creation map as a form of the interface using web based software based technology. Marr (2006) claimed that providing a solution online allowed better accessibility of the performance framework and promoted collaboration amongst its stakeholders. To manage the complexity and differing perceptions Marr (2006) proposed a multi-dimensional approach so all stakeholders could relate to the presented performance information. Differing perceptions of performance management have already been highlighted within the primary data see **section 7.1** and the literature reviews see Pettigrew et al, (1999) and De Waal (2008).

Within the interviews a senior manager highlighted that to allow stakeholders to collaborate and work together there is a necessity to build a community-based performance framework. It may be expected that the *NHS Outcomes Framework 2011/12* (DOH, 2010) may have provided the opportunity for this to occur,

although a senior manager stated this may not necessarily be the case, see transcript below:

'But you need to have everyone signed up to that is that is what you are saying?' (Researcher)

'Yes and that is what it is, it's almost like having to build a performance framework for the health community you could even include social care as they are a part of that work and I know the outcomes framework is expected to join up with a wider view although I still do not sense the performance frameworks have yet.' (Delegate)

Taken from: Interview 001

The primary research has identified that there is a need to look at a whole health community-based performance frameworks that could be designed with the joint involvement of organisations that have an impact on patient outcomes and pathways and may be the way forward for performance management in the future. This may be enhanced via the collaborative learning based system approaches proposed by Senge (1990), Santos et al (2007) and Busi & Bittici (2006). One senior manager commented on new performance approaches post-reforms, *Equity and Excellence* (DOH, 2010), that it is less about performance (command and control) and more about how organisations influence via a partnership approach, therefore performance management may have a potential to support this.

According to Santos et al (2007) (Marr, 2006) business performance, information/ intelligence systems are considered important to support the development of performance management frameworks and we will focus on this in the next section.

7.9 Performance information & systems

The main related themes concerning performance information systems that emerged as a result of the primary research are listed below:

- The Business Intelligence Team and wider staff are key to supporting performance information systems
- Information systems do not capture the right information and are limited in scope
- There is a need for greater sharing of information across and within the organisation
- Data quality is poor, incorrect and of insufficient quality to be meaningful to staff
- There is a lack of resources and training on information systems
- Current information systems are not automated

During the surveys in the study it was evident from the data there was a strong level of cynicism from staff and senior managers towards the current performance information management system that had a purpose of capturing essential intelligence and information to measure the organisations performance.

De Waal et al, (2002) and Marr (2006) who were highlighted within the literature review found that information and intelligence are critical for effective performance management to occur. Neely (2008) claimed that a good performance management information system should enable informed decisions, as it evidences efficiency and effectiveness via the acquisition, collation sorting,

analysis, interpreting and dissemination of information. Otley (1999) supported the above claim placing greater emphasis on the importance of effective information systems that may essentially provide a role in supporting the communication and information flow for feedback and feed forward purposes that may support double loop learning (Agyris, 1978).

It emerged from the focus groups discussions that there were potential opportunities for the case study organisation to use the data and information system to capture a single truth across the commissioner and provider, see facilitator's notes below:

'What are the opportunities for performance management in the NHS? (Researcher)

'Both parties (commissioner & provider) could work to agreeing that performance data could be viewed as the evidence of delivery.' (Facilitator)

Taken from: focus group facilitator's notes: Q3

However, criticism was raised from staff towards the established performance management during the focus groups that highlighted a number of problems that included the following:

What do you perceive as the barriers to the delivery of performance management? (Researcher)

- *Poor resources IT systems*
- *No mechanisms for recording patient clinical output/user outcomes*
- *Use of data – what is needed do clinicians understand the need*
- *Data quality*
- *IT does not work*
- *Understanding including IT*
- *Irregular review of performance data by clinicians /managers*

- *Different data collection systems ability to access systems*
- *Insufficient data management*
- *Data integrity – acceptance*
- *Informatics – limited in scope*
- *Systems can't talk to each other*
- *Getting reports out (from the system) easily*
- *System integrity – IT & process reliance, input vs output, cost, usability, training*
- *Not timely*
- *Trust in system (IT or other) in each other*
- *Lack of support and training*

(Delegates)

Taken from: focus group flip chart notes Q2

The above barriers towards performance management by staff and senior management raised above may potentially be preventing the right picture of performance to emerge for the purpose of strategic planning, programme development and budget setting. It was claimed by staff during the focus groups that the current intelligence system in place may not necessarily be reflecting or evidencing the work that staff were setting out to achieve, having the resources and time was a major factor to conduct necessary analysis and to improve the current system.

'What do you perceive as the barriers to the delivery of performance management?' (Researcher)

'This was very much coupled along with the lack of resources and time that was required to fulfil performance management requirements whether that was to provide the data requirements or the time to conduct the analysis.' (Facilitator)

Taken from: focus group facilitator's notes: Q2

The focus groups requested that there is a need to capture the right information accurately in real time as closely as possible. Marr (2006) looked at the benefits of automation to address these issues and in doing so support and releasing as many resources as possible. Automated decision support was identified within the conceptual model to address the potential barriers that emerged from the literature review. By automating a system there may also be the potential for the organisation to make the data more accessible a concern that was raised by staff within the surveys. A senior manager within the interviews admitted that the client study organisation needed to invest more time and effort into the development of the system, however there was also a need from within the focus groups for better interpretation of the data; staff proposed that some form of a data management handbook may be developed to address this.

The meaningfulness of the data was considered important by staff and senior managers and therefore a redesign of the current measures was recommended, a senior manager from within interviews proposed that both commissioners and providers need to jointly work together with staff at all levels. A requirement of meaningful measures was requested by staff to allow a level of freedom and autonomy for the organisation, the need to provide staff freedom was previously outlined by Bevan (2009) within the literature review. An example of meaningful information was proposed by staff within the surveys that included clinical outcomes, statistical process control, social inclusion, payment by results and service line reporting.

In parallel to the resource concerns and the meaningfulness of the data that was highlighted earlier, the Business Intelligence Team within the focus group sessions had a real concern regarding data quality, see facilitator's notes below:

'It was remarked that there were significant data issues that needed to be addressed first to ensure that real performance management frameworks could be implemented effectively within the organisation.' (Facilitator)

Taken from: Facilitators notes from B I Team focus group session

It was also commented by the staff that data quality was an issue towards the perception towards performance management, see notes below:

What is your current perception of performance management? (Researcher)

- *Hard to understand all the info*
- *Unsure if stats are correct*
- *Audit/collection of data can be seen as a stick to beat us*
- *Not always current information (stats are too old)*
- *Information to improve services*
- *Acceptance of data Quality….*
- *Epex (system issues)*
- *Is the data correct?*

(Participant)

Taken from: focus group flip chart notes Q1

The staff that input onto the performance intelligence system such as health practitioners was generally concerned that the current system was not suitably designed to capture the right information and that the system was poor in its support and delivery. In parallel, the analysts or the extractors of the data from the Business Intelligence Team accused the system inputters of not accepting

the data as a truth that reflected actual performance. Due to these concerns raised by the inputters and extractors of the system, there was a potential inability for the Business Intelligence Team to utilise the data for reporting purposes and to present it as an actual evidence base and for the inputting staff to accept and take responsibility for what had been imputed into the system. The focus groups have highlighted that poor systems and data quality are an important factor to deliver performance management, see flip chart notes below:

What do you perceive as the barriers to the delivery of performance management? (Researcher)

- *Poor resources IT systems*
- *No mechanisms for recording patient clinical output/user outcomes*
- *Use of data – what is needed do clinicians understand the need*
- *Data quality*
- *IT does not work*
- *Understanding including IT*
- *Irregular review of performance data by clinicians /managers*
- *Different data collection systems ability to access systems*
- *Insufficient data management*
- *Data integrity – acceptance*
- *Informatics – limited in scope*
- *Systems can't talk to each other*
- *Getting reports out (from the system) easily*
- *System integrity – IT & process reliance, input vs output, cost, usability, training*
- *Not timely*
- *Trust in system (IT or other) in each other*
- *Lack of support and training*
  (Participants)

Taken from: focus group flip chart notes Q2

The performance information system needed to support effective decision making at all levels of the organisation (Marr, 2006) but for the case study organisation to achieve this, there was a need to ensure that the information

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system can be redesigned towards the needs of both inputters and extractors to address data quality. This would require a more detailed audit on the performance information system to be conducted by the Business Intelligence Team in collaboration with inputting staff and senior managers ensuring alignment at all levels, similar to the collaborative change management model proposed by Busi & Bittici (2006).

Within the surveys and focus groups staff felt there needed to be a level of freedom provided (Seddon, 2005) to enable them to input accurate information whilst at the same time be in a position to validate whether the presented information from the Business Intelligence Team was accurate and correct. The staff outside business intelligence felt there was insufficient training provided by the case study organisation to extract data for themselves and to conduct their own audits and validation to improve data quality and to monitor their own performance and staff were very much reliant on the Business Intelligence team to support them. It was suggested by staff within the survey that perhaps a monthly system of reporting and regular feedback to the operational teams could be developed to allow for an understanding of the data, information and performance to allow necessary improvement action to occur.

Senior managers within the interviews had noted that utilising effective performance information systems may provide a number of benefits such as, being able to conduct effective comparable measurement or benchmarking (Neely, 1998) (Rightcare, 2010) and to enable the organisation to establish its performance position or status against measures at every level allowing new

ways of working and redesign to emerge. However, to benchmark, there would be a need for accurate information and standardisation across the organisation so measurement may occur against other comparable partner organisations and teams. This is potentially a dichotomy as this may restrict and impact on the freedoms which staff was calling for earlier within this section to design locally based measures within the system. To address this there may be an opportunity to develop a community of practice (Wenger & Snyder, 2000) where it has been claimed that all backgrounds and professions are provided with an opportunity to work in a more collaborative way.

The interviews did confirm that a more open and transparent approach towards the data and the intelligence system may provide a real focus for performance management, by moving staff and senior management away from the judgemental command and control approach that was identified by Seddon (2005) and by using the intelligence and information systems as an asset towards improvement, development and learning (Marr, 2006).

The interviews had identified that a large amount of performance information alongside data tools was made available within the previous performance management frameworks, *Developing the Performance Regime* (DOH, 2008) although was not necessarily available within the new *NHS Outcomes Framework 2011/12* (DOH, 2010). A senior manager claimed that a package of information/intelligence or toolkit was provided against a number performance areas and targets to support performance delivery, the senior manager claimed this made it easier for organisations to manage performance and to deliver the

service expected against the big ticket or areas of importance that was deemed by the Department of Health that was being measured nationally, see comments below:

'Wrapped around it we had national guidance on how a service should operate and what the quality standards of the service are, those things were not measured those things were not audited or performance managed it all sat around still performing four week quits but it did describe very clearly a quality four week quit looks like what a good service looks like.' (Participant)

Taken from: Interview 003

The senior manager also pointed out the toolkits provided an opportunity for the organisation to look at any underlying measures, although the toolkits were very much related to national centralised intelligence systems that were supported by the Department of Health. However, when the new performance management framework was implemented during post reforms of *Equity and Excellence* (DOH, 2010) the Department of Health had claimed to relax the monitoring of centralised targets to enable outcome measurement and in doing so the number of the central intelligence systems were reduced, this has been highlighted previously within study within Exploratory Study stage 2 and the Department of health ceased to provide the supporting toolkits. The senior manager during the interviews called for the above toolkits highlighted earlier to be reinstated regardless of the need for Department of Health to deliver target based or outcome based frameworks.

Another senior manager within another interview claimed that a majority of cases the information systems that were established pre-reforms had the ability to

provide the organisation with a tool that could drill down into a much coarser detailed granularity. However, within the interview, the senior manager was not clear as to whether this intelligence system had been shared with staff and may have been used for senior management decision making although the staff were placed in a position, in essence, to feed the beast with data with little feedback being provided to address that data quality issues. The requirement to make the information more accessible by sharing at all levels has been considered and important for the development of performance management, see below:

'Whilst I am one of those big advocates of sharing and using for the right purposes and I think the more you can understand how the system behaves is absolutely critical. To me sharing a lot of that intelligence is absolutely fundamental to really manage the system.' (Delegate)

Taken from: Interview 004

In summary, there appears from the primary research above that there are a number of potential benefits that may impact on the development of the performance management framework for the case study organisation by improving the intelligence system by working with staff and managers collaboratively at all levels. Business Intelligence teams may be required to provide the right toolkits and to share systems and knowledge across the organisation, although staff may need to take ownership and acceptance of the data. It may be required for this to be seen as a cyclical and reciprocal process and building upon what is working as outlined by the double loop learning process (Agyris, 1978). This was supported by Santos et al (2007) who claimed that

improvement of business performance information/ intelligence systems is less likely to occur if a learning enabled approach is not adopted.

Development will need to be managed to utilise a collaborative approach (Busi & Bittici, 2006) as for example, the task may involve the collection and collation of more data from frontline staff who had stated within the surveys they were already working within limited resources to deliver performance management and at the time of the survey claimed they were on work overload.

7.10 Training and knowledge

The main related themes concerning training and knowledge that emerged as a result of the primary research are listed below:

- Performance management should be a part of the induction programme
- There is little training available on performance management,
- Knowledge on performance is gained from national literature and conferences etc.
- There is a requirement for a performance measures toolkit

The staff surveys had highlighted a number of themed areas, shown in **figure 8.10** below: (N.B percentages are based on a number of related issues raised).
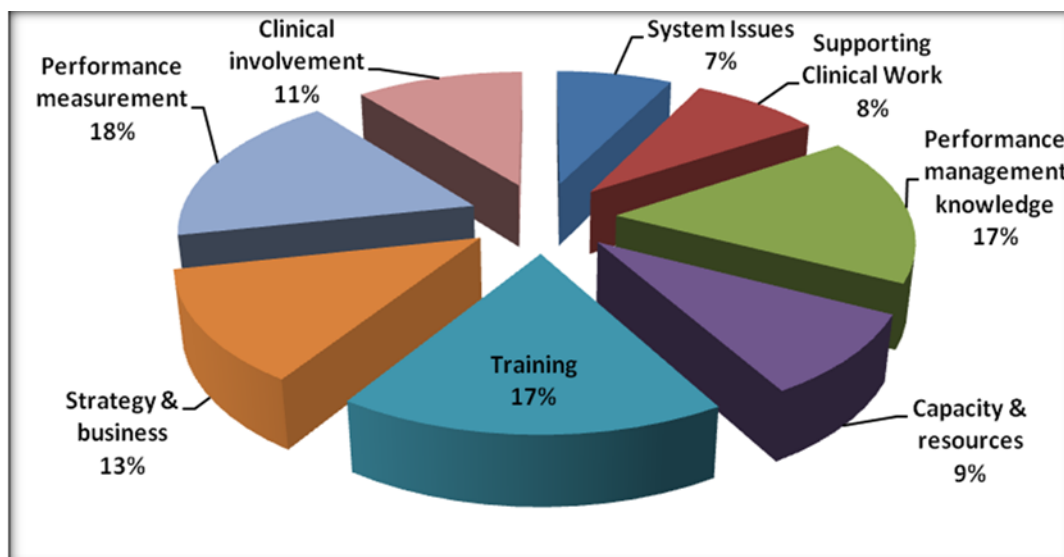
Figure 8.10 Factors that had emerged from the staff survey

Source: Healthy Performance attitudes & beliefs survey

Figure 8.10 above highlights that training and knowledge from the staff survey were perceived as an important factor that impacts on the delivery of performance management. It was commented within the survey that historically performance management was previously conducted by senior managers; however, at the time when the survey was conducted, it was claimed that there was an increasing expectation being placed on staff at a number levels to become more involved in the performance issues. However, it emerged from the surveys that training surrounding performance management was not matching staff expectations leaving staff ill-equipped to deliver on the performance management role.

The chart in **figure 8.10** indicates that training and knowledge regarding performance management was a predominant issue for the survey participants making up at least 34% of the issues raised, other related issues that emerged from the surveys included a lack of training on the performance management

system with a purpose for staff to extract the correct data and information. Greater awareness was required regarding performance indicators to enable managers to measure their team's performance and for participants to have a better understanding on what is being reported and the systems that capture the intelligence.

A lack of shared understanding and knowledge of performance management amongst the professional groups was noted by the study during the primary research stage. Multiple perceptions and knowledge surrounding performance management and its role were prevalent; this was identified previously within the study from the literature review that was conducted by Petttigrew et al (1999) when identifying the determining factors that were impacting on performance management. It was not clear from the primary data whether this perception was caused by a lack of training being provided by the case study organisation or through a lack of available literature nationally within the NHS. Petttigrew et al (1999) claimed there had been published research on performance measurement in the NHS but there was less concerning overall performance management utilisation.

A comment provided within the survey highlighted that real value regarding performance management is realised when sufficient knowledge is gained regarding the meaning of the targets and the systems, see comments below:

'Training to have better understanding on what we must report on and what we currently report and the systems used' (Delegate)

More awareness for managers on performance indicators training in how to measure and assure that service delivers on those targets.' (Delegate)

Taken from: Performance Management Survey

This need to obtain training to establish the meaningfulness of the performance data has been stated within the literature on a number of occasions (Collier, 1997, Bevan, 2009, Marr, 2009); this was very much supported by the senior manager's transcripts within the interviews, see comments below:

'What do we really know because there is not necessarily that consistency of recording practices sometimes it understands and knowledge that enables you to know the real underlying performance' (Delegate)

'I think for me that is what is useful so you can understand what is happening around individual performance areas to actually try and achieve the outcome.' (Delegate)

Taken from; Interview 004

An area for training that was raised within the interviews was to support the evidence base for the strategic planning process by obtaining the right knowledge surrounding the delivery of services. By having technical performance management knowledge available combined with service related experience it may provide a much richer and more detailed accurate understanding to set the future performance requirements of the organisation that may be flexible to the changing organisation to support organisational health outlined by Bevan (2009) and Keller & Price (2011).

The survey raised the issue of training in performance management as a necessity even highlighting the need for performance management training to be included as part of staff mandatory training.

'Performance management should be a proper part of the induction of all managers and team leaders and also an account of the direction of service line management is taking the service.' (Delegate)

<div align="right">Taken from: Performance Management Survey</div>

A suggestion for a measures toolkit was proposed by a senior manager within the interviews, the toolkit produced may identify a benchmark for the service and provide the relevant knowledge for the service to meet the required standards to improve their performance, see below:

'Wrapped around it we had national guidance on how a service should operate and what the quality standards of the service are, those things were not measured those things were not audited or performance managed it all sat around still performing four week quits but it did describe very clearly a quality four week quit looks like what a good service looks like.'

<div align="right">Taken from: Interview 003</div>

This would require the support of a network of skilled individuals to work alongside the teams to conduct an audit to identify any potential gaps; this will be discussed further within the recommendations in section.

7.11 Chapter Summary

The findings and analysis from the primary data above produced a significant amount of data that had to be distilled into a number of themed areas.

The role of performance management provided differing perceptions amongst the delegates and this was found to be the case within the literature (Pettigrew et al, 1999). Interestingly staff did not perceive performance management to be a waste of time but an essential process for the case study organisation to adopt although it can be very time-consuming.

It was too early at the time of the interviews to consider the effectiveness of any newly adopted framework as a result of the NHS reforms. Overall a shared perception of performance management from the primary data had confirmed that performance management should be about supporting the right things that provide real value and purpose for the individual, this notion of intrinsic value was supported within the literature by Marr (2006) Michelli (2009) & Reynolds & Ablett, (1998).

The primary data had confirmed that a top-down centrally driven framework has been implemented by the central government, although there was a call from delegates for the NHS to adopt a more locally defined framework. Staff had perceived performance management to be associated with the need to deliver centrally imposed targets a very Taylorist approach (Taylor, 1912) this may have been supported by centrally held information and the role of external organisations imposing a command and control approach.

To establish more locally defined frameworks there was a requirement for the NHS to recognise more local quality based outcomes so service teams have an opportunity to evidence their work to commissioners, by building a more locally

defined framework there may be the potential to provide a greater level of freedom and autonomy for staff (Bevan, 2009, Keller & Price, 2011).

Risks were raised regarding process-driven targets as they can be deemed as too numerical or quantifiable and not necessarily providing the staff and senior managers with the bigger detailed picture. It was recognised within the data that targets may promote a more mechanistic interventionist approach that was identified by Seddon (2003) & Cooperider & Whitney (2005). To counteract these more outcomes-based measures were being called for by the research delegates although it was reported within the interviews that there is a lack of detailed drill-down data that making it more difficult to measure monitor outcomes.

There is a requirement to involve staff more within the strategic planning process to promote alignment of the organisation's goals and objectives. This would require having the right technical people in place to support staff with the strategic planning process. Within the NHS performance management is still being used traditionally for financial measurement and it was claimed that efficiency is very much shaping the performance management agenda and was being used as a tool for contractual purposes. Any new framework would need to balance the financial elements equally with other relevant measures (Kaplan & Norton, 1992).

There appeared to be a number of problems with the performance information system within the case study organisation creating barriers for staff to engage with the performance management agenda. Intelligence will need to capture the right measures, it was recognised this may need to be addressed by staff working

alongside the business intelligence team to jointly develop the system and to explore system automation to support limited staff resources and capacity (Marr, 2006).

It was perceived that there was a lack of training, knowledge and awareness surrounding performance management and a number of proposals were provided that included delivering performance management training as part of the case study organisation's mandatory training requirements.

The above is just a summary of the findings the next stage for the study will be to establish whether the primary data can answer the set research questions and whether a theoretical contribution can be provided.

8. Conclusion & Contribution to Knowledge

This thesis set out to identify the factors that impacted on performance management frameworks in the English National Health Service to build an understanding to support the development of future performance frameworks.

Conducting the research has been time-consuming over a number of years whilst significant strategic reforms were implemented by the UK Government; however, this provided an added opportunity allowing a review of the common trends and emerging themes. The literature yielded a number of indications concerning the factors regarding performance management that provided the study with direction and clarity on the existing position of NHS performance frameworks.

The literature was found to be both wide and broad and was very much consisted of unstructured texts and lacked a cohesive body of knowledge (Neely, 2007). By not having the related literature at the early stages that focused on performance management within an NHS context, it was difficult to narrow and distill down to the more specific factors. A further problem was that the texts that were extracted and evaluated had straddled both commercial and public sectors. The commercial sector was very much based on profit and financial return whereas the public sector concentrated primarily on the delivery of public outcomes and efficiency, this made comparability more difficult due to the variation in objectives and purpose.

The breadth of the "performance management" field cannot stand in isolation within NHS business management as there are many compounding factors and

interrelated elements that may have an influence on its architecture and design. This was highlighted by the themed analysis that was presented from the primary research data that was yielded from within the case study organisation. Perhaps the most significant challenge that was faced by this study was eliciting future positive states from the research participants to enable a future design to be expressed. The appreciative inquiry approach (Cooperider & Whitney, 2001) presented semi-structured questions that aimed to elicit a future state that focussed on the positives of performance management, but as there were so many factors that needed to be addressed organizationally and the current lack of knowledge and skills related to the chosen field it made it far more difficult for the participants to focus on future design.

The level of cynicism that was prevalent from both senior management and staff on a number of related issues and the field's multi-dimensional nature (Pettigrew et al, 1999) meant there were a significant amount of interdependencies and historical legacies that needed to be unbundled. Some of the concerns could have been addressed by implementing small but very achievable designs, whilst other issues required wholesale strategic change and development. It was difficult to establish whether these issues were generalised across the English NHS or isolated to just the case study organisation.

It was important to ensure that the primary data analysis proceeded in an iterative way, referring back to the literature review, however, the primary data also provided an opportunity to search areas that may not have been considered at the literature review stage that enabled the study to delve deeper into the detail.

Overall this study reaffirmed a number of areas that had been identified within the literature concerning performance management, whether performance management is accepted as a benefit or a hindrance generally to service delivery and strategic development within the English NHS it has now been confirmed by the case study organisation via the study that it is an integral and essential part of its business. The internal performance management framework, system or approach within the case study organisation is not being perceived or considered as a model of best practice and it has its design faults, even though Boorman (2009) had identified the workforce element to be a practice model, but there are benefits as a tool in supporting senior management and staff to deliver better care to patients and the public.

From this point Chapter, 9 will focus on concluding the study by answering the research questions that were set at the end of the literature review and will move on to present a theoretical contribution to the field. Having outlined the contribution to knowledge the study will set out a model for delivery and a number of recommendations for the case study organisation to support the development of a learning enabled organisation. Chapter 9 will then consider the implications that the models and recommendations may have on future practice and will set out a process for implementation.

Chapter 9 will then conclude highlighting the limitations of the study overall. The researcher will then recommend possible future research.

8.1 Answering the research questions

It is important at this point to return to the research questions to see whether they have been answered as a result of conducting the primary research stage. Before answering the questions, it would be important to return to the aim of this study that was outlined in **section 3.1** of the thesis;

"To explore what factors surrounding performance management impact externally and internally on the organisation and the individual that will enable an alternative approach or model towards performance management to emerge, whilst uncovering the importance of these factors within an English National Health Service context'

This thesis implemented a number of qualitative methods surveys, focus groups and semi-structured interviews to capture data the concerns, barriers and factors regarding performance management to answer the research questions this was implemented utilising the following process outlined in **figure 9.1** on the next page:
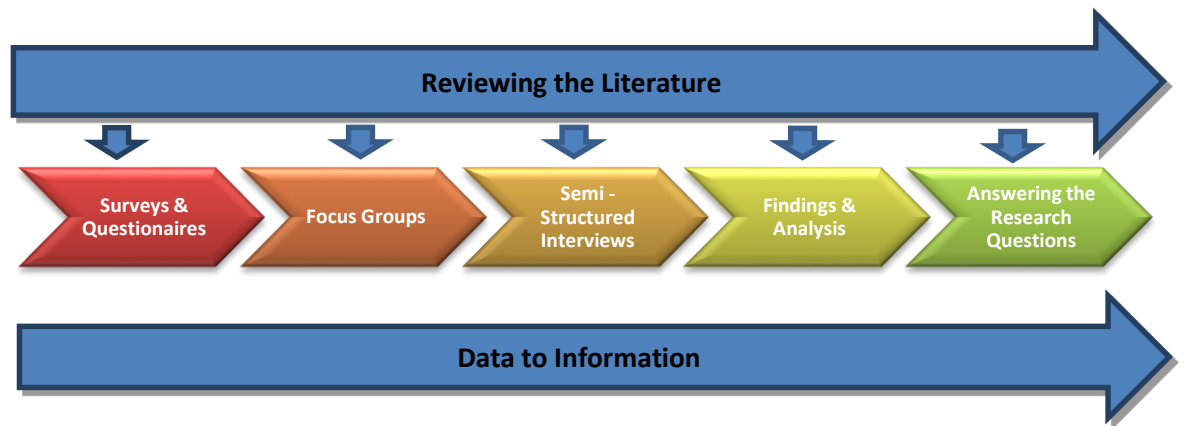
Figure 9.1 Primary Research Process

Figure 9.1 above highlights the need to ensure the literature was continually reviewed throughout the primary research process and also the constant requirement to collect data that was needed to be interpreted and transformed into information. Due to the prolonged timescale of the primary research period, it was important to ensure that up to date literature was reviewed and that it constantly influenced the next steps along the process continuum.

The next stage of the process was to attempt to answer the set research questions posed for the primary research stage:

1. How do staff perceive the meaning, purpose and culture of performance management within the NHS?

This first question presented an opportunity to explore with individuals the effects of the phenomena to close the gap of knowledge that was previously inherent within the literature where there were present multiple perceptions as towards its purpose and meaning, this was indicated previously within the literature by Santos et al, (2007) & Pettigrew et al, (1999). The question was answered overall during the surveys and focus groups see **section 7.1** 'The role, purpose & approach of performance management'.

We can now return again to the purpose of performance management by considering the proposed role presented by Michelli (2009) so we can establish whether the question was fully answered from the primary research and findings:

Performance management has a role in:

• Implementing strategy

The findings had identified that staff had considered its purpose to be important as part of the strategic planning process and business planning cycles.

• Supporting decision making- processes

Performance management was perceived to have a purpose in the business planning cycle where strategic decisions would need to be taken and it was commented that it had an essential role in financial decision making.

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- Aligning behaviours

It was evident in the findings that there was a necessity to link staff with organisational strategic aims and that alignment could be provided by looking at the levels of involvement and interaction.

- Allocating resources

Finance and efficiencies were a dominant factor within the findings and the role performance management could play. It was noted that staff could see the positive value it could play on the delivery of value for money, it was noted that performance management had a role in looking at the value of the provider services.

- Complying with rules and regulations, providing internal and external accountability

Staff were very aware there was a need to comply with a commissioner or with senior management this was expressed on a number of occasions, it was remarked that performance management may be best sited within senior management as opposed to being utilised at an operational level. The need to deliver on process based targets may be associated with the need to comply with a level of internal and external accountability.

2. What is the constructed reality of NHS staff surrounding performance management as a framework to support the organisational strategic development process?

It was clear that there were a number of factors that were highlighted within the literature, surveys and focus groups that were aligned to the perceptions and constructed reality of staff; this can be illustrated in **Table 9.1** below:

Factors perceived by NHS staff that were affecting performance management that was established from the surveys, interviews and literature.	Suggested alternative approach from the literature and findings
Command & control approach	Learning enabled approach
Relationship between culture and performance	Greater involvement and interaction and the sharing of performance information and knowledge at all levels of the organisation
Intrinsic value and motivation	Reflective practice based on double loop learning
Centrally driven frameworks	More locally defined frameworks
Process driven targets that hit the target but miss the point	Locally identified sub measures that provide meaning to staff
Performance information and data not sufficiently accurate	Develop systems to capture service level information and performance to be accessible at different levels of the organisation
Performance management used predominantly for the purpose of finance	Balance all dimensions and elements of performance management with equal weighting including quality
Staff at all levels need to be aligned to the strategic objectives	Support increased staff involvement within the strategic planning process

**Table 9.1 Factors perceived to be affecting performance management
and the alternative approaches**

The above factors in the left hand column in **table 9.1** were taken from the perceptions of staff that indicates that the strategic development process could

be supported and alternative approaches could be adopted as highlighted in the right hand column in **table 9.1.**

3. What is the relationship between NHS staff and the established performance management systems and tools?

From the literature it was evident a multitude of performance management based system and tools had emerged originally from within the commercial sector, tools that were highlighted within the interviews such as, KPIs and balanced scorecards (Kaplan & Norton, 1992) did appear to be established within the NHS and were known to staff to balance financial metrics alongside non-financial measures, to monitor quality and service improvement.

It was clear within the interviews that a relationship had been formed by NHS staff towards adopted performance management tools, however they were mainly used within a senior management or a commissioning context so it was more likely to be senior management that had a focus or an awareness of their existence. From the interviews and surveys staff had perceived in general the tools were being used as a conceptual approach towards the development of NHS management as a means of accountability or command and control (Seddon, 2005, Marr 2008 & Neely, 2007) this may potentially create a barrier towards their adoption by all non-management staff within the NHS.

From the interviews NHS staff were able to identify the tools were being imposed from external agencies and adopted within internal departments, although arguably from the literature its effectiveness was very much still out for debate. The star rating systems imposed by the Healthcare Commission (2008)

did not necessarily evidence whether a NHS Trust was performing any better or worse, it was difficult to establish overall from NHS staff whether they were able to identify whether the tools had a positive impact on their roles.

Business performance management software such as QPR had been adopted to monitor key performance indicators but there was a lack of knowledge amongst staff as to how they were of benefit towards the day to day operational delivery of services. There was a perception that performance management was a tool for senior management rather than a real support towards frontline NHS services.

4. What steps can NHS organisations take to develop more effective approaches to the management of performance?

The above question will be covered in more detail later in the thesis in **section 8.2**, but overall the findings indicated there may be an opportunity for the organisation to move towards an alternative approach towards learning see **table 9.1,** to balance with the requirements of the existing top-down command and control approach. Command and control was identified as a common approach to performance management in the English NHS and the public sectors (Marr, 2008a) (Michelli, 2009) and is very much based on mechanistic principles that have been outlined previously by Taylor (1798). The results and findings indicated that it may be feasible to move towards a more organic learning-based organisation outlined by Senge (1990), Bevan (2009), Schein (1996), Keller & Price (2011), Mintzberg & Heyden (1999), Argyris (1999), Reynolds & Ablett (1998), Stata, (1989) & Wenger & Snyder (2000). However, this would require

further testing and study to establish whether it may or may not have a negative or positive impact on the identified factors concerning performance management. Potentially a whole system change (Seddon, 2005) may need to be measured over a more longitudinal effect to answer this question. It was possible to identify a set of recommendations that had emerged from the findings to support the implementation of an alternative approach this has been set out in **section 8.4**.

8.2 The theoretical contribution

The next section of the thesis looks at whether a theory could emerge from the primary data. Social constructionism theory was chosen to look at the descriptions and narratives from the participants; this was mainly due to the need to understand perceptions and describe the intangible beliefs concerning the phenomenon (Denscombe, 2003).

The study chose not to adopt a positivist approach as the study required looking at the realities that were formed from within the individuals, providing them with a level of unconditional regard towards the expected responses (Rogers, 1951). A form of collaborative based appreciative inquiry (Cooperider et al, 2005) was adopted that allowed the participants to think freely and openly.

The intention was to answer the research questions with a view to allowing an alternative approach to emerge, impacts on the existing performance management system that were found within the primary research stage included, that command and control and process driven measures were being imposed as accountability-based approaches by arm's length external agencies. This made

it very difficult to fully identify an alternative theoretical contribution. Bearing in mind it was stated within the literature review that there is a need for a cohesive body of knowledge (Neely et al, 2007) concerning the phenomenon, although the study was in a position to present a number of staff realities that had evidenced a number of barriers that were preventing staff from fully exploiting the full potential of the field.

It was initially noted that there was a lack of academic studies focusing on the factors surrounding performance management within an English NHS context; this study now provides a baseline of data that both balances senior management and staff level perspectives. For whatever reason Mannion et al (2005) Gerowitz et al (1996) conducted large-scale organisational culture assessment on the English NHS and had based their empirical studies from data yielded from senior management, however, it is staff at all levels that has an impact on organisational performance directly or indirectly.

8.3 Learning enabled approach

The theoretical contribution will be taken a huge step forward and the study will now proceed to present a future conceptual model of development titled 'Healthy Performance' this includes a set of practical recommendations for the case study organisation to consider. The model and recommendations have been formed from the findings and analysis taken from **chapter 7**.

The new model has the potential to support the existing PPCT performance management framework that was mapped out in Exploratory Stage 3 in **section**

5, It was concluded from the primary research that the current framework was very much command and control based. Healthy Performance will place a greater emphasis on a more learning enabled approach (Marr, 2006) (Argyris et al, 1978) (Argris, 1999) (Senge, 1990) in comparison to the existing controlling practices by allowing staff to engage and learn in the performance management process.

Marr (2006) described the importance of the learning enabled organisation in that it allowed individuals and teams to engage in a dialogue, reflect on practices and challenge values, beliefs and assumptions. Crossan et al (1999) saw learning organisations as an opportunity to interpret, integrate and link both individuals and groups. Healthy Performance will provide a model that allows this to occur by adopting a number of tasks and methods to move from the traditional mechanistic approach supported by Taylor (1912) to the more organic, developmental, appreciative inquiry approach set out by Cooperider & Whitney (2005).

The 'Healthy Performance' model or toolkit will aim to support individuals and groups in continuing to work within the constraints imposed by a command and control approach. This will provide senior managers and staff with an opportunity to adopt a much wider range of learning based methodology, by building upon or providing an adjunct to the existing framework of the case study organisation, therefore, enhancing a new organic approach to counteract or bring into balance as an equilibrium with the mechanistic.

The study previously proposed a conceptual model, see **figure 6.2** below, that was developed from the literature review and the exploratory studies. The conceptual model supported the formulation of the research questions that were tested and provided a conceptualised understanding of the phenomenon. The model in **figure 6.2** and **appendix I** exposed the impacting barriers towards the delivery of performance management which was contained within the boxes at the top.
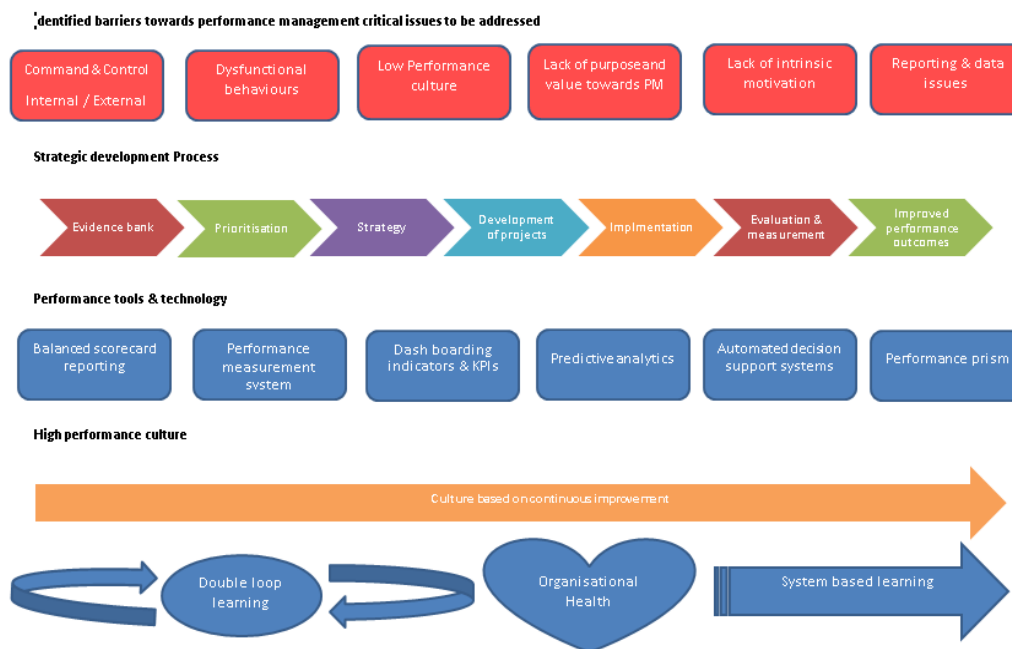
Figure 6.2: Conceptual model for performance management

The above model in **figure 6.2** had indicated that learning enabled approaches may be adopted to support a high performance culture (Cook, 2001, Michelli, 2009, Rowden, 2001, Juechter et al, 1998, Collins & Porras, 1995, Graham, 2004 & Reid & Hubbell, 2005) this would require continuous improvement that is underpinned by double loop learning set out by Senge (1990). Every aspect of

the new 'Healthy Performance' model will take into consideration the need for consistent improvement through double loop learning (Agyris, 1978) that should include the practice of review, creating insights to create actions and decisions by focusing on not just targets and indicators but looking at the underlying issues of project implementation and the feedback created from it. Before the model is presented a set of recommendations were formed from the findings and analysis that will now be covered in **section 8.4.**

8.4 Recommendations

One of the senior managers highlighted within the interviews that the performance management approach should be about engaging staff (Taylor et al, 1999), having a conversation with them and providing them with a package of support that will enable them to meet local need and will allow them to work better and perform better. The recommendations below will now move the theoretical contribution beyond its support to academia, by suggesting a set of real world practical actions for implementation. The recommendations were formed from the emerging issues identified from within the findings and analysis chapter, see **Chapter 7.**

An important issue that emerged from the findings was that there was a need for staff and senior management to be aligned to the organisational culture. Collier (1997) supported this and had concluded from his research conducted on the police force that this could have been addressed via better communication through the sharing of knowledge with a common approach of togetherness.

To enhance better communication for staff and senior management there is an opportunity for all disciplines to work cohesively utilising a collaborative-based approach similar to the model set out by Busci & Bittci (2006) in **figure 7.3.** Crossan et al (1999) had proposed that learning could be enhanced via institutionalising-linking the individual and group at all levels. To enhance the learning enabled approach an opportunity may exist within the strategic planning process where there is a requirement for the case study organisation to review the evidence base and to set out its strategic priorities. By enhancing the involvement of staff at all levels within the strategic planning process this may provide a better understanding of the development and design of the adopted performance management framework and the underlying priorities.

Recommendation 1: Increase staff and senior management involvement and engagement in the evaluation and planning of the annual strategic plan.

It was highlighted within the surveys that cost and financial information were not necessarily being seen as of interest to staff unless the true actual cost of activity could be broken down into its component parts. This would suggest incorporating system based learning information that would need to be presented to a care pathway system (Seddon, 2003). Staff also suggested that there was a need to ensure that all associated costs should be presented to evidence total patient outcomes. Activity based costing is a methodology that was first pioneered by Johnson & Kaplan (1987) and supported by Cokins (2004) & Parmenter (2007) (Armstrong, 2002) (Sandison, et al, 2003). Johnson & Kaplan (1987) who

provided an application that reported cost items along a set process to identify customer and stakeholder outcomes.

Recommendation 2: *Provide relevant cost information to staff by breaking the activity costs down into component parts to support learning and the design and development of future work streams and programmes*

There was an issue raised within the surveys and the interviews concerning the design of the existing performance measures in that they had to be more real to the staff delivering the service to ensure adoption. The need to balance measurement has been already outlined by Kaplan & Norton (1992) regarding the balanced scorecard. A senior manager within the interviews called for existing performance measures to be balanced to uncover financial opportunities, the senior manager highlighted an example where spend was unbalanced by only being applied to blocked bed days rather than alongside non-bed days.

Recommendation 3: *Review and redesign existing performance measures to balance performance perspectives so information and intelligence can be used practically by staff at all levels*

The primary data found that there was a need for staff to have a clearer understanding of how their work overall impact on the case study organisation and its overall resources. Schien (1996) claimed that organisational learning failures can be due to lack of communication but this can be addressed by working within the subcultures of the professional groups and interacting using

the same language and jargon. Juechter et al (1998) proposed that to enable better clarity and to promote a high-performance culture there was a need for coaches who had the skills that could guide and facilitate. The reality of budgets, cost and performance management from the focus groups was seen as the preserve of managers. Cost and performance information may provide staff with an increased awareness to potentially support better value for money (Cokins, 2004) (Parmenter, 2007) to guide and support a social constructivist approach (Denscombe, 2003). There is an opportunity for staff that may not necessarily be financial management accountants who are operating within the service teams to act as cost and performance management champions to support their teams internally.

The champions can support the development of balancing different performance elements at service team level to develop and design a specific team balanced performance scorecard (Kaplan & Norton, 1992).

Recommendation 4*: Develop cost and performance management champions as guides and facilitators at service team level that can design a development training programme to bring together all the performance elements into balance inclusive of finance, growth, learning and quality.*

Another important aspect that the recommendations need to consider to support the learning enabled organisation (Schien, 1996), (Argyris & Schon, 1978) is the need for staff involvement and interaction. Within the interviews it was perceived by staff that only the Executive Board and senior managers would have full exposure to the performance frameworks therefore not allowing them to

contribute to the strategic development of the organisation, placing emphasis on the need for a performance management design to interact with all levels of the organisation this may be achieved by involving staff more within the business planning process or aligning staff objectives with the requirements set out within the performance management framework. Schien (1996) warned that executives can band together and depersonalise their employees adding that executives and service staff may not necessarily agree on how organisations can work together. To address this mutual understanding, involvement and interaction are required, to take this a stage further there is an opportunity to involve staff and senior managers within the development of the performance frameworks but it would need to be aligned and reported at all levels. Intelligence would need to be presented in a format that is clear and understandable at all levels that allowed staff to participate.

Recommendation 5: *Staff involvement at all levels to design the performance frameworks providing different levels of detailed granularity and involving service staff to provide real world perspective at organisational performance reviews.*

Marr (2006) highlighted the importance of the performance review is an important opportunity to create dialogue at all levels around the performance issues, allowing individuals to inquire, share meanings and understand the complexity of issues. It is narrative dialogue that allows the process of reflection, evaluation and communicative action to occur (Habermas, 1979, 1984).

An appreciative inquiry based approach (Cooperider & Whitney, 2005) could be utilised to focus on what can be uncovered in the better performing areas to promote engagement of a multi-professional group. This approach has been utilised by a number of local authorities in England which was evident from a number of case studies conducted by the Centre for Public Scrutiny (2012), its adoption and success is due to a number of factors but more importantly it allows a cohesive focus to become the reality of the participants whilst being able to view the whole system (Seddon, 2003).

Business intelligence has an opportunity to facilitate these review meetings as they will be bringing the evidence bank and intelligence for the strategic planning process to the group from an independent perspective. Service teams have an opportunity to place their service level meanings behind the intelligence to look at cause and effect providing a secondary gain to address any outstanding data quality and intelligence system issues that were previously raised during the surveys, focus groups and interviews. These review forums could be online for more flexibility but the forums will look at jointly designing performance measures so that relevant and meaningful indicators can be provided to service teams, with an approach of joint investigation and to achieve togetherness that was highlighted previously by Collier (1997).

Recommendation 6: *Business Intelligence and performance champions to develop performance review forums as peer group meetings.*

From the literature review and the primary research, it was evident that there were multiple perspectives in relation to the role and purpose of performance management this was also highlighted by authors such as Santos et al, (2007) & Pettigrew et al, (1999). It was concluded that there may never be a definitive all-encompassing performance management definition but a meaning may need to be applied to allow a cohesive aligned perspective to be formed. The study was able to identify a working definition from the literature that could be used within an English NHS context see below:

'Performance management is a systematic and strategic based approach that incorporates, evidence, learning and knowledge alongside the continued cyclical refinement of its strategic, business planning, reporting and decision-making processes. Performance management identifies that success and results are achieved by enhancing the individual value of its employees'

Taken from: Healthy Performance literature review chapter 4, **section 4.2**

For the above working definition to be effective there would be a requirement for this to be reviewed and communicated at all levels. The Induction and mandatory training process provide an opportunity for the organisation to communicate the above working definition alongside its purpose and role and the organisations move towards a learning enabled performance management approach, to provide awareness and to allow staff at all levels to consider how this could be adopted to support their current working practices.

Recommendation 7*: The role, purpose and definition of performance management as a learning approach to be included as part of staff induction programme.*

Staff expressed during the surveys and focus groups the need to have the freedom to input accurate information whilst being in a position to validate whether the information was accurate and correct. We have already stated that the performance review meetings may provide an opportunity to support data quality issues, however, there is also a requirement for a feedback reporting mechanism that allows a double loop learning process (Senge, 1990) to be developed.

Recommendation 8*: Business intelligence to conduct an audit or review that involves staff/user within the data collection and evaluation to look at potential redesign of the information system architecture, hierarchy and reporting system.*

To support the double loop learning process there will be a requirement for staff to access timely and relevant data this was raised during the primary research stage; this could be achieved by adopting a performance management system that utilises automated technology. Marr (2006) made reference to the potential benefits of automated systems claiming that they allowed collaborative performance management approaches (Busci & Bittici, 2006) to occur. An example of automation can be found in **figure 9.4** below:

Figure 9.4 Automated performance management reporting system has been removed due to Copyright restrictions

Adapted from: Marr, (2006) Page186

Recommendation 9: Implement an automated reporting system to provide real-time reports made accessible to all staff at all levels.

A senior manager during the interviews highlighted that previous process targets that were implemented within the pre-NHS reforms outlined in the document, *Health & Social Care Act 2013* (DOH 2012) were implemented with a package or toolkit to support delivery. The toolkits were considered as an invaluable resource by service teams and were provided centrally from the Department of Health;

however, as a result of the reforms and the relaxation of targets, the support was withdrawn. There is now an opportunity to develop a more locally based solution that could involve bringing together a collaborative task group consisting of the relevant professional groups that could collate the packages for the teams but also investigate and research the best practice models and high performing trusts. There were a number of benchmarking resources within the NHS that were highlighted within the exploratory study that could support delivery, for example, NHS Comparators, Health Investment Packs & the NHS Atlas of Variation as outlined by Right care (DOH, 2010).

Recommendation 10: *Develop a development toolkit for each Key performance measure that provides a package of support and relevant information and intelligence on best practice models across the NHS*

The surveys highlighted that staff were poorly equipped in relation to skills and knowledge to deal with the performance agenda. At the time of conducting the surveys there was no training in performance management available, therefore the researcher took an opportunity to set up and design a performance management awareness training event and workshop, the flyer and programme of the day can be found in **Appendix E.** The practical one-day interactive awareness session was intended for team managers who had a responsibility for delivering the performance management of their service.

Recommendation 11: *Roll out, expand and develop a programme of training on performance management to enhance the knowledge and skills of staff and senior managers.*

Communities of practice (Wenger & Snyder, 2000) have been adopted for a number of years across business and the healthcare sectors having being identified as a concept for understanding knowledge sharing, management, and creation. The literature found that communities of practice have now become increasingly popular and there is now an opportunity to adopt a community of practice for performance management within the case study organisation. A community of practice for performance management should bring together representatives from all teams and professional groups to focus on the knowledge sharing aspect of the chosen field that should be separate from the performance reviews already highlighted.

Recommendation 12: *Develop a community of practice across the case study organisation that includes a wide professional group from all levels that includes business intelligence analysts that operate and design the performance management system.*

8.5 Healthy Performance Model

Now the study has presented its recommendations it can now proceed to propose a new conceptual model for the case study organisation based on the findings taken from within the literature review, exploratory studies and primary research stages, see the 'Healthy Performance' model in **figure 9.5** below:
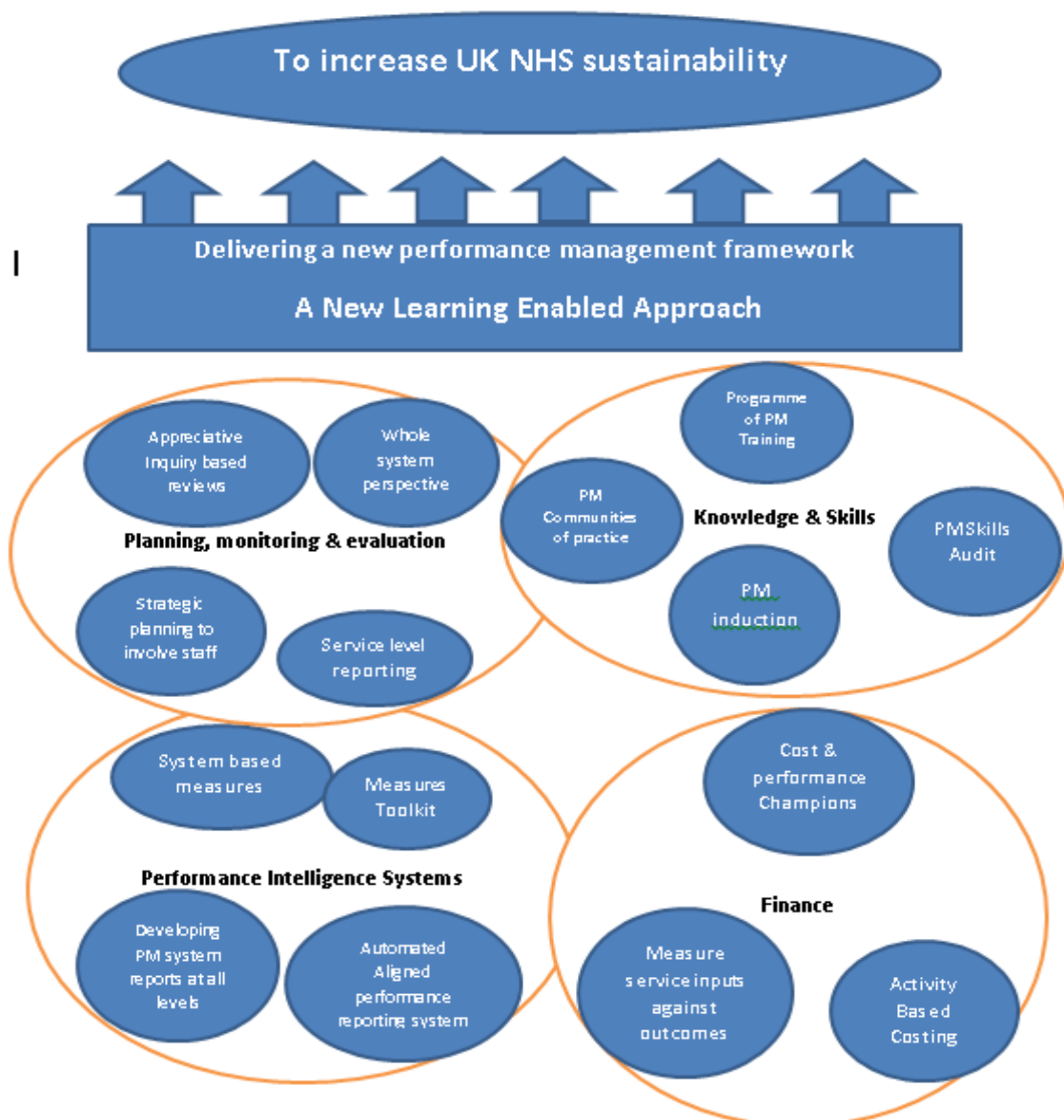
Figure 9.5: The Healthy Performance Model

The above model in **figure 9.5** considers a number of dimensions that have emerged from the primary research which supports the development of a new learning enabled performance management framework and conceptualises the proposed recommendations highlighted in the previous section.

The main dimensions:

- Planning, monitoring and evaluation

- Knowledge and skills

- Performance intelligence systems

- Finance

The above dimensions are balanced quadrants and therefore carry equal weighting and priority similar to the balanced scorecard set out by Kaplan & Norton (1991), the above model in figure 9.5 is presented as a bundled value creation map (Marr, 2006) (Bocci et al, 2006) to illustrate and visualise. The Healthy Performance model highlights the importance of balancing the essential components of a learning enabled approach and its influence on a new performance management framework and ultimately its contribution towards the future sustainability of the English NHS. The dimensions represent the four key factors that may support a future performance management framework.

The dimensions were considered by the study during the primary research stage as the four most dominant areas that could present opportunities for development to make the performance management framework more resilient and higher performing. The model in **figure 9.5** is to be used as an adjunct to the existing

performance management approach that requires the delivery of command and control accountability resulting from demands imposed by external agencies and the public. This has been illustrated in **figure 9.6** below:
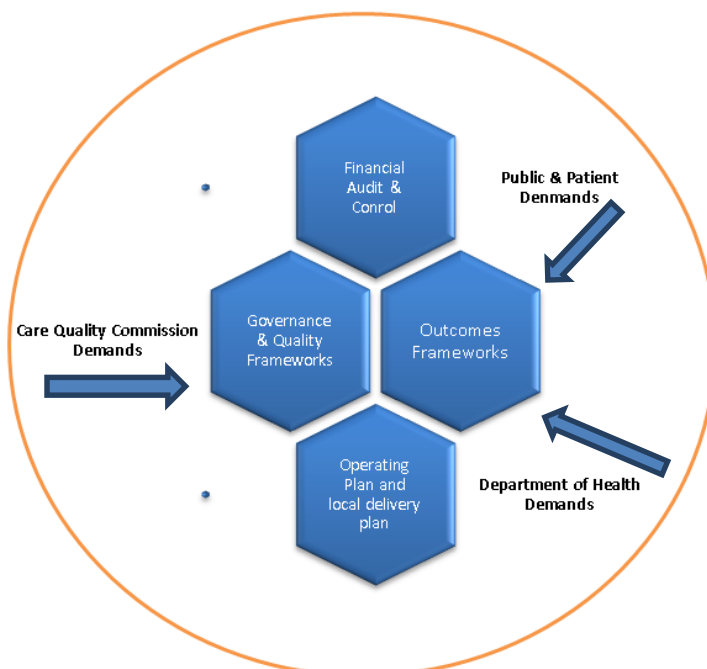
Figure 9.6 Current demands placed on English NHS organisations

Figure 9.6 highlights the demands that are placed on the case study organisation the Healthy Performance model outlined in **figure 9.5** will support these current demands, this will need to be implemented and tested at a later date to ensure the Healthy performance model can achieve a good fit that complements the demands set out in **figure 9.6.** The next section looks at how the Healthy Performance model can be implemented in practice.

8.6 Implementing the model into practice

Now the Healthy Performance model and a set of recommendations have been proposed see **figure 9.5**, the study will now consider how it may be implemented within the case study organisation and adopted over a reasonable period of time.

The study is aware that change within a complex system such as the English NHS is not an easy task as there are set standard operating procedures in place for a number of working practices that need to be consistently adhered to minimise potential risk. Requesting that staff make changes to their existing working practices over an immediate period may be met with a level of cynicism from staff, de Waal et al (2008) for example found after conducting an extensive literature search and survey on a number of organisations that an insufficient commitment or behaviour towards performance management system adoption may be displayed from staff if they do not see the positive impact it may have on them.

The learning enabled approach is much more about a step change in culture and an emergence of a new cultural reality as it should not just be about changing an existing process. Dent (1991) emphasised the importance of cultural properties that may be present within an organisation when introducing new innovations and highlighted that this takes a certain time period to bed in. To ensure the model can be adopted the case study organisation will need to gain the approval from the relevant organisational bodies and committees to win over the hearts and minds of the staff and senior managers operating within the organisation. This could take a prolonged and if not staggered period of implementation that may create a potential for a time lag, hence the need to look at an annual cyclical process of development as highlighted in **figure 9.7** below:
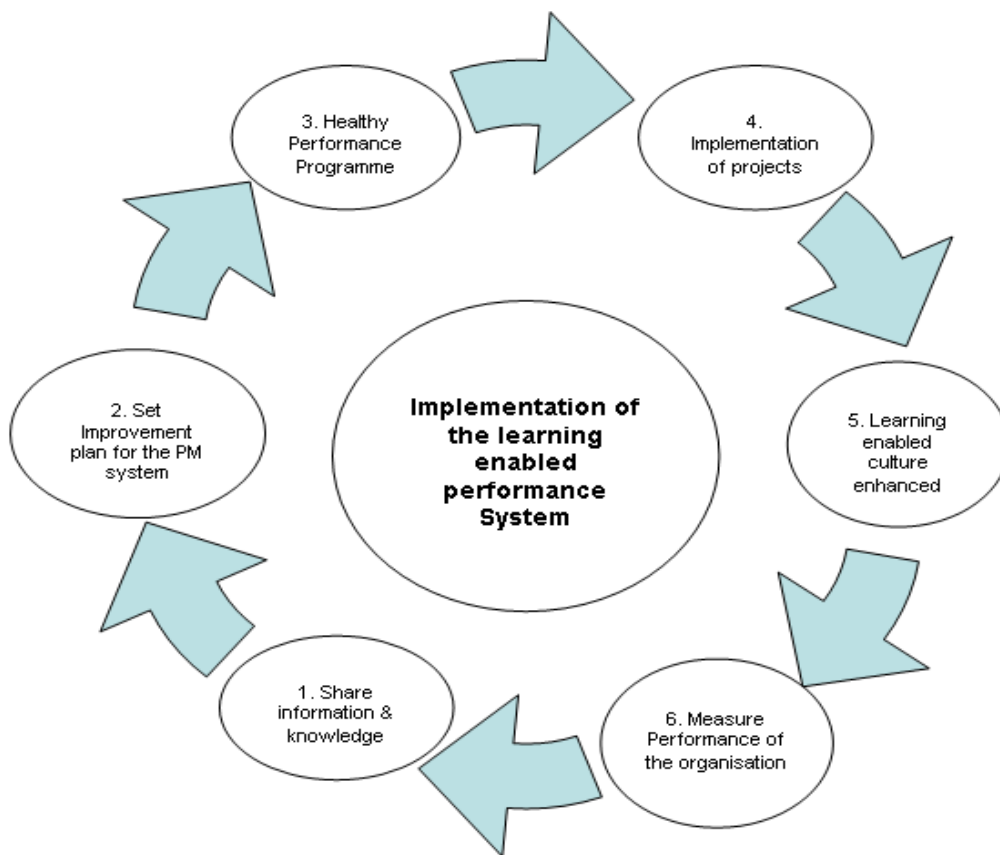
Figure 9.7: Annual Healthy Performance implementation cycle

Figure 9.7 above provides a programme of change very much based on the double loop learning (Senge, 1990 & Argyris,1978) and appreciative inquiry approaches (Cooperider et al, 1987, 2001, 2005, CfPS, 2012). The first stage requires a level of organisational commitment from senior management and staff to share performance and knowledge and to invite the introduction of a new model for managing performance 'Healthy performance as set out in **figure 9.5** this should allow a normalisation process to occur. It is important to ensure interactiveness and involvement are provided from the early stages, the sessions should focus on what can be changed and what can be built upon as opposed to the linear process of learning that only focuses on what has failed or is a problem.

An improvement or implementation plan is then developed to work on incorporating the learning enabled methods; this is then initiated for practice identifying a range of projects managed via an adopted programme management package similar to the *Managing Successful Programs* (Sowden, 2011).

Evaluations and learning are then later conducted and the findings are fed back into the sharing of knowledge and then the process starts again. As highlighted earlier to ensure the model can be embedded the process needs to initially take sufficient time to be implemented, **figure 9.8** highlights how this can be achieved over a set period of eighteen months.
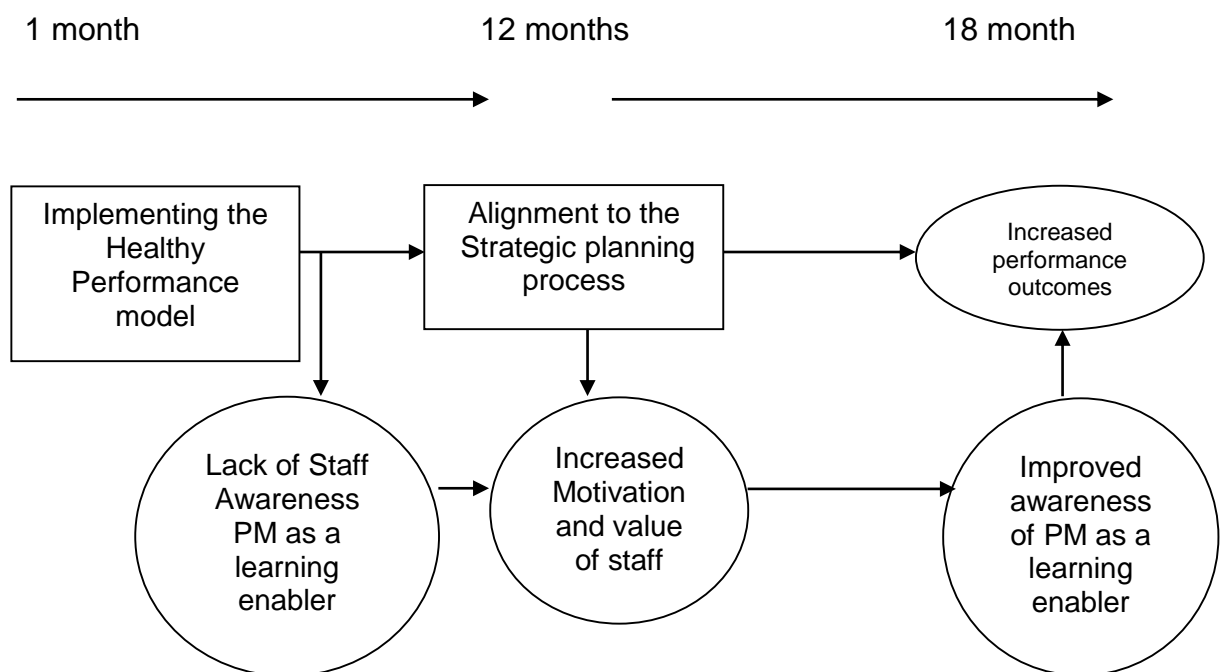
Figure 9.8: Healthy Performance implementation continuum

8.7 Values of the researcher within the study

The methodology that was adopted for the primary research stage involved qualitative ethnographical approaches (Werner & Schoepfle, 1987) providing an opportunity to operate within the reality of the individuals that participated. Ethnography was previously criticised as a valid methodology within the study as it does not rely on quantitative statistical scientific measurement to evidence its independence, rigour, validity and reliability (Breakwell et al, 1997). Interpretation and meaning of the researcher and the position they hold within the chosen field can be held up for scrutiny, although there is an openness and transparency towards ethnographical qualitative based research when capturing the data that is not found when adopting quantitative based methodologies (Denscombe, 2003).

The researcher was aware that it was important to recognise that their own perceptions, beliefs, identity and experiences had a role in creating, analysing and interpreting the data (Denscombe, 2003). A totally independent position of the researcher was achievable as the researcher was already operating within the case study organisational environment where the delegates may have already had preconceived opinions on the researcher's role.

To mitigate against this the researcher already had a background in existential psychotherapy from which they were operating from that was developed from his previous readings from the work of Carl Rogers (1951, 1961). Rogers (1951) pioneered the person centred therapy approach that came from the Humanistic School of Thought. Carl Rogers (1961) looked at the implications of the therapist

and their values within the client and therapist relationship ensuring an understanding of independence could be achieved within the relationship by adopting a position of unconditional positive regard.

Other works that supported this phenomenological approach included, Syngg & Combs (1949) who conducted work on individual behaviour and the work of Edmund Husserl (Smith & Smith, 1995) who has already been noted in the philosophical approaches that can be found earlier in the study.

The researcher was self-aware of the need to exercise unconditional positive regard (Rogers, 1951) with the research participants to step into their realities to ensure that they were as free from judgement as possible. The researcher was able to achieve this by being able to existentially reflect on their own values and recognise the common values they shared with the participants, for example, the need to uphold the values and behaviours of the NHS ensuring that services should be needs based and that services should be provided to point where they are free at the point of delivery as set out by the NHS Constitution Review that was conducted by Lord Darzi (2007).

8.8 Limitations of the study

No research study is totally free from limitations however it is important to consider what can limit the findings, therefore, this next section covers some of the limitations to ensure objectivity, reliability, validity and bias was taken into consideration.

The methodology was a qualitative ethnographical study that required the researcher to be self-aware of their own beliefs, identity and background (Denscombe, 2003) when dealing with the sample population, this was covered in **section 6** when the study reviewed the researcher's values. It was important for the researcher not to be bound up with the 'self' (Denscombe, 2003) as it risked miss-interpreting the findings. It was important for the researcher to code and categorise the field notes appropriately from a perspective of how would anybody else that was independent of the organisation or from the chosen field approach this task. The researcher kept a journal and all transcripts and field notes were fed back to participants to obtain their feedback.

The primary research was very much focused on the internal realities of the participants utilising a social constructionist approach, (Gergen, 1982, 1985 & 1994). However, the literature had highlighted that there were a number of external influences from scrutiny agencies such as, the South West Strategic Health Authority (2008), Audit Commission and Healthcare Commission (2008) that may have directly or indirectly impacted by the factors surrounding performance management. Unfortunately, these influences were not captured apart from within the semi-structured interviews where one of the participants had a previous professional background and was able to discuss openly his experiences.

It could be argued that the sample population was not totally representative of the multi-professional mix that was employed within the case study organisation as there were no medical consultants involved in the study.

Another confounding factor may have been that it may have been difficult to establish whether the beliefs and values presented were either professional or service/team based related. It is fair to say that it may have been difficult to capture every aspect of a participant's perspective concerning performance management, the study was aware that there may have been a number of differing experiences and potential variables that may have been presented such as, professional background, culture etc.

Another limitation that may need to be considered was the limited sample size of the semi-structured interviews; the size chosen was due to the accessibility of the lead professionals who were working within the chosen field that consisted of limited numbers. Potential participants that may have been included had moved on from the case study organisation as a result of organisational restructuring due to the implementation of *Equity and Excellence* (DOH, 2010).

When the surveys, focus groups and semi-structured interviews were conducted they had been implemented across a wide timeline due to these reforms and restructures, by targeting a smaller more influential number of participants within performance management it had allowed for the common trends to emerge amongst comparable professionals, this may not have occurred if the sample had been opened wider to a mix where there may have non-representative meanings or interpretations.

The study was mindful of the potential dynamic of groupthink (Hammond, 2013), to ensure bias was not introduced into the data due to these phenomena the

study used an eclectic mix of qualitative methods, a form of triangulation, (Denscombe, 2003); this ensured that limitations and risks were mitigated against as much as possible.

8.9 Areas of possible future research

The study has been able to provide a model and a set of recommendations and has been able to collate relevant literature and primary research data that has led to its presented findings. Due to its generalizability, the platform of information that has been collated as a result of the study potentially could be utilised to continue further research within the chosen field.

The case study organisation ceased to be a legal entity and has been replaced by a number of organisations due to the reforms set out in Equity and Excellence (DOH, 2010). The NEW Devon Clinical Commissioning Group (DCCG) that now commissions the healthcare needs of the Plymouth population may have a future interest in the findings and may wish to consider adopting the model and recommendations. It should be noted that DCCG is purely a commissioning body, whereas PPCT was a commissioner and a provider of healthcare services and it was service team staff that were major contributors towards the findings. If the findings were adopted by another NHS organisation there may be a potential opportunity to conduct further primary research to test the effectiveness of the model and recommendations. There may be an opportunity to conduct positivistic quantitative studies to balance alongside the qualitative social constructionist approach that was adopted for this study.

The economic evaluation was conducted at the exploratory stage however due to the concerns surrounding the lack of validity of the data produced it was discounted for further study and therefore did not influence the results and findings. In the future this data may become more robust, timely and more accurate alongside the development of a data capture intelligence system, if this was to become the case there may be an opportunity to reinitiate the comparative investigation and compare the historical data alongside the performance output and then in parallel with the data captured from the surveys, focus groups and interviews identify whether there is a relationship.

The study looked at staff and senior management by investigating the factors and implications surrounding performance management from an organisational perspective, this now provides an opportunity for future research to explore a more specific discrete team within an organisation to enrich the findings further and to delve deeper into the internal realities of the participants.

The study was conducted at a specific time within NHS history; no doubt there will be significant changes on the horizon that may impact on the current systems of performance management as it is envisaged it will not become a static or fixed phenomenon. The sustainability of the NHS due to public and ministerial interest (Plym, 2015) will continue to become a chosen area of research, there may be a period of time in the future when questions could be raised by the public regarding NHS longevity as an institutionalised nationalised subscribed system of healthcare, this was already challenged as a result of the *Darzi Review* (DOH, 2007). The study findings, model and set of recommendations has a potential to

be challenged in the future as a result of implementation to discover whether adopting a learning enabled performance management approaches alongside command and control was the most suitable option to adopt.

8.10 Concluding remarks

The study has set out and been able to investigate the factors surrounding performance management within the NHS, while the academic field was found to be extensive with a significant volume of literature that provided a number of approaches and frameworks a key achievement of this study has been to extract the knowledge and learning's taken from the broad sources identified from within the private and public sectors and to place them within an English NHS context.

The study achieved this by producing a set of results and findings from conducting primary research from a qualitative ethnographical approach also utilising quantitative surveys looking at the beliefs, perceptions and views obtained from the realities formed from a number of professional staff operating within the English NHS. This has included a wide range of staff not just senior management where previous empirical studies had based their findings mainly on senior management; see Mannion, Davies, Marshall, M (2005). The primary research allowed a new model and a set of recommendations to emerge that can now be shared across the NHS with comparable or similar healthcare organisations.

A set of recommendations has been produced that can support the future implementation of a new learning enabled performance management approach,

therefore the study has met its aims and intentions to provide an original contribution to knowledge and the chosen field.

The study started the journey looking at methods and tools for performance management with an intention to identify an alternative approach towards performance management. Our aim was to autonomy and freedom of the individual that allowed them to use their judgement and knowledge. However, as a result of the study, there may not be one single approach the NHS needs to consider towards performance management but a balance of both command and control and learning enabled. The study has now provided a case for the NHS to now consider both rather than the one command and control approach.

It is fair to state that performance management within the NHS is set to become the subject of an ever evolving continuous process of change as it reforms and redesigns to keep up with the continued demands and pressures imposed upon it. To support the development of the NHS in England the study has provided a platform from where research can continue to keep raising the important questions to improve management of its performance and to maintain its sustainability into the future, to support its continued requirement to keep striving to support the health and well-being of the English population.

9. Appendices

Appendix A: Study participants

Participant Profiles
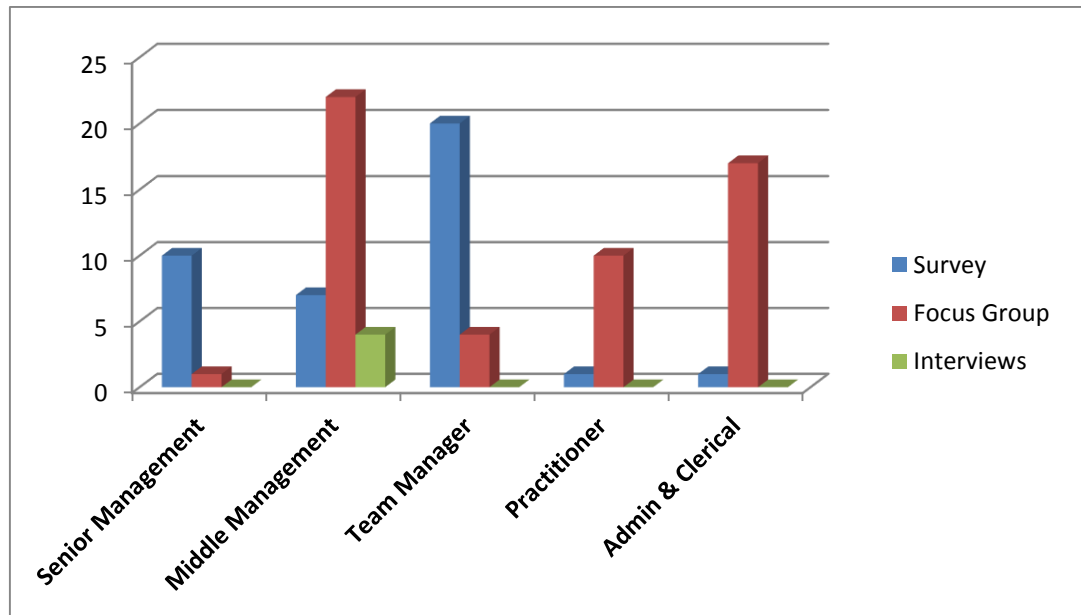
% of Professional Groups Involved in the survey
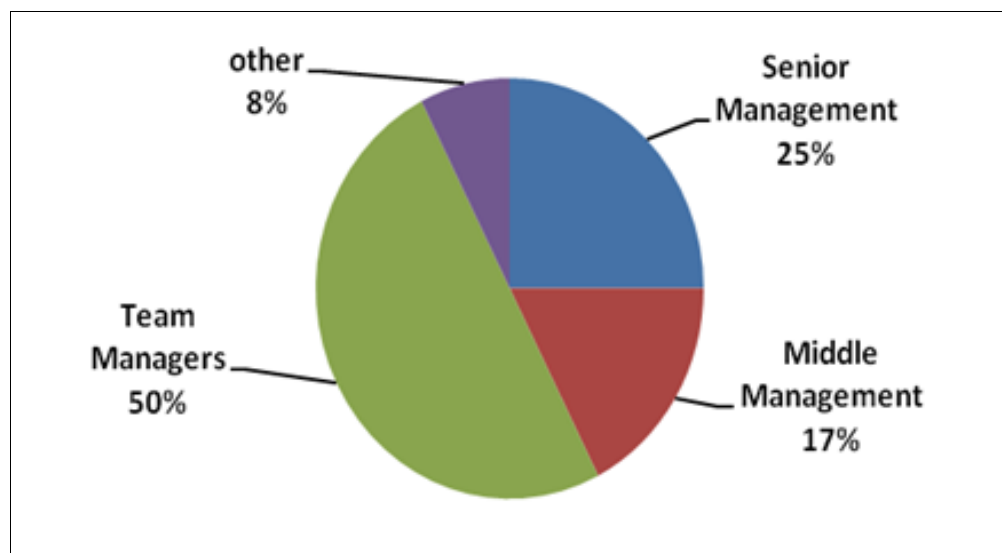
1. Survey Participant Profiles

Professional Groups	
Senior Management	10
Middle Management	7
Team Manager	20
Practitioner	1
Admin & Clerical	1
Or Other…	1
Total Participants	40

2. Focus Group Participant Profile

Professional Groups	
Senior Management	1
Middle Management	22
Team Manager	4
Practitioner	10
Admin & Clerical	17
Or Other…	
Total Participants	56

3. Interview Participant Profile

Professional Groups	
Senior Management	4
Middle Management	0
Team Manager	0
Practitioner	0
Admin & Clerical	0
Or Other…	
Total Participants	4

Performance Management Survey

Please Note

It can be widely accepted that the term 'performance management' can be understood and mean the adoption and implementation of different approaches perceived from various professional groups and backgrounds.

Please be aware for the purpose of this survey, the term 'performance management' refers to the support of business decision making process at all levels and to the broad delivery of performance measurement.

Before conducting the survey please read the information sheet that accompanies the questionnaire.

The survey should not take no more than 10 minutes for you to complete.

Please could you circle or tick ✓ your professional group that is most appropriate?

<div align="center">

Senior Management

Middle Management

Team Manager

Practitioner

Admin & Clerical

Or Other ……………………………

</div>

N.B. Please do not provide any form of personnel identification on the questionnaire.

(Please tick ✓ the box that applies the most for each statement)

1.	Performance management:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
a.	Is an essential process to be implemented by the NHS?	☐	☐	☐	☐	☐
b.	Is an essential process to be implemented by management?	☐	☐	☐	☐	☐
c.	Is an essential process to be conducted by clinical staff and practitioners?	☐	☐	☐	☐	☐
d.	Is a waste of time and effort for the NHS, management and staff?	☐	☐	☐	☐	☐
e.	Provides effective alignment to strategic planning.	☐	☐	☐	☐	☐
f.	Provides effective alignment to decision making.	☐	☐	☐	☐	☐
g.	Provides effective alignment to meeting the objectives of the PCT.	☐	☐	☐	☐	☐
h.	Has the ability to support the PCT to deliver from a basis of 'value for money'	☐	☐	☐	☐	☐
If other, please comment						

(Please tick ✓ the box that applies the most for each statement)

2.	Performance management should provide the following functions:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
a.	Measuring performance.	☐	☐	☐	☐	☐
b.	Developing, designing, implementing and monitoring targets and indicators	☐	☐	☐	☐	☐
c.	Governance (clinical or business)	☐	☐	☐	☐	☐
d.	Support strategic planning	☐	☐	☐	☐	☐
e.	Enable the commissioning of services and the monitoring of contracts	☐	☐	☐	☐	☐
f.	Providing an evidence based decision making tool to managers and practitioners	☐	☐	☐	☐	☐
g.	Reporting performance	☐	☐	☐	☐	☐
h.	Providing business intelligence and information	☐	☐	☐	☐	☐
i.	A performance advisory service	☐	☐	☐	☐	☐
J.	A support towards organisational development	☐	☐	☐	☐	☐
If other, please comment here						

(Please tick ☐ the box that applies the most for each statement)

3.	The main barrier towards the delivery of a performance management based approach is that:	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
a.	Information systems do not capture the real performance that we deliver	☐	☐	☐	☐	☐
b.	The time to deliver the requirements amongst other priorities.	☐	☐	☐	☐	☐
c.	Lack of promotion and awareness of performance frameworks	☐	☐	☐	☐	☐
d.	Performance information is not sufficiently accessible enough	☐	☐	☐	☐	☐
e.	There is a cynicism of its adoption amongst clinical practitioners	☐	☐	☐	☐	☐
f	There is a cynicism of its adoption amongst managers	☐	☐	☐	☐	☐
g.	It is not sufficiently presented in a balanced way to show finance, workforce and service activity in a clear meaningful format	☐	☐	☐	☐	☐
If other please comment						

4. How would you rate the opportunity you have been provided in the past as a manager or a member of staff being involved in the design and development of the performance management agenda?

(Please Circle)

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      0           5          10
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   not involved        fully Involved
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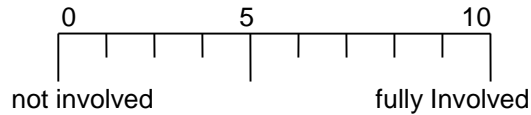
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5. Are you fully aware of the performance management frameworks the Provider Directorate is required to deliver, whether from regulatory or external bodies or from internally designed business processes?

(Please circle)

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      0           5          10
      ┌─┬─┬─┬─┬─┬─┬─┬─┬─┬─┐
   not Involved       fully Involved
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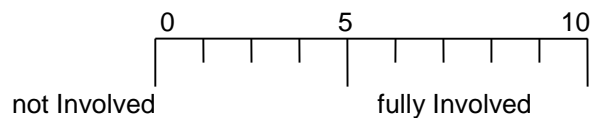
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6. If you had a choice on what performance measures need to be monitored on an on-going basis by the Directorate or the PCT, what would they be?

Please list or make comment within the box below

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7. Do you feel you have received sufficient training to meet the requirements to deliver a performance management based approach within your role?

(Please circle)

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        0           5              10
        |  |  |  |  |  |  |  |  |  |
    not sufficient        fully sufficient
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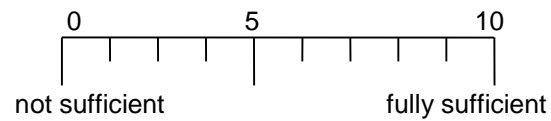
Please provide comment on what training needs to be delivered?

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8. Do you feel that the ability to deliver a performance management based approach is dependent on your professional background?

(Please circle)

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        0           5              10
        |  |  |  |  |  |  |  |  |  |
    not dependant        very dependant
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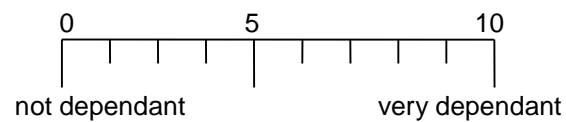
Please make comment within the box below

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9. What improvements do you feel could be made to the current performance management arrangements to support operational services?

Please feel free to list or make comment within the box below

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Thank you for your valuable time and input

Please forward your survey sheet back to the facilitator or send to:

Jeremy Walding
Performance Manager
BDQSS
CRT Block
Mount Gould Hospital
Plymouth

jeremy.walding@plymouth.nhs.uk

PERFORMANCE MANAGEMENT SURVEY

INFORMATION SHEET

You are being invited to volunteer to take part in a survey that is being facilitated by the Plymouth PCT Provider Directorate Business Development and Quality Support Service. Before you decide to take part, it is important for you to understand why the survey is being conducted and what it will involve for you. Please take the time to read the following information carefully and discuss it with the facilitator if you wish. Ask if there is anything that is not clear or if you would like more information or further clarity. Please do not ask for the facilitator to provide their view or perception as a means to answer the question as validity of the survey is required to be maintained.

Take the time to decide whether or not you wish to take part in the survey.

1. The Purpose of the Survey:

The purpose of the survey is to identify how the Business Development and Quality Support Service can establish the existing beliefs and attitudes concerning performance management delivery to further develop the support for its management, staff and practitioners.

2. Why have you been chosen?

You have been chosen for the study as you may have a direct or indirect influence on the PCT's ability to deliver a performance management based approach. Also you may have a good broad understanding of the needs and the issues concerning this area.

3. Do you have to take part?

It is up to you to decide whether or not to take part. If you decide to take part, you will have supported by a facilitator. If you decide not to take part, you are still free to withdraw at any time and will not be required to provide any reason if you feel it is not necessary.

4. What do I have to do?

This is not a test of knowledge or your skills. All you need to do is to answer a number of questions that are provided on the questionnaire sheet. The format is a Likert rating scale style questionnaire that will be provided beforehand and requires you to provide a tick that most applies to your perception and beliefs and to rate from 0 - 10.

You are not required to answer all the questions and can comment freely at will if necessary in the boxes provided. There are no right or wrong answers but they should be true to you at the time when you filled in the survey, as you should only answer the questions from your perception, beliefs or attitudes.

5. What are the possible benefits in taking part?

You will potentially be adding value to the performance management process in the future and may be adding useful information to help shape the understanding of it and enable the development of the service and the frameworks required.

6. Will your taking part in this study be kept confidential?

All information which is collected will remain anonymous so that you cannot be directly identified personally from it. Please do not provide any other form of personal identification apart from circling or ticking your professional group on the front sheet. Names of delegates involved in the survey will not be published internally within the organisation or forwarded to external agencies or bodies.

7. Contact for Further Information

If you have any queries, please do not hesitate to contact:

Jeremy Walding
Performance Manager
BDQSS
CRT Office
Mount Gould Hospital Site
Plymouth
PL4 7QD

Tel: 01752 272592

Email: jeremy.waling@plymouth.nhs.uk

Thank you for taking part in this survey, your participation is appreciated.

Appendix C: Invitation letter to interview

ENTERPRISE
WITH
PLYMOUTH
UNIVERSITY

NHS
Devon, Plymouth and Torbay

NHS Devon, Plymouth & Torbay
The Public Dispensary
18 Catherine Street
Plymouth
PL1 2AD

Re: Healthy Performance- Research Interview Invitation

Dear (name will be included),

We would like to invite you to participate in a research interview for a new exciting academic PhD study in performance management. Your specialist role and experience in performance management within the NHS provides an opportunity to add value to our study below:

'Healthy Performance'

A comparative study on NHS performance management frameworks during a period of transition in order to recommend and design a new performance framework

The purpose of the interview is to support a research project which aims to determine a better designed and more effective performance management framework to improve an NHS organisation's performance. This study aims to identify a number of themes in particular looking at existing performance management frameworks in the NHS, to understand what approaches towards implementation work effectively. The expected outcomes are to provide NHS organisations with a set of recommendations and guidance to support implementation of future performance management frameworks.

With your role, experience and knowledge it would be very much appreciated if you could support this study to add value to our project for the benefit of other NHS organisations and the wider academic community.

The interview process should take no longer than 30 minutes to complete and will be recorded using audio equipment. If you prefer the interview can be conducted over the telephone or the researcher could visit your location. Recordings will not be used for any future research beyond this project and will remain entirely confidential. If you are willing to provide consent to participate you will be fully entitled to withdraw from the study at any stage and no personal

information will be disclosed, involvement is purely voluntary and separate from your normal duties.

More details are provided on the information sheet attached.

If you have an interest and would be willing to participate please could you contact the researcher on: 01752 315768 or alternatively email: jeremy.walding@nhs.net

If you would like further details, please do not hesitate to contact me.

Your participation in the research would be very much appreciated

Yours sincerely

Jeremy Walding
Head of Public Health Business
NHS Devon, Plymouth & Torbay
Plymouth Public Health
The Public Dispensary
18 Catherine Street
Plymouth
PL1 2AD

Tel: 01752 315768
Email: jeremy.walding@nhs.net

Appendix D: Semi-structured interview questions

The semi-structured interviews will be conducted on a 1:1 basis with participants from the case study organisation. The interview format will be based on an *appreciative inquiry* theoretical framework to illicit the areas that work well with existing frameworks to enable a better designed framework to emerge. The questions have been formulated by utilising the 4-D guide (Cooperider, Whitney & Stavros, 2005) set out below:

4. **DISCOVER:** The identification of organizational processes that work well.
5. **DREAM:** The envisioning of processes that would work well in the future.
6. **DESIGN:** Planning and prioritizing processes that would work well.
7. **DESTINY** (or **DELIVER**): The implementation (execution) of the proposed design.

Introduction

Researcher will explain the following:
1. Outline of the research being conducted and the researcher role
2. Details of the researching organisation
3. How long the interview may take?
4. The purpose of the interview
5. Ethical & confidentiality issues
6. State there is no right or wrong answers to the questions

Discovery Phase

1. Please could you outline your role briefly within the organisation?
2. Very briefly how would you describe performance management frameworks in the NHS?
3. Please could you describe your organisations current performance management framework?
4. What impact do you have on the implementation and design of your organisation's performance management framework?
5. What are the best elements of your current performance management framework?

Further probing if required

1. Looking at your organisation's performance profile it would appear that you are delivering better performance than your ONS cluster group in the areas of ??What impact did your performance management framework have on these areas?
2. What performance management approach/design or culture did your organisation implement to achieve this?

Dream Phase

1. What position would your organisation be if an effective new performance management framework would be in place that achieved all its expected outcomes?
2. What benefits would the organisation reap if this was in place?

Design Phase

1. What changes would you need to make to your current performance management framework to enable this to happen?
2. What new approach, design and process can enable that?
3. What would be the most important and effective element of its design and approach?

Destiny Phase

1. What is the feasibility to design and implement this framework in the future?

CONSENT FORM

Title of Research: Healthy Performance

Name of Researcher: Jeremy Walding

Please tick Box

1. I can confirm that I have read and understood the information sheet and delegate brief for the above research and have had the opportunity to ask questions.

   ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

   ☐

3. I agree to take part in the above research.

   ☐

4. I consent to audio equipment being used for recording the interview.

   ☐

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____

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Appendix E Performance Management Training

Performance Management Demystified –
What managers need to know
1 Day

This practical one-day interactive awareness session is intended for anyone who manages a team and is therefore responsible for delivering the performance management of their service and its activity. It is expected that delegates will be able to understand the concept of performance management better to enable evidence based decisions to occur.

Delegates will have an opportunity to consider the following:

> ➢ Discover a basic concept to performance manage your service and activity.
> ➢ Understand the different expectations staff and managers might have in relation to defining what performance management is.
> ➢ Develop a performance management based approach to support day to day monitoring, reporting and to improve service delivery.
> ➢ Be able to develop a basic framework to performance manage from and keep on track to minimise any potential risks
> ➢ Learn real practical tools to enable you to deliver from a performance management based approach.

Professional Training and Development

Tel: 01752 314100

Internal 41100

Fax: 01752 204179

Provides learning relevant to the following KSF dimensions:

C1   Communication
C2   Personal and people development
C5   Quality
G6   People Management

Note: identifying exact dimensions and levels depends on the context, the individual's role, and therefore how they will be applying the skills.

CONSENT FORM

Title of Research: Healthy Performance

Name of Researcher: Jeremy Walding

Please tick Box

5. I can confirm that I have read and understood the information sheet and delegate brief for the above research and have had the opportunity to ask questions.

☐

6. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

☐

7. I agree to take part in the above research.

☐

8. I consent to digital audio equipment being used for recording the interview.

☐

_____   _____   _____

Name of Participant   Date   Signature

_____   _____   _____

Researcher   Date

INFORMATION SHEET

'Healthy Performance'

A comparative study on NHS performance management frameworks during a period of transition in order to recommend and design a new performance framework

You are being invited to participate in a new exciting academic PhD research study. Before you decide to take part, it is important for you to understand why the research is being conducted and what it will involve.

Please take the time to read the following information carefully and discuss it with the researcher before the interview if you wish. Ask if there is anything that is not clear or if you would like more information.

Take the time to decide whether or not you wish to take part in the interview.

Thank you for reading this:

8. The Purpose of the Study:

The purpose of the study is to identify how the NHS can design a more effective performance management framework and by improving its performance to deliver services for its users, carers, tax payers and the general public. The study will identify a number of themes in particular looking at the effectiveness of existing performance management frameworks in the NHS.

9. Why have you been chosen?

You have been chosen for the study as you will have direct experience or influence on the implementation of your organisation's performance management framework. Also you will have a good broad understanding of the relevant themes and issues relating to them.

10. Do you have to take part?

It is up to you to decide whether or not to take part. If you would like to take part, you will be given this information sheet and a delegate brief to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

11. What do you have to do?

A 1 -1 or alternatively a telephone based interview date will be arranged at a convenient time for you to attend. The venue could be in a location of your choice. You may also invite another person if you feel you may need support. All you need to do is to answer a number of semi-structured questions that will be provided beforehand. You are not required to answer all the questions and you can talk freely at will if necessary. The style of the interview and the questioning will be indirect and will be recorded on an audio cassette tape machine for the purposes of transcribing at a later date. You will have an opportunity to request a copy of the transcripts and a brief summary of the key points.

12. What are the possible benefits in taking part?

You will add value to a PhD research study that may provide recommendations towards the design of future performance management frameworks for the wider NHS.

13. By taking part in this study will it be kept confidential?

All information which is collected about you will not be personally identifiable and all information collected will be anonymised and kept locked and secure. All information collected or published will not identify your individual name and address.

14. What will happen to the results of the research study?

If possible, the final results will be published through a thesis document. The final report will be completed before the 1st September 2014, and will be submitted to Plymouth University, Business School and NHS Plymouth, to enable the assessment to be internally and externally examined. If you are interested, you can have a copy of the final report and published results on request. You will not be identified by name in any report/publication unless requested.

15. Who is organising and funding the research?

Being a simple data collection from a semi-structured interview, it is being funded through general course fees by NHS Plymouth. The research is being organised by the named Researcher and the Plymouth Business School that is a part of Plymouth University Faculty of Social Science and Business.

16. Who will be reviewing the ethics of the study from the NHS?

As the research only involves NHS staff, the study does not require review by an NHS Research Ethics Committee in accordance with the new Governance policy set 1st September 2011. The researcher will uphold the requirements set under arrangements for Research Ethics Committees (GAfREC), paragraph 2.3.1 as listed in Research involving staff. The researcher will adhere to the ethics

requirements and policies set by the Plymouth University Ethics Committee and the researchers employing organisation.

17. Contact for Further Information

If you have any queries, please do not hesitate to contact:

Jeremy Walding
NHS Plymouth
The Public Dispensary
18 Catherine Street
Plymouth
PL1 2AD

Tel: 01752 315768

Email: jeremy.walding@nhs .net

Thanks you for taking part in this study and the interview. Your participation is very much appreciated.

You will be given a copy of the information sheet and a signed consent form to keep if you wish.

Appendix F: Themed evidence

1. The Role, Purpose & Approach of Performance Management

INT 001: I think if you start to try and work out the actual benefits of performing well in say the impact of how many life years you could save in XXXX you will find you will be getting into the thousands of life years. The good services that are getting on their net impact would be on that sort of magnitude given the mortality rates they are good across the board in most areas albeit a couple of exceptions that are more reasonably well known due to where we are. So I really do believe performance management does have a very large influence albeit very hard to prove it.

INT 001: I think there is this danger that it's coming up with a few numbers but I think you have to look at a number of organisations that are not doing it and then suddenly you realise the potential scale

INT 001: I think mid Staffordshire is a classic example of when it goes wrong and badly wrong it could go, the key of keeping organisations at that forefront in terms of their overall impact can be quite huge.

INT 001: Yes, and it is always about communication for me a performance framework is a communication tool that lets everyone understand what is going on and what their contribution is to the overall vision of healthcare in XXX.

INT 001: Then suddenly a complex structure and I think that is the real difference over the years is that we have gone from a very simple performance system now to a very complex one and we make decisions to make the whole system whilst delivering quality, the dynamics are very different now.

INT 002: What he really wanted to know (Chief Executive) and he was really a man who did not like process he wanted to know who was causing the problems and how do we make it better and you go in and make sure you make it better, a massively interventionist approach.

INT 002: So my perception I suppose of how to do this has been how we are emphasising the partnership element and exercising the support element. I certainly have been trying to use the influence if you like via the front door, it's about influence not performance.

INT 002: There has been a lot of discourse analysis (on the old approach) there has been a lot of words we have not been able to use publicly because we need to be very careful we do not get tarred with the old brush.

INT 002: That is how you might have a conversation about performance management in the past but now we would be offering a package of support to enable you to meet your local need basically work better and perform better.

INT 002: Researcher
Do you think that your previous performance management approach produced better results than your current performance management?

Delegate
Well it's difficult because if you look at where we are now and what has happened over the last eighteen months then we have seen in the XXX XXX (geographical area of

England) one of the biggest performance slides nationally. We have adopted a different approach with different factors associated but I don't think the approach has led to that.

INT 003: Performance management is really important it is very useful, it works politically it works managerially but I think the bit that gets overlooked is the leadership aspect which is not so easy to qualify and quantify.

INT 004: I suppose we are not performance managed in the normal sense either the whole regime has changed a bit. Whilst they are completely relaxed they are quite conscious not to talk about performance management in a traditional sense, albeit you can hear the rumblings going on about 4 hour waits in A&E and the ministerial interest in that and that increases the focus on it.

INT 004:

Researcher

Do you think that the previous performance management system produced better results than the current system?

Delegate

I think the jury is out probably out on that, the new system is very difficult to say what it would of achieved and you got to add into that a lot of the confusion of setting up a whole new organization. Over that six months during the transition phase we did not have much control over the whole performance as to what was happening we were focusing more internally.

INT 004: The danger is what we have done is throwing the baby out with the bath water sort of really and say we don't do performance management, well we sort of still got to and it is actually got to be more intelligence applied to it really to understand that it really is behind this performance and actually and see it more as a whole system of performance rather than any individual area or particular number you would change.

INT 004: You keep an eye on the target and if it is going off in terms of its underlying performance trying to understand the cause and effect of it is critical and actually having the ability to do that comes the real question you are looking to answer.

INT 004: You can drill down to understand what the cause and effect might be so I think there is the danger you could lose that ability to interrogate and that is where the real power of performance management is for me.

INT 004: It is really about doing the right thing for the right reasons.

INT 004: I think it (performance management framework) needs to do in terms of being what are core framework what we are working towards I just don't see it driving that agenda it does not prove anything yet such as emergency admissions per head of population per XX locality or across the CCG being relatively low.

INT 004: There is certainly a need to have more visibility with performance more generally whether it is a specific high level framework or just using information more to make better decisions I think there is definitely a big call for that and I think that it will all improve over time

Survey**:** The Purpose of performance management is that it is an essential process to be implemented by the NHS, managers, clinical staff and managers and it is not a waste of time for managers, clinical staff and practitioners.

Survey: The systems can be over elaborate and sometimes misdirected i.e can hit the target but miss the point

Survey: Performance only effective if targets are right in the first place

Survey: This is a developing agenda which is growing in importance and will help managers operationally and strategically.

Survey: Again feeling of being poorly equipped to have adequate awareness of the performance management framework.

Survey: Performance managers seem to have assumed team leaders etc.. Know what to do when in fact they have been overwhelmed by their clinical and clinical management responsibilities.

Survey: Everyone can have an input if they are trained and the vision explained commitment through involvement - empowerment and a feeling of control.

Survey: Begin from scratch not that it is all bad, but a root and branch review would enable us to move to a model of excellence.

Survey: Performance management needs to sit within services and support. It can be perceived as a stick rather than a carrot.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – The question did raise a number of interesting issues, for example, performance management is viewed as a tick box exercise that had to be performed and was mainly for the benefit of senior managers not frontline staff.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – It was perceived that the whole field was designed purely to support senior managers as opposed to support frontline staff and team leaders of NHS services.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – A culture of performance management has emerged as a means to greater understanding of why we do what we do and for what purpose.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – However it was remarked that it has the potential to paint a real picture to enable staff and managers with an opportunity to reflect on their performance and provide a way to change ways of working and processes if the results that were being achieved were desirable.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – It was commonly agreed that the performance management agenda was significantly important and was becoming more so within the organisation but also within their everyday practice.

Focus Group Flip Chart Notes Q1. What is your current perception of performance management? –

- ➢ Not a co-ordinated approach – much is duplicated
- ➢ Perception could be done better? Culture, understanding - why do we do what we do?
- ➢ Unsure of what they want
- ➢ Paints a picture
- ➢ Helps units to reflect and recognise performance
- ➢ Good in theory vs practice dilemma
- ➢ Support service demands are becoming unbearable – Too burdensome
- ➢ Supporting mechanisms i.e staff to enable the above and do the job
- ➢ No vision
- ➢ Very important and becoming more so
- ➢ Can't be avoided

Focus Group Flip Chart Notes Q2. What do you perceive as the barriers to the delivery of performance management? –

- ➢ Time consuming / another add on perception of bureaucracy

2. Centrally Driven Frameworks (Command & Control)

INT 001: Less centrally driven wider framework that is now centrally required, Performance manger is involved due to awareness of central government agenda.

INT 001: The easiest areas to manage and report on are those that are centrally driven simply because you have a clear definition of what the indicator is so you automatically get a performance framework built alongside.

INT 001: Centrally prescribed needs to be covered off first do not want the board to be shocked that a target has come off track. A lot of the performance is prescribed for the organisation.

INT 001: It becomes a very easy set of information to collate it is also easy to benchmark yourself against other organisations so you got a level of self-awareness where you stand in the greater scheme of things and I think it is all those issues that makes those kind of indicators and measures much more easy to pull together so basically a lot of the thinking has been done for you.

INT 001: So taking away the beauracracy by taking away the centrally driven performance framework will actually make more work for people like myself whilst it opens up levels of freedom to build a performance framework it makes it more time consuming to do so.

INT 001: In some ways in order to do it you have to be self-aware of what your current performance is. In order to build a framework, you got to pitch it back to a certain extent as to what is nationally driven data in order to benchmark.

INT 001: Researcher
So do you think if it had a national focus it would have better outcomes?

Delegate
Yes, a lot of senior managers are always very political in their motivations that they want the organisation they are managing to be in the best possible light and a national indicator shines a spotlight on a particular issue clambering to be as good as they can be out of the spotlight performing badly on that particular measure so it becomes a political game to see what is going on to make sure they are not being exposed.

NT 001: Researcher
Would you say that the national command and control approach compared to the local approach has an influence on the culture of the organisation in relation to performance management?

Delegate
For performance management I am saying absolutely because you almost have to do the nationals. The key is I don't think the national framework should never be so large and comprehensive that it swallows local monitoring or performance frameworks. There is a balance to be struck there is a danger that there is so much that it becomes feeding the beast and too big an element of the job and therefore any local sensitivity would actually really benefit the organisation and being lost in the all-encompassing national agenda. So there is a balance to be struck there by being not too bureaucratically centrally driven.

INT 001: it is nationally happening already referral to treatment times are already slipping and a number of organisations are showing signs of becoming more unstable, so yes the national framework will tell you that but it won't tell them why or from an operational management perspective and it will not have enough information to go on to manage the local healthcare economy.

INT 002: Because of that and because of certain elements of politics as we started out with Labour it was very centralist, it was absolutely fine and it was expected that we would performance manage against target and local targets the same stuff you saw in the NHS I suppose like the LDP and that kind of framework.

INT 002: I can remember being in meeting being told by my Chief Executive that he needed exactly to know what was going on, as in who was doing what they should be doing.

INT 002: It was not necessarily a supportive approach (old approach to PM) and to be fair it did change over time as it had to change over time as the politics changed and when the new Government came in it did significantly change.

INT 002: It was seen as survival as we were an arm's length body (old approach to PM), I suppose there was the problem that we did and we were vulnerable we have to operate in a way that was acceptable to the broader politic, but we were vulnerable in that we could of got rid of at any stage.

INT 002: If we thought there were performance issues locally (old approach) with manager's staff or senior managers we would strongly be encouraged to go round and get rid of. Basically if they were not working you make it very clear to their management that they were not working and you don't want them there and you were quite ruthless, a very ruthless approach to achieving the targets, but to be fair and this sounds awful, but it did work and worked well.

INT 002: I was saying to XXXX (Executive Director) there was an element where by XXX (Executive Lead) at one stage I remember being at an all staff event and he got up on

the stage and said looking at the audience and said, 'Nobody likes us and we don't care and that's what I told the Minister the other day. And at the moment that is absolutely true and I am quite happy to hear because I know that if nobody likes us and we don't care you are going out there and getting the job done you don't make friends, you are not there to make friends you are there to get the job done.' (old approach)

INT 002: When we had a teaching Health Authority and probation leads, police leads, Department of Health, regional leads on it so at the particular time we had a robust regional structure, so if you like our protection and it came to regional level, by making alliances there and by using the performance management frameworks of our regional partners we could expose performance weaknesses of all the local delivery agencies.

INT 002: So we would all gang up and look at who was doing well and those not doing well across the agenda, and then because we did not really have any real teeth or leverage we used to use their teeth (regional alliances) and levers to make sure that the threats that we made could actually hurt them if they needed to.

INT 002: So it wasn't that we merely there to kick people around what we did do was we identified shortcomings (old approach) and then put in support but in a very critical way, critical in a negative way about this entirely deficit model, you're not doing this if you are doing this you need to do that and going as high as we could to achieve it.

INT 002: You know in terms of my boss at the time XXX XXXX that was probably in the performance management sort of heyday if you like, he did his best to make friends with Chief Executives so he could get an audience to prioritise it, and a threat of a Ministerial visit at the time was brilliant as they become more interested, I think we might need to bring a Minister down that happened that did happen and it made people move because if you worked in the NHS and the Minister was going to come down.

INT 002: What we cannot do is use the same language (i.e Performance management) because we will be told you will be performance managing and you will not be operating according to a local agenda and we should be supporting local rather than intervening from a centralist position.

INT 002: From a local member's perspective if they thought that providers were not being adequately challenged that would be unacceptable to us nationally and it would be unacceptable to us.

INT 003: Currently we have the public health outcomes framework which is a very clear framework which comes from central government.

INT 003: Well we had the strategic health authority which we had to report to and so we had our local delivery plans that very clear committed activity which we had to deliver against and certainly, I mean I never really saw it as we was high performers in my world and we always hit our targets and certainly there was a lot of pressure, a lot of perceived pressure to deliver against these targets that we reported to the strategic health authority in which were ultimately reported to the Department of Health.

INT 003: They (providers of services) are used to being fleeced and punished or penalised so they are used to being compromised or penalised having not to hit that particular target and being beaten over the head with it and so yes I think that it is going

to take time to get the provider to understand that is not the case now what this comes down to is trust, it's all about trust and one of the fundamental flaws of commissioning in my opinion.

INT 003: Move away from previous set ups I guess where you had someone in an ivory tower who had a huge bunch of big matrix of targets and numbers and then enforced and projected them out into the world.

INT 004 If you are back into the old NHS XXX days it was clearly defined performance framework and nationally prescribed leaning towards the performance approach that was adopted with performance indicators a very defined approach.

INT 004: I think the one advantage we have as a CCG now is that we are bigger than acute trusts in financial terms; XXX PCT had XXX Hospital Trust that had a bigger footprint. It had a certain amount of clout and thinking in the new CCG we can to a certain extent play one trust off against another and we can do things across the whole patch.

INT 004:

Researcher

So what you are saying is nationally there are positives in something being nationally set?

Delegate

I think so because it is sometimes the external challenge that says you have got to sort this out.

INT 004: Do you have enough clout to force that through and in a lot of cases you don't. Although nationally they are saying this is what you are going to do then everyone follows down the route of well okay then we have to no one wants to be seen not playing ball.

INT 004: To chase after purely for political end you will end up with this perverse incentive people not trying to achieve performance targets in the correct spirit with what they are all about and that's when you get your real problems,

Survey: Not involved in any significant ways with regard to design and development, performance management is imposed.

Survey: Would need to monitor national targets however should be able to decide local targets.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – This was reinforced by the association with audit and collection to be an essential part of the process to be ultimately used as a stick against frontline staff rather than a carrot or a tool for learning and knowledge.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – It was noted that the current performance management framework is internally imposed top down as opposed to externally impose. Command and control

approaches were highlighted stating that performance is managed reactively as opposed to proactively.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – The nature of performance management was perceived as checking up on frontline services rather than be a supportive learning framework.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – Performance management is still in its infancy very top down and meaningless to the majority of the workforce.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – Performance management is very business driven approach, target orientated and is very much a separation between senior management and clinician and the agenda is very much externally driven.

Focus Group Flip Chart Notes Q1. What is your current perception of performance management? –

- ➢ SHA / DoH – legal obligations, directives
- ➢ Checking up rather than being supportive
- ➢ Top down rather than bottom up
- ➢ Top down enforcement (another task in an already bust agenda)
- ➢ There is a 'fear' around what happens if we do not perform well
- ➢ Feels like a 'stick' rather than a helpful thing
- ➢ Feels separate – externally driven
- ➢ Commissioners – The influences of control
- ➢ Compliance of legal obligations
- ➢ 'Top down' approach
- ➢ Driven by government drivers
- ➢ Monitoring frameworks

Focus Group Facilitators Notes: Q2. What do you perceive as the barriers to the delivery of performance management? - The barrier of bureaucracy was another common issue that emerged with the process being very hierarchal exercising a form of control.

Focus Group Facilitators Notes: Q2. What do you perceive as the barriers to the delivery of performance management? - The main emphasis of the debates was that management was not setting the agenda to improve services with its fixation on centrally imposed performance frameworks.

Focus Group Flip Chart Notes Q2. What do you perceive as the barriers to the delivery of performance management? –

- ➢ What performance management do we need to do? Who decides – providers or commissioners
- ➢ Other people's agenda
- ➢ Government driven and not locally needs driven
- ➢ Old style performance management

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Focus Group Flip Chart Notes Q3. What are the opportunities for performance management in the NHS? –

- ➤ To be able to talk to commissioners with evidence
- ➤ Support robust negotiating

3. Locally defined frameworks

INT 001: Building a locally defined framework is a harder thing to do so taking away the beauracratic by taking away the centrally driven performance framework. Makes it more time consuming to do so, in some ways in order to do it you have to be self-aware of what your current performance is in order to build a framework.

INT 001: Because of my role and awareness of the central government agenda it is almost that I make sure I have the central prescribed is covered off before we start and then there is greater scope for what's left and that is the bit that is shaped more locally.

INT 001: Yes, and partly the lack of capacity is at fault in terms of can we build a framework with much wider measures within it and especially now with all the reorganisation going on capacity has been eroded to a certain extent so you got to make sure you keep one eye on future need and actually building a locally defined framework is a harder thing to do.

INT 001: Chasing individual targets is never a great thing we try to rebalance and reshape the whole system and I think that is the best model or tends to be that balanced scorecard system or having your different indicators all focusing on core issues and that way you can get you have to try and triangulate.

INT 001: Researcher
So they may not be the areas which are being looked at nationally but they are the areas that need to be looked at locally so you can keep your eye on them?

INT 001: Researcher
Is the locally designed more complex and more effective than perhaps nationally prescript?

Delegate
Nationally I don't think they could prescribe this as the system it would become too complex and they will always struggle with it other than measures related to financial balance and those types of scenarios and that is already there in the operating framework, they have got that top level stuff, it will give you enough to manage your service

Delegate
That is the framework that has become more dominant as a performance framework within the last 12 months.

INT 001: So teasing out that balance (outcomes and process driven) is that important element as to how we develop the framework but also it's creating that line of sight

between absolute top level outcomes that we had before with what happens operationally.

INT 001: It's the balance it is having the right measures and the right types of measures in there and you got everything in a basket together so you understand what the issues are

INT 001: It's always about balance, in terms of the new framework we need to make sure we watch all areas and we want that to reduce but we do not want that to go up, It's having that wider view of things, and even if that is not being reported directly to the Board when something goes wrong they should have visibility of that and why has it gone wrong.

INT 002: That is how you might have a conversation about performance management in the past but now we would be offering a package of support to enable you to meet your local need basically work better and perform better.

INT 002: Difficulty we have got with our notion of priorities and the PHOF (performance framework) that says something about priorities and then a local framework always going to have the issue about how do we balance the tension how do we do it in a way that enables us to move things forward as best as we can to support your local area.

INT 002: I think what our approach offers now which is different from what it has offered in the past is either ability for a local and rounded response, even if we focus on a variety of different metrics under the old regime if you like you are defining the focus locally.

INT 002 You do need to influence effectively and shape and you can't shape and influence if the person will not listen to you or think they should not listen to you or part listen to you and does not understand, so you have to make sure that all of those things are addressed in order to have an effective relationship that better meets local need.

INT 002 You might as well carry on the way you are might you be honest if all you done is replicated a national system locally.

INT 002: Because we needed to continue to deliver we had to deliver in a different way in a politically acceptable way. Since then to the last few months I have spent far more time thinking about how we do business than what I did in the first few months. It felt like in order to be effective and get our point across there has to be a very specific bespoke local response if it is not relevant to them in terms of their local need areas are just going to tell us where to go.

INT 002: You can share policy documents there is no point trying to engage on a national agenda with the local environment if there is not pre-thinking about what does it mean for them. Otherwise you are just handing something over saying this is a wonderful thing you might want to look at it or put it on a shelf; you have to make it real for people for them to be able to see if.

INT 002: We have got start thinking locally about how we join it up because literally they are the ones that make the change. I might say anything I might want to; they do not think in that way or see the benefit looking in that way then there will not be any change.

INT 003: We have to record and report our activity and progress against the set of structured outcomes. We then take that and translate that locally and make local

decisions around how we will plan our commissioning and who we will commission and who we will commission to deliver against the public health outcomes framework.

INT 003: That's a philosophy or an approach of having it locally owning it being able to change it being able to make it work for the population it works under the localism agenda for the to effectively happen you got to have time you need leadership you need trust you need good relationships.

INT 004: I think it is certainly easier from our point of view to see a national position, so speaking from more my perspective there were a number of things nationally that we were doing locally, you can see those sort of dashboards and pitch the information very easily so purely from a XXX locality perspective I have lost all that sort of access to information and of course we are sort of planning on a locality level.

Survey: Performance management should be based within the services; however, these shouldn't obstruct from patient care, result in lots more paperwork and stress for staff who should be supported to do the clinical work they were trained for this is fine providing it does not hinder the clinical work done by practitioners.

Survey: Performance management should be based within the services.

Survey: Systems should capture quality standards

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – They also highlighted that there are competing priorities that are expected to be a balanced with performance management and that there is no centrally co-ordinating approach.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – There is a view that different organisation delivers performance management to suit their requirements.

Focus Group Flip Chart Notes Q1. What is your current perception of performance management? –

➢ Provides structure for organisations

Focus Group Flip Chart Notes Q2. What do you perceive as the barriers to the delivery of performance management? –

➢ Flexible structures
➢ Insufficient structure planning in place
➢ Culture not promoting supportive systems to enable to empower staff
➢ Inflexibility

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Performance management's ability to provide a minimisation of the blame culture between commissioners and providers was seen as a positive side as there was a common agreed framework.

4. **Process driven targets**

INT 001: Less process driven targets, need process measures to inform you how you are achieving.

INT 001: It always carries more political weight if you are looking at 18-week referral to treatment and waits in A&E they are the hard hitting targets politically focused targets with resources that get allocated to the achievement of those targets that is substantial.

INT 001: A lot of the other targets do not have the same profile so you can see when you have got that hierarchical right up to the ministerial level right down to the SHA level those are the ones we want to focus on.

INT 001: So the way we do it is to aggregate up all the initiatives that say reduce non elective activity it then becomes how much does non-elective activity should we produce. Nationally they want to measure the total level of non-elective activity and we need to know down at initiative level which ones are working and which ones are not to ensure we are achieving that same scale of improvement.

INT 001: I think taking one measure in isolation can give you a very warped view I think and yes people have got to see there are reductions in non-elective activity is a positive thing but you also have to understand the impact on other areas.

INT 002: I suppose it was very performance driven and very target orientated it was very much around process and volume and not outcome and very interventionist.

INT 002: We had to move away from being quite so target driven and operating in a far more supportive way as we needed to survive.

INT 002: I mean there was more than the doubling of the number in treatment, waiting times went from massively high levels in excess of a year in many areas of the South West to a maximum of weeks, and capacity expanded, waiting times reduced, workforce massively increased and all targets had a were around about capacity and efficacy of treatment that were achieved within the expected time frame.

INT 002: To be honest in terms of achieving results it depends on what results you want to achieve. If you think the right number is fifty and you want somebody to get to fifty whatever that would be about or round about the old way would get you to fifty but it won't get you a good rounded view on how you got there and allow the local service to develop in a rounded way to view it.

INT 002: I do think that you need quantifiable information in order to make some kind of judgement or to enable some people to make some kind of judgement around about it. I do also think that a degree of target setting focuses the mind.

INT 003: And so we design a suite of health improvement services and then design lots of outcome measures and process measures to assure ourselves as best we can to make sure all the providers we commission.

INT 003: A lot of perceived pressure to deliver against these targets that we reported to the strategic health authority in which were ultimately reported to the Department of Health.

INT 003: And so they were very direct targets four week quitters, smoking at time of delivery those types of things and very kind of reduced straight to the point they did not capture the whole quality of activity of work that we were doing.

INT 003: It was not just to bang out four week quitters our job is to help people stop smoking.

INT 003: It just so happened we had to tick this box which was in some ways a useful benchmark to measure ourselves against, but if you were a cynical negative service which we were not you could do pretty rubbish job and still tick the box but we had to walk this line and balance this act of providing the service

INT 003: I became very disillusioned with the targets to begin with I hate them because I had all this passion and enthusiasm inside of me like caring for the client making a difference to the world and somebody somewhere was reducing it down to four week quits then and banging me over the head and giving me a load of stress and putting pressure on me just to bang out four week quits.

INT 003: So I became very defensive about targets that were imposed on me and had no negotiation in terms of what they were it was just a number that was seen to be pulled out of the sky and I had to deliver these units or widgets against it, so I became very defensive about it

INT 003: I do believe there are a lot of people in the Department of Health, in the strategic health authority within the PCT who do care about the quality of what's going on and do understand that the service that we are trying to provide but they have got to benchmark against something, they have to monitor and evaluate against something,

INT 003: So the four-week smoking quitters is the best solution to that I am sure it's neat its measurable it fits all your smart requirements but it does tell you the whole picture so I began to use my role and power and influence that I did have at the time to paint that picture to show people all of the stuff that sits around it to interpret that number.

INT 003: If you have an expert interpreting that number that fine but quite often that number get used and banded around by people that don't understand and don't have the insight who can't who do not have the dialogue to interpret it what's behind and what is happening and what it means and so everything gets reduced down to effectively something that is meaningless and process driven and reduced down to managerialism and control.

INT 003: I have seen them (services) which are absolutely shocking and I have seen them and am completely focused on one sole purpose that is to fill the number in the box and actually it's a waste of time and even further waste of resources.

INT 003: What we are finding by the way is that providers are defaulting to this place panicking and flapping with not hitting particular targets and doing particular types of work that I don't want them to be doing but it is their interpretation and they are doing action and activity to fulfil the performance measure that we have written in the service specification.

INT 003:

Researcher
So you had the tools there?

Delegate
Completely that wrapped around this central column of banging out four week quitters and that was hugely useful you had a very strong established measurement quantifiable thing to measure and then you had a huge suite of material and evidence base which supported what good quality interventions look like.

INT 003:
Researcher
If all those tools were available and that whole package to support which you had with the previous framework, if they were available in the current framework would you get better results?

Delegate
Yes because it makes it very easy to commissioners and performance management matrix designers to plug in the evidence base and the quality

INT 003: The acid test which makes the difference comes back to the relationship and if you have got that good strong relationship as a commissioner and a provider and you have got that communication and a good level of trust then you can start to negotiate and correctly employ all those tools (learning based).

INT 003: Performance management measure which gives them a complete headache loads of paperwork to do, they have got to capture the data that s really difficult and they spend 60% of their time chasing the number an actually what you want them to be doing is sitting down with people caring for them and looking after them.

INT 003: If you want to absolutely destroy and undermine and obliterate creativity then the golden rule is measure everything that could be measured so let's not do that let's look at things that are sensible.

INT 003: The world we work in public health we deal with very complex problems on a population scale so reducing services and activities actions and interventions on to quantifiable spread sheets is just part of the picture.

INT 004: National targets that have been set under the old PCT days are still being used in the new performance framework, so 4 hour wait in A&E 18-week referral to treatment all those targets from the old performance days are still there in the new context so it has not gone completely.

INT 004: Externally driven performance frameworks is not something I am personally averse to I think being what you need to be guarded against is the perverse incentive built into the system and that is where seeing the real issues occurring in performance terms it is never the performance target that is actually the problem it is when it is taken to the extremes that it becomes problematic.

INT 004: :Look at 4 hour waits in A&E the very fact that the whole waiting times within in departments is skewed towards everything that has happened in the last five ten minutes before the four hours is up is indicative of systems morphing to achieve that target rather than really understanding the spirit of the target that is actually about proving the system

and flows through it to make it work and the moment organisations start to skewing themselves to achieve something perversely that is when the whole performance framework breaks down.

Survey: Performance only effective if targets are right in the first place.

Survey: Depends on how well the process is applied and whether potential benefits are realised.

Survey: There should be key targets/local targets/HR and staff resources/ information on quality/ finance and budgets/strategic and business planning.

Survey: There should be Quality not quantity.

Survey: Id move away from bums on seats approach (throughput activity etc.) and look at quality. That's much harder to measure and would take some thinking about, but offer all we exist to provide a quality effective health service

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – There is a desire from senior management to set targets and performance management is seen as key to this.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – This should be consistent with the same principles measuring similar indicators such as, bed capacity, waiting lists etc…. the numbers game is a dominant approach that was perceived by all the delegates that evidences a consistent view of process based targets as opposed to the use of outcome measures.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – On the flipside of process based measures was the organisations ability to use performance management as a learning tool this was perceived as lacking as its use was being implemented to meet the control based approach for contract measurement and commissioning that was influencing the senior manager's approach.

Focus Group Flip Chart Notes Q1. What is your current perception of performance management? –

- ➢ It's quantitative rather than qualitative
- ➢ Government target driven
- ➢ Meeting targets but it should not lose quality
- ➢ Overriding principles – targets, benchmarking, auditing (internal/external, measurement, demand vs capacity
- ➢ e.g numbers again!!
- ➢ Person centred care – How many visits???
- ➢ About numbers!!?
- ➢ Number of visits / contracts
- ➢ Waiting list targets
- ➢ Appraisals /IPR (workforce measurement)
- ➢ Skill mix / workforce development
- ➢ Meeting national set targets for HR patients waits, for A&E, MIU environments
- ➢ 18 week waiting lists

> ➢ Feels like a reactive, audit based process

Focus Group Flip Chart Notes Q2. What do you perceive as the barriers to the delivery of performance management? –

> ➢ Reactive processes
> ➢ Emphasis on finance/ targets, rather than quality
> ➢ Understanding knowledge (training) of why i.e. targets

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Government targets are seen as an inhibiter to adopt a more learning based approach.

Focus Group Flip Chart Notes Q3. What are the opportunities for performance management in the NHS? –

> ➢ Meet targets e.g RTT & standards

5. Outcomes based approach

INT 001: More outcomes based although they are not timely, they can take a year to report/measure. Get a few areas where the outcomes are generally very good and others where we just seem to have deep seated problems.

INT 001: I ensure we have activity measures we got the staff and the beds etc. and we keep an eye on patient safety to try and ensure you are achieving this level of change are we then in danger of achieving worse outcomes and we want to make sure we watch both at the same time.

INT 001: There is certainly more that we can do, I would like to build in more outcomes into it partly as it is nationally driven but partly because it is the right thing to do. What you are trying to achieve is the best possible outcome with your resource.

INT 001: The other side is that we know that resource envelope is going to be more stretched year on year, so it may not always prove outcomes are better so the alternative is can you can maintain outcomes at lower cost.

INT 001: Two years ago it was nationally driven based on activity targets reducing waiting times, now with the overall economic problem the agenda has shifted to a more complex one actually we are trying to improve outcomes.

INT 001: Nationally they will just measure the top level numbers but they will still have their outcomes they can focus on but outcomes you only get the occasional red flag against them because a lot of them are banned by statistical confidence rules. There are not many outcomes that we can flag up as being a problem anyway that does not mean we have massive performance issues that are going to show up over the years.

INT 002: As in who was doing it, who was not doing it, rather than being focused on that macro level although what was the outcome don't worry about the process what's the outcome?

INT 002: Because they are allowed to performance manage (new approach) so we now equip them to make the performance judgement about their outcome and their context.

INT 002: If what we are doing now is adopting that different approach whereby we are interested in what the outcome is locally then all we can do is have a far more rounded growth a lot less linear if you like or directional and have a system which actually relates to local need that can grow rather than something that is nationally driven and I think there is a strength to that.

INT 002: I am really keen that we start to unpack the language of recovery (outcome based approach to drug intervention) and think of it in its component elements

INT 002: If we would just drive on and focusing on single mindly on successful completions (KPI's) to some extent we miss some of the really core components which is how do you ensure that people successfully complete completions from treatment and remain drug free and recovered.

INT 002: And then you start talking about what is the support to start reducing those inequalities and as soon as you do that you get your judgements about performance.

INT 003: We have to record and report our activity and progress against the set of structured outcomes. We then take that and translate that locally and make local decisions around how we will plan our commissioning and who we will commission and who we will commission to deliver against the public health outcomes framework.

INT 003: And so we design a suite of health improvement services and then design lots of outcome measures and process measures to assure ourselves as best we can to make sure all the providers we commission.

INT 003: To assure ourselves we have got the correct activity outcomes delivered against what our aspiration is and against the public health outcomes framework.

INT 003: And with that comes a whole load of quality activity and that was always a view and the approach and philosophy that we took in XXX was we were very much focused on the quality of the service and how we provide the service the difference it made to individuals lives, that was what we cared about the clinical quality and proficiency of the service we are providing.

INT 003: The way we saw it which was around evidence based practice and quality, customer care whilst delivering against the cold hard target of four-week quitter.

INT 003: That it is a better system (outcomes based approach) because it is less inclined to have this situation when someone high up the food chain does a bunch of numbers on a spread sheet and a bunch of colours that go red, orange and green and makes assumptions, huge assumptions about what that means.

INT 003: For example, how satisfied are the clients, client satisfaction and trying to qualify, quantify that is something we have not been measured before so we have our four-week quitter still but we got a whole bunch of other things we are measuring some are process some are outcome to give a richer picture of how services is doing. So if I, I

would much rather have 1800 four week quitters where customer satisfaction is really high than 2000 quitters where customer satisfaction is coming back really low.

INT 003: Involving members of the public involving people using the service is very important and getting an understanding of their perceptions and what is important to them. Getting to four weeks might not be their agenda might not be important to them so let's talk about measuring something or performance managing against something that is important to the population we are serving but also something that works.

INT 004 Now the transition entered the CCG and now it has moved towards the outcomes framework certainly at a national level that is what is viewed by some, but internally they retained a lot of the old performance management frameworks.

INT 004: So it sorts of works for a lot of things when you talk about the higher level mortality outcome measures that becomes more problematic because the XX locality is not visible nor would XXX Hospital Trust be visible.

INT 004: Trying to work to a new model rather than working to tried and tested model it was a new shift towards outcomes, the problem with outcomes is that they are very difficult to monitor.

INT 004: From my perspective I do not see much of the outcomes framework, so I am in two minds as to what extent that is really the driver behind what it is that we do. Because the outcomes framework is not updated quick enough I cannot see how that is working through.

INT 004: The focus on quality and outcomes structurally and in terms of what we are trying to do but I don't sense it being formed up with the clarity of reporting we need to do or have to be on a provider by provider level and don't sense the CCG is really driving this at all.

INT 004: It is that focus of outcomes being very rare that you can't drill down into them that is part of the problem and you really don't know what is driving them and actually the ability to understand what is driving them is actually more important in cases then the number itself and because of the very nature of outcomes they become an overview of what has been done they do not give you that granularity of detail which is important to understanding them.

INT 004: I think there is probably a slightly lesser risk with outcomes rather some of the old performance targets as perverse outcomes could also occur so then they are not completely gone by any means.

INT 004: It is all about the stability within the system and how you maintain that, so I think there is it sometimes not easy to translate that into a small set of national measures that actually fully define it, I can recognise the challenge and problems with that but I know they tried to solve that with the outcomes framework even though being slightly cynical its not sensitive enough to identify the differences between organisations.

INT 004: Could you compare XXX CCG with XXX CCG no you couldn't and our outcomes are fundamentally different and therefore what are we trying to achieve different so what is it telling us about the system which becomes quite a tricky problem so what is it saying

what are we trying to do and I am not sure the outcomes framework is really driving these improvements.

INT 004: Not the outcome as is what is monitored but the outcome as it what is best for the service that is ultimately where I want to get to I suppose.

Survey: Include user satisfaction objective outcome measures e.g level of disability etc .reactive activities versus proactive activities to see if one influences the other.

Survey: Exploring actual work /content of intervention and outcomes include clinical outcome measures.

Survey: Amount of work achieved with positive outcomes for patients - not necessarily linked to discharge of service.

Survey: Would like to be able to capture some of the qualitative outcomes in a meaningful way.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – There was a lack of data issue that needed to be addressed providing an inability to measure quality outcomes from the existing data.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? –There are unclear outcomes with no vision.

Focus Group Flip Chart Notes Q1. What is your current perception of performance management? –

  ➢ Does not show quality
  ➢ Business driven not patient/carer focussed
  ➢ Standards for better health
  ➢ Unclear outcomes

Focus Group Flip Chart Notes Q2. What do you perceive as the barriers to the delivery of performance management? –

  ➢ Client / patient perceptions
  ➢ Focus – patients /service

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Performance management does have the potential to look at evidencing good quality services and identifying what quality actually is that may have gone unnoticed in the past.

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Performance management provides a good learning tool to be proactive rather than be reactive with service delivery.

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - This would produce a more beneficial impact with less stressed patients and less complaints improving reputation management. Other positives included greater reflective learning, leaner working practice, more motivated and committed staff and a clearer vision and outcomes.

Focus Group Flip Chart Notes Q3. What are the opportunities for performance management in the NHS? –

- ➢ Patient- good quality service at point of delivery
- ➢ Objective and proof of effectiveness
- ➢ Enhancing patient pathways
- ➢ Improved services – changes, clinical
- ➢ Outcomes – will be able to demonstrate
- ➢ Appreciation of quality issues throughout the NHS
- ➢ Less stressed patients
- ➢ Less complaints

Focus Group session with Plymouth PCT Business Intelligence team - The measurement and delivery of performance information regarding quality outcomes is a potential challenge to the business intelligence team as existing cultural attitudes and beliefs were very much borne as a result that performance management focuses too much on data collation for decision making process.

Focus Group session with Plymouth PCT Business Intelligence team - Quality should be stated a numerical value that should have an equal balance of importance alongside workforce and financial information.

6. Strategic Planning

INT 004:

Researcher

If you were able to design your own performance management system without limitations or barriers what sort of design would it be or approach?

Delegate

That is a very broad question I will need to ponder that for several weeks. I think for me it has got to try and find what direction you are trying to take it's all about strategic alignment as the NHS is facing these financial pressures with demand growing and essentially operating in a flat cash environment.

INT 004: I think there is an element of that to go in the strategic nature of the things we are trying to do and it is understanding the different behaviours that sort of underpin it. So when you know your direction of travel you then need your data systems to be aligned to that strategic framework and then your performance targets align to them data systems and then that will give you a greater clarity of what it is you are trying to achieve.

Survey: There should be key targets/local targets/HR and staff resources/ information on quality/ finance and budgets/strategic and business planning.

Survey: Provides effective alignment to strategic planning, decision making and meeting the strategic objectives for the PCT.

Survey: The links between the planning cycles and the performance frameworks are not fully integrated

Survey: Much stronger communication is required to ensure people are aware of the links to the strategic aims of the PCT

Survey: An overall strategy what links all directorates. Each directorate seems to be doing its own and then provides self-praise. It is a bit insular and does not improve the organisation as a whole.

Survey: It is sometimes difficult to access the right people to talk to- people who have on overview of the whole PCT service who can advise and support clear business planning e.g commissioners, people in their directorates.

Survey: Clearer picture from above to see how service areas can contribute.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – Performance management is very business driven approach, target orientated.

Focus Group Flip Chart Notes Q1. What is your current perception of performance management? –

- ➢ Employment contracts (needs to be a part of)
- ➢ Staff individual appraisal KSF
- ➢ Directorate – strategic
- ➢ Trust – strategic

Focus Group Facilitators Notes: Q2. What do you perceive as the barriers to the delivery of performance management? - It was stated that there was an unclear relationship towards the move towards service improvement.

Focus Group Flip Chart Notes Q2. What do you perceive as the barriers to the delivery of performance management? –

- ➢ Lack of sharing the organisational vision
- ➢ Us not setting the agenda
- ➢ Competing roles and priorities
- ➢ Recruiting staff/skill mix
- ➢ Static workforce

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Lack of flexible structures to allow teams on the ground to function more effectively, placing frontline staff in a position to deal with the day to day immediacy of the service and therefore placing the service in a more reactive rather than learning, strategic planning or proactive approach.

Focus Group Flip Chart Notes Q3. What are the opportunities for performance management in the NHS? –

- ➢ Brave new world
- ➢ Clarity – Where we are? Where we have come from? Where we need to go? & how do we get there?

- Identification of bottle necks to improvement
- Identification of which services need more support
- Concrete evidence for planning which is understood by all stakeholders
- Answers the question, ''How are we doing?''
- Aid problem solving
- Trends
- Everyone (all staff patients and public) could see our performance level and how we are progressing
- Able to know where we are going
- Clear direction of travel
- Proactive – control forward planning, reflective learning, reflective learning = leaner working practice,
- More motivated & committed staff, clearer vision.

7. Finance & Efficiencies

INT 001: Efficiency being used for performance frameworks for financial requirements is shaping performance frameworks.

INT 001: We also have the Qipp agenda and the need to save large sums of money over the next five or so years, that's become a bigger element of the core performance framework for the PCT. We recognise we need to have quite large scale shifts in service provision across the whole health community in order to remain financially solvent if you like and the drive to achieve that is actually becoming a dominant factor in the overall shaping of the performance framework for the PCT.

INT 001: I don't think there is necessarily one perfect solution (framework approach/design) and I think that it's interesting how the Qipp with that need to save a lot of money over a long period of time and how important that is shaping the framework.

INT 001: I think we have done reasonably well so far as it is just about on an even keel certainly for the last year I would say that we have plucked the low hanging fruit in terms of efficiency improvements. I think because this is going to rumble on for a number of years I think financial pressures are going to keep on increasing as risks become ever greater, to me the Qipp bit is increasing and becoming a more dominant part of the framework.

INT 001: Two years ago it was nationally driven based on activity targets reducing waiting times, now with the overall economic problem the agenda has shifted to a more complex one actually we are trying to improve outcomes, save money and keep waiting times stable and something may have to give with that framework unless you can make very significant efficiencies.

INT 001: About five years ago we had a situation where we basically had ever increasing resources, what the organisation tended to do where it had money is to decide what to do with it. Nationally performance frameworks you needed to reduce 18-week referral to treatments you addressed that by spending on more treatment the simple linear decision making, what we now got is we are not going to get any more money going up and therefore we need to think where are we going to take resources away to then shift from one bit of the system to another.

INT 002: In the very early days for example, the XXX intervention programmes or XX programmes just started so there was fresh Home Office money new clearly identified crime reduction money, it would get results at any cost these are the targets, go in and do it you know.

INT 002: I suppose it was a means to acknowledging the fact that people believed for example, (old approach) that the budget was ring fenced and we still talk about it as if it was and it never was and we just said it was. People believed it because they wanted to believe, as joint commissioning managers believed it because they realised it was useful for them and they told Directors of Public Health that it was there because they wanted to and Directors of Public Health adopted that approach and I am sure they actually realised that it was not really ring fenced. It was a convenient rouse to ensure nobody nicked the money.

INT 002: Looking at it you would wonder how it possibly could have been achieved (old approach), it was achieved through money and the micro management of money and the influences around it, money went out and there were very significant increases in people's drugs budgets, huge increases and how that particularly did not get diverted was the basis of the culture that was around about us having plans that we sat round the table that I described that regional management group and we had approved their spending plans.

INT 002: Asked questions as to why you are investing in money in that area there if the performance looks like this, why are you doing it?

INT 002: Because you was perceived as being a failing area, where there had been a significant investment in funding it did not look good on your CV so it was that kind of manipulative approach (old approach), its so many million miles away from where we are now but it was the expected way to work.

INT 002: So it is less about a linear approach you know making sure that we attract money for drugs and alcohol, its more around looking at the broad resources that are available out there and how they can meet the needs of the local drug using population.

INT 002: I used to commission services so I come from a background of contract and currency and looking at performance but to be fair I always think that context is everything when you look at a figure.

INT 002: Performance management is desirable you know within the politic of this at the moment to happen it's either at the local where is your money effectively being spent or not effectively spent.

INT 002 Holding people to account to be achieving best value, looking for efficiencies and to be encouraging partnership and where people are performing to be making judgements may be looking at clauses to reduce funding,

INT 002 Why would you give the money to local areas to spend for local democracy to be in charge of spend if you don't expect to have some kind of change in the profile (performance).

INT 003: I saw them more as leverage to justify the funding that we got the resources what we got and the activity that we got against the specific targets which were very important to the local organisations to achieve against, but actually that was not our job,

INT 003: When you are hard pushed for resources and cash it is very easy to fall into the trap of what is the minimum amount of spend the minimum amount of effort the minimum amount of work we can do and the minimum amount of banding or people that work in the team, but still tick the box of 2000 four week quitters.

INT 003: One agenda on the commissioner side is how I can get the provider to do as much as possible for as little input for as little money because the pressures are very significant in the public sector, providers mission is how can I safe guard my margins I need to protect my staff, my activity and everything we have to do, so I need to do as little as possible whilst still ticking all the boxes.

INT 004: From my perspective I do not see much of the outcomes framework, so I am in two minds as to what extent that is really the driver behind what it is that we do. My real sense is that it is shifting more towards the finance and Qipp side of it as that is where the greatest risks lie.

INT 004: It seems to be shifted towards quality and safety making sure providers is delivering their contracts and then is financial stability the NHS is really getting to that tipping point. And having to make radical decisions to maintain that financial stability and inevitably that performance framework has got to move to mirror that and that is becoming the dominant factor really.

INT 004: I think the pressure to move towards the finance would have occurred anyway.

INT 004:

Researcher

If you were able to design your own performance management system without limitations or barriers what sort of design would it be or approach?

Delegate

That is a very broad question I will need to ponder that for several weeks. I think for me it has got to try and find what direction you are trying to take it's all about strategic alignment as the NHS is facing these financial pressures with demand growing and essentially operating in a flat cash environment. For me that is the thing probably trump all the others yes we are trying to improve quality but in some cases we might be trying to maintain the same level of quality within lower resources and high demand,

INT 004: It is about maintaining the quality or improvement whilst within the financial constraints that we got that is probably the biggest challenge.

Survey: Enable the commissioning of services and the monitoring of contracts

Survey: It has the ability to support the PCT to deliver from a basis of value for money.

Survey: At our level we have some influence on this. But other drivers (usually to do with financial recovery or cost cutting) steer things away from quality and effectiveness

Survey: More integrated HR and finance information is required to provide a balanced view.

Survey: True cost of activity versus outcome i.e true cost of providing a service as an inpatient versus the cost of providing some services in the community against patient outcome.

Survey: Service level agreements make the reality of what a service needs to do. That service budgets, staff allocations etc. Reflect performance reality

Survey: Finance spending use of a service i.e non bed day instead of blocked bed days.

Survey: Performance Management needs to be applied to the organisation to improve productivity is measured on what it means is used with commissioner's provider services and public health

Survey: Would appreciate a yearly update to clarify targets and how these are linked to SLA's.

Survey: Presentation to all staff so there is an understanding and clarity about how their work impacts on the PCT and its resources.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – Performance management does not have the ability to identify quality delivery in frontline services and only has a purpose to measure for financial purposes and requirements.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – It was stated that performance management has been implemented to support the business planning process for Payment by Results, service level agreements, appraisals, skill mix and workforce development.

Focus Group Flip Chart Notes Q1. What is your current perception of performance management? –

 - ➤ The need to know resources
 - ➤ Money – value for money
 - ➤ Service level agreements –It is changing but not sure of our influence on these changes
 - ➤ Payment by results
 - ➤ Team – budget related, whole service systems management

Focus Group Flip Chart Notes Q2. What do you perceive as the barriers to the delivery of performance management? –

 - ➤ Staff- lack of resource
 - ➤ Admin support (lack of
 - ➤ Staff sickness levels and stress
 - ➤ Finance / budget constraints

> ➢ Resources – Human, financial, training
> ➢ Budget awareness
> ➢ Disinvestment
> ➢ Emphasis on finance/ targets, rather than quality

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Performance management provides an opportunity to evidence good value for money provide an opportunity for the public to scrutinise the services to establish what value and quality of service NHS organisations are providing for the resources and inputs invested.

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - The delivery of performance management has an opportunity to enhance the ability for a service to deliver more cost effective services; value for money could also be achieved with a view of redirecting resources into more effective services. It has the potential to support better proactive patient management by identifying the right skill mix to meet the demands. This allows the opportunity to deliver higher quality services and will ultimately result in a less stressed workforce with more positive implications on cost management.

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Performance management has the potential to provide transparency, greater accountability evidence effectiveness.

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Performance management approaches has the ability to identify resources in the system to look at building a case for a balanced view of cost vs quality.

Focus Group Flip Chart Notes Q3. What are the opportunities for performance management in the NHS? –

> ➢ Finance
> ➢ Protects the public purse
> ➢ Target resources – show deficits
> ➢ Generating income
> ➢ Easily identify resources needed and have a good case
> ➢ Cost effective value for money = redirect resources into the service – proactive patient management

Focus Group session with Plymouth PCT Business Intelligence team - Existing cultural attitudes and beliefs were very much borne as a result that performance management focuses too much on data collation for decision making process that is too focused on cost and volume of services.

8. Levels of Interaction

INT 001: People in the organisation have different levels of interactions with it. People have different views of performance management.

INT 001: I think for me there is a dangerous world with developing performance frameworks with only seeing them as a Board or senior executive framework when actually they are really designed to be for the whole organisation, so it has got be for all levels of staff and there is also a tendency PCT's especially I see them as a series of committees in a lot of ways so you have to feed the right information to the right committee to ensure they can see what is going on to make the right decisions then get down to the operational layer.

INT 001: You have to build a structure for the needs of all those groups and I think that is the way I built the performance framework to try and meet the needs of everybody at different layers but it is a multi-tiered structure now.

INT 001: In terms of if it works well it can have a huge impact because it is all about how you align (performance management) it at all levels of the organisation and because PCT's are in a slight unique position sort of management of the local health economy actually it is going to influence the lives of a large amount of people in XXX.

INT 001: I think that it is constantly working in progress in some ways but you have to take the organisation with you.

Survey: Lack of promotion and awareness of performance frameworks.

Survey: There is a cynicism regarding performance frameworks amongst clinical practitioners.

Survey: Cynicism is gradually reducing

Survey: It is very difficult to deliver on all the different requirements different teams expect

Survey: There has been increasing opportunities to be included over the past 18 months with the retirement of the previous service manager

Survey: Historically in our service this work has been done by senior managers. However, in the last 18 months there has been an increasing expectation that my level will have involvement

Survey: I have an awareness of my own service some of the provider targets e.g through CPA i.e across service but limited awareness of the provider service as a whole

Survey: As a new manager within the service recruitment problems time constraints do not allow full involvement in performance management processes.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – It was stated that commissioner's culture regarding performance needs to align alongside provider's culture towards delivery for a new style of performance management to emerge.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – Performance management is still in its infancy very top down and meaningless to the majority of the workforce

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? – Very much a separation between senior management and clinician and the agenda is very much externally driven.

Focus Group Flip Chart Notes Q1. What is your current perception of performance management? –

- ➢ Meaningless to the majority of the workforce
- ➢ Where is service user views/involvement?
- ➢ Seen as a separate from the day to day work (clinical)
- ➢ Not always relevant to your area
- ➢ Not within our control
- ➢ Out of context
- ➢ Sub directorate – service interaction

Focus Group Facilitators Notes: Q2. What do you perceive as the barriers to the delivery of performance management? - Established staff attitudes towards performance management that was very apathetic in nature did come through and was exposed during the feedback session for this question.

Focus Group Facilitators Notes: Q2. What do you perceive as the barriers to the delivery of performance management? - Frontline staff felt that performance management is about delivering another parties agenda rather than frontline activities that they were experiencing. It was remarked that performance management has a more corporate language attuned for senior managers and not frontline that could be alien to a person who is trained clinically.

Focus Group Facilitators Notes: Q2. What do you perceive as the barriers to the delivery of performance management? - The barriers towards performance management that emerged had common themes of poor leadership, lack of organisational vision and a culture that was inherent that did not provide a sufficient support to enable and empower frontline staff to adopt it.

Focus Group Facilitators Notes: Q2. What do you perceive as the barriers to the delivery of performance management? - A significant barrier that emerged from the discussion was regarding lack of adoption or sign up from frontline staff that was promoting a lack of clinical relevance towards performance management.

Focus Group Flip Chart Notes Q2. What do you perceive as the barriers to the delivery of performance management? –

- ➢ Poor leadership
- ➢ Lack of consultation
- ➢ Lack of sharing the organisational vision
- ➢ Leadership – not sharing
- ➢ Inflexibility
- ➢ Staff engagement / management training/ progress made through time not skill
- ➢ Low morale, understaffed
- ➢ Lack of co-ordination
- ➢ Speed of requests
- ➢ Changing client groups

- ➢ Language used
- ➢ Admin support (lack of) knowing who's who
- ➢ Agreement between senior management teams & clinicians
- ➢ Lack of information, feedback
- ➢ Does not have clinical relevance so lack of staff sign up
- ➢ Unclear relationship to genuine service improvement
- ➢ Not everyone wanting to be involved or to change
- ➢ Us not setting the agenda
- ➢ Conflicts of interest
- ➢ Staff attitude
- ➢ Not everyone fits into a box

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Some emerging themes did present themselves with the discussion such as providing an opportunity for commissioners to talk to providers on an equal playing field.

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Performance management was termed as a brave new world providing greater clarity and direction of working for frontline staff. There is a necessity for performance management to be delivered at all levels providing input also from users and frontline staff into the process.

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Involvement needs to be at all levels performance information needs to be accessible to frontline staff, patients, public and managers.

Focus Group Flip Chart Notes Q3. What are the opportunities for performance management in the NHS? –

- ➢ Stop the blame culture
- ➢ Mechanism – For input from all levels including users
- ➢ Transparency
- ➢ Support robust negotiating
- ➢ Ability to be proactive not reactive

9. Performance Information Systems

INT 001: There is a need for performance information for different reasons. There is a need for people at lower levels of the board to own their own performance. Need to feed the right information to the right committee to ensure they can make the right decisions. It then needs to get down to the operational level for good project management and service redesign.

INT 001: I do not think there is any hard and fast right or wrong answers people will have different needs in terms of information and performance

INT 002: So the point I suppose is that what we talk about, performance is benchmarking comparison about data, we talk about characteristics in your data and we talk about meeting local need, It is things as such, it takes the locus of performance management

the judgemental element which in the past sat with me and my colleagues, it now identifies non-judgementally characteristics.

INT 002: I think it's actually where you want the dialogue to happen that is important and I suppose in a sense it would personally I think the ability to have a conversation about data is really useful.

INT 002: Talking about characteristics and doing benchmark comparative data and I think that gets you round it.

INT 004: We do not get access to all the information that you would get across the whole CCG. The Business Intelligence Team would need to break this down so we can get a XXX locality view of high level measures, outcomes framework and so on.

INT 004: Where it is changing XXX locality is different there is a performance dashboard that has been developed but it has not been the national view of the data so the work has to be done with some of the high level measures to sub divide so it is not always straight forward for measures to be split out. If you look all the work was to report nationally the data say C Diff we would not necessary see C Diff as XX locality as national analysis but you can do it locally,

INT 004: That extra level of detail suddenly becomes a little trickier to find and access and its performance framework and clarity at a PCT level meant all other data was configured to that level that just meant it was very much easily what the problem is what we got is we are operating on a sub locality basis rather than a whole CCG level that is still not there.

INT 004:

Researcher

So if that element of that information and intelligence or that package of information and intelligence which used to be with those performance areas performance targets for example, in the previous approach was with you now would life be better would it be easier to manage your performance?

Delegate

If would help just in terms of giving that clarity of what is there and it is almost a by-product of having a very clear performance management framework, it is also all the supplementary information that is also more readily available at the same time and it is almost the by-product that has enabled it to happen.

INT 004: We want to be able to interrogate the data ourselves in order to check that this is the right interpretation certainly I think that has been sorted out nationally we must have to do a bit more ourselves but still cannot answer all the questions all the time really.

INT 004: Whilst I am one of those big advocates of sharing and using for the right purposes and I think the more you can understand how the system behaves is absolutely critical. To me sharing a lot of that intelligence is absolutely fundamental to really managing the system.

INT 004: So there is certain resistance within XXX Hospitals Trust to change the way they record data but they know it is going to influence that particular figure.

INT 004: I don't think that there are any major warning flags for me there but it is very hard to be absolutely sure of there being an issue as there needs to be good recording practices and without visibility of what is going on and not being able to drill into these figures you cannot always tell.

INT 004: Your performance targets align to them data systems and then that will give you a greater clarity of what it is you are trying to achieve.

INT 004: Probably one of the biggest shake ups moving from a PCT to a CCG is that a lot of those information reporting systems got thrown up in the air and have not quite bedded down yet.

INT 004: I think thinking back is the area we should have invested more time and effort in (performance information system) the early days of the CCG to make sure we got those systems up and running asap.

Survey: Information systems do not capture the real performance that we deliver

Survey: Performance information is not sufficiently accessible enough.

Survey: it is not sufficiently presented to show finance, workforce and service activity in a meaningful format.

Survey: Systems could be adopted to deliver more meaningful and accessible information.

Survey: Performance information does not reflect performance delivered.

Survey: supports providing business intelligence and information

Survey: Providing evidence based decision making tool to managers and practitioners

Survey: Providing evidence based decision making tool to managers and practitioners

Survey: Business Intelligence has an important role to play.

Survey: There needs to be greater information sharing in relation to the frameworks, outcomes and development and training requirements.

Survey: there needs to be more information on Clinical outcomes/statistical process control/social inclusion/ pbr and service line reporting & value for money indicators

Survey. IT systems which don't work reliably are a problem to performance information

Survey: Need regular feedback of information to make the data meaningful.

Survey: A monthly system of reporting in a joined up presentation needing understanding and action.

Focus Group Facilitators Notes: Q1. What is your current perception of performance management? - The performance data is incorrect and not robust, data quality needs to

be of sufficient quality to enable the baseline to be developed to provide a platform of performance to be able to predict future performance.

Focus Group Flip Chart Notes Q1. What is your current perception of performance management? –

- ➢ Hard to understand all the info
- ➢ Unsure if stats are correct
- ➢ Audit/collection of data can be seen as a stick to beat us
- ➢ Not always current information (stats are too old)
- ➢ Information to improve services
- ➢ Acceptance of data Quality….
- ➢ Epex (system issues)
- ➢ Is the data correct?

Focus Group Facilitators Notes: Q2. What do you perceive as the barriers to the delivery of performance management? - This was very much coupled along with the lack of resources and time that was required to fulfil performance management requirements whether that was to provide the data requirements or conduct the analysis.

Focus Group Facilitators Notes: Q2. What do you perceive as the barriers to the delivery of performance management? - Information was a key problem along with data integrity and acceptance that the data was providing a true position that was actual and evidence based.

Focus Group Flip Chart Notes Q2. What do you perceive as the barriers to the delivery of performance management? –

- ➢ Poor resources IT systems
- ➢ No mechanisms for recording patient clinical output / user outcomes
- ➢ Use of data – what is needed do clinicians understand the need
- ➢ Data quality
- ➢ IT does not work
- ➢ Understanding including IT
- ➢ Irregular review of performance data by clinicians /managers
- ➢ Different data collection systems ability to access systems
- ➢ Insufficient data management
- ➢ Data integrity – acceptance
- ➢ Informatics – limited in scope
- ➢ Systems can't talk to each other
- ➢ Getting reports out (from the system) easily
- ➢ System integrity – IT & process reliance, input vs output, cost, usability, training
- ➢ Not timely
- ➢ Trust in system (IT or other) in each other
- ➢ Lack of support and training

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Both parties (commissioner & provider) could work to agreeing that performance data could be viewed as the evidence of delivery.

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Involvement needs to be at all levels performance information needs to be accessible to frontline staff, patients, public and managers.

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - It was noted that there was a significant lack of information that was being provided to frontline staff hindering their ability to develop and improve their services. Insufficient data and systems not capturing the right intelligence was predominantly the issue and causing a level of frustration amongst frontline staff.

Focus Group Flip Chart Notes Q3. What are the opportunities for performance management in the NHS? –

> ➢ Data management handbook for Advanced Health Practitioner's

Focus Group session with Plymouth PCT Business Intelligence team - The common areas that were discussed focussed on the need for data acceptance was in place and there was a need for frontline staff to deal with data quality issues so good valid robust data could be used to populate the performance framework.

Focus Group session with Plymouth PCT Business Intelligence team - It was remarked that there were significant data issues that need to be addressed first to ensure that real performance management frameworks could be implemented effectively within the organisation.

Focus Group session with Plymouth PCT Business Intelligence team - There was a common consensus that business intelligence is key to the performance management process to enable managers to conduct the decision making process.

10. Multi-organisational/professional engagement

INT 001: A performance framework is good because it engages the whole health community not just your organisation. Performance sharing is easy if you have one trust and one commissioning organisation. It is more difficult though with multiple providers and differing boundaries. Having a simple relationship enables better information sharing. get a few areas where the outcomes are generally very good and others where we just seem to have deep seated problems and its then how the whole health community works together to challenge those issues.

INT001: Those boundaries make a lot of performance sharing a lot easier than say a large county wide place with a multiple of providers and those different boundary debates by having that simple relationship with other providers it does make information sharing better.

INT 001: Whether this type of framework is the reason for driving it more often or not it is down to more individual managers in certain areas being more competent and therefore you always get a few areas where the outcomes are generally very good and others where we just seem to have deep seated problems and its then how the whole health community works together to challenge those issues.

INT 001: We have been trying to shift activity away from acute hospital into community we do that to ensure whatever we are doing is a more efficient way of delivering services.

INT 001: Researcher
But you need to have everyone signed up to that is that is what you are saying?

Delegate
Yes, and that is what it is, it's almost like having to build a performance framework for the health community you could even include social care as they are a part of that work and I know the outcomes framework is expected to join up as a wider view although I still do not sense the performance frameworks have yet.

INT 002: That kind of ruthless element (old approach) was very good at doing that, what it did do was make partnership difficult, because it made at the particular stage we did have regional partners that we could form alliances with in terms of governance structures in terms of performance management and we had a regional management group where we had, who was it at it then?

INT 002: INT 002: So my perception I suppose of how to do this has been how we are emphasising the partnership element and exercising the support element. I certainly have been trying to use the influence if you like via the front door, it's about influence not performance,

INT 002: We can have a dialogue, we will commission this with local stakeholders and they apply the judgement to identify whether that is a performance issue they want, because they are allowed to performance manage so we now equip them to make the performance judgement about their outcome and their context.

INT 002: We'll just have a more robust engagement with a variety of stakeholders to try and highlight the differences and really ask the question is you comfortable with your system and your team with the local need.

INT 002: Is it effective compared to that team over there your comparators and the debate has said it for you. Just look at it and if it is 35% there and 50% there how do we explain away the difference for similar areas when actually it is round about performance differences.

INT 002: I think what this approach does offer and I am beginning to see it is an ability to think across silos. The old approach was very silo'd based with specialist teams this that and another, there were a great many gains that could be made across the broad public health agenda through this approach I don't think would happen if the more siloed and centralist approach and I think it is even down to the language.

INT 002 It does mean there is a focus on partnership and support and relationships, more support on relationships and relationship building and trust and understanding.

INT 002: If you have a team of people you can have that dialogue rather than working in siloes I talking about alcohol and drugs and someone else surely about sexual health and somebody else about health protection and nobody ever talking to each other you miss the opportunity.

INT 002: There is a bit about taking people conceptually on a journey in terms of our regional meetings and the way that we engage with commissioners and providers exposing them to new ways of thinking and to encourage them to think about it.

INT 002: How do you get those ideas out there and get people to run with them, they will not just get up and run with it they need to work it through, see what it means locally, see

how it goes, see how flexible it is so they can align everything up locally in order to do that.

INT 003: What's our approach it stems around our culture, approach and style I think the aspiration is it could be a lot more collaborative, closer cohesion working with the providers and understanding what meaning of these measurements are, how to interpret them and its always trying to communicate to the provider what is the spirit of what we are trying to do.

INT 003: Putting a bunch of numbers in the middle and figures is not consistent with facilitating trust, it facilitates competition which means you internalise and you see other people and everything as a threat and it also puts two people who should be working together collaboratively and positively two separate agendas.

INT 003: The first step to that is the much more flexible much looser and have a constant communication around the meaning and understanding of what the targets are what the performance management what are the outcomes we want and agree those together because it is not in the interests for anybody for people to be doing action and activity which is not benefiting the client and the communities that we serve for the sake of getting a number in a box.

INT 003: But the approach is to work with the provider on what the matrix looks like. I am quite pragmatic to sit down with the provider and see look we have put these we have created a whole suite of outcome measures and process measures whatever and they are all there to try and guide the service give the service leverage and say and stand up and say we need to perform and act and behave in this particular way and we have got to and we are being measured against X and Y and produce A and B.

INT 003: So negotiating the framework and the target rather than owning it ourselves and projecting it onto the provider it should be sat down and negotiated and we should keep them sensible and reduced and concise as possible.

INT 004:

Researcher

So that supplementary information you were talking about is that something you can gain from the provider?

Delegate

Sometimes it can be provider sometimes it is national data or you can try to come at it from a slightly different angle its possible although of course, if you get it from the provider you often get into well are you going to pay me to get it type of stuff to do that analysis but that in itself causes issues because there is no spare money in the system.
INT 004: We are working really hard between all our providers to share all their demand information so we can really understand how the winter pressures build in the system I think people are really seeing the advantages of pooling that information together everyone is sharing the same view situation that clarity really helps.

INT 004: That enabled all those partnership boards very focused on achieving a very particular goal so they were all willing to help to try and achieve it so it gave us that external scrutiny.

INT 004: It is not just for the CCG or any one organization to do it you need to get all the organizations signed up to the same agenda.

INT 004: I think having open information you can understand what it is because certainly I would say the CCG wants to do the right thing for the right reasons so having supplementary information means that make sure that happens.

INT 004: A lot of those information reporting systems got thrown up in the air and have not quite bedded down yet. So there is an element in order to fill that gap when we relied on individual providers, maintaining the consistency of reporting rather than us just replacing it with a CCG view of the world

Survey: A collective approach from the organization to support managers in collecting an inputting finance and service development information.

Survey: What patients consider important with due consideration for resource.

Survey: Raising awareness and link to service areas

Survey: People from a technical/information background often find it easier to engage with the performance agenda.

Survey: It does help to have an understanding of clinical work but not essential 5. It does not matter what you contribute to the organisation it should be delivered at a standard that strives to be the best it can.

Survey: As a manager with clinical input and a very clinical background, performance measurement sometimes seems alien although were often doing a lot of it anyway- may be perception.

Survey: Note also this is dependent on all staff at all levels understanding what performance management is.

Survey: More regular communication and face to face meetings

Survey: Continue input from performance management team on a regular basis.

Focus Group Flip Chart Notes Q1. What is your current perception of performance management? -

> ➤ Not always a joined up approach with our partners
> ➤ How does different performance organisation deliver performance management / it is the same principles etc.?

Focus Group Flip Chart Notes Q2. What do you perceive as the barriers to the delivery of performance management? –

> ➤ Complex adaptive system
> ➤ Trust between organisations – duplication
> ➤ Perceived lack of joined up thinking – common sense
> ➤ Partners – outside influences
> ➤ Team working – internal & external = one NHS

Focus Group Facilitators Notes: Q3. What are the opportunities for performance management in the NHS? - Has the potential to understand patient pathways and provide transparent information to enhance partnerships across the community.

Focus Group Flip Chart Notes Q3. What are the opportunities for performance management in the NHS? –

- ➢ Guidance – inter service cooperation
- ➢ Stop the blame culture
- ➢ Partnership across communities
- ➢ Support robust negotiating
- ➢ Appreciation of quality issues throughout the NHS

11. Training and Knowledge

INT 002: I think effective change having people on board in our organisation who are prepared to work with that change and to use different tools is really important, they have to get it don't they and I think we are still in the process of getting it things always change don't they, you have to respond in accordance with those changes.

INT 002: Local public health should tell us we are operating in old ways; we have to make sure we are confident and comfortable with working in the new world all of our staff within teams needs to be on message with that.

INT 003: What is the evidence base around the interventions is the range of evidence base is what has a strong evidence base what has not so strong evidence base, so you had this whole huge again communication of meaning and dialogue and training and understanding.

INT 003: Wrapped around it we had national guidance on how a service should operate and what the quality standards of the service are, those things were not measured those things were not audited or performance managed it all sat around still performing four week quits but it did describe very clearly a quality four week quit looks like what a good service looks like.

INT 004: So for me I have always been the one that has advocated that applying the real knowledge as to what is really going on in this specific area it is of most value rather than just the individual target.

INT 004: What do we really know because there is not necessarily that consistency of recording practices sometimes it understands and knowledge that enables you to know the real underlying performance.

INT 004: I think for me that is what is useful so you can understand what is happening around individual performance areas to actually try and achieve the outcome,

Survey: There is little training available directly in the PCT, currently knowledge is gained from national literature / conferences etc.

Survey: Training is required on epex getting information out of the system via epex, this generally dire ad hoc.

Survey: I need more training on how to do this effectively but more than that I need a clear sense of direction.

Survey: With adequate training and support your professional background should influence our ability to deliver

Survey: Performance management should be a proper part of the induction of all managers and team leaders and also account of the direction of service line management is taking the service.

Survey: There needs to be a dedicated performance manager to support each directorate with training for managers on performance management tools, techniques and expectations

Survey: More awareness for managers on performance indicators training in how to measure and assure that service delivers on those targets

Survey: Training to have a better understanding on what we must report on and what we currently report on and the systems used.

Focus Group Flip Chart Notes Q1. What is your current perception of performance management? –

- ➢ We need the appropriate skills to input
- ➢ We do not know what we should be doing.
- ➢ Mandatory training (needs to be a part of)

Focus Group Flip Chart Notes Q2. What do you perceive as the barriers to the delivery of performance management? –

- ➢ University training not enough staff to meet demand
- ➢ Lack of knowledge
- ➢ Skill mix
- ➢ Lack of training /education on how to do it
- ➢ Understanding knowledge (training) of why i.e targets
- ➢ Staff attitude
- ➢ Experience
- ➢ Not everyone fits into a box

Focus Group Flip Chart Notes Q3. What are the opportunities for performance management in the NHS? –

Appendix G: Ethical approval

Dear Jeremy,

Thank you for your email. I can confirm that as your study only involves NHS staff, your project would no longer require review by an NHS Research Ethics Committee in accordance with the new Governance Arrangements for Research Ethics Committees (GAfREC), which was released on 1st September 2011. I have inserted the relevant GAfREC paragraph relating to studies involving NHS staff below:

'Employers owe a duty of care to their employees. It is different from the duty of care that care providers owe to users of their services. RECs are not expected to assume employers' responsibilities or liabilities, or to act as a substitute for employers' proper management of health and safety in the workplace. It is for employers to ensure that they are fulfilling their duties as employers when their employees take part in research. Research involving staff of the services listed in paragraph 2.3.1, who are recruited by virtue of their professional role, does not therefore require REC review except where it would otherwise require REC review under this document (for example, because there is a legal requirement for REC review, or because the research also involves patients or service users as research participants)'

You may wish to contact Plymouth University Ethics Committee as your project may require review by the University Committee instead.

Good luck with your research.

Charlotte Allen Committee Coordinator (2011)

South West - Cornwall & Plymouth National Research Ethics Service (NRES)

Jeremy Walding
PBS, PGR Student

Ref: PBS.UPC/FREAC/FREAC1112.24/clc
Date: 17 April, 2012

Dear Jeremy

Ethical Approval Application No: FREAC1112.24
Title: Health Performance. An Ethnographical Study On Performance Management
      Frameworks Within The NHS

The Faculty Research Ethical Approval Committee has considered the revised ethical
approval form and is now fully satisfied that the project complies with the University of
Plymouth's ethical standards for research involving human participants.

Approval is for the duration of the project. Should you wish to extend the project, you would
need to seek further ethical approval.

We would like to wish you good luck with your research project.

Yours sincerely

(Sent as email attachment)

Dr Syamantak Bhattacharya
Chair
Faculty Research Ethics Approval Committee
Plymouth Business School

Appendix H: Survey questionnaire results

Survey Results

Q.1

Questionaire Results						
Question Number	**Description**	**Likert Preference Score**				
Q.1	**Performance Management**	**Strongly Agree**	**Agree**	**Neither agree or disagree**	**Disagree**	**Strongly disagree**
a	Is an essential process to be implemented by the NHS	18	19	3		
b	Is an essential process to be implemented by management	18	20	2		
c	Is an essential process to be conducted by clinical staff and practitioners.	10	24	3	3	
d	Is a waste of time and effort for the NHS, management and staff			6	21	13
e	Provides effective alignment to strategic planning.	8	24	8		
f	Provides effective alignment to decision making.	9	21	6	2	
g	Provides effective alignment to meeting the objectives of the PCT.	12	25	3		
h	Has the ability to support the PCT to deliver from a basis of 'value for money'	10	25	5	1	
Comments						
	The systems can be over elaborate and sometimes misdirected i.e can hit the target but miss the point. 2. I have answered these questions with the understanding (rightly or wrongly) that performance management is about supporting staff to carry out clinical work effectively and to their best allowing for good quality service. 3. I have no idea about what performance management is in reality or its impact on clinical staff, meeting objectives in reality (rather than in theory) 4. Can be dependant on process and how implemented also how linked with strategy both organisational and departmental.					

Q.2

Question Number	Description	Likert Preference Score				
Q.2	Performance Management	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
a	Measuring performance	15	23	2		
b	Developing, designing, implementing and monitoring targets and indicators	17	19	4		
c	Governance (clinical or business)	12	17	10		
d	Support strategic planning	15	24	2		
e	Enable the commissioning of services and the monitoring of contracts	14	21	6		
f	Providing an evidence based decision making tool to managers and practitioners	14	20	7		
g	Reporting performance	19	18	4		
h	Providing business intelligence and information	14	20	7		
i	A performance advisory service	10	19	11		
j	A support towards organisational development	16	19	6		
Comments						

1. Performance only effective if targets are right in the first place. 2. Performance management should be based within the services. 3. However these shouldn't obstruct from patient care, result in lots more paperwork and stress for staff who should be supported to do the clinical work they were trained for. 4. This is fine providing it does not hinder the clininical work done by practitioners. The danger is this is what is actually happening right now. 5. Again it depends on how well the process is applied and whether potential benefits are realised.

Q.3

Question Number	Description	Likert Preference Score				
Q.3	The main barrier towards the delivery of a performance management based approach is that	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
a	Information systems do not capture the real performance that we deliver	19	14	7		
b	The time to deliver the requirements amongst other priorities	6	16	6	11	
c	Lack of promotion and awareness of performance frameworks	9	17	10	3	
d	Performance information is not sufficiently accessible enough	8	25	3	2	
e	There is a cynicism of its adoption amongst clinical practitioners	9	19	6	5	
f	There is a cynicism of its adoption amongst managers	3	16	12	8	1
g	It is not sufficiently presented in a balanced way to show finance, workforce and service activity in a clear meaningful format	5	26	7	1	
Comments						

1. Systems could be adopted to deliver more meaningful and accessible information. 2. It is very difficult to deliver on all the different requirements different teams expect of us. Not necessarily promotion more clinical specialist role. Performance information does not reflect performance delivered. It not significantly presented or maybe I have missed the point. 3. A scorecard will assist this. 4. I think the cynicism is gradually reducing. 5. a & b these could be if systems were able to capture quality standards. 6. Depnds on the system and the service.

Q.4 - 9

Number	Description	Score	3.5	No of Reponses	39	
Q.4	How would you rate the opportunity you have been provided in the past as a manager or a member of staff being involved in the design and development of the performance management agenda?	1. The links between the planning cycles and the performance frameworks are not fully integrated. 2. Business Intelligence has an important role to play. 3. Although role has just changed -little involvement in previous role. 4. Only in the last year has involvement occurred and this was from a baseline of no actual knowledge about what was entailed. 4. At our level we have some influence on this. But other drivers (usually to do with financial recovery or cost cutting) steer things away from quality and effectiveness. 4. (not Involved) this has significantly impacted upon my answers above. 5. Always involved in workforce planning. 6. There has been increasing opportunities to be included over the past 18 months with the retirement of the previous service manager. 7. Been involved in some way working in partnership with other organisations but limited within the NHS. 8. This is a developing agenda which is growing in importance and will help managers operationally and strategically. 9. Not involved in any significant ways with regard to design and development, performance management is imposed. 10. Historically in our service this work has been done by senior managers. However in the last 18 months there has been an increasing expectation that my level will have involvement. This is a good development but awareness of training has not matched the expectation therefore leaving me feeling ill equipped.11. Local as above, regional and national- not at all			

Number	Description	Score	4.3	No of Reponses	40	
Q.5	Are you fully aware of the performance management frameworks the Provider Directorate is required to deliver, whether from regulatory or external bodies or from internally designed business processes?	1. Working in a corporate role I only have a partial role. 2. Being close to the Performance manager has helped but to me the requirements are not fully documented and visible. A good example is RTT 18 week internal transfers. The letter never got out of building 1. 3. Partly because the service does not fit neatly in any area/directorate. Not fully ware but partially aware. 4. Not joined up in a clear way. 5. Aware of internal performance management frameworks and ATD analysis and SLA. 6. Probably more aware than most people but I am also ware of the need of changes. 7. I have an awareness of my own service some of the provider targets e.g through CPA i.e across service but limited awareness of the provider service as a whole. 8. There needs to be greater information sharing in relation to the frameworks, outcomes and development and training requirements. 9. As a new manager within the service recruitment problems time constraints do not allow full involvement in managerial processes. 10. Very little input or understanding of the wider issues.			

Number	Description	Score	N/A			
Q.6	If you had a choice on what performance measures need to be monitored on an ongoing basis by the Directorate or the PCT, what would they be?	1. Clinical outcomes/statisitical process control/social inclusion/ pbr and service line reporting & value for money indicators 2. More integrated HR and finance information is required to provide a balanced view. 3. There should be key targets/local targets/HR and staff resources/ information on quality/ finance and budgets/strategic and business planning. 4. Quality not quantity. 5. What patients consider important with due consideration for resource. 6. Patient and staff satisfaction and value for money. 6. True cost of activity versus outcome i.e true cost of providing a service as an inpatient versus the cost of providing some services in the community against patient outcome. Patient feedback on pathways of care. Also need waiting lists, bed days contact time etc.. 7. How much clinical work is threatened by time spent on paperwork. IT systems which dont work reliably. 8. That service level agreements make the reality of what a service needs to do. That service budgets, staff allocations etc.. reflect reality. 9. Id move away from a bums on seats approach (thoughput, activity etc..) and look at quality. thats much harder to measure and would take some thinking about, but offer all we exist to provide a qulity effective health service. 10. Number of patient contacts and quality of service provided. 11. Exploring actual work /content of intervention and outcomes.			

Number	Description	Score	3.4	No of Reponses	40	
Q.7	Do you feel you have received sufficient training to meet the requirements to deliver a performance management based approach within your role?	1. There is little training available directly in the PCT. Currently knowledge is gained from national literature / conferences etc.. 2. Performance Management needs to be applied to the organisation to improve productivity is measured on what it means is used with commissioners provider services and public health. 3. Rasing awareness and link to service areas. 7. Training on epex getting information out of the system via epex, this generally dire ad hoc. A collective approach from the organisation to support managers in collecting an inputting finance and service development information. 4. No! The processes have been dumped upon us without any real support form line management. Performance managers seem to have assumed team leaders etc.. know what to do when in fact they have been overwhelmed by their clinincal and clinical management responsibilities. 5. I need more training on how to do this effectively but more that that I need a clear sense of direction rather than what feels disjointed and conflicting demands. 6. Would appreciate a yearly update to clarify targets and how these are linked to SLA's. 7. Have not recieved any training except			

Number	Description	Score	4.4	No of Reponses	38	
Q.8	Do you feel that the ability to deliver a performance management based approach is dependant on your professional background?	1. People from a technical/information background often find it easier to engage with the performance agenda. 2. marked because I have been exposed to it but if the organisation should pick up even if mine was zero(not dependant) 3. Rasing awareness and link to service areas 4. Not if adequate training is given. 4. It does help to have an understanding of clinical work but not essential 5. It does not maytter what you contribute to the organisation it should be delivered at a standard that strives to be the best it can. 6. Common sense is essential. 7. As a manager with clinincal input and a very clinical background, performance measurement sometimes seems alien although were often doing a lot of it anyway- may be perception. 8. Need to be patient non judgemental and able to listen and make a difference. 9. With adequate training and support your professional background should not influence ability to deliver. 10. Everyone can learn but you eed to know your own service well. 11. Everyone can have an input if they are trained and the vision explained = commitment through involvement - empowerment and a feeling of control.			

Number	Description	Score	N/A			
Q.9	What improvements do you feel could be made to the current performance management arrangements to support operational services?	1. Begin from scratch not that it is all bad, but a root and branch review would enable us to move to a model of excellence. 2. Much stronger communication is required to ensure people are aware of the links to the strategic aims of the PCT. 3. An overall strategy what links all directorates. Each directorate seems to be doing its own and then provides self-praise. It is a bit insular and does not improve the organisation as a whole. Note also this is dependant on all staff at all levels understanding what performance amanagement is. 4. More regular communication and face to face meetings. 5. Activity vs expectation 6. Performance management needs to sit within services and support. It can be percieved as a stick rather than a carrott. 7. Visibility and a link to service areas. 8. A new system!! epex is laboriuos and is consistently bad throughout the organisation. Working together from business intelligence and services. Epex is imputted by clinincian but often unaware what activity is extracted to monitor the service. 9. The service as a whole is undergoing change and direction of travel or vision and is not clear. It is difficult to be clear about need/service development. It is sometimes difficult to access the right people to talk to- people who have on overview of the whole PCT service who can advise and support clear business planning e.g commissioners, people in other directorates. 10. Performance management should be a proper part of the			

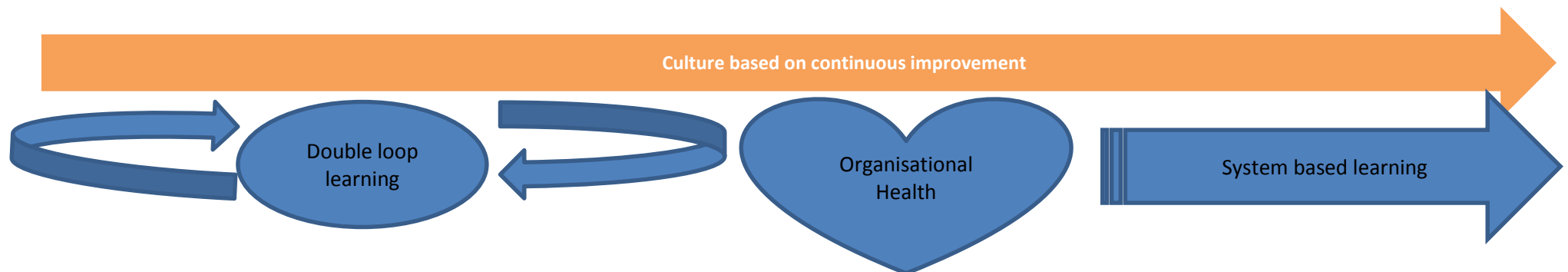**Appendix I Conceptual Performance Framework**

Identified barriers towards

Command & Control Internal / External	Dysfunctional behaviours	Low Performance culture	Lack of purpose and value towards PM	Lack of intrinsic motivation	Reporting & data issues

Strategic development Process

Evidence bank → Prioritisation → Strategy → Development of projects → Implmentation → Evaluation & measurement → Improved performance outcomes

Performance tools & technology

Balanced scorecard reporting	Performance measurement svstem	Dash boarding indicators & KPIs	Predictive analytics	Automated decision support systems	Performance prism

High performance culture

Culture based on continuous improvement

Double loop learning

Organisational Health

System based learning

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