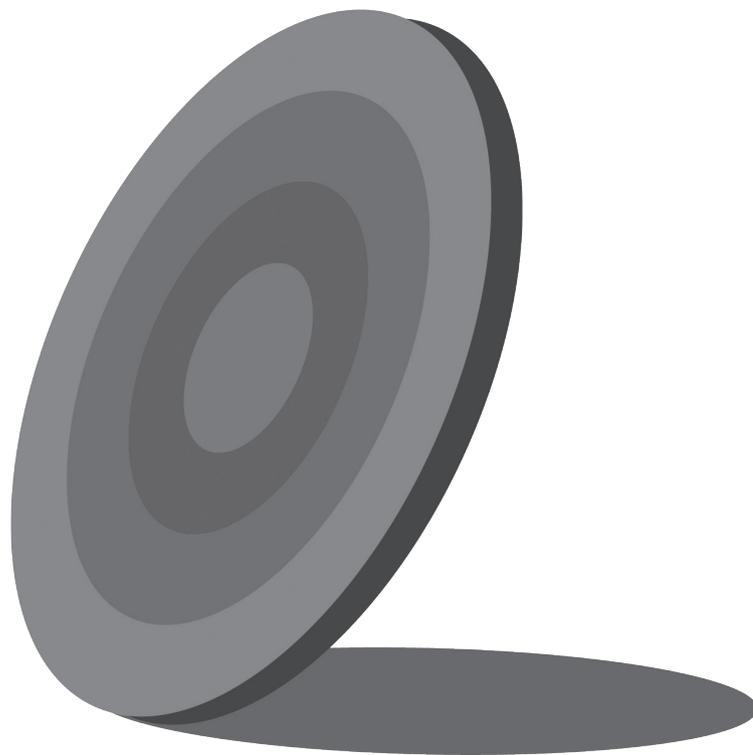


Evidence scan: The impact of performance targets within the NHS and internationally

ICF International



Supplement
October 2015

About this report

This report was written by Hannah Atherton and colleagues.

ICF International
30 St Paul's Square
Birmingham
B3 1QZ, UK

www.icfi.com/regions/europe/united-kingdom



The report was produced as part of the Health Foundation's work on the effective use of targets in the NHS and, in particular, to support the development of the report *On targets: How targets can be most effective in the English NHS*.



For more details of this work, see www.health.org.uk/publication/on-targets

Evidence scan: The impact of performance targets within the NHS and internationally is published by the Health Foundation, 90 Long Acre, London WC2E 9RA

© 2015 The Health Foundation

Contents

Executive summary	4
1. Introduction	7
2. Creating and embedding targets: Improving Access to Psychological Therapies	10
3. When targets are successful and lead to quality improvement: healthcare-associated infections	17
4. Unintended consequences of performance targets: the four-hour A&E target	24
5. When targets are ambitious and prove difficult to meet: the health inequalities target	35
6. International case studies	47
7. Conclusion	50
Annex 1: Evidence scan search terms	53
Annex 2: Search results	60
Annex 3: Key performance indicators (KPIs)	61
Annex 4: Evidence scan references	62

Executive summary

This evidence scan was commissioned to support the Health Foundation's work exploring the effective use of performance targets in the NHS. It reviews evidence on the impact of a range of national performance targets on the delivery of NHS care. International examples are also included as an additional source of evidence.

The evidence scan began with exploratory work around four central themes in performance target setting and implementation in the NHS, including a number of high-profile targets. Initial research reviewed a list of 20 targets, from which four were chosen to explore in depth, on the basis of the breadth of the evidence available and their coverage of the central themes.

Central theme	Chosen targets
Creating and embedding targets	Improving Access to Psychological Therapies (IAPT)
When targets are successful and lead to quality improvement	Health care-associated infections (HCAIs)
Unintended consequences of performance targets	Accident and Emergency (A&E) (four-hour target)
When targets are ambitious and prove difficult to meet	Health inequalities

Differences in the experiences of the four countries of the UK: England, Scotland, Wales and Northern Ireland, were also explored. The international examples chosen were from Belgium (Flanders), Germany, the Netherlands and New Zealand.

Evidence was gathered from a range of sources including searches of bibliographic databases and grey literature sources.

Key learning

The review found that some performance targets are intended to be aspirational when they are conceived, but this is not always clear in their implementation. Thus, debate tends to focus on their achievements *per se* rather than any progress made or wider learning generated. Targets may also be problematic when they are poorly planned, draw on a weak evidence base, or are rushed (perhaps in response to an emergent issue). Investments may be made in changing practices to meet targets when achievement is unlikely or extremely challenging.

This evidence scan discusses examples where targets were changed after problems were revealed. It finds that where an iterative approach to targets is adopted, and learning from implementation is used to adapt them, success is more likely. The evidence in this review shows that the aspiration to achieve the target can lead to positive changes in organisational culture, but that these changes need time to become embedded.

Each chapter of this report focuses on the evidence from a specific performance target, reflecting one of the central themes and the learning that this provides.

Chapter 2 (the IAPT example), which explores creating and embedding targets, suggests that an iterative approach to target setting and making changes is beneficial. It was also found that collaborative working assisted implementation, and the availability of outcomes data was very important in monitoring and making subsequent amendments. The psychological therapies target in Wales lacked consistent robust data about the provision or use of psychological therapies; consequently, there was little information available about the target or whether it was achieved.

Targets that led to quality improvement in the NHS are explored in chapter 3. The HCAI targets were met; a review of the literature revealed that embedding the targets within a broader process of cultural change was central to this success. The close involvement of management and staff, as well as the availability of financial and other resources, was fundamental to this. Monitoring progress and performance was significant in helping the NHS to achieve the targets set.

Chapter 4 considers unintended consequences of performance targets, using the example of the four-hour A&E waiting-time target. The evidence shows that performance targets can be a proxy for wider system failure or success and can have wider consequences. The evidence from this chapter underlines the importance of clear guidelines to reduce the risk of misinterpretation or 'gaming'. It also illustrates the importance of considering the local context for the delivery of a target. In addition, the review shows how wider indicators can be beneficial in interpreting performance. For example, in Northern Ireland, the A&E performance target took a more complex view of waiting times, which took outcomes into consideration.

Chapter 5 reviews the health inequalities target as an example of an ambitious target that is difficult to meet, with a wide but complex evidence base. Health inequalities have many facets, many of which lie outside the remit of the NHS. A key criticism of the health inequalities policy and its associated target was that while its intentions were good, implementation and initial learning were poor. The target was left to local determination and was often developed without reference to the wider evidence base. Due to the very complex nature of this issue, the evidence shows that more time should have been allowed to deliver sustainable change.

Nonetheless, the evidence identifies a number of positive consequences from the introduction of the target, including condition-related improvements and improvements to mortality rates. This is important because it suggests that although the target did not achieve what it intended, its introduction still led to positive progress on the key determinants of life expectancy. The Welsh government's target was focused on health *inequities* rather than *inequalities*,* as the available evidence suggested that this was where it could achieve greatest impact. The Scottish government placed high priority on collaboration when developing its health inequality targets; a 'task force' collaboration kept momentum behind the work.

The international case studies provide useful learning about how performance targets are designed and implemented. The State Health Conferences organised in Germany and the Local Health Networks in Belgium illustrate positive structures for collaborative working when setting targets. The Netherlands provides a good example of how the wider context can shape the design of indicators. The Dutch health service is not state-run and so targets are not set by government; setting targets thus needs to be done collaboratively with all the key players, but also requires accountability to inform others of the findings of the indicators.

* The World Health Organisation (www.who.int/hia/about/glos/en/index1.html) offers the following definitions: health inequities are avoidable inequalities in health between groups of people within countries and between countries; health inequalities are differences in health status or in the distribution of health determinants between different population groups.

Conclusion

The evidence scan demonstrates the complexity involved in developing, implementing and embedding successful performance targets in the health system. The examples from across the UK and internationally show that the different ways in which targets are introduced have implications for their effectiveness. The themes discussed below appear to be most strongly associated with success.

Clarity

The evidence shows that where there is a lack of clarity around the purpose of the target, problems are likely to arise. This can be a consequence of poor consultation and understanding of context. Clear guidelines ensure consistent implementation and monitoring.

Collaboration and consensus

The UK and international examples all illustrate the importance of initial consultation when creating a target and of ongoing review during implementation, which should include stakeholders at all levels. Collaboration can be used in piloting and testing targets to develop the evidence base and learn in more detail about issues that may arise in fuller implementation.

A robust evidence base

The evidence scan shows the importance of a robust evidence base for targets that are clearly linked to policy. Evidence can help to shape a target that can be implemented effectively and is clearly related to practice. Where pilots are not completed or the subject area is not well understood or researched, then targets risk being problematic.

Target governance

For a target to be successful in changing practice, there must be clear lines of accountability, from the local to the regional or national levels, so that at the broader system level, performance can be monitored and action taken where it is required.

Understanding context

The evidence suggests that understanding the socio-economic, institutional and practice context is fundamental for the design and implementation of an effective target.

Using a wide set of metrics

A set of metrics alongside a performance target will present a clearer picture than a single measure. While single numerical performance metrics are important, focusing on them in isolation may miss wider system influences and consequences.

1. Introduction

Performance targets in the NHS have had a high political and public profile since their introduction in the early 1990s. They have been used in all four countries of the UK: England, Scotland, Wales and Northern Ireland. The issues that targets aim to address, and their definitions, have changed over time; in some cases, changes have been quite nuanced, while in others the targets have simply been abolished. New governments and secretaries of state have amended and replaced targets to reflect changing priorities. Despite this, there have been few attempts to systematically review the impact of existing targets in order to inform new ones.

In July 2015 the Health Foundation commissioned ICF to undertake an evidence scan to explore the impact (positive and negative) of a range of national NHS performance targets on the delivery of care. International examples were also identified as a potential source of evidence.

This report presents the findings of the evidence scan. This introductory chapter provides some background to the subject of target setting in the NHS and outlines the research methodology. Subsequent chapters each explore an example target to identify learning around a set of central themes that emerged from the review, as well as a summary of findings from international examples. The report concludes with a discussion of the learning that has emerged throughout the evidence scan.

1.1 Background

The Patient's Charter, created by John Major's Conservative government in 1991, included the first maximum waiting-time guarantee for inpatient treatment. In 1997, Tony Blair's newly elected Labour government introduced stringent performance measurement systems across a range of public services. These included more than 600 performance targets.¹ The NHS Plan, published by the Department of Health (DH) in 2000, stated that the NHS must be 'A health service designed around the patient'. It argued that there was 'A lack of clear incentives and levers to improve performance'² and that consequently, national standards were needed. A 'balanced scorecard' performance measurement system was implemented by the DH, along with an annual system of 'star ratings' for public health care organisations.²

In 2001 the Prime Minister's Delivery Unit (PMDU) was created to scrutinise the performance of public services against targets and standards, holding managers to account. As the decade progressed, targets were increasingly managed centrally and included in key government publications and priority frameworks. These developments have been significant in introducing and embedding performance targets in the NHS.

Over the past 15 years, as targets have evolved, so has the commentary and body of literature discussing them and their use. Performance targets are seen by some commentators and researchers as tools to improve accountability and transparency, and improve performance (for example, Boyne and Chen 2006³; Micheli and Neely 2010⁴).

Hauck and Street⁵ examined performance management regimes in the NHS in England and Wales following devolution, focusing on the use of waiting-time targets. Data were analysed for a six-year period from one Welsh and three English hospital trusts close to the English–Welsh border. This analysis found that the stronger performance management regime operating in England appears to have contributed to higher levels of performance in those hospitals. Willcox *et al* (2007)⁶ compared government attempts to reduce waiting times in Australia, Canada, England, New Zealand, and Wales from 2000 to 2005. They concluded that ‘England has achieved the most sustained improvement, linked to major funding boosts, ambitious waiting-time targets, and a rigorous performance management system.’

Yet there have also been a number of concerns raised relating to the use and impact of targets, especially as they become more stringent. Bevan and Hood (2006) argued that: ‘Governance by targets rests on the assumption that targets change the behaviour of individuals and organizations . . .’⁷ They argued that there are shortcomings in what they term a ‘targets and terror’ approach to improving the performance of public services. In particular, they reasoned that using targets as a form of governance risks over-reliance on ‘synecdoche’ – taking a part to represent the whole. They also contended that targets can never be immune to some form of gaming (manipulating the results so that the outcome looks more positive than it actually is). Wheeler (2000)⁸ argued that when people are pressured to meet a target, it is inevitable that their behaviour is altered. While this may lead to improvement in the system, it can also distort it.

Guilfoyle (2012)¹ discussed the complexity of some performance targets, suggesting that the level of complexity can compromise their correct measurement and lead to different interpretations. He proposes ‘the systems approach’ as a solution, whereby performance targets are considered as part of wider systems rather than independent entities.

In recent years there have been several reviews of performance targets, two of which provide a useful overview of their advantages and disadvantages. Mannion and Braithwaite (2012)⁹ reviewed evidence of the consequences associated with the introduction of national performance measurement systems in the NHS, with the aim of informing the development of similar programmes proposed for Australia. They identified 20 different ‘dysfunctional consequences’, which they organised under four key themes:

- poor measurement
- misplaced incentives and sanctions
- breach of trust
- politicisation of performance systems.

The recommendation from their review was that any individual or organisation producing or implementing performance targets or indicators needs to balance effective performance measurement and management against the potential drawbacks and undesirable consequences.

A recent Dr Foster report in April 2015¹⁰ focused on the ‘uses and abuses’ of performance measures and their unintended consequences. Tunnel vision, bullying and gaming were identified as key risks to the effectiveness of performance targets. The report identified five steps that could be taken to reduce misuse of performance data and increase its benefits:

- make data quality as important as hitting targets
- measure the context not just the indicator
- avoid thresholds and consider the potential to incentivise gaming
- be more open
- apply measures fairly.

Performance targets can be high profile, contentious and complex. This report explores the evolution of four key performance targets, selected as illustrative examples, introduced and implemented across the UK in the past 15 years. It examines the available evidence, analyses and describes the evolution of each target, highlights any changes made as well as challenges and successes, and the outcomes attributed to each target. The review draws on important differences in approach across the four countries of the UK and from international learning. The final chapter sets out key learning points for the development and implementation of future performance targets in the NHS.

1.2 Evidence scan methodology

The evidence scan began with exploratory work around central themes in performance target setting and implementation in the NHS, including a number of high-profile targets. Initial research reviewed a list of 20 targets, of which four were chosen as the focus for the evidence scan, based on the wealth of published material available for each and their coverage of key issues in the wider literature.

A review protocol was developed to explore each of the four targets, the themes identified for discussion, the experience of implementation in the four countries of the UK, relevant international examples (agreed with the Health Foundation), and a range of academic and other sources of evidence.

The search inclusion criteria were:

- dated from 2000 to the present
- focuses on health care performance targets or indicators in England, Scotland, Northern Ireland and Wales
- focuses on health care performance targets or indicators in New Zealand, Germany, Belgium or the Netherlands.

Annex 1 provides the search terms in full.

The evidence sources explored were:

- peer-reviewed articles
- official government policy documents
- parliamentary reports
- government agency documents
- evaluation reports
- performance management reports
- performance reporting data (eg, official statistics)
- third sector organisations' publications.

In total, the search brought up approximately 700 relevant articles (this includes articles appearing more than once across a number of search terms). Following a first-stage review of the relevance and utility of each source based on its abstract, a second stage and full review was undertaken for 110 sources, of which 100 were identified for inclusion in the evidence scan.

Annex 2 details the initial search results and the subsequent number of results after each review, leading to the number of search results referenced in the evidence scan.

2. Creating and embedding targets: Improving Access to Psychological Therapies

Key learning from this chapter

The availability of outcomes data was important for monitoring success

The availability of outcomes data was pivotal to monitoring the IAPT programme and its targets. Due to the availability of consistent and robust data, the targets were evidence-based in their design, and were monitored and amended based on evidence gathered during implementation. There appears to be a lack of consistent robust data on the provision or use of psychological therapies in Wales; consequently, there was little available information about any targets or whether they have been achieved.

The target benefited from an iterative approach

In this example, the target was developed by using evidence to inform its design and using experience during its implementation. Learning was generated through piloting, and the target amended following review, as there was a clear rationale for making changes.

Collaborative working assisted implementation

Scotland provided a good example of collaborative working. Key stakeholders in the workforce, including staff delivering care, were involved in the design and implementation of the performance target, which provided a firm foundation.

2.1 Introduction

The extent to which a performance target ‘succeeds’ in measuring what it was designed to, and whether it has the intended effect, can depend on how it was developed. The target for Improving Access to Psychological Therapies (IAPT) was introduced in response to increasing evidence of effectiveness of these interventions. This chapter explores the development and implementation of the IAPT target to identify learning about the process of creating and embedding targets.

2.2 Background

The term ‘psychological therapies’ covers a wide range of different models, including psychodynamic, cognitive behavioural, arts-based and systemic approaches.¹¹ From 2000, the use of psychological therapies to treat anxiety and depression began to gain widespread credibility. In 2004, the National Institute for Health and Care Excellence (NICE) introduced clinical guidelines strongly supporting the use of certain psychological therapies (NICE 2004,¹² 2004,¹³ 2005,¹⁴ 2005,¹⁵ 2006¹⁶). A national shortage of cognitive behavioural therapy (CBT) practitioners, who are skilled in helping people recover from depression and anxiety disorders, was identified as preventing the routine NHS delivery of the guidelines.

In 2006, arguments began to emerge that an increase in access to psychological therapies would provide value for money by reducing depression and anxiety-related costs such as welfare benefits and medical costs while also increasing revenues from increased productivity and keeping more people in work.¹⁷ The argument was advanced in academic articles and key documents such as *The Depression Report*, which called for ‘a new deal for depression and anxiety – a complete revolution.’¹⁸

2.3 How the performance target was developed

2.3.1 The Improving Access to Psychological Therapies (IAPT) programme

The IAPT pilot

In 2006, the Department of Health (DH) established two pilot projects (in Newham and Doncaster) to test the outcomes from implementing NICE guidelines if a local area was given increased funding to recruit and deploy additional psychological therapists.¹⁹ The pilot sites collected demographic and outcomes data, which allowed an evaluation to assess the impact on inequalities, recovery rates and length of waits. The evidence from the pilot indicated that CBT was as effective as medication in helping people with depression and anxiety disorders – and better at preventing relapse.²⁰ After the initial pilot, the DH developed the programme further to continue the development of the evidence base for psychological therapy. A number of IAPT Pathfinders were established in 2007/08, which used redesign techniques to implement a defined care pathway, service specification and service framework.²¹ As with the pilots, the approach was evidence-based, with a clearly defined framework.

The introduction of the IAPT programme nationally

In October 2007, after the Pathfinder programme had begun to be implemented, a three-year programme of increased funding for IAPT was announced. The programme built on the findings of the pilot and Pathfinder sites and would implement the NICE guidelines nationally. The pledge was that by 2010/11, the NHS would be spending at least £170m per year on expanding psychological therapies. The aim was for the money to be used to train 3,600 extra therapists over three years to treat 900,000 more people.

2.3.2 National guidance on implementing the programme

In the 2008 policy guidance *Improving Access to Psychological Therapies implementation plan: national guidelines for regional delivery*,²² the DH detailed performance indicators for strategic health authorities (SHAs) and primary care trusts (PCTs), which were intended to ensure the achievement of national outcomes that the then Secretary of State committed the NHS to delivering in return for the additional resources provided. The national commitments were as follows:

- PCT coverage – at least 20 PCTs to implement IAPT services in 2008/09, and this coverage should increase over 2009/10 and 2010/11.
- Building a skilled workforce – training programmes to deliver 3,600 therapists by 2010/11 with an appropriate skill-mix and supervision arrangements.
- Extending access to NICE-compliant services – 900,000 more people accessing treatment, with half of those who complete the programme moving to recovery and 25,000 fewer on sick pay and benefits by 2010/11.
- To achieve these national commitments, PCTs were required to complete the IAPT key performance indicators (KPIs). Thus, they were the agreed mechanism for demonstrating regional and national progress against the Secretary of State for Health’s public commitments on IAPT.

Please see annex 3 for details of the KPIs.

2.3.3 National targets

Following the 2010 general election, the coalition government committed to further improve access to IAPT services. It set the following target:

*'By 2015: IAPT services should be treating at least 900,000 patients annually, or 15% of the total estimate of 6 million people in England with common mental health disorders.'*¹⁷

The 15% threshold for the target allows for a degree of local variation in performance and patient preference.

In addition, it was expected that:

*'50% of those who have completed treatment would move to recovery, and 25,000 fewer people would be on sick pay or receiving state benefits.'*¹⁷

IAPT service providers would submit patients' clinical records to the Health and Social Care Information Centre (HSCIC). These data would be transferred securely, anonymised and aggregated as the basis of publicly available management reports on the overall performance of the service. This ensured transparency and allowed trends to be identified to inform investment and service improvement decisions at local, regional and national levels.

Due to the availability of the data, many changes have since been made to improve the implementation of the programme and to ensure that the targets can be achieved. A key example is in relation to waiting times.

2.3.3.1 Example: a national waiting-time target

A key priority of the IAPT programme was to reduce the time people waited for treatment, which has been monitored since roll-out in 2008. The measure of waiting time was based on the time between the date when a referral was accepted to the date of the first therapeutic session (ie 'treatment', or 'assessment and treatment') and is included as KPI 3b (see annex 3). Services were instructed to measure and monitor waiting times with the aim of ensuring that no patient would wait longer than a locally stipulated maximum.²³

Feedback from local data workshops conducted throughout 2011/12 highlighted inconsistencies in measurement due to local interpretation of guidance and the different IT systems used by services. Subsequent guidance (2012/13) attempted to address these issues.²³

Despite the comprehensive set of KPIs and the sustained focus on performance monitoring for the IAPT programme, in its 2013 report, *We still need to talk*,²⁴ the mental health charity Mind raised concerns about unequal access to psychological therapies. The report called on (the newly established) NHS England to urgently introduce national standards that would allow access to evidence-based talking therapies within 28 days of a referral, with quicker access for people experiencing a mental health emergency.

Concerns about waiting times were also raised in the Royal College of Psychiatrists' National Audit of Psychological Therapies for Anxiety and Depression (NAPT), which was carried out for a second time in 2013.²⁵ The NAPT found evidence that waiting times for therapy were now shorter and that more services were measuring their outcomes than previously (the baseline audit took place in 2011). However, service users were still concerned about waiting times, with only two-thirds believing they had a reasonable wait to start treatment; feedback from the NAPT's service user reference groups highlighted a desire for much shorter waiting times than indicated in the standards, as well as more help with managing the wait.

The Health and Social Care Act 2012²⁶ moved policy towards parity for physical and mental health. Reflecting this, the NHS Mandate for 2015/16 includes a specific standard for adult IAPT services.

The standard stated that in addition to maintaining at least 15% of adults with relevant disorders having timely access to IAPT services, with a recovery rate of 50%, NHS England will ensure that: ‘...by March 2016, 75% of people referred to the IAPT programme begin treatment within 6 weeks of referral, and 95% begin treatment within 18 weeks of referral.’²⁷

Clinical commissioning groups (CCGs) were required to submit plans to meet this standard in 2015/16 and these plans are to be monitored throughout the year. Monitoring will be at CCG level, but national reports will also include a service provider view. This is important as it shows a commitment to monitor the targets locally in a planned way, but also to keep national oversight and transparency.

The staged approach to setting the target has meant that evidence has been available to ensure that they are set in a realistic way. The commitment is to ensure that no person waits longer than necessary for a course of treatment. The IAPT service model that was piloted acknowledges that some people may benefit from a single treatment session and need no further treatment or are signposted to another, more appropriate service. In order to differentiate between the two groups of people and provide greater transparency, the headline performance target introduced in 2015 will capture waits from referral to the start of treatment for those who have two or more sessions. In order to ensure that no patients are missed, a secondary measure monitored locally will capture waits from referral to first treatment appointment for all people who enter the service; this will include people who receive just a single treatment session. The expectation is that this will be monitored locally for breaches at 6 weeks and 18 weeks. Reporting will start from April 2015, including, for the first time, all patients completing a course of treatment.²⁷

2.4 Was the target achieved?

Since 2012, IAPT performance data have been published monthly. The latest statistical release of the data for April 2015 (published in July 2015) covers organisations delivering IAPT services for adults in England. In relation to recovery rate and access, the data show:²⁸

- 91% started treatment at caseness, of which 45% moved to recovery and 43% showed reliable recovery
- an annualised access rate of 15.6%, meeting the 15% target.²⁹

In relation to the proposed 2016 waiting-time target:

- 80% (35,276) waited less than 6 weeks to enter treatment and 96% waited less than 18 weeks to enter treatment.

2.5 What are the differences between experiences in England and the other UK countries?

2.5.1 Psychological therapies in Wales

Although Wales does not have a national IAPT programme, there are a number of targets relating to psychological therapies. The Welsh government proposed³⁰ a waiting-time target for psychological therapies in 2007:

‘All patients subject to the Care Programme Approach (CPA) who are assessed to require access to evidence based psychological therapies will commence therapy within 3 months of assessment.’

The target is different from that in England as it focused only on people with severe or high-intensity problems, and not those with low-intensity problems. Subsequently, the target was removed after one year (although there was an expectation that the level of service would be continued). In part, this was due to the quality of the data available for monitoring the target. NHS Wales reported:

*'At present there is a serious shortfall in the amount of useful data that is collected for mental health especially in regards to community information such as this. Proceeding with the collection of any identified useful information is imperative. If the data is not collected the service may interpret this as the target no longer being a priority and will therefore not be achieved. There will be inequity of provision and access to this service across Wales. There will be a lack of information for commissioning purposes.'*³⁰

In this example, the target came before the data collection requirements had been fully explored, as had occurred with IAPT.

The Mental Health (Wales) Measure 2010³¹ put in place new requirements on Local Health Boards (LHBs) and local authorities in respect of care and treatment planning for all persons receiving secondary mental health services. Section 18(1) of the Measure stipulated:

'That a relevant patient's care coordinator must work with the relevant patient and the patient's mental health service providers, with a view to agreeing the outcomes which the provision of mental health services for the patient are designed to achieve, including... medical and other forms of treatment including psychological interventions.'

The National Service Model for Local Primary Care Services (NSM) was developed to support implementation of the Measure. The NSM identified that in order to meet its objectives there needed to be a requirement to provide wider access to psychological therapies. Responsibility was given to LHBs to ensure that a range of psychological therapies were available.

The 2012 policy guidance *Psychological therapies in Wales*³² had a vision to 'Help improve the nation's health and wellbeing by offering the people of Wales appropriate access to services that are both psychologically minded and psychologically therapeutic.' LHBs and local authorities were responsible for increasing the availability of, and access to, psychological therapies in the treatment of mental disorder and common mental health problems. The guidance set out quality standards for psychological interventions in Wales. Each LHB Psychological Therapy Management Committee (PTMC) had to take responsibility for the delivery of the programme and how well it performed.

A review of the provision of psychological therapies in Wales in 2012³³ found that in the main, therapy approaches were in line with NICE guidelines and the 'Psychological Therapies in Wales: Policy Implementation Guidance' described above. However, there were inconsistencies in quality of and access to service and treatment delivery. This was found to be problematic at the regional, service and practitioner levels.

The review also uncovered concerns that GP referrals could overwhelm primary care. At that time, most mental health teams were in the process of developing a single point of access for primary and secondary care services and were using the stepped care approach to treatment. Criticism of the national approach to psychological therapies was raised; it was felt that the service was hampered by the historical predominance of the medical model within NHS settings, which was thought to impact on the expectations of staff and their perceived roles. Also in relation to staff, NHS Wales reported that the creation and implementation of IAPT in England had had a knock-on effect. It identified a specific risk concerning the recruitment and retention of psychological therapy staff in Wales due to the competition for staff from other parts of the UK. In contrast to England, Wales did not have a strategic programme to meet the training and development needs of its staff, and so arguably working in England was more appealing.

There appeared to have been little progress since 2012, and in 2015, *Together for mental health*³⁴ set out a 10-year strategy for mental health in Wales. It reiterated the commitments made in 2012 but did not introduce any national targets. Responsibility for local monitoring remains with LHBs and local authorities. There remains a lack of consistent robust data about the provision or use of psychological therapies in Wales; consequently, there is little available information about any targets or whether they have been achieved.

2.5.2 Psychological therapies in Scotland

In 2006, the argument for increasing the availability of psychological therapies was laid out by the Scottish Executive Health Department (SEHD) in the delivery plan *Delivering for mental Health*. The Scottish government made a commitment to:

*'Increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers.'*³⁵

It committed to working with NHS Education for Scotland, Health Boards and other service providers to increase workforce capacity to deliver psychological therapies and support service change.

The 2008 Matrix³⁶ grew out of requests from NHS Boards for advice on commissioning psychological therapies in local areas, to enable them to plan and provide the most effective psychological treatments for their particular patient population. It provided a summary of the current evidence base for various therapeutic approaches, a template to help identify key service gaps, and advice on governance issues.

Performance (HEAT) targets

Each year, the Scottish government agrees a suite of national NHS performance targets known as HEAT targets.³⁷ NHS Boards then need to state how they will commit to meet their targets as outlined in their annual Local Delivery Plans. NHS Scotland performance against the HEAT targets and standards contributes to the delivery of the Scottish government's purpose and national outcomes, and NHS Scotland's quality ambitions.

The HEAT³⁸ targets apply to local NHS Boards and include a psychological therapies target, to:

'Deliver faster access to mental health services by delivering 18 weeks referral to treatment for Psychological therapies from December 2014.'

NHS Boards were required to make monthly data submissions of the HEAT targets to the Information Services Division (ISD), Scotland's national organisation for health information, statistics and IT services. Progress against the target would be monitored by review visits, based on an existing agreement between the Reshaping Care and Mental Health Division and the NHS Boards.

ISD's Mental Health Programme³⁹ worked with NHS Boards to gather information to help set and measure the target. An information review was carried out in May and July 2010 to capture key information on the current structure, management, monitoring and waiting times for psychological therapies. This information enabled the Scottish government to set an informed target.

ISD and NHS Education for Scotland ran a series of workshops across a number of NHS Boards in October 2010⁴⁰ to define and agree key measurement points for the target. Based on feedback from these workshops, it was decided that the waiting time would be measured from the date the referral was received to the date psychological therapy commenced as planned. ISD has worked with key stakeholders to develop and refine a reporting template (an Excel document) to monitor progress against the HEAT target.

2.6 Key learning

The IAPT performance target is just one example of how targets can be created and embedded. It was chosen as a case study because of the long process of development and review, including the introduction of a national approach to performance management.

Sound performance measurement based on evidence

The IAPT programme stipulated a minimum dataset, which recorded the care provided to each service user and their clinical progress. The availability of detailed outcomes data was pivotal to the monitoring of the programme and its targets. This review has found that due to the availability of consistent and robust data, the targets have been both evidence-based in their design, and have been monitored and amended based on evidence gathered during implementation. Without an evidence base, it is not possible to evaluate the effectiveness of an intervention. The targets have been fully embedded in the programme as it has progressed. Clear guidance and support has been provided and the target kept under review. In contrast, the lack of an evidence base caused problems in Wales. The initial psychological therapies performance target introduced there in 2007 was removed after one year because lack of data with which to monitor the target was identified as a key issue limiting its effectiveness.

Taking an iterative approach

The IAPT example illustrates an iterative approach to developing and monitoring targets, starting with key performance indicators and moving towards detailed national targets. Such an approach helps to develop a target by using evidence to inform its design and using experience during its implementation. Learning is generated through piloting, and the target is amended on the basis of review where there is a clear rationale for making changes.

Collaboration

Similarly, Scotland provided a good example of collaborative working, which led to setting an ‘informed’ target with key measurement points. Key stakeholders were involved not only in the design of the target, but also its measurement and the reporting template. The target remains in place many years later.

The use of multiple performance targets

There appears to have been some confusion between national and local targets in England. Local reporting of targets to PCTs informed national monitoring, without an explicit national performance target as such.

The targets were then added into the outcomes framework, with a commitment to a national target in England from 2015 onwards. So while the performance targets have been created and tested during implementation of the IAPT programme, it has taken some time for them to be introduced on a national level in a mandatory sense. The increased publicity around the national targets, which has occurred alongside the UK government’s increased focus on mental health, has reinvigorated commitment to these targets and increased demands for transparency.

3. When targets are successful and lead to quality improvement: health care-associated infections

Key learning from this chapter

Targets were successfully embedded within a change of organisational culture

The improvement in patient experiences of health care-associated infections (HCAIs) in this example illustrates the impact that targets can have when embedded in a wider process of change in organisational culture.

Monitoring progress helped to achieve the targets

The targets created a degree of accountability for everyone involved in patient care and allowed changes to be made to achieve them.

Financial and other resources played a key role in achieving the targets

The sizeable increase in resources dedicated to tackling HCAIs through national initiatives, new equipment and cleaning staff may have made the targets easier to achieve.

Close involvement of management was important

NHS trusts that saw the greatest reductions in HCAIs were those that demonstrated strong leadership at board level as well as effective ward management.

Close monitoring of performance was effective

The real-time reporting of relevant data was a good source of intelligence, which NHS trusts used to concentrate their efforts. The data enabled individual acute trusts to understand the pattern and prevalence of HCAIs at a local level. This was essential for enabling change and witnessing the effectiveness of their actions.

3.1 Introduction

The term HCAI encompasses a wide range of infections, including Methicillin-resistant *Staphylococcus aureus* bloodstream infections (MRSA), urinary tract infections (UTIs), *Clostridium difficile* infection (CDI, also known as *C.difficile*), and infections of the bones, joints and central nervous system.⁴¹ HCAIs develop either as a result of being in contact with a health care setting or as a direct result of a health care intervention. Essentially, the infection was not present or incubating at the time of a patient's admission to the health care setting.⁴² This chapter describes the introduction and development of targets to reduce the prevalence of two of the most well-known HCAIs – MRSA and CDI – and the impact on patient care.

3.2 Background

MRSA is a type of bacteria that is resistant to a number of commonly used antibiotics, which means it can be more difficult to treat compared to other bacterial infections. The bacteria are usually spread through skin-to-skin contact with someone who has the infection or the

bacteria living on their skin.⁴³ CDI is also a bacterial infection that can affect the digestive system and most frequently affects those who have been treated with antibiotics. The bacteria do not commonly cause problems in healthy people; however, certain antibiotics can affect the natural balance of bacteria within the gut, which protects against CDI.⁴⁴

In early 2000, there was relatively little attention paid to HCAs nationally, with both MRSA and CDI having a low profile across the UK. But two reports from the National Audit Office (NAO) in the first half of the decade changed the landscape and demanded that greater attention be paid to HCAs in the NHS. Although the NAO identified a lack of robust, national aggregate data on the total number of HCAs in England, the evidence that was available suggested that action was needed. Reports stated that at any one time, 9% of hospital patients had an infection they caught in hospital, with at least 300,000 hospital-acquired infections a year costing the NHS approximately £1bn a year.⁴⁵

The NAO argued that the impact of this on patient care could not be underestimated – HCAs were potentially extending the length of a patient's stay in a health care setting and, in the worst cases, causing permanent disability or even death.⁴⁶ DH guidance from 1995 suggested that HCAs were the direct cause of around 5,000 deaths a year and a contributing factor in around 15,000 deaths.

3.3 How the performance target was developed

3.3.1 Setting targets for improvement

Mandatory surveillance of MRSA bloodstream infections had been introduced in 2001 but in the three years that followed, the number of reported cases increased by 5%, showing little progress in management of the infection.

In November 2004, the government introduced a target: To reduce MRSA bloodstream infections across all NHS acute hospital and acute foundation trusts by 50% by 2008.⁴¹

The target was later slightly modified to reflect the fact that some NHS trusts already had low numbers (<12) of MRSA cases and, as such, could not reasonably be expected to achieve a 50% reduction. In addition, a 60% trajectory was introduced whereby chief executives of strategic health authorities (SHAs) were asked to submit individual acute trust monthly trajectories for reducing the number of MRSA bloodstream infections by 60% by 2007–08 against a 2003–04 baseline.⁴¹

A target for reducing CDIs was introduced two years later (CDIs came to the public's attention following the first huge outbreak at Stoke Mandeville Hospital in 2005).⁴⁷ The previous year, mandatory surveillance of CDI had been introduced with a requirement that trusts report the total number of cases every quarter for all patients aged 65 years and over. Close monitoring revealed that between 2004 and 2006, the number of cases among patients in this age group had increased by 25%. Subsequently, in early 2007, the Health Protection Agency introduced a new reporting system for all patients aged two and over. This was then followed by the announcement of a national target to reduce the number of CDIs.

Target: to reduce CDIs across all ages by 30% by 2010–11, against a 2007–08 baseline.

This national target followed two highly critical investigations by the Healthcare Commission of CDI outbreaks at Stoke Mandeville Hospital and Maidstone and Tunbridge Wells NHS Trust.⁴⁸

3.4 Was the target achieved?

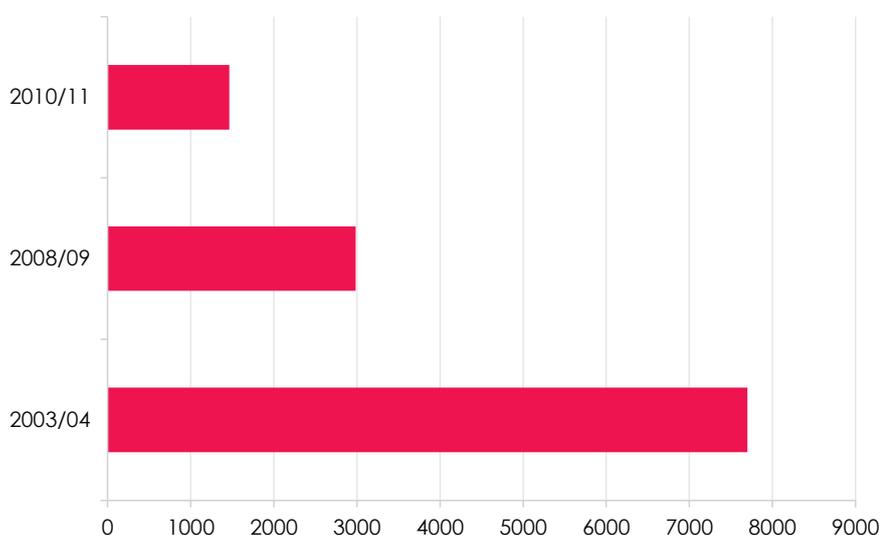
3.4.1 HCAI targets have had a measurable impact

The introduction of targets for both MRSA and CDI was followed by significant, quantifiable reductions in the number of patients who acquired either infection as a result of contact with a health care setting.

By the end of March 2008, the NHS had achieved a 57% reduction in MRSA bloodstream infections (against a target of 50%).⁴²

Since 2003/04, quarterly reports on MRSA infections showed a slow reduction in the numbers occurring, with a rapid reduction in 2006. On aggregate, the number of MRSA bloodstream infections fell from 7,700 in 2003/04 to 2,984 in 2008/09, which represents a 61% reduction (see figure 1).

Figure 1: The number of aggregate MRSA bloodstream infections, 2003 to 2011



The number of cases continued to fall even after the target was achieved in 2008. By 2010/11, an 81% reduction compared with the 2003/04 baseline had been achieved, alongside a shift in the balance of cases resulting from hospital care compared with those associated with other parts of the health care system.⁴⁹

The reduction in the number of cases has coincided with fewer deaths from MRSA (that is, where the death certificate cited MRSA as the underlying cause), from 480 in 2006 to 133 in 2009. By 2012, the number had fallen again to 38.⁵⁰

Reflecting this significant reduction, the MRSA target was replaced by an ongoing objective* to maintain the momentum for reducing the number of patients acquiring a health care-related infection. The objective required all acute and primary care trusts to reduce their MRSA rates to meet the current median, with those already below the median aiming to further reduce the number of cases by at least 20%.

More recently, reflecting the fact that tackling HCAIs remains a key government priority, NHS England has set out a 'zero tolerance' approach to avoidable MRSA infections in *Everyone counts: planning for patients 2013/14*. By that time, with around one-sixth of trusts reporting zero cases of MRSA over the period of a year, it was felt that the point had been reached

* The move from target to objective reflected a change in culture wherein reducing HCAI was seen as aligning with the underlying purpose of health care more generally and embedding it in the system as a whole rather than a specific issue to be dealt with discretely.

whereby preventable MRSA bloodstream infections should no longer be acceptable in NHS-funded services.⁵¹ To help control the level of increasingly complex MRSA infections, all cases are now subject to an urgent post-infection review to assess which organisation the case should be apportioned to, so that an investigation can be carried out and the learning shared.

By 2009/10, the total number of CDIs had achieved a reduction of 54% compared with the 2007/08 baseline.

After the CDI target had been achieved, it too was converted to an objective, with the general expectation that there would be significant continued reductions in the number of cases.⁵² Reflecting regional variation in the number of CDIs, NHS England now publishes CDI objectives for acute trusts and CCGs for each financial year. The objectives are tailored to reflect individual circumstances, and display a need for organisations with higher rates of infection to achieve more than those with lower rates.⁵³ Exhibiting the level of progress made in reducing the number of cases of CDI, NHS England acknowledged that:

‘There are indications that, for some organisations at least, the level of CDIs may be approaching their irreducible minimum level at which these infections will occur regardless of the quality of care provided.’⁵³

However, the latest *Annual epidemiological commentary* from Public Health England reports the first increase in CDIs since the introduction of mandatory surveillance in 2007. The increase is largely unexplained, although various factors are suggested as having a potential impact, including reductions in financial sanctions imposed on trusts for cases of CDI and an increase in the number of infections not being traditionally defined as hospital-onset. The commentary reflects that:

‘If increases in C. difficile infections continue in 2015/16, renewed emphasis on infection prevention and control and associated audit methodologies may be required. In addition, as the proportion of C. difficile infections in England not traditionally defined as hospital-onset increases, additional interventions in the community and primary care will need to be identified and actioned to continue to tackle C. difficile infections.’⁵⁴

3.4.2 The targets were effective for a range of reasons

The introduction of targets for MRSA and CDI was followed by a significant reduction in the number of patients affected by either one. The factors that appear to be associated with this success are discussed below. The DH announced that it intended to reduce MRSA bloodstream infection rates by employing the same approach it had used in achieving targets for waiting times – a combination of financial incentives, close performance management, and engaging senior staff.

A shift in attitudes

In the years following the introduction of mandatory surveillance and targets, there has been a cultural shift within the NHS in attitudes towards infection control and prevention. In the early 2000s, this was not afforded a platform and remained a low priority across the health care sector. But after several high-profile reports and outbreaks of HCAs, there began to be a change in the way infection control was perceived; cleanliness, hand hygiene and other evidence-based infection control interventions became a priority, and remains a regular board agenda item in most trusts today. Infection prevention and control was increasingly recognised as a joint responsibility, involving NHS staff, managers, and the government/DH.

Getting management engaged with the issue

As well as shared responsibility for tackling HCAs, many staff (according to the NAO) identified that the most important action their trust had taken to improve infection prevention and control was the development of senior management leadership and engagement with the issue.⁴¹ Trusts that saw the greatest reductions in cases of MRSA and CDI were those that demonstrated strong leadership at board level as well as effective ward management.⁴¹ This was

also reflected at a national level; the government and DH provided a ‘corporate environment’ focused on infection prevention and control wherein standards were set and monitored. This created pressure for service improvement through effective and centralised management – something that was largely missing in the quest to meet A&E waiting-time targets.

Close monitoring of performance

Close performance monitoring was introduced for MRSA in 2001 and CDI in 2004. This involved real-time reporting of infection-relevant data – a source of intelligence that NHS trusts could use to concentrate their efforts to tackle infection. The surveillance data enabled individual acute trusts to understand the pattern and prevalence of both HCAs at a local level, which proved essential for enabling change and witnessing the effectiveness of their actions, as also evidenced with the IAPT targets. Additionally, the direct reporting of MRSA and CDI data to individual NHS trust boards increased the importance attributed to controlling these infections, as it increased accountability at all levels.

Increased and centralised focus

The introduction of national targets and subsequent performance management focused the attention of the NHS on infection prevention and control. This encouraged all bodies involved in tackling HCAs to pull together and focus on a common goal, similar to the approach adopted in New Zealand¹¹⁶ to tackle A&E waiting times. This sustained national focus is also reflected in the inclusion of MRSA and CDI in domain five of the NHS Outcomes Framework 2015/16, which is used to support health care improvements.

Legislation

The change in attitude towards the importance of HCAs was cemented in legislation with the establishment of the Health Act 2006, which introduced new laws around preventing and controlling HCAs. Now, for the first time, NHS trusts were legally required to have systems in place to minimise the risk of HCAs. Two years later, under the Health and Social Care Act 2008, a revised code of practice extended the requirements for infection prevention and control to health care settings in the independent sector.

National initiatives to improve the conditions of health care settings

The HCAI targets were accompanied by a range of initiatives intended to reduce the number of cases from the ‘ground’ up. Initiatives included: ‘Saving Lives’, a programme designed to reduce HCAs including MRSA; a ‘Deep Clean’ announced by the Secretary of State to be completed by all NHS trusts by the end of March 2008; and the National Patient Safety Agency’s ‘Clean Your Hands’ campaign, which was extended to include PCT’s. The introduction of targets in a culture increasingly driven to improve patient care and infection control allowed for goals to be commonly aligned; moreover, it enabled a broader cultural change in favour of behaviours that improve prevention of HCAs.

Financial penalties

Centrally issued penalties also helped ensure that HCAI targets were viewed as the responsibility of the trust board, not just clinicians and middle management.⁵⁵ Reducing the incidence of both MRSA and CDI was one of the national measures used to calculate the quality premium for CCGs in 2013/14, which resulted in a reduction to the quality premium received if infections are attributed to their care. This measurement was removed from the quality premium for CCGs in 2014/2015 and in line with this, NHS England reduced the penalty that could be applied to each case of CDI in excess of acute targets to £10,000 (from £50,000).⁵⁵

Increased funding within the NHS

Although the factors described above have all played a considerable part in achieving the targets set for reducing HCAs, much of this work was carried out against a backdrop of increased funding within the NHS. In 2004 – the year in which the MRSA target was first introduced – expenditure on HCAs was around £6.5m. This compares to approximately £10m

spent in 2007/08, when the CDI target was introduced, and £24.5m in 2008/09.⁵⁴ The sizeable increase in resource dedicated to tackling HCAs through national initiatives, new equipment and cleaners could arguably have made the targets easier to achieve.

Latest figures (at the time of writing) indicate that the introduction of targets for MRSA have been particularly effective in shifting the focus to prevention. The *Quarterly epidemiological commentary* published by Public Health England for the first quarter of 2015 shows a general increasing trend in all reported cases of MSSA (Methicillin-susceptible *Staphylococcus aureus*) bacteraemia, with an overall increase of 16.9% from October 2011 to March 2015. Similarly, the reported rate of *E.coli* bacteraemia has increased 5.4% over the same period.⁵⁶ Neither infection has an assigned target.

As discussed above, latest figures for CDI also show a recent increase in the number of cases reported, with most cases now among non-inpatients and those not traditionally defined as having a 'hospital-onset infection'. This suggests that increased funding in acute care has had an impact on the level of infections; however, there may now be a need to focus on the community and primary care settings to continue to tackle the rate of infections.

3.5 What are the differences between England and other UK countries?

3.5.1 HCAI targets in Wales

In Wales, there have been specific targets in place for MRSA, MSSA and CDI from 2010, and since this date there have been significant reductions in rates of these infections.⁵⁷ A new national target has recently been set, which requires NHS Wales to reduce the rate of MRSA and CDI by at least 50% between April 2014 and 30 September 2015 (compared to the 2012/13 population rates). In order to achieve the national targets, the targets for each organisation will differ based on their population levels and previous incidence rates.

Public Health Wales is providing individual health boards with detailed trajectories and information on how these reduce the number of infections.

3.5.2 HCAI targets in Northern Ireland

In September 2007, the Northern Ireland Health and Social Care system introduced infection reduction targets and announced additional funding for tackling HCAs. The Public Health Agency and the Health and Social Care Board ensured that priority was given to infection prevention and control. Incidences of both infections (MRSA and CDI) have subsequently reduced significantly.⁵⁸ *The Health and Social Care Commissioning Plan Direction 2015* states that targets are to be set at a national level to reduce MRSA and CDI infections compared with the 2014/15 baseline. The targets will depend on the results of the analysis of 2014/2015 performance and benchmarking processes.⁵⁹

3.5.3 HCAI targets in Scotland

Targets have been in place in Scotland for a number of years, with a Local Delivery Plan HEAT target issued by the Scottish government Health Directorate in 2007. Rates of MRSA/MSSA have reduced dramatically since this target was introduced.⁶⁰

From 1 October 2014, all NHS Scotland boards have been submitting data to Health Protection Scotland as part of the mandatory Scottish Government Enhanced SAB Surveillance process.

The Scottish government has set a target to further reduce HCAs so that by early 2015, NHS boards' *staphylococcus aureus* bacteraemia (including MRSA) cases are 0.24 or less per 1,000 acute occupied bed days; the rate of CDIs in patients aged 15 and over should be 0.32 cases or less per 1,000 total occupied bed days.⁶¹

3.6 Key learning

Targets for HCAs were introduced in the NHS following (and partly due to) a real shift in attitude from the government towards the role of the system in preventing and controlling infection.

Embedding targets in culture change

The lower rates of HCAs shows the impact that targets can have when embedded alongside a change in organisational culture, whereby leadership is centralised, performance is monitored, and there is 'buy-in' at every level of the health care system.

Monitoring progress, enhancing accountability

Reporting of progress against targets helped to ensure that they were achieved, creating a degree of accountability for everyone involved in patient care. In this instance, the success that followed the introduction of HCAI targets suggests that such measures can have a sustainable impact if they are collectively embraced by and embedded in the system.

Financial backing

The HCAI targets were achieved against a backdrop of increased funding. The increased funding could have made the targets easier to achieve, as hospitals were able to increase resource and could finance the purchase of relevant equipment to help prevent the spread of infection.

Close management involvement

Trusts that achieved large decreases in HCAs had strong leadership at board level as well as effective ward management. This resulted in effective and centralised management – something that was largely missing for A&E waiting-time targets.

Close performance surveillance

The real-time reporting of infection-relevant data was a good source of intelligence, which NHS trusts used to concentrate their efforts around tackling infection. The surveillance data enabled individual acute trusts to understand the pattern and prevalence of both infections at a local level, which proved essential for enabling change and witnessing the effectiveness of their actions, as also evidenced with the IAPT targets. Additionally, the direct reporting of MRSA and CDI data to trust boards increased the importance attributed to controlling these infections and increased accountability.

4. Unintended consequences of performance targets: the four-hour A&E target

Key learning from this chapter

Clear guidelines are important

Some of those involved cited unclear guidance as a reason for failure to understand this target. The evidence suggests that clear guidelines are important, not only for the target itself but also for how it is implemented and how data are recorded.

Both local and national factors must be considered

Knowing about the specific characteristics that could influence performance will lead to a greater chance of success when trying to reach performance targets. It is important to maintain a national and a local view; this should be done in such a way that lines of accountability are clear and there is no confusion over local or national responsibility (as was the case in this example). In Northern Ireland, the performance target took a more complex view of A&E waiting times than in the other three UK countries, giving some consideration to outcomes. In addition, the targets were locally developed in the first instance before a national target was introduced, and this learning was beneficial to their implementation.

Using a range of metrics alongside a target can help to view it in context

Key metrics, alongside a performance target, will present a clearer picture of the state of a service and provide greater insight into the percentage result for the target. The percentage target result should not be considered in isolation; other outcomes (which may not be as easily measurable but may be significant in a positive or negative way) should be considered too. This example illustrates that learning and success cannot always be quantitatively measured, but can be gleaned if there is further exploration of the findings around a given target.

Performance targets can be a proxy for broader failure or success

Performance targets can be an important tool to trigger self-reflection and change. They can also serve as proxies of system-wide performance or at least as a red flag so that the organisations in question can be assessed in more detail (as happened in this example, which eventually led to positive change).

4.1 Introduction

Since its introduction in 2000 (for implementation by 2004), the accident and emergency (A&E) waiting-time performance target has been the focus of considerable attention and high-profile comment, including during the 2015 general election. Much of the academic and popular commentary has been negative, focusing (for instance) on an apparent potential for manipulation

(or ‘gaming’). Nonetheless, the target has led to broad improvements in terms of reduced waiting times, and has provided new insights into performance. This chapter explores the evolution of the target and learning from the evidence about its positive and negative consequences.

4.2 Background

The NHS Plan in 2000³ set a number of objectives for reduced waiting times, which were to be achieved by 2004. These were to deliver what the strategy termed a ‘war on waiting’. The following A&E target was introduced from the year 2000:

*By 2004 no one should be waiting more than four hours in accident and emergency (A&E) from arrival to admission, transfer or discharge. Trusts would need to ensure that as a minimum they maintained performance at 98% within four hours.*³

This target was described by the Department of Health (DH) as ‘ground-breaking’⁶² and more ambitious than any international equivalent. Speaking about the target in 2004, Mike Hayward, Professional Nurse Advisor for Emergency Care at the Royal College of Nursing, commented:

‘There is absolutely no doubt that the four hour target has been the single most important catalyst for effective change within emergency care. Although at times the journey has been tough, clinicians have worked together innovatively and collaboratively to directly influence and improve the delivery of patient care and experience. Emergency care teams have risen to the challenge and demonstrated how pushing the boundaries has revolutionised the emergency patient’s journey.’

This chapter discusses the learning that has emerged during implementation of the target, from its introduction until the present day (2015).

4.3 How the performance target was implemented

4.3.1 Implementing the target

There is evidence that rather than developing or amending the four-hour target, efforts were made to amend the system or situation around it so that the target could be achieved. After it was introduced, a number of programmes were implemented to try and improve the A&E experience for the patient and help NHS trusts meet the target of seeing, treating, admitting or discharging all patients within four hours of arrival at A&E, by December 2004. These included the Emergency Services Collaborative (ESC), a national programme introduced in 2002 that aimed to improve the emergency care experiences of carers and patients through enhanced working practices. The ESC involved sharing good practice to improve care and reduce waiting times. The programme appeared to be a success, with an increase from 79% of A&E attenders being seen within the four-hour target in December 2002 to 98% by December 2004. The team that led the work detailed what they felt were the critical success factors for leading national and local improvement programmes. They included the following:⁶³

- Tailoring the approach to the local context, previous achievements and challenges.
- Providing clear links to strategic deliverables, as without this the programme cannot be afforded the organisational priority it needs.
- Ensuring the programme is integral and targeted. Service improvement works best within a performance management framework.
- Linking to clinical outcomes to be clinically relevant and support governance.
- Understanding demand and capacity before embarking on whole-system programmes of change; improving management of discharge to improve timeliness of bed availability.

- Setting performance trajectories on intelligent interpretation of local data – for example, breach analysis where simple changes inform steeper trajectories. Also, rewarding sites for overall improvement through continuous improvement rather than benchmarking against others (who may already be at the required performance level and have not engaged in making any improvements to date).
- The research illustrated the importance of the context around the target and the performance management that had to take place in order for the target to be achieved and not breached.

In 2005, the House of Commons Committee of Public Accounts published a report reviewing improvements in emergency care in England.⁶⁴ It explored the positive changes that had been made by the DH to try and provide new emergency care services for the convenience of the patient, such as minor injury units and walk-in centres. Despite the services being well received, the Public Accounts Committee argued that they were mainly addressing previously unmet demand rather than taking pressure off existing A&E services. The report identified that a reduction in A&E waiting times was the improvement most patients wanted to see. The 2004 *Transforming emergency care in England* report by Professor Sir George Alberti supported this.⁶² Similarly, survey data collected by the Healthcare Commission (now the Care Quality Commission (CQC)) showed that there was a strong link between the length of time patients spend waiting in A&E and how they rate their experience overall.⁶⁵

4.3.2 The path of the target from 2005 onwards

From April 2005, the target for four-hour maximum total time in A&E was included as part of the framework of health and social care performance standards assessed by the Healthcare Commission as part of its overview of services. The four-hour target was listed as an ‘existing commitment’ in the NHS Operating Framework from 2006/07 onwards, until 2010/11, when the revised NHS Operating Framework⁶⁶ introduced changes to the measurement of waiting times in A&E departments.

In 2011, the newly elected coalition government’s Secretary of State for Health, Andrew Lansley, planned to introduce a new set of clinical quality indicators to replace the previous four-hour waiting-time target and measure the quality of care delivered in A&E departments in England. The initial intention was to pilot the indicators for emergency care, with a view to them being fully embedded from 2011/12. In the meantime, the four-hour A&E standard continued to apply. However, on clinical advice, the threshold changed from 98% to 95%.

With regard to the new indicators, the A&E Clinical Quality Indicators Implementation Guidance⁶⁷ explained that:

‘This set of indicators is part of a project to develop system indicators across the whole of urgent and emergency care. Ambulance indicators are also being developed with the same domains as the A&E indicators. With continuing development, a system will evolve that also covers the other components of urgent and emergency care including hospital based assessment units. Work is also being undertaken relating to urgent primary care and telephone-based health services. These indicators will have a commonality of topics and will help to promote greater integration and a consistent and improving level of service across the whole urgent and emergency care system.’

In July 2011, an article in the *Nursing Times*⁶⁸ reported that:

‘The government has retreated from plans to fully implement a set of performance indicators, which measure for time to initial assessment and time to treatment by a decision-making clinician – two tasks often undertaken by nurses. The indicators replaced the four hour A&E standard in April.’

This was thought to be due to concerns about the quality of data on the new indicators. NHS trusts were asked to measure only two of the new indicators and had to continue meeting the four-hour A&E target. Reflecting the continued importance of A&E waiting times to patient experience and outcomes, the target reappeared in the next Operating Framework, published in 2012/13.⁶⁹ The target was named as: PHQ23: A&E Waiting Time-Total Time in the A&E Department. The target was reaffirmed and has remained in place since.

4.3.3 Understanding A&E as part of a wider system

The four-hour target is not the only performance indicator for the urgent care system. In its 2014 report, QualityWatch (a joint research programme between Nuffield Trust and the Health Foundation)⁷⁰ noted that while the time from arrival to departure is the highest-profile performance indicator, it is not the only way of gauging the performance of an A&E department. ‘Trolley waits’ – that is, the time between the A&E doctor making the decision to admit and the patient arriving in an inpatient bed – have also increased in recent years, adding to crowding in A&E departments. A&E performance is also gauged by NHS England through measures such as the time from arrival to initial assessment, the number of patients leaving the unit without being seen, and the proportion of patients returning to A&E within seven days. Wider metrics can include the impact of A&E on other services such as ambulance diverts and cancelled operations.

As the DH acknowledged in its 2004 report, *Transforming emergency care in England*,⁶² any problems in emergency services do not exist in isolation. What happens in A&E departments can have an effect on other parts of the health system; equally, what happens in A&E is almost entirely dependent on how the whole of the local health care system is working. The way that the overall emergency care system is organised can affect the ability of A&E departments to meet waiting-time targets.

From the start, policymakers’ approach to introducing the four-hour target was to reiterate that NHS trusts must monitor the target and consider what local action was needed to solve any problems or challenges.

The 2013 Foundation Trust Network (now NHS Providers) report, *Emergency care and emergency services: view from the frontline*,⁷¹ argued that the four-hour performance target and any failures to meet it were only a proxy for system-wide performance failures. They specified that a ‘whole system approach’ was needed to tackle these issues in the longer term, and that this would require fundamental redesign of the whole pathway (including appropriate investment in primary, community and social care services and much better patient signposting to these services). The Network surveyed its members operating on the frontline of the urgent and emergency care pathway. Their response to the target was broadly positive. The report noted strong anecdotal support for the 95% A&E wait-time target as a good and effective barometer of the overall health of the whole emergency and urgent care pathway (ie, not just hospital A&E performance).

The DH report, *Transforming emergency care in England* (2004)⁶² presented a number of examples of how NHS trusts have improved their performance against the four-hour target by taking a system-wide approach (see box overleaf).

Transforming emergency care in England, Department of Health, 2004

By 2009, Airedale NHS Trust had achieved consistently outstanding performance against the four-hour A&E wait-time target, by restructuring around patient flow. 'Service working groups' were set up, focusing on one area of patient flow, such as emergency care, replacing the traditional departmental groups. The focus on patient flow led to faster treatment, which subsequently improved the patient experience of emergency care. A range of new ideas and processes were described as being key to this success:

- All senior nurses in A&E were trained as Emergency Nurse Practitioners so that they could see and treat patients instead of patients having to wait to see a doctor.
- The trust worked with Huddersfield University to develop an academic training programme for this new role.
- A&E processes were improved to speed up assessment, prioritise patients needing immediate or urgent treatment, and reduce waits for treatment or further referral.

Royal United Hospitals Bath NHS Foundation Trust saw a dramatic improvement in performance against the four-hour target by 2004. In the summer of 2001, its A&E department saw, treated and discharged only around 50% of patients within four hours. By August 2004 this figure had risen to 98.5%. Together with the minor injuries units, the overall figure reached 99.4%.

This dramatic improvement was achieved by collaborative working across all staff groups, empowering the site team to drive through changes together with senior nurses from the emergency department, medical assessment unit and surgical assessment unit. It was aided by the close involvement of consultants and Senior House Officers (SHOs), with more proactive management of discharge planning and improved documentation and information for patients.

As with Airedale NHS Trust, Basildon and Thurrock University Hospitals NHS Foundation Trust made changes to its working practices after the A&E target was introduced in 2004 to try and improve waiting times and improve their performance in relation to the target. In May 2004, the A&E department was achieving an average of 73.13% against the four-hour target of 95%. The trust recognised that it was imperative to understand the reasons for the poor performance (and identified issues around staffing and capacity) and provide solutions to address them.⁷²

The problems were seemingly addressed by the introduction of a Breach Avoidance Facilitator (BAF) role. Senior nursing staff were utilised to fill this role, providing a trouble-shooting function to help manage the A&E four-hour target. The introduction of the BAF role and an electronic handover form were considered to be the primary motivators for a rapid change in the achievement of the four-hour target.⁸³ Other developments introduced at that time included: recruiting more Emergency Nurse Practitioners; commissioning of an A&E Observations Unit; matching the human resources to the time-defined needs of the service; and introduction of a Rapid Assessment and initial Patient Treatment (RAPT) team.

While the trust introduced what appeared to be successful changes, performance against the target deteriorated a number of years later, such that in 2012, the target was missed, with 92.3% of patients attending A&E seen within four hours.⁷³ As well as failing to achieve the target, the trust was facing other significant performance issues. On 6 February 2013, the Prime Minister announced that he had asked Professor Sir Bruce Keogh, NHS Medical Director for England, to review the quality of care and treatment provided across 14 hospital trusts, of which Basildon was one.⁷³

Also in 2013, the regulator, Monitor, took action against the NHS trust, and the breaching of the A&E target was one of several reasons for this. After the Keogh Review, the trust responded and reported that there had subsequently been:

*'A concerted team effort to improve performance and reduce waiting times in A&E. Steps taken include improved bed management, additional staff and rapid assessment and treatment by a senior doctor and nurses... In addition, to further reduce patient waiting times additional evening and weekend clinics are being held.'*⁷⁴

In March 2014, Monitor lifted the licence conditions that had been enforced as part of the regulatory action, reflecting the significant improvements which had taken place, including the appointment of three additional paediatric consultants and the introduction of a dedicated children's assessment area in A&E. In addition, the CQC inspection of the hospital in 2015 found that the A&E service was improving and patients were mostly seen within the four-hour target. The trust was described as working with commissioners, GPs and other providers to ensure that pathways of care were in place to meet patients' needs.⁷⁵

In this instance, failure to achieve the A&E four-hour target was one of several indications that there were problems within the trust. Addressing the target required a range of interventions across the wider system, not simply a focus on A&E in isolation. This suggests that a target can play a role in alerting performance managers to problems as part of a wider suite of measures as well as having value in and of itself.

4.3.4 The contribution of other influences on performance

QualityWatch⁶⁹ completed analysis on pseudonymised person-level Hospital Episode Statistics (HES) A&E data from April 2010 to March 2013. The objective of the study was to assess the contribution made by three commonly cited causes of additional pressure on major A&E departments to patterns of performance on the four-hour target. These factors are:

- capacity – have occupancy rates of A&E departments increased?
- case-mix – has the age distribution or morbidity of people using A&E changed significantly?
- external factors – what impact does change in temperature and availability of GP services have on A&E targets?

In terms of capacity, the number of people being treated in England's A&E units increased by 8% between 2010/11 and 2012/13. Through analysis of routine data, QualityWatch⁷⁰ was able to estimate levels of occupancy in excess of what a department would usually expect for a given time of the week. This measure was an indication of the 'pressure' in the department and was found to be associated with longer average waiting times and increased likelihood of breaching the four-hour target. The relationship between occupancy and long waits was strong, indicating that occupancy does have an effect on likelihood to breach the waiting-time target

For case-mix, QualityWatch⁷⁰ found that A&E departments see a greater proportion of older people than they did previously and rates of attendance for older people are growing disproportionately. The change in age distribution of A&E users appears to account for 11% of the increase in breaches of the four-hour target between 2011/12 and 2012/13. Patients with long term conditions also contributed to the increase in A&E waiting times. However, the proportion of people with one or more long-term condition attending A&E did not change notably between 2010/11 and 2012/13 – which means that long-term conditions are unlikely to have contributed to the decline in performance against the four-hour target. QualityWatch also found that other expressions of case-mix showed no particular change over time.

Additionally, the QualityWatch⁷⁰ research discovered that colder temperatures are associated with longer A&E waiting times, but the effect is complex and linked to changes in attendance patterns. The winter months in 2012/13 were apparently colder than those in 2011/12, but

this alone could not explain the 19% decline in A&E performance over this period. The research found that while patient satisfaction with access to their GP appears to be linked to rates of attendance at A&E, there is no evidence for patient satisfaction being associated with achievement of the four-hour target.

In early 2015, the Royal College of Emergency Medicine reported a possible connection between the A&E four-hour target and exit block (when patients cannot be transferred from A&E to a hospital bed).⁷⁶ As of December 2014, performance against the four-hour target for all four nations of the UK was reported to have fallen significantly short. NHS England reported that in the first three quarters of 2014/15 there were more four-hour target breaches than in the whole of 2013/14. According to the Royal College, exit block can have a number of adverse consequences, including the following:

- Increased patient mortality – the magnitude of the effect is about 13 deaths a year per department seeing 50,000 patients.
- Increased length of stay of admitted patients, which only serves to exacerbate the problem.
- Delays to time-critical interventions – with less frequent and less adequate pain relief, and delayed antibiotic administration.
- Increased risk of adverse events.
- Decreased departmental function – ‘under triage’, inferior care in terms of standard performance measures and delays to departures.
- Decreased patient satisfaction.
- Increased staff stress and burnout.
- Increased number of patients whose operations are cancelled, wasting surgical capacity.

Conversely, research by Weber, Mason, Freeman and Coster (2012)⁷⁷ showed no detrimental effect on patient care due to the four-hour target. A purposive sample of 15 English A&E departments completed in 2012 was designed to establish what happened to admissions, laboratory and imaging investigations, deaths in the emergency department, and return visits before and after the four-hour target was introduced. The study concluded that the four-hour target did not result in poorer quality of emergency department care. The effect on quality (or lack of it) was likely to be related to processes implemented to guard against inadequate evaluation and unnecessary admissions. The study concluded that targets *per se* may not be harmful as long as they remain focused on the patient.

Jones and Schimanski (2010)⁷⁸ found no clear evidence that the four-hour target has had any effect on the quality of care in A&E departments in the UK. However, they raised a concern about the lack of evidence *either way* on this:

‘Given that approximately £820 000 000.00 was invested directly into EDs [A&E] in the UK from 1998 to 2007, this lack of evidence is quite remarkable.’

4.3.5 Gaming or manipulation of data

In April 2015, Dr Foster – a company specialising in supporting the health sector with data analytics – published a report⁹ detailing what it argued were ‘uses and abuses of performance data’. The A&E four-hour target was featured as an example of distortion: ‘what gets measured gets mis-managed’. The report alleged that there are numerous changes being made to patient pathways as a result of intense pressure to meet the target, but that do not lead to better care. These include: patients being held in ambulances outside hospitals to delay the ‘clock starting’; rooms and even corridors being designated as acute observation units so that patients can be

categorised as having left A&E; and patients being admitted at the four-hour point to avoid breaches of the target, where admission could have been avoided if those patients had been properly assessed.

The Dr Foster report recommended that performance management frameworks need to comprise sets of counterbalancing measures for every target, which should be designed to guard against negative consequences for patients. In the case of four-hour waits in A&E, the appropriate measures would include: ambulance queueing times; re-attendance rates; average risk scores of admitted patients or the number of patients with bottom-quartile risk scores; and number of short-stay admissions.

An example of what some term 'gaming' (or manipulation) of the A&E four-hour target took place at Nottingham University Hospital.⁷⁹ A review into the hospital in 2010 found that the back-timing of patients' discharges from A&E had been happening over at least the past four years. The review reported a number of reasons why this occurred:

- There was no system in place to ensure that the rules governing the four-hour target were followed in the A&E department.
- There had been no audit of the EDIS (electronic medical records system) since its implementation in terms of patient discharge times.
- There were inadequate systems in place within the NHS trust to enable staff to raise issues and concerns from the front line and ensure that these were known about and resolved at board level where appropriate.
- There was considerable pressure within the NHS trust to hit the four-hour target, which led to the bending of rules in terms of discharge times.
- There was a lack of formal communication and training for staff in terms of guidance on collection of data relating to discharge time.
- There was no clear chain of accountability and responsibility for the rules around discharge times, through the levels of management between the A&E department and the executive director responsible.
- Most staff believed they were following the rules.

There was no evidence that such problems affected the trust's recording of data against any other performance targets. However, all system processes relating to major national targets were subject to audit. Remedial action was taken where appropriate and there was then significant oversight by the lead primary care trust (PCT).

4.3.6 Pressure to achieve

Mid Staffordshire NHS Foundation Trust provides a very high-profile example of how performance targets can negatively affect the culture of an organisation. According to the 2013 report by the independent Francis Inquiry, which examined the causes of failings in care at Mid Staffordshire between 2005 and 2009, the board placed high priority on compliance with nationally set targets and, in particular, the four-hour A&E target.⁸⁰

The inquiry reported that pressure from senior levels down to the front line to meet the target generated fear that breaching the targets could lead to people losing their jobs. Thus, the drive to meet the waiting-time target had a detrimental effect on staff and on the standard of care delivered.⁸⁰

DH guidance on the target distinguishes between clinical exceptions to the target and breaches of it. It stated that in doubt or debate, the decision must always err on the side of patient safety and welfare. In the example of Mid Staffordshire, the inquiry found that no breaches were treated as acceptable. As a result, clinicians were making decisions based on achievement of a numerical target rather than patient welfare and service quality.⁸⁰

4.4 Was the target achieved?

Since the four-hour A&E wait target was introduced in January 2004, the percentage of people seen in A&E in less than four hours has broadly increased. The 98% target was reached in the second quarter of 2005/06. Over the next five years, performance fluctuated between 96% and 98%, and while there were large increases in the number of people using minor A&E departments, increases in major A&E attendances were small. A reduction in performance to 95% in 2010 was associated with an increase in patients waiting more than four hours in major A&Es. However, performance remained broadly in line with the new target until the second quarter of 2012/13, when waiting times began to increase. By the final quarter of 2014/15, achievement had fallen to 88% – the worst level since the target was introduced.⁸¹

While the percentage results are the focus of the four-hour performance target for A&E, they are not the only outcome from its implementation that is identified in the literature. An article by Robert Royce in *Health Service Journal* (HSJ) in 2014⁸¹ analysed the performance of 142 acute trusts against the four-hour A&E target. The review looked at major (or type 1) attendances, because they were argued to be a better representation of A&E workload than ‘all types’, which include urgent care centres and walk-in clinic patients.

Royce⁸¹ found that only 34 trusts (24%) achieved the 95% four-hour target in all three years (2011 to 2014). Four trusts failed to hit 95% in any of the 12 quarters. The number of foundation trusts that failed to hit 95% almost doubled in three years, from 26 in 2011/12 to 48 in 2013/14, out of 81 acute foundation trusts. His analysis suggested that there were few similarities between the trusts that did hit or exceed the 95% target consistently; all 10 were foundation trusts, but beyond that, similarities were reported to be hard to find. The author argues that acute trusts and commissioners had been focused on minimising four-hour target breaches.

4.5 What are the differences between England and other UK countries?

4.5.1 The A&E four-hour target in Northern Ireland

A&E waiting times were reported to be 31% higher in Northern Ireland than in England in 2003/04. Addressing this problem created a challenge for the Northern Ireland government. Performance management and target setting in A&E was reported to be poor.⁸²

The Northern Ireland Health Department had used the A&E four-hour target to measure waiting times, but this was not a national target and was not established as a performance target. This was recognised as a missed opportunity:

‘Evidence from a Departmental review showed that Northern Ireland was out performing England and Wales on the 4 hour wait indicator in 2001-2002, the Department failed to capitalise on this and establish it as a performance target.’⁸²

The Northern Ireland government recognised that causes of A&E department pressures might not be identical either within Northern Ireland or across the UK; they judged that the first step in making improvements would be to develop local strategies based on local issues. A diagnostic tool allowed trusts to break down delays into several causes, the four most common being: waiting for assessment; waiting to see a specialist; waiting for a bed; and waiting for diagnostic tests. Looking at things in this way allowed trusts to pinpoint the reasons for delays, and to use the results to make improvements.⁸³

A detailed analysis of patient flows was carried out at every A&E department, including minor injury units, from 2005 to 2007. This revealed ways in which patient flow could be improved, and from January to June 2007, trusts were required to implement a number of actions to improve waiting times.⁸³

The Northern Ireland Audit Office⁸³ report acknowledged that the targets set were focused on reducing long waits, but that there was also a risk that if attention is concentrated solely on meeting the A&E target, then less attention is paid to the timely completion of treatment for patients who could be properly managed in a shorter timescale. It was suggested that hospitals should monitor the processes within A&E and use any available benchmarking information to ensure that A&E patients do not spend any longer in the department than is clinically necessary. From April 2007, a target was introduced stipulating that no patient should wait longer than 12 hours in A&E until they are either admitted, or treated and discharged home. The target was changed in March 2008 to the following:

95% of patients who attend A&E should be either treated and discharged home, or admitted within four hours of their arrival at the department.

This performance target therefore takes a more complex view of A&E waiting times, as it considers outcomes. In addition, the targets were developed locally in the first instance before a national target was introduced.

4.5.2 The A&E four-hour target in Scotland

From the 31 December 2007 the Scottish government introduced the following target:

98% of new and unplanned return attendances at an A&E service should be admitted, transferred or discharged within four hours.

This was the measure by which the Scottish government monitored NHS boards' performance within A&E Services.

In 2013, the Scottish government introduced a new target (a HEAT target) to support the sustainable delivery of 4 hour A&E performance all year round. The first target milestone was for 95% of patients to wait no more than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment by the year ending September 2014.

From September 2013 the aim was that 98% of new and unplanned return attendances at an A&E service should be admitted, transferred or discharged within four hours. The Scottish government reported at the time that some boards were already meeting this Standard. They stated that:

'Boards at or above 95% will be expected to demonstrate progress towards the 98% Standard over the same period, and Boards at 98% will be expected to demonstrate that they will be able to sustain that position.'

The Scottish government wrote to all boards on the 25th February 2013, to inform them that this new target would begin in April 2013 (As part of the new HEAT year of 2013/14).

4.6 Key learning

The importance of guidelines

The findings of the evidence scan suggest that all stakeholders (at local and national levels) involved in trying to achieve targets need a clear understanding of how they are to be implemented, measured and recorded. For targets to be effective, it is important to monitor not just the target but also how it is implemented and how data are recorded. What emerges from the discussion in this chapter is that targets must be consistently implemented with clear

guidelines so that there is limited scope for gaming or manipulation. This suggests that a form of quality assurance is required to ensure that guidelines are being followed correctly. More than one example included in this chapter references a lack of understanding of guidelines for the correct implementation of a target.

Considering local and national factors

Research conducted by QualityWatch, which examines the factors that can affect performance around the four-hour target, highlights the importance of taking a local view, focusing on how individual NHS trusts manage their performance. Case-mix and capacity, for example, will differ for each NHS trust, and so knowing about the specific characteristics that could influence performance will lead to a greater chance of success when trying to reach targets. It is important to maintain a national and local/regional view, so that while data are reported from the trust to the national body, they are used locally to manage performance more effectively. This should be done in such a way that accountability is clear and there is no confusion over who has local or national responsibility.

Using a range of metrics

As explored in the discussion, A&E performance can be measured in many ways. These include time from arrival to initial assessment, and the number of patients leaving the unit without being seen, as well as wider metrics covering the effect on other services such as cancelled operations and ambulance services. This suggests that a range of metrics might be more appropriate for understanding a single issue such as waiting times. Where such metrics are available, they can be used alongside a single target metric to provide a fuller understanding of the target metric itself. Or, as in the examples of Northern Ireland and Scotland, a single target can include a more nuanced approach by making reference to a multi-dimensional metric.

Performance targets can be a proxy for system-wide performance

In some of the examples discussed, the A&E target appears to serve as a proxy for system-wide failures. The evidence scan shows that problems with achieving the four-hour target in particular have, on occasion, happened alongside other major problems within an NHS trust. In one case, an NHS trust was incorrectly recording information on the A&E target breaches; once this had been identified, the trust reviewed all of its processes. While the introduction of the four-hour target in some ways caused this trust some problems, it also enabled it to identify other problems that could then be resolved, so that the trust's wider performance could then improve.

The effects of the pressure to succeed

The evidence scan includes a high-profile example of the dangers of strong pressure to achieve a target. The Francis Inquiry highlighted failures at Mid Staffordshire NHS Foundation Trust, and problems due to bullying and fear, in relation to reaching the four-hour target. In this case, the target did not seem to be well understood and was used in a way that damaged rather than enriched the hospital's organisational culture. This further suggests a need to monitor the way in which targets are being implemented, and not just whether they are achieved. However, the pressure to succeed can also lead to positive consequences; there are examples of efforts to change the system or culture around the A&E performance target, such as programmes being introduced or new job roles created, which have led to positive change.

5. When targets are ambitious and prove difficult to meet: the health inequalities target

Key learning from this chapter

Complex performance targets present a greater challenge

The health inequalities target explored in this chapter drew on a wide but complex evidence base, focusing on an area with many contributing factors over which the NHS and local authorities had limited influence or control. Health inequalities have many facets and the focus on socio-economic aspects might have led to other aspects going unnoticed. The Welsh government's target was focused on health *inequities* rather than *inequalities*, based on evidence which suggested that this was where greatest impact could be achieved. The review also highlights the effect that outside influences can have (especially from England as a neighbouring country) on domestic policy.

Weak implementation can undermine the best of intentions

A key criticism of the health inequalities policy and accompanying target was that while the intentions were good, implementation and initial learning were poor. The target was often determined locally without drawing on a wider evidence base. However, there have been a number of valuable lessons learnt in the longer term from the implementation of the target itself.

Sustainable change takes time

Changes as complex as those required for reducing health inequalities can only be made over a long period of time, and outcomes may only be visible after a number of years. The evidence in this review suggests that for such ambitious and complex areas, longer-term policies, strategies and targets should be considered.

Targets that are not met can still have positive consequences

There were a number of positive consequences from the introduction of the health inequalities target, including condition-related improvements and improvements to mortality rates. This is significant, because it indicates that although the target did not achieve what it intended, there were still some positive outcomes, including on the key determinants of life expectancy.

5.1 Introduction

This chapter focuses on performance targets that were introduced to reduce health inequalities. Health inequalities are a complex issue for policy makers to address. They involve a wide range of determinants of physical and mental health and, accordingly, require a wide range of stakeholders working together to address them. It was chosen as a topic for this evidence scan as an illustrative example of when targets are ambitious and prove difficult to meet.

This chapter provides background to the complexity of health inequalities and describes the contexts in which targets were introduced, before exploring their implementation and the learning generated.

5.2 Background

'Health inequalities' refers to the differences in health status or in the distribution of health determinants between different population groups. These differences are inequitable when they can be determined as being unfair or avoidable.⁸⁴ Such differences can have a huge impact; they result in certain groups experiencing poorer health and living shorter lives. Some differences between groups that have an impact on health, such as ethnicity, may be fixed. Others are caused by social or geographical factors (also known as 'health inequities') and can be avoided or mitigated.⁸⁵

It is now generally accepted that while some health inequalities are the result of biological differences or choices made by individuals, some are pre-determined. Reflecting this, health inequality has been a key policy issue across the UK for the past 15–20 years. Analysis of life expectancy at birth by socio-economic position reveals a clear gradient. Boys whose parent(s) had an occupation classified as 'higher managers and professionals' could be expected to live 5.8 years longer than boys whose parents were classified as having 'routine and manual' occupations.⁸⁷ The Strategic Review of Health Inequalities in England (known as the Marmot Review)⁸⁶ was commissioned in 2008 by the then Secretary of State for Health to propose the most effective evidence-based strategies for reducing health inequalities in England. It reported that people living in the poorest neighbourhoods in England will, on average, die seven years earlier than those living in the richest neighbourhoods.

Life expectancy is higher in England than in any of the other three UK countries. In England, male life expectancy increased from 77.9 years in 2006–08 to 79.2 years in 2010–12. The corresponding increase for women was from 82.0 to 83.0 years. Over the same period, life expectancy at birth in Scotland (the country with the lowest figures) increased from 75.1 to 76.6 years for men and from 79.9 to 80.8 years for women.⁸⁷ All four UK countries have seen increases in life expectancy over time, albeit to varying extents. The greatest increase since 2000–02 was observed in Scotland for men (3.3 years) and in England for women (2.4 years). Conversely, the smallest increase was in Northern Ireland for men (2.6 years) and in Scotland for women (2.0 years). The Marmot Review⁸⁶ argued that tackling health inequalities was a matter of social justice, and could deliver real economic benefits and savings. It called for action to tackle the social gradient in health outcomes.

In 2005, the World Health Organization (WHO) Regional Office for Europe⁸⁸ stated that inequalities in health are a problem in all developed countries. Its report reviewed public health policies in 13 developed countries to establish how they define and measure health inequalities, and the strategic approaches adopted to tackle them. The countries studied were: Australia, Canada, Denmark, England, Finland, Ireland, New Zealand, Northern Ireland, Norway, Scotland, Sweden, the United States and Wales. The report is based on policy documents that were available up to and including October 2004. England was the only country identified as having a separate comprehensive policy on inequalities in health (at that time). WHO stated that all countries set an overarching goal to reduce inequalities in health and recognised that interventions to achieve this must tackle the macro environmental factors (income and education), the physical and social environment, as well as adverse health behaviours and access to health care.

5.3 How the performance target was developed

The Marmot Review⁸⁶ was the most recent major, independent review to explore health inequalities and make recommendations to government. Previous to this, the Acheson Report (1998)⁸⁹ was the result of an independent inquiry commissioned by the newly elected Labour government in 1997. It found that there had been little progress since the 1987 Whitehead Report, which explored the same issue. The Acheson Report called for action on a broad front, including evaluating all relevant policies in terms of their impact on health inequalities. It also reported that the living standards of poor households needed to be addressed. The Labour government subsequently introduced a number of initiatives to tackle health inequalities, including, in 2000, specific targets.

5.3.1 The introduction of health inequality targets in England

The Spending Review (2000) set a target for the Department of Health (DH) to:

Narrow the health gap between socio-economic groups and between the most deprived areas and the rest of the country, in childhood and throughout life.²

In 2002, this was revised. The new target was to:

Reduce inequality by 2010 by 10% as measured by life expectancy at birth and infant mortality.⁹⁰

The intention was to provide a focus for short-term and medium-term action, with the DH having lead responsibility. In response, the DH developed a strategic approach to tackling health inequalities, which continued during the first half of the decade. Its cross-government health inequalities strategy, *A Programme for Action*,⁹¹ was published in 2003 and called on primary care trusts (PCTs) and strategic health authorities (SHAs) to ensure that tackling health inequalities was central to their planning and performance management systems. The strategy acknowledged that it was a relatively short period in which to expect change in such persistent and long-term trends. A number of interventions were suggested, based on an analysis of available evidence, which were expected to make key contributions to achieving the life expectancy target – for example, to reduce smoking in manual social groups through extended cessation services, complementary tobacco education campaigns and other supporting interventions.

The strategy acknowledged that health inequalities cannot be tackled effectively by NHS interventions alone. It stated the importance of action at national and local levels, involving government departments, NHS organisations and local authorities.

In 2004, the DH revised the health inequalities target further:

To reduce by 2010, by at least 10%, the gap in life expectancy between 70 ‘spearhead’ local authority areas – a fixed group of areas with high levels of deprivation and poor health outcomes – and the population as a whole.

This focus on fixed ‘spearhead’ areas was seen as a practical way of focusing activity and measuring progress. Just under half (48%) of all local authority wards with the worst life expectancy were in a spearhead area. The decision to focus on disadvantaged areas with the greatest needs marked a stronger emphasis on the target and aimed to embed it into local areas that needed to see improvements most. The infant mortality aspect of the target adopted a similar approach to address the high number of infant deaths. Forty-three local authority areas with the highest number of infant deaths in the target group were identified as key to delivering this part of the target.

5.4 How the performance target was implemented

When the 2000 target was set, it was regarded as aspirational because there was little in the way of evidence available to underpin it and its implementation. The 2002 target (requiring reductions by 2010) was more tightly focused. Yet, an NAO review (2012)⁹² found that for a number of reasons, implementation of the health inequalities strategy towards the 2010 reduction specified in the target faced a number of challenges:

- It took time for the DH to embed health inequalities in the policy and planning frameworks of the NHS. Although included in 2003–06 policy and planning frameworks, key developments were the inclusion of health inequalities as a top-six NHS priority in 2006 and the associated introduction of a health inequalities performance indicator for the NHS, subject to scrutiny by SHAs.
- PCTs lacked evidence on the cost-effectiveness of interventions to prevent or reduce health inequalities relative to their other priorities.
- There was a lack of effective measures to demonstrate that the strategy was on track to deliver the target. Performance management by the DH was not based on monitoring key interventions, but focused instead on changes to life expectancy and mortality rates. As a result, it was not clear why areas were performing well or poorly, and what action was needed to address poor performance.

Prior to making the reduction of health inequalities an NHS priority in 2006, the DH had tried to better understand the drivers of life expectancy gaps for men and women and develop more robust evidence on the interventions that could have a rapid impact. From 2006–07, the DH promoted a series of actions to address health inequalities at the local level:

- It reorganised PCTs to make them more closely aligned to local authorities, which then provided a more effective infrastructure to tackle the health inequalities agenda.
- Following the 2007 Comprehensive Spending Review, SHAs were asked to actively monitor performance against a ‘vital sign’ performance indicator: designating the need to ‘reduce the inequality gap in all-age, all-cause mortality rates.’⁹³
- The NHS and local government’s performance management systems were aligned through the use of the all-age, all-cause mortality indicator in both systems (in addition, Joint Strategic Needs Assessments and Local Area Agreements – both statutory requirements from April 2008⁹⁴ – have helped to identify local need and priorities for action).
- It established the Health Inequalities National Support Team to provide support to spearhead PCTs and local authorities to tackle health inequalities.
- It made available an innovative support tool (the Health Inequalities Intervention Tool) to help PCTs and local authorities identify the causes of death that were driving local health inequalities and quantify the impact that three key interventions could have on local health inequality gaps. Work underpinning this tool began in 2001.

However, the 2012 NAO report⁹² stated that the Department of Health’s strategic direction on health inequalities was only matched by focused action (and a requirement to report that action) at the local level from 2006/07 – leaving little time for impact before the 2010 target date.

Post-2010, Buck and Maguire’s opinion (in a 2015 report by The King’s Fund⁹⁵) is that there was a loss of momentum in policy and action on health inequalities from the DH and NHS England under the coalition government. More specifically:

'The systematic performance management, support system and expertise that underpinned the former inequalities targets were dismantled. NHS England needs to address this, to expect and demand more from the NHS in terms of action on inequalities in health. But the NHS and its leadership need to go further if they are to maximise the contribution to reducing inequalities in health.'

5.5 Accountability for meeting the performance target

5.5.1 Challenges in meeting the target

From 2008/09, the Health Select Committee⁹⁶ undertook a major review of progress in addressing health inequalities. It argued that even if progress was being made and conditions were improving for the most disadvantaged groups, this would not be reflected in the target. On visits to Norway and the Netherlands, the Committee found that by having a target which explicitly aims to reduce inequalities, rather than simply improving the health of the poor, England had one of the toughest targets in the world. It was suggested that a better approach might be to focus on improving the health of the most disadvantaged groups rather than on narrowing differences.

5.5.2 The multidisciplinary nature of health inequalities

An example of how social determinants can affect health is provided in a Royal College of Nursing report in 2012,⁹⁷ which considers the association between housing and health inequalities. Many factors can affect a person's physical and mental wellbeing, including how habitable their house is (for example, whether it is dry and safe from hazards), access to services nearby, and whether their house is safe and secure. As the report notes:

*'Poor quality housing can be the cause of numerous physical and mental health problems which can result in unnecessary hospital admissions, force longer than necessary hospital stays... and ultimately cause death.'*⁹⁷

Living in cold and inappropriate conditions is thought to cause excess winter deaths, respiratory problems for children, and put adolescents at greater risk of multiple mental health problems.⁹⁸

Health inequalities are complex and can be influenced by other factors outside the control of local health services; in some cases, though, these factors have been taken into account when embedding targets. Although it was not an explicit focus of the health inequalities target, the 2008/09 Health Select Committee Inquiry⁹⁶ found evidence that some PCTs were implementing their local policies in a multidimensional way. An example was shared from Tower Hamlets. Due to its diverse population, this PCT concentrated on ethnicity and implemented patient profiling in general practices so that it could measure ethnicity in a much more comprehensive way. The PCT felt it would help them to measure equity of access and equity of health outcomes in relation to some factors that are part and parcel of their local population. In its evidence to the Committee, it stated:

*'We are not doing that because that has been a target set for us: that is because we understand that for us to be successful in what we are trying to do around health improvement that is a key component—for us to be able to understand and measure our achievements and successes in future years.'*⁹⁶

The target was underpinned by associated objectives, including one relating to reducing infant mortality: starting with children under 12 months, the aim was to reduce by at least 10% the gap in mortality between children with parents in the routine and manual group and the population as a whole by 2010. The Review of the Health Inequalities Infant Mortality PSA Target⁹⁹ (the associated objective) was published in February 2007. This was a major, cross-government, cross-agency review. It aimed to show how the DH, working with its partners,

could help deliver this target. The review contains a number of findings that are useful for our discussion. The data for 2002–04 showed that, while rates in the ‘routine and manual’ group are continuing to improve, the gap between this group and the population as a whole has widened to 19% from the target baseline in 1997–99 of 13%.

Tackling health inequalities in infant mortality at a local level was recognised to be complicated due to the relatively small numbers of infant deaths in individual localities. To help investigate local progress, the review identified the 43 local authority areas that faced the biggest challenge in reducing infant mortality in the routine and manual group. These were areas with 20 or more infant deaths in the group over a three-year period, 2002–04. Local progress in these areas was found to be far from uniform. Census data from 2001 showed that 7% of people comprising this occupation group were from black and minority ethnic communities. However, when looking at the 43 areas with the highest numbers of routine and manual group infant deaths, this proportion increased to 14%. This suggests that reductions in infant mortality for black and minority ethnic groups could have a greater impact on the target group compared to the population as a whole. This level of detail and the associated intricacies are not taken into account as part of the target.

The review team visited six local areas and three children’s centres around the country. During each visit, they interviewed a range of local NHS and local government staff to gain different perspectives. The key message from the fieldwork was that the infant mortality target was not known or understood despite individual examples of leadership and good practice.

The visits identified four challenges to delivering the target:⁹⁹

- No recognition of the target or the widening gap between the ‘routine and manual’ group and the overall population.
- Services were not fully delivering to the target group.
- Lack of leadership and systems to support delivery.
- Lack of knowledge and understanding of the target.

It is clear that if a target is not well understood, developing and implementing a plan to achieve it is difficult.

5.5.3 The importance of time

Some commentators argued that 10 years was not a sufficient amount of time to achieve the level of change suggested in the national target for 2010. Professor Sir Michael Marmot, Chair of the Marmot Review, argued that a more realistic ambition would be ‘closing the health gap in a generation.’⁸⁶

There were also concerns raised that the focus on meeting the national target (which compared average rates for whole PCTs against national averages) could mask local inequalities within a PCT’s area and population. Tower Hamlets discussed the problems it had in its diverse borough when presenting evidence to the Health Select Committee:

‘We can do the comparison of Tower Hamlets versus other PCTs in our Spearhead group over the rest of the country, but actually if we look at men living in Bethnal Green and men living in Millwall, there is a difference of eight years in terms of life expectancy. There are some interesting statistics and we are looking a bit more at this; but looking at Spitalfields, which is predominantly a Bangladeshi community, the life expectancy there for women is higher than the national average; so we have actually got some unexpected statistics.’⁹⁶

5.5.4 A lack of focus on what works

A key criticism of the health inequalities policy and accompanying target was that while its intentions were good, the implementation and learning were poor. As Professor Sally Macintyre (Director of the Medical Research Council Social and Public Health Sciences Unit) stated in her evidence to the Health Select Committee:

*'Few interventions are rolled out in ways which permit rigorous evaluation: often they lack clear or measurable goals, baseline information, cost/benefit data, and control or comparison groups or areas'*⁹⁶

The Health Select Committee,⁹⁶ in its inquiry, found that despite a 10-year push to tackle health inequalities, and despite significant government effort and investment, there was still very little evidence on which interventions actually worked. It was reported that PCTs found it difficult to make decisions about interventions with very little evidence. Many interventions were rolled out without having been evaluated.

According to several respected academics, including Professors Judge and Macintyre, the main reason for the difficulty in evaluating complex interventions lies at a far earlier stage in the policy process; insufficient thought given to the design and introduction of these policies makes meaningful evaluation impossible. It is crucial for policy and evaluation plans to be designed thoughtfully and in conjunction with one another, but this rarely happens.

*'All too often, this has not been the case and policies have been rushed in, and programmes have been manipulated, to meet political and other constraints.'*⁹⁶

The DH reviewed progress towards the target, and progress on health inequalities over the past 10 years was summed up by the Health Select Committee as: 'Much achieved; more to do.'⁹⁶

5.6 Was the target achieved?

Despite limited progress towards achieving the target, many commentators have argued that it at least brought the issue to the fore, galvanising policy makers and the health service to address a long-neglected area. The Healthcare Commission argued that missing the target should not be viewed as failure:

*'Without these targets, the situation would have been worse. In combination with the health inequalities elements of other related targets, the target has provided a focus for commissioners and service providers and has driven improvement in several areas including teenage pregnancy, infant health, tobacco control and life expectancy. We therefore congratulate Government on setting the target and establishing a Health Inequalities Unit. These were brave decisions and gave a strong message, raising the profile of health inequalities and adding to the debate.'*⁹⁶

The King's Fund recently (2015)⁹⁵ completed analysis of 'the Marmot curve', which shows 'how life expectancy and disability-free life expectancy are systematically and consistently related to differences in income deprivation across thousands of small areas in England'. The 2015 analysis updated that curve from 1999–2003 and 2006–10 and found significant improvement during these periods – the whole curve shifted upwards, reflecting improvements in life expectancy across England, while the gradient between life expectancy and income deprivation became less steep.

For 2006–10, the analysis found that having a higher prevalence of income deprivation relative to other communities seemed to have a smaller effect on a communities' life expectancy than in 1999–2003. The health inequalities target did not focus on narrowing income-related health inequalities, but on closing the life expectancy gap between spearhead local authority areas and England as a whole. Thus, this outcome was a consequence that had not been anticipated.

As highlighted in The King's Fund report,⁹⁵ the Labour government 'failed' in terms of achieving the health inequalities target, at least in a numerical sense; but it did preside over an improvement in the Marmot curve and in several areas that are key determinants of life expectancy.

5.7 What are the differences between England and other UK countries?

5.7.1 The health inequalities target in Wales

Wales differs from other areas of the UK because its health inequality policy focuses on *inequities* rather than *inequalities*. Inequity refers to 'Unfair, avoidable differences arising from poor governance, corruption or cultural exclusion' while inequality refers to 'the uneven distribution of health or health resources as a result of genetic or other factors or the lack of resources.'¹⁰⁰ The Welsh government's argued that while health inequalities can be difficult to avoid because they result from inherent differences between individuals and population groups, health inequities are aspects that can more easily be addressed.

Its 2011 Strategic Action Plan for reducing inequities in health, *Fairer health outcomes for all*,¹⁰¹ sets out a systematic approach to achieving greater health equity. It emphasises the importance of action not only among the most deprived people in a community, but across the social gradient, as well as the need for evidence to inform action.

The Strategic Action Plan claims that:

*'The Welsh Assembly Government remains committed to quality universal services which encourage and support people to flourish and to avoid poor health... the leadership and accountability of the NHS to improve health and wellbeing, and to reduce health inequities, is now central to the transformational approach to planning and delivery. This is a fundamental shift in achieving sustainable health and wellbeing for the people of Wales. At the same time... the design and delivery of key central policies and programmes is being, and will be, shaped to reduce health inequities.'*¹⁰¹

The Welsh government's aspirations were:

- By 2020, to improve healthy life expectancy for everyone and to close the gap between each quintile of deprivation by an average of 2.5%. Progress in this overarching target was linked to other health targets, such as those focused on tobacco.
- To support one of the three strategic objectives in the Child Poverty Strategy, which is to reduce the inequalities that currently exist in the health, education and economic outcomes of children and families living in low-income households.

The Welsh government pledged to take an evidence-based approach with action across the social determinants of health and across the life-course. It did, however, raise some concerns around the influence of action taken by the UK government or European Union, which they reported would either support or undermine efforts to reduce health inequities. Certain aspects such as employment, direct or indirect taxation, benefits and pensions do not come under the Welsh Assembly's remit. It stated in the plan that:

*'A particularly important area for inter-governmental dialogue relates to ensuring that people have sufficient money to lead a healthy life, as this has been recognised as a highly significant cause of health inequities.'*¹⁰¹

The approach in Wales appears to be sensible, focusing on an evidence-based method but also on health inequities rather than inequalities, as the aspect it felt it could have most impact on. The Welsh case also highlighted the effect that outside influences, especially from other countries, can have on domestic policy.

5.7.2 The health inequalities target in Scotland

Health inequalities are a significant challenge in Scotland and the Scottish government has taken action to reduce them. Their approach since 2008 has been driven by a ‘Ministerial Task Force’,¹⁰² comprising government ministers and local government together with the NHS, third sector and research community. The approach was a collective one; the plans to tackle health inequality were discussed with a range of frontline staff, managers, the public, local authorities and the business community. This reflected an acknowledgement that much of the change recommended by the Ministerial Task Force could only be generated locally, through the people in public services who work to meet their clients’ needs day in, day out.

In order to reduce inequalities in healthy life expectancy and wellbeing generally, the Ministerial Task Force¹⁰² identified certain priority areas for action:

- Children’s very early years, where inequalities may first arise and influence the rest of their lives.
- The high economic, social and health burden imposed by mental illness, and the corresponding requirement to improve mental wellbeing.
- The ‘big killer’ diseases: cardiovascular disease and cancer. Some risk factors for these, such as smoking, are strongly linked to deprivation.
- Drug and alcohol problems and links to violence that affect younger men in particular, and where inequalities are widening.

In the light of these priorities, and evidence about what causes inequalities in health, the Ministerial Task Force agreed key principles:

- Improving the whole range of circumstances and environments that offer opportunities to improve people’s life circumstances and hence their health.
- Addressing the intergenerational factors that risk perpetuating Scotland’s health inequalities from parent to child, particularly by supporting the best possible start in life for all children in Scotland.
- Engaging individuals, families and communities most at risk of poor health in services and decisions relevant to their health.
- Delivering health and other public services that are universal, but also targeted and tailored to meet the needs of those most at risk of poor health.

The Ministerial Task Force reconvened in 2010¹⁰³ to review progress. It confirmed that action should continue at national and local levels on all of the framework’s recommendations. A further review took place in 2013, and reported that:

*‘The strategy was bold, grounded in good evidence and has made progress in some areas. The improvements in the overall health of the population and the decrease in average mortality rates have continued. However, the gap between those with the best and the worst health outcomes persists and too many Scots still die prematurely.’*¹⁰⁴

It concluded that actions have been more focused on mitigating the consequences of social inequalities, like smoking and alcohol misuse, than on addressing the long-term underlying causes, such as poverty and low incomes. In 2007, the Scottish government proposed a number of health inequality targets on the basis that reducing health inequalities is a vital component of achieving sustainable economic growth. Part of the ‘population’ target commits to increasing life expectancy:

- to match average European population growth over the period from 2007 to 2017
- supported by increased healthy life expectancy in Scotland over the period from 2007 to 2017.¹⁰⁵

A 'solidarity' target aims to not only 'increase overall income' but also 'the proportion of income earned by the three lowest income deciles as a group by 2017'.¹⁰⁵

Inequality-related indicators also make up some of the national indicators being used to track progress towards the achievement of national outcomes. Examples include decreasing the percentage of the population living in poverty (including, as a separate target, decreasing the numbers of children living in material deprivation), and reducing premature mortality.

The Scottish government placed high priority on collaboration when developing its health inequality targets; it recognised the importance of engaging those people who would implement the changes needed to achieve the target. The 'task force' collaboration kept momentum behind the work. As was the case in England, reviews identified that progress had been made, but perhaps not where intended. The focus had been on mitigating the effects of social inequality rather than tackling the underlying causes of inequality. This led to an amendment of the targets to refocus efforts.

5.7.3 The health inequalities target in Northern Ireland

The Investing for Health (IfH) strategy was launched in March 2002.¹⁰⁶ It contained a framework for action to improve health and wellbeing and reduce inequalities by partnership working among departments, public and voluntary bodies, local communities, district councils and social partners. The strategy aimed to shift the emphasis from ill health to focus on prevention to tackle social, economic, physical and cultural factors.

Unlike the public health strategies of many other countries, including England, the goals, objectives and associated targets in Northern Ireland were not focused on diseases but on the wider determinants of health, including:

- educational attainment
- living and working conditions
- the wider environment
- mental and emotional health and wellbeing
- accidental death and injuries
- healthy lifestyle choices.

This was in recognition of the fact that a wide range of factors influence health and wellbeing.

The strategy was developed collaboratively by a cross-departmental group of senior officials from all Northern Ireland government departments.

In the first year, it focused on developing the processes and structures necessary to ensure successful implementation. Its introduction led to the creation of cross-departmental strategies and action plans and a number of new initiatives.

Health impact assessment

As well as introducing the strategy, the Northern Ireland government also built in monitoring and pilots. When endorsing IfH, all departments agreed to assess and evaluate the health implications of significant new policy developments in order to minimise the harm to health and maximise the benefits of those policies.

The IfH programme was described in a research study and compared to an identified example in Spain¹⁰⁷ as:

‘...working well operationally; what it has lacked is political and interdepartmental leadership. The positive experiences of Barcelona in seeking to reduce health inequalities show that “a strong and permanent political commitment”, alongside an evidence base and the instruments for effective intervention, is critical to success.’

In 2004, the Department of Health, Social Services and Public Safety published its 20-year vision for health and wellbeing, *A Healthier Future*.¹⁰⁸ The document removed the aspect of time from the targets. Life expectancy was now to be improved towards the EU level by an unspecified amount, and the broad social thrust of the original targets – which spanned poverty, education, housing, the environment and lifestyle – was narrowed to a focus on life expectancy alone.

A whole-system strategic framework for public health 2013–23¹⁰⁹

This 10-year public health strategic framework builds on the IfH strategy. A shared set of values was proposed to underpin action, based on the following principles:

- Social justice, equity and inclusion: all citizens should have the right to the highest attainable standard of health.
- Engagement and empowerment: individuals and communities should be fully involved in decision making on matters relating to health, and empowered to protect their own health, making best use of assets.
- Collaboration: public policies should contribute to protecting and improving health and wellbeing, and public bodies should work in partnership with local communities and interest groups.
- Evidence-informed: actions should be informed by the best available evidence and should be subject to evaluation.
- Addressing local need: actions should be focused on individuals, families and communities in their social and economic context.

To support the strategy, a monitoring framework was developed. Data and research groups were set up to support it, and a set of key indicators was agreed to facilitate high-level monitoring of progress. The information from the indicators will be publicly available.

5.8 Key learning

The lack of knowledge and evidence base

When the 2000 target was set, it was regarded as aspirational because there was little in the way of evidence available to underpin it as a focus for performance management, and to inform its implementation. It took time for the DH to embed health inequalities in the policy and planning frameworks of the NHS, leaving little time for impact before the 2010 target date.

The evidence review suggests that the introduction and implementation of the target has progressed along with the understanding of health inequalities. Health inequalities are now more well-known and discussed and have become part of the language of the NHS and of local government.

Weak implementation can undermine the best of intentions

A key criticism of the health inequalities policy and accompanying target was that while its intentions were good, implementation and early learning were poor. Much of the learning was in the later stages of implementation, some years after the target was introduced.

However, despite the lack of evaluation and issues around implementation of measures to address the target, a number of valuable lessons can be learnt. It is possible that the policy would not have been driven forward without a target to draw attention to the issue, and to measure or at least raise questions about progress. Progress, however, takes time, which is also needed for learning to emerge.

In contrast to England, Wales took an evidence-based approach that led to a focus on health inequities rather than inequalities. The Scottish government placed high priority on collaboration when developing its health inequality targets, acknowledging the importance of engaging those who would be implementing the changes needed to achieve the target.

It takes time to deliver sustainable change

Several commentators have drawn attention to the time required to make any real and sustainable change in reducing health inequalities. It is only now, in 2015, according to analysis by The King's Fund, that any benefits or changes are becoming apparent. What is clear is that changes as complex as those related to health inequalities and the social determinants of health will not be rapid.

Positive consequences of the performance target

There were a number of positive consequences of the introduction of the health inequalities target, including condition-related improvements and improvements to mortality rates. This is important, because it suggests that while the target did not achieve what it intended (in terms of a percentage reduction in the life expectancy gap), it still achieved positive outcomes and had a positive impact on the key determinants of health.

6. International case studies

The tables below provide details of key learning from four international cases studies, focusing on performance targets in Belgium, Germany, the Netherlands and New Zealand.

International learning on performance targets

Belgium, Flanders

Target type: Preventive measures

Background	Key learning from the literature
<p>Belgium was identified as a case study because of the Local Health Networks (LHNs) created in 1998 to help reach targets (focusing on preventive action) collaboratively with health organisations working at the local level. The Flemish government brought together key stakeholders with a role in promoting health to form the LHNs. The networks lead health promotion at the district level and are made up of existing structures and local initiatives (including health and welfare workers). LHNs work closely with the Flemish Institute of Health Promotion and Sickness Prevention, targeting groups including 'schools, working environments, local communities and the underprivileged'.¹¹⁰</p>	<ul style="list-style-type: none">• Studies accessed as part of the review suggested that some targets were vague and could not be measured, suggesting a need for clear and well-defined baseline measures.¹¹¹• The literature discussed a lack of effective monitoring of some performance targets in Belgium and concerns were also raised about the lack of (or late development of) implementation plans.• There was also a reported lack of clarity with regards to ownership. If accountability is not clear, then it is less likely that responsibility will be taken for achieving the targets (or not).

Germany: North Rhine-Westphalia

Target type: Health target programme

Background	Key learning from the literature
<p>Germany was chosen as a case study because it was understood that targets are set collaboratively through a conference, which brings together key stakeholders (such as local politicians, health professionals, health insurers and welfare organisations). In 1984, the WHO set its targets 'health for all by the year 2000' followed, in 2000, by 'Health for all in the 21st Century'. Literature identified for this case study highlights how these WHO targets were used as a basis for the development of health targets in Germany.</p>	<ul style="list-style-type: none"> • In 1993, North Rhine-Westphalia started to develop its health target programme. The key instrument was the State Health Conference (SHC), which established working groups with implementation steps, links to actors, specific time frames for implementation and 'quantification and development of evaluations'.¹¹² • The SHC has 'passed numerous joint resolutions with concrete recommendations for the various partners in health topics of principle [sic] importance'.¹¹² The model has since been implemented in towns and cities across Germany. • A 'cancer control' target gave rise to concerted action against breast cancer. 'For the first time quality assurance and a structured approach took place. This has only been possible thanks to the existence of quality criteria and common health targets'.¹¹³

Netherlands

Target type: Patient care-centric indicators

Background	Key learning from the literature
<p>The Netherlands was chosen as a case study due to the collaborative setting of targets outside of government control, as well as increased accountability resulting from their use. The Dutch health system is not provided by the state (as in the UK) but is based on a social insurance system. Care is provided by private self-employed practitioners and private/not-for profit organisations. Quality standards are not imposed by the government, and so in order to define indicators, there needs to be collaboration and negotiation among the different stakeholders in the system.¹¹⁴ Three regulated markets have been introduced: health insurance market, purchaser market and health care market. Obligatory hospital performance indicators for patient safety and clinical effectiveness were developed in 2003 by the Dutch Health Care Inspectorate (aiming for feasibility). In doing so, indicators provided actual data on performance from all Dutch hospitals and are published online.</p>	<ul style="list-style-type: none"> • The structure of indicator setting is outside of government control. All key stakeholders are required to participate. • Steering Committees 'negotiate and implement national agreements per health sector about indicators for external accountability'.¹¹⁵ This structure has led to information on performance that was not previously available. Dutch hospitals must submit self-calculated performance indicator scores to an inspectorate, which are then published. They are made publicly available online.

New Zealand

Target type: The introduction of a six-hour waiting-time target, based on the UK four-hour target

Background	Key learning from the literature
<p>The six-hour target emerged from an influential report by the Working Group for Achieving Quality in Emergency Departments in 2008.¹¹⁶ This group was a key outcome of a national workshop attended by 70 health sector representatives, arguably the first ‘visible’ national and multidisciplinary endeavour in New Zealand to discuss and explore the issue of emergency department (ED) service quality.¹¹⁶</p> <p>‘All District Health Boards (DHBs) who run the country’s public hospitals must ensure that 95% of patients will be admitted, discharged or transferred to an ED within six hours.’ This is the first time that a comprehensive health policy and performance target focused on ED length of stay has been introduced at a national level in New Zealand’s health sector.</p>	<ul style="list-style-type: none">• The literature reviewed suggests that the target improved visibility of, and accountability for, the problem of ED overcrowding. Nonetheless, some health care professionals interviewed in Chalmers (2014)¹³⁹ felt that the target is too generous, arguing that six hours is still too long to wait.• Some literature identifies how the target empowers ED staff to progress patients and escalate problems. It has reduced the placing of patients in ED corridors, providing them with certainty about their length of stay and a more efficient visit.• The target has also reportedly improved department efficiency, brought in extra resources and made better use of existing resources, and improved learning and development. It has also improved relations between services and professionals.• Other analysis identifies: gaming behaviour (usually in the form of inappropriate stopping of the target clock, or altering the status of the ED admission); micromanagement behaviours; wards in chaos; and risks to medical teaching activity, standards of clinical care and responsibilities of the hospital. Thus, there is no consistent picture of the target’s effectiveness.

7. Conclusion

This evidence scan has reviewed the trajectory of key health care performance targets in the UK to elicit learning from their development and implementation, as well as briefly considering other approaches used in different countries. This conclusion summarises the key findings, with reference to the examples of wider literature included in chapter 1.

Performance targets in the NHS have had a high profile since their introduction in 2000. Much of the comment and debate has focused on negative rather than positive impacts, especially concerning targets that were not met. But if we are to really learn from targets and their impacts, a more nuanced discussion is required.

It is important to acknowledge that a target does not have to have been met to be successful; rather, a good target measures what it was intended to achieve and provides intelligence for performance management during its implementation.

Targets that prove problematic tend to have some common features. This review has shown that some are intended to be aspirational when they are conceived, but this is not always clear in their implementation; thus the debate around them may focus on achievement *per se* rather than any progress made.

Targets are also problematic when they are poorly planned or draw on a limited evidence base – perhaps when rushed in response to an emergent issue. Investments may be made in changing practices to meet targets in cases where achievement is unlikely or extremely challenging. This evidence scan has discussed examples where targets were changed after problems were revealed. It finds that where an iterative approach is taken, with targets amended in light of learning during implementation, success is more likely. The evidence in this review shows that the aspiration to achieve the target can lead to positive change in terms of organisational culture, but embedding this change can take considerable time.

Suggesting that a performance target ‘does not work’ on the basis of whether it is achieved may mean that positive consequences go unrecognised. Targets can be considered successful if they highlight poor care or bad practice, enabling those problems to be investigated further. Performance targets can increase accountability and transparency, but only when introduced and implemented appropriately. Understanding targets as broad ‘indicators of performance’ can focus attention on processes as well as outcomes.

This evidence scan has demonstrated the complexity involved in developing, implementing and embedding successful performance targets in the health system. The examples from across the UK and internationally show that the different ways in which targets are introduced have implications for their effectiveness. The themes discussed below appear to be most strongly associated with success.

7.1 Clarity

The evidence shows that where there is a lack of clarity around the purpose of the target, problems are likely to arise. Negative outcomes such as gaming or manipulation may be more likely when guidelines for meeting the target are not clear. Guilfoyle (2012)¹ also draws attention to the fact that complexity can lead to different interpretations of targets. A lack of clarity may also be understood as a consequence of poor consultation and understanding of context, including of the wider evidence base.

For a target to be successful at a national level and comparable across different settings, it must be implemented consistently, with clear guidelines and appropriate monitoring. The need for clarity was highlighted in the Belgian, German and Dutch literature reviewed. The Belgian case study included in this evidence scan highlights the failure of targets that were not accompanied with clear strategies to achieve them. The Dutch example shows how ambiguous targets lead to different interpretations and therefore different indicator scores. These and the German case study highlighted the need for greater transparency in target setting, with clear baseline measures.

7.2 Collaboration and consensus

UK experiences and international examples illustrate the importance both of initial consultation when creating a target and ongoing review during implementation. Early consultation with those tasked with implementation helps to pre-empt any problems that might become apparent once a target is established. Collaboration requires more detailed, longer-term engagement that reflects a longer-term working relationship. Collaboration can be used in piloting and testing targets to develop the evidence base and to learn in more detail about issues that may arise during fuller implementation. Consultation and collaboration is important at all levels: with staff on the front line, but also with those in more strategic positions who will be using the results to performance manage and /or aide decision making, as well as being accountable to NHS bodies.

The evidence scan shows that targets were most successful when they took an iterative approach from the start and made changes during implementation based on what had been learnt. The State Health Conferences organised in Germany and the Local Health Networks in Belgium illustrate positive structures for collaborative working when setting targets. Such collaboration may temper the 'dysfunctional consequences' of performance targets in health identified by Mannion and Braithwaite's (2012) review.⁸

7.3 A robust evidence base

This evidence scan has shown the importance of a robust evidence base for targets that are clearly linked to policy. An evidence base can help shape a target that can be implemented effectively and is clearly related to practice. Outcomes data from the psychological therapies pilot provided a solid basis for programme design and implementation, as well as performance management.

Where pilots are not completed or the subject area is not well understood or researched, then targets risk being problematic. The health inequalities target covered multiple areas of policy and practice; despite a strong evidence base across these areas, the target was not developed in the joined-up way that this suggested. The evidence generated when a target is implemented can provide important learning if kept under review, both in terms of the processes affecting the achievement of a target (or otherwise) but also for understanding what constitutes good or bad performance against aspirational goals.

7.4 Target governance

For a target to be successful in changing practice, there must be clear lines of accountability at all levels. Performance needs to be managed at a local level, with ownership of the target and the practice that informs it. There needs to be accountability from the local to regional or national levels, so that at the broader system level, performance can be monitored and action taken where it is required.

There are some examples within the review where accountability was not clear or there were tensions between different levels of the system. Clarity around governance from the outset, with regular review, addresses this risk. Hauck and Street (2007)⁵ argued that their analysis, comparing Welsh and English hospitals, showed how structured performance management improves care outcomes.

For health care-associated infections, the targets created a degree of accountability for everyone involved in patient care. The review suggests that strong leadership and close monitoring, which enabled changes to practice, produced positive results.

7.5 Understanding context

The health inequalities target provides a good example of how an understanding of the context is fundamental for the design and implementation of an effective target. Health inequalities are determined by a complex set of variables, the relationship between which is not fully understood. The initial health inequalities target in England did not fully consider this complexity and was consequently operationalised as an aspiration.

By way of contrast, the Welsh government chose to focus on health *inequities* rather than *inequalities* as the evidence base suggested this was an area where action could have greatest impact. The institutional and practice contexts for targets should also be considered. In the case of psychological therapies, training needed to be introduced to establish the intervention before a target was introduced. Changes in practice clearly have resource implications that need to be considered and explored during the consultation stage of target design.

Finally, understanding the broader context is also important in learning from the success (or otherwise) of performance against a target. Infection prevention and control targets (for MRSA and CDI) were established in a climate of political expediency supported by a high level of resourcing, creating a context in which they were more likely to succeed.

The indicators used in the Netherlands are a good example of how wider context can shape the design of indicators. Targets are not set by government; instead, a collaborative approach involves all key stakeholders negotiating to set targets (rather than a stated ideal).

7.6 The use of a wide set of metrics

A set of metrics alongside a performance target will present a clearer picture than a single measure. The greater the insight, the better the understanding of performance and of what can be done to improve outcomes. While any single numerical performance metric is important, focusing on these in isolation may miss wider system influences and consequences. This echoes the argument of Bevan and Hood (2006): that one part should not be taken to represent the whole.⁷

Annex 1: Evidence scan search terms

Section 1: Context – search terms

Please note each term will be repeated for England, Scotland, Ireland and Wales; and, for each of the comparator countries.

- Healthcare performance targets
- Healthcare performance indicators
- Healthcare performance targets successes
- Healthcare performance targets challenges
- Healthcare performance indicators successes
- Healthcare performance indicators challenges
- NHS targets successes
- NHS targets challenges
- Impact of NHS targets
- Impact of healthcare performance targets
- Impact of healthcare performance indicators
- Learning from NHS targets
- Learning from healthcare performance targets
- Learning from healthcare performance indicators

Section 2: Creating and embedding targets – search terms

- England, Northern Ireland, Scotland and Wales (as separate search terms and in combination with):
 - improving access to psychological therapies
 - improving access to psychological therapies policy
 - improving access to psychological therapies target
 - psychological therapies 50% recovery rate target
 - access to psychological therapies for 15% of people

- England, Northern Ireland, Scotland and Wales (as separate search terms and in combination with) Psychological therapies AND [search term]:
 - capacity
 - recovery rates
 - targets
 - policy
 - improvement in the quality of care
 - public engagement
 - better access
 - better outcomes

- England, Northern Ireland, Scotland and Wales (as separate search terms and in combination with) Psychological therapies targets AND [search term]
 - performance management
 - difficulties in setting
 - reaching
 - gaming of/ manipulation of
 - achievement of
 - outcomes of
 - governance of
 - monitoring of
 - inequality in the setting of
 - inequality in the reaching of

Section 3: When targets are successful and lead to quality improvement – search terms

- England, Northern Ireland, Scotland and Wales (as separate search terms and in combination with) MRSA AND:
 - infection control target
 - performance indicator
 - quality improvement
 - improvements in rate of infection
 - reaching infection control target
 - changes to infection control target
 - success of infection control target
 - public engagement with the target
 - performance management of target
 - disincentive to improve target
 - gaming of/ manipulation of target
 - achievement of target
 - outcomes of target
 - monitoring of target
 - governance of target

- England, Northern Ireland, Scotland and Wales (as separate search terms and in combination with) Clostridium Difficile AND:
 - infection control target
 - performance indicator
 - quality improvement
 - improvements in rate of infection
 - reaching infection control target
 - changes to infection control target
 - success of infection control target
 - public engagement with the target
 - performance management of target
 - disincentive to improve target
 - gaming of/ manipulation of target
 - achievement of target
 - outcomes of target
 - monitoring of target
 - governance of target

Section 4: Unintended consequences of performance targets – search terms

- England, Northern Ireland, Scotland and Wales (as separate search terms and in combination with)
 - 24 hour primary care professional target
 - seeing a primary care professional within 24 hours
 - seeing a GP within 48 hours
 - 48 hour appointment with a GP target
 - improving access to primary care

- England, Northern Ireland, Scotland and Wales (as separate search terms and in combination with) [search term] AND primary care targets:
 - changes to
 - removal of
 - consequences of the removal of
 - achievement of
 - policy for
 - improvement in the quality of care
 - public engagement in amendment of
 - performance management of
 - difficulties in setting
 - difficulties in maintaining
 - gaming of/ manipulation of
 - reasons for removing
 - reaction to the removal of
 - effect on patient care of the removal of
 - outcomes of the
 - governance of the
 - monitoring of the
 - inequality in the setting of
 - inequality in the reaching of
 - A&E 4 hour target.

- connection with the A&E 4 hour target.
 - changes to the 4 hour A&E target
 - removal of the 4 hour A&E target
 - reinstatement of the 4 hour A&E target
 - reason for removal of the 4 hour A&E target
 - consequences of the removal of the 4 hour A&E target
 - achievement of the 4 hour A&E target
- England, Northern Ireland, Scotland and Wales (as separate search terms and in combination with) the 4 hour A&E target AND
 - policy
 - improving access to A&E
 - improvement in the quality of care
 - public engagement
 - performance management
 - difficulties in setting the target
 - difficulties in maintaining the target
 - gaming of/ manipulation
 - removing the target
 - reaction to the removal of the target
 - effect on patient care of the removal of the target
 - effect on patient care of not reaching the target
 - outcomes
 - governance of
 - monitoring of
 - inequality in setting
 - inequality in reaching

Section 5: When targets are ambitious and prove difficult to meet – search terms

Target: Reduction in health inequalities

Description: By 2010 to reduce inequalities in health outcomes by 10 % as measured by infant mortality and life expectancy at birth.

- England, Northern Ireland, Scotland and Wales (as separate search terms and in combination with) health inequality AND
 - policy
 - life expectancy target
 - infant mortality target
 - life expectancy measurement
 - infant mortality measurement
 - mortality gap in children under one years old
 - reducing gap in life expectancy in local authorities
 - reducing gap in life expectancy in areas with poor health outcomes
 - deprivation indicators
 - target
 - quality improvement
 - approach
 - barriers to changes

- amends to targets
- reason for not achieving target
- consequences of not achieving target

- England, Northern Ireland, Scotland and Wales (as separate search terms and in combination with) health inequality target AND
 - improvement in the quality of care
 - public engagement
 - performance management
 - difficulties in setting
 - difficulties in achieving
 - gaming/manipulation
 - successes of
 - components of
 - changes to/reason for changes to
 - outcomes
 - governance
 - monitoring
 - inequality in setting
 - inequality in reaching

- England, Northern Ireland, Scotland and Wales (as separate search terms) AND
 - health outcomes equity gap

International examples search terms

New Zealand search terms

- New Zealand (in combination with) A&E target; AND:
 - achievement
 - policy
 - improving access
 - public engagement
 - performance management
 - difficulties
 - gaming
 - manipulation
 - Primary care.
 - quality measures
 - patient care
 - outcomes
 - governance
 - monitoring
 - inequality in the setting of healthcare targets
 - inequality in the reaching of healthcare targets

Germany search terms

- North Rhine Westphalia (in combination with) healthcare target: AND:
 - achievement
 - outcomes
 - governance
 - monitoring
 - policy
 - public engagement
 - performance management
 - gaming of/ manipulation
 - quality measures
 - good patient care
 - outcomes
 - governance
 - monitoring
 - inequality in the setting of healthcare targets
 - inequality in the reaching of healthcare targets

- North Rhine Westphalia (in combination with):
 - healthcare targets creation
 - healthcare targets collaboration
 - healthcare targets responsibility

Belgium search terms

- Flanders Belgium (in combination with):
- Health promotion
- Flanders Belgium (in combination with) [search term] AND healthcare targets:
 - health promotion
 - collaboration
 - creation
 - achievement
 - outcome
 - responsibility
 - governance
 - monitoring
 - policy
 - access
 - public engagement
 - performance management
 - gaming of/ manipulation
 - quality measures
 - good patient care

Netherlands search terms

Please note targets are predominantly called performance indicators in the Netherlands.

- Netherlands (in combination with) healthcare AND performance indicators AND:
 - patient organisation involvement
 - public involvement
 - accountability
 - collaboration
 - process of creating performance indicators
 - achievement
 - outcome
 - responsibility for performance indicators
 - governance
 - monitoring
 - lack of achievement of
 - policy
 - performance management
 - difficulties in setting
 - difficulties in maintaining
 - gaming of/ manipulation of
 - quality measures
 - good patient care

Annex 2: Search results

The following diagrams illustrate the process of selecting the literature to use for the evidence scan. The initial figure is the literature found based on the search terms entered for each theme. The subsequent figures are based on subsequent review of the literature and selection of the most relevant for each theme. For the international searches, the most relevant results for each search are included in the first number.

Context

74 → 25 → 9

Creating and embedding targets

359 → 101 → 44

When targets are successful and lead to quality improvement

242 → 90 → 19

Unintended consequences of targets

324 → 68 → 22

When targets are ambitious and prove difficult to meet

393 → 350 → 68 → 36 → 25

International case studies

Netherlands

21 → 11 → 5 → 8

New Zealand

6 → 5

Germany

12 → 5 → 1

Belgium

4 → 4 → 4

Annex 3: Key performance indicators (KPIs)

- Vital signs indicators – more people accessing treatment.
- Extending access to NICE-compliant services – half of those who leave treatment moving to recovery.
- Helping people back to work – fewer people on sick pay and benefits.
- Building a skilled workforce – newly trained high- and low-intensity workers.

Collection of the data was via the NHS Health and Social Care Information Centre's web-based system, Omnibus. The Omnibus system allowed real-time access to the data via a web portal. Data were collected from PCTs on a quarterly basis, with the first return at the end of December 2008. These data were available to strategic health authorities (SHAs) and the DH, and formed the basis of reports to the IAPT National Programme Board.¹¹⁷

The KPIs used are set out in Table A1.

Table A1 Key performance indicators

Performance indicator number	Performance indicator description
KPI 1	The number of people who have depression and/or anxiety disorders obtained from the Psychiatric Morbidity Survey
KPI 2	The number of people diagnosed with depression or anxiety obtained from GP Practices data systems.
KPI 3a	The number of people who have been referred for psychological therapies during the reporting quarter. This KPI is referred to as SQU16_03 in the Technical Guidance for the 2011/12 Operating Framework.
KPI 3b	The number of active referrals who have waited more than 28 days from referral to first treatment/ first therapeutic session (at the end of the reporting quarter).
KPI 4	The number of people who have entered psychological therapies (i.e. had their first therapeutic session) during the reporting quarter). This KPI is referred to as SQU16_01 in the Technical Guidance for the 2011/12 Operating Framework.
KPI 5	The number of people who have completed treatment (minimum two treatment contacts) during the reporting quarter, broken down by age and sex.
KPI 6a	The number of people who are 'moving to recovery' (of those who have completed treatment, those who at initial assessment achieved 'caseness' and at final session did not) during the reporting quarter.
KPI 6b	The number of people who have completed treatment not at clinical caseness at initial assessment.
KPI 7	The number of people moving off sick pay or benefits during the reporting quarter. IAPT KPI guidance 2011-12 v2.2.

Annex 4: Evidence scan references

- 1 Guilfoyle S. On target? Public sector performance management: recurrent themes, consequences and questions. *Policing*. 2012;1–11 doi:10.1093/police/pas001 (accessed 17 July 2015).
- 2 Department of Health. *The NHS Plan: a plan for investment, a plan for reform*. London: Department of Health, 2000.
- 3 Boyne GA, Chen AA. Performance targets and public service improvements. *Journal of Public Administration Research and Theory*. 2006;17:455–477 doi: 10.1093/jopart/mul007 (accessed 17 July 2015).
- 4 Micheli P, Neely A. Performance measurement in the public sector in England: searching for the golden thread. *Public Administration Review* 2010;July/August: 592–600 doi: 10.1111/j.1540-6210.2010.02180.x (accessed 17 July 2015).
- 5 Hauck K, Street A. Do targets matter? A comparison of English and Welsh health priorities. *Health Economics*. 2007;275–290 doi: 10.1002/hec.1153 (accessed 17 July 2015).
- 6 Willcox S, Seddon M, Dunn S, Edwards RT, Pearse J, and Tu JV. Measuring and reducing waiting times: a cross-national comparison of strategies. *Health Affairs (Millwood)*. 2007;26(4):1078–87. doi: 10.1377/hlthaff.26.4.1078 (accessed 17 July 2015).
- 7 Bevan G, Hood C. What's measured is what matters: targets and gaming in the English public health care system. *Public Administration*. 2006;84(3):517–538.
- 8 Wheeler DJ. *Understanding Variation: The Key to Managing Chaos*. Tennessee. SPC Press, 2000.
- 9 Mannion R, Braithwaite J. Unintended consequences of performance measurement in healthcare: 20 salutary lessons from the English National Health Service. *Internal medical journal*. 2012; 5: 569–574 doi:10.1111/j.1445-5994.2012.02766.x (accessed 17 July 2015).
- 10 Shaw J, Taylor R, Dix K. *Uses and abuses of performance data in healthcare*. Dr Foster, 2015.
- 11 Department of Health. *Organising and delivering psychological therapies*. London: Department of Health, 2004.
- 12 National Institute for Health and Care Excellence (NICE). *Anxiety: Management of Anxiety (Panic Disorder, With and Without Agoraphobia, and Generalised Anxiety Disorder) in Adults in Primary, Secondary and Community Care. Clinical Guideline*. London: NICE, 2004.
- 13 National Institute for Health and Care Excellence (NICE) *Depression: Management of Depression in Primary and Secondary Care. Clinical Guideline*. London: NICE, 2004.
- 14 National Institute for Health and Care Excellence (NICE) *Obsessive – Compulsive Disorder: Core Interventions in the Treatment of Obsessive – Compulsive Disorder and Body Dysmorphic Disorder. Clinical Guideline 31*. London: NICE, 2005.
- 15 National Institute for Health and Care Excellence (NICE) *The Management of PTSD in Adults and Children in Primary and Secondary Care. Clinical Guideline 26*. London: NICE, 2005.
- 16 National Institute for Health and Care Excellence (NICE) *Computerized Cognitive Behaviour Therapy for Depression and Anxiety. Technology Appraisal 97*. London: NICE, 2006.
- 17 Department of Health. *IAPT three-year report. The first million patients*. London: Department of Health, 2012.
- 18 Bell, S., Clark, D., Knapp, M., Layard, R. Lord; Meacher, M. C., Priebe, S., Thornicroft, G., Turnberg, L. A. and Wright, B. (2006), *The Depression Report: A New Deal For Depression and Anxiety Disorders*, (London: London School of Economics).
- 19 Clark DM. Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *International Review of Psychiatry*. 2011; 23: 375–384. www.iapt.nhs.uk/silo/files/clark-2011-implementing-nice-guidelines-the-iapt-experience.pdf (accessed 17 July 2015).
- 20 Department of Health. *Talking therapies: a four-year plan of action*. London: Department of Health, 2011.
- 21 Department of Health. *Improving Access to Psychological Therapies. Specification for the commissioner-led Pathfinder programme*. London: Department of Health, 2007.
- 22 Department of Health. *Improving Access to Psychological Therapies. Implementation Plan: National guidelines for regional delivery*. London: Department of Health, 2008.
- 23 Improving Access to Psychological Therapies. Re: Changes to KPI 3b and 4. www.iapt.nhs.uk/silo/files/clarification-kpi-guidance-201213-feb.pdf (accessed 28 July 2015).
- 24 Mind. *We still need to talk. A report on access to talking therapies*. London: Mind, 2013. www.mind.org.uk/media/494424/we-still-need-to-talk_report.pdf (accessed 6 October 2015).
- 25 Royal College of Psychiatrists. *Second Round of the National Audit of Psychological Therapies for Anxiety and Depression (NAPT)*. London: Royal College of Psychiatrists, 2013.
- 26 Department of Health. *Health and Social Care Act 2012*.
- 27 NHS England. *Improving Access to Psychological Therapies (IAPT) waiting times guidance and FAQs*. London: NHS England, 2015.

- 28 Health and Social Care Information Centre. *Reports from IAPT*. www.hscic.gov.uk/iaptreports (accessed 17 July 2015).
- 29 Dorman F. *Better access to talking therapies. What are the options?* Health Foundation blog, 10 April 2015. www.health.org.uk/blog/better-access-talking-therapies-what-are-options (accessed 17 July 2015).
- 30 NHS Wales. *Information standard development proposal for new or changed information standard waiting times for psychological therapies*. Welsh Assembly Government, 2007.
- 31 Welsh government. *Mental health measure*. Cardiff: Welsh government, 2010.
- 32 NHS Wales. *Psychological Therapies in Wales: policy implementation guidance*. Cardiff: NHS Wales, 2012.
- 33 Welsh government. *Review of access to, and implementation of, psychological therapy treatments in Wales*. Cardiff: Welsh government, 2012.
- 34 Welsh government. *Together for mental health – a strategy for mental health and wellbeing in Wales*. Cardiff: Welsh government, 2015.
- 35 NHS Scotland. *Delivering for mental health*. Edinburgh: Scottish Executive, 2006.
- 36 Education for Scotland. *Mental health in Scotland: a guide to delivering evidence-based psychological therapies in Scotland*. The Matrix, 2008.
- 37 NHS National Services Scotland. *HEAT target overview*. www.isdscotland.org/Health-Topics/Quality-Indicators/HEAT/ (accessed 17 July 2015).
- 38 NHS National Services Scotland. *Psychological therapies Heat access target*. 2010.
- 39 NHS National Services Scotland. *Mental Health homepage*. <http://www.isdscotland.org/Health-Topics/Mental-Health/> (accessed 17 July 2015).
- 40 NHS Education for Scotland. *A Guide to delivering evidence-based Psychological Therapies in Scotland*. The Scottish Government, 2011.
- 41 National Audit Office. *Reducing healthcare associated infections in hospitals in England*. London: National Audit Office, 2009.
- 42 House of Commons Public Accounts Committee. *Reducing Healthcare Associated Infection in Hospitals in England Fifty-second Report of Session 2008–09*. House of Commons, 1999.
- 43 NHS Choices. *MRSA infection*. www.nhs.uk/conditions/MRSA/Pages/Introduction.aspx (accessed 17 July 2015).
- 44 NHS Choices. *Clostridium difficile*. www.nhs.uk/conditions/clostridium-difficile/pages/introduction.aspx (accessed 17 July 2015).
- 45 National Audit Office. *Improving patient care by reducing the risk of hospital acquired infection: a progress report*. London: National Audit Office, 2004.
- 46 National Audit Office. *The management and control of hospital acquired infection in acute NHS trusts in England*. London: National Audit Office, 2000. www.nao.org.uk/wp-content/uploads/2000/02/9900230.pdf (accessed 7 October 2015).
- 47 Healthcare Commission. *Investigation into outbreaks of Clostridium difficile at Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust*, 2006. www.buckinghamshirehospitals.nhs.uk/healthcarecommission/HCC-Investigation-into-the-Outbreak-of-Clostridium-Difficile.pdf (accessed 17 July 2015).
- 48 Duerden B. Contribution of a government target to controlling Clostridium difficile in the NHS in England. *Anaerobe*. 2011;17(4):175–179. 10.1016/j.anaerobe.2010.12.004. (accessed 17 July 2015).
- 49 Duerden B. MRSA: why have we got it and can we do anything about it? *Eye*. 2011;26(2):218–221. DOI:10.1038/eye.2011.314. (accessed 28 July 2015).
- 50 Office for National Statistics. *Deaths involving MRSA: England and Wales, 2008 to 2012*. London: Office for National Statistics, 2013.
- 51 NHS England. *Zero tolerance – guidance on the post infection review*. London: NHS England, 2015.
- 52 Royal College of Nursing. *Infection prevention and control within health and social care: commissioning, performance management and regulation arrangements (England)*. London: Royal College of Nursing, 2013.
- 53 NHS England. *Clostridium difficile infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation*. London: NHS England, 2015.
- 54 Public Health England. *MRSA, MSSA and E. coli bacteraemia, and C. difficile infection: annual epidemiological commentary*. (Up to January–March 2015). London: Public Health England, 2015.
- 55 Deloitte blog. *How targets helped reduce healthcare associated infections in English hospitals*. 16 April 2015. <http://blogs.deloitte.co.uk/health/2015/04/have-targets-reduced-healthcare-associated-infections.html> (accessed 28 July 2015).
- 56 Public Health England. *Quarterly Epidemiological Commentary: Mandatory MRSA, MSSA and E. coli bacteraemia, and C. difficile infection data (up to January–March 2015)*. 2015.
- 57 Welsh Healthcare Associated Infection Programme (WHAIP). *Clostridium difficile and Staphylococcus aureus bacteraemia monthly update*. www.wales.nhs.uk/sites3/page.cfm?orgid=379&pid=67899 (accessed 28 July 2015).
- 58 Health Protection Scotland (HPS). *Staphylococcus aureus bacteraemia quarterly report*. Glasgow: Health Protection Scotland, 2012.
- 59 Department of Health. *Social Services and Public Safety. The Health and Social Care Commissioning Plan Direction (Northern Ireland) 2015*. www.dhsspsni.gov.uk/2015-16-commissioning-plan-direction.pdf (accessed 6 October 2015).
- 60 Health Protection Scotland. *Healthcare associated infection annual report 2013*. Glasgow: Health Protection Scotland, 2014.
- 61 The Scottish government. *Preventing healthcare infections*. www.gov.scot/Topics/Health/Services/Preventing-Healthcare-Infections (accessed 28 July 2015).
- 62 Alberti P. *Transforming emergency care in England. A report by Professor Sir George Alberti*. London: Department of Health, 2004.
- 63 Institute for Healthcare Improvement. *Leading improvements in emergency flow*. NHS Modernisation Agency improvement story. www.ihl.org/resources/Pages/ImprovementStories/LeadingImprovementsinEmergencyFlow.aspx (accessed 28 July 2015).
- 64 Department of Health. *Improving emergency care in England. Sixteenth report of session 2004–05*. House of Commons Committee of Public Accounts, 2005.
- 65 Care Quality Commission. *Accident and emergency survey 2014*. London: Care Quality Commission. www.cqc.org.uk/content/accident-and-emergency-survey-2014 (accessed 28 July 2015).
- 66 Department of Health. *The Operating Framework for the NHS in England 2010/11*. London: Department of Health, 2010.
- 67 A&E Clinical Quality Indicators Implementation Guidance. London: Department of Health, 2010.

- 68 Calkin S. Trusts struggling with new A&E indicators. *Nursing Times*. <http://www.nursingtimes.net/nursing-practice/specialisms/accident-and-emergency/rcn-trusts-struggling-with-new-ae-indicators/5031990.article> July 5 2011. <http://m.nursingtimes.net/5031990.article> (accessed 28 July 2015).
- 69 Department of Health. *The Operating Framework for the NHS in England 2012/13*. London: Department of Health, 2013.
- 70 Blunt I. *Focus on: A&E attendances. Why are patients waiting longer?* London: QualityWatch/ the Health Foundation and Nuffield Trust, 2014
- 71 Foundation Trust Network. *Emergency care and emergency services 2013: view from the frontline*. London: Foundation Trust Network, 2013.
- 72 Cronin JG, Wright J. Breach avoidance facilitator – managing the A&E 4-hour target. *Accident and Emergency Nursing*. 2006;14(1):43–48 www.ncbi.nlm.nih.gov/pubmed/16377191 (accessed 28 July 2015).
- 73 NHS. *Report for Basildon and Thurrock University Hospitals NHS Foundation Trust Review into the Quality of Care & Treatment provided by 14 Hospital Trusts in England, 2013*.
- 74 Basildon and Thurrock Hospital. Monitor lifts trust licence conditions. www.hsj.co.uk/Journals/2014/08/22/c/q/a/PR-08-14-Monitor-lifts-licence-conditions.pdf (accessed 28 July 2015).
- 75 Care Quality Commission. *Basildon and Thurrock University Hospitals NHS Foundation Trust, quality report*. Essex: Care Quality Commission, 2014.
- 76 The Royal College of Emergency Medicine. *Exit Block in Emergency Departments – 6-month review*. London: Royal College of Emergency Medicine, 2015.
- 77 Weber EJ, Mason S, Freeman JV, Coster J. Implications of England's four-hour target for quality of care and resource use in the emergency department. *Annals of Emergency Medicine*. 2012;60(6):699–706. DOI: 10.1016/j.annemergmed.(accessed 17 July 2015),
- 78 Jones P, Schimanski K. The four hour target to reduce Emergency Department 'waiting time': a systematic review of clinical outcomes. *Emergency Medicine Australasia*. 2010; 22(5):391–398. doi: 10.1111/j.1742-6723.2010.01330. (accessed 17 July 2015).
- 79 Ken J CBE, Derek E, Colclough, S and Williamson, S. *Review into the Four Hour Emergency Access Reporting at Nottingham University Hospital Final Report*. Somerset: Deardon consulting limited. 2010
- 80 Robert Francis QC. *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 Volume I*. London: The Stationery Office, 2010.
- 81 Royce R. Four hours in A&E: what the target tells us about trusts. *HSJ, June 4 2014*. www.hsj.co.uk/four-hours-in-ae-what-the-target-tells-us-about-trusts/5071094.article#VbiOGPIVhBc (accessed 28 July 2015).
- 82 Department of Agriculture and Rural Development. *Northern Ireland Strategy Plan For Implementation Of The EU Rural Development Regulation In 2007 – 2013*. Northern Ireland Government. 2007
- 83 Northern Ireland Audit Office. *Transforming emergency care in Northern Ireland*. Belfast: The Stationery Office, 2008.
- 84 World Health Organization. *Social determinants of health*. www.who.int/social_determinants/en/ (accessed 28 July 2015).
- 85 National Institute for Health and Care Excellence (NICE). *Health inequalities and population health. NICE briefing LGB4*, London: NICE, 2012.
- 86 The Marmot Review. *Fair society, healthy lives. Strategic review of health inequalities in England post-2010*. London: The Marmot Review, 2008.
- 87 Office for National Statistics. *Statistical bulletin: life expectancy at birth and at age 65 by local areas in the United Kingdom, 2006-08 to 2010-12*. www.ons.gov.uk/ons/rel/subnational-health4/life-expec-at-birth-age-65/2006-08-to-2010-12/stb-life-expectancy-at-birth-2006-08-to-2010-12.html?format=print (accessed 28 July 2015).
- 88 Crombie I, Irvine L, Elliott L, Wallace H. *Closing the health inequalities gap: an international perspective*. Denmark: WHO Regional Office for Europe, 2005. www.who.int/social_determinants/resources/closing_h_inequalities_gap.pdf (accessed 7 October 2015).
- 89 Department of Health. *Independent inquiry into inequalities in health report*. Chairman: Sir Donald Acheson. London: The Stationery Office, 1998.
- 90 House of Commons Committee of Public Accounts. *Tackling inequalities in life expectancy in areas with the worst health and deprivation. Third report of session 2010–11*. London: The Stationery Office Limited, 2012.
- 91 Department of Health. *Tackling health inequalities: a programme for action*. London: Department of Health, 2003.
- 92 National Audit Office. *Tackling inequalities in life expectancy in areas with the worst health and deprivation*. Department of Health: London, 2010.
- 93 Department of Health. *Operational plans 2008/09-2010/11 (Implementing the 2008/09 Operating Framework) National Planning Guidance and 'vital signs'*. London: Department of Health, 2008.
- 94 Department of Health. *Joint Strategic Needs Assessment*. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/JointStrategicNeedsAssessment/DH_086692 (accessed 28 July 2015).
- 95 Buck D, Maguire D. *Inequalities in life expectancy: changes over time and implications for policy*. London: The King's Fund, 2015.
- 96 House of Commons Health Committee. *Health inequalities. Third report of session 2008–09*. London: The Stationery Office Limited, 2009.
- 97 Royal College of Nursing. *Health inequalities and the social determinants of health*. London: Royal College of Nursing, 2012.
- 98 Marmot Review Team. *The health impacts of cold homes and fuel poverty*. London: Friends of the Earth and the Marmot Review Team, 2012.
- 99 Department of Health. *Implementation plan for reducing health inequalities in infant mortality: a good practice guide*. London: Department of Health, 2007.
- 100 Global Health Europe. *Inequity and inequality in health*. www.globalhealthurope.org/index.php/resources/glossary/values/179-inequity-and-inequality-in-health (accessed 28 July 2015).
- 101 Welsh Assembly government. *Fairer health outcomes for all: reducing inequities in health Strategic Action Plan*. Cardiff: Welsh Assembly government, 2008.
- 102 The Scottish government. *Equally well: report of the Ministerial Task force on health inequalities*. Edinburgh: The Scottish government, 2008.
- 103 The Scottish government. *Annual report of the Chief Medical Officer*. Edinburgh: The Scottish government, 2010.

- 104 NHS Scotland. *Health inequalities policy review for the Scottish Ministerial Task Force on health inequalities*. Edinburgh: NHS Scotland, 2013.
- 105 The Scottish government. *Population targets*. www.gov.scot/About/Performance/scotPerforms/purpose/population (accessed 28 July 2015).
- 106 Northern Ireland Department of Health, Social Services and Public Safety. *Investing for health*. Belfast: Department of Health, Social Services and Public Safety, 2002.
- 107 Wilson R, Oliver Q. *A picture of health? Tackling health inequalities in Northern Ireland*, 2007. www.robinwilson.eu/sites/default/files/PictureofHealth.pdf (accessed 7 October 2015).
- 108 Northern Ireland Department of Health, Social Services and Public Safety. *A healthier future*. Belfast: Department of Health, Social Services and Public Safety, 2004.
- 109 Northern Ireland Department of Health, Social Services and Public Safety. *Making life better, a whole system strategic framework for public health, 2013–2023*. Belfast: Department of Health, Social Services and Public Safety, 2014.
- 110 Gerkens S, Merkur MS. Belgium. Health system review. *Health Systems in Transition*. 2010;12(5):1–266. doi: <http://eprints.lse.ac.uk/29128/> (accessed 28 July 2015).
- 111 Van den Broucke, cited in Wismar M, McKee M, Ernst K, Srivastava D, Busse R. *Health targets in Europe: learning from experience*. Denmark: World Health Organization, on behalf of the European Observatory on Health Systems and Policies, 2008.
- 112 Weihrauch, B. Health targets as a means of a rational health policy in North Rhine-Westphalia. *The European Journal of Public Health*. 2000;10(4):34–37. http://dx.DOI.org/10.1093/eurpub/10.suppl_4.34 (accessed 17 July 2015).
- 113 Institute for Advanced Studies. *Health system watch quarterly IV 2005*. 2005.
- 114 Delnoij DMJ, Rademakers J, Groenewegen PP. The Dutch consumer quality index: an example of stakeholder involvement in indicator development. *BMC Health Services Research*. 2010;6(10):88. doi: 10.1186/1472-6963-10-88 (accessed 17 July 2015).
- 115 Wollersheim H, Hermens R, Hulscher M, Braspenning J, Ouwens M, Schouten J, Marres H, Dijkstra R, Grol R. Clinical indicators: development and applications. *The Journal of Medicine*, 2007;(65)1:15–22. www.researchgate.net/publication/6510929_Clinical_indicators_Development_and_applications (accessed 17 July 2015).
- 116 Ministry of Health. *Working Group for achieving quality in emergency departments. Recommendations to improve quality and the measurement of quality in New Zealand emergency departments*. Wellington: Ministry of Health, 2008.

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK.

Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

We make links between the knowledge we gain from working with those delivering health and health care and our research and analysis. Our aspiration is to create a virtuous circle, using what we know works on the ground to inform effective policymaking and vice versa.

We believe good health and health care are key to a flourishing society. Through sharing what we learn, collaborating with others and building people's skills and knowledge, we aim to make a difference and contribute to a healthier population.

The Health Foundation
90 Long Acre
London WC2E 9RA

T 020 7257 8000
E info@health.org.uk

Registered charity number: 286967
Registered company number: 1714937

For more information, visit:

www.health.org.uk

Follow us on Twitter:

www.twitter.com/HealthFdn

Sign up for our email newsletter:

www.health.org.uk/enewsletter