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Hindsight 2020

Lessons on setting targets in health and social care

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After the 2015 general election, the new government refreshed the central approach to business planning, and asked departments to set out their high-level objectives for 2020. The intention was to improve the way it monitored its own performance and to allow the public to track progress against key outcomes.

Published in early 2016, and agreed with the Cabinet Office and HM Treasury, the Department of Health's **Shared delivery plan: 2015 to 2020** described the government's commitment to the NHS and social care over that period. It promised to invest £10 billion more on the NHS by 2020, and included other eye-catching ambitions such as increasing GP numbers, integrating health and care services, improving access to psychological therapies, and capping social care costs.

While the Department is not a delivery body in itself (it can only oversee delivery by others), following the NHS reforms in 2013 the annual 'mandates' to the Department's key arm's-length bodies set the direction for the health service. After the delivery plan was agreed, these mandates included the expected contribution of each arm's-length body to the government's goals for 2020.

So now that 2020 has arrived, and with the benefit of hindsight, how have health and social care fared on the targets they were set? Which key goals have been hit, which are being missed, and which have by now been removed altogether?

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A mixed scorecard

Key targets – and corresponding progress – from the Department's *Shared delivery plan: 2015 to 2020* and mandate to NHS England for 2016/17

	Original target for 2020	Indications on progress to date
Investment	Invest £10 billion more on the NHS by 2020.	NHS England's **budget** – even after accounting for inflation – was over £17 billion higher in 2019/20 than the expenditure level five years earlier.
Social care	Limit individual liabilities from April 2020, protecting people from unlimited costs if they develop very serious care needs.	No such commitment has been forthcoming, and a green paper for adult social care promised for summer 2017 has yet to be published.
General practice	5,000 more GPs.	Since September 2016, the **number** of full-time equivalent, fully qualified, permanent GPs has fallen by 1,634 (from 28,592 to 26,958).
	Ensure by 2020 that everyone should be able to see a GP seven days a week from 8am to 8pm.	Since October 2018, everyone in the country has **reportedly** been able to access general practice appointments in the evening and weekends, albeit the weekend offering has softened to just "meet local population needs".
Waiting times	95% of people attending A&E seen within four hours.	In **November 2019**, 81% were admitted, transferred or discharged within four hours, falling to 71% to major (type 1) A&E departments.
	75% of Category A ambulance calls responded to within eight minutes.	The indicator has since changed, but **performance** against this target has been declining and was last met in January 2014.
	At least 92% of patients on incomplete non-emergency pathways to have been waiting no more than 18 weeks from referral; no-one waits more than 52 weeks.	As of **October 2019**, 85% of patients waiting had been so for at most 18 weeks, with 1,321 patients having been waiting for more than 52 weeks.

	Original target for 2020	Indications on progress to date
Digital health records	By 2020 all health and care records will be digital and updated in real time.	🔴 As of summer 2019, just 12% of organisations were **considered** to be on track to meet the government's target.
Efficiency	Year-on-year gains in NHS efficiency and productivity (2–3% each year), including from reducing growth in activity.	🟠 Estimates suggest that there have been positive efficiency gains. However, the extent is unclear and limited progress has been made on reducing the growth in activity. **Efficiency targets have been reduced in 2019 to 1.1%.**
Mental health	Increased access to psychological therapies from 15% to 25% of those who might benefit.	🟠 In the year to **September 2019**, the number of people referred to the Improving Access to Psychological Therapies (IAPT) programme starting treatment increased to 1.2 million, but still short of the originally intended level of 1.5 million by 2020.

As we can see from this sample of targets, progress against the ambitions of four years ago is mixed. In reality, many of the stated ambitions have changed over time, and the different nature and impact of the targets renders any effort to establish a single rating on progress across all the targets implausible. But, for those that are measurable, some key themes do emerge:

- There has certainly been significant progress made against some targets.
- In some cases, the targets have been achieved but perhaps not quite in line with the original ambition.
- However, it is fairly clear that some of the high-profile original ambitions are going to be missed.

Lessons can be learnt from the previous performance management regime

So what can we learn from target setting in this way? Here we outline the key lessons on what might help in future, looking specifically at:

- the conditions for success in achieving cross-departmental goals
- the importance and risks of political and personal imperative
- ensuring performance measures are relevant, both to the end goal and to the body being held to account for delivery.

Key lessons

Targets should be meaningful and measurable

Reflecting on the performance targets set in the original shared delivery plan, some were explicit on how progress should be measured – a key example being the pledge of investing £10 billion more by 2020. For other targets it is unclear whether there was ever any certainty about how these should be measured, or how clinically meaningful they are.

- Performance targets should be clinically meaningful, as illustrated by looking at the key target of A&E waiting times. In March 2019, the Review of NHS Access Standards was published, which proposed that the current four-hour A&E target should be replaced by four new measures, which could have important **implications** for patients. This review suggests moving away from setting a maximum time spent in A&E – instead looking to the average time across patients.
- For targets to be measurable, there should be transparency in reporting. If targets are not measurable and reporting is not transparent (i.e. if they're not in annual reports), it is often not possible to determine whether they have been achieved. An example is the 2020 Dementia Challenge (described further below), due to the complexity of activities within the dementia strategy.
- When deciding what is meaningful, relevant and achievable, the relationship between inputs, outputs and outcomes needs to be understood. The original performance targets show demonstrable variation in whether they were focused towards inputs (e.g. staff), outputs (e.g. seven-day GP appointments) or outcomes that could be interim (e.g. waiting times) or proxy (e.g. satisfaction as recorded by the Friends and Family Test). But a 2018 **report** on shared departmental plans and performance management concluded that "departments remain weak on setting out their understanding of the relationship between inputs, outputs and outcomes".

  Looking further back, the previous **Public Service Agreement** model of performance management – which between 1998 and 2010 saw around 600 performance targets set across government – encouraged departments to focus on the delivery of long-term outcomes, "regardless of political cycles

or day-to-day urgencies". But PSAs were subsequently **abolished** in 2010 on the basis that government "cannot commit to outcomes but can commit to inputs". Many have **since viewed** this shift on setting performance targets as a mistake.

- In setting performance targets, the consequences, cost-effectiveness and resources that will be required should be assessed. Commitments that don't show sufficient consideration to costs might well impact on other services, the quality of care, or actually increase costs. A key example is the pledge for seven-day access to GPs, which – without achieving wider benefits – may well not **represent** value for money given the potential costs of the additional appointments.

Political leadership can help to meet targets

Strong leadership is repeatedly discussed as a key factor in ensuring policies are successfully implemented and targets achieved – this has been **described** as especially relevant in the health sector where a coherent strategic vision is almost imperative to succeed. The targets in the shared delivery plans highlight a number of ways in which political leadership (or lack thereof) has helped or hindered the achievement of targets over the last five years.

- Many of the targets that were originally set out were copied almost word for word from the incoming government's **manifesto**. These included commitments on funding, seven-day access to GP services, protection against social care costs for homeowners, and electronic access to health records. Arguably, the imperative to meet electoral promises has proven a predictor of the targets that would be met or at least remain a key priority. For instance, ambitions to roll out extended access to GPs were brought forward from 2020 to 2019, and have been delivered (to some extent) much earlier than anticipated, by 2018. That said, the social care targets suggest this is not a strict rule.

- Some manifesto pledges were even given explicit political attention, with then Prime Minister David Cameron lending his name to the **2020 Dementia Challenge** – such a personal backing perhaps explaining the level of detail included in the accompanying strategy document, and why this has remained a consistent priority in subsequent delivery plans. As the **National Audit Office** have argued, "staff involved in business planning say they find it difficult to say no to new ministerial priorities". That said,

despite remaining high on the agenda, the complexity of activities included in the dementia strategy make it hard to quickly assess what progress has been made.

- Conversely, targets that have required collaboration between public bodies, but which have not been supplemented with a clear sense of leadership, seem to have been the most difficult to achieve. Introducing a cap on social care charges, for example, would require approval from the Treasury, while creating integration plans across the country requires the involvement of local authorities.

Beware being overly ambitious

Over time, studies have illustrated our biases when making predictions and, in particular, our pervasive tendency for over-optimism. Indeed optimism bias transcends gender, ethnicity, nationality and ages and, remarkably, **species**. And indeed the history of the NHS is littered with examples of worthy ambitions and stretch targets that are fairly to wholly unrealistic.

Perhaps unsurprisingly therefore, some of the targets that were set after 2015 have by now been dropped, while others have seen their goalposts moved and others pushed into the future – as shown here.

Examples of targets that have seen their goalposts moved, or which no longer exist

	Original target	Revised target	Outcome
Weekend general practice	Ensure by 2020 that everyone should be able to see a GP seven days a week, from 8am to 8pm (**Shared Delivery Plan 2016**)	Services to be available for an additional 1.5 hours on every weekday evening after 6.30pm, and on Saturdays and Sundays, to meet local population needs (**National Audit Office 2017 report**)	**Moved goalposts**
Patient experience	Maintain and increase the number of people recommending services in the Friends and Family Test (currently 88–96%) (**2016/17 mandate**)	Missing	**Dropped**

	Original target	Revised target	Outcome
Seven-day hospital services	2020 ambition to roll out seven-day services in hospital to 100% of the population, so patients receive the same standards of care, seven days a week (**2016/17 mandate**)	All hospitals with major A&E departments will provide same-day emergency care services at least 12 hours a day, seven days a week by the end of 2019/20 (**NHSE & NHSI 2019/20 accountability framework**)	**Moved goalposts**
GP numbers	5,000 extra doctors by 2020 in general practice (**2016/17 mandate**)	Increasing the number of doctors working in primary care by 5,000 “as soon as possible” (**2019 interim workforce strategy**)	**Shifting delivery dates**
Social care	Cap charges for residential social care and limit individual liabilities (for social care) from April 2020 and guarantee that people will not have to sell their home to fund social care (**Shared Delivery Plan 2016**)	Missing	**Dropped**

In terms of optimism, it would be difficult to overestimate the level of demand for – and therefore spend on – the NHS. It could certainly be considered a success that levels of investment in the NHS are higher than had been committed to in 2015. But a less favourable interpretation would be that efforts to control demand for services or make efficiencies have fallen short. It is convenient – but wrong – to assume that, so long as the increased costs are met eventually, this is not a problem.

As we have previously **highlighted**, the link between financial and workforce plans mean that optimism around the former can lead to hugely problematic underestimates on the number of staff that will be needed in the future. In fact, as the government spending watchdog has **highlighted**: “Over-optimistic plans which are not aligned to resources create in-year spending pressures and put value for money at risk.”

Conclusions and recommendations

In late 2018, we published a series of **articles** about learning the lessons on developing NHS national strategies. We issued a reminder on the factors that always seem to be forgotten, and end up tending to trip up even the best thought-out visions. Many of those lessons are relevant when it comes to setting performance measurements in health and social care.

Given the huge expenditure on health and social care, demonstrating value is important and poor performance monitoring regimes can **incentivise** dishonesty, gaming and ignoring the real issues.

On the other hand, a good performance management system can create a virtuous cycle of positive and sustainable improvement. As the Institute for Government noted in their report on the history of PSAs: "The PSA framework was never a perfect system, but it was a flexible system that evolved because people thought it was worth evolving. The targets gradually became smarter in response to challenges, difficulties and unintended consequences."

We conclude with some policy recommendations that might help inform future performance management:

1. Create the conditions for success in achieving cross-departmental goals

Improvements in population health, and even in health care, require a number of bodies to work collaboratively. This is reflected at the highest level between government departments, as well as at local level. We suggest three conditions are required for successful delivery of goals that span departments:

- Political leadership: ideally the goal needs to be important to a central leader. At the most senior level, this would be the Prime Minister. But this has some caveats to it, as we'll shortly come to.
- Alignment of budgets: this may be in cash or in kind, such as the establishment of a joint unit across two bodies to deliver a goal.
- Systematic planning and performance management across government, enabling consistency of goals and performance measures across departments.

Not one of these conditions is sufficient in itself, but the combination of all three is powerful. These conditions were very much in evidence during the later era of PSAs, as the Institute for Government identified in their report.

> **"During this time, there was an increasing realisation among politicians and officials that a number of high level priority outcomes straddled departmental boundaries and thus improvements had to be made in the delivery of 'cross-cutting' outcomes. There was strong support for this approach from several senior secretaries of state – for example, John Prescott reportedly remarked: 'This is why I came into politics.' There was also a conscious effort to change the language and style of performance, reflecting many of the persistent criticisms of top-down targets."**

2. Recognise the importance and risks of political and personal imperative

Notwithstanding the point that political leadership is a factor in successful cross-departmental working, it also has risks. The personal drive of the Prime Minister or Secretary of State on a goal can move the dial, but when that person moves on, the focus will shift. Ministers should select the goals they personally prioritise with care. There is also a risk that ministers will identify a solution – and a performance measure – that addresses a symptom rather than the underlying problem, or which has unintended consequences in other areas, which leads us on to our next recommendation.

3. Ensure performance measures are relevant both to the end goal and to the body being held to account

Having a range of types of indicators – from levels of spend to resource numbers (e.g. staff), interim outcomes (e.g. waiting times) and proxy outcomes (e.g. Friends and Family Test) – is obviously compelling as some are more reactive and readily measurable, while others are more meaningful to patients and the public.

There can be a long timelag between an operational change, or set of changes, in a service, and improved health outcomes, but operational measures are

relatively easy to measure over the short term. The role of the policy function should be to develop the logic model that links operational goals set for delivery bodies – which may well reflect levels of input as well as output – to the longer-term outcome targets set at departmental level.

One potential impact of civil service cuts over recent years may have been a loss of the analytical capability that provides insight into the root causes of issues that ministers wish to address, and which can therefore identify the most appropriate levers to pull and targets to set. Investment in good data analysts does not have the same headline-grabbing potential as investing in new doctors, but it could have a very positive impact on performance.

Finally, it is worth noting that, for all the flaws in the current approach to target setting and managing performance, we will never know what the counterfactual would have been had previous governments not set the range of targets they did. Even where targets were missed or dropped, they were part of an overall drive to demonstrate measurable improvement in the experience and outcomes for those who use health and social care services.

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