Have targets done more harm than good in the English NHS?

James Gubb argues that the focus on targets has ignored underlying problems important to patient care but **Gwyn Bevan** believes it has resulted in real improvements in care

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YES One of the most pervasive beliefs in government is that quality in the NHS is a function of individuals who need buttons pressed and levers pulled by targets to deliver optimal performance.[1] This is misguided. The most intractable problems in health care—the lack of communication, leadership, and teamwork; the lack of integration; and the lack of any meaningful, patient focused, quality framework—are systemic or cultural.[2-5] And targets have only made them worse. If you treat people like knaves and pawns, they will behave like them.[6]

Perhaps the most influential management revolution of the past century was led by Taiichi Ohno at Toyota.[7] Systems or "lean" thinking saw Toyota become the world leader in manufacturing; applied to health care it is again showing the way. Flinders Medical Centre in Australia was one of the first to take up the principle and after two and a half years was doing 15-20% more work, with fewer safety incidents, on the same budget, using the same infrastructure, staff, and technology. More recently, Bolton NHS Trust, using less space and fewer resources, reduced its average turnaround time in pathology from over 24 hours to 2-3 hours.[8 9]

Wrong focus

Lean thinking exposes the fallacy of targets. Premised on value to the customer, local leadership, and looking at systems as a whole, lean thinking aims to improve flow and eliminate waste across a system by getting the right things to the right place, at the right time, in the right quantities.[10] Targets do exactly the opposite: they devalue the customer (patient) by focusing attention on an arbitrary number, devalue local leadership by relying on central control, and break systems into silos by focusing attention on parts rather than the whole.

Emergency medicine is a case in point. Although official statistics show that 98% of patients were seen in under the four hour target,[11] academics have used queuing theory—a mathematical analysis of waiting time statistics—to show this can have been achieved only by "the employment of dubious management tactics."[12] Well documented examples, confirmed in surveys by the British Medical Association,[13] include moving patients

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NO John Major's government introduced targets as standards for hospital waiting times and ambulance response times to emergency calls in 1991 as part of *The Patient's Charter*.[1] The regime of star ratings tested the efficacy of taking targets seriously. The regime applied to the NHS in England from 2001 to 2005[2] and was unusual because it rewarded success and penalised failure in a process of naming and shaming. It replaced a system of perverse incentives that penalised success and rewarded failure—for example, by rewarding hospitals with long waiting lists with extra money to bail them out.[3] In Wales and Scotland, however, a system of perverse incentives continued.[4 5]

The charter standard for ambulance response times—that 75% of category A calls (those for conditions that may be life threatening) be met within eight minutes—applied in England from 2001[6] and will apply for Scotland from April 2009[7]; for Northern Ireland, the target was 70% by March 2008,[8] and for Wales, 65% for 2008-9.[9] The charter standards for maximum hospital waiting times (for 1995) were six months for GP referral to a first outpatient appointment and 18 months for hospital admission for inpatient or day case treatment.[10] For Northern Ireland, by March 2009, the targets are 9 weeks for a first outpatient appointment and 13 weeks for hospital admission.[11] For the other countries, targets apply from GP referral to hospital admission and are 18 weeks for England (by December 2008)[12] and Scotland (by 2011)[7] and 26 weeks for Wales (by 2009).[13] The English NHS has had the most demanding targets and the best performance over the period when star ratings applied to ambulance response times (from 2002) and hospital waiting times (from 2001) (see table on bmj.com); despite the English NHS having the lowest spend per capita.

Four detailed studies have consistently confirmed the comparative excellence of performance in England under the regime of star ratings. Scotland's published statistics on hospital waiting times are not comparable with those of other UK countries. However, Propper and colleagues used rigorous econometric analysis of three different datasets to compare outcomes from England's "stringently-monitored targets policy with associated sanctions for failure" with those from the Scottish system of "aspirational and

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to clinical decision units, making patients wait in ambulances, admitting patients unnecessarily, discharging people too early, and miscoding data.[12 14 15] All are detrimental to patient care, yet politically charged league tables show only those that do not meet the target.[16]

Critics will say that this was a badly designed target, or that audit should have been more effective.[15] Indeed, studies have shown targets inducing change and delivering against their narrowly defined goals.[15 17] Waiting times have fallen for inpatients, outpatients, in accident and emergency, and across the referral to treatment pathway; increases in staff numbers and facilities typically exceeded targets set out in the NHS Plan; and rates of meticillin resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* infection are falling.

However, it is the wider impact we should be concerned with. What you can't see and measure doesn't exist. The target is met and taken as evidence of good performance, but its true impact is concealed. After targets were introduced for inpatient and outpatient waiting times, median waits increased, waiting time was shifted to diagnostics,[14] and bed occupancy rose to levels associated with excessive risk of infection.[18] Yet the government's solution was to search for the right target—and introduce further targets for 18 week referral to treatment and infection rates for MRSA and *C difficile*—rather than understand the extent of the problems they cause.[19]

Undermining staff

The most pernicious outcome of this has been on the ability of organisations to develop a self improving culture that truly puts patients at centre stage. Pressure to score short term goals has left measurement associated with spin, selection, and punishment, rather than the ability to learn.[3] When only 26% of accident and emergency staff view figures submitted by their department as a fair reflection of performance,[13] meaningful analysis of service development becomes incredibly difficult.[20] The four hour target is met, but who is asking why the patient was in the emergency department in the first place, whether the patient is actually on the road to recovery, and whether the rapid transfer from accident and emergency has actually just left the patient waiting elsewhere (and for longer)?

The preoccupation with hitting targets results in the actual journey an individual patient experiences becoming secondary; performance is determined against crude indicators, not the expectations and experience of those using the service.

The American statistician W Edwards Deming once warned that 97% of what is important either isn't measured or isn't measurable.[21] Good medicine is premised on values—on kindness, caring, good communication, honesty, and, above all, trust.[22] When clinicians are seeing numbers, not the patient—and believe targets have undermined clinical decision making—such values are left in a parlous state at precisely the time when the most pressing challenge facing the NHS is to revive the first purpose of clinical medicine: to relieve human suffering.[23-25] Measurement should be focused on the culture we are trying to create, not the culture we are trying to escape from. Targets suit politicians, not patients.

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historical targets with no associated sanctions and little bite."[14] They concluded that the "regime in England lowered the proportion of people waiting for elective treatment relative to Scotland." Willcox and colleagues compared governments' attempts to reduce waiting times in Australia, Canada, England, New Zealand, and Wales from 2000 to 2005 and concluded that "England has achieved the most sustained improvement, linked to major funding boosts, ambitious waiting-time targets, and a rigorous performance management system."[15]

The Auditor General for Wales identified the cause of longer waiting times in Wales than England as ineffective performance management and called for "more robust incentives and sanctions to drive continuous improvement in waiting time performance."[4] The auditor also described how the failure of the Welsh ambulance services to meet the 75% target had resulted in less demanding targets being set, which had also been missed, and identified systemic weaknesses in performance management.[16]

Tackle gaming

My analyses of the star ratings system have always pointed out improvements in reported performance and dysfunctional consequences. There is evidence of three types of gaming: neglect of what has not been targeted (such as, value for money), manipulation of data (for waiting times and ambulance response times), and "hitting the target and missing the point" (for example, by cancelling and delaying follow-up outpatient appointments, which were not targeted).[2 17-19] Labour's target regime is the worst system ever invented, except for all the others. Gaming does not mean that we ought to reject targets but rather that they are being taken seriously; we should therefore make audit and random checks on gaming practices integral to an effective regime of targets.

Conservative policies for the NHS are to scrap Labour's top-down process targets and replace them with outcome measures, implying that there is a policy choice between the two.[20] But better outcomes follow from treating ill people more quickly, particularly for diagnosis or treatment of cancers[21] and ambulance response times to category A calls.[22] Most of the evidence contradicts the hypothesis that longer hospital waiting times in Wales have enabled it to achieve better outcomes than in England. Wales has higher mortality from causes considered amenable to health care, coronary heart disease, stroke, and diabetes[23] and lower rates of admission to

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stroke units, which will result in poorer outcomes.[24] Detailed analysis of four hospitals along the border found the Welsh hospital had the highest mortality and, unlike in the English hospitals, mortality was increasing.[25]

Private enterprises recognise the "bottom line" as a constraint, but that success comes from pursuit of other objectives. The targets that the NHS in England are now required to achieve for hospital waiting times and ambulance response times are what we ought to expect from a modern well funded NHS, and are the equivalent of the "bottom line" for private enterprises. As the Darzi review recognises,[26] the next logical step is to maintain these standards but focus on continuing to improve clinical outcomes to narrow the gap with international benchmarks.[27]

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