IS IT TIME TO GET RID OF NHS TARGETS?

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Executive Summary

Every organisation large or small works to set targets and the NHS is no different. Working to targets has become a part of NHS work culture and a daily reality for the managers, administrators, and commissioners responsible for health service delivery. Indeed many of these targets are to be found in the NHS constitution and enshrined in law as part of the patient rights regarding what they can expect from the health service.¹

There are severe financial penalties for missing targets and even though hospitals work hard to avoid these, inevitably many find themselves in breach of one target or the other. Only last month the media reported that hospitals in South West England were fined millions of pounds over missed targets despite some of them battling huge deficits.² NHS data made available in the same month revealed that the NHS in England met its A&E waiting time target for the first time since the previous September. The desired 95% target had been missed for 33 weeks consecutively.³ ⁴ Where majority of trusts are failing to meet this and other targets, perhaps the time is right for reform.

This article identifies and defines some key targets which feature in current discourse about the NHS and questions their relevance to the realities facing the health service.

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5 ways to make targets work

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The case for targets

Since the inception of the NHS, different governments have introduced various policy initiatives to improve service quality and outcomes within the organisation. Many of the targets which exist today were introduced in the late 1990s and early 2000s by the New Labour government that set about to rigorously pursue a regime of performance-driven targets in order to combat falling efficiency and quality standards in the NHS. Targets are used by NHS commissioners as a mechanism to drive operational performance and improve financial accountability of health service providers and there is some evidence to show that strict implementation of targets can lead to improved performance. The targets introduced by the government in the early 2000s are credited for significant improvements in treatment waiting times in England in the years following their introduction. However, missing targets can have significant financial or reputational implications for the organisations affected.

Key NHS Targets

The most high profile targets used in the NHS are those that relate to the time which patients have to wait before they receive care. Key amongst these is the four hour Accident and Emergency (A&E) waiting time target, a standard contractual requirement for all NHS hospitals. The four hours measures the time from arrival at the A&E unit to admission, transfer or discharge, and hospitals are expected to see 95% of attending patients within this time. This target is considered by many to be the NHS’ flagship target because it is seen as an indicator (rightly or wrongly) of NHS overall performance. It has been the subject of increased media scrutiny recently because of a consistent breach by hospitals. Last winter’s A&E waiting times were reported to be at their worst levels in a decade. Also, in February 2015, Monitor, the health sector regulator in England, reported that in the third quarter of the 2014/15 financial year, there was an unprecedented increase in the number of NHS foundation trusts that breached the A&E target when compared to the same period in the previous year (from 33 to 66). See Figure 1.

Another key waiting time target is the 18-week referral to treatment time. This target protects patients’ right to gain access to consultant led treatment for non-urgent conditions within a maximum of 18 weeks from referral. This right is protected in law and applies to both inpatient (for procedures that require a stay in hospital) and outpatient (routine and minor procedures which only require a day visit to hospital) referrals. Hospitals are expected to provide treatment for 90% of inpatients and 95% of outpatients within 18 weeks of referral from their GP. In 2012, a third referral to treatment standard known as the ‘incomplete pathway’ was introduced to measure all patients still waiting at the end of each month. Its purpose was to incentivise hospitals to treat those patients who had waited the longest, and

Figure 1- Number of Foundation Trusts breaching A&E target. (Source: Monitor 2015)
stipulates that 92% of all patients waiting to start treatment should have been waiting for no more than 18 weeks.\textsuperscript{13} Barring a dip in performance when these targets were suspended by the coalition government in 2010/11, they have largely been met since their introduction in early 2010.\textsuperscript{14} However, recently the NHS has struggled to maintain this trend and since 2014 there has been a slight decline in performance below set levels.\textsuperscript{15} See Figure 2.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure2.png}
\caption{Percentage of Foundation Trust patients seen within 18 weeks (Source: Monitor 2015)}
\end{figure}

Closely linked to the 18-week referral target is the diagnostic waiting time target which measures the time it takes to wait for a diagnostic test after referral. Current guidance states that patients waiting for a diagnostic test are expected to wait for no more than 6 weeks after referral and hospitals are expected to offer tests to 99\% of referred patients within this timeframe.\textsuperscript{16} Meeting the diagnostic waiting time target has a significant impact on achieving the 18-week referral target and this may be a reason why many hospitals tend to perform relatively well on this indicator.

Within the NHS, cancer patients can expect to be seen and receive treatment more quickly. Consequently, there are numerous cancer waiting time targets. Prominent amongst these are the following: \textsuperscript{17, 18}

(a) A maximum two-week wait for urgent GP referrals to a specialist where cancer is suspected (otherwise known as the two-week pathway). Providers are required to meet a target of 93\% of patients referred via this pathway.

(b) A maximum 62-day wait to the start of treatment for patients who receive a positive cancer diagnosis via the two-week pathway in at least 85\% of these patients.

(c) A maximum 31-day wait from diagnosis to first definitive treatment for all cancers (irrespective of the referral pathway). Performance on this standard is measured against a 96\% target.

Cancer is an emotive subject and NHS performance on cancer treatment often generates a great deal of attention. Recent analysis by Macmillan Cancer Support, a prominent cancer charity (which showed that UK five year survival rates for many common cancers were ‘stuck in the 1990s’ when compared against those in many other European countries) has brought the disease into even sharper focus.\textsuperscript{19} The report also coincided with release of data which showed that some NHS cancer waiting time targets had been breached.\textsuperscript{20}

\section*{The jury is still out}

The jury is still out on whether targets are good for long term sustainable performance or not. Advocates maintain that targets have been associated with significant improvements in service delivery and that without them the quality of NHS care would rapidly fall to unacceptable levels. As an example, they highlight the marked rise in the number of patients that waited for longer than usual to receive NHS treatment following the suspension of the 18-week referral to treatment target in 2010.\textsuperscript{21} The government was forced to re-instate the target in an attempt to reduce the number of patients that had waited for treatment for longer than 18 weeks.\textsuperscript{22}

On the other side of the divide, there are questions about the clinical justification behind many targets and the argument that too much focus is placed on them to the detriment of other outcomes based measures of care (which may be more meaningful to patients and clinicians). The view is that while a
heavily target driven healthcare system may result in short term positive improvements in care processes, these gains are cosmetic and often fail to tackle underlying systemic inadequacies and hold back real transformation of the health service. Moreover, it seems rather contradictory that hospitals continue to be hit with huge fines for missing targets at a time when NHS service providers find it hard to juggle responsibilities and balance books. See Figure 3.

Figure 3 - Trusts in deficit (Source: The Kings Fund 2015)

Although local Clinical Commissioning Groups (CCGs) are charged with redirecting monies obtained from fines to other parts of the NHS, hospitals have little say about how these funds are administered.

Conclusions

It is not a bad thing for the NHS to maintain targets in areas where there is evidence to show that they drive quality and enhance performance. However, a more sustainable approach requires less fixation on a single unit of measurement and greater opportunity for local flexibility (within acceptable limits) when evaluating performance. For instance, while evidence shows that people who stay longer at A&E have worse outcomes, there is no apparent justification for making a maximum of 4 (or indeed 3.5 or 5) hours the acceptable period of time for all patients to wait before receiving treatment at A&E. It might be more productive for both patients and clinicians if hospitals are allowed to exercise some flexibility based on clinical priority. In addition, the introduction of targets that focus on patient outcomes can be inherently more motivational to staff and help to identify areas where locally relevant improvements to care might be made. The NHS Friends and Family Test which aims to measure the experience of care amongst patients and NHS staff is a step in the right direction, when managed properly and with some degree of local flexibility.

Finally, setting targets without adequate investment in infrastructure and workforce places undue stress on NHS staff and can result in harm to patients as highlighted in the Francis Report on the Mid-Staffordshire Hospital scandal. Simon Stevens, Chief Executive of the NHS, acknowledges that in order for the NHS to cope with ever increasing demand and continue to make efficiency gains, significant operational investment is required. Without solid financial backing from the government of the day, the NHS will find it even harder to meet its commitments.

Hospitals continue to be hit with huge fines for missing targets at a time when NHS service providers find it hard to juggle responsibilities and balance their books.
References
