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SHA Commentary on Proposals for League Tables in the NHS

Introduction

This document sets out our view on the proposals to introduce League Tables for the NHS from April 2025 as currently proposed by the SoS for Health. League tables are commonly used to indicate comparative performance in areas such as sport; however, the concept of League Tables in the NHS has been met with some dismay, resistance, criticism and anxiety.

It is understood that Performance Indicators and League Tables represent an attempt to foster public accountability. However, we believe that the concept of a League Table with regard to a health service is problematic for numerous reasons. We believe that there are better ways to achieve accountability and quality for NHS Services. League Tables are based on the premise that there are good and bad providers. They foster the ethos of competition and choice and are part of the neoliberal mindset. Essentially ALL NHS services should deliver excellent and appropriate care to the populations they serve and should be supported in their journey to do so.

Hitting the Target but Missing the Point

Performance indicators (and associated League Tables) force institutions to hit set targets, with the targets being a numerical proxy for what are understood to be excellent care and system success. Some targets - such as waiting list times - are more or less absolute (you hit the target or you don't), but the actual determinant of an excellent service is that the wait is appropriate for the condition and patient concerned and in the context of the system within which it operates, so that the patient received the right care at the right time. So if reduced waiting times means that waiting lists are culled inappropriately, that GPs are urged not to refer patients, that denominators are manipulated, or that wider objectives in terms of quality of care are compromised, the target may do more harm than good in terms of both efficiency and quality.

Likewise, if A&E wait targets mean that ambulances have to queue outside of A&E- because patient waiting time is not counted until they are inside A&E- there is a potentially harmful distortion of the care pathway.

Thus, a more useful approach to Wait Times would be to aim for a standard benchmark (such as referral to treatment) but to have a system of prioritisation and review in place - including clinical audit - so that the institution can be assured and provide assurance that waiting times are appropriate and that care is not compromised by longer waits than necessary.

Furthermore, workers may be doing their very best, but the parameters within which they are working may mean that the "target" is inappropriate or even harmful and it may result in unintended adverse consequences. The most that a performance indicator can and should do is to provide comparative data that aids understanding and may point to ways in which services should and might be improved. As an extension of this problem, publishing metrics without understanding and/or context may result in scaremongering and distraction.

League tables - in that they consolidate numerous performance measures - suffer all the flaws of performance indicators in that they consolidate different proxies for excellent care - potentially without the context being understood or available.

Balanced Scorecard Approach

There is a need for a set of metrics that indicate overall organisation performance, thus providing accountability. These metrics should be set in context - such as reference to local population and geographic characteristics.

For example, high levels of foot amputation would be correlated with levels of diabetes; but levels of diabetes - and the failure to manage it - also correlate with the levels of ethnic minorities within the population.

So simply ranking foot amputations per million population (pmp) without understanding the population and disease context would be unhelpful. Essentially, where patient data

is concerned, the data must be in the context of clinical and public health dimensions. And the purpose of the metrics should be to identify, understand and address indicated problems, and not to award gongs and wooden spoons.

By way of historic context, The DoH introduced a Performance Assessment Framework for the NHS in 2009 based on a Balanced Scorecard approach using finance and quality indicators, with the stated intention that quality be at the heart of the framework. Where the Framework indicated problems, there would be commissioner intervention (within the context of a Reinstated NHS, this would be management intervention). The framework has been developed and amended to operate within the context of the Integrated Care Boards now in place in England.

The consultation for the current NHS Oversight Framework is here. It is very much a balanced scorecard approach with emphasis being on support and intervention rather than naming and shaming. An example of another current framework in place is that of NHS Wales.

Statistical Process Control Approach (SPC)

This approach would enable providers and systems to track their performance in statistically robust ways which would be much less likely to be misunderstood and misused. We refer to this method here for further study.[1]

SoS Current NHS Proposals: Naming and Shaming

Wes Streeting plans to publish a league table of the best and worst performing NHS Trusts in the country from April 2025. He will sack "Failing bosses". Criteria will include waiting times for A&E and surgery, financial health, and leadership quality. "High Performing Trusts" will get additional funding for equipment and infrastructure. The natural reaction from NHS managers and staff is that it would lead to unnecessary shaming without addressing deeper systemic issues.

Indeed, where there are systemic issues that need to be addressed, the shaming of organisations and the withdrawal of funding support is likely to worsen levels of anxiety and distress within the organisation, compared with the extra funding awarded to 'higher performing' Trusts. This would most likely exacerbate the difference in service and treatment outcomes for patients.

Conclusion

It is our view that the idea that "League Tables" will mend the NHS is badly mistaken. It is more likely to set providers against each other, foster a blame culture, and stress and demoralise staff. Moreover, it is based on a flawed assumption that performance indicators are useful and accurate measures of quality that address systemic issues and which do not distort priorities. Performance Indicators and league tables fail on all of these points.

We would propose the further development of a balanced scorecard approach that sets patient care in the context of the whole system and that enables all parts of the system - nationally and locally - to collaborate in the overall best interests of the population's health. We would further propose the consideration of an SPC approach to the monitoring of service parameters.

Briefing from SHA Officers:

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[1] Statistical Process Control (SPC) is a method designed to monitor and control product or process variability using statistical tools. It tracks processes over time and enables statistically significant changes or occurrences (for example, variances over and above 2 or 3 standard deviations from the historic system mean) to be identified.