

ACCESS TO HOSPITAL CARE – IS THE NHS ON TARGET?

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This briefing is the fourth in our series – it focuses on access to hospital services in the English NHS and assesses performance against six key waiting time targets. It looks at how national performance has changed over the course of this parliament and if targets are still being met.

Previous briefings in the series examined: the state of general practice; rationing in health care; and the reasons behind the ‘crisis’ in A&E.

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KEY POINTS

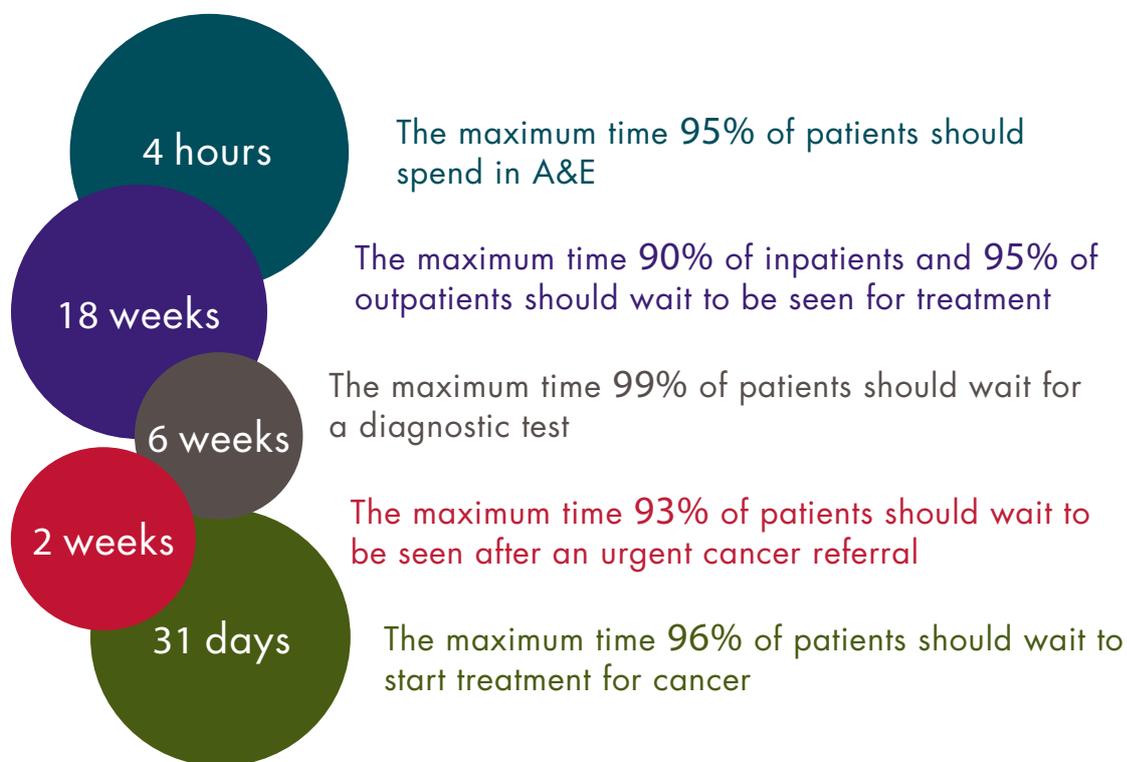
- **Is the NHS meeting national targets?** The vast majority of patients in the English NHS continue to receive services and treatments within the target timescales. However, performance has declined more recently: half of the six measures we examine – A&E, inpatient treatment and diagnostic tests – missed their target in the last quarter. The four-hour major A&E target has been breached at a national level since the second quarter of 2012/13. There has also been some decline in performance for cancer referral and outpatient treatment (although these targets are still being met). Cancer treatment is the only measure maintaining past performance.
- **Do all hospitals follow the same trend?** This decline in performance is across the board and not restricted to specific hospitals. The worst-performing hospitals have been getting worse in most measures for a while, but most recently, performance has also started to decline in the ‘top’ hospitals, particularly in A&E, inpatient treatment and, to a lesser extent, outpatient treatment. This suggests the challenge of maintaining good performance is starting to show more broadly and in many hospitals. These problems may therefore be more systemic rather than being due to local and managerial failings.
- **Do changes in activity lead to changes in performance?** Longer waiting times could simply result from hospitals having to carry out more procedures – i.e. increased activity. Our analysis shows that increases in hospital activity are not always associated with a decrease in waiting time performance. Diagnostic tests and urgent cancer referrals have seen huge increases in activity (11.5% and 12.7% respectively) but only relatively smaller declines in performance (-0.6% and -0.9%). On the other hand, inpatient treatment has seen a small decrease in activity (-0.3%) but a much larger decline in performance (-2.5%). Some measures have therefore coped well with large increases in activity, whereas others have not – suggesting that something more complex is happening.
- **Does performance on different measures cluster within hospitals?** Our analysis shows that many hospitals are struggling to meet targets in the same services – for example, A&E and inpatient treatment waiting times – rather than a few hospitals failing to meet targets in all/many access measures. Failure to meet, for example, the four-hour A&E target appears to have very little bearing on performance against other measures. This again suggests that these problems may be systemic and that applying extra pressure at hospital level is not the best approach to reversing the recent performance drop.

- **What can targets tell us?** While performance against targets merely hints at the broader quality of services, changes in performance do deserve further investigation. The use of targets, together with other support initiatives, has in the past been associated with substantial gains in performance. The response to declining performance is crucial, and must be dictated by a deeper understanding of the nature of the decline. Finding appropriate and tailored solutions for each case is essential to improving how patients access hospital services.

INTRODUCTION

The quality of health care is a complex thing to describe and measure. The QualityWatch programme¹ takes a broad look at the quality of health and social care and has shown that, despite long-term improvements, we are starting to see an increasing number of lapses in NHS performance.² With the NHS looking set to be a key issue in the general election,³ issues of quality will become ever more topical. One of the key measures of the quality of a health service is the ability of patients to access timely care – indeed, 24 per cent of voters believe that long waiting times for treatment are the biggest problem facing the NHS.⁴ In this briefing we examine six of the highest-profile measures of access to hospital care in England.*

FIGURE 1: SIX KEY HOSPITAL TARGETS IN THE NHS



We look at how national performance on these measures has changed over the course of this parliament, and if targets are still being met. Of course, national performance is the sum of performance in every hospital in England and decline in performance can take different forms. In some cases, poor performance in a small number of hospitals might be responsible for what appears to be a national problem – indicating a need for targeted action. In other cases, problems may be spread across most

* Where 'hospitals' are referred to in this briefing, this refers to the 156 acute hospital trusts in England.¹³

hospitals – which suggests that a more universal approach to finding solutions is needed. There is also a question about the extent to which performance problems are the result of periods of high demand;⁵ we explore how changes in activity relate to performance in these measures. We look beyond the basics to ask some key questions:



Is the NHS meeting national targets?



Do all hospitals follow the same trend?



Do changes in activity relate to changes in performance?



Does performance on different measures cluster within hospitals?

UNDERSTANDING ACCESS TARGETS

The ability to access timely care, for a wide range of different services, is one of the most commonly used markers of quality for health systems. We have chosen six key measures of access to hospital care. These are some of the key targets set out in *The Handbook to the NHS Constitution*⁶ and their importance was reinforced in a joint letter to hospitals from the chief executives of NHS England, the Trust Development Authority and Monitor in September 2014.⁷

Broadly speaking, a ‘target’ is a rule that states that a service needs to be delivered within a specific time frame, to a certain proportion of patients. They are typically explicit statements of political priorities, and the length of time patients were waiting to access services in the early 2000s resulted in the creation of target waiting times.⁸ These set a maximum time that patients should expect to wait, and the target that only a certain percentage of people should wait longer than that (to allow for genuine clinical exceptions). Although many targets were introduced around this time, the access targets tended to be prioritised and motivated with specialist improvement programmes, increases in funding and relentless performance management.⁹

There were huge gains made – for example in 2000, on average people were waiting 12 to 13 weeks for inpatient treatments; this had fallen to around four to five weeks by 2008.¹⁰ The principle of accountability and performance management through targets was continued by the Coalition Government in the form of the NHS Mandate¹¹ and the NHS Outcomes Framework.¹²

To compare performance in different measures over the same time, data have been aggregated into quarters and we looked at performance since Quarter 1 in 2010/11 (April to June 2010), to cover the course of this parliament. Looking beyond the England average, we also highlight how

performance against each target has changed at hospital level. This analysis includes the 156 acute trusts in England.¹³

We show performance in 'top' and 'bottom' hospitals for each measure, defined as the performance of the 15th ranked hospital (the top ten per cent, or first decile) and the 141st (the bottom ten per cent or ninth decile) in each quarter.

As hospitals differ in the range of services they offer not all hospitals will be included in each measure. For example, a hospital may not have a major A&E unit (so won't report against the four-hour A&E target) but may run diagnostic tests (so will report against the six-week diagnostic test target). Percentile ranking of hospitals was adjusted accordingly. Additionally, hospitals may not report data consistently in all time points – possibly due to data issues. Although other providers appear in some measures, using only these 156 we hoped to provide a consistent picture as possible. As the purpose of this analysis is not to comment on how particular hospitals have performed, they have been anonymised in this briefing.

It is important to note that firstly, this analysis presents just a handful of measures and that secondly, targets only provide a snapshot of a particular service; there are many more indicators available, which can contribute to a more sophisticated picture of how well people access hospital services. Beyond these there are many more factors, such as the nature and quality of local social care and primary care services, that affect how people access hospital services, so it is important to consider this analysis in that context. There are programmes of work which track a wider range of measures, such as QualityWatch.¹ All data in this briefing are from NHS England.¹⁴

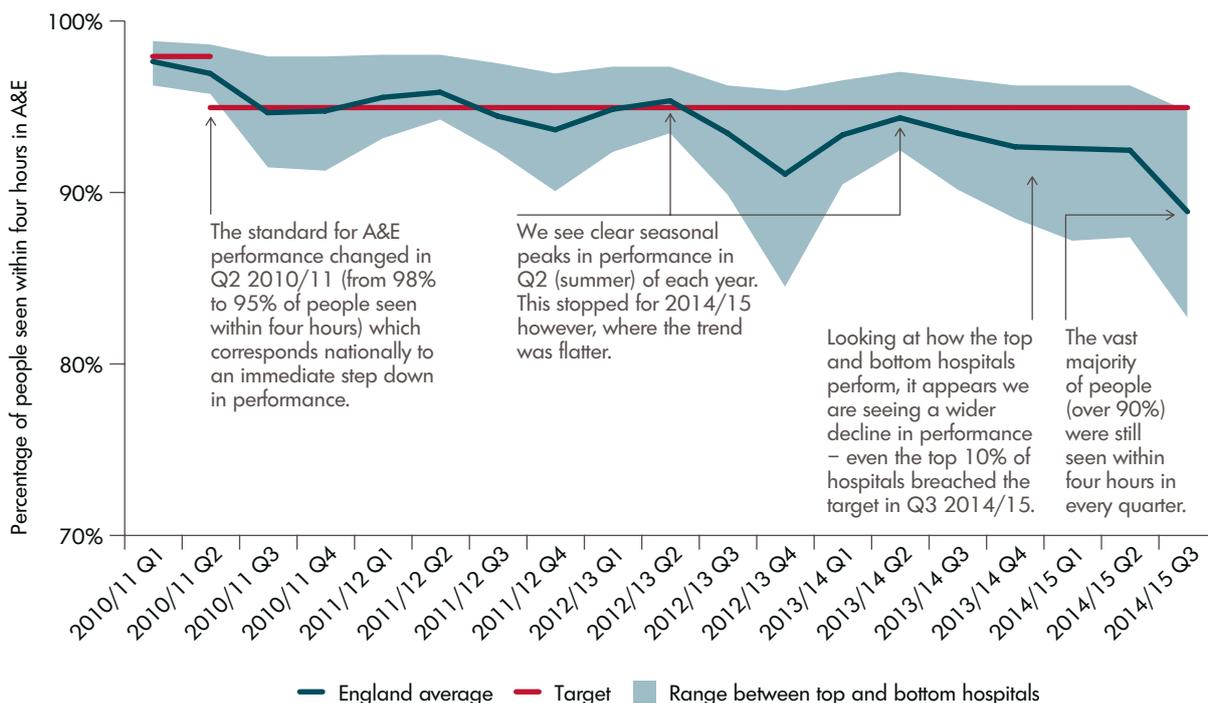
IS THE NHS MEETING NATIONAL TARGETS AND ARE ALL HOSPITALS FOLLOWING THE SAME TRENDS?

A&E ATTENDANCES

Every minute an average of 40 people arrive at an A&E department in England and the number of annual attendees has increased markedly over time. In 2003/04 the number of people attending A&E was 16.5 million; this number grew to 21.8 million in 2013/14.¹⁵

The key access measure for A&E in England is the four-hour target. This counts patients who spend more than four hours between arriving at A&E and leaving the department (having been either discharged or admitted to hospital). This is particularly challenging for major A&E departments, which treat the most serious cases. It is performance at these major departments which is examined in this briefing.

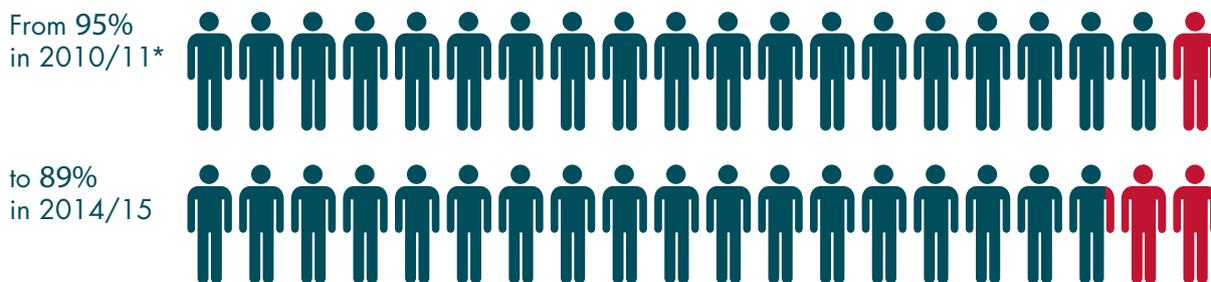
FIGURE 2: PROPORTION OF PEOPLE SPENDING MORE THAN FOUR HOURS IN MAJOR A&E



Average performance at hospital level against the four-hour A&E target has gradually deteriorated over time, with the national target being missed in major A&E departments every quarter since the second quarter of 2012/13 (see Figure 2). There are many reasons for this, which have been discussed at length elsewhere.¹⁶ However, the figure demonstrates two important points. First, performance against the target (which had been sustained from 2005 to 2010) has declined notably at national level. Second, the decline in both the top and bottom ten per cent of hospitals shows that the majority of hospitals have been affected.

Although these changes indicate a reduction in performance, it is worth remembering that the vast majority of patients are still spending less than four hours in major A&E (as shown in Figure 3).

FIGURE 3: THE PERCENTAGE OF PATIENTS SPENDING LESS THAN FOUR HOURS IN A&E



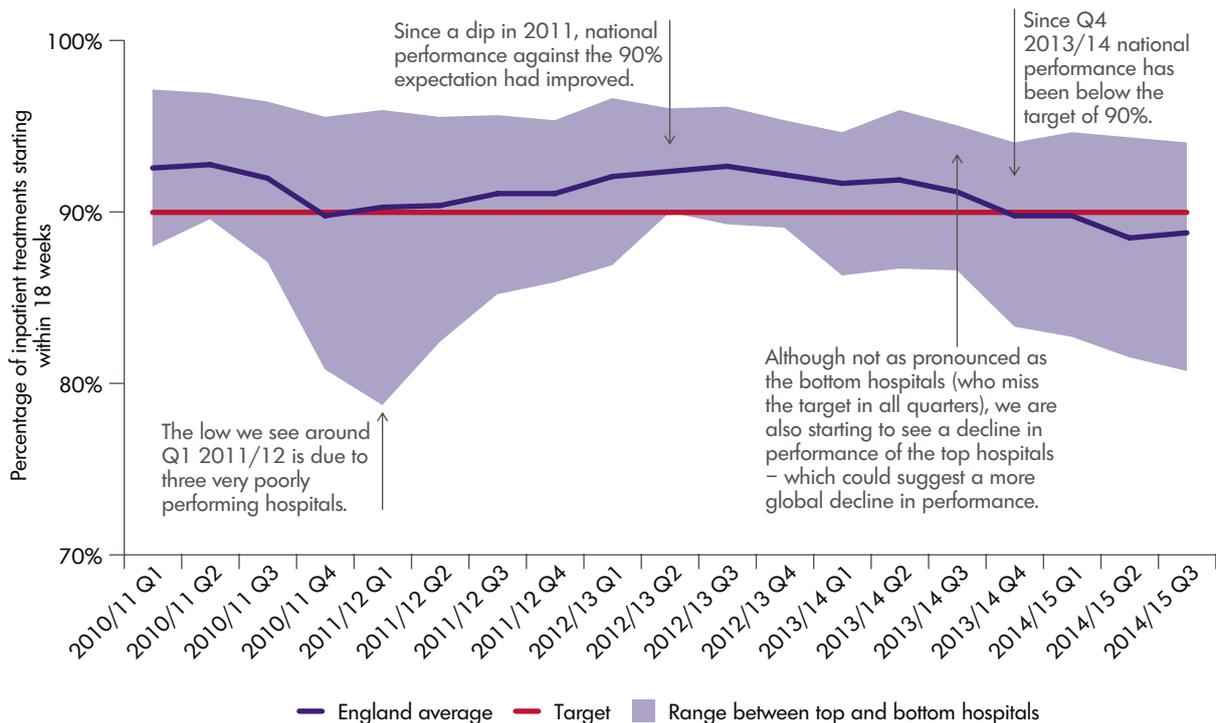
*This chart compares performance in Q3 2010/11 to Q3 2014/15 in major A&E departments.

PLANNED TREATMENT

How long they wait for treatment is hugely important to patients and their families. Planned treatment includes both inpatient and outpatient appointments. Inpatient treatment includes significant operations such as hip replacements, which may require the patient to stay in hospital. Outpatient treatments include more minor procedures, such as a session of rehabilitation after a fall. There were a total of 13.3 million planned inpatient and outpatient treatments in England in 2008/09; this increased to 13.9 million in 2013/14 – roughly 50,000 every working day.

The importance of reducing waiting times for planned treatments was recognised in March 2010, when the target was added as a patient right to the NHS Constitution. It states that ‘patients who need non-emergency treatment should start it within 18 weeks of referral from their GP or consultant’.⁶ This comes with the target that 90 per cent of inpatient treatments and 95 per cent of outpatient treatments start within 18 weeks. Patients who choose to wait longer for treatments, or cases where there is a clinical decision to delay the start of treatment, are excluded from these targets.

FIGURE 4: PROPORTION OF PEOPLE WHO STARTED INPATIENT TREATMENT WITHIN 18 WEEKS



Despite generally good performance against the 18-week target up to the end of 2013/14, in recent quarters there has been a notable decline (see Figure 4). This appears to be consistent across hospitals, with the top and bottom ten per cent of hospitals following the downward trend.

In August 2014, the Secretary of State for Health, Rt Hon Jeremy Hunt MP, announced a ‘relaxation’ of the 18-week treatment waiting time targets.¹⁷ This was intended to give hospitals breathing space to treat people who had been waiting the longest time (over 52 weeks) for treatment and allowed hospitals to temporarily breach their 18-week targets without penalty. The relaxation of the target has come with an associated decline in national performance in the second and third quarters of 2014/15. It is unclear how successful this initiative will be and there are real doubts around whether hospitals will be able to prioritise the treatment of those waiting longest.¹⁸

However, just like A&E, while performance has fallen below the target level, the majority of patients are still receiving treatment within the expected timeframe (as shown in Figure 5).

FIGURE 5: THE PERCENTAGE OF PATIENTS RECEIVING INPATIENT TREATMENT WITHIN 18 WEEKS



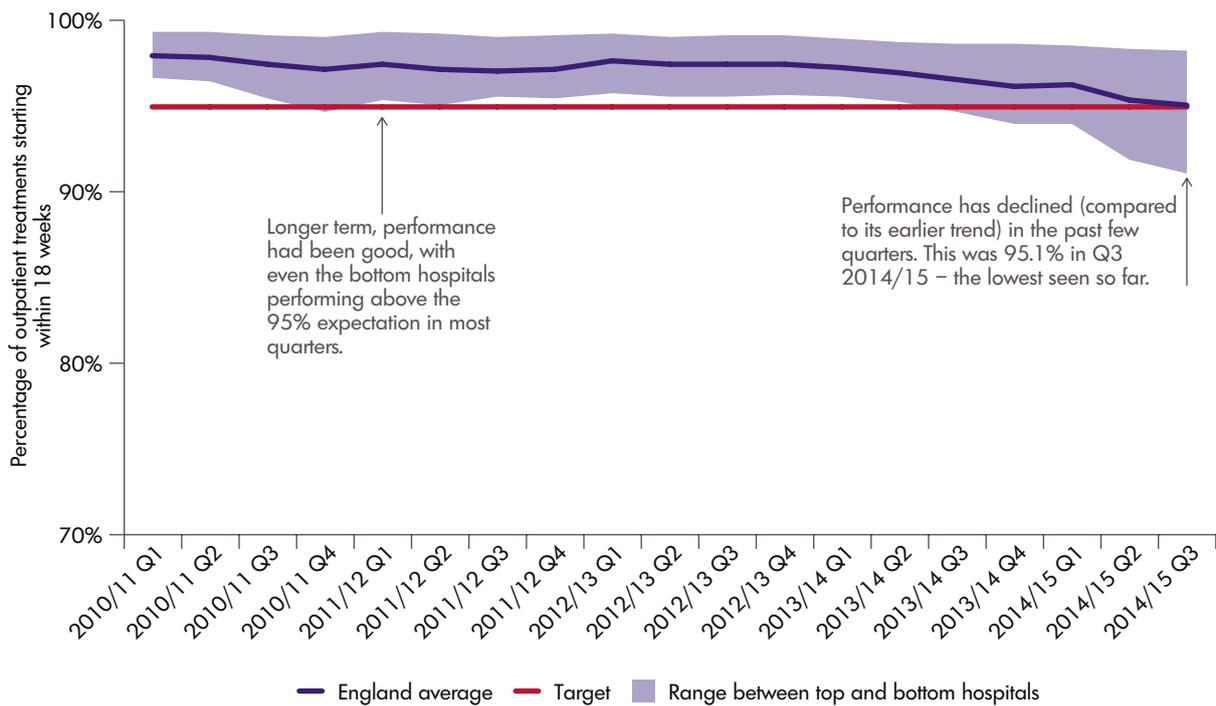
* This chart compares performance in Q3 2010/11 to Q3 2014/15.

Performance for inpatient treatments has declined in recent quarters, but is this also the case for outpatient treatments (Figure 6)?

In the longer term, performance against the 18-week outpatient target has been good; however it has declined in recent quarters. In the second and third quarters of 2014/15, this came close to breaching the target for the first time. As above, the ‘relaxation’ of targets was in effect in these quarters so may explain this decline.

Compliance with the 18-week threshold is just one aspect of measuring waiting list performance; there are many other measures that contribute to the overall picture. These include the median time people spend waiting for treatments or counting the small number of people who wait a very long time (over 52 weeks) for treatment.

FIGURE 6: PROPORTION OF PEOPLE WHO STARTED OUTPATIENT TREATMENT WITHIN 18 WEEKS



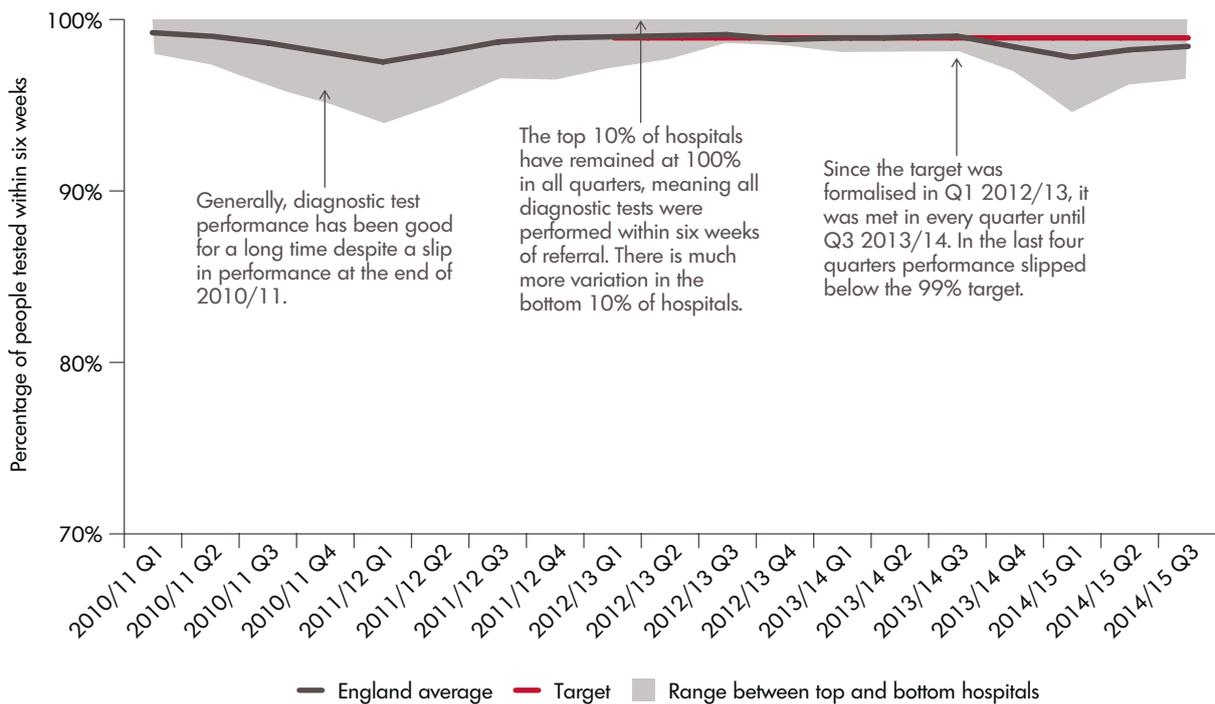
To stop the list from growing, the number of people leaving to start treatment has to be greater than the number of new people joining. This means that if many more people join the list needing treatment, hospitals need to increase the number of treatments they do. This activity – the number of inpatient and outpatient treatments – has changed very little over time. From 2013/14 (Quarter 3) to 2014/15 (Quarter 3), the number of inpatient treatments actually decreased slightly (by roughly 3,000) and the number of outpatient treatments grew by two per cent (roughly 53,000). However, we know that the number of people being referred for treatment or on the waiting list increased by three per cent in the same period: at the end of Quarter 3 there were 2.9 million people waiting for inpatient or outpatient treatment. It is therefore likely that the decline in performance against these measures is due in part to activity not increasing to match the growing number of people waiting for treatment.

DIAGNOSTIC TESTS

Just as waiting for treatment is undesirable, so is the time spent waiting for a diagnostic test to discover which treatments may be needed. Every year the NHS performs millions of diagnostic tests and the number has grown markedly over time, from 6.6 million in 2010/11 to 8.8 million in 2013/14. The six-week target for diagnostic testing (see below) includes 15 key tests covering three broad groups: imaging, physiological measurement and endoscopy.¹⁹ These are tests such as: Computer Tomography (CT scans) used to look for tumours, urodynamic tests to look at how the bladder is working or gastroscopy tests, where a camera is used to look inside the stomach.

In the NHS, diagnostic tests and treatments are strongly linked. In order for treatments to start within 18 weeks, patients should undergo any diagnostic tests they have been referred for within six weeks. This was first introduced as a 'milestone' in March 2008 and was updated in 2012/13, with the target that 99 per cent of patients referred would have their test within that time.²⁰

FIGURE 7: PROPORTION OF PEOPLE WHO HAD A DIAGNOSTIC TEST WITHIN SIX WEEKS



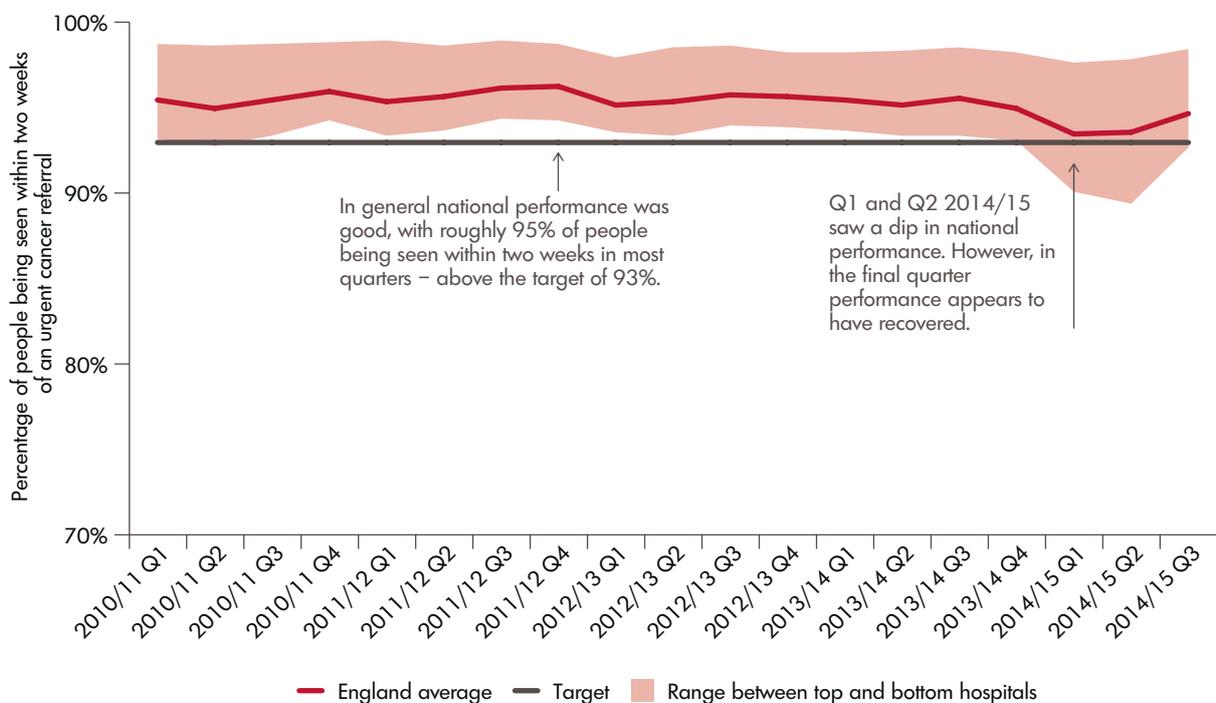
The diagnostic test target is one of the most frequently achieved of those described in this briefing, despite having the highest expectation (99 per cent) for patients meeting the target (see Figure 7). The number of people being referred for a diagnostic test has increased greatly over this time. Quarter 3 of 2014/15 saw an increase of over 240,000 more tests than Quarter 3 of 2013/14 – an 11.5 per cent increase in one year. This is one of the biggest increases in activity of all the measures included in this briefing.

There are seasonal peaks in the number of tests happening in winter of each year, but this is not reflected in a decline in national performance. This suggests that, at least looking at a national level, changes in demand for diagnostic tests appear to be accommodated comfortably. On this measure the range in hospital-level performance is also narrower, with the top hospitals remaining at 100 per cent performance in all quarters.

URGENT CANCER REFERRAL

There are some additional targets for patients who may have cancer. The first is that patients referred from a GP with suspected cancer should be seen by a specialist (in an outpatient appointment) within two weeks. This was introduced in *The NHS Cancer Plan* in 2000;²¹ the target that 93 per cent of patients would be seen within two weeks was introduced in 2009. This was to ensure that cancer would be diagnosed as early as possible, so that vital treatment can begin (see Figure 8).

FIGURE 8: PROPORTION OF PEOPLE BEING SEEN WITHIN TWO WEEKS OF AN URGENT CANCER REFERRAL

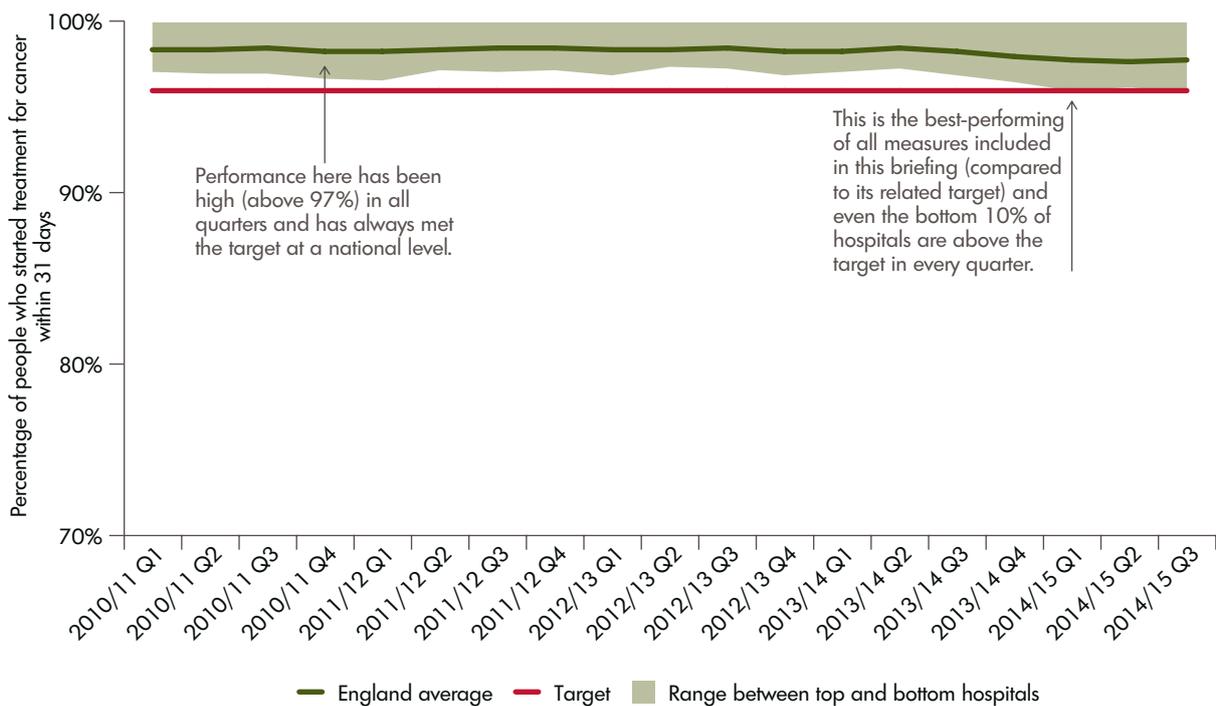


Despite a dip in the last few quarters, performance against the urgent cancer referral target is one of the better-performing measures looked at in this briefing. The number of people referred with a suspected cancer has been increasing and in Quarter 3 of 2014/15 there were 45,000 extra referrals compared to the year before – a 12.7% increase. This is a large increase in activity, which may have contributed to the decline in performance seen in recent quarters. Despite this increase the target is still being met nationally, which suggests that hospitals are so far able to cope with these changes.

CANCER TREATMENT

Another aspiration introduced in *The NHS Cancer Plan* in 2000²¹ was that, once diagnosed, patients should start treatment for cancer within 31 days. The associated target is that 96 per cent of patients start their treatment within 31 days. Again, this is to ensure that people are able to start vital treatment without delay (see Figure 9).

FIGURE 9: PROPORTION OF PEOPLE WHO STARTED TREATMENT FOR CANCER WITHIN 31 DAYS



Again, this is a strongly performing measure. However, it is worth noting that this is the measure which includes the lowest number of patients and that activity has increased little over time. In the third quarter of 2014/15, this was 350 more than the previous year – increasing from 68,780 to 69,130.

There are several other targets for treating people who may have cancer. Some of these cover waiting times for specific cancers or for specific treatments.⁶ This analysis only includes the two most well-known targets which cover all cancers and all treatments. Performance against these appears to be good, but we know there has been declining performance in other targets. The target which covers the whole pathway – from referral, diagnosis and first treatment, that ‘a maximum two-month (62-day) wait from urgent referral for suspected cancer to first treatment for all – was missed in the last four quarters.²² So while some targets are holding up, there are signs of concern elsewhere.

SUMMARY

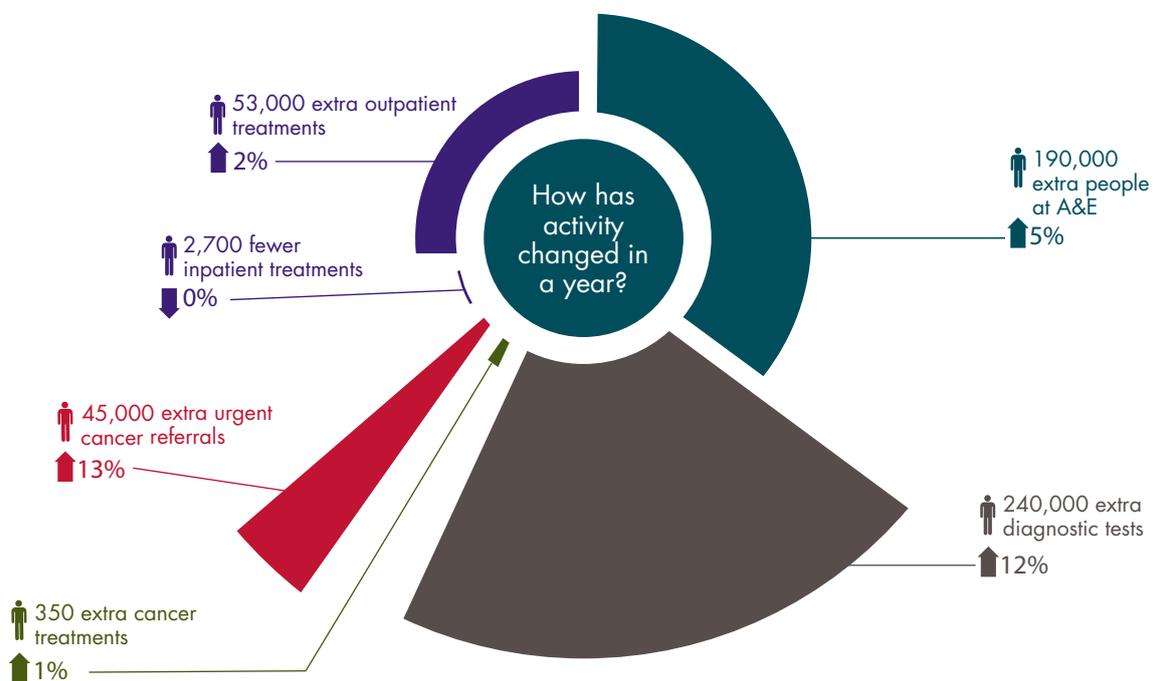
Longer-term performance in these access targets has been good, but we have seen a decline in performance (compared to earlier trends) in nearly all measures in the most recent quarters. Out of the six measures included, three – A&E, inpatient treatment and diagnostic tests – missed their target at a national level in the last quarter. Although still meeting their target, there has been some decline in performance for cancer referral and outpatient treatment. Cancer treatment is the only measure maintaining past performance.

These trends appear to be echoed throughout all hospitals, with the top and bottom ten per cent following similar deterioration in performance against most measures. In particular A&E, inpatient treatment and outpatient treatment all show a more global decline in performance against their targets.

DO CHANGES IN ACTIVITY RELATE TO CHANGES IN PERFORMANCE?

A common theme when discussing NHS performance is to cite the growing demand for services. It may be that longer waiting times are the result of simply seeing more people in the hospital system. Clearly it is crucial to understand how much a change in activity – the number of people or procedures – has affected performance. Figure 10 shows how much activity has changed and how many patients or procedures that affects, comparing the third quarter of 2013/14 to the third quarter of 2014/15.

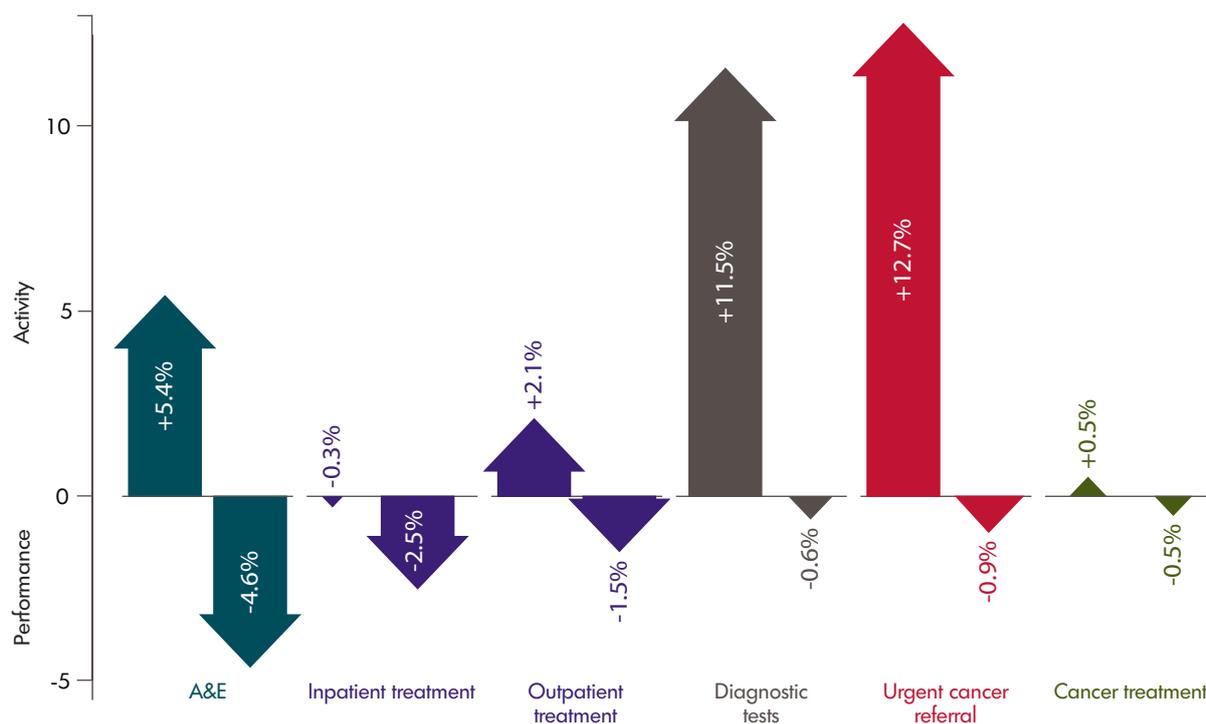
FIGURE 10: HOW ACTIVITY HAS CHANGED AND HOW MANY PATIENTS OR PROCEDURES THAT AFFECTS; COMPARING Q3 2013/14 TO Q3 2014/15



Note: percentages have been rounded

Figure 10 shows an increase in activity over the last year in all measures except inpatient treatments, but does this link to a decline in performance? Figure 11 shows how changes in activity (comparing the third quarter of 2013/14 to the third quarter of 2014/15) relate to changes in performance over that time.

FIGURE 11: CHANGES IN ACTIVITY AND PERFORMANCE (COMPARING Q3 2013/14 TO Q3 2014/15)



For half our measures – A&E, outpatient activity and cancer treatment – activity and performance have changed at a similar rate; with the increase in activity being roughly similar to the decrease in performance. This might suggest that, for these measures, the increase in activity may be contributing to the decrease in performance. However, we see different relationships in our other measures.

Diagnostic tests and urgent cancer referrals have seen huge increases in activity (11.5% and 12.7% respectively) but only a relatively smaller decline in performance in each case (-0.6% and -0.9%). This suggests that these measures have coped well with large increases in activity. Finally, inpatient treatment has actually had a small decrease in activity (-0.3%) but a much bigger decline (-2.5%) in performance, suggesting something much more complex is happening. Figure 11 shows that an increase in activity doesn't always relate to a decrease in performance; this relationship is not clear-cut and we need more research to understand what – beyond activity – is contributing to changes in performance.

DOES PERFORMANCE ON DIFFERENT MEASURES OF ACCESS CLUSTER WITHIN HOSPITALS?

The analysis above shows that performance is declining against many measures of access, but also that in each measure many hospitals continue to meet the target, while others were falling short. A key question is whether the same hospitals are missing the target in all measures. Unpicking this relationship should help us understand if certain hospitals are struggling to cope in many areas of the system or whether many hospitals are struggling with the same things.

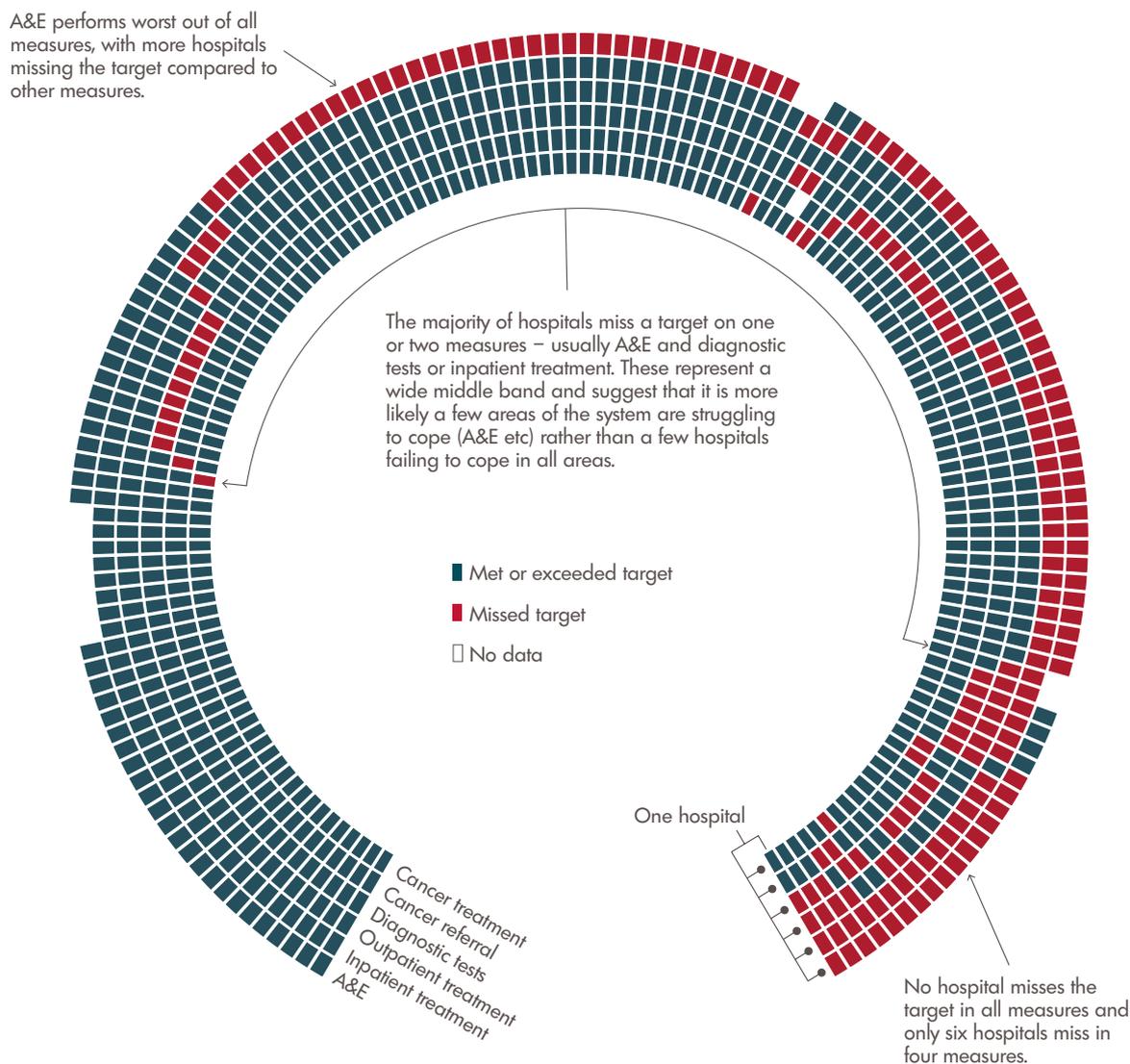
Understanding the relationship between separate but interlinked services is a complex problem. Correlations between access measures at hospital level are typically weak, but this could in part be due to the range of performance being tightly distributed around the targets. At face value, though, it does suggest that performance against one target (such as A&E) has little relationship to another target (such as inpatient treatments) at a hospital level.

Another approach is to construct a heat map for whether or not hospitals achieved their targets in 2013/14 (see Figure 12). In this figure, each row of the circle is an access measure and each slice is a hospital, with squares coloured green where a target is met and red where it was missed. Hospitals are ordered by the number of targets met, from left to right.

One clear feature of the heat map is that colours cluster along the rows (that is, within target areas and across hospitals) rather than within the slices (hospitals). This suggests a more systemic problem that is affecting the delivery of the target in many hospitals, rather than issues with the performance and management of individual hospitals.

It is interesting that many hospitals are failing to meet the target for diagnostic tests, even though national performance is very good. This is due to a very high threshold and the inherent limitation of presenting performance as pass/fail (for example, a hospital that performs 98.9% of diagnostic tests within six weeks is not practically different from one that performs 99.0%).

FIGURE 12: HOSPITAL PERFORMANCE AGAINST SELECTED TARGETS IN 2013/14



In fact, there were no hospitals that failed to meet any of the six access measures in 2013/14. This suggests that applying extra pressure at hospital level is not the best approach to reversing the recent performance drop. In the cases where most hospitals were able to meet the target (such as cancer treatment and outpatient treatment) it is possible that the limited number of services not meeting the target could operate more efficiently. But again, the experience of targets in the 2000s suggests that simply increasing the pressure is unlikely to be sufficient and that additional target support programmes are required.²³ Lastly, measures where a large number of hospitals struggled to meet the target would be better addressed with national strategic programmes, such as the Urgent Care Review.²⁴ However, the way in which hospital performance responds to management is complex and the subject of much study and debate.²⁵

CONCLUSIONS

Many of the measures we examined receive a lot of national political and media attention and whether or not the target is being met is often used as a marker of how frontline NHS services are coping with current demands. These are some of the most frequently reported and readily available data we have at a national level, so they can be an immediate and useful way to explore changes and impact. This briefing set out to ask some key questions:



IS THE NHS MEETING NATIONAL TARGETS?

Looking at longer-term performance, most of the access measures have been performing well. In particular, we see improvements within measures where targets had been introduced. The clear exception to this is A&E and inpatient treatments. Both have been showing longer-term decline; in particular, A&E has been breaching the four-hour target at a national level since the second quarter of 2012/13.

More generally, there has been a decline in performance (compared to earlier trends) in nearly all measures in the most recent quarters. Out of the six measures included, half – A&E, inpatient treatment and diagnostic tests – missed their target in the last quarter; and, although still meeting their target, there has been some decline in performance for cancer referral and outpatient treatment. Cancer treatment is the only measure maintaining past performance.



DO ALL HOSPITALS FOLLOW THE SAME TREND?

Looking at the variation in hospital performance, we are seeing a more global decline in performance alongside many national measures. While we have seen the worst-performing hospitals getting worse in most measures for a while, we have also started to see a decline at the best-performing hospitals; this is particularly the case in A&E, inpatient treatment and, to a lesser extent, in outpatient treatment. There is also much more variation in how the worst-performing hospitals perform in all measures – though this is likely to be due to the targets being so near to 100 per cent, which restricts the variation at top hospitals. This suggests the challenge of maintaining good performance is starting to show more broadly and in many hospitals. It is also important to note that, despite declining performance, the vast majority of people receive services and treatments within the target timeframes.



DO CHANGES IN ACTIVITY RELATE TO CHANGES IN PERFORMANCE?

One aim of this briefing was to explore whether we have experienced a period of high demand and how changes in activity relate to performance. The reasons for increasing activity are complex¹⁶ and will be different for each service. We saw a growth in activity for nearly all measures over the last year – with the biggest increases seen for cancer referrals and diagnostic tests. However, these increases don't necessarily relate to longer waiting times. Diagnostic waits, for example, have increased greatly in number but performance has been generally maintained over the last year. There are some areas where we have seen a relatively small increase or decline in activity – such as A&E or inpatient treatments – but have shown bigger declines in performance, suggesting this is not a simple relationship. There are many other factors that contribute to declining performance, such as the complexity of the condition or procedure. However, it is important to remember how changes in activity – particularly increases – can affect performance and how hospitals plan their services for future demand.



DOES PERFORMANCE ON DIFFERENT MEASURES CLUSTER WITHIN HOSPITALS?

We saw similar patterns of declining performance in access measures at a national level, which suggested that we would see a clear relationship between these measures at a hospital level. For example, if a hospital fails to meet an A&E target they are more likely to also miss an inpatient treatment target. We found that many hospitals were struggling to meet targets in the same areas – A&E and treatment waiting times – rather than a few hospitals failing to meet all/many access targets. This suggests systemic problems affecting the delivery of these services in many hospitals, rather than issues with performance and management of individual hospitals.

LESSONS FOR POLICY-MAKERS AND POLITICAL LEADERS

The use of targets, together with other support initiatives, has in the past been associated with substantial gains in performance. While they merely hint at the broader quality of services, changes in performance against these targets do deserve further investigation. Simply removing targets because they become challenging to deliver may remove one visible symptom of declining performance but will do little to address the underlying cause.

The response to declining performance is crucial, and must be dictated by a deeper understanding of the nature of the decline. For example, failures linked with problems in individual services or at particular points in time may be best addressed with support directed towards struggling services. Hospitals failing across a wide range of measures may suggest an issue with overall hospital management and require a different response. Yet the analysis in this briefing would suggest that the national decline in performance is more likely due to systemic problems affecting certain services.

Selecting the wrong response – often a result of a fixation with high-profile pass/fail measures judged in isolation – can be harmful. For example, aggressive performance management and financial incentives are becoming increasingly unhelpful.²⁵ These measures are especially ill-judged when the causes of declining performance are not well understood. For example, this briefing has shown that the relationship between activity and performance is not clear-cut: it is not simply that rising activity leads to declining performance. Other briefings in this series highlight the range of factors causing challenges to service delivery in general practice²⁶ and in A&E.¹⁵

Clearly, performance against targets does not describe the total quality of care people receive. It is also true that the vast majority of patients continue to receive the care they need within the expected timescales. However, performance has declined, which has significant implications. The ways in which political leaders, policy-makers and the health service respond will be crucial. Failure to understand the nature of the decline and a lack of appropriate cross-party support for the solutions is likely to result in continued political brawling, an increasingly demoralised NHS, and ultimately poorer access to hospital care for patients.

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