

Measuring our NHS: transforming Scotland's approach

Our National Health Service is one of Scotland's most treasured assets. It delivers critical services across Scotland 365 days a year.

Yet how we measure what the NHS does and the difference it makes is in itself a significant challenge. The BMA Scotland view is that the current system and narrative around measuring NHS activity is based on an oversimplified view of what constitutes 'success' and more often 'failure' and fails to reflect the complexity, range and sheer scale of all the NHS does.

Monitoring the performance of NHS and measuring what it does is a vital part of running the whole system. It can help identify pressures, gaps in resource, increased demand and if data from that is used properly that will help to produce targeted solutions that benefit both patients and healthcare professionals.

It is neither realistic or desirable to propose that we would stop measuring, recording and assessing NHS activity. Indeed, the positives associated with setting evidence based goals and aims and associated targets has helped deliver improvements in resources and treatment pathways – although that risks those being in isolation rather than considering the whole healthcare system. There is also no argument that patients should be given a transparent and realistic indication of how long it will take for them to get the treatment they need and that such a system should strive to eradicate inappropriately lengthy waits for investigation or treatment.

However, those positive aspects aside, BMA Scotland believes we do need a wholesale shift in approach which moves away from a blunt focus on targets which doesn't take account of clinical need, and a simplistic narrative that either considers waiting times targets in total for all conditions, or focuses on only one clinical area in a 'cherry picking' fashion.

A key contribution this debate came from BMA President Elect, Prof Dr Sir Harry Burns' [Review of targets and indicators for health and social care in Scotland](#) which BMA Scotland believes remains absolutely relevant today and deserves both fresh consideration, and renewed action.

At the heart of the review was the simple premise that you need to know what you want the system to achieve before then setting out what you should measure.

In the review's own words:

'If we are to adopt a rational system of targets and indicators for health and social care, we need to agree the aim of the system, the outcomes which would deliver that aim, and we need to understand what action could be taken that would deliver those outcomes. Once we know the drivers of improvement, we can then identify the indicators that would reassure us that improvement is taking place. Once the indicators are known to provide useful information, targets for improvement might be set.'

As Scotland approaches the 2021 election, we would urge all those setting out proposals on measuring our NHS to heed these words and adopt this approach. It is only by fundamentally reassessing our asks of the NHS that a much-improved system of measurement, focussed on outcomes can be effectively designed.

There is no doubt this will be challenging for politicians seeking vote winning soundbites. But to again refer to the Burns' review:

'Permission to change the amount of managerial and political capital invested in targets is needed in order to rebalance the current, disproportionate focus on delivering against targets over other priorities. The totemic status of targets means strong political leadership from the centre of government will be necessary to make such changes stick.'

Of course, we do not start with a blank sheet of paper – although there is an appeal in the idea of starting afresh. Equally we accept the political reality and indeed the crucial role of scrutiny of what our NHS does, how it performs, and then informing what improvements could be made.

It is from that point that we ask all political parties, ahead of next year's election, and following the huge impact of COVID to engage in careful and mature consideration of how we measure the activity of our NHS. In the BMA's view, this should begin by ending the narrative of targets entirely. From this base we should ask what we want our NHS to achieve in its entirety and then set out a system of measurement that flows from those overall aims.

Equally, the BMA know that parties will be considering specific proposals. When they are doing that, we ask that they consider the following four key principles that again draw on the findings of the Burns review – which put simply are:

- Is a proposal realistic?
- Is it evidence-based and outcome focussed?
- Have health and care staff been involved in designing the aim?
- Does it take into account impact and relationship with other parts of health and social care.

To consider each of these in more detail:

1 Is this a realistic proposal and are the resources – both staffing and financial in place, long term to ensure it can be achieved?

We must be sure that what we ask of our NHS is realistically achievable.

Some of the current targets are based on 100 per cent, blanket achievement. For any organisation, let alone one as complex as the NHS, it is simply not possible to work on such a basis. It is neither achievable, but it is also simply not right to treat all patients the same. Of course, people should expect to be seen in a timely fashion, but simply pushing everyone through on the same timescales gives no room to ensure urgent cases are prioritised. It also provides an all too ready opportunity to apportion blame and suck in resources attempting to improve performance against what are completely unrealistic aims – and purely for purposes of presentation. This spending can be a short term, quick fix solution that is made in isolation, focussed purely on improving one measure. We would question whether this spending actually improves patient experience – or adds greater value than if it was spent elsewhere.

How we measure our NHS is often set without any involvement, let alone impact assessment on staff, or a clear plan which demonstrates the indicators are deliverable within both the staffing and financial resources available. Pre-pandemic there were growing and worrying consultant vacancies, yet no account of that seemed to be taken in terms of the suite of targets in place. Equally there were plans to recruit another 800 GPs – demonstrating the substantial issues in primary care. On that basis, pledges on targets simply must take staffing levels into account. In terms of finances, Audit Scotland found the NHS was struggling to become financially sustainable, while boards are continually asked to make efficiency savings they find harder and harder to deliver. In that environment, demanding the NHS meets aims that are based on what might make a good soundbite, yet take no account of resources available are completely unacceptable and a change of direction is urgently needed.

2 Is the proposal evidenced based and does it provide insight on the quality of care delivered, or patient safety and outcomes for patients?

For far too long targets have been set based simply on quantity and timing, giving no indication of quality, safety or outcomes. The percentage of people seen within a certain time – particularly for elective care – gives a very blunt measurement of how the system is performing. It says nothing about the quality of care delivered, or the outcomes of those receiving care. While for some conditions, such as cancer, speed of treatment is clearly vital, the BMA is not aware of any clinical evidence that blanket treatment targets for all conditions provides any insight of improved outcomes or a healthier population. Equally such measurement – particularly in isolation doesn’t provide insight on what the reasons are for not meeting an aim, and how improvements might be delivered. Yet these figures are often used to assess whether the NHS in Scotland is succeeding or failing. Conversely, if the population becomes less healthy as attention is devoted simply to through-put, the target itself becomes even harder to achieve.

3 Have health and social care staff been involved in developing the measurement proposal and does it allow for considered clinical input to ensure judgement of doctors is valued and relevant?

The BMA view is that too often targets have been 'done too' health and social care staff, rather than 'developed with' them.

As Prof Dr Sir Harry Burns review pointed out:

'They [Health and Social Care staff] are more likely to feel valued and empowered if they have been involved in shaping indicators and targets and are given responsibility and recognition for developing new approaches and using them to improve care.'

Involving staff in considering the best measures for our NHS, rather than imposing them, then handing out blame when they are not met, needs to be at the heart of our future approach.

Equally, a target culture, has in the BMA view, been used in recent years to supersede the views of clinicians in some circumstances. Simply setting a blanket approach to a time within which a patient may be seen takes little account of the need to prioritise some cases, while others may not prove so damaging to health if left longer – accepting people have a right to timely care. It can mean those cases approaching a deadline are seen urgently, simply as there is a concern they may breach the target. Equally some patients may wish to take time to consider what is best for them in terms of treatment, and whether they wish to receive it at all, given the personal circumstances they may be in. Finally, given the often complex nature of diagnosis, there may well be value in taking time to ensure that the right decisions on treatment are made, in consultation with the patient. All this means the push to meet targets can also lead to pressure placed on clinical judgement – at a time when there are still serious issues with culture in our NHS that remain to be addressed. Not only that, it can also reduce patient choice and input, the very people targets are meant to benefit.

To further highlight the Burn's review:

'[Treatment Time] guarantees, therefore, cut across clinical judgement, and can interfere with patient choice. Another problem with a fixed target is that there is a risk that patients with less serious conditions who may be close to breaching the target are treated before patients with serious conditions whose clinical priority for treatment is greater. The guarantee, in that case, comes before clinical priority. That should not be the case.'

The clinical input to measuring our NHS should also be an iterative process. Fixed goals tie systems to aims that may become less and less realistic as circumstances develop. The impact of COVID illustrates that starkly. But equally, external elements such as public spending cuts – like those dictated by the period of austerity this country experienced – can impact on what is and isn't achievable. In contrast, areas or teams that achieve aims can experience complacency and stop seeking the continuous improvement required.

4 Does the target recognise a whole system approach – and acknowledge the potential impact on other parts of the NHS and care system across Scotland?

When implementing targets or measurement, it is important to consider the impact across the whole system. Does devoting resource to seeing all patients within 12 weeks impact on the ability to tackle issues with delayed discharge? Do the aims set out by the IJBs work effectively in the context of targets in secondary care?

To quote the Burns' review:

'Targets tend to focus attention of only one element of a system and may divert attention away from other areas requiring attention which, as well as being other aspects of the hospital setting, includes available care and support within the community.'

For too long targets have been set and judged in isolation. This has fostered again a culture of blame or failure when one particular target is missed, and then a short-term approach to fixing the immediate issue which is most high profile in the media and public discourse at that time. Instead, a more rounded judgement of all the complex, interacting factors are required. That should include the health of the population and more measurement of 'upstream' prevention issues. We should stop blaming the NHS for not meeting targets when demand is growing out of all proportion of what it can be reasonably expected to deal with.

Here it is important to again emphasise that measurement of what the NHS does is not in itself damaging. For example, the 4 hour A&E target has often been the subject of much debate, and for some time there has been a good case for not calling this a target but a standard, recognising that long waits in emergency departments are undesirable and may be of detriment to clinical outcomes. The aim that patients should be seen, treated and then either admitted or discharged within 4 hours does of itself, emphasise that urgent healthcare needs should be dealt with in a timely fashion. It is also supported by evidence which suggests that long waits have patient safety implications. On that basis, there is a case for continuing to measure waits and assessing performance. The issue comes when performance in this area deteriorates and is simply ascribed to a 'failure' in A&E, when of course the whole system of both secondary care (inpatient beds, availability, delays in triage to or admission to appropriate specialty) and primary care but as importantly patients accessing the most appropriate part of healthcare for their condition and its urgency.

It is also important that a different approach to targets, which largely apply to secondary care, does increase the workload of primary care and GPs. This means transparency and honesty about waiting times for specific investigations, services and conditions so that both GPs and secondary care give clear and realistic messaging to patients about their likely 'clinical journey' from request for investigation or specialist opinion to the conclusion of their treatment. That also requires a strong, well supported and effective primary/secondary care interface that leads to joined up decision making based on clinical priority.

Conclusion

While this paper looks at the challenge of measuring the NHS in terms of the system, at the heart of the proposals we make is an aim to make things work better not just for the NHS or for doctors – but also, and most importantly, patients.

In some ways it may seem contradictory to suggest that radically altering our approach targets will benefit those needing treatment – but BMA Scotland believes it will. As we have set out in the paper, we would still absolutely expect measurement and scrutiny and patients to be given a realistic and appropriate expectation of the time they should be waiting for any time of treatment. But we believe this measurement should be used in a much more mature and intelligent way, to target improvements rather than apportion blame. We have to be honest that it is a waste of NHS time having any doctor, anywhere in the system, explaining to a patient why an unrealistic promise from a politician is going to be broken. Not only that, such scenarios lead to a breakdown of trust, between the patient and the system and between NHS staff and those who run the service.

We must do better than a system that spends all of its time robotically asking, 'How much and how many'. Instead we want a system that has time to ask itself, how can we really be better? We want a system that has time for doctors to ask how our patients really are and to think about how they can deliver better, more personal care.

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