

What do NHS managers really think?

Targets are history and it's a
good thing



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It features NHS news, guidance and discussion topics and features regular polling and surveys of manager's personal thinking and attitudes.



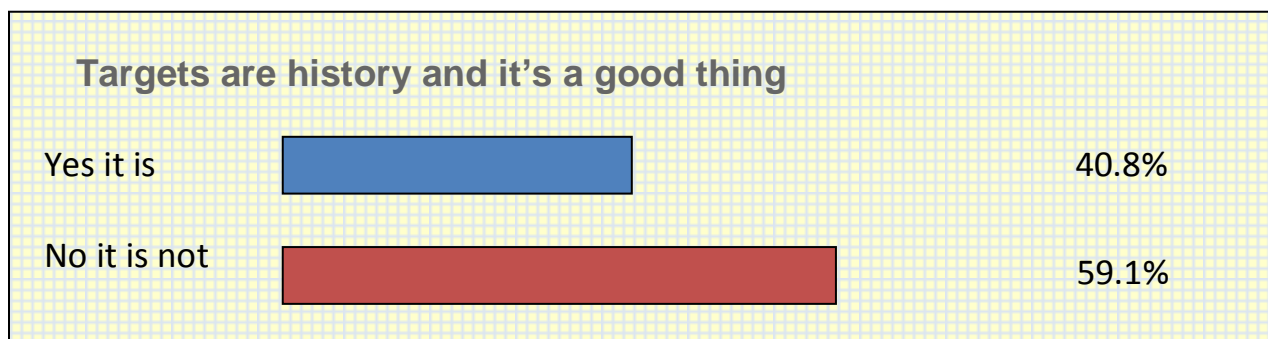
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THE QUESTION



This is an interesting result. It would be easy to imagine managers would be pleased to see the back of Targets. Not so. In fact the comments provide a narrative that seems to say; 'we've worked hard to achieve them', 'don't throw the baby out with the bathwater', 'it's good for the patients'.

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YOUR COMMENTS

- Where would the level of patient access be without targets? What will happen to patient's access now? All the progress made since the advent of the NHS Plan will slowly (or quickly) be undone.
- We need some appropriate targets or things will start to drift
- Meaningful targets are needed to ensure that patients are getting the right treatment in the right place at the right time
- The service has worked incredibly hard over the last few years and on the whole the targets have delivered significant improvements in quality. Surly this has got to be a good thing?
- Targets are one way of making us all account for what we do. So whether their removal is a good thing or not depends on what replaces them. We will have to demonstrate our individual and collective efficiency and effectiveness one way or another.
- Try getting a decent outcome, if you can't get timely access to the service you need. We must never go back to using waiting times as the financial safety valve.
- They are not really history, just being called something else.... or re-invented. Patients, citizens, the media and above all clinicians campaigned for years and years to have them - under both previous governments (Labour and Tory) - they have driven up quality (and outcomes) and make patients feel better. They make people (service delivers - clinicians and managers) concentrate, focus and take action.
- Managing the 18 weeks target has not been easy, but we can't go back to the ridiculous waiting times of the past. We're only just beginning to get it right!

- In the absence of a true market in healthcare and real patient choice, targets are the only way to ensure a minimum standard to public
- Targets do, at least, stimulate productivity. Areas without targets tend to get sidelined. Without targets, for many people, it is human nature to "do what is easiest", rather than what is best for patients.
- Targets are really important, but must make clinical sense first and also make operational sense. For example; I drive our AMU towards a "Door to Doctor" target of 30 minutes. This is good clinical sense - see the worried frightened patient early, treat before deterioration, or if not ill send them home. I report on performance to target every weekday.
- As an NHS manager in service delivery it's quite simple. What you do not measure and have no target for, you do not achieve. Targets stopped patients being left on the 'too hard, undecided what to do' pile. Yes, they do put pressure on the system to perform - for the patients benefit. I can remember prior to the 18 week waiting target patients taking a year to get bypass surgery and some died whilst waiting. Surely we haven't forgotten that price already?
- Actually targets aren't history; they will be refined or called something else. Why? Partly because the customer (that's you and me) wants to know what standards to expect and partly because no government would stand for a deterioration in services anyway. The real problem with targets is how they have been performance managed from the centre. This has concentrated on the outcome (target hit yes/no) rather than being concerned with how they are being achieved.
- Clinicians/clinical managers cannot be relied upon to proactively and energetically manage waiting lists without the pressure of targets - as history tells us prior to the 18w target.
- All it ever has been is a tick-box culture. It never improved the care offered - it took time away from nurses and GPs who had to prepare reports etc. More tedious was the requirement for specific coding eg ECGs - after all it is STILL and ECG!!! I have spent two days dealing with PCT issues on PRIMIS prevalence exception reporting on informed dissents! Why, oh why? And now, tons of paperwork for DES, LES and NES to be done in duplicate. This is time and money that could have been better spent

- Not all targets are bad and, being publicly accountable, we should expect targets and standards to be set. However, they need to be relevant, realistic and genuinely achievable, not open to manipulation.
- Targets focus the mind and actions. Maybe they didn't always work effectively, but by and large they did and were beneficial for patients.
- The NHS should be able to offer some guarantees. The 18 week referral to treatment target should be called a guarantee, and failure to meet it should carry a sanction.
- This is not in the patients interest and I wonder if the funding cuts will have such severe implications that the targets needed to be removed to avoid every Trust failing. This government was never going to aid the NHS
- It is good that the mindless micro-management of target performance monitoring is history. Broad access targets are still desirable - don't forget that millions of people waited in misery to enable surgeons to get fat on private practice before targets came in.
- Delighted to see the 24/28 hour targets go. These were never a true reflection of appointment availability and very subjective. I am more interested in seeing the whole picture and see how this fits into the broader changes we are expecting in primary care
- Goals are required in any business or service, but targets diminish individual, discretionary decision making in the complex world of patient care. Targets and idiosyncratic patients have never mixed and never will.
- They should go now and let quality become the focus. Let the professionals choose and get rid of the "non jobs"
- Providing there is accountability for prioritisation by the purse string holders when the waiting times grow, as they undoubtedly will, to prevent a resumption of post code lotteries.
- Need to remove the bureaucracy associated with monitoring targets not managers at an operational level
- Targets are good to aim for but where the performance management corrupts behaviour, it is not. A small number of targets are good but based on outcomes not process!

- Lucky old England, wish the same would happen in Wales. The gulf between NHS Wales and England (Scotland & NI for that matter) is going to grow and we will have a multi tier NHS system in the UK

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