of Imperial College London, who chaired the seminar, has argued that the market had never been properly tested because there has been no long-term consistency due to frequent political changes. Ham concurrs with this pointing out that the English health system has been the subject of endless new initiatives, in which reform is laid upon reform, and stability is lacking.

Secondly, tensions lie between self-improvement, self-regulation and external pressures. Where the best balance lies between these forms of regulation gives rise to further questions on the role of managers, peer reviews and external regulators. Thirdly, there is concern that the use of targets tends to concentrate activity on the areas measured, whilst neglecting other areas, so that what gets measured gets managed, but questions remain over that which is not measured.

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The performance paradigm in the English NHS:

Potential, pitfalls, and prospects

Mark Exworthy

Summary: Managing the performance of health services has become a dominant paradigm in policy and research in many countries over the past two decades. Attention has been directed to the development and implementation of performance ‘products’ such as management systems and metrics (for example, indicators). Whilst this approach offers some benefits, the limitations of relying solely on this approach are increasingly apparent. It is not always clear how such ‘products’ generate improved performance and whether unintended consequences are apparent elsewhere in the health system. Understandings about performance could benefit from stronger and more explicit conceptual foundations. This article highlights one example of how research could be broadened to elicit a more rounded perspective on performance; namely, a focus on ‘informal’ aspects of performance. The article concludes that continued pressure from government, the public and health service users will demand on-going improvements. However, it is likely that, in an era of constrained budgets, new ways of thinking must be sought to meet rising expectations.

Keywords: Performance, health policy, NHS, subjectivity, England.

Potentials and pitfalls of performance

Over the past two decades, in many countries, the performance paradigm has become firmly established by governments seeking to manage public services, to control professionals, to contain costs and to accommodate rising public expectations. It is not surprising, therefore, that notions of performance have been central to the way in which health policy has developed. The National Health Service (NHS) in England is no exception; indeed, it has arguably been at the forefront of developments. To examine the potential, pitfalls and prospects of the performance paradigm, this article focuses on the English NHS.

Varying notions of ‘performance’ have been prevalent and different approaches
have previously been attempted. For example, Smith has defined performance management as a: “set of managerial instruments designed to secure optimal performance of the health care system over time, in line with policy objectives”.

Performance has thus become a central pre-occupation of health policy-makers and managers over the past twenty years or so. The performance paradigm has been pivotal to the wave of approaches to managing public services (especially health services) that have been called ‘new public management’ (NPM).

Managers were given specific responsibility for managing the performance of services and staff. Performance was thus not only to be measured but also to be actively ‘managed’. Many governments, especially those in the ‘Anglo’ and northern European countries, often had a revolutionary zeal towards NPM in being able to transform services through a greater focus on managing performance and service improvement. Osbourne and Gaebler were at the forefront of promoting NPM in the form of ‘entrepreneurial government.’ A new approach to performance was central to their thesis: “Entrepreneurial governments promote competition between service providers… they measure the performance of their agencies, focusing not on inputs but outcomes. They are driven by their goals – their missions – not by their rules and regulations”.

A key aspect of the performance paradigm has been the development and introduction of quantitative metrics, comprising performance indicators, targets, benchmarks and comparisons. Services and the activities of staff had to be standardised in order to facilitate such measures and aid comparisons. Information from such comparisons was also central to the operation of market-style mechanisms, introduced by the separation of purchasers and providers – another key feature of NPM. It follows that qualitative measures have been less evident.

The performance paradigm has received much negative criticism for its shortcomings. Any performance system suffers from incompleteness; it is inevitable that some aspect of service delivery will be omitted from performance measures. The implication is that measured aspects get priority and unmeasured ones are neglected; hence, the adage ‘what gets measured gets done’. This can lead to behaviour whereby agents ‘game’ the performance system as an end in itself. Attribution of decisions to subsequent performance is complicated by the open systems within which health services operate, as well as the robustness of the measures themselves. Patient behaviour, plus the many interactions with different agencies, makes assessment of (health) outcomes problematic. Attribution is further hampered by ‘performance churn’ whereby there is little consistency in performance measures between successive applications. This makes it difficult to gauge whether ‘performance’ (as measured by those indicators) has improved or not over time. This churn highlights a final factor – the short-term focus of many performance systems. Annual measures may not necessarily capture ‘improvements’ and yet managers are held accountable over this short time period.

Health services are characterised by generic features which make direct comparisons of performance difficult, including:
- ambiguous goals;
- few reliable measures of effectiveness;
- multiple definitions of ‘success’ which are likely to compete and conflict;
- complexity of cases (such as individuals with multiple social problems or co-morbidities);
- perverse incentives (including the so-called ‘efficiency trap’ whereby ‘good’ organisations were not rewarded);
- limited ‘user choice’, implying a greater reliance on professional proxies (such as GPs or care managers); and
- professional dominance.

In England, the approach to performance management in the NHS has consisted of guidance, monitoring and response. Over the past decade or so, this English performance paradigm has tended to be centralised.

The shifting parameters of performance
The traditional approach to managing performance has been a minimalist one with few (if any) explicit mechanisms to deal with ‘poor’ performance and promote ‘good’ performance. This approach is outlined in Table 1.

More recently, the approach to managing health service performance has evolved with three developments being prominent:

1. New ‘steering’ organisations including regulators, such as the Care Quality Commission (CQC) or the Office of Standards in Education (OFSTED);
2. Extensive use of information technology (in performance management);
3. Greater challenge to professional norms and practices.

These features are consistent with the emergence of post-bureaucratic organisations. The traditional approach has thus undergone transformative change but the ‘new’ approach remains emergent in different spheres of health policy. Not all performance measures are, for example, directed towards individuals; organisations remain the predominant unit of analysis. Nonetheless, the direction of travel away from the traditional approach is clear (Table 2).

The implications of this approach are becoming increasingly apparent. First, the number of stakeholders involved in performance is increasing and goes well beyond traditional health policy networks. For example, the growth of summative performance has been associated with new regulatory regimes such as the CQC which assess the quality of service and financial management. Equally, patients, the public and the media have become more centrally involved, not least through their use of the disseminated performance information. Second, the growing attention on named individuals is challenging professionals’ practice. Previously held claims of professional autonomy have been challenged, for example, by the disclosure of clinical performance on the internet (see next section). Third, performance measures are increasingly addressing (multiple) clinical outcomes rather than just inputs (such as staffing).

Performance in practice: a case-study
Case-studies can illustrate the shortcomings of existing performance systems and also the shifting parameters of performance in health systems. Here, the case of ‘informal’ performance is used to illustrate the need to broaden perspectives on performance.

The English performance paradigm has primarily been quantitative in nature, through measures such as rankings, league tables and performance indicators. These measures become the ‘official’ metrics, published by government agencies. They are retrospective in that they report previous performance from previous time
periods. Moreover, these data do not cover all of the areas which would enable rounded judgements to be made about an organisation’s performance. This approach can be described as ‘formal’ performance, akin to the notion of ‘hard’ information. Formal measures imply a degree of precision and are apparently objective statements. They also have a function as a ‘safety net’ for managers and others in that it directs attention to minimal standards of performance. It thus tends to focus on ‘poor’ performance rather than improving good performance.

A different approach is the notion of ‘informal’ performance. This refers to the ‘soft’ information that is founded on subjective judgements and perceptions. It refers to the ways in which performance is conceived, constructed and managed through a series of subjective judgements. It can be found in notions of reputation, goodwill, tacit knowledge and credibility. Health managers might, for example, refer to another as a ‘safe pair of hands’ or on the need to ‘keep an eye on them.’ Others might question ‘what is really happening?’ despite the surfeit of formal performance data. Informal performance may be biased and incomplete but, if it affects agents’ behaviour towards managing performance, it nonetheless has real effects. Informal performance comprises qualitative information that can be prospective. Goddard et al suggest that informal performance plays substitution and complementary functions in relation to formal performance. The application of notions of informal performance is illustrated below.

**Autonomy of NHS Foundation Trusts:**

Since 2004, the policy of Foundation Trusts (FTs) in England has granted greater autonomy to high ‘performing’ Trusts as a way of enabling further performance improvements. In general, FTs have not ‘performed’ as expected, raising the possibility that autonomy is not such a panacea after all. Technically, FTs do have the ability to exercise autonomy through their ability, for example, to retain savings and to avoid traditional NHS performance management mechanisms. However, it is apparent that many FTs have lacked the willingness to exercise such autonomy. The reasons for this unwillingness include:

- the greater risk to which FTs are exposed;
- continued uncertainty about the components of health system reform (such as the extent of competition);
- the generally weak levels of engagement and legitimacy that FTs have secured from local stakeholders;
- the fear of negative impact of autonomous decisions upon the local health economy; and
- the degree of extant autonomy already enjoyed by these high ‘performing’ organisations.

There is a need to explore the informal performance aspects of FT managers’ motivations and attitudes towards the award and use of autonomy.

**Mid-Staffordshire NHS Foundation Trust:**

As an FT, ‘Mid-Staffs’ was a supposedly high performing organisation. However, such performance was illusory. Its performance failings came to light when data revealed that:

“At least 400 patients died unnecessarily after undergoing treatment between 2005 and 2008 at the hospital, where regulators later found a catalogue of failings including poor accident and emergency care, bad hygiene, and patients being helped by relatives because staff were too busy.”

Moreover, its ‘formal’ performance had been less than ideal to become an FT, as Paton notes:

“In the four years from 2002 until 2005 (the last year of the star ratings system which ranked trusts from 0- to 3-stars), Stafford had got, respectively, 2, 3, 0 and 1 star. Yet it was encouraged or ‘invited’ to seek FT status.”

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**Table 1. The ‘traditional’ approach to performance**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Hallmarks of the traditional approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unit of analysis</td>
<td>Organisational level (such as the hospital, school or prison)</td>
</tr>
<tr>
<td>2. Specificity</td>
<td>Anonymous</td>
</tr>
<tr>
<td>3. Motivation</td>
<td>Intrinsic</td>
</tr>
<tr>
<td>4. Participation by practitioner</td>
<td>Voluntary</td>
</tr>
<tr>
<td>5. Focus</td>
<td>Inputs (e.g. staffing) and outputs (e.g. service delivery)</td>
</tr>
<tr>
<td>6. Purpose</td>
<td>Developmental and formative</td>
</tr>
<tr>
<td>7. Reference group</td>
<td>Professional peers (e.g. peer review by fellow clinicians)</td>
</tr>
</tbody>
</table>

**Table 2. The ‘emergent’ approach to performance**

<table>
<thead>
<tr>
<th>Feature</th>
<th>Hallmarks of the ‘emergent’ approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unit of analysis</td>
<td>Individual (such as the surgeon)</td>
</tr>
<tr>
<td>2. Specificity</td>
<td>Named</td>
</tr>
<tr>
<td>3. Motivation</td>
<td>Extrinsic</td>
</tr>
<tr>
<td>4. Participation by practitioner</td>
<td>Compulsory</td>
</tr>
<tr>
<td>5. Focus</td>
<td>Outputs and outcomes</td>
</tr>
<tr>
<td>6. Purpose</td>
<td>Judgemental and summative</td>
</tr>
<tr>
<td>7. Reference group</td>
<td>External</td>
</tr>
</tbody>
</table>
The performance paradigm was ‘gamed’ by Mid-Staffs’ managers to meet targets, rather than necessarily delivering good patient care.22 However, from the Francis inquiry, it appeared that patients and staff ‘knew’ about ‘poor’ performance:

“I remember at the time when our staffing levels were cut and we were just literally running around. Our ward was known as Beirut from several other wards. I heard it nicknamed that. ITU used to call us Beirut… I remember saying: this will have repercussions, this can’t go on like this. Because relatives were regularly coming up to us and saying: my Mum has been buzzing for this long, there has been a buzzer going there for that long”.

The behaviour of managers and perceptions of staff and the public tend to suggest that the informal performance of Mid-Staffs was apparent but overlooked by the dominant formal performance mode.

This case-study does not necessarily imply that informal performance should be prioritised above formal performance. Rather, both forms need to be considered, not least because the boundary between them is not fixed or permanent. It is thus vital to examine the interaction and reaction between the two in order to assess the ways in which performance is conceived, constructed and reproduced in local and national health systems.

Prospects for performance

This article has sought to take a critical look at the way in which notions of performance have been applied in the English NHS. It has shown that performance is a contested concept which does not necessarily determine specific courses of action. Performance is thus political, as Stewart and Walsh23 argue that there is a “need to recognise the imperfections and limitations of [performance] measures, and to use them as a means of supporting politically informed judgements”.

Research and policy needs to pay much closer attention to the contested nature of performance, for example through an examination of the interplay between formal and informal aspects of performance. This might be achieved by addressing the coherence, capacity and clinical engagement of performance paradigms.5

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