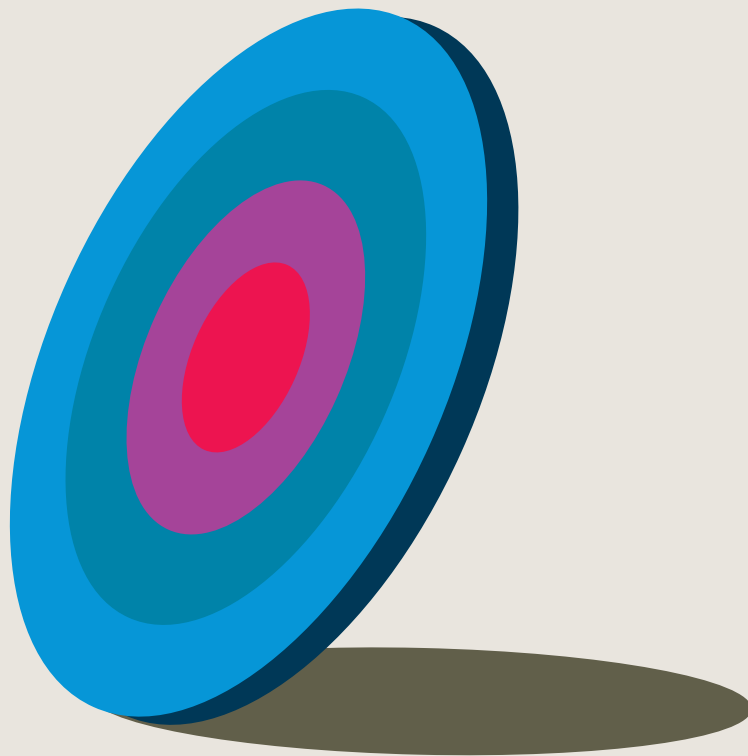


On targets: How targets can be most effective in the English NHS

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Policy analysis

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Overview

The use of national targets in the English NHS divides opinion. Debate typically centres on whether the ability of targets to improve performance outweighs their unintended consequences – the potential to ‘hit the target and miss the point’. However, the NHS looks set to retain targets in some form for the foreseeable future: the government has recently set new targets for mental health and cancer diagnosis, while the imperative to meet access targets in emergency and elective care remains. As such, the need to learn from accumulated experience of using targets over the last 25 years could not be clearer.

This report does not set out to determine whether targets, as a concept, are good or bad, but focuses on how targets can be most effective for improving quality of care. It builds on the evidence base regarding the impact of targets to identify good practice in designing new or improved targets, and considers how policymakers can apply these lessons to the challenges facing the NHS.

Key points

Targets are one means to achieve progress against a priority, but not all priorities lend themselves to a target. Before deciding on a new national target, policymakers need to consider whether it is the most effective and appropriate means of achieving the desired outcome. This is most likely to be the case where the following five tests are met:

- There is a widely recognised and pressing problem, which requires policy action at a national rather than local level.
- The problem is likely to be amenable to action by those who are accountable for the target.
- The necessary resources to take action already exist or can be developed.
- Changes in performance can be adequately measured.
- A new target will align well with what already exists or is planned elsewhere in the system, including consideration of the volume of targets already in place, with minimal negative consequences.

Design of any new target needs to be pragmatic, collaborative and iterative.

- **Pragmatism** is needed to deal with gaps in the evidence base and to develop appropriate proxy measures where outcome measures aren't suitable (but then to recognise them for the proxies they are).
- **Collaboration** is needed to ensure targets are designed with and by those they impact on: both those tasked with delivering them and service users. Targets need to reflect the outcomes important to patients and to facilitate person-centred, holistic care. Achieving sustainable changes in behaviour also requires targets to align with the intrinsic motivations of NHS staff. Genuine involvement of a broad spectrum of people in designing targets improves the chances of hitting the point as well as the target.
- **Iteration** is crucial, from design through implementation and beyond. No target can ever be failsafe, and all targets should be regularly reviewed to ensure that lessons can be learned, problems are dealt with and benefits are maximised.

Reliance on sanctions (financial or otherwise) is not a sustainable way of meeting targets in the current climate: a much more balanced approach to implementation is needed. This should focus less on penalties and more on proactive support to facilitate the capacity and capability required within local commissioners and providers to make sustainable improvement. Many agencies now set national targets in some form (including the Department of Health, NHS England and regulators). Despite different purposes, there are lessons which each of these bodies can learn about their individual and collective impact. The creation of the new NHS Improvement (to be formed from Monitor and the NHS Trust Development Authority) offers a particular opportunity to refresh ways of working in relation to existing and new targets.

The existing suite of targets needs to change, but this will require strong political leadership and should be gradual not wholesale. Removing targets without a credible alternative in place is not without risk, but there is a strong case for clarifying how the existing targets fit within the vision for wider transformations in care. Permission to change the amount of managerial and political capital invested in targets is needed in order to rebalance the current, disproportionate focus on delivering against targets over other priorities. The totemic status of targets means strong political leadership from the centre of government will be necessary to make such changes stick.

Context

Every Secretary of State for Health wants the NHS to make visible improvements.¹ Various policy levers may be used in pursuit of change but, faced with the complexity of the English NHS, governments tend to set some relatively simple objectives for improving performance.

In the last 25 years, successive governments have set national targets for the NHS in England. Some are overtly targets, such as those set by the Secretary of State for Health via the mandate to NHS England.² Others have become *de facto* targets, for example, through inclusion in the Quality and Outcomes Framework (QOF) for GP practices, or the various assurance frameworks for clinical commissioning groups, NHS trusts and foundation trusts.

Unlike many other policy levers, there is clear evidence that targets have had a substantial impact on performance and behaviours, albeit not always in ways policymakers intended. Table 1 summarises the overall contribution targets have made to improvements in NHS performance, as well as the various negative and unintended consequences.

National targets serve many purposes:⁹ providing accountability to the government and the public; clarifying a consistent national standard which all work to; aligning performance to priorities; improving operational performance; and helping to focus contracts. Targets have historically been most prevalent in England, with several now enshrined as legal rights in the NHS Constitution.¹⁰ Governments in Scotland, Wales and Northern Ireland have forged distinctive approaches to targets,¹¹ but each uses them.

National targets have been used as basic standards of what the public should expect from the NHS. This arguably began with the waiting time guarantee in the Patient's Charter published by the Conservative government in 1991.¹² Through the 2000 NHS Plan,¹³ the Labour government substantially increased both the number of targets and their prominence. However, later strategies emphasised 'a reduction in national targets'¹⁴ and sought to balance fewer 'national requirements' with more 'priorities for local action'.¹⁵ In part, this reflected ambitions to reduce the reliance on command and control by national bodies, and to create 'a self-improving system driven by local priorities'.¹⁶ Efforts to reduce the prominence of targets were also driven by concerns about the growing burdens of the 'targets and terror' regime.¹⁷

The reforms undertaken by the 2010–15 coalition government sought to continue the shift away from national targets. The coalition moved quickly to end performance management of the 18-weeks target* and announced that the A&E target†,¹⁸ would be replaced with a suite of quality measures from 2011/12.¹⁹ Yet the latter remains in place and, five years on, the performance of the NHS against both targets remains subject to frequent and intense scrutiny from government and national bodies.²⁰

* A right for all patients to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.

† A target that at least 95% of patients will have a maximum four-hour wait in A&E from arrival to admission, transfer or discharge.

Table 1: The impact of national targets³

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|--|--|
| <p>Targets – and the regime of accountability for delivery around them – have provided strong incentives to improve quality of care...</p> <p>Example: Average waiting times for routine, planned treatment have fallen from over 40 weeks in the late 1980s to less than 10 weeks in recent years,⁴ with various targets along the way having a noticeable impact on this trend.</p> | <p>...But there have been instances where reported performance has improved without services improving for patients: ‘hitting the target but missing the point’.</p> <p>Example: Cancelling procedures along parts of the pathway not covered by the target (for instance aftercare) in an attempt to direct resource towards the targeted area of referral to treatment, even though overall patient outcomes could be negatively affected.⁵</p> |
| <p>Targets offer a simple measure of performance in a complex system...</p> <p>Example: At least 95% of patients must wait no longer than four hours in A&E from arrival to admission, transfer or discharge.</p> | <p>...But may lead to a disproportionate focus on areas which are measured at the expense of those which aren't.</p> <p>Example: Reports that the Quality and Outcomes Framework (QOF) had a negative impact on holistic care in general practice, with the targets skewing focus towards single-conditions or issues.⁶</p> |
| <p>Targets provide one way of putting government priorities for the NHS in the spotlight and help to direct effort and resources...</p> <p>Example: The targets relating to reductions in health care-associated infections (HCAs) were set against a backdrop of increased funding (rising from £6.5m spend on HCAs in 2004/05 when the MRSA target was first introduced to £24.5m in 2008/09), as well as targeted initiatives such as ‘deep cleans’, legislation and a systematic campaign to attempt to change behaviours.⁷</p> | <p>...But there have been reports of gaming and manipulation of data.</p> <p>Example: Some ambulance trusts reported reaching patients in less than one minute (a near impossible time), suggesting manipulation of the data to meet the target.⁸</p> |

Recent changes aim to address some of the perverse incentives associated with the 18-week referral to treatment targets, following concerns that lower priority was being given to patients who had already waited longer than the target time.²¹ However, attempts to make a more fundamental shift away from targets altogether have been largely unsuccessful and targets look set to remain part of the NHS for the foreseeable future. For example, new targets for mental health and cancer have been announced in the last 12 months,^{22,23} pilots are underway to amend the ambulance response time targets,²⁴ and there is continuing pressure on providers of NHS services to meet a range of access targets.²⁵

This report does not set out to determine whether the concept of targets is good or bad, but focuses on how targets, where used, can be most effective in improving quality of care. It builds on the evidence regarding the impact of targets to identify good practice in designing new or improved targets, and considers how policymakers can apply these lessons to the challenges facing the NHS.

Method

At the outset of this work, we defined national targets as any performance objective, set at a national level, where relevant providers and/or commissioners of care are expected to achieve a minimum level of performance against particular metrics within a set deadline.

This definition captured a range of performance objectives not explicitly referred to as targets by policymakers: including standards, existing commitments, objectives and ambitions. These are targets in all but name. Examples of specific targets considered in this work included but were not limited to: access targets such as the maximum waiting times included within the NHS Constitution; outcome targets such as reductions in health care-associated infections (HCAIs) or ambitions to narrow health inequalities; or input targets such as various national workforce recruitment goals. Many of the performance objectives used in pay for performance schemes – including the QOF – also fell within our definition.

This work focuses on national targets – those set by national bodies and those which apply across the whole of England – and the role that national policymakers play. However, many of the lessons from this report will be of equal relevance to those working with locally determined targets and for policymakers in other countries of the UK. We also excluded regulatory requirements, such as those used by the Care Quality Commission, from the scope of this work. This is because such requirements are intended to represent minimum expectations for how services will be delivered, enforced through statutory powers. Whereas targets are often (at least initially) ambitions for improvement over and above current levels of performance.

To inform this report, we undertook the following activities:^{*}

- We interviewed around 40 senior figures with expertise or experience of setting, managing or reviewing targets in health care. These ranged from academics to national policymakers, those within regulatory bodies nationally to clinicians and managers directly involved with commissioning and providing front-line services, and those working in the current policy context to those who were involved in the targets regime of previous years.[†]
- In partnership with NHS Providers and the NHS Alliance, we organised two roundtable events with senior clinicians, managers and patient leaders from providers of NHS services spanning the acute, mental health, ambulance, community and primary care sectors.
- We commissioned original research by insight agency BritainThinks into public attitudes to targets. This involved two focus groups and two full-day deliberative events in London and Manchester with a representative cross-section of the public. Around 70 members of the public took part in total.
- We supplemented our fieldwork with a review of the existing evidence on the impact of targets, both in the UK and internationally.⁷

* See www.health.org.uk/publication/on-targets for more details about these activities, and associated resources.

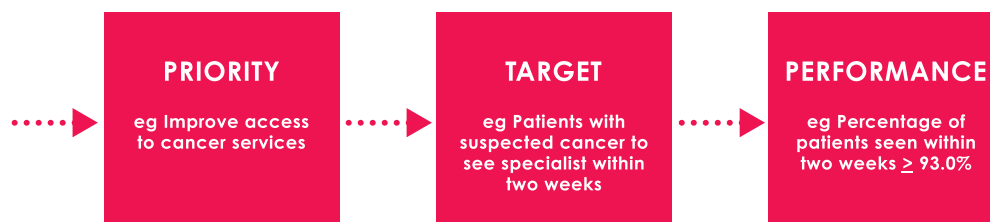
† A selection of quotes from these interviewees are included throughout this report.

When to set targets

This section summarises key learning on the circumstances in which national targets have proved most effective.

Targets have been criticised for being ‘politically motivated’,²⁶ but all governments set priorities for how the NHS should use public resources. National targets stem from, and act as a proxy for achieving, a wider priority. This is illustrated in figure 1, using the example of improving access to cancer services.

Figure 1: Priorities, targets and performance: a worked example



Selecting priorities, and choosing which priorities require targets, are both decisions where government has a key part to play. However, participants at our deliberative events drew a clear distinction between:

- the ‘what’ of choosing priorities for the NHS, where a large majority expected their concerns as an electorate to be reflected by government; and
- the ‘how’ of determining the most appropriate way of achieving the ‘what’, where participants unanimously agreed that government expectations should be shaped by available evidence and a cross-section of informed patients and professionals.

Several interviewees offered persuasive arguments that some ‘politically motivated’ targets have driven the NHS to achieve far more ambitious improvements than it would have set for itself, with interviewees citing the waiting times standards (particularly 18-weeks referral to treatment) and the MRSA targets as examples of this.

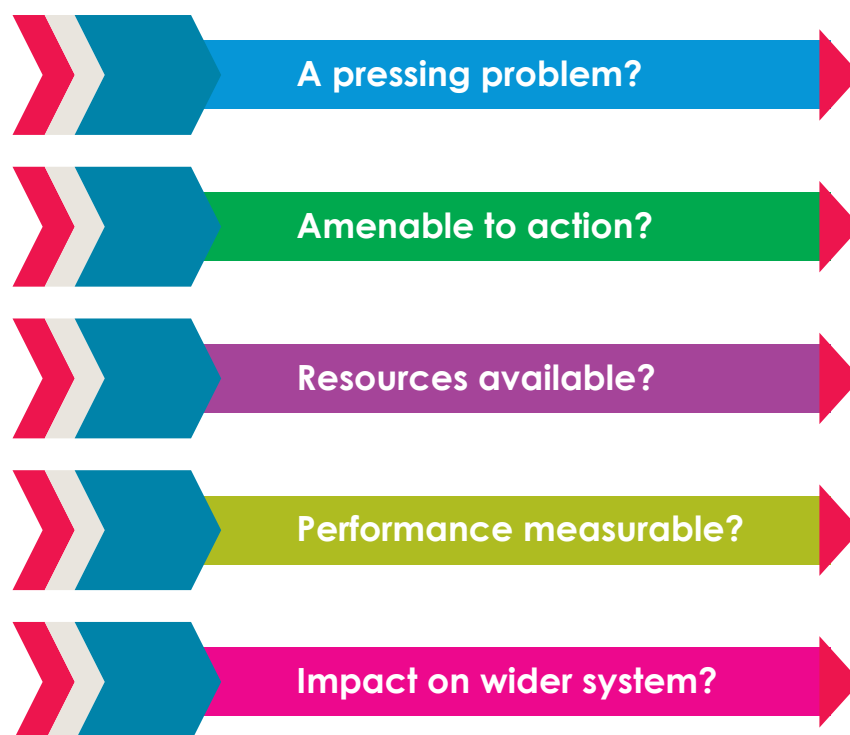
‘The [MRSA] target brought home the severity of the situation and changed our perception of the problem. Before, we thought it was just an unavoidable consequence of treatment and the target really helped to address that complacency.’ – Clinician

Final responsibility for the overall implications of targets rests with ministers, so the current financial climate obliges government to be clear about the feasibility and costs (including opportunity costs) associated with new targets. Experience suggests that setting a large number

of targets may also be counterproductive.⁸ Government will always set priorities for the NHS, but can exercise judgement about whether the most effective approach to implementing a priority requires a target.

Analysis of the evidence and opinion collected through this project suggests that a national target is more likely to be appropriate and effective if five tests, illustrated in figure 2, are all met. We go on to discuss these tests in more detail.

Figure 2: Five tests to consider before deciding if a national target could be appropriate



1. There is a widely recognised and pressing problem which requires policy action at a national rather than a local level

A number of the national targets associated with significant improvements in quality since 2000 were set by government in response to overwhelming public concern about serious deficits in NHS performance. These include, for example, reducing waiting times, tackling MRSA and improving community mental health services. Widespread recognition of these issues meant that these targets tapped into the intrinsic motivation of many health professionals.²⁷ In contrast, failing to align intrinsic and extrinsic motivation appears more likely to lead providers to take the path of least resistance to meet the target. The primary care access target set by the NHS Plan in 2000, for example, was reportedly met at least in part by GP practices preventing patients from booking appointments in advance.²⁸ Several interviewees attributed this to the government not having made a sufficient case to GPs for improving urgent access. The problem may not yet be fully understood, but the urgency and importance of the case for setting a target, whether that stems from clinical evidence or public concern, should be widely acknowledged.

‘Gaming happens most when you incentivise people to do things they don’t believe in.’ Clinician

Given the wider ambitions of the system to move to a more locally responsive, autonomous approach to problem solving, considering a local approach to target setting would be a useful starting position. This would mean local providers or areas could attempt to address the

problem with solutions tailored to their population needs. It would also allow a target to take into account individual baseline positions on the issue (ie those with bigger problems will need to do more than those already leading the field). However, there will be cases where national consistency of approach is needed, whether because of the scale of the problem or to guard against significant inequity.

2. The problem is likely to be amenable to action by those who are accountable for the target

National targets are unlikely to have the intended impact unless the NHS – and local partners, particularly local government – have a high degree of influence and control over factors that affect performance. Targets for reducing HCAIs enabled infections to be attributed to the relevant provider, so providers were not held accountable for infections outside of their control. In contrast, health inequalities are an area where performance is influenced by a broad range of determinants, of which health care is only one. Targets for reducing health inequalities were originally based on changes to life expectancy and mortality rates, and as a result it was unclear why areas were performing poorly or what action was needed to improve performance. Refocusing the target on monitoring key interventions was necessary in order to make progress.

‘We need to take a long look at accountability: the people calling the shots aren’t those being held accountable for the outcome.’ NHS manager

3. The necessary resources to take action already exist or can be developed

In this context, we use resources to mean the capability and capacity to take the actions necessary to improve performance. Reducing waiting times for elective care, for example, means the capacity to treat patients needs to grow more quickly than demand and the flow of patients around the system needs to improve.²⁹ Therefore, achieving waiting time targets relies partly on the availability of the resources required to grow capacity. National targets that have formed part of a broader strategy or programme of work to support change also appear more likely to achieve the intended impact. The target for reducing the number of MRSA infections, for example, formed part of a wider programme of infection control that included legislation, proactive support to develop and spread good practice, and a range of initiatives.⁷ A broader strategy for change may also anchor the target in a wider narrative on the need to improve performance, the purpose of the target and the factors that will drive improvement.

‘Targets have worked where specific people have been held to account for achievement, and the same people have been able to do something about it that has an effect almost immediately.’ Academic

4. Changes in performance can be adequately measured

Having sufficient capability and capacity to measure performance is strongly linked to the impact of any target. Some aspects of health and care – compassionate care, for example – cannot yet be measured in a meaningful way using service data, whereas others such as waiting times are relatively easy to measure. That something cannot be easily measured does not mean it should not be a priority – compassionate care matters to people and their families and should matter to the system – but a target is unlikely to be an appropriate means of improving performance. Where the capability to measure performance exists but not the capacity, developing robust metrics and reliable data collection is required before a target can be set. A useful starting point for policymakers is ‘eight characteristics of effective performance measures’, published in 2006 by a range of national organisations working in collaboration.³⁰

‘Some things are difficult to measure, but we need the will to create measures of what’s important.’ System leader

5. A new target will align well with what already exists or is planned elsewhere in the system, with minimal negative consequences

Targets don't exist in a vacuum: they are affected by and impact on other areas, often in ways which might not be immediately obvious and may be subject to change over time. Many of the targets introduced in the 2000s were accompanied by dedicated resources, but this is unlikely to be realistic in the current climate: leading to an opportunity cost on those areas where money needs to be given up to resource them. Similarly, having too many targets can lead to 'priority thickets', where the number of competing priorities causes confusion about what really matters.³¹ These conflicts could be real or perceived. Some participants at our roundtables queried whether the messages around safe staffing ratios fit with those about efficiency and deficit reduction, especially in relation to agency staffing. Policymakers need to assess whether and how targets in one area could impact on other areas and actively address any conflict as it is discovered. The volume of targets in the system at any one time is also an important consideration. If the target adds to, rather than replaces, an existing target, there are risks of demotivated staff, confused messages about which targets are most important given limited resource and even a reinforced culture of compliance over improvement. If an alternative to a new target is available to achieve the same end, it is worthy of serious consideration.

'The amount of effort in an organisation is limited, so achieving one target may mean something else has to go by the by.' Academic

These five tests provide a set of criteria for policymakers as to whether a target is appropriate for any given area. The provision of health care is complex, and the promotion of health even more so. As such a wide range of factors go into determining eventual health outcomes for individuals, predicting what will happen following the introduction of any national intervention designed to improve quality is exceptionally challenging. The implication is that many priorities for action in health care and health would not pass these five tests, and are unlikely to be appropriate for targets.

The right approach for policymakers must be to start with humility: that the use of targets being appropriate for any given area is likely to be the exception, not the rule. The wrong approach is to let targets be the end rather than the means. Starting with the question 'how can I use targets here?' rather than 'are targets appropriate?' risks creating a disconnect between the overall issue (eg quality of care received in A&E) and what can be constructed as a target (eg four-hour A&E waiting times), skewing attention to the target, not the wider goal.

How to design targets

Having established that an issue is appropriate for the use of a target, the specific target then needs to be designed.

Deciding the scope and ambition of the target

Most national targets have three main variables. All relevant stakeholders should be involved in decisions about these wherever possible. The variables are:

- **Who and what are included within the scope of the target.** For example, the now defunct (due to new evidence) four-hour ‘call to balloon’ target for primary angioplasty pertained only to a particular treatment, whereas the 18-weeks referral to treatment targets cover consultant-led pathways across many specialties. The breadth of a target is often largely determined by the priority it stems from, but policymakers will need to decide who and what should be covered. Patients, treatments and services excluded from the target are likely to be deprioritised and this needs to be recognised as a consequence of setting a target.
- **The scope of the pathway covered by the target.** For example, the 14- and 31-day cancer waiting time targets cover two distinct stages of the pathway (respectively, the time from referral to first outpatient appointment, and diagnosis to start of first treatment). Setting targets for individual stages of treatment may offer greater clarity about what should happen when, but there is a risk that patients find themselves in stages not covered by the targets and so may be deprioritised.³² In contrast, the 62-day cancer target – along with the 18-weeks referral to treatment target – covers total time from GP referral to start of treatment. Incorporating as much of the patient journey as reasonably possible, rather than individual stages of treatment, is more challenging technically but has been highlighted as good practice in performance measurement.³³
- **The ambition required by the target.** Setting a challenging but achievable threshold for a target is critical. Requiring the NHS to achieve a target in all relevant cases should be avoided unless there is a clear basis for doing so. If a single breach of the target means failure, there is little incentive to improve performance after the breach has occurred. Most waiting time targets have a threshold intended to allow for clinical exceptions and patients choosing to wait longer than the target time. If there is no incentive to improve performance above the threshold, however, this may cause a ‘cliff edge’, where those beyond the threshold aren’t prioritised in the same way. Other targets have used individual provider baseline performance as a starting point then asked each provider for improvement on this by a particular amount along a trajectory (ie a ‘stretch target’). This is a useful approach which can have benefits if it encourages continuous improvement and can take account of local context to set realistic goals, but doesn’t offer the same level of national consistency in terms of a minimum expected level of performance.

Take a pragmatic approach

Policymakers need to take a pragmatic approach to target design. National targets based on measures of activity or processes – including many of those set in the last 25 years – have been criticised for making the NHS accountable for what it does, rather than the benefits achieved for patients. Outcome measures are not always readily available in a meaningful form, and if they are there can sometimes be arguments against attributing single interventions to any changes in the outcome. There is no reason why policymakers should not aspire to outcome-based targets, but where suitable outcome measures are not available or able to be easily developed policymakers can seek to select or develop an activity or process measure that offers a suitable proxy. In addition, some process-based targets are clinically relevant in their own right³⁴ and – where there are gaps in the evidence base – other process targets may be necessary to avoid distorting priorities. There is a compelling basis for the current 31-day radiotherapy target, for example, and equivalent targets for chemotherapy and surgery ensure each type of treatment has equal priority, despite the absence of a similar evidence base.³⁵ Process and activity-based targets may offer a pragmatic and useful alternative, but only where they are understood as a proxy rather than an end in themselves and are performance managed accordingly.

‘Process versus outcome is nonsense, we need a mix of both and can’t just do one or the other. We especially need process in the short term because it’s impossible to improve outcomes quickly without having huge amounts of data.’ Clinician

There need to be clear arrangements for how the NHS will be held to account for achieving national targets. This should reflect the relative ability of the different organisations within local health economies to influence performance. The mismatch between the capacity to act and accountability for the A&E waiting time target, where acute providers are held accountable for performance influenced by other providers within the health economy, was repeatedly highlighted during the course of our research. Holding health economies collectively accountable for aspects of performance influenced by multiple organisations will only work if the contribution of each can be disaggregated to clarify why targets are not being achieved. As the NHS develops new models of integrated care, this capacity to act is increasingly likely to be shared between two or more providers. A move to a whole-systems approach does not necessarily make specific targets inappropriate, but increases the complexity of performance management arrangements and makes achieving the effective design and measurement of the impact of targets more challenging.

‘There will always be areas where there is no evidence to draw on. Targets should always be evidence-informed but not necessarily evidence-based.’ Academic

Collaborate widely

For target design to be effective, it should happen through collaboration with a wide range of people. Relevant, and where possible clinical, evidence should inform the design of a national target, but meaningfully involving stakeholders in co-designing targets is even more important. This was a point repeatedly raised by both professionals and the public in our research. The target for administering thrombolysis for heart attack within 60 minutes from ‘call to needle’, for example, was drawn from clinical evidence that treatment is more effective if administered within one hour of the onset of symptoms. But in many cases the available evidence does not always provide such clarity. For instance, there is evidence that crowding in A&E departments is associated with higher mortality, but limited guidance on how a target for addressing crowding could be framed. Nevertheless, there was a strong imperative for reducing waiting times and the resulting target has led to a dramatic reduction in waiting times and a range of other improvements in urgent and emergency care. Sometimes what the public considers to be a significant issue of quality won’t align with what professionals understand the clinical evidence to be for effectiveness of care (for instance in the case of the 48-hour GP access

target). Differences in priority and gaps in the evidence base are not a barrier, but reiterate the need to co-design targets with relevant patient and professional groups to maximise alignment with patient need, clinical and operational practice and professionals’ intrinsic motivation.

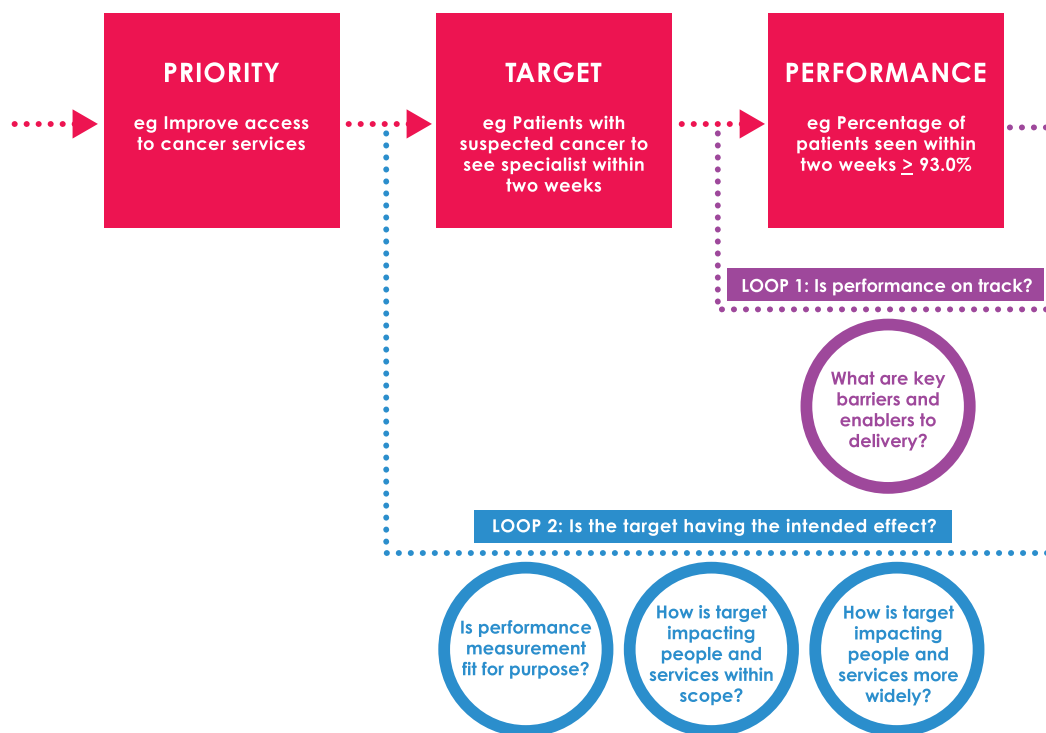
‘Ownership is also key because most people will do the expedient thing which isn’t always the right thing.’ Clinician

Use a continuing and iterative process

Setting a new national target should only be the first step in a continuing and iterative process. Developments in technology, clinical practice and performance measurement may necessitate changes to ensure existing targets remain relevant. Even when a target has been set in response to a widely accepted problem, the nature of that problem may change and evolve over time. For example, the number of MRSA infections has reduced to a small number of increasing complex cases, requiring changes to the target to ensure providers have stretching but realistic goals.

The NHS is a complex adaptive system and, by definition, the consequences of introducing or changing a target are never entirely predictable. It may be possible to anticipate some unintended consequences, but others only become clear with experience. Having a clear mechanism to understand the impact of a new target can help highlight whether the target is having the intended impact and, if not, why. As shown in figure 3, such ‘feedback loops’ are essential in order to generate information for those setting and monitoring performance against targets about the lessons that can be learned along the way.

Figure 3: Is the NHS performing against priority targets?



The NHS is used to measuring whether performance is on track (loop 1). This is a routine part of targets and the performance management culture around them. Less time is routinely devoted to whether the indicator remains an appropriate way of measuring progress (loop 2). Measures may need to change in response to feedback about unintended consequences and changes in technology, knowledge, practice and context, or alternative indicators may offer a better representation of performance. The recent changes to the 18-week referral to treatment targets²¹ may be a helpful sign of change in this area.

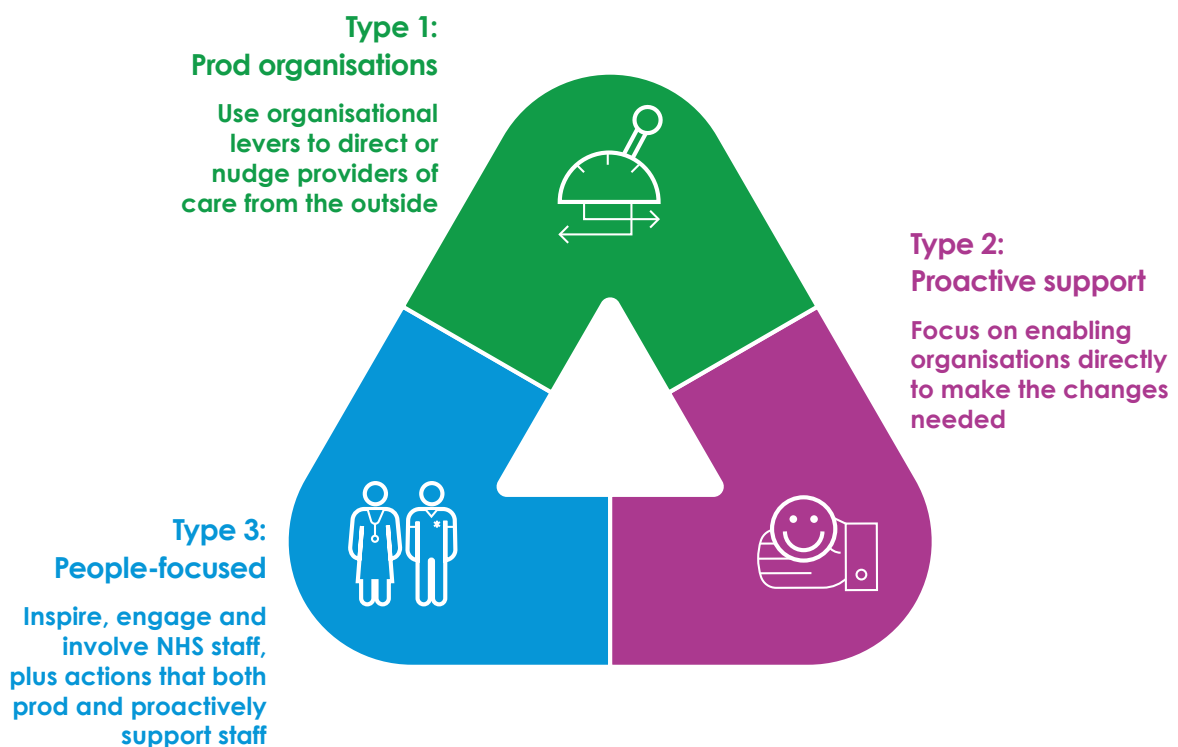
Feedback should be sought from as wide a range of people and sources as possible. Our roundtable events demonstrated the value of review and engagement: participants agreed a set of criteria for what a good target should look like and were then put into groups to design a new target. To some extent, each group was blind to many of the drawbacks of the target they designed but these issues were rapidly identified by other groups. Bringing data together with feedback from relevant patient and professional groups will provide insight into unintended consequences, and help guide policymakers to eliminate these as far as possible. The very nature of unintended consequences means that it is impossible to spot many of these upfront, so the regular use of open questions to understand what is really happening can help to uncover issues or opportunities which might not be immediately obvious.

How to implement targets

The majority of our interviewees suggested that achieving success with any target depends not only on the target design, but also on the approach taken to implementing the target.

The various methods taken to implementing targets should be viewed in the wider context of different approaches to enabling change. As summarised in figure 4, previous work by the Health Foundation argued that policymakers follow three broad types of approach.³⁶

Figure 4: Three types of approach to bringing about change



National targets are a ‘prod’ approach to stimulating change, requiring the NHS to comply with an externally imposed standard. Prods also feature heavily in the approaches used in delivering targets, including performance management, payment systems and contractual rewards and penalties.

‘What really impresses people overseas when you talk about UK performance targets is that results actually happened in response, that there were strings attached to make them work.’
Academic

Performance management – which accompanied many of the national targets set in the 2000s – is a systematic approach to agreeing local plans for achieving targets, reviewing progress and agreeing remedial action where performance was off track. This can assume different degrees of intensity, ranging from a gentle nudge and support for improving performance to a process involving serious consequences for underperformance. At times, performance management has involved ‘naming and shaming’ to damage the reputation of poor performing NHS organisations (and the career prospects of their senior managers). This proved effective in the 2000s: performance against comparable targets improved more rapidly in England than in Scotland, where a more consensual approach was taken (at least initially).¹¹ ‘Naming and shaming’ may be less productive in the current climate, as growth in demand and constrained finances limit the ability of individual NHS organisations to improve performance. Nevertheless, intelligent performance management has the potential to provide the NHS with appropriate challenge: focusing efforts on improving performance while remaining mindful of the constraints, and even acting to remove barriers and share good practice.

More recently, there has been a shift away from performance management to place an increasing emphasis on the use of transparency, financial incentives and contractual levers to drive improvements in performance. However, there is limited evidence that pay for performance and financial penalties have had a significant impact.³⁷ In primary care, the impact of QOF has been a controversial topic and its evidence base is inconclusive.^{38,39} This difference of views was reflected by participants at our primary care roundtable and by interviewees, some of whom saw the financial incentive as the key to achieving real traction, where others felt this improvement could have happened without attaching monetary value to it. A number of our interviewees and attendees of the provider workshops expressed particular frustration with mandatory performance penalties, particularly those applied to performance against the 18-weeks referral to treatment target, for being too blunt a tool rather than encouraging people to actively work together to solve the underlying problems. In addition, many professionals and members of the public that we spoke to perceived financial penalties as perverse during a period when many providers are experiencing deficits.

‘We get lots of stick at the moment about ambulance handover fines, which are extremely punitive and there’s no evidence that delays are decreasing as a consequence.’ Clinician

Targets are more likely to have the intended impact where they are accompanied by proactive support. Intensive Support Teams (ISTs)⁴⁰ play an important role in improving performance against a wide range of national targets by providing proactive support to enable providers to make the changes required to improve performance. For example, the Emergency Services Collaborative introduced in 2002 involved sharing good practice to improve care and reduce waiting times, and was associated with an increase from 79% of A&E attenders being seen within the four-hour target in December 2002 to 98% by December 2004.

‘You need a blend of developmental support and hard edge performance management.’
Academic

Such proactive support is no panacea for improving performance: IST-style approaches tend to be advisory rather than hands on, but can support the development and spread of good practice, and help providers to make sense of the complexities of service delivery. This supportive, enabling role can provide a helpful complement to traditional performance management and assurance: helping to direct support to where it is most needed, and providing more nuanced and detailed insight into the reasons for underperformance. This synergy between ‘rigorous’ performance management and practical support for service improvement was identified as an important factor in achieving the waiting time targets set via the NHS Cancer Plan in 2000.⁴¹

Even where targets might be set in 'appropriate' areas, it doesn't mean the implementation of them will be responded to equally across the board. Participants in this research repeatedly cited differing approaches that they had witnessed when working in or with different organisations. Some had positive experiences of targets being used as a catalyst to make changes they saw as important, and with all members of the team being clear about their part to play in that. Some talked about how targets had allowed their managers and clinicians to come together to discuss a common goal, and encouraged a much more 'team-based' approach to tackling issues. However, many people spoke of organisations which hadn't managed targets well, with examples given of 'an industry of gaming' occurring or entrenched bullying becoming an acceptable way of getting things done. The organisational culture and leadership failed to tackle these issues and the subsequent impact on morale led to consequences beyond performance. The frequently overlooked importance of context⁴² means that similar interventions can lead to different outcomes, so policymakers need to adapt any support and assurance accordingly. Ongoing support may be needed to take account of the people factors involved in making change happen locally, especially to encourage effective leadership and management. Strong communications and engagement with staff at all levels of the system and across different organisations can help to inspire and motivate local networks for change.

How to remove targets

The government in England has considerable experience of setting national targets but it is much harder to find examples of major targets that have been removed altogether. Targets that have been removed have either been less salient to the public, or replaced with more stretching ambitions. There are no easy answers to why attempts to move away from targets have been so limited and what policymakers can and should do differently.

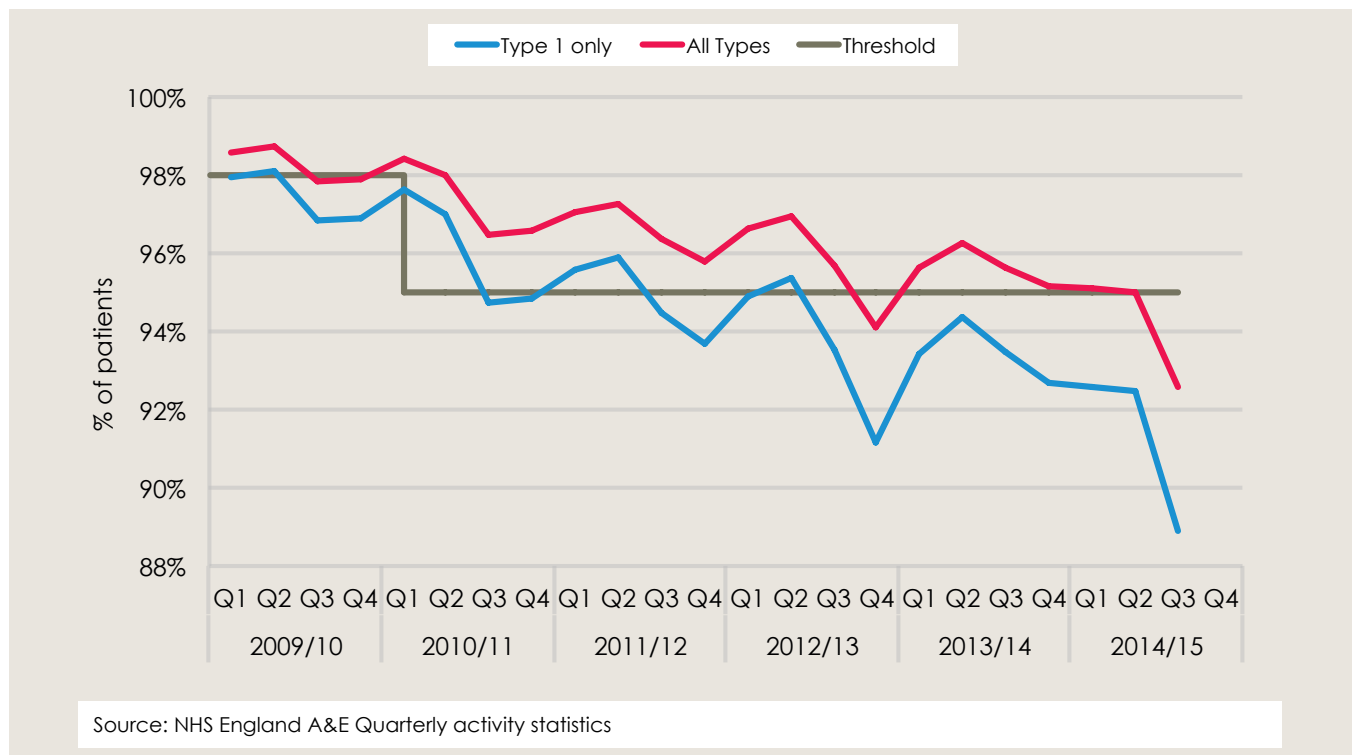
HCAIs may be an example of where the changes in culture and clinical practice that accompanied targets may have led to sustained improvements in performance despite comparatively minimal performance management. The number and rate of MRSA and *C.difficile* infections has continued to fall after the initial targets to achieve substantial reductions were achieved. Whether these improvements can be sustained over the longer term remains to be seen, however, and as the number of *C.difficile* infections increased in 2014/15,⁴³ concerns about performance may be reignited.

The risk of deterioration in performance means that governments have been understandably reticent about removing high profile national targets. In 2010, the coalition government announced that the four-hour A&E target would be subsumed into a broader set of quality metrics. The target and its performance management practices remained in place with a reduced threshold for achieving it while the metrics were being developed. Performance began to fall as soon as the reduced threshold was introduced, as shown in figure 5. Five years on, the target remains in place and, while performance against the broader quality metrics is reported publicly, it has a far lower profile than the target. Most interviewees attributed the failure to remove the target to the high profile debate over the Health and Social Care Act 2012, which meant the government couldn't risk any further political capital.

'When the Health and Social Care Bill ran into controversy in parliament the Prime Minister gave a speech saying that the A&E target must be delivered no matter what. There was no way back after that.' Senior official

In contrast, despite some initial negative media coverage of recent changes to the ambulance response time target, there are promising signs that pilots could now be extended more widely. This could in part be down to being able to communicate a strong case for change (more time for clinical decision making for safer, more effective outcomes), the safeguards in place (no change to be made in life-threatening cases) and the approach of piloting and learning from changes gradually rather than rolling out in one go.²⁴ The use of pilots to make changes gradually reinforces the benefits of an iterative rather than blanket approach to targets, whether new or amended.

Figure 5: Performance against the four-hour A&E target, 2009/10–2014/15



At our deliberative events, we tested a number of alternatives to the current set of national targets, including:

- removing targets altogether
- getting rid of some targets
- keeping targets, but scrapping rewards and penalties
- setting targets locally
- allowing hospitals to decide how closely they stick to targets.

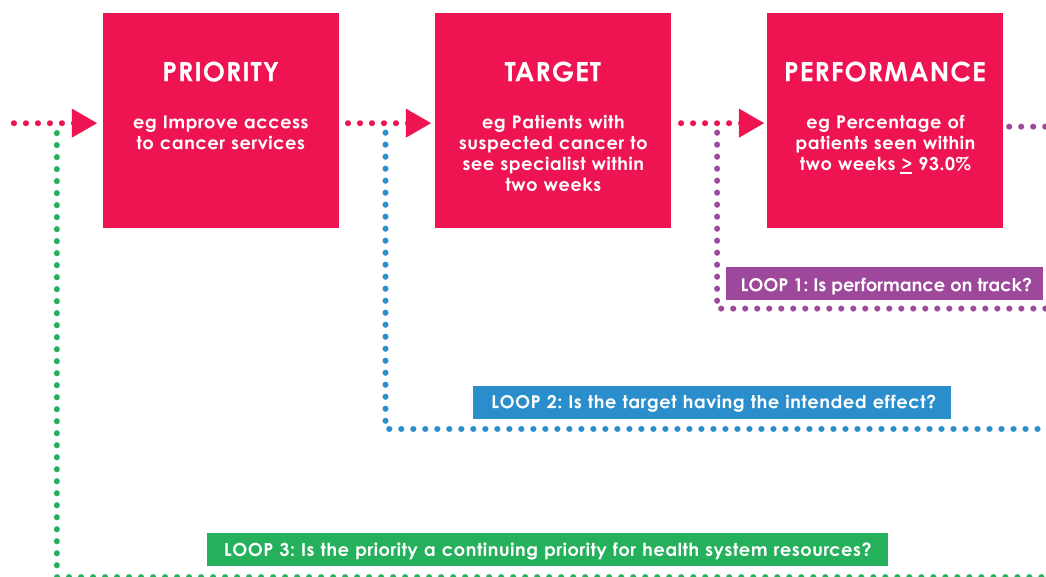
While initially attracted to the idea of local flexibility in the approach to targets, support for this option diminished due to concerns about fairness for patients and, to a lesser extent, front-line staff. There was also a feeling among members of the public at these deliberative events that, ultimately, services cannot be trusted to deliver care without oversight. Professionals, on the other hand, were more likely to express support for greater local flexibility in relation to how targets are interpreted. However, some queried what the knock-on effect would be on variation, acknowledging that one benefit of national targets is consistency. Some also stressed that experiences of how local targets had been managed weren't any better than national targets and potentially even exacerbated by multiple agents being involved. Nonetheless, all participants wanted a 'common sense' approach that includes some provision for flexibility in areas with particularly pressing challenges.

'I work with a range of different commissioners, all of whom want slightly different things done in a slightly different way. A single target is appealing to cut through all of this.' Mental health provider.

Ultimately, for many, the challenge of removing targets came down to being clear what the priorities are and how any change affects this or not. Very little time is systematically devoted to whether the priority that gives rise to the target remains the most pressing objective for

the NHS. For the NHS to remain responsive, government needs to become more comfortable with asking these open questions rather than simply adding to what's gone before. This suggests the need for a crucial, third feedback loop to be considered by policymakers as they review progress.

Figure 6: Is the NHS performing against priority targets and do the targets reflect the priorities for the NHS?



Setting any changes to targets in the context of how they do and don't impact on changes to priorities more broadly is crucial. A majority of public participants thought the Secretary of State for Health should be responsible for making and communicating decisions about changes to targets, as targets and political priorities are often so closely intertwined. However, a significant number of participants felt that politicians are so disliked that the public has stopped hearing what they say. This group felt that, in order to be heard, changes should be announced by someone without political affiliation. Professionals were, on the whole, more wary about the role politicians should play, believing that messages would resonate with them more if they came from peers or leaders in their respective fields, such as clinical or operational leaders. However, they also acknowledged that elected politicians are unlikely to want or be able to step away from targets completely.

With the political context as it is, findings from our discussions with members of the public and professionals indicate that strong political willpower is a prerequisite for any substantial changes to national targets. This need for strong leadership for change reaches right to the top of government (ie No.10 as well as the Secretary of State), as targets have historically featured high on the agenda of successive prime ministers. However, this leadership needs to be balanced and supported by a clear role for independent expertise to advise on the clinical and operational impact of any changes, and how best to overcome any issues. Not only does such advice make the changes more salient to professionals, but also to the public when communicating them.

What next for the current generation of targets?

The NHS in England currently has a set of national targets that largely focus on waiting times for episodes of acute care or long-term condition management within individual GP practices. These have played a part in driving up performance over the past two decades, but now appear to conflict with the current and future agenda. Single-issue, condition- or service-specific targets don't chime with the NHS's own vision for whole-person care delivered by a whole-system approach. Operational pressures facing the NHS mean providers are increasingly struggling to meet some of the current targets,⁴⁴ but at the same time, the system is trying to make wider, more transformational change. This means the current targets need review.

The answer is not to plug all the gaps with new targets. Not all behaviour change can be positively influenced by targets. Even with a changed way of working around them, targets are likely to remain 'prod' mechanisms which won't necessarily be suited to encouraging sustainable, continuous improvement.

Nor is the answer to simply remove all existing targets. Lessons from Andrew Lansley's attempts to make widespread changes to targets show that it is politically and operationally difficult to do this without risking a drop in performance, a political backlash, or both. To remove national targets without a credible alternative already in place is likely to mean that standards in that area slip.

Instead, there will need to be a gradual shift away from national targets as the dominant choice from the policy toolbox, recognising that they reinforce a culture of compliance. This should form part of a wider move away from prodding organisations in favour of investing far more in proactive support for change.³⁶

Promising signs of progress are appearing in terms of the attempt to minimise the burden associated with targets in the system: NHS England has announced the streamlining of some of the measurement protocols around certain targets, such as 18-weeks referral to treatment, or by aligning reporting cycles for nationally reported data including the four-hour A&E target.²¹

But a review of targets needs to go beyond the measures themselves, and dig much deeper into how targets are being used. More fundamentally, any review needs to consider whether the priorities that targets serve are still the correct priorities and whether targets are still the best way to achieve them.

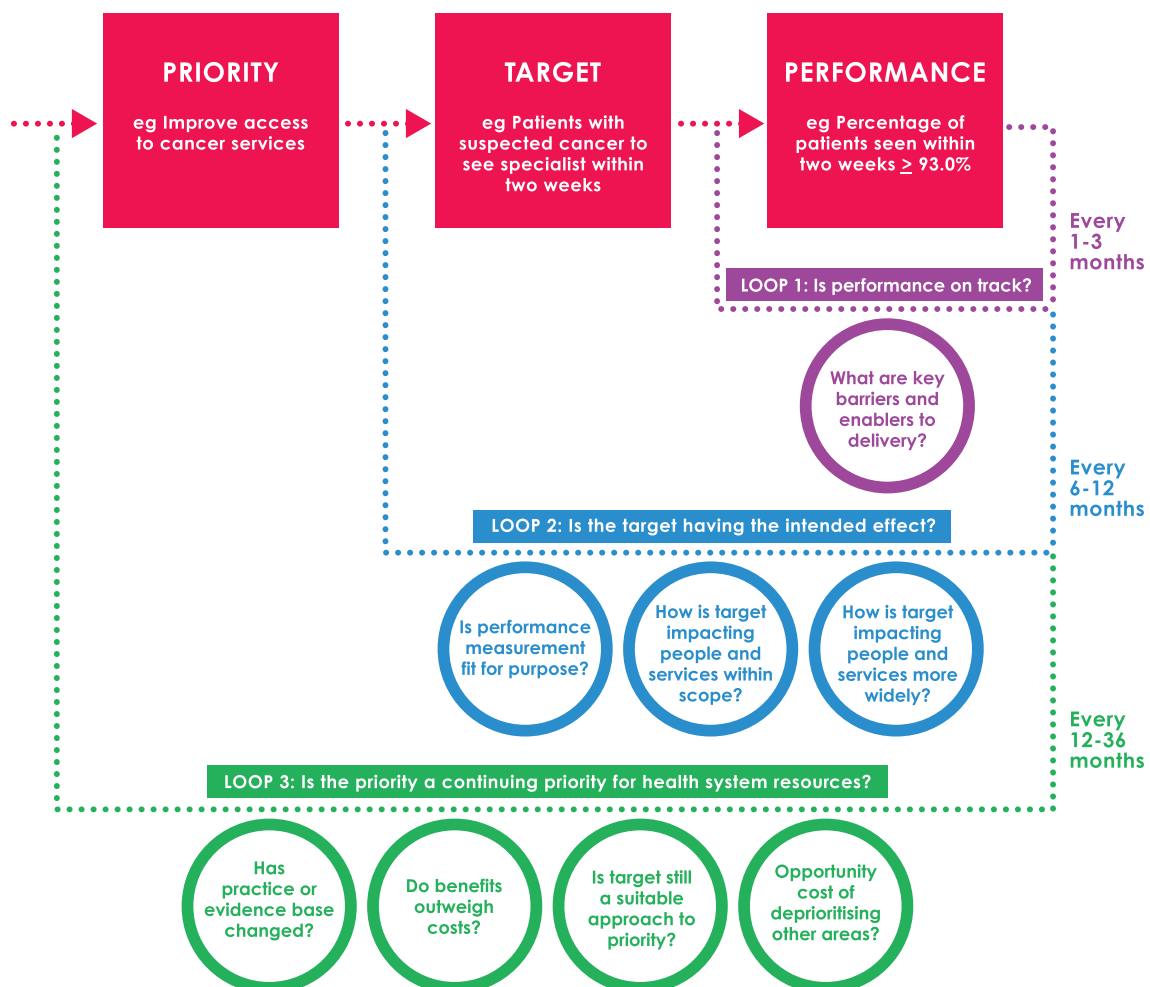
Resetting the default focus

When policymakers decide to set a new target – such as the new waiting time targets for mental health⁴⁵ – they should take into account the practical lessons set out in this report to avoid some of the pitfalls associated with previous targets. As a starting point, policymakers could routinely ask themselves whether the five tests identified by this work (figure 2) apply to the challenges they are seeking to address through targets.

Two such challenges – the need to improve care in traditionally under-resourced areas such as mental health, and the need to redesign and deliver new models of care – offer practical and current examples.

- The need to improve timely access to mental health services is widely recognised as a pressing problem by professionals, the public and politicians. Access (defined by waiting times) is easily measurable, even if the data collection takes time to develop. Waiting times should be amenable to action by providers and commissioners working in tandem (and indeed improvements in access to mental health services have already been made⁴⁶). There has been growing recognition of the need for greater resource (both capacity and capability) in mental health services to support the improvements required, although more can be done here. While there is an opportunity cost, there is a clear case for prioritising mental health services to achieve parity with physical health – not least given the potential for a positive impact on the NHS more widely (eg A&E, primary care or other services). At first sight, access to mental health services could lend itself to a carefully designed and implemented target.
- Developing new models of care is widely acknowledged as a pressing problem, and there is a clear alignment with wider strategy.⁴⁷ However, it involves such a diversity of approaches and agents in the system that a generic target is unlikely to be successful: if everyone is responsible, no one is accountable. Equally, it is likely to be difficult to measure impact as it involves complex concepts, and despite an ongoing push to develop the capacity and capability to make the transformation needed, resource for change (both financial and headspace) is scarce in light of other competing priorities.⁴⁸ Here a one size fits all target is unlikely to be a useful approach.

Figure 7 – Is the NHS performing against priority targets and do the targets reflect the priorities for the NHS? Asking detailed questions on a regular basis



When a candidate for a new or amended target is identified, policymakers need to take a pragmatic, collaborative and iterative approach, as described in the previous chapters. The three feedback loops provide a framework for policymakers to keep the new and existing targets under review. Figure 7 suggests some possible timeframes for how often such reviews might be needed and some of the key issues to consider. Corporate memory is sometimes a challenge in policymaking, so policymakers could consider setting ‘sunset clauses’ into their targets upfront to force themselves or their successors to undergo this exercise when the time comes. However, true feedback needs to avoid becoming a tick box exercise, so mechanisms for real-time and regular feedback which are acted on proportionately are likely to be more appropriate.

Resetting the default ways of working

The current approach to performance management and assurance can and should change. The traditional ‘parent’ and ‘child’ model of performance management from the national bodies doesn’t fit with a vision for local health economies to be leading and solving problems locally or for a continuous learning system focused on improvement.

Multiple national agencies are involved in setting or administering targets in some form, including the Department of Health, NHS England, NHS Improvement and others. Many of the findings from this work apply to all of these bodies, but individual lessons can also be learned based on the organisation’s particular remit.

The creation of NHS Improvement offers a rare and valuable opportunity to reset the default ways of working with providers in relation to targets. Providers will still be accountable for meeting targets, as now, but NHS Improvement could focus much less on performance management and assurance of targets and much more on offering proactive support to providers to meet them. This could be through ensuring that providers have the resources needed to address priorities, supporting them to build capability for improvement, or facilitating learning and peer support. As organisations will respond to targets in different ways, a tailored approach which is proportionate to need is necessary. NHS Improvement can also use the intelligence it gathers through this work to give advice to ministers about new or amended targets, based on the current operational climate.

Continuing deterioration in the financial position of the NHS, with more than three-quarters of providers now in deficit,⁴⁹ is likely to limit the effectiveness of the financial sanctions in the NHS Standard Contract as a means for driving improvement. NHS England, with NHS Improvement, could examine the balance of incentives between sanctions and support to see if it is optimal in driving change. This should form part of the review being undertaken into the current range of financial sanctions, as part of developing the NHS Standard Contract for 2016/17.⁵⁰

Ministers need to provide more positive political leadership on targets. Positive messages of support will be of more use to front-line staff in meeting the challenge than punitive messages of blame, whether these are real or perceived. A number of people we met during the course of our research referenced familiar anecdotes of political ‘interference’ which they saw as typifying negative preconceptions about how system leaders behave in relation to targets. This was often related to stories which they themselves weren’t directly involved in, but had heard via the media or other networks. They admitted that such reports served to re-affirm an assumption of unhelpful ‘top-down control’ which meant in turn that they didn’t feel much direct ownership or engagement with the matter at hand.

Our work does not suggest that there is an ‘optimal’ number of national targets for the NHS but it did highlight the difficulties encountered when the volume is too great or unevenly distributed across the system. All national bodies need to be aware of the cumulative impact of their ‘asks’ of the system and those that their colleagues in other organisations are also making. Such alignment needs to avoid an increase in the volume of ‘must-dos’ coming out of various national organisations, but also to consider how these messages fit together.

Repositioning targets in light of the bigger picture

All national bodies have a crucial role to play in bringing focus and coherence to the system. Better design and implementation of targets from the centre will help make them more fit for purpose, but does not resolve the more fundamental questions of whether targets can co-exist in a landscape being driven towards whole-system, person-centred outcomes. Resource for change is finite, and this includes the headspace available to prioritise competing requests. More focus devoted to maintaining and improving performance against targets means less headspace available for addressing the challenges set out in the Five Year Forward View. This may require policymakers to be clear about the ‘vital’ indicators that represent the top priorities for the system. National bodies urgently need to develop a collective understanding about how the current set of national targets fit with the vision for the next 5–10 years, including a clear narrative about the role that targets do or don’t play within this. This will be challenging given the totemic status of some targets, but the beginning of a new parliament offers the best opportunity to try.

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