This witty and telling contribution comes from a reader whom we have agreed to call Mark Antony...........

Friends, Readers, countrymen, lend me your ears;
I come to bury targets, not to praise them;
The evil that targets do lives after them,
The good is oft interred with their bones,
So let it be with targets ... The noble Lansley
Hath told you targets were bad:
If it were so, it was a grievous fault,
And grievously hath targets answered it ...
Here, under leave of Lansley and the rest,
(For Lansley is a wise man;
So are they all; all wise men)
Come I to speak in targets' funeral ...
They were my friends, timely and fair to me:
But Lansley says they were bad;
And Lansley is a wise man....
They hath brought many patients prompter treatment,
Whose wellbeing after did the general coffers fill:
Did this in targets seem bad?
For the patients that waited in pain, targets have brought improvements:
Poor incentives should be shown by better evidence:
Yet Lansley says they were bad;
And Lansley is a wise man.
You all did see that on 18-week targets
Organisations united to improve patient pathways,
Removing delays and waste: was this bad?
Yet Lansley says they were bad;
And, sure, he is a wise man.
I speak not to disprove what Lansley spoke,
But here I am to speak what I do know.
You all did implement them once, not without cause:
What cause withholds you then to mourn for them?
O judgement! Thou art fled to brutish beasts,
And men have lost their reason.... Bear with me;
My heart is in the coffin there with the targets,
And I must pause till it come back to me.
(With apologies to William Shakespeare)

Having said that, there were problems with the way that targets were implemented. The *SMART* acronym (Specific, Measurable, Achievable, Relevant, and Timely, or similar) may be simplistic, but showed up some of the difficulties.

While the targets were generally 'specific', they were not always 'measurable' at least at the time they were introduced. 18-week targets required linking up of GP, PCT, and Acute systems to be able to measure the results at all. This in itself was a good thing, as some of this data helps with care pathway analysis for commissioning and quality improvement.

‘Achievable’ is often only shown by experience (and excuses!) which is why some people prefer ‘agreed’ as this component, but it also ties in with having adequate resources.

Simply imposing a target without agreeing the resources needed to achieve it is simply a recipe for disaster, or the type of gaming that has been seen over the A&E 4-hour target, where people find ways of meeting the letter rather than the spirit of the law.

You would be judged on meeting your target, but would still have to explain why your target falls short of the ‘goal’.

Having a national ‘goal’ of 4 hours, but with local ‘agreed’ targets may be a better way of driving improvements.

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If everyone else meets the ‘goal’ then having a weaker local ‘target’ is hard to justify. Given the desire for local resource planning and prioritisation, then imposition of national targets makes no sense.

‘Relevant’ can have many aspects, including local commitment to the spirit of the target. If the aim is not seen to be meaningful, then people will try to meet the ‘target’ as easily as possible – usually through gaming or fudging the figures.

This is itself an interesting point for discussion: were the ‘targets’ as much a way of changing local priorities to focus on the patient experience rather than organisational convenience? A way of making organisations think in terms of workflow, rather than events and so identifying pointless activities which added nothing to patient care?

‘Timely’ or time-bound were clearly very much part of the targets and the deadlines for their delivery.

Looking back at documents of about 10 years ago, which calmly stated waiting times of 2 years for some operations, shows how much things have moved forward because of the targets.

The problem with the time-frames imposed was that it forced some organisations to cheat, probably with the hope of doing it properly later, but inevitably they never got around to it as the ‘cheating’ was easier and became routine and institutionalised.

The cheating was what was wrong not necessarily the targets themselves.

Targets work if they are adopted locally. The SMART acronym is an attempt to make this happen, but is no means the full picture. What these targets had over previous ‘targets’ was that they focused on patient care rather than purely financial achievements of reducing costs.

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As other industries have shown, improving quality is a key step in reducing waste. The core problem is that the NHS has no way of gauging ‘quality’, as it rarely (there are notable exceptions) determines the process of care nor the outcome of care (what happens to the patient) so that we know what works and what doesn’t.

The work by Professor Jarman and Dr Foster from HES statistics on post-operative mortality was fairly crude but the closest measure to quality of care we had – the publication of their figures led to a far greater scrutiny of how hospitals were being run in terms of delivering adequate care.

Targets that focus on the care delivered should help improve the NHS; even ‘target by proxy measures’ may help, but will clearly be less effective if people focus on just the figures rather than the aim.