Briefing Paper

Achieving high performance in health care systems: the impact and influence of organisational arrangements

NHS managers and policy-makers need evidence about how an organisation's form and function affect its performance in achieving government objectives. This briefing paper reports the main findings from a systematic review of the literature undertaken by Manchester University. It illustrates what is known and not known about how organisational factors influence performance. The results presented here have important implications for future research and policy. For full access to the report, containing all the supporting evidence referred to in this briefing paper please go to: **www.sdo.lshtm.ac.uk/studyinghealthcare.htm#sheaff**

Key messages

- Highly centralised and bureaucratic organisational structures are not associated with high performance, especially in rapidly-changing settings.
- Organisational change needs to be developed from within, not just imposed from outside. Professional engagement and leadership are crucial.
- Frequent reforms have made the NHS unstable, leading to falls in performance in some areas of activity.
- Mergers may not achieve what matters, such as concentrating expertise or removing duplication.
- Occupational 'silos' promote technical change and innovation, but make change management harder.
- The public are reluctant to use 'choice' to influence the services their GPs provide.
- Governments should be cautious about promoting the use of for-profit hospitals.
- No one size fits all: local flexibility in organisational arrangements is important to ensure the best fit to local contexts and cultures, which is what improves performance.

sdo
NHS Service Delivery and Organisation R&D Programme

What NHS managers and policy makers *should know*

The research set out to investigate whether a relationship existed between the way various organisational 'forms' impacted on the ability of the NHS to achieve its objectives. The research found a highly complex relationship between organisational performance and a range of influencing factors such as the organisation's size, structure, leadership style, work culture and economic environment. External factors such as changing political and social contexts were also found to influence the effective functioning of a health care organisation. Consequently, the research concluded that few, if any, simple organisational levers can be pulled to influence performance and that no consistent relationship existed between an organisation's size and its performance. However, a number of key messages emerged from the research that provide a set of clear and important findings for NHS managers and policy-makers.

1. Highly centralised organisations are not associated with optimal performance

The research found that hierarchical and bureaucratic organisations work best in stable conditions, where processes and outcomes are clearly defined and agreed. Tools such as guidelines can work very effectively, but the evidence suggests that sharp differences exist within organisations in terms of rank, income and status. These sectors often disempower staff and inhibit effective communication and innovation.

Research in Scotland found that NHS commissioners were reluctant to be too explicit in their decision-making for fear of giving higher authorities and trusts a weapon against them.[1] Elsewhere, a hierarchical culture has been found to lead NHS managers in England to challenge clinicians' values rather than collaborate with them.[2]

The research concluded that such findings should be taken as a warning about centralising the internal structures and management processes of NHS organisations. Similarly, the research implied that organisations based on 'networks' or other horizontal structures are often best adapted to the rapid change and uncertainty that frequent government initiatives can bring, though their management is problematic. The research found some evidence to suggest that decentralisation may increase quality improvement, job satisfaction, efficiency and managerial effectiveness.

2. Organisational change needs to be developed from within, not imposed from outside, since professional engagement and leadership are crucial

The research found that engaging staff was important in achieving organisational objectives successfully, particularly in ensuring the success of managerial change initiatives. In particular, the support of medical professionals was found to be essential for implementing any meaningful and sustained change. Moreover, organisations with simply and clearly expressed goals and priorities were more likely to achieve them and to implement change.

According to a comprehensive 1992 study of strategic change management in the NHS by Warwick Business School, internal professional support was the single most significant factor for changing clinical practice, managing

***innovation and fostering team-working.*[3] *Such findings have been widely corroborated by the majority of later reviews on organisational change in the NHS and internationally.*[4-9]**

3. Frequent reforms have made the NHS unstable

The research found very strong evidence to show that frequent NHS reforms are likely to inhibit collaboration between organisations and care sectors. In particular, the research found that organisational reforms are often poorly coordinated leading to mismatches between the objectives of different professionals groups and health and social care institutions.

***Evidence from research into the history of community mental health services provision suggests that difficulties between organisations arise not because of an unwillingness to work together but because of contradictory policies: whilst the NHS operates an internal market approach, local government is characterised by a system of tight controls.*[10]**

4. Mergers often miss the point

The research concluded that mergers should not take place merely to achieve a particular organisational size but should concentrate primarily on making the most effective use of expertise, complementary skills and technologies, and/or reducing unnecessary task duplication. Mergers in which organisations keep separate their core activities and resources were unlikely to improve productivity or efficiency.

***Research into the impact of NHS mergers has shown they may delay other changes and hamper service delivery without improving recruitment and retention or cutting management costs.*[11]**

5. Occupational 'silos' hamper change and innovation

The research found evidence to suggest that NHS trust structures have preserved medical autonomy rather than enabled support for the organisations themselves. These 'semi-detached silos' promote technical expertise but preserve the profession's power within an organisation, which can make it more difficult to manage change at whole-organisation level. Occupational silos also conflict with managing patient services in care groups or care pathways. The research concluded that the imposition of structural changes would not necessarily eliminate differences between occupational cultures, but that workplace teams may compensate for some adverse effects of the silos. The research suggested that 'matrix' structures may offer a solution in parts of the NHS.

6. Publishing clinical performance information does not influence consumer choice

The research found that, on the whole, the public does not search out information on clinical performance, does not generally understand it, often distrusts it and usually fails to make use of it. The public also appear reluctant to use 'choice' by exploiting or promoting competition to influence the services their GPs provide. This suggests the NHS needs to develop other ways to make services more responsive to users' needs.

***Research on the relationship between patients and GPs in Scotland have shown that they have made little use of published clinical outcome data, and it has rarely been used to help improve quality in hospital trusts. This has been attributed to the clinical outcome indicators' lack of credibility due to poor data quality, limited dissemination, weak incentives to take action and a belief that soft information is more important when assessing clinical performance.*[12]**

However, the research suggested that health care providers do appear to be influenced by information about clinical outcomes. For example, poorly performing US hospitals tend to discredit the data and question its value, while privately using it to focus on quality issues. In the UK, the evidence shows that some people think politicians publish performance data to impel professionals to work harder.

7. The government should be cautious about promoting for-profit hospitals

Evidence from the research does not support the assumption that for-profit hospitals are less risk-averse, more innovative and more active in managing quality and attain higher productivity than non-profit hospitals. 'Public firms', for example, were found to have achieved advantages traditionally associated with profit-making companies, such as decentralisation, clearer goals, cost control and performance-related pay – as well as the more doubtful 'advantage' of workforce reduction. From the evidence uncovered, the research suggested that NHS policy-makers might concentrate on developing new and better-adjusted forms of 'public firm' by refining the NHS trust model, rather than relying on for-profit hospital provision.

Evidence from research into patient survival and costs in US hospitals has shown that more preferable outcomes have resulted from within non-profit structures. For example, a study of 38 million US patient episodes found strong evidence that patients survived longer if they had been treated in non-profit hospitals.[13] ***Another US study found significantly higher costs to purchasers in for-profit than non-profit hospitals.***[14]

8. There is no 'one right size' for each kind of NHS body

The research showed how the complex interplay between organisational performance and a range of contextual factors meant that there was little scope in adopting a 'one size fits all' policy for NHS organisations. Small organisations, it was found, can often take advantage of flexibility and scope for 'charismatic' management, while large ones may enjoy specialisation and formalisation. Whilst the research suggested there may be a threshold 'floor' or 'ceiling' for the scale for each organisational process, it was observed how most organisations have many such functions, with many different thresholds. No consistent relationship, therefore, exists between an organisation's size and its performance.

What we don't know:
areas for further investigation

The research found that much of the literature examining the relationship between organisational form and function and organisational performance was weak and inconsistent in its messages. Key areas where the evidence was unclear include:

Impact of competition

Some evidence from this research suggests that competition lowers costs and prices, but has less impact on improving clinical outcomes than it does on organisational processes. The NHS internal market, for example, seems to have had a marginal impact on quality, equity, efficiency and choice, though greater impact on productivity.

Effects of leadership style

Different leadership styles are needed for different environments, and they impact strongly on staff motivation but less strongly on outcomes. However, the evidence is insufficient to suggest any particular style is more effective than another.

Performance management

Highly centralised performance management brings improved co-ordination and integration, but it is unclear whether these benefits outweigh the unintended and dysfunctional consequences of managing organisations in that way.

The research also revealed a number of significant areas of importance to the performance of the NHS, where little or no research was available to inform organisational practices. In particular, the research found deficiencies in the following key areas:

- studies linking specific health care organisational structures to policy outcomes
- the effectiveness of structures of non-hierarchical organisations, such as GP co-operatives and professional partnerships
- the impact and effectiveness of providing NHS services in collaboration with voluntary bodies and local government
- comparative analyses examining the NHS and other public sector organisational structures
- the outcomes of structural innovation in primary-care led funding, such as locality and/or practice-based commissioning
- how workplace teams and groups structure themselves around processes of care in NHS trusts and PCTs, and how they can become more patient-focused; and
- new organisational structures in health care and the public sector outside the UK.

About the *Study*

The study was led by Dr Rod Sheaff, senior research fellow at the National Primary Care Research and Development Centre, Manchester University.

The resulting report, Organisational factors and performance: a review of the literature, was authored by Rod Sheaff, Bernard Dowling, Martin Marshall and Rod McNally (all of the National Primary Care Research and Development Centre – Manchester University), Jill Schofield (Department of Public Management and Sociology, Aston Business School – Aston University) and Russell Mannion (Centre for Health Economics – University of York), London, 2004.

Consultation with NHS decision-makers included telephone interviews with chief executives of seven primary care trusts, two NHS acute hospital trusts, two mental health trusts, one care trust and three strategic health authorities. Interviews were also held with three directors of public health, representatives of three national-level NHS advisory bodies, a modern matron, an NHS-based OD consultant and a development manager from a tertiary acute trust. A focus group included public health and health promotion managers, a head of hospital paramedical services, a GP and nurse managers.

References

1 Miller P, Vale L. Programme approach to managing informed commissioning. Health Services Management Research 2001,159-164.

2 Marshall MN, Mannion R, Nelson E, Davies HT. Managing change in the culture of general practice: qualitative case studies in primary care trusts. *BMJ,* 2003, 327 (7415): 599-602.

3 Pettigrew A, Ferlie E, McKee L, Moore C (1992) *Shaping Strategic Change: making change in large-scale organisations*. London, Sage.

4 Redfern S, Christian S (2003) Achieving change in health care practice. *Journal of Evaluation in Clinical Practice*, 9 (2) 225-238.

5 Walston S, Bogue R (1999) The effects of re-engineering: fad or competitive factor? *Journal of Health Care Management*, 44 (6) 456-474.

6 Wallace L, Freeman T, Latham L, Walshe K, Spurgeon P (2001) Organisational strategies for changing clinical practice: how trusts are meeting the challenges of clinical governance. *Quality in Health Care*, 10 (2) 76-82.

7 Ferlie E (1997) Large scale organisational change in health care: a review of the literature. *Journal of Health Services Research and Policy*, 180-189.

8 Shortell S, Bennet C, Byck G (1998) Assessing the impact of continuous quality improvement on clinical practice: what it will take to accelerate progress. *Milbank Quarterly*, 76 (4) 593-624.

9 Packwood T, Pollit C, Roberts S (1998) 'Good medicine?' A study of business process re-engineering in a hospital. *Policy and Politics*, 26 (4) 401-415.

10 Ledwith F (1999) Policy contradictions and collaboration in community mental health services in Britain. *International Journal of Public Sector Management*, 12 (3) 236-248.

11 Fulop N, Protopsaltis G, Hutchings A, King A, Allen P, Normand C *et al* (2002) Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis. *BMJ*, 325 (7358) 246-249.

12 Mannion R, Goddard M. Performance measurement and improvement in health care. Applied Health Economics and Health Policy 2002, 1 (1): 13-24.

13 Devereaux P, Choi P, Lacchetti C, Weaver B, Schunemann H, Haines T *et al* (2002) A systematic review and meta-analysis of studies comparing mortality rates for private for-profit and private not-for-profit hospitals. *Canadian Medical Association Journal*, 166 (11) 1399-1406.

14 Devereaux P, Heels-Ansdell D, Lacchetti C, Haines T, Cook D, Ravindran N *et al* (2004) Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis. *Canadian Medical Association Journal*, 170 (12) 1817-1824.

Further *Information*

The full report, this briefing paper and details of current SDO research in the field can be downloaded at:
www.lshtm.ac.uk/studyinghealthcare.htm#sheaff

About the SDO Programme

The SDO R&D Programme is a national research programme managed by the National Co-ordinating Centre for NHS Service Delivery and Organisation Research and Development (NCCSDO) under contract from the Department of Health's R&D Division.

For further information about the NCCSDO or the SDO Programme visit our website at www.sdo.lshtm.ac.uk or contact:

NCCSDO
London School of Hygiene & Tropical Medicine
99 Gower Street
London WC1E 6AZ
Tel: +44 (0)20 7612 7980
Fax: +44 (0)20 7612 7979
Email: sdo@lshtm.ac.uk

sdo
NHS Service Delivery and Organisation R&D Programme

Design: signgraphicdesign.co.uk

Disclaimer

This report presents independent research commissioned by the National Institute for Health Research (NIHR). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the SDO programme or the Department of Health

Addendum

This document was published by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, managed by the London School of Hygiene and Tropical Medicine.

The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact sdo@southampton.ac.uk