Comparative Governance Arrangements and Comparative Performance: A Qualitative and Quantitative Study

John Storey, Richard Holti &
Nik Winchester

Research Aims

- To examine governance, incentives and outcomes from the perspective of the various actors who design, implement and respond to programmes at multiple levels in the NHS
- To assess the impact of initiatives in terms of the metrics identified by the actors as critical.
- To understand the logics and cause-effect assumptions which underpin proposals for change.
- To compare systems using quantitative measures and to iterate between performance data and the interpretive worlds.

Focal points

1) **Design** - what national-level system designers *intend and expect* when they make policy choices affecting organisational forms;
2) **Making sense** - how directors and managers at other levels *interpret and respond* to the policy message they receive concerning governance and organisation;
3) **Implementing** - the organisation and governance *design principles* used by organisation level directors and managers;
4) **Reactions** - how healthcare staff *perceive and respond* to the governance and incentive messages they receive.

Self-sustaining Reforms

Transactions

Money following patients (Payment by results)

Choice and Voice

More choice for patients

Practice Based Commissioning

Stronger PCTs with fair funding

Better Care
Better patient experience
Better value for money

Provider Diversity

All Trusts able to apply for FT status

New providers,

e.g. social enterprise

Independent Sector adding capacity and innovation

Better information

Regulation for access and quality

Regulation

National System-level Governance Reforms

Market	Hierarchy	Regulation	Collaboration
•Choice •Provider diversity/ Challenge & competition •FT Competition •Payment by results	•Targets •Political imperatives	•Monitor •HCC •NAO etc	•Practice-based Commissioning •Local health economies

Uneasy Mix of Market/Regulation/Contracting/Collaboration

Sense-making & interpretation

"Corporate Governance" (Trust level)

Clinical governance

Integrated governance

Sense-making & interpretation at clinical practice level

Units of analysis:

a) Macro-level: the whole view – the NHS as a totality. The focus here is upon variety and patterns. DoH policy level

b) Meso-level: a series of studies (eg SHA/Trusts /Networks). The focus here is upon the vertical and horizontal interconnections.

c) Micro-level – governance/organisational form activity within specific Trusts and their behavioural and performance outcomes.

Work to date

- DoH & Cabinet Office; National Clinical Directors
- National comparisons – Scotland, Wales, NI.
- NHS Confederation & Foundation Trust Network
- SHAs & Office of SHAs
- Regulators including Monitor
- Acute Trusts: eg: UCLH, Kings College Hospital, Luton & Dunstable; Peterborough; Doncaster; Northampton
- Various PCTs
- Mental Health Trusts
- Postal survey
- Website

Findings at acute trust level – framework for analysis

Governance Mechanisms	Requirements & stimuli	Responses	Issues
Conformance Risk management and avoidance			
Competition Development of competitive capabilities at Trust Level			
Collaboration Development of systemic capabilities with partners			

Findings at acute trust level - 1

Governance Mechanisms	Requirements & stimuli	Responses	Issues
Conformance	•Monitor & Healthcare Commission requirements •Wide ranging audits •Other regulators •DoH targets •PFI as capital funding mechanism •Need to redeem past financial and legal failures	•Establish Committee structure for various aspects of risk management •Give prominent role to Non-Execs •Sharp, concentrated focus on key targets – eg 18 weeks •Set up intensive performance reporting: against wide-ranging set of criteria, related to overall Trust performance targets	•Finding balance of non exec role is difficult – involvement without becoming managerial •Danger of being over-reassured by formal structures e.g. infection/MRSA remains a prominent threat to reputation •Patient experience does not fall easily within existing external reporting requirements, targets & committee structures •PFI facility and service performance difficult to manage effectively

Findings at acute trust level - 2

Governance Mechanisms	Requirements & stimuli	Responses	Issues
Competition	•Payment by results18 weeks referral target •FT status encourages exploration of new markets	•Establish decentralised responsibility for performance, including financial surplus/loss •Introduce process redesign and improvement techniques within clinical areas in order to support demanding performance improvement targets •Move to strategic planning of services within clinical areas, in the light of performance information •Consider how to use distinctive capabilities in new markets •Recruit new Business Development managers in order to explore market share	•Accurate cost information very difficult to provide at clinical level •Future of cross-subsidies of currently uneconomic but possibly vital services under debate - but examples of cases for continuation exist •"Lean" techniques applied to existing service models have a limited potential •New services will require an in-house investment appraisal function – a "new product board". •Tarrifs for tertiary services are more exposed and sensitive now •How are tertiary services to be commissioned? Need better information on market share in different service areas

Findings at acute trust level - 3

Governance Mechanisms	Requirements & stimuli	Responses	Issues
Collaboration	•Practice-based commissioning encourages primary care groups to optimise their budget •Pressures from medical schools and government to merge those acute trusts linked to the same medical school •Need to resolve division of labour between teaching hospitals and DGH •Government pressure to involve private sector	•Seek involvement with surrounding PCTs and GP groupings to reduce referrals in order to use acute capacity better, including helping establish "services in the community" •Explore research collaborations	•Lack of PCT forums and systems for working with acute trusts in setting up new services •Lack of DoH tariffs for paying acute trusts for advising "community-based services". •Lack of meaningful systems for measuring outcomes for patients cared for "in the community" •Patients may prefer hospital treatment

Final Points

- We have indicated findings only from the acute sector trusts and not from the wider study
- The current phase of the project is focused on PCTs and mental health trusts
- The next phase will focus more on comparisons with Scotland, Wales and Northern Ireland.
- Future research will look at healthcare governance internationally