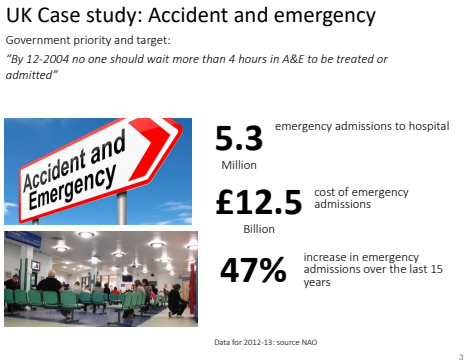
PMDU case study 1: reducing accident and emergency waiting time

This Public Service Agreement had the target that by December 2004 no one should wait more than 4 hours in A&E to be treated or admitted. Since 12 million unfortunate people pass through A&E every year, this was a significant goal for the health service and the government.

A&E in the UK

A&E waiting times were a source of huge criticism of the government in 2001 – pictures of people waiting in corridors and waiting rooms for 12 hours or even days – on chairs and trolleys.

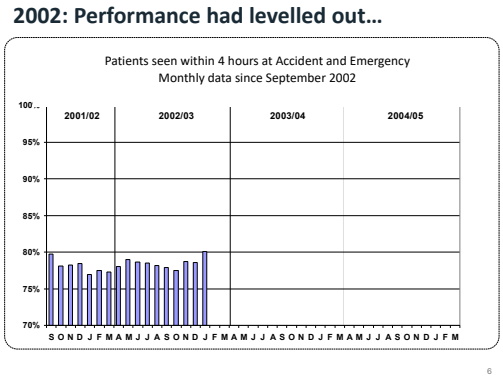
Some health professional argued this didn't really matter.



Performance had levelled out

But if you focus on what people care about need to look hard at what customer research tells us about what they find frustrating about the health service. This is up there near the top of people's list.

As you can see performance levelled off well short of the target until early 2003



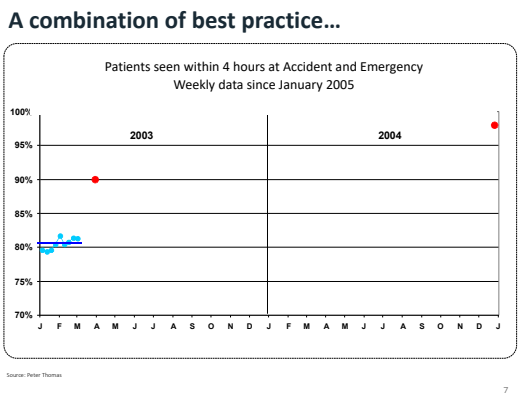
Spreading good practice was key

We carried out our first joint service priority review in late summer 2002.

As a result in In January 2003 weekly rather than monthly monitoring was introduced.

Ministers had taken three decisive steps.

1. From Secretary of State Alan Milburn down, it was made clear that this target was a priority and did matter.
2. Accident and Emergency performance was included in the hospital star ratings, the health equivalent of league tables.

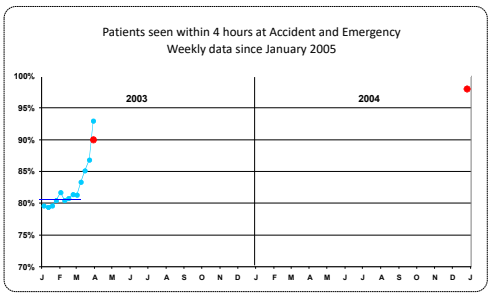


3. Finally, a proven best practice, developed in one or two A&E departments, was rolled out to all of them. Called "See and Treat" it involved dealing with minor injuries promptly rather than using a triage process.

This combination had an immediate impact on the data. Remarkably, the March 2003 milestone - the key measure in the star ratings - was achieved.

When we talked about this story of progress at the time - a lot of people said - ah well people just fiddled the performance on overtime to make the target because they knew it only mattered on march 31st.

…and accountability had a major impact



Source: Peter Thomas

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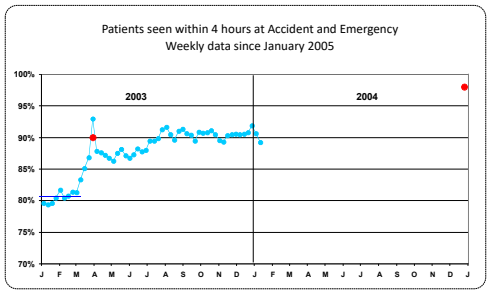
So what happened next.

And though, inevitably, performance then slipped back again, crucially it stabilised at a new much higher level.

A surge of optimism flooded through the health service.

What had happened?

Performance improved significantly…



Source: Peter Thomas

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Getting off the plateau…

First, priorities had been clarified. In general, the NHS has been very disciplined about prioritisation and is an example to the rest of the public sector in this respect.

Second, the diagnosis of the problem was good and clear so people knew what had to be done.

Third, from early 2003 there was a relentless weekly focus on the data. The entire system, at every level, was confronting the hard facts about performance and making decisions on the basis of the data. In other words, a process of rapid feedback and refinement was put in place.

Fourth, clear sharp accountability with rewards and consequences was put in place: hospitals that do well in star ratings benefit; by contrast, there are major consequences for chief executives of no star trusts.

Fifth, a practical proven best practice was rapidly adopted across a system. The imperative provided by the target made people try it - and they saw it worked and stuck with it.

Finally, staff in A&E became engaged. Well-respected clinicians as well as administrators promoted the strategy and helped it gain support. Above all, the delivery of improved results led to improved customer relations which in turn made A&E a more satisfying place to work. In other words, improved results led to staff engagement not the other way round.

… but performance levelled out again

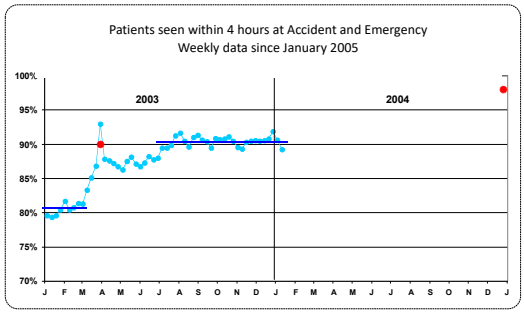
After the surge of optimism, a degree of complacency had set in.

Meanwhile the very success of “See and Treat” had laid bare the more complex barriers.

For example, both the management of consultants and management of bed space across an entire hospital, not just in the A&E department, have a major bearing on A&E performance.

By December 2003, performance was, once again, distinctly off-track and there was only a year left to meet the target.

…but performance levelled out again



Source: Peter Thomas

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We carried out a further service review.

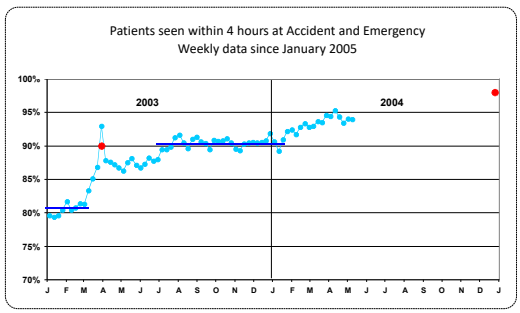
Again decisive action was taken and again performance lifted off the plateau.

How focused action took us off the plateau

Whilst nothing was certain then.. the eventual story was going beyond the target and hitting 98% consistently until the end of the labour governments.

What had happened?

Focused action took us off the plateau



Source: Peter Thomas

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Getting back on track

First, the priority was reaffirmed. The leadership, both political and official, in the Department of Health didn’t flinch. They made it very clear they expected the target to be met.

Second, various excuses for not meeting the target were taken off the table. For example, the possibility of certain clinical exceptions in rare cases was accepted. Programmes which weren’t delivering results, such as the Emergency Care collaborative were refocused or bypassed.

Third, further steps were taken to build capacity. Best practice in bed management and the deployment of consultants was analysed, identified, disseminated and increasingly adopted. Moreover each A&E department drew up a plan for how it would meet the target. Those A&E departments which were some way adrift, are being provided with extra support from respected experts.

Finally, success was not just encouraged but incentivised. Each A&E department can earn financial rewards for meeting quarterly milestones through this year and for hitting the final target. A department that meets all the milestones and hits the target could receive as much as £500,000 additional capital.

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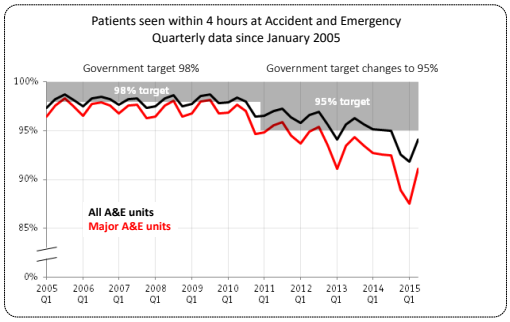
Performance was sustained until 2010..

The incoming coalition government abolished public service agreements and the delivery unit. Prime Minster Cameron ran a famously chilled no 10 in his early years leaving departments to get on with it. There was a poorly conceived effort to abandon targets that were not seen to within the direct control of the government.

I worked in Justice Department at the time and no-one thought the public would tolerate a government that said it couldn't take responsibility for the level of crime. But that was their initial impulse.

They had fallen for the largely false narrative fuelled by some academics that the delivery case studies were the result of 'terror and targets' or control freakery at Blair's governmental sofa.

The improvements lasted until 2010



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The health sector is frequently cited by those hostile to performance management as an example of the gaming and dysfunction that must inevitably be at the heart of the performance regime. Whilst there are examples of such behaviour it is a lazy stereotype. This case study shows the PSA's and central functions of support and challenge are about something else altogether. The decline of performance and citizen satisfaction with waiting times since both were abolished tells its own story.

Key features of The PMDU approach

Tools and routines

Service priority reviews were key catalyst to each stage of shifting performance. All reforms need refreshing and revitalising.

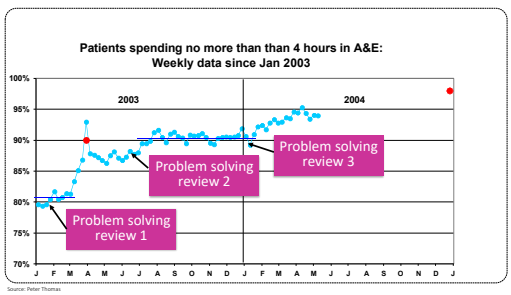
And reviews work if you turn the findings into a new trajectory – the follow the cycle of tracking progress – holding stocktakes – and learning lessons from what is going well and what isn't.

How priority reviews helped

They help you to build trust and good relationships with ministers and officials. You have helped them succeed – they get the credit - and they will want to work with you again.

Phase 3: Problem solving reviews

Collaborative problem solving service reviews' were key to each stage of shifting performance in our case study.



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They create clear actions with timescales that can be monitored

You keep looking at your delivery trajectory to see if the actions are workingBy doing things – you learn about what works and what doesn't.

The strong focus on action to tackle evidenced problems – not just hunches or treating symptoms.

Approach and way of working

The values and ways of working from the centre were intentionally different from the norm:

In the UK, central units are often seen as highly bureaucratic entities which chase progress, but do little to add value to what department's are already doing

In the case of PMDU, the relationship between the centre and the departments was based on: sharing responsibility for progress; helping solve problems collaboratively rather than just telling depts. what to do.

Credit for success stayed with departments.

People

The skill and knowledge mix of the central team helped with this.

Barber was given a £2 million consultancy budget and built a core team of approximately 40 people drawn from the Civil Service, local government and consultancies.

Barber personally handpicked many of the applicants, tapping into the expertise that existed in different sectors. The team was also deliberately kept small to maintain focus and momentum

There was a huge collective investment in training and tools. The team modelled open, peer challenge in how it quality assured its own work and reflected on progress.

Source

The slides and supporting narrative are drawn from contemporaneous public Slide Decks used widely by PMDU staff internally and externally to explain, encourage and disseminate the PMDU approach and PMDU collaborated with departments to help them succeed.