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Performance Anxiety

Approaches to Accountability: indicators across different sectors

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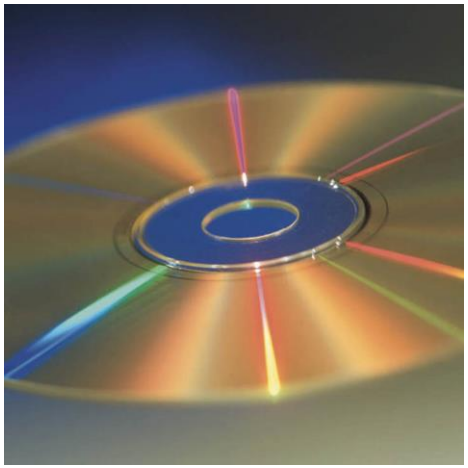
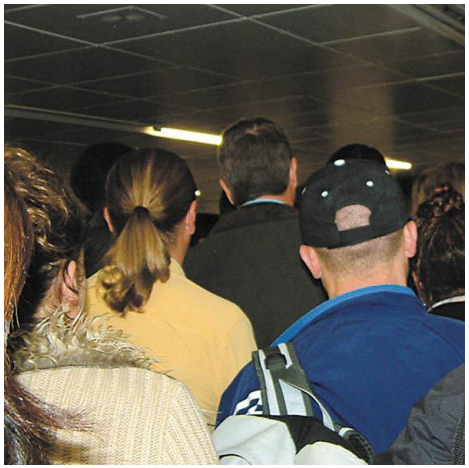
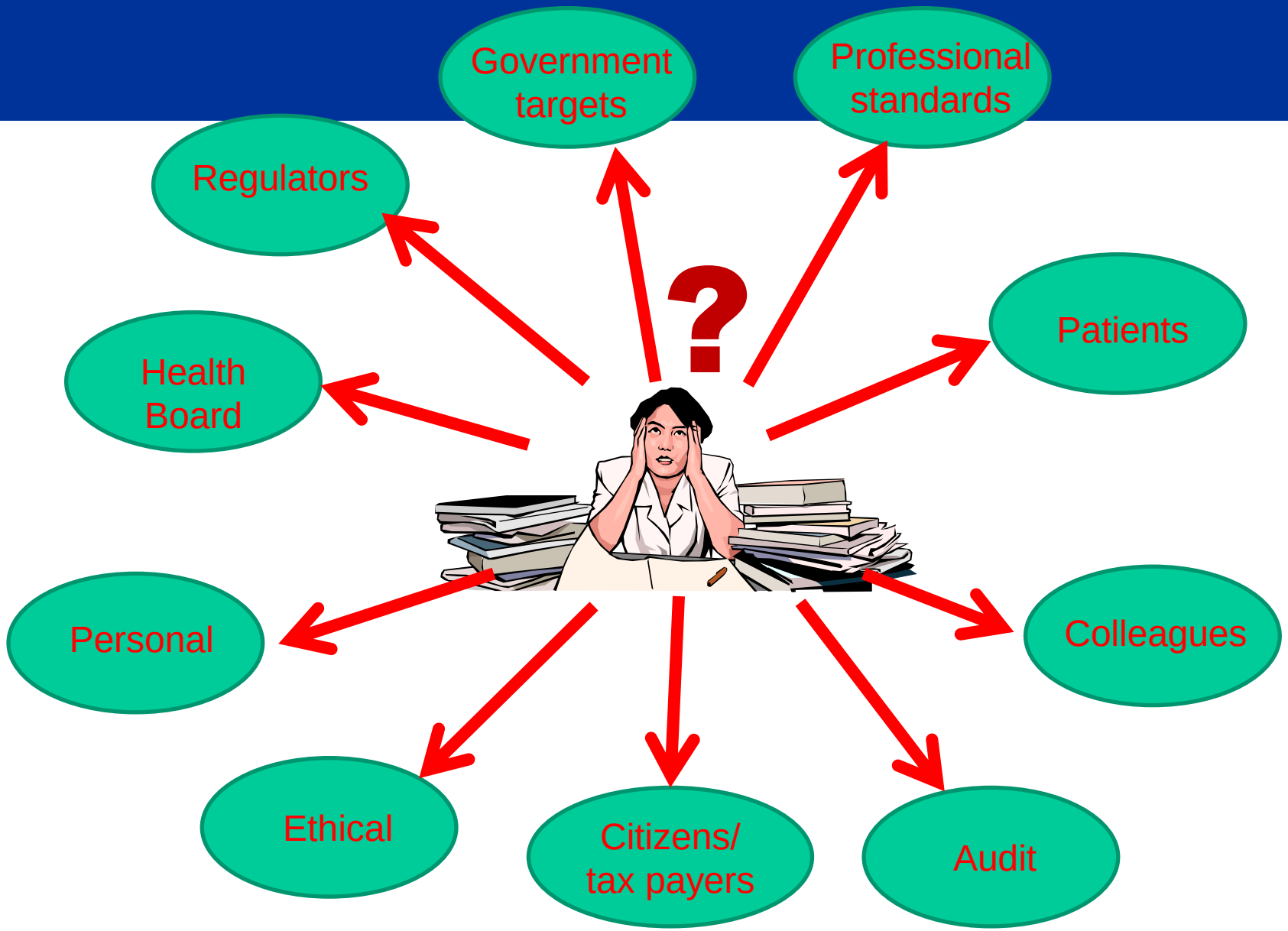





Government targets
Professional standards
Regulators
Patients
Health Board
Personal
Colleagues
Ethical
Citizens/ tax payers
Audit

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.”

Smith et al: *Performance Measurement for Health System Improvement* Cambridge University Press 2009.

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.

Different sectors	Different measures

• Acute care
  • Clinical outcomes
  • Patient safety
  • Length of stay
	• Physical setting
	• Technical skills and knowledge
	• Care performance

• Primary medical care
  • Accessibility
  • Clinical outcomes
  • Continuity of care
	• Technical skills and knowledge
	• Care performance
	• Quality of life

• Community care
  • Continuity of care
  • Long-term continuous support
  • Social support
	• Care performance
	• Quality of life
	• Personal autonomy

• Social care
  • Social support
  • Carer-service user relationship
  • Emphasis on self-determination
	• Quality of life
	• Personal autonomy
	• informal

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

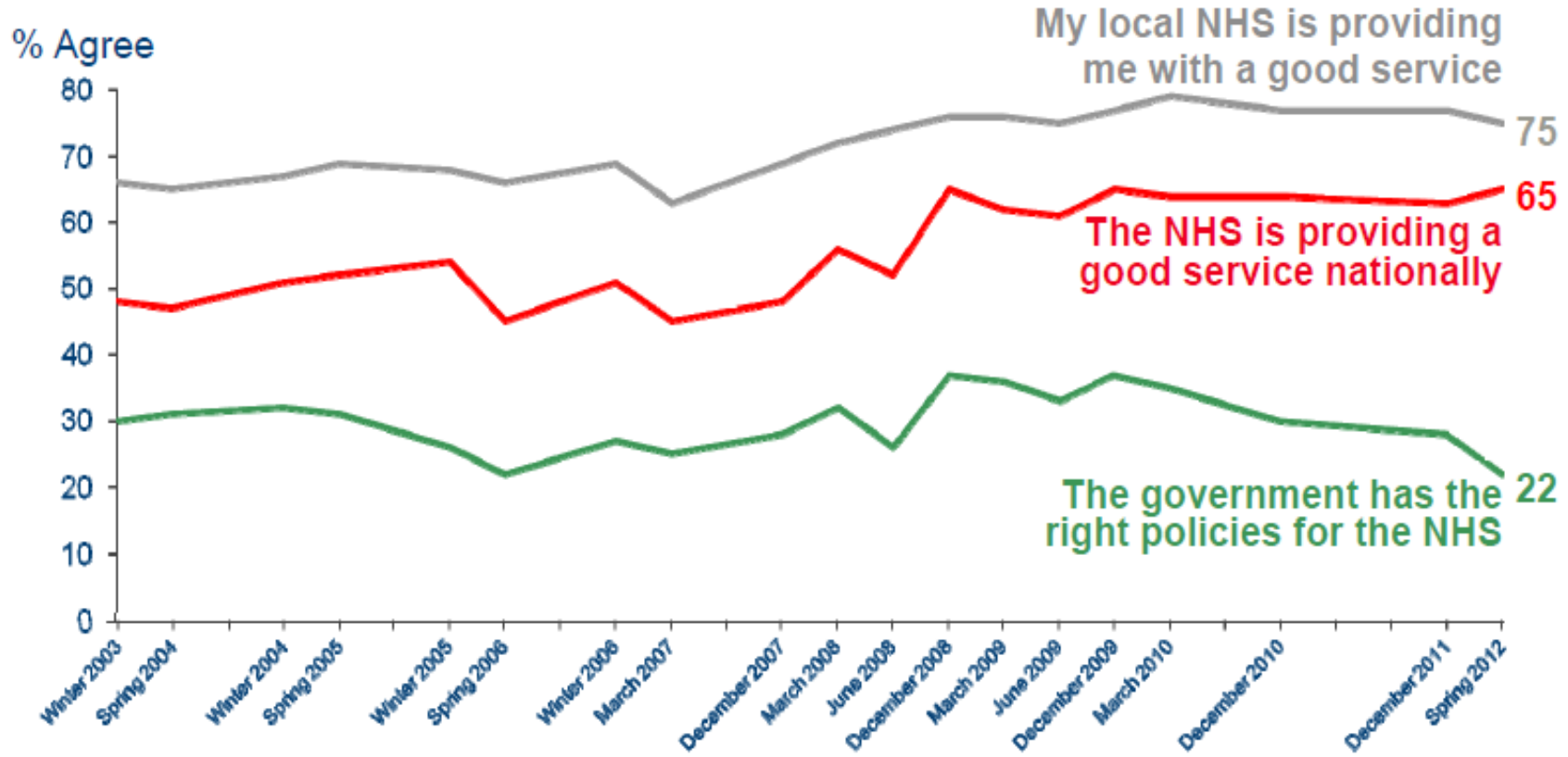
	Acute care	Primary care	Community care	Social care
Search properties	Important	Resources and staff important	Staff important	Staffing has some importance
	Clearly defined inputs	Premises and facilities less relevant	Primarily staff activities and is context driven	Context driven such as people's own homes, informal care
Experience properties	Less important?	Important	Very important	Predominant
	Patient satisfaction, growing interest in PROMs	Continuity of care and relationships are relevant but difficult to measure	Quality of life and views of users hard to measure	Quality of life and views of users hard to measure
Credence properties	Key component	Very important	Important	Limited
	Defined skills and competencies	Less specific and some co-production	Less specific with co-production	Often informal with co-production

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?



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 health 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

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
i Adults ii *Children and young people*
1b Life expectancy at 75
i Males ii Females

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease* (PHOF 4.4)
1.2 Under 75 mortality rate from respiratory disease* (PHOF 4.7)
1.3 Under 75 mortality rate from liver disease* (PHOF 4.6)
1.4 Under 75 mortality rate from cancer* (PHOF 4.5)
i *One- and* ii *Five-year survival from all cancers*
iii *One- and* iv *Five-year survival from breast, lung and colorectal cancer*

Reducing premature death in people with serious mental illness
1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF 4.9)

Reducing deaths in babies and young children
1.6 i Infant mortality* (PHOF 4.1)
ii Neonatal mortality and stillbirths
iii *Five year survival from all cancers in children*

Reducing premature death in people with a learning disability
1.7 *Excess under 60 mortality rate in adults with a learning disability*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions** (ASCOF 1A)

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition**

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions** * (ASCOF 1E PHOF 1.8)

Reducing time spent in hospital by people with long-term conditions
2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers** (ASCOF 1D)

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness **** (ASCOF 1F & PHOF 1.8)

Enhancing quality of life for people with dementia
2.6 i Estimated diagnosis rate for people with dementia* (PHOF 4.16)
ii *A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life**** (ASCOF 2F)

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital* (PHOF 4.11)

Improvement areas

Improving outcomes from planned treatments
3.1 Total health gain as assessed by patients for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia iv Varicose veins
v *Psychological therapies*

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 Proportion of people who recover from major trauma

Improving recovery from stroke
3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

Improving recovery from fragility fractures
3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation service*** (ASCOF 2B)
ii Proportion offered rehabilitation following discharge from acute or community hospital

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
**** Indicator complementary with Adult Social Care Outcomes Framework and Public Health Outcomes Framework

Indicators in italics are placeholders, pending development or identification

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services
ii GP Out of Hours services
iii NHS Dental Services
4b Patient experience of hospital care
4c *Friends and family test*

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 Bereaved carers' views on the quality of care in the last 3 months of life

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator is under development*

Improving people's experience of integrated care
4.9 *An indicator is under development* *** (ASCOF 3E)

5 Treating and caring for people in a safe environment and protect them from avoidable harm

Overarching indicators

5a Patient safety incidents reported
5b Safety incidents involving severe harm or death
5c *Hospital deaths attributable to problems in care*

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI)
i MRSA
ii C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

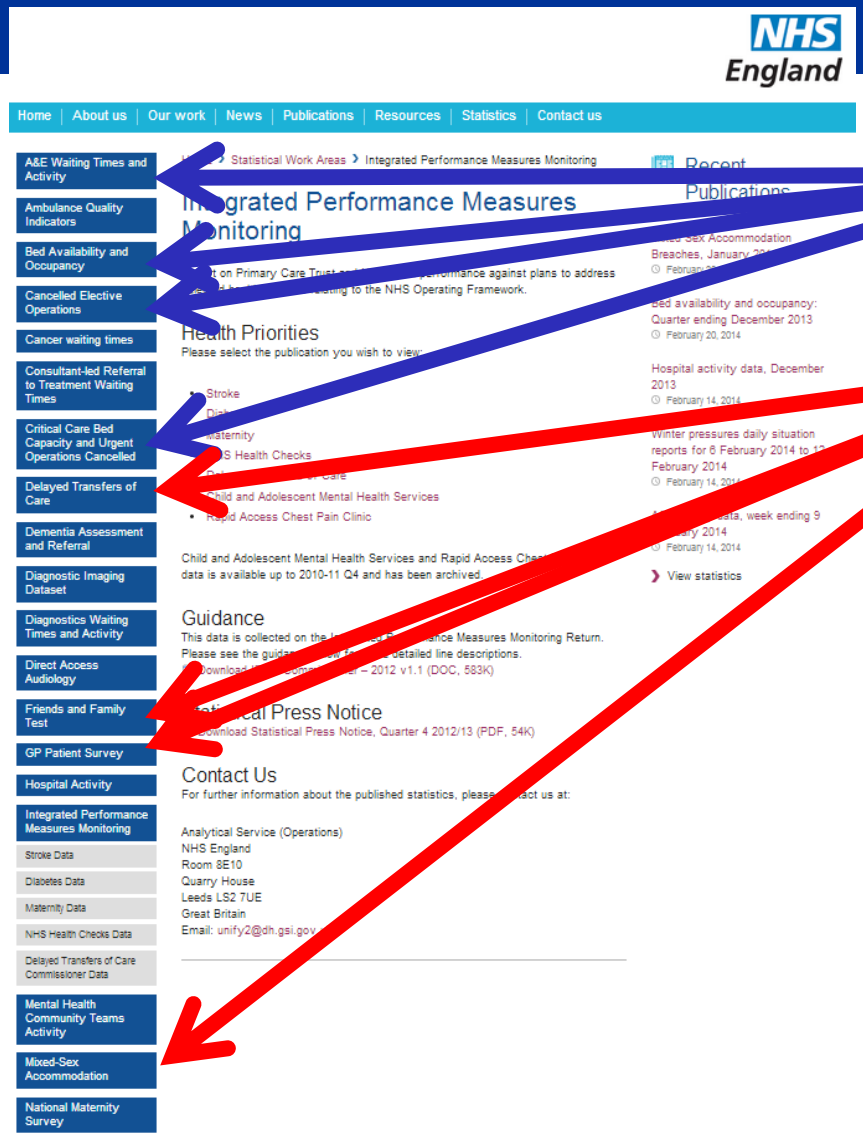
Breaking down the indicators

		Sub-national breakdown				*Equality and Inequality Strands (National Only)*							
	International comparisons	Regional	CCG level	Local Authority	Provider	Deprivation (via postcode or area)	Socio-economic group (NSSEC)	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation
1. Preventing people from dying prematurely													
1a Potential Years of Life Lost (PYLL) from causes considered amenable to health care i adults ii *children and young people*	P	P*	P*	P*	N/A	P	P*	P	N	N	P	N	N
1b Life expectancy at 75	Y	Y*	N	Y*	N/A	Y	P*	N/A	N	N	Y	N	N
1.1 Under 75 mortality rate from cardiovascular disease	Y	Y*	Y*	Y*	N/A	P	P*	Y	N	N	Y	N	N
1.2 Under 75 mortality rate from respiratory disease	Y*	Y*	Y*	Y*	N/A	P	P*	Y	N	N	Y	N	N
1.3 Under 75 mortality rate from liver disease	Y	Y*	N	Y*	N/A	P	P*	Y	N	N	Y	N	N
1.4. Under 75 mortality from cancer	Y	Y*	Y*	Y*	N/A	P	P*	Y	P	N	Y	N	N
1.4.i *One-year survival for all cancers*	Y*	P	P	P	N/A	P	P*	Y*	P*	N	P	N	N

Still work in progress …..

	International comparisons	Sub-national breakdown				Equality and Inequality Strands (National Only)							
		Regional	CCG level	Local Authority	Provider	Deprivation (via postcode or area)	Socio-economic group (NSSEC)	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation
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)	N	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.i 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.ii 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

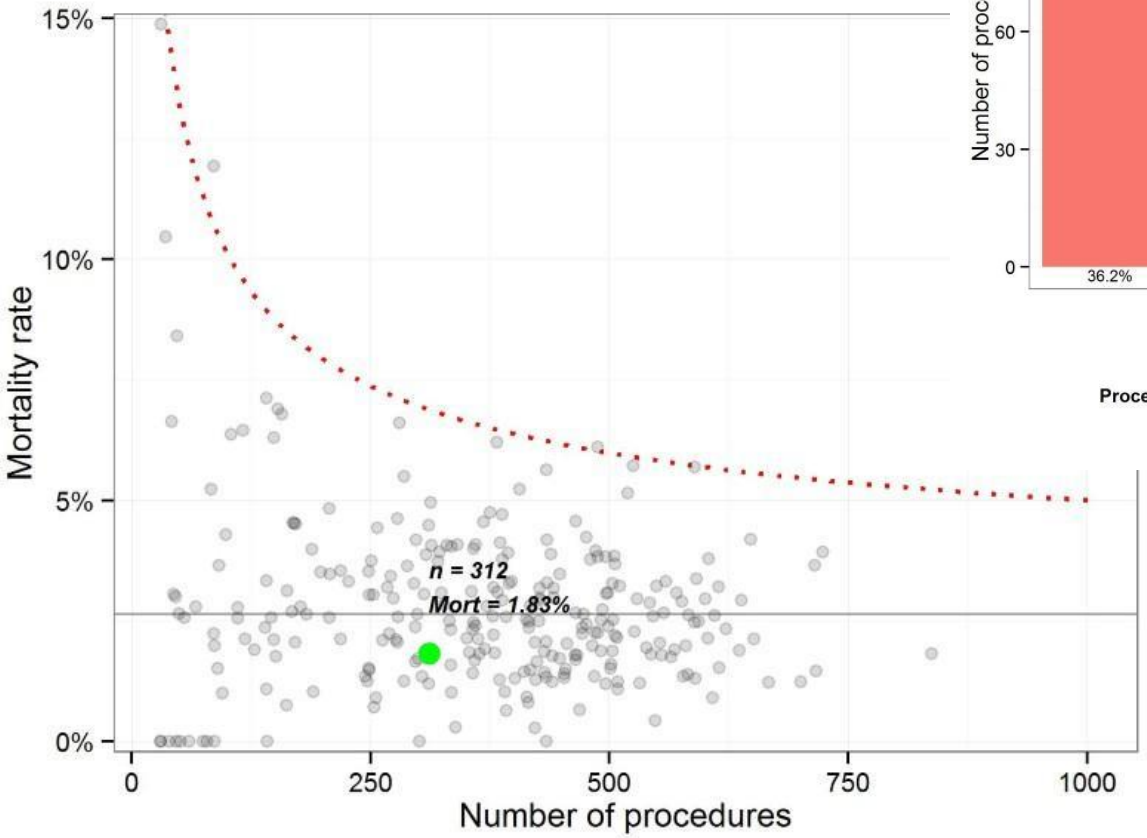
Experience measures

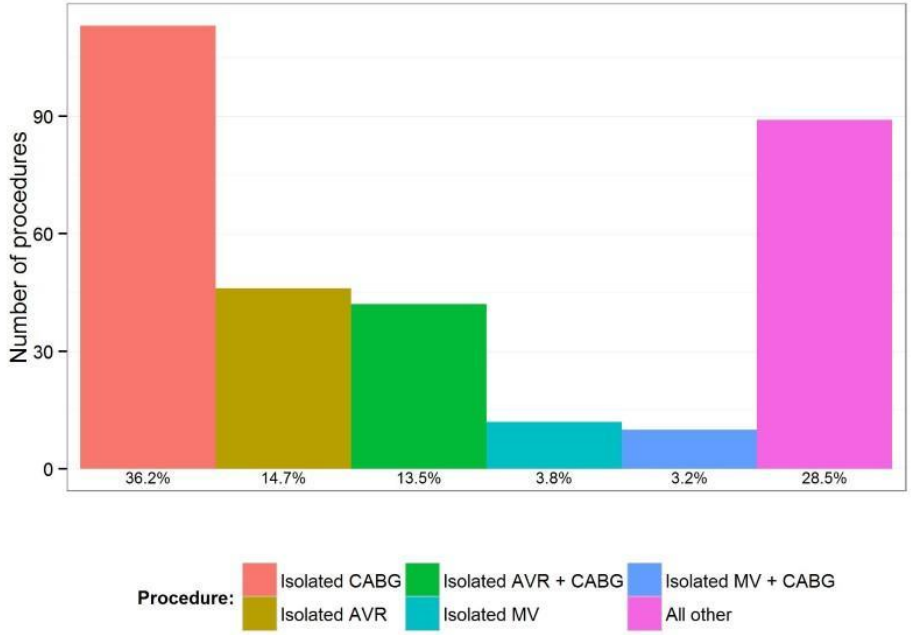
- PROMs

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)

DOMAINS

DOMAIN 1:	DOMAIN 2:	DOMAIN 3:	DOMAIN 4:
Improving the wider determinants of health	Health improvement	Health protection	Healthcare public health and preventing premature mortality
Objective: Improvements against wider factors that affect health and wellbeing, and health inequalities	Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities	Objective: The population's health is protected from major incidents and other threats, while reducing health inequalities	Objective: Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities
Indicators Indicators Indicators } *Across the life course*	*Indicators Indicators Indicators* } *Across the life course*	*Indicators Indicators Indicators* } *Across the life course*	*Indicators Indicators Indicators* } *Across the life course*

Objective

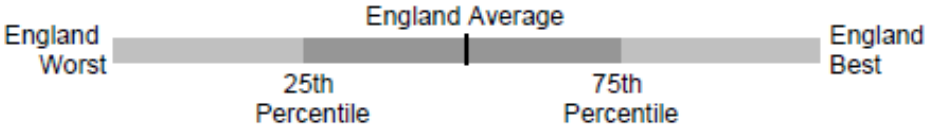
People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

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

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	159589	10.9	20.3	83.7		0.0
	2 Proportion of children in poverty	49980	18.5	21.1	45.9		6.2
	3 Statutory homelessness	970	1.7	2.3	9.7		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	9940	61.1	59.0	31.9		81.0
	5 Violent crime	16279	11.4	13.6	32.7		4.2
	6 Long term unemployment	6700	7.3	9.5	31.3		1.2
Children's and young people's health	7 Smoking in pregnancy ‡	2611	15.2	13.3	30.0		2.9
	8 Starting breast feeding ‡	12485	73.1	74.8	41.8		96.0
	9 Obese Children (Year 6) ‡	2583	18.3	19.2	28.5		10.3
	10 Alcohol-specific hospital stays (under 18)	171	54.9	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	938	33.2	34.0	58.5		11.7
Adults' health and lifestyle	12 Adults smoking	n/a	20.1	20.0	29.4		8.2
	13 Increasing and higher risk drinking	n/a	23.1	22.3	25.1		15.7
	14 Healthy eating adults	n/a	27.3	28.7	19.3		47.8
	15 Physically active adults	n/a	57.2	56.0	43.8		68.5
	16 Obese adults ‡	n/a	26.3	24.2	30.7		13.9

How do we measure things that are relevant to improving performance?

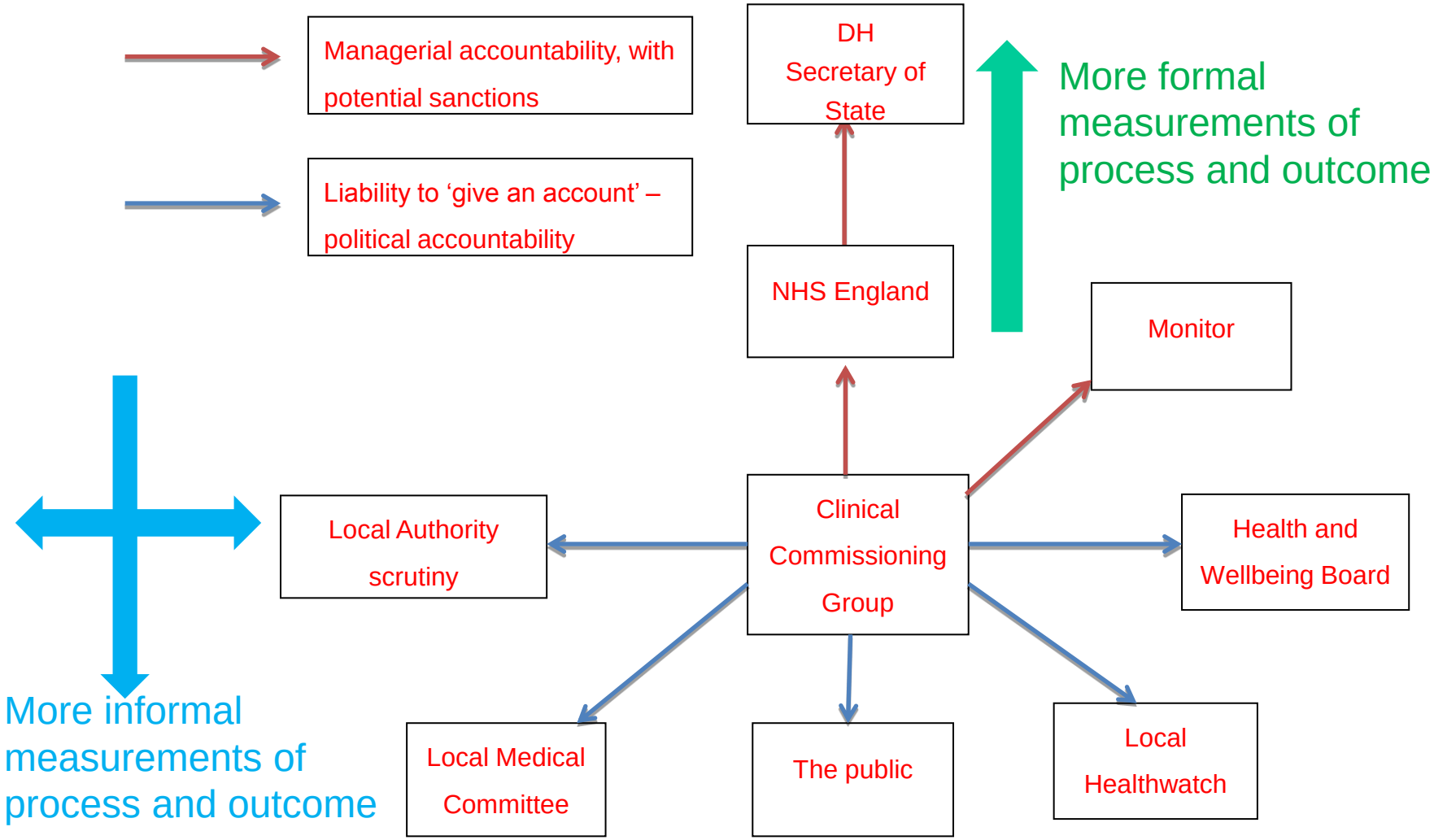
- Financial incentives can improve performance:
  - NHS Advancing Quality scheme (NW England) produced approximately 5200 quality-adjusted life years
  - £4.4m in reductions in hospital LOS - but cost £13.3m!
  - QOF costs over £1billion
  - Increased recording and some improvement in disease registers 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

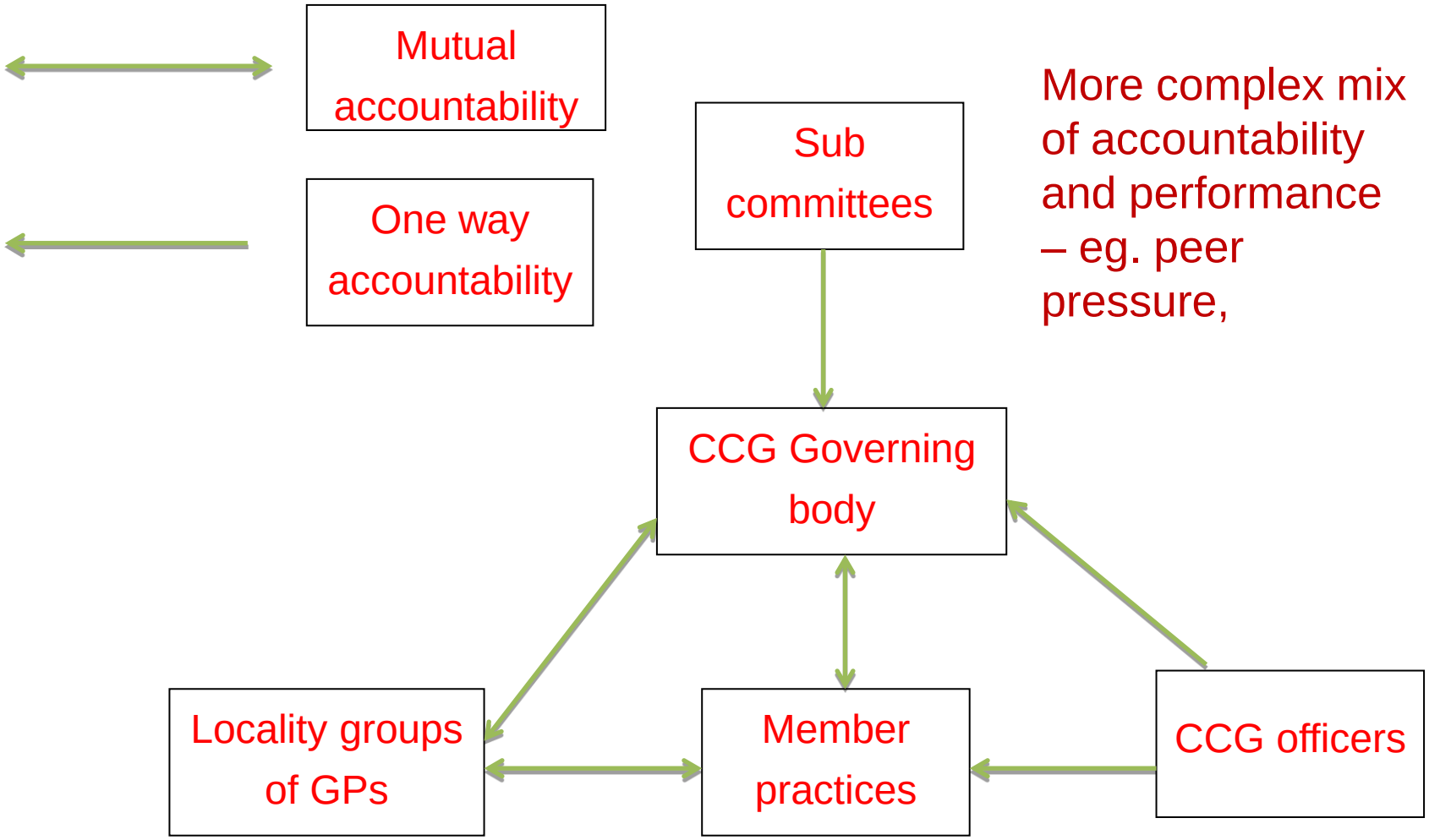
	Focus on quality of performance achievement		
Focus on quality of performance actions		LOW	HIGH
	HIGH	COMPETENCE	PRODUCTIVITY
	LOW	PRODUCTION	RESULTS

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



English Clinical Commissioning Groups – internal accountability



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)

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