



The Better Metrics project: one year after launch

A briefing on the results of research into the dissemination
and implementation of better metrics in NHS organisations

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Briefing paper

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Introduction

This briefing paper is for those who:

- were involved in producing the Better Metrics document in 2004/2005
- participated in the Better Metrics steering group's evaluation of the dissemination of Better Metrics in 2006
- are interested in using the Better Metrics guidance in the near future

Better Metrics is a project to develop clinically relevant measures of performance and assist local services in developing their own.

For those who only seek a quick overview, the key messages, background and recommendations sections are suggested.

This briefing paper is based on a pilot research project that followed up how Better Metrics had been disseminated at the senior level of NHS organisations, namely in the then 28 strategic health authorities (SHAs), 302 primary care trusts (PCTs) and 81 mental health trusts (MHTs).

From this, we are able to paint a picture of the dissemination and implementation of Better Metrics by mid-2006. We have also identified some of the obstacles to implementation. We hope by sharing our findings, people can make objective decisions on how best to use Better Metrics, based on the experiences presented.

Key messages

- After a year of launching the Better Metrics project on the internet, about half [52% (118/225)] of respondents from SHAs, PCTs and MHTs were aware of it. 57% (55/96) of respondents who had heard of Better Metrics could see its relevance; 6% (6/96) did not and 37% (35/96) were not sure.
- The general comments about Better Metrics were positive and encouraging in terms of perceived relevance and purpose. Overall, the perceptions were largely dependent on the organisation's circumstances (particular interest, priority, and individual organisation's readiness to adopt the metrics).
- About 23% (26/115) of respondents who had heard of Better Metrics had used it for some purpose. About 19% (16/84) of respondents from PCTs who had heard of Better Metrics had used it specifically for local delivery planning (LDP).
- Among those respondents aware of Better Metrics and who also thought the metrics were relevant to them, 46% (25/55) had discussed the project within their organisation and 38% (21/25) had used Better Metrics for some purpose. Among those from PCTs in this category, 34% (14/41) had used Better Metrics specifically for LDP.
- The study identified a range of factors, both positive and negative, that might have influenced the dissemination and implementation process of Better Metrics. Lack of marketing; not being a 'must-do'; lack of perceived immediate impact; and less favourable timing were some of the factors that might have delayed the implementation of Better Metrics.

These are based on an organisational participation rate of 55%.

Background

The Better Metrics project arose from discussions at the NHS's 'top team' (the meeting of strategic health authority chief executives with the (then) NHS Chief Executive, Sir Nigel Crisp, and Department of Health national clinical directors, directors and other lead officers).

There had been a general concern that clinicians practising in the NHS and practitioners in other agencies working closely with the NHS, had not always been engaged by the targets and other indicators used to manage and assess performance in the NHS. For example, local clinicians might not always be aware of the targets being measured, or the components of their organisation's (then) star rating indicators, and were unlikely to be using them as part of their service quality improvement initiatives. This was despite widespread clinical support for central initiatives such as the *NHS Plan* and national service frameworks. One possible explanation for this was that some

of the existing performance measures were not sufficiently relevant to clinicians' day-to-day practice, or to the patients they were treating.

In January 2004, the 'top team' agreed to support a project to develop more clinically relevant measures of performance. These measures have been termed 'metrics' to avoid confusion with other terms such as targets, indicators or benchmarks – the aim is that the proposed 'metrics' could be used for any of these purposes. The project also aimed to produce some criteria for what makes a 'good metric', to assist local services in developing their own.

When the Better Metrics project was launched, it was hoped that the 'metrics' could assist:

- PCTs in defining local targets, where a topic covered by a metric has been identified by a PCT as an area within which a local target could be set
- the Healthcare Commission as part of its consultation in developing criteria to assess clinical effectiveness or other relevant standards in an area covered by a metric
- as indicators for local quality improvement initiatives

The development of Better Metrics was pragmatic and was intended for rapid dissemination within the NHS, rather than as a formal 'academic' exercise. The aim was developmental; to revise the metrics regularly in response to comments and evaluations of how useful they are locally.

A Better Metrics document, containing a list of metrics, was first published on the Office of Strategic Health Authorities website (www.osha.nhs.uk) in November 2004. Better Metrics was also mentioned in the DH Technical Note on Local Delivery Planning for 2005/8 http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleaqueletters/DH_4095438

It was subsequently announced in January 2005 in various DH bulletins including the *Chief Executive Bulletin*, *Medical Directors' Bulletin* and *Chief Nursing Officer Bulletin*. A sixth version of the document was published in March 2005, and the current, seventh version (revised in March 2006) is now available on the Healthcare Commission's website (www.healthcarecommission.org.uk/serviceproviderinformation.cfm).

Aims and objectives

This pilot evaluation of the project aimed to follow up, a year after its launch, how Better Metrics had been disseminated at the senior level of targeted NHS organisations. This overall aim was achieved by the following objectives:

- how widely Better Metrics was known by the NHS organisations investigated (evaluated by a web survey)
- the general feelings and level of understanding about Better Metrics (web survey and interview)

- whether PCTs had used the metrics for their local delivery plan or in any other way (web survey and interview)
- the potential factors were that had significantly influenced decision on implementation and action (interview)

Practical findings

Table 1. Summary of findings		
Objectives	Areas being investigated	Summary of findings
How widely was BM known? (based on 225 respondents representing 227 organisations)	Overall	52% (118/225) respondents (SHAs 83%; PCTs 51%; MHT 46%).
	When	Over a half had heard within five months after launch.
	Where	32% heard from internet; 42% from colleagues.
General reaction to and understanding of BM (based on interview and questionnaire survey)	About BM project and document	Contents: perceived to be needed, particularly for MHTs. Presentation: big, but manageable volume; layout good; user-friendly. Credibility: high. Involving users: did to a degree, though unevenly across the country. How BMs should be used: unclear. Evaluation: method not in place.
	Comprehension	Over half claimed the purposes were clear to them. However, they were not clear on how exactly to use them and how BM fits into the existing system.
	Relevance	It was acknowledged that BM was relevant to them, however the immediate relevance was not understood – reasons were varied.
Implementation of BM (based on those who were aware of BM: 118). Note: where the denominator is less than 118, it indicates missing responses for individuals.	Used for any purpose (see table 2 for details)	23% (26/118) of respondents said their organisation had used BM (SHAs 28%; PCTs 21%; MHTs 24%).
	Used for LDP	19% (16/84) of respondents from PCTs said their PCT had used for LDP.
	Discussed in senior management team	28% (33/118) were discussed in organisations (SHAs 13%; PCTs 27%; MHTs 47%).

Table 1 continued on following page

Objectives	Areas being investigated	Summary of findings
Influential factors (based on both survey and interviews)	Marketing	Web publication: the original publication on the internet was only the second main route of awareness of BM; confusion from it not being final; how to use it while it kept changing. Endorsement: not enough and not clear – no clear recommendation from DH to use it.
	Not 'must-do'; not 'ready-made tool'	Not must-do, therefore not a priority. Not ready to use, therefore lack of time or capacity to use as a tool as it needed further development.
	Lack of immediate impact	Add-on value; whether benefits outweighed effort; whether organisations would be benchmarked were all unclear.
	Timing	Produced in time, though unclear how to deal with the work already in progress that was based on other pre-BM documents. Organisation not stable at the time. Capacity to receive and disseminate the relevant knowledge varied hugely amongst the organisations.

How widely was the Better Metrics project known by the NHS organisations investigated?

The awareness of the project was reasonably high. Over half of all organisations that responded had heard of it. More than half became aware of the project within six months of its launch. About one third had heard of it via the *Chief Executive Bulletin* where Better Metrics was initially published; just over a third heard from their colleagues. About 5% of respondents had heard about the project from our survey.

What were the general feelings and level of understanding of Better Metrics?

Over 81% (95/117) of respondents who had heard of the project had at least skim-read the project document. They believed that Better Metrics could contribute to the overall change process in the NHS. They also believed that Better Metrics shared their local values and the goals of their services. It seemed to be important to know who the producers were and responses indicated that the credibility of Better Metrics was high. The opportunity to be involved in the development process, by contacting the project leads with queries or comments, was perceived as a positive feature.

Respondents thought the Better Metrics document was easy to follow and clearly presented. More than half [57% (55/96)] who were aware of Better

Metrics said that each of the four purposes¹ of the project were clear to them and said that the metrics were relevant to them. Thirty seven per cent (35/96) were not sure and about 6% (6/96) said they were not relevant.

Although respondents may have said Better Metrics was relevant, how they evaluated the relevance was based on a range of issues:

- clinical coverage, for example if certain areas of their interests were covered in the metrics, they were relevant
- if metrics were 'must-dos', or if they were to be benchmarked by them, then Better Metrics could be perceived as highly relevant to them
- timing, for example Better Metrics might be relevant but not a current priority; or it might be relevant under normal circumstances, but not when the organisation was about to change

Had they used Better Metrics?

Overall, around 23% (26/115) of respondents to the survey who were aware of Better Metrics said their organisation had used (or planned to use) the metrics for some purpose. The areas of use are shown in Table 2.

In addition, 19% (16/84) of respondents from PCTs who were aware of Better Metrics said their organisations had used it specifically for their local delivery plan. Overall, 28% (33/118) of those who were aware of Better Metrics had discussed the use of it at relevant high level meetings (for example, board meeting, professional executive committee or clinical governance executives): 13% (2/15) from SHAs; 27% (23/86) from PCTs and 47% (8/17) from MHTs.

¹ Purposes: 1. to help PCT to set local targets 2. to help SHA to oversee local organisations to meet both national and local targets 3. to help HC to assess standards 4. to help all to develop clinically relevant indicators for quality improvement and performance management.

Table 2. Areas in which BM had been used or was planned to be used	
Areas in which BM had been used or was planned to be used	Organisation reporting use in this area
Developed a metric for diabetes which relates to targets from the national service framework	SHA
Diabetes developmental work in GP and diabetes services quality assessment	PCT
Developing scorecards and benchmarking	SHA
Encouraged wider thinking in terms of local service providers, local area agreement outcomes and targets	SHA
Supporting Local Area Agreement development	PCT
To help practice-based commissioning clusters commission for quality	SHA
Agreeing local clinical indicators	PCT
By Learning Disability Partnership Board to assess current service provision/performance	PCT
Workshop on learning disabilities around health action plans	PCT
To identify best practice in community learning disability services	PCT
Used them in a joint performance framework with local mental health trusts	PCT, MHT
Working with GPs to help data collection in primary care to help improve awareness of people with learning disability, to use it in conjunction with quality outcomes frameworks	PCT
Setting targets to monitor progress of the local breastfeeding action plan and development of local public service agreement targets	PCT
Community strategy	PCT
Establishing national service framework targets	PCT
To support a cross-referencing framework for assessing the links around pieces of work with core standards, targets, activity data	PCT
To provide a framework for assessing/performance managing the progress against national service frameworks	PCT
Put them in all performance frameworks for the PCT's disease specific groups	PCT
For public health performance management framework	PCT
To re-define and develop the performance reports	MHT
Some used in the consideration of performance at board level	MHT
Used for audit and effectiveness in benchmarking GP	PCT
To specify work on learning disabilities/mental health with external partners	PCT
Changing internal 'assurance' arrangements in the light of BM and other documents	MHT
Discussed – intended to link it to clinical governance work and MEDICS audits (<i>sic</i>)	PCT
Initial thinking about how could use it to improve quality of service in a more relevant way	MHT
Will be taking to commissioning groups for specific areas	PCT

The potential factors that significantly influenced decisions on implementation and action

1. Publication only on internet; marketing

Although the Better Metrics document was published on the internet (including the *Chief Executive Bulletin*, *Medical Directors' Bulletin*, *Chief Nursing Officer Bulletin*, Department of Health website), our survey revealed that the greatest number of respondents became aware of the project from their colleagues. The internet was only the second most common way of respondents finding out about it.

While it was acknowledged by interviewees that internet publishing has become routine working practice, they nevertheless believed that the web version of the Better Metrics document was not a 'final version'. They believed that they would receive a hard copy. Some were confused about how one could use the metrics when the Better Metrics documents continue to change. Others admitted that they had not paid much attention to Better Metrics because "nobody had recommended to them to use it" despite them seeing it on the website (*Chief Executive Bulletin*).

This indicates that the use of the internet among NHS organisations might not be as wide spread as we thought. Also, the habit of looking up certain websites seems to vary depending on the individual.

The way that information cascades within each organisation seems to vary hugely. It was more developed in some organisations than in others. In the organisations where the information cascade system was less developed or less efficient, the reliance was on individual leaders to spot the relevant information and send to appropriate people within the organisation.

2. Not being a 'must-do'; not a 'ready-made' tool

Some mixed perceptions and confusion about Better Metrics implementation were revealed. On the one hand, it was understood that the metrics were optional and not "yet another must-do"; however, on the other hand, this would mean that they were likely to be pushed off the list of priorities. Better Metrics was designed to be used as guidance to develop relevant measures or indicators and not a 'ready-made' tool. Some respondents wished it was something that could "be just taken from the shelf and ready to use".

3. Lack of immediate impact

While 57% (55/96) of those in the survey who had heard of Better Metrics acknowledged that it was relevant to them, interviewees reported that the decision to implement would have been based on the immediate impact expected from using it. They would be balancing out:

- whether or not there was an obvious add-on value from using Better Metrics
- how Better Metrics related to the existing benchmarking system they were using
- how the benefits weighed against the efforts

- whether or not they would be benchmarked by the Healthcare Commission if using Better Metrics

Having clear answers to the above questions were said to determine whether Better Metrics was implemented.

4. Timing

The timing of the Better Metrics project was generally acknowledged to be right in theory because of the wide concerns about less clinically relevant targets and ‘must-dos’. Some respondents however, were confused as to what to do with their existing incomplete work, which was based on the standards and benchmarks produced before Better Metrics – did they “have to throw them away and start over again by using Better Metrics?” In addition, by the time of the survey, the most recent NHS organisational reconfiguration was on the way. This “disruption” was said to have affected many NHS organisations’ readiness to implement Better Metrics.

Implications of the findings

The findings indicated that the Better Metrics document was perceived as a helpful piece of guidance on clinical indicators/measures. In particular, respondents claimed that this was something that had not been previously available for MHTs.

The following issues might have delayed or hindered the implementation of Better Metrics:

- internet publishing seems to have reached only half of its targeted audience
- there was not a clear endorsement from national organisations
- there was some confusion relating to unclear messages to the potential users, such as the association with other existing policies/standards and how organisations would be assessed on using or not using Better Metrics
- the impact of changes to organisational structure

Recommendations to the Better Metrics steering group

1. Clarify the position of the Healthcare Commission, Department of Health and other relevant national agencies on using Better Metrics in the changing world of metrics and indicators (including Better Metrics’ status and relationship to other national initiatives), and publish a statement to this effect.
2. Market links to the website; make links between key websites.
3. Provide more support for local organisations, such as presentation materials; cascade briefings via SHAs and other networks.
4. Clarify the issues that caused some confusion such as:

- if the internet version is the final version; consider producing an annual hard copy report, present clarifying statements on the internet
- how Better Metrics should be used in parallel with other documents or whether it should replace them, for example how it is associated with the assessment of standards; *Better Care Better Value* metrics (www.productivity.nhs.uk) and other documents
- consider what measures could be put in place to benchmark organisations using Better Metrics

5. Organise subsequent workshops to exchange experiences or knowledge.

6. Conduct follow-up surveys on implementing Better Metrics on a regular basis. (See 'further research').

About this study

Design and setting

All medical directors/directors of public health and chief executives from the then 28 strategic health authorities, 302 primary care trusts and 81 mental health trusts in England were invited to complete an on-line survey.

Eight senior members from the NHS organisations listed above, in the north east of England, took part in semi-structured interviews.

As no acute trusts had contacted the project prior to the survey, acute trusts were not included in this study.

The overall response rate at organisation level was 55.2% (227/411); the breakdown by organisation was: SHA response rate 64.3% (18/28); PCT 57% (172/302); and MHT 45.7% (37/81).

About the research team

This pilot research study was led by Dr P Whitty and conducted by Dr M Pu, MSc student at Newcastle University, in 2006.

Further research

The Better Metrics steering group should commission a similar study in 2008, when NHS organisations have stabilised. A short web-based questionnaire could be circulated at regular intervals as a monitoring tool. This is particularly important as Better Metrics is a 'rolling document', and requires on-going development. A larger number of interviews covering different geographic areas in England will be necessary to gain a fuller, in depth understanding of the perceptions of the project and the influential factors for implementing Better Metrics.