PERFORMANCE REVIEW AND GENERAL MANAGEMENT

By: Gordon Best, Director, King's Fund College

Robin Douglas, Fellow in Health and Social Services Development, King's Fund College

Nigel Webb, Fellow in Human Resource Management, King's Fund College

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INTRODUCTION AND BACKGROUND

The formal review of organisational performance at regular intervals is a relatively new idea to the NHS. Indeed, the hierarchical review process whereby the DHSS reviews regional plans and performance, regions review districts, and districts review individual units, was only introduced in 1984. Since that time, much water has passed under the bridge and the review process is now a well-established and integral part of NHS general management.

The most recent - and perhaps most significant - development in strengthening performance review within the service has been the introduction of Individual Performance Review (IPR) for all General Managers. This development, while clearly important, is hardly surprising: within industry, IPR dates back to the 1950's and is firmly a part of the general management tradition. IPR in fact grows out of a particular approach to general management known as Management by Objectives (MBO) (1).

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In outline, MBO is a way of identifying and setting organisational (or corporate) objectives; establishing the feasibility of achieving those objectives; and then formalising feedback so that management can determine whether the organisation is achieving the objectives. Although the results of applying MBO within industry and government have been mixed, such attempts have at least had the merit of obliging management to be more explicit about corporate objectives as well as about how performance is to be measured and judged.

Within the MBO framework, it is assumed that an individual manager's objectives (as established through IPR) will be consistent with and indeed, grow out of, wider organisational objectives. In the private sector for example, if corporate objectives call for an increase in sales and market share, it would be unthinkable to encourage senior management to pursue individual objectives consistent with retrenchment and negative growth. More subtly perhaps, if corporate objectives change, it is assumed that individual manager's objectives will change accordingly. Within the private sector, no well-managed organisation separates the process of corporate objective-setting from the process of individual performance review for senior management. This dictum of good management reflects a compelling logic: namely, <u>if senior managers are expected to take the lead in pursuing and implementing corporate objectives, then their own objectives must reflect this reality</u>.

The introduction of general management in the NHS means that health authorities must be prepared to address this same issue. General management implies, among other things, the existence of clear corporate goals and priorities, openly arrived at, and which move beyond a narrow concern with financial targets and service efficiency. For the first time, therefore, regions, districts and units are having to grapple with the problems of determining explicit priorities and goals for directing managerial and organisational behaviour. In practice, this has led health authorities to adopt a wide variety of so-called objectives ranging on the one hand, from vague statements of intent containing little guidance for managerial action to, on the other, lists of specific tasks which not only bear little relation to a corporate overview, but do not differ markedly from actions that were previously expected of administrators.

Moreover, even where authority-wide objectives exist, in, for example, "mission" statements, or in a District's Strategic Plan, health authorities seem to have difficulty in translating their policies into IPR objectives for senior managers. There are a number of reasons for this:

* First, it is in part due to a general lack of familiarity and experience in carrying out performance review. It is no simple task to establish clear objectives and then systematically review performance against these objectives, in an organisation as complex

as the NHS. Indeed, there is not even an agreed vocabulary for discussing NHS priorities and health authority performance.

* Second, confusion arises because general management often means different things to different participants in the performance review process. In particular, many chairmen and general managers fail to distinguish between general management and line management. For many concerned with the performance review process, general management is seen to consist of little more than a strong line of managerial authority running hierarchically through the service with each level in the hierarchy effectively telling the next level down what its performance will consist of and how it will be judged. In an organisation as large and complex as the NHS, this over-simple view of management and authority is unlikely to provide a workable basis for performance review.

* A third and related reason can be traced to the recent increase in the 'top down' pressure on general managers which may well be distorting the performance review process. For example, while district chairmen are expected to agree managerial objectives for the coming year with their general managers, it is often only a matter of weeks before a DHSS circular directs both chairmen and general managers to devote their efforts to a task which bears little or no relationship to the previously agreed objectives.

* Finally, performance review is complicated by the fact that there are multiple and sometimes conflicting lines of managerial accountability within the NHS. At different times and for different issues, a district general manager may be variously accountable to his or her health authority; to the district chairman; to the broader community; to the regional general manager; to the DHSS; or in many cases, to some combination of these interests. Such overlapping and changing patterns of managerial accountability lead not only to a lack of clarity about objectives, but also about how performance is to be judged.

Clearly, if general management and general managers are to make an <u>effective</u> contribution to an improved NHS, it will be necessary to devise an approach to performance review which addresses these types of difficulties. In this chapter, we set out a framework for doing this. The chapter is organised as follows:

* Section 1 provides a vocabulary intended to clarify the objective-setting and performance review processes.

* Section 2 then presents an example of how this vocabulary can be incorporated within a broader MBO framework and used as a basis for performance review.

* The concluding section then draws attention to the intrinsic tension between the 'top down' and 'bottom up' pressures on general managers in the NHS. It is our contention that the success or otherwise of general management depends on these pressures being effectively reconciled within the performance review process.

SECTION 1. The Language of Performance Review

It is useful to consider three different aspects of the performance review process: namely,

* the LANGUAGE in which it is conducted: for example, the degree of clarity of the goals and intentions expressed by the process, the levels of understanding of all the parties involved as to the nature of what is expected and the meaning of the term "performance";

* the MEANS by which it is operated: for example, issues of personality, power and authority, clarity and validity of information, commitment or otherwise to the process, the nature of controls, motivation and rewards;

* the CULTURE in which it operates: for example, the degree of trust within the organisation, the expectation and degree of involvement of participants, the recognition and reaction to failure and success.

All three of these areas require consideration if the NHS is to develop an effective means for reviewing and improving performance. In this chapter however, we shall concentrate on the first two areas although in conclusion, we shall touch on the third.

As noted earlier, there is no generally accepted language or vocabulary for discussing NHS performance. The introduction of IPR for general managers has however, had the effect of highlighting this as an important problem. Present guidance on IPR (2), for example, distinguishes between long-term goals or purposes, key objectives, and targets. This distinction is made by defining higher level statements as concerned with "what" and more specific or detailed items, as "how". The guidance also suggests that managers' objectives should include at least three different sorts, i.e. innovative objectives such as the development of new services; maintenance objectives such as maintaining financial control; and human resource objectives focussing on staff development. And while such distinctions are fine as far as they go, they are of limited use in developing a framework that connects directly individual endeavour with overall organisational intent.

For this purpose, it is helpful to think in terms of three different kinds of objectives an organisation may wish to pursue: namely,

* IMPACT OBJECTIVES. These reflect the ends or final outcomes of the organisation's work. Impacts define the "what" that should be at the centre of all activity.

* SERVICE OBJECTIVES. The means of achieving the ends identified above. In human service organisations there is rarely one way of achieving impact objectives - it is important to distinguish between the many different possible approaches.

* LOGISTIC OBJECTIVES. These reflect the necessary preconditions for the service objectives to be met. Logistics describe the organisational arrangements, processes and resources that must be mobilised to enable the service to be offered.

An impact objective is a statement about particular ends. They are used to describe the real reason for the organisation's existence. An impact objective may look something like: 'Our aim is to ensure the highest possible standard of health care for the residents of X'. This statement may have a caveat such as 'within the finance available', or a statement about the standards which will define the desired impact. The most important point here is that impact objectives are about the experiences of those people for whom the NHS was set up - those people it directly or indirectly serves.

Impact objectives can be identified at many levels from the highly generalised (better health ... etc), to the very detailed and specific ('Mr/Mrs Jones to manage happily in their own homes'). One of the most difficult tasks that managers face is to make the connection between what they do daily and the achievement of these impact objectives. Senior managers particularly, are very unlikely to be involved in anything that contributes directly to a specific impact objective being met. This is all the more reason for their involvement in discussions associated with these types of statements. Unless there is some input from the managers who will be expected to make the impact objectives happen not

only will commitment to those objectives be reduced, but it will be even more difficult for them to make the connection between their daily activities and overall corporate goals. The critisism that managers have no understanding or commitment to the 'real' aims of the service stems in part from the inability of many managers to forge a convincing link between their authority's impact objectives and their own work.

Impact objectives are therefore, crucial to any organisational strategy. They identify the planned outputs of the organisation and by choosing to identify some and not others, they also declare organisational priorities.

Service objectives are the means by which impact objectives are achieved in human service organisations. The need to separate out impact and service objectives lies in the reality that there are likely to be many different services or combination of services which could be developed in pursuit of a desired outcome. Often, there is continuing debate about which services or combinations of services are likely to provide the best means for achieving a given impact. Service objectives, written explicitly, allow us to identify some of these differences and to forge a link between the development (or rundown) of specific services, and the objectives of the organisation as a whole.

The clear difference between service and impact statements is that one indicates what the service is likely to provide and the other describes the results. For example, one service

objective maybe to ensure that (say) 90% of the school population is vaccinated against the usual infections and 95% against rubella. In deciding this, the health authority has (a) sharpened its definition of its impact objective of better health (ie to ensure a rubella free population) and (b) set a standard. Both of these may change over time so that next year the impact objective may remain but its definition change or the standard differ (for example the standard may rise to 95% general vaccination rate and 100% for rubella).

Logistic objectives will reflect the internal organisational prerequisites to the achievement of service objectives. To continue with the example above, a health authority which did not have a vaccination or school health service would have to create and maintain such a service before being able to achieve its service objective. Organising and creating a vaccination and immunisation service would therefore generate a variety of 'lower level' logistic objectives including the design, development, resource acquisition and planning tasks necessary to develop this service.

A common problem arises here. The introduction of general management has rightly encouraged general managers to think strategically. Thus they have an obvious and key role to play in establishing impact and service objectives. However, it is wrong to assume - as often happens - that logistic objectives are not the concern of general managers. While general managers are likely to work directly with their

Authority, other senior managers and professionals in determining impact and service objectives, much of the work of their subordinates will be measured in terms of logistic objectives. Unless there is clarity about what objectives are being measured and how these relate to the personal objectives of different managers within the organisation, the whole process of performance review will become meaningless.

The distinctions made here between impact, service and logistic objectives are not meant simply to reflect a distinction between ends and means: all three types of objectives are concerned with both ends and means. The key difference between this framework and one such as the maintenance/human resource/innovation/dichotomy is that while both could cover the same ground, the former highlights the connections between different types of objectives: i.e., a logistic objective is pursued in order to enable a service objective to achieve an impact objective.

SECTION TWO - An Example

An impact objective may be "To achieve improved health status for the local population". A service objective can be seen as both a means of achieving this impact objective and a way of defining it more precisely. As above, an example might be: "To reach a 90% rubella vaccination level". In order to assess whether or not this is being achieved, it would in principle, be possible to monitor vaccination returns.

In this example - which is drawn from a recent experience - the impact objective is clear, the service objective is explicit and the idea of monitoring progress is, in principle, feasible. In the real world however, things are rarely this straightforward. Indeed, in the district from which this example is drawn, the vaccination service was far from well-managed with very poor - and therefore inaccurate - vaccination records. Further, although the DGM was aware of the 90% immunisation service objective, he had not been directly involved in working out how progress towards the objective was to be recorded and quantified. In these circumstances, it was not surprising to find that different managers (and others) within the organisation held different views about what population the percentage vaccination rate was meant to apply to - e.g. 90% of the total population? the school population?, the district's childrens services planning population? etc.

Perhaps more importantly, if this situation had persisted, it is likely that at year's end, the DGM would have been able to demonstrate that a 90% vaccination rate had been achieved for some population - for example, the school age population within the local authority boundaries. Given this, it is also likely that the authority Chairman would have concluded that the DGM had achieved this service objective, perhaps without considering whether - in terms of real outcomes for the patients of the district - this was the relevant population to be immunised. Clearly, the service objective set for senior management had not been related clearly to what the organisation as a whole was trying to achieve.

In practice, this kind of difficulty often arises and can usually be traced to one of two kinds of difficulties. First, the process whereby impact objectives are set, often excludes many of the managers who will be expected to deliver the services intended to achieve the desired impact. As a consequence, the objective is not properly 'owned' by these managers who therefore fail to understand higher management's intent. Secondly, senior managers often regard logistic objectives as outside their area of interest. As such, inadequate attention is given to the closer definition of service objectives, their validity and the feasibility of achieving them.

In the example above, had more junior managers been consulted when the DGM was agreeing service targets there would have been an opportunity for subordinate managers to contribute and to raise questions of validity and feasibility. Had this happened, some attention at least would have been given to the logistics of how the immunisation and vaccination service was structured and run and on the need for improved information systems. Given this, there would have been little chance of the DGM overlooking the critical issue of which population the authority wished to use in evaluating the impact of its service.

To avoid these kinds of pitfalls in practice, it is possible to adopt a more systematic and explicit approach to the objective-setting process. One such approach grows out of the MBO framework noted earlier. Within this framework, the

objective-setting process is usually subdivided into three fairly discreet phases as follows (3):

* Isolating Objectives: The process of isolating objectives is aimed at identifying a list of attractive and needed potential objectives. This phase begins with the deliberate and systematic identification of the results needed by the organisation for survival, growth, improvement, or problem resolution. Key organisational questions are posed: Where are we? How did we get here? Why are we deficient? What are our opportunities? Broad, potentially usable objectives are identified and it is at this stage that drift, aimless tendencies, or incorrect directions are detected, stopped, or re-directed.

* Setting Objectives: The broad areas of potentially usable targets identified during phase one provide the basis for adopting and setting objectives. This phase is intended to relate these potential objectives to the resources of the organisation and in particular, to those who will be expected to deliver the results implied by the objectives. This involves senior management in a form of participation from which a formal statement of objectives emerges. This statement proposes that an individual manager, a group of managers, a part of the organisation or the entire organisation commit themselves to one or more

objectives. It is based on the principle that the organisation gets maximum results from people, when they are involved in and accountable for, results.

* Validating Objectives: This phase is intended to test the validity and feasibility of the objectives before the organisation becomes committed formnally to pursuing them. As middle and junior managers are frequently involved in the validation process, it is also a means of gaining further commitment to the objectives. This phase determines the confidence an individual manager or group of managers, may have that an objective can be attained within a given time scale. The validation process simulates in a 'dry run' manner changes and errors or difficulties that may emerge when attempts are made to implement objectives. The validation procedure translates a formal statement of an objective to a statement of commitment. This commitment is binding, since a pledge or promise is made to deliver a given set of results. The validation procedure assures that resources, facilities, methods, people and management are ready and willing to reach a desire goal.

Figure 1 (page 16) illustrates how this framework can be used to begin to construct an explicit and practical basis for conducting performance review within a health authority. The salient features of the framework in Figure 1 are:

PHASE	ORGANISATIONAL FOCUS	PRIMARY RESPONSIBILITY
ISOLATING IMPACT OBJECTIVES	Organisation-wide Goals and Objectives	Health Authority and Top Management
SETTING SERVICE OBJECTIVES	Personal Targets and Objectives For Top and Senior Management	Top and Senior Management
VALIDATING LOGISTIC OBJECTIVES	Personal Targets and Objectives for Senior, Middle and Junior Management	Senior, Middle or Junior Management

Figure 1: NHS Performance Review: the Objective-Setting Process

1) It portrays an objective-setting process that progresses from broad considerations of the desired impact of the organisation as a whole, through to testing the feasibility of, and gaining commitment to, specific service and logistic targets which will need to be met to achieve the desired impact.

2) It links organisational and personal objectives: many of the IPR targets set for middle and junior management emerge from senior management's service targets which in turn, arise from the authority's statement of impact objectives.

3) It suggests that different tiers of management should have primary responsibility for and involvement in, the objective-setting process. In particular, it implies that the health authority's primary responsibility should be to isolate organisation-wide impact objectives, and to review the performance of top managers in relation to the achievement of service objectives. Equally, it implies that top and senior management should have principal responsibility for setting service objectives and for reviewing middle and junior management's performance in relation to the logistic objectives these give rise to. Finally, it implies that middle and junior managers should have principal responsibility for the validation process.

This kind of framework may be able to be used to strengthen NHS performance review because it begins to clarify who should be involved in the processes of isolating, setting and validating objectives and what kinds of information are needed at each stage in the process. It can also accommodate objectives relating to innovation, maintenance and human resources while integrating them within a more coherent framework. As such, it may help authorities and their managers to avoid at least some of the pitfalls highlighted in the example above.

This kind of framework does however, have a number of implications which may not be welcome by some authorities. For example, one implication is that health authorities themselves should restrict their roles largely to the identification of impact objectives and the review of top managers' performance. A second implication is that the great majority of managers within an authority will find that many of their IPR targets consist of service and/or logistic objectives which could (incorrectly) be perceived as relatively unimportant means to achieving higher needs. The alternative however, is to perpetuate the all too common practice of authority members attempting to take managerial decisions while at the same time, the majority of their managers pursue broad, but imprecise, objectives which provide little or no link between managerial action and real outcomes for patients.

CONCLUSION

In this chapter we have sought to construct a framework and provide a vocabulary for strengthening the performance review process. The framework as set out here does not address every aspect of NHS performance review - for example, we have made no mention of the importance of personal development targets for managers. What the framework does highlight is the crucial importance of forging an explicit and direct link between managers' personal objectives and those of the organisation as a whole (i.e. the health authority). It also stresses the importance of different tiers of management and groups of managers 'owning' different types of inter-related objectives.

In the longer term, the use and development of this kind of framework could make a major contribution to improved NHS general management. There is however, at least one current development in NHS management which could undermine the achievement of this aspiration.

As noted earlier, many who are a party to the performance review process within the service, fail to distinguish between general management and line management. From this perspective, the way to strengthen and improve general management is to strengthen line management. Equally, the way to strengthen line management is to reinforce line authority down through the NHS hierarchy (i.e. from the DHSS to RHAs; from RHAs to DHAs; etc.), while simultaneously requiring that lines of accountability upwards are

strengthened. In this way, directives and instructions from above become key ingredients in the definition of health authority and senior management 'performance', while evidence that managers are conforming to these directives becomes the primary basis for assessing performance.

General management in the NHS is and ought to be concerned with much more than simply the demands and requisites of line management. There is undeniably and correctly a 'top down' element to NHS general management. The NHS is after all, a national service and so NHS managers must in important part, be seen as the servants of relevant government ministers and ultimately, Parliament itself. There is also however, a 'bottom up' element to NHS general management which grows out of the recognition that - like all responsible managers - NHS managers have a responsibility to look after the needs of their customers (i.e. patients), their staff and their community. In theory, it is the local health authority that represents and gives voice to these local dimensions of each manager's performance.

From this perspective then, NHS general management is about much more than simply line management. In essence, it is about managers devising the most effective means of realising the intent of 'top down' policy while taking account of their own authority's local constraints and requirements. This is a more profound challenge than that of simply conforming to central directives and is without doubt, the key challenge that must be met if NHS general management is to forge a link between performance review and an improved deal for patients.

In the context of this chapter, general management in the NHS implies a review process in which each authority's statement of impact objectives contains some at least, designed to realise the intent of 'top down' policy. Given this, local management would then be expected to devise strategies for achieving service and logistic targets which would realise the intent of these policies in ways suited to local circumstances. In this manner, each health authority's capacity to deliver on service and logistic targets would be enhanced and over the medium term, NHS general management would be better placed to realise the intent of policy - be it from above or below.

At present, the reality is very different. Since the introduction of general management in the NHS, by far the great majority of directives emanating from above have been concerned with achieving logistic - or on occasion, service - targets. The centre has shown little interest in the development of impact statements or measures and, as a consequence, performance review at regional and district level has been predominantly concerned with logistic questions. In parallel, local health authorities have been left to formulate well-intentioned but usually ineffective statements of intent while watching their senior managers' devote most of their energies to tackling logistic and service issues. Clearly, this is one approach to the performance review process. Sadly, it has little to do with strengthening NHS general management.

REFERENCES

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