Performance Anxiety

Approaches to Accountability: indicators across different sectors

Professor Stephen Peckham
Government targets

Professional standards

Regulators

Health Board

Personal

Ethical

Citizens/tax payers

Audit

Patients

Colleagues
Performance of what?

- Health system – eg. government accountability to the public:
  - Population health
  - Equity
  - Effective use of money
- Delivery of healthcare – provider organisations, clinicians:
  - Improve services
  - Meet local needs
  - Deliver high quality patient care
  - Deliver safe care
“In practice the development of performance measurement has rarely been pursued with a clear picture of what specific information is needed by the multiple users. Instead, performance measurement systems typically present a wide range of data, often chosen because of relative convenience and accessibility, in the hope that some of the information will be useful to a variety of users.”

Accountability or Performance?

• A key characteristic of “New Public Management” has been the shift in public services from being organisationally accountable to democratic government to forms of accountability involving more direct provider-consumer connections.

• Central to this is a rhetoric that suggests:
  • greater accountability = improved performance
  • performance measurement = accountability
Defining Accountability

• a relationship between an actor and a forum, in which the actor has an obligation to explain his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences

  • Accountability of what to whom
  • To give account

• We may be interested in holding to account for things or actions that are not normally equated with performance – or may be viewed differently depending on what different “forums” find important
Performance measurement: some fundamental questions

• Who or what is being measured?
  • Organisations/professionals
  • Patient care/population health
  • Production/competence/results/productivity

• How is it being measured?
  - Performance against metrics
  - Performance against targets
  - Use of thresholds and standards
  - Informal measures

• Who is it being measured for?
  • Government/funder
  • Regulators
  • Patients
  • Themselves
What should we measure?

• Research in the human services – for example education, health and social care – suggests that variations in the quantities of a service (e.g. class size in schools, or hours of home care) have a smaller impact on outcomes than the personal circumstances of the individuals involved, including material, psychological, social and cultural influences.

• But these also vary dependent on the technical nature of the task (production and competence).

• How do we ensure we measure what is important and not simply just make the things we measure become important?
“Hard” and “Soft” measures of performance

How do we discern what contributes towards high quality care and improved health system performance?

• What is good policy?
  • What is the role of the hospital board and how do we measure its performance

• Who defines good care?
  • Morbidity and mortality
  • Patient reported outcome measures
  • Dignity, personal care

• What is good decision-making?
  • What is a good manager?
  • What is a good clinical decision?
What is good performance?

Distinguishing between formal and informal performance is useful:

• Formal performance (eg. activity or finance metrics) provides a safety net for poorly performing organisations but offers weak incentives for high performing organisations.

• Informal performance (eg. reputation, trust) substitutes for and/or complements formal performance, offering rich insights but lacking consistency.
<table>
<thead>
<tr>
<th>Different sectors</th>
<th>Different measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acute care</td>
<td>• Physical setting</td>
</tr>
<tr>
<td>• Clinical outcomes</td>
<td>• Technical skills and knowledge</td>
</tr>
<tr>
<td>• Patient safety</td>
<td>• Care performance</td>
</tr>
<tr>
<td>• Length of stay</td>
<td></td>
</tr>
<tr>
<td>• Primary medical care</td>
<td>• Technical skills and knowledge</td>
</tr>
<tr>
<td>• Accessibility</td>
<td>• Care performance</td>
</tr>
<tr>
<td>• Clinical outcomes</td>
<td>• Quality of life</td>
</tr>
<tr>
<td>• Continuity of care</td>
<td></td>
</tr>
<tr>
<td>• Community care</td>
<td>• Care performance</td>
</tr>
<tr>
<td>• Continuity of care</td>
<td>• Quality of life</td>
</tr>
<tr>
<td>• Long-term continuous support</td>
<td></td>
</tr>
<tr>
<td>• Social support</td>
<td>• Personal autonomy</td>
</tr>
<tr>
<td>• Social care</td>
<td>• Quality of life</td>
</tr>
<tr>
<td>• Social support</td>
<td>• Personal autonomy</td>
</tr>
<tr>
<td>• Carer-service user relationship</td>
<td>• informal</td>
</tr>
<tr>
<td>• Emphasis on self-determination</td>
<td></td>
</tr>
</tbody>
</table>
Approaches to measuring performance

Performance measures can be separated into three broad areas:

1. **Search properties - structural indicators such as inputs**
   - Premises
   - Organisational settings
   - Resources
   - staff

2. **Experience properties - process as experienced by user**
   - Quality of care
   - Accessibility

3. **Credence properties – the actions of the care giver**
   - Technical skill
   - Competence in providing care
### Mapping indicators by sector

<table>
<thead>
<tr>
<th></th>
<th>Acute care</th>
<th>Primary care</th>
<th>Community care</th>
<th>Social care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Search properties</strong></td>
<td>Important</td>
<td>Resources and staff important</td>
<td>Staff important</td>
<td>Staffing has some importance</td>
</tr>
<tr>
<td>Clear defined inputs</td>
<td>Premises and facilities less relevant</td>
<td>Primarily staff activities and is context driven</td>
<td>Context driven such as people’s own homes, informal care</td>
<td></td>
</tr>
<tr>
<td><strong>Experience properties</strong></td>
<td>Less important?</td>
<td>Important</td>
<td>Very important</td>
<td>Predominant</td>
</tr>
<tr>
<td>Patient satisfaction, growing interest in PROMs</td>
<td>Continuity of care and relationships are relevant but difficult to measure</td>
<td>Quality of life and views of users hard to measure</td>
<td>Quality of life and views of users hard to measure</td>
<td></td>
</tr>
<tr>
<td><strong>Credence properties</strong></td>
<td>Key component</td>
<td>Very important</td>
<td>Important</td>
<td>Limited</td>
</tr>
<tr>
<td>Defined skills and competencies</td>
<td>Less specific and some co-production</td>
<td>Less specific with co-production</td>
<td>Often informal with co-production</td>
<td></td>
</tr>
</tbody>
</table>
Measuring performance in the English NHS

• Growing concern about quality (Francis and Berwick reports)
• Public perception surveys
• Increased regulator functions – Monitor, CQC
• Use of composite outcome measures – egEQ-5D for all hip and knee replacement procedures, hernia repair and varicose veins
• Outcomes frameworks for NHS commissioners and providers
• Public Health Outcomes Framework
• Use of outcomes funding – P4P, CQUIN, PbR
NHS perception gap

Q To what extent, if at all, do you agree or disagree with the following statements?

% Agree

- My local NHS is providing me with a good service
  - 75

- The NHS is providing a good service nationally
  - 65

- The government has the right policies for the NHS
  - 22

Base: Adults aged 16+ in England (c. 1000 per wave)

Source: Ipsos MORI/DH Perceptions of the NHS Tracker
English NHS Mandate – Accounting to Government

THE MANDATE – at a glance

The Mandate is structured around five key areas, which align with the NHS Outcomes Framework, as well as including additional direction on topics such as finance. (This is only a summary – see the Mandate for details.)

1. Preventing people from dying prematurely
   We want England to become among the best in Europe at preventing ill-health, and providing better early diagnosis and treatment of conditions such as cancer and heart disease, so that more of us can enjoy the prospect of a long and healthy old age.
   Objectives include:
   - supporting the earlier diagnosis of illness;
   - ensuring people have access to the right treatment when they need it;
   - reducing unjustified variation between hospitals in avoidable deaths;
   - using every contact with NHS staff as an opportunity to help people stay in good health.

2. Enhancing quality of life for people with long-term conditions
   We want the NHS to be among the best in Europe at supporting people to manage ongoing physical and mental health conditions, such as diabetes and depression, so that people can experience a better quality of life, and so that care feels much more joined up.
   Objectives include:
   - involving people in their own care and treatment;
   - the use of technology (e.g. ordering repeat prescriptions online);
   - better integration of care across different services;
   - better diagnosis, treatment and care of those with dementia.

3. Helping people to recover from episodes of ill health or following injury
   The Board is being asked to highlight the differences in quality and results between services across the country in order to share best practice, and improve services.
   - ensuring greater equality between access to mental and physical health services;
   - improving transparency through publication of data, and involving local people in decision-making about services.

4. Ensuring that people have a positive experience of care
   The Board is being asked to make sure we experience better care, not just better treatment, particularly for older people and at the end of people’s lives.
   Objectives include:
   - measuring and understanding how people feel about their care (“the friends and family test”);
   - ensuring vulnerable people receive safe, appropriate, high quality care;
   - improving the standards of care and experience for women during pregnancy;
   - supporting children and young people with specific health and care needs;
   - providing good quality care seven days of the week;
   - improve access and waiting times for all mental health services, including IAPT.

5. Treating and caring for people in a safe environment and protecting them from avoidable harm.
   The Board is being asked to continue to reduce the number of incidents of avoidable harm and make progress towards embedding a culture of patient safety through improved reporting of incidents.

6. Freeing the NHS to innovate
   We want to get the best health outcomes for patients through objectives that include:
   - strengthening autonomy at the local level;
   - promoting research and innovation;
   - controlling incentives, such as introducing the quality premium for CCGs;
   - leading the continued drive for efficiency savings, while maintaining quality, through QUIPP.

7. The broader role of the NHS in society
   We want the Board to promote and support participation by NHS organisations and NHS patients in research, to improve patient outcomes and to contribute to economic growth. The Board must also seek to make partnership working a success.

8. Finance
   The Board’s revenue budget for 2013-14 is £95.6 billion. Its objective is to ensure good financial management and improvements in value for money across the NHS.
NHS England Outcomes Framework

1. Preventing people from dying prematurely
   - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
   - Life expectancy at 75
     - Males
     - Females
   - One- and five-year survival from all cancers
   - One- and five-year survival from breast, lung and colorectal cancer
   - Excess under 75 mortality rate in adults with serious mental illness
   - Neonatal and stillbirths
   - Five-year survival from all cancers in children
   - Excess under 60 mortality rate in adults with a learning disability

2. Enhancing quality of life for people with long-term conditions
   - Health-related quality of life for people with long-term conditions** (ASCOF 1A)
   - Employment of people with long-term conditions** (ASCOF 1E PHOF 1.8)
   - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
   - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 10s
   - Employment of people with mental illness** (ASCOF 1F & PHOF 1.8)
   - Health-related quality of life for carers** (ASCOF 1D)
   - Estimated diagnosis rate for people with dementia* (PHOF 4.10)

3. Helping people to recover from episodes of ill health or following injury
   - Emergency admissions for acute conditions that should not usually require hospital admission
   - Emergency readmissions within 30 days of discharge from hospital* (PHOF 4.11)
   - Total health gain as assessed by patients for elective procedures
   - Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months
   - Proportion of patients recovering to their previous levels of mobility/ability at 63 and 120 days
   - Proportion offered rehabilitation following discharge from acute or community hospital

4. Ensuring that people have a positive experience of care
   - Patient experience of primary care
   - GP services
   - Out-of-hours services
   - NHS Dental Services
   - Patient experience of hospital care
   - Friends and family test

5. Treating and caring for people in a safe environment and protect them from avoidable harm
   - Patient safety incidents reported
   - Safety incidents involving severe harm or death
   - Hospital deaths attributable to problems in care
   - Incidence of hospital-acquired bloodstream infections (VTE)
   - Incidence of healthcare associated infections (HAI)
   - Incidence of meticillin-resistant Staphylococcus aureus (MRSA)
   - Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
   - Incidence of medication errors causing serious harm
   - Admission of full-term babies to neonatal care
   - Delivering safe care to children in acute settings
   - Incidence of harm to children due to failure to monitor

NHS Outcomes Framework 2013/14 at a glance

Alignment across the Health and Social Care System
- Indicator shared with Public Health Outcomes Framework (PHOF)
- Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)
- Indicator shared with Adult Social Care Outcomes Framework (ASCOF)
- Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes Framework

*Indicators in italics are placeholders, pending development or identification.
## Breaking down the indicators

<table>
<thead>
<tr>
<th>1. Preventing people from dying prematurely</th>
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<tbody>
<tr>
<td><strong>1a Potential Years of Life Lost (PYLL) from causes considered amenable to health care</strong></td>
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<tr>
<td><strong>i adults</strong></td>
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<tr>
<td>International comparisons</td>
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<td>P</td>
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<tr>
<td><strong>1b Life expectancy at 75</strong></td>
</tr>
<tr>
<td>Y</td>
</tr>
<tr>
<td><strong>1.1 Under 75 mortality rate from cardiovascular disease</strong></td>
</tr>
<tr>
<td>Y</td>
</tr>
<tr>
<td><strong>1.2 Under 75 mortality rate from respiratory disease</strong></td>
</tr>
<tr>
<td>Y*</td>
</tr>
<tr>
<td><strong>1.3 Under 75 mortality rate from liver disease</strong></td>
</tr>
<tr>
<td>Y</td>
</tr>
<tr>
<td><strong>1.4. Under 75 mortality from cancer</strong></td>
</tr>
<tr>
<td>Y</td>
</tr>
<tr>
<td><strong>1.4.1 One-year survival for all cancers</strong></td>
</tr>
<tr>
<td>Y*</td>
</tr>
</tbody>
</table>
### Still work in progress …..

<table>
<thead>
<tr>
<th>Sub-national breakdown</th>
<th>Equality and Inequality Strands (National Only)</th>
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</thead>
<tbody>
<tr>
<td>International comparisons</td>
<td></td>
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<tr>
<td>Regional</td>
<td></td>
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<tr>
<td>CCG level</td>
<td></td>
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<tr>
<td>Local Authority</td>
<td></td>
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<tr>
<td>Provider</td>
<td></td>
</tr>
<tr>
<td>deprivation (via postcode area)</td>
<td></td>
</tr>
<tr>
<td>Socio-economic group (NSSEC)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
</tr>
</tbody>
</table>

#### 3.1v Number of elective procedures weighted by effectiveness - psychological therapies
Possible disaggregations to be assessed once the indicator is developed

#### 3.2 Emergency admissions for children with lower respiratory tract infections (LRTI)
| Y | Y | Y | P | Y | N | Y | Y | N | Y | N | N |

#### 3.3 An indicator on recovery from injuries and trauma
Possible disaggregations to be assessed once the indicator is developed

#### 3.4 An indicator on the proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months
Possible disaggregations to be assessed once the indicator is developed

#### 3.5.1 The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 days
| N | N/A | N | N | TBD | N | N | P | N | N | Y | N | N |

#### 3.5.2 The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 120 days
| N | N/A | N | N | TBD | N | N | P | N | N | Y | N | N |
NHS performance measures

- Structural measures
- Experience measures
- PROMs
- Technical measures
  - Appraisal
  - Accreditation
  - Re-validation
  - Audit
  - Develop core competencies
  - Physician report cards
Consultant Comparative data

NHS Choices

http://www.nhs.uk/choiceintheNHS/Yourchoices/consultant-choice/Pages/consultant-data.aspx
Public Health Outcomes Framework

OUTCOMES

Vision: To improve and protect the nation’s health and wellbeing, and improve the health of the poorest fastest

Outcome 1: Increased healthy life expectancy
Taking account of the health quality as well as the length of life
(Note: This measure uses a self-reported health assessment, applied to life expectancy.)

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities
Through greater improvements in more disadvantaged communities
(Note: These two measures would work as a package covering both morbidity and mortality, addressing within-area differences and between area differences)

Objective
People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators
- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions*
- Child development at 2-2½ years (under development)
- Excess weight in 4-5 and 10-11 year olds*
- Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- Emotional well-being of looked after children
- Smoking prevalence – 15 year olds (placeholder)
- Self-harm
- Diet
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- Cancer diagnosed at stage 1 and 2
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible*
- Self-reported wellbeing
- Falls and injuries in people aged 65 and over
Public health profiles – Kent County Council

<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Local No. Per Year</th>
<th>Local Value</th>
<th>Eng Avg</th>
<th>Eng Worst</th>
<th>England Range</th>
<th>Eng Best</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Deprivation</td>
<td>159589</td>
<td>10.9</td>
<td>20.3</td>
<td>83.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of children in poverty</td>
<td>40080</td>
<td>18.5</td>
<td>21.1</td>
<td>45.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Statutory homelessness</td>
<td>970</td>
<td>1.7</td>
<td>2.3</td>
<td>9.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>GCSE achieved (5A*-C inc. Eng &amp; Maths)</td>
<td>9040</td>
<td>61.1</td>
<td>50.0</td>
<td>31.9</td>
<td></td>
<td>81.0</td>
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<tr>
<td></td>
<td>Violent crime</td>
<td>16279</td>
<td>11.4</td>
<td>13.6</td>
<td>32.7</td>
<td></td>
<td>4.2</td>
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<tr>
<td></td>
<td>Long term unemployment</td>
<td>6700</td>
<td>7.3</td>
<td>9.5</td>
<td>31.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smoking in pregnancy ‡</td>
<td>2811</td>
<td>15.2</td>
<td>13.3</td>
<td>30.0</td>
<td></td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>Starting breast feeding ‡</td>
<td>12485</td>
<td>73.1</td>
<td>74.8</td>
<td>41.8</td>
<td></td>
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<tr>
<td></td>
<td>Obese Children (Year 6) ‡</td>
<td>2583</td>
<td>18.3</td>
<td>19.2</td>
<td>28.5</td>
<td></td>
<td>10.3</td>
</tr>
<tr>
<td></td>
<td>Alcohol-specific hospital stays (under 18)</td>
<td>171</td>
<td>54.9</td>
<td>61.8</td>
<td>154.9</td>
<td></td>
<td>12.5</td>
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<tr>
<td></td>
<td>Teenage pregnancy (under 18) ‡</td>
<td>938</td>
<td>33.2</td>
<td>34.0</td>
<td>58.5</td>
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<td>11.7</td>
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<tr>
<td></td>
<td>Adults smoking</td>
<td>n/a</td>
<td>20.1</td>
<td>20.0</td>
<td>29.4</td>
<td></td>
<td>8.2</td>
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<tr>
<td></td>
<td>Increasing and higher risk drinking</td>
<td>n/a</td>
<td>23.1</td>
<td>22.3</td>
<td>25.1</td>
<td></td>
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<tr>
<td></td>
<td>Healthy eating adults</td>
<td>n/a</td>
<td>27.3</td>
<td>28.7</td>
<td>19.3</td>
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<td>47.8</td>
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<tr>
<td></td>
<td>Physically active adults</td>
<td>n/a</td>
<td>57.2</td>
<td>56.0</td>
<td>43.8</td>
<td></td>
<td>68.5</td>
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<tr>
<td></td>
<td>Obese adults ‡</td>
<td>n/a</td>
<td>28.3</td>
<td>24.2</td>
<td>30.7</td>
<td></td>
<td>13.9</td>
</tr>
</tbody>
</table>
How do we measure things that are relevant to improving performance?

- Financial incentives can improve performance:
  - NHS Advancing Quality scheme (NW England) produced approximately 5200 quality-adjusted life years
  - £4.4m in reductions in hospital LOS - but cost £13.3m!
  - QOF costs over £1 billion
  - Increased recording and some improvement in disease registers especially in more deprived areas
  - Little evidence of improvement impact
  - No clear cost savings or improvement in health outcomes

- Evidence suggests non-incentivised areas are ignored
- However, improvements continue in other non-incentivised areas
- Need to align measures across sectors – focus on patient care (and patient perspectives?)
And so … back to the accountability/performance relationship

<table>
<thead>
<tr>
<th>Focus on quality of performance actions</th>
<th>LOW</th>
<th>HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td></td>
<td>COMPETENCE</td>
</tr>
<tr>
<td>LOW</td>
<td>PRODUCTION</td>
<td>RESULTS</td>
</tr>
</tbody>
</table>

Accountability can involve performance measurement but is not always a necessary component and performance measurement is also an approach to practice improvement.
English Clinical Commissioning Groups – external accountability

Managerial accountability, with potential sanctions

Liability to 'give an account' – political accountability

DH Secretary of State

NHS England

Monitor

Local Authority scrutiny

Clinical Commissioning Group

The public

Local Medical Committee

Health and Wellbeing Board

Local Healthwatch

More formal measurements of process and outcome

More informal measurements of process and outcome
English Clinical Commissioning Groups – internal accountability

Mutual accountability

One way accountability

Sub committees

CCG Governing body

Locality groups of GPs

Member practices

CCG officers

More complex mix of accountability and performance – eg. peer pressure,
Performance measures: the evidence

- Current experience suggests we focus more on process measurements and single disease measures.
- But useful for measuring the quality of homogeneous processes and quality of care where technical skill is not so important.
- Emphasis is mainly on production measures with some productivity measures.
- Performance measures can skew activity prioritising those things that are measured over what might be important.
- Performance measurement occurs within a political context.
Challenges

• How to measure competence and the quality of care given that underpins trust relationships between practitioners and patients/service users
• Difficult to measure results that are meaningful and acceptable
• Need to develop measures for care practices to meet the needs of people with multiple health and social care needs
• How to measure care rather than interventions or technical skill
• Need to develop clear governance structures that provide a balance between formal and informal performance measurement.
• Need to develop the concept of quality before thinking about the right measures
• Need to balance extrinsic motivation (external incentives) and intrinsic motivation (desire to see continuous improvement)
Centre for Health Services Studies
www.kent.ac.uk/chss