HfMA CIMA

Raising the Standard of Performance Reporting in the NHS

A Guide to Best Practice in Performance Reporting to NHS Boards

Preface

Published by the CIMA and the Healthcare Financial Management Association

This publication and all its contents were developed by CIMA/HFMA NHS Performance Reporting Project Group.
The members of the group were:

Hilary Ayerst,
Director of Finance and Resources, Lewisham PCT
Steven Bliss,
Head of Financial Performance, Thames Valley Strategic Health Authority
Neil Ferrelly,
Director of Finance and Information, Harrow PCT
Tim France,
National Finance Lead, Deputy Director of Finance, NHS Professionals Special Health Authority,
Simon Wombwell, *Deputy Director of Finance, Oxford Radcliffe NHS Trust*
With Judy Finn, Stathis Gould *and* Russell Green *of CIMA, and* Anna Green *of HFMA*.

CIMA and HFMA are keen to obtain feedback on ways in which the content, style and layout can be improved to better meet the needs of its users. Please forward your comments to technical.dept@hfma.org.uk or to the address listed.

ISBN 1-904624-08-1

The group would like to thank all those who contributed to this guide by responding to the questionnaire, providing example board reports and reviewing drafts of the guide. Particular thanks are due to Guy's and St Thomas' Hospital Trust and Kingston Primary Care Trust for allowing examples from their reports to be reproduced here.

Cover design and final production by FM Litho Design & Print.

Healthcare Financial Management Association,
Suite 32, Albert House,
111 Victoria Street,
Bristol BS1 6AX
Tel.: (44) 0117 929 4789

CIMA
26 Chapter Street
London SW1P 4NP
Tel.: (44) 020 7663 5441

Contents

Foreword

Effective management of performance is a key success criterion for all organisations in today's NHS. Better clinical outcomes, service delivery and efficiency depend on it. To achieve this demands good quality information on and interpretation of performance to enable the boards of NHS organisations to make the right decisions on where effort should be focused.

In its recent report *Achieving First-class Financial Management in the NHS, the Audit Commission said* "Getting the basics right is crucial. Effective decision-making processes supported by robust planning, budget setting and monitoring clearly all go towards providing a strong platform from which to work. Despite this, many NHS organisations could do more to provide this platform and some struggle to achieve it."

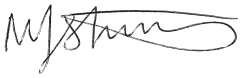
CIMA and the HFMA realise that the task facing finance directors and managers charged with producing performance reports for their boards is made particularly difficult by the plethora of information available from the many reports produced for different audiences. It is a challenge linking these together in a robust, coherent and concise way. Key indicators for the organisation need to be identified and presented in the most effective way possible. It is also increasingly important to understand the organisation's performance against the background of the entire local health economy.

Poor performance reporting will lead to misguided decision making at the highest level. We have therefore combined our resources to produce a good practice guide to assist finance and performance managers in improving their board reporting and in addressing some of the shortcomings identified in the Audit Commission's report. It provides a practical approach to developing and improving reporting to an individual organisation's board.

We believe that there are a number of essential requirements for successful board reporting. The focus must be on the key indicators of the organisation's performance, with identification of linkages between the indicators to give a robust and comprehensive picture of performance. Clarity of presentation is imperative, incorporating graphical representation of trend, forecast and other types of statistical analysis accompanied by supporting narrative that adds value to the figures. Finally, the frequency and scope of reporting must be aligned to the decision-making processes of the organisation.

We hope that by presenting a model for board reporting which addresses these fundamentals, this guide will make a timely and valuable contribution in equipping the NHS to improve its decision making and, in turn, the services which it provides.

Charles Tilley
Chief Executive CIMA



Mark Knight
Chief Executive HFMA

Overview

Developing leadership in performance reporting

CIMA and the HFMA have produced this guide to provide advice and suggestions on how to improve the reporting of performance in the NHS, particularly to boards. It is in response to a perceived need for better performance reporting and is primarily for three groups of people. Firstly, it should be of value to NHS Finance Directors, especially those recently appointed. Secondly, NHS staff who prepare performance reports should find it particularly valuable. The third main group is board and audit committee members, who need to ensure that performance is properly reported.

Although this guide is for NHS Boards, members of executive teams and committees such as Professional Executive Committees in PCTs have an important role in performance management, particularly from a clinical perspective. They should also find the principles in this guide useful in considering their reporting needs.

Why should the NHS review its performance reporting now?

CIMA research conducted at the end of 2003 shows that performance reporting in the NHS is inconsistent, and sometimes poor in terms of quality of content and presentation. There is a clear opportunity to raise the standard of reporting across the board in all NHS organisations and make some quick wins on improving the focus of management attention.

The standard of reporting is crucial to the decision-making needs of Boards. This report is designed to help those preparing Board reports to structure them in a way that is insightful and of maximum value to directors and management in generating action on those issues that require attention.

All organisations need to review how they report, especially when the environment in which they operate is changing. Research by the American Institute of Certified Public Accountants cited in CIMA's technical briefing in 2002, Latest Trends in Corporate Performance Measurement, lists common reasons for reviewing performance measures, of which most can be seen to apply to today's NHS:

- *Financial problems*

  In the commercial world these reveal themselves as a decrease in profitability, whilst in the NHS a failure to break even. Particular pressures result and at present include public Trust overspends, notably in Bristol, where poor reporting and forecasting contributed. Another is the continuing tendency for healthcare to overspend if not controlled, as neither the providers nor the consumers of healthcare have any strong financial incentive to manage demand. Furthermore, high levels of financial risk were revealed in some of the board papers reviewed for this project.

  The NHS's traditional ways of balancing the books have largely been removed. Slippage in investments is difficult when there are explicit targets to hit. Brokerage between organisations is now discouraged in the interests of transparency. Capital to revenue transfers will be impossible from 2004/5. Hence the risk of financial failure is increased, and consequently performance reporting needs reviewing and strengthening on an on-going basis.

- *Change in strategy*

  There has been a rapid expansion in NHS funding and expectations, coupled with growing diversity of provision.

Overview - continued

Commissioning has been moved from health authorities to PCTs. New providers are now encouraged. Power is being decentralised where possible, although all key targets are set nationally. Performance reporting needs to adapt.

- *Redesign of business processes*
  Work is being shifted from inpatient to day case, from primary to secondary care, and (sometimes) from the NHS to other providers. Pathways of care are being re-designed. NHS Direct is providing advice previously given by GPs or A&E departments. Most consultants and GPs are now working to new contracts, which may change how care is provided.

- *New technology*
  There is continuing to be a rapid increase in the NHS's information technology, for example for electronic booking and electronic prescribing. On the clinical side, new NICE recommendations and NSFs introduce new methods of treatment.

- *New competition*
  The NHS is deliberately breaking existing semi-monopolies and encouraging diversity of provision. Choice is one of the key objectives, which implies competition. Competition is growing, within the NHS and from independent sector treatment centres. Payment by Results is one of the biggest changes ever to hit the NHS, and will facilitate choice and competition (on quality and waiting times, not price).

- *To attract and retain staff*
  This is one of the NHS's biggest challenges, essential to deliver the NHS Plan. There are many recruitment initiatives. NHS Professionals has been created to manage some of the gaps. However, our research suggests that reporting of staffing issues are still not covered adequately in board reporting.

HOW HAS THIS REVIEW BEEN DONE?

Three methods of research were used in this project:

- *A literature review*
  This draws from good practice and previous research in performance reporting and recent developments (mainly in the commercial sector).

- *A questionnaire on what is currently reported*
  Ninety NHS organisations (about one sixth of the NHS) completed the questionnaire which informed us of the types of indicators being included in reports.

- *A review of complete board performance reports*
  Complete reports from 20 organisations were examined in detail to supplement the questionnaire. This was intended mainly to look for examples of good practice, which are described later in the report, but it also revealed some common problems. A checklist used in this analysis can be found in Appendix 2.

Chapter 1: Review of current practice

To help gain a view of current trends in reporting to Boards, a survey of all Trusts and PCTs informed our insight into current practice. Ninety responses were received to the survey that can be found at Appendix 1. In addition to this survey, around 20 actual board reports were analysed to look for exemplar reporting which has contributed to our best practice guidance later in this report.

The responses to our survey indicate that generally reporting to boards, as might be expected, is determined by the nature of the organisation. However, a concern is that a significant minority are not reporting some of the most basic information such as financial data, including accounts, cash management and financial balance position, and non-financial activity performance information.

It is also evident that while a number of organisations add an extra dimension to their reporting to aid decision making by the use of traffic lights, performance measurement frameworks and graphics, many do little to enhance raw data to ensure better analysis and presentation.

Headline findings include:

Finance based indicators

Only about 80 per cent of Trusts and PCTs report key financial measures monthly

This means that 20 per cent do not report on a monthly basis financial balance, level of cash releasing savings, drug expenditure, capital expenditure, cash flow, balance sheet or aged debtors. This information has to be considered regularly and should be reported, with key variances analysed and explained, to provide for sufficient control in any organisation.

About 70 per cent report progress with cost improvement programmes

With the never-ending focus in the NHS on achieving better levels of operational efficiency, there would be an expectation that a board needs to understand its performance in relation to cost reduction programmes. Going forward, the new Payment by Results regime will require NHS trusts, which are competing for patients, to have a greater understanding of their initiatives to control cost and spur efficiencies.

Only 40 per cent reported agency staff costs

Where it is a strategic imperative to reduce agency costs, as a proportion of total staff cost, effective control is not possible without an understanding of agency staff costs. Without knowing this data, boards will find it difficult to identify this as an issue and develop a management a response for dealing with it.

Only 42 per cent report both actual and forecast cash flow

This is not only a statutory target measure, but also one that is critical to enable the board to maintain management control. All NHS organisations are required to put in place adequate controls on cash management to contain cash spend within limits. In the Department of Health report, *Delivering Excellence in Financial Governance*, it is recommended that there is daily, weekly and monthly review of actual cash flow against forecasts and the timely investigation of any variances.

Non-financial indicators

Workforce targets

Although the workforce targets included in the survey were very generic, the results indicate that very few Trusts and PCTs report workforce issues regularly. This is despite 60 per cent or so of total costs in the NHS being people related. Less that one third of acute trusts that responded reported any information on workforce measures – in fact this was the least reported of the non-financial indicators.

Review of current practice - continued

Patient experience

Only 34 per cent of respondents appeared to report anything within this area. This may be because the information needed is only available quarterly or annually. Key star ratings such as improving the MRSA bacteria score (87 per cent) were not reported. With the recent emphasis by government and service providers on the need to improve the NHS patient experience, it is concerning that measures of performance relating to this objective are not reported by many NHS organisations. Over the last seven or eight years, there has been a sustained focus on improving the NHS complaints procedure, particularly in encouraging services to use complaints as a basis of being more responsive and improving delivery. It is disappointing to note that not all report complaints resolutions to their Boards (85 per cent of respondents report on complaint resolutions). Of these it would also be interesting to know how many discussed the effectiveness of the processes behind its complaints resolution at least periodically in its reporting.

Other highlights

Only 12 per cent of respondents reported anything on Health Inequalities and only 8 per cent on drugs

Presentation

Only around 25 per cent and 30 per cent use graphs and traffic lights respectively for financial numbers

Most common key targets are more easily digestible when presented graphically rather than as a mass of data, for example pie charts for capital spend.

Although this is generally accepted as best practice, it is not an approach adopted by the majority.

Around 40 [excluding SHAs] per cent have adopted a Balanced Scorecard type framework

The main measures included in these scorecards are inpatient and outpatient access and complaints.

High level summary of results by organisation type

The following table summarises some key comparisons between different types of organisation. The details of responses can be found in Appendix 3.

	Acute Trusts	Primary Care Trusts	Mental Health Trusts	Ambulance Trusts	Strategic Health Authorites
Number of Returns*	28	36	5	10	4
Financial Balance - Reported Monthly	75%	75%	80%	100%	50%
Financial Balance - Forecast	78%	67%	100%	100%	100%
Access Targets	75%	80%	40%	60% *(Response Times)*	75%
Use of Graphs - Finance	50%	30%	20%	33%	25%
Use of Graphs - Access	57%	50%	0%	60%	75%
Use of Balanced Scorecard	33%	22%	40%	70%	0%
Use of Traffic Lights for Finance	29%	31%	20%	10%	25%

* *Seven responses were from unknown sources*

Chapter 2: The principles of good performance reporting

The NHS generates immense amounts of data. However in order for this information to be of use, it must be translated into useful information. This chapter considers the reasons why performance should be measured and the role of the board in managing that performance. The chapter then discusses the key characteristics of good performance reports, and the issues facing NHS organisations in designing effective performance reports for the board.

Why measure performance?

There is ever increasing pressure on organisations in the Health Service to report on and manage performance. There are several reasons to measure performance, which are discussed in the following paragraphs.

For government accountability

All organisations of any type are subject to external reporting requirements to some degree. However as part of a publicly funded service, the NHS is obliged to produce substantial amounts of information to the government and other public bodies. This includes returns covering all aspects of the organisation's activities, such as the final accounts.

For public accountability

There is increased pressure to provide performance information to the general public and to demonstrate accountability for the public funds being used. As the Department of Health said in the April 2002 document *Delivering the NHS Plan* "the provision of substantial additional resources for the NHS makes improvements in the system of public accountability more necessary. The NHS now needs to more coherently account for how resources have been used and how performance has improved, both nationally and locally". One high profile example of information used to inform the public is the star rating, but there are also many other performance targets covering all aspects of the organisation's activities. Programme budgeting will add further information on how each PCT's money is spent.

Today's NHS organisations operate in an environment where the public is much better educated about the services available and concerned about the quality of them. Access to information is easier and patients expect more to be provided. The listening exercise carried out in 2001 to inform the development of the NHS National Plan highlighted the public's concerns about under performance and the desire to make "professionals and organisations accountable for what they do". (See the Department of Health publication *Shifting Gears, a report on the NHS plan public consultation*).

Alongside this is the imperative outlined in the NHS Plan to improve patient choice. To enable this, organisations will be expected to provide more information about the quality and performance of health services.

To enable effective decision making and control

There will always be intense pressure on resources for healthcare as costs such as prescribing and staff costs tend to rise faster than general inflation. Organisations will need to look for innovative approaches to achieve the necessary improvements, and to do this will need robust budgeting, reporting and control processes. Without a good understanding of the organisation's performance, it is impossible to make the right decisions about conflicting priorities and direct resources where they are most needed.

The drive for continuous improvement means identifying areas of poor performance and the actions to be taken. This is only possible with adequate performance information which looks both at internal performance and trends but also enables organisations to bench-mark themselves against others.

The principles of good performance reporting - continued

In its recent report, *Corporate Governance: Improvement and trust in local public services*, the Audit Commission identified clear links between flawed decision making, sometimes leading directly to service failure, and inadequate information, which was left unchallenged. In some cases boards were not properly informed by managers, while in others information was simply wrong or out-of-date.

The performance management culture

Central to the evolving structure of the NHS is the principle of devolution of power to local organisation, with increasing autonomy earned as performance improves. An important part of this is the development of a system which aims to use financial incentives to encourage good performance, "held together by a common set of values, national standards and a tough system of inspection" *(Delivering the NHS Plan)*. The performance of an organisation will have a direct impact on its resources and ability to make its own decisions.

THE ROLE OF THE BOARD

This guide is primarily concerned with reporting to the board and the provision of information to enable the board to fulfil its role. There are a number of different aspects to this role which will impact on the need for information.

The role of the NHS Boards is described by the NHS Appointments Committee in *Governing the NHS: A guide for NHS Boards*. Four main aspects to the role were identified:

- *Collective responsibility for adding value to the organisation*
  The Board is collectively responsible for promoting the success of the organisation by directing and supervising the organisation's affairs.

- *Leadership and control*
  The Board's role is to provide active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed.

- *Looking ahead*
  The Board should set the organisation's strategic aims, ensure that the necessary financial and human resources are in place for the organisation to meet its objectives, and review management performance.

- *Setting and maintaining values*
  The Board should set the organisation's values and standards and ensure that its obligations to patients, the local community and the Secretary of State are understood and met.

This role is likely to be increasingly under the spotlight as Trusts move to Foundation status. Regulators will expect to see Boards of Foundation Trusts receiving effective and comprehensive reports which will enable them to play their key role in managing and improving all aspects of Trust performance. Key issues in addition to having a collective responsibility to adding value to an organisation include:

Leadership and control

The board is responsible for driving forward change, through a control framework which will maximise success and minimise failure. This means taking an overview of the whole organisation, continually reviewing its corporate and clinical governance and financial management, and asking challenging questions.

The principles of good performance reporting - continued

Looking ahead

The overall objectives of any NHS organisation will be determined by the government's priorities for improving healthcare. However, the board's responsibility is to ensure that the plans developed to achieve these objectives reflect the current local situation and needs. They are also responsible for ensuring that progress is made against the plan. To meet both these requirements demands effective measurement of current performance and monitoring of changes in performance. This is particularly challenging in the context of the improvement and modernisation agenda before NHS organisations.

Setting and maintaining values

The Board is responsible for ensuring that the organisation meets both outcome and professional standards. The assessment of many of these is carried out by independent inspectors, but there should also be an internal assessment of performance. In addition, as organisations entrusted with public resources and providing a public service, there is an obligation to ensure that public expectations are reflected in everything the organisation does.

Public accountability also demands openness, and with board meetings open to the public the board is the public face of the organisation. This will have implications for the design of performance reports provided to the board.

WHAT MAKES A GOOD PERFORMANCE REPORT?

The board reports should present the information and analysis necessary for the board to carry out its role and make effective decisions. The reports should enable them to challenge and understand current performance, and identify actions which need to be taken to improve. This has implications not just for the quality of the data collected but also the way it is collated, presented and interpreted. A number of key characteristics of good information are discussed in the following paragraphs.

Relevant

There is an immense amount of data collected across NHS organisations, and it is easy to see how the board could be overwhelmed by the presentation of irrelevant detail. Information should be focused on the key issues, and provide sufficient detail for informed decisions to be taken, but not so much that the key messages are obscured. These key areas will fall into several different groupings; they may be indicators on which the organisation is being measured by the outside world, such as for star ratings. They may also include those areas in which success is necessary to meet the organisation's strategic objectives, and areas of particularly poor performance which have been identified as needing improvement.

The focus of the reporting will obviously depend on the type of organisation – for example a mental health trust will have very different priorities and need to consider very different indicators from an acute trust. This will apply to both clinical and non-clinical indicators.

In order to fulfil its role in the strategic, long-term planning of the organisation, it will need information about past, present and future performance. The board report must include analysis of trends, current performance and an assessment of likely future developments.

Timely

Historically, information within the NHS has taken a long time to produce – it was common for information to be reported two months after the activity had taken place. However, over recent years substantial improvements have been made, although there is still some way to go before information is available as quickly as in the best-run commercial organisations. Information should be available early enough for problems

The principles of good performance reporting - continued

to be identified and actions to be taken to address them. It may be better to receive slightly imperfect or incomplete information which meets acceptable levels of precision than complete information too late. The use of trend and forecast information can help to give early warning of emerging problems.

Reliable

The Board must have confidence in the information. This means that data behind the information must be of good quality from trustworthy sources. It should also be unbiased. The use of modern technology has enabled large amounts of data to be processed without error, but the reliability of the information produced will still be determined by that of the input data.

Comprehensive

The board is responsible for all aspects of the organisation's performance, and needs information relating to all activities. The reports provided to the board therefore need to include the full breadth of activities, whilst accepting that some key measures can only be reported quarterly or annually. Reports, ideally, should not just cover financial and activity information but incorporate all areas of governance of the organisation including clinical governance and risk management. The use of tools such as the Balanced Scorecard can be useful in this. Where possible information should be quantitative, but will also need to reflect some qualitative issues as well. Where areas are inter-related, the information should show the links between different indicators. In its recent report, *Targets in the Public Sector*, the Audit Commission highlights the usefulness of "clusters" of indicators to measure performance in the round, such as the measurement of the pattern of re-admissions where a local health economy is trying to improve hospital discharge arrangements.

Most of the information will be internal, that is information relating to the organisation itself and the immediate health economy. However to give a full picture of performance, benchmarking comparisons with other similar organisations may be of use.

Integrated

In addition to the information needed internally, NHS organisations are required to provide information for a range of external purposes. Wherever possible the information should be integrated within the organisation such that the data collected should be managed so as to satisfy both internal and external needs and minimise duplication of effort. Beyond the organisation itself, the linking of organisations throughout the NHS through local service providers and other national developments in information technology should enable integration of information exchanged between organisations.

Comparable

In order to convey a complete picture of performance the information provided should enable comparisons of actual performance with both the expected and target performance and the past. In addition to providing early warnings, analysis of trends enables the board to see whether improvement is being made and whether targets are likely to be reached.

Clear and understandable

It is important that the information provided is clear and unambiguous, with some interpretation. It should be as easy to understand as possible to all board members, whatever their background and specialism, and ideally to members of the public as well. Diagrams, graphs and graphics such as traffic lights systems can greatly enhance the clarity of information. Appropriate narrative is also important in providing further explanation of performance.

The principles of good performance reporting - continued

Concise

Board members do not have unlimited time to review reports, and it is important that information is conveyed as concisely as possible to allow space for debate, discussion and decision making about actions to resolve any problems highlighted. It should therefore focus on the key performance indicators and not be cluttered with more data than required. However management should be able to drill down to a further level of detail if required to explain the higher level indicators.

Reports should also concentrate on material information – that is items whose size or nature means that they will have an impact on decision making.

ISSUES TO BE CONSIDERED IN DESIGNING REPORTS

In reporting to the board there are a number of issues which will need consideration. Some of these relate to organisations in any sector, while others are unique to the public sector or the NHS. Anyone producing performance reports will need to be aware of and take account of these issues.

What are the key drivers of performance?

The actual level of performance is never the whole story. Once the key top-level indicators have been identified it is important to identify the drivers of that performance. These will also need to be measured to enable variations in performance to be understood.
For example, a problem in surgical waiting times may be due to a number of factors, such as theatre availability, bed utilisation, staffing and referral levels. It may be necessary to carry out a certain amount of analysis to identify the factors which are of greatest importance in a particular organisation. Health care organisations are very complex and generate large amounts of data – focusing the reporting will be a challenging task. These key drivers will also change over time, and there should be a continuous process of review.

Targets should not lead to perverse incentives

Where targets are set for the performance of individuals, teams or organisations it is important that they do not lead to undesirable actions which have a detrimental effect on other aspects of the organisation's performance such as the quality of care received by patients. For example, a GP practice's response to a target of a maximum wait of 48 hours for an appointment might be to prevent advance booking of appointments, thus making it more difficult for patients requiring regular routine appointments who need to plan ahead to avoid inconveniencing employers.

Defining "good performance"

The definition of good performance is particularly difficult for qualitative measures such as patient satisfaction or quality of care. However where this is not defined externally it is important that there is consensus within the organisation on the measures to be used. These will need to be full discussion and consultation and agreement with individuals or teams to be measured.

The problem of conflicting priorities

In deciding what information to report on and the key performance indicators for the organisation it may be necessary to reconcile conflicting priorities.
NHS organisations will always need to balance political imperatives and local patient needs, national targets and local circumstances.

There are also areas of activity within healthcare where action to improve one aspect of performance can easily have a detrimental effect on another – in this

The principles of good performance reporting - continued

case all interrelated components of performance may need to be measured. One of the most obvious examples of this is the conflict between reductions in waiting times and clinical priorities.

Comparing like with like

The question of how to ensure that comparisons are truly like for like is an issue not only across organisations but also within them, for example when comparing performance across specialties. Variations may be due to genuine differences in efficiency or effectiveness, but may also be the result of other factors such as case mix and socio-economic factors. National "league tables" and "star ratings" are often criticised for attempting to compare organisations without taking account of factors outside the organisation's control. For a performance report using such comparisons it is important to investigate and understand these factors and ensure that data is interpreted in the light of this.

Incorporate meaningful clinical indicators

The primary objective of the NHS is to improve the health of the population. However it has always been more difficult to find meaningful outcome measures, which has tended to mean that performance reports have focused on activity and finance measures. This has been exacerbated by government demands to meet targets in the NHS Plan. There is now, though, an increasing focus on health outcomes, and developing appropriate indicators presents a challenge to managers. Integrating clinical governance reporting with other performance, as suggested earlier, should help to provide a more balanced picture.

Links with other organisations

Increasingly NHS organisations are working in close co-operation with one another or jointly with other agencies, such as social services. In order to provide a complete picture, reporting will need to include measures of performance relating to joint activities, and may in some cases even incorporate performance information from other bodies, if that has an impact on the organisation's own ability to perform.

Determining the scope of the report

Some indicators will be of core importance to the organisation and will need to feature in board reports every month. However there are also areas which need to be reported on less regularly, for example those which change more slowly, or which are a result of a periodic review. It is important to determine the frequency at which individual indicators need to be reported, for example monthly, quarterly or annually, and develop reports accordingly. For example, one possible approach might be produce a monthly report of core indicators accompanied by a report in which other areas are included in turn according to a rotating programme.

Chapter 3: A model for board reporting

We suggest a structure for a board report that all organisations could pursue. Each section within a 'model' report is dealt with in turn, with advice on content and hints on how to make the report more effective.

GENERAL ISSUES TO CONSIDER

When designing and developing board reports there are some general issues which need to be considered:

Frequency and scope of reports

Senior managers of organisations may need to receive weekly information on breaches of important indicators. The Board itself will generally meet on a monthly basis and will need to see those key indicators which require regular examination presented on each occasion. There may also be further information on other indicators which the board need to consider, perhaps on an exception basis, such as secondary indicators highlighting issues arising. However, it is important not to overload the board with an excess of data.

One method may be to produce a second, fuller report on a less frequent (probably quarterly) basis which includes additional indicators, so that at every third meeting the focus is on those rather than the monthly reporting. A possible approach is to consider the performance of the organisation in two parts, firstly the indicators relating to the day-to-day operation, which need to be reported on monthly, and secondly those relating to strategic issues which have a longer-term focus. These could provide the content for a quarterly report.

The report should cover the full range of activities undertaken and include both financial and non-financial in order to give the board an integrated picture of the organisation's performance. Currently many organisations produce two or more separate reports reflecting the functional split of responsibilities in the organisation. However we suggest that every effort should be made to develop a single combined report, which will obviously mean different departments working very closely together. We recognise that this is sometimes difficult to accomplish, but for reporting to be most effective all the information and its presentation and interpretation should be consistent and integrated. This is often best achieved where one person takes overall responsibility for all the reporting.

Timeliness of reporting

If the board report is to lead to action to correct or improve performance, the information must be timely. Ideally, the report should be produced within 2 weeks of the activities being reported.

OUTLINE CONTENT OF THE REPORT

The report should consist of six main sections, which will be discussed in more depth in subsequent sections of this chapter. These sections are as follows:

- *Executive summary*
- *Analysis and presentation of performance indicators*
- *Key indicators*
- *Secondary indicators*
- *Action plan*
- *Consideration of future developments*

THE EXECUTIVE SUMMARY

It is useful to produce a summary of the key points as the first page of the report. The purpose of the summary is to draw attention to those indicators that need to be discussed and noted or which require decisions to be made. To ensure that the summary is focused on the key issues it should be no more than one page long. This will also prevent the summary from becoming verbose. A bullet point format is probably the clearest way of conveying the necessary information. Each bullet point should relate to one indicator or group of related indicators that relate to a key issue or decision, which are included in more detail within the report. It is important that the summary is clearly based on the information contained in the report. A supplementary form of presentation for the summary is a tabular format (see the example overleaf).
Tools such as traffic lights can be used to good effect in such a summary.

A model for board reporting - continued

PRIMARY CARE TRUST

Balanced Scorecard for April - December 2002

KEY:		
	On or Above Target	Green
	Below Target	Red
	Improvement from last period	Improved
	Same performance as Last Period	Same
	Reduction in performance from Last Period	Worse

Indicative targets used for HR indicators	Period	Target	Actual	Variance	% Var	*Last Var*	Indicator	Movement
DELIVERING KEY TARGETS:								
Out Patients Waiting								
Maximum Wait > 21 weeks	Nov	53	93	-40	-75.50%	*-49*	Red	Improved
Reduce numbers waiting > 13 wks	Nov	488	967	-479	-98.20%	*-336*	Red	Worse
In Patients Waiting								
Maximum Wait 12 months	Nov	70	59	11	15.70%	*9*	Green	Improved
Reduce numbers waiting > 9 mths	Nov	273	317	-44	-16.10%	*-40*	Red	Worse
Reduction in Overall IP list size	Nov	3887	3921	-34	-0.90%	*0*	Red	Worse
A&E Waiting								
% Patients waiting under 4hrs from arrival at A&E	Dec	90.00%	60.20%	-29.80%		*-32.50%*	Red	Improved
Primary Care Access								
% Patients seen by P.Care Professional <24hrs	Dec	90.00%	70.00%	-20.00%		*-21.00%*	Red	Improved
% Patients seen by GP <48hrs	Dec	90.00%	86.00%	-4.00%		*-4.00%*	Red	Same
STAFF & PATIENT FOCUS:								
Staffing								
Staff turnover rate		3.50%	0.94%	2.56%		*2.21%*	Green	Improved
Nursing Vacancy Rate		15.00%	15.29%	-0.29%		*-0.84%*	Red	Improved
Level of nurse bank/agency usage		15.00%	16.20%	-1.20%		*-1.50%*	Red	Improved
Sickness Absence Rate		4.00%	3.50%	0.50%		*-0.47%*	Green	Improved
Patients								
Number of Patients Allocated to a GP within 24 hours		100%	100%	0%		*0%*	Green	Same
Written complaints received		39	34	5	12.80%	*5*	Green	Same
CLINICAL FOCUS:								
Cancer Waiting Times								
% Patients seen < 2 weeks from Urgent referral for suspected Ca to 1st O/P Appointment		100.00%	97.20%	-2.80%		*-2.80%*	Red	Same
% Patients seen < 2 weeks from Urgent referral for breast Ca		100.00%	100.00%	0.00%		*0.00%*	Green	Same
% Eligible patients receiving thrombolysis within 20 mins of arrival at	Sept ytd	75.00%	85.00%	10.00%		*10.00%*	Green	Same
Delayed Discharges								
20% reduction of acute beds blocked by delayed discharge RBK residents	Dec	16	10	6	37.50%	*-8*	Green	Improved
Decrease in delayed discharge from	Dec	28	26	2	7.10%	*-26*	Green	Improved
FINANCE & ACTIVITY:								
Overall Financial Balance		140,168	139,918	250	0%	*0*	Green	Improved
Financial Risks								
Prescribing predicted outturn against		15,934	16,893	-959	-6%	*-943*	Red	Worse
Acute Service Agreements predicted outturn against plan		66,852	66,852	0	0%	*0*	Green	Same
Individual Placements predicted outturn against plan		723	1,291	-568	-79%	*-258*	Red	Worse
Primary Care allocations predicted outturn against plan		5,040	4,940	100	2%	*100*	Green	Same
PCT Provider Services								
Provider Services allocations predicted outturn against plan		26,170	25,844	326	1%	*0*	Green	Improved
Provider Services External Income predicted outturn		8,441	8,441	0	0%	*0*	Green	Same
Capital Resource Limit - predicted outturn against plan		202	102	100	50%	*100*	Green	Same
Public Sector payments compliance		90.00%	90.10%	0.10%		*89.90%*	Green	Improved

A model for board reporting - continued

ANALYSIS AND PRESENTATION OF PERFORMANCE INDICATORS

The main content of the report should be the analysis and presentation of the performance indicators identified by the organisation as tracking key performance drivers. The emphasis should be on the key performance indicators; these are the indicators which have been assessed as relating to the most important drivers of the organisation's performance. Such performance indicators are integral to the meaningful assessment of the organisation's activities and provide a comparator and tool for measuring and monitoring performance levels at discrete points in time, over a period of time, and in comparison with other organisations. If the correct indicators are chosen, and appropriate targets set, the organisation can ascertain the extent to which policies and strategies are being met.

The key performance indicators should be supported by secondary indicators. These may relate to areas which are important but which are not assessed as critical, or which aid the understanding of the organisation of performance in key areas.

If the report includes too many indicators, it will be difficult to focus attention on the most important issues. It is better to have a shorter focused report that is read carefully by board members than a very lengthy one, none of which is read properly. We would suggest that the maximum length of this part of the report should be 10 pages, with not more than 10 key performance indicators and 20 secondary indicators.

The grid shown in Appendix 4 gives details of possible key and secondary indicators as identified by members of the CIMA/ HFMA Project Group. The first section shows the indicators which we believe to be key, and the second section shows the range of possible measures from which the secondary indicators are likely to be chosen. Certain groups of indicators such as patient satisfaction and workforce indicators are unlikely to appear in monthly reporting, but are probably best reported in an annual report. Conversely, for finance it is suggested that all indicators, whether key or not, should be reported monthly.

Identifying key performance indicators

There is no definitive list of key performance indicators – they will be different for each organisation, although the list will probably be similar for organisations of the same type. Identifying them requires an understanding the current performance of the organisation, in order to determine where improvement is needed.

The identification process must also be linked to the business planning process to ensure that the indicators reflect the strategic objectives. The indicators chosen should include those about which the board is expected to make decisions and those against which it will be judged, such as current government and local priorities and policies. It will also need to reflect operational issues in which the board is not directly involved but which they need to be aware of. It is likely that the list of key indicators will remain the same within the financial year – however it should be kept under review in order that changes can be made as circumstances alter.

Some NHS organisations have found the Balanced Scorecard a useful tool to ensure that the different aspects of performance are reflected in the reporting. Although developed for use in the private sector, the Balanced Scorecard can be adapted for public sector organisations, and a variety of different methods such as traffic lights can be used to display the information. The box below considers the application of the Balanced Scorecard to the NHS.

A model for board reporting - continued

The Balanced Scorecard in the NHS -

Based on material from the CIMA Technical Briefing the Balanced Scorecard – an overview available from www.cimaglobal.com

The Balanced Scorecard is a tool developed by Kaplan and Norton to articulate, execute and monitor strategy using a mix of financial and non-financial measures. It is designed to translate vision and strategy into objectives and measures across four balanced perspectives: financial, customers, internal business processes and learning and growth. It, therefore, focuses on all the activities that generate financial results, rather than the financial side alone. The scorecard depicts strategy as a series of cause-and-effect relationships between critical variables and gives a framework for ensuring that strategy is translated into a coherent set of performance measures. The use of a hierarchy of scorecards cascading through the organisation ensures that strategy and performance measurement is closely aligned.

At first sight the Balanced Scorecard appears to be a tool designed for profit-making businesses. Whilst in the NHS optimising the use of resources, particularly finance, is key, organisations do not exist primarily to maximise returns.

The original architecture of the Balanced Scorecard places the four perspectives in a hierarchy, with the financial perspective at the top. This is obviously not appropriate in the NHS and may either lead to the dismissal of the technique as irrelevant or the development of a Scorecard with its main theme as operational excellence, and organisations taking their current mission as a given and trying simply to work more efficiently. To use the Balanced Scorecard as an effective tool for strategic management, it is important to recognise that it is just that – a tool to be adapted as appropriate to the needs of the organisation rather than one which has to be applied in the same way in every organisation.

In addition, the strategic objectives of health service organisations are not measurable simply in financial terms. This can be reflected in a Scorecard with a slightly different structure and emphasis. For example it may mean changing the order of the perspectives in the hierarchy so that the customer perspective appears at the top or it may involve introducing an overall objective or mission which is supported by all four of the perspectives. Alternatively, it may involve redefining the perspectives according to the key areas of importance to the organisation.

Importantly, however the Scorecard is adapted, it is necessary to ensure that cause-effect relationships still exist between the overall objectives and the various perspectives of performance. These relationships preferably need a degree of empirical underpinning where statistical analysis can demonstrate the importance and nature of relationships between non-financial drivers of performance and the financial performance. (See CIMA visiting professor lecture 2004, Professor D Larcker – http://www.cimaglobal.com/downloads/larcker_presentation.pps, and the CIMA report Getting performance measurement right with the balanced scorecard and strategy mapping to be published in autumn 2004).

A problem facing NHS organisations is the definition of the customer. The ultimate consumer is generally not the same as the body providing the funding. Organisations have many different stakeholders, such as government, users, funding bodies and other agencies. It may be appropriate to include objectives for several different groups as part of the customer perspective before looking at for example, the internal processes required to meet the objectives of each different group.

A model for board reporting - continued

There are a number of other tools which may be useful in the identification process. These include:

- European Foundation for Quality Management (EFQM) Excellence model
- Benchmarking

Further information can be found in CIMA's Technical Briefing *Latest trends in corporate performance measurement* available from www.cimaglobal.com.

There are a number of reasons for including an indicator in the list of key measures. The area concerned may be:

- *A political imperative*
  This category includes those which are seen by government as "must-dos" for every Trust or Health Authority, such as waiting times.

- *Vital to the achievement of the organisation's strategy*
  These will emerge from the strategic planning process. An example of such an indicator would be reduced length of stay linked to a PFI project which is about a decrease in the number of beds.

- *A key local issue or Strategic* Health Authority imperative
  This will include areas which have been identified as important within the local health economy and requiring particular levels of performance by all organisations within it.

- *A particular pressure within the organisation*
  These are areas which have been identified as presenting a particular challenge or risk to the organisation, such as exceptional cost pressures or areas of very poor performance. For example there may be a single area preventing achievement of 3 star status.

It is important that the process for identification of key (and secondary) indicators is not confined to those activities which are purely internal to the organisation. As partnership working increases with other organisations such as social services, the selected indicators may need to include some covering joint working, which are agreed and monitored jointly with social services or other partners.

Secondary indicators

The list of secondary indicators is likely to vary more between organisations than the key performance measures. The secondary indicators are likely to reflect more local and organisation-specific issues but the list may also include those which are less likely to go wrong or which change slowly but still need monitoring, such as cancer waits or smoking cessation rates. The list may also change over time with changes in the organisation's performance and in the environment.

The secondary indicators will generally not need to be reported in the same depth as key indicators. It may also be possible to use exception reporting for secondary indicators, by including details of the measures only where there is a significant change or a problem is identified. This prevents the report being overloaded with data for which the board does not need to take particular note of.

Presenting the information

There will be a large amount of information to present – therefore it is essential that the messages are conveyed in the most effective way possible. This will generally entail the use of graphs and other pictorial methods such as traffic lights or the Balanced Scorecard, which are usually the clearest way of conveying the performance measures and their implications.

The graphical presentation will need some narrative to explain reasons behind variances in the measures. It is important that this is as concise as possible and adds value to the rest of the report. The box opposite includes tips for writing good narrative.

A model for board reporting - continued

TIPS FOR NARRATIVE WRITING

1. *Let the pictures tell the story*
2. *Don't comment if there's nothing to say – all the words should add value*
3. *Limit comments to the reasons for variances and the corrective action required*
4. *All significant variances and causation should be explained*
5. *If you can't explain the variance, investigate it - interpretation requires detective work.*
6. *Use tools such as benchmarking to aid in the investigation where possible*
7. *Don't assume that reasons for variances will be obvious to the board - Is a variance endemic of the process(es) behind service delivery and if so what changes to the process and activities might improve service delivery and impact the variance?*
8. *Keep the narrative short*
9. *Focus on the issues which need to be considered at board level*
10. *Ensure the narrative relates to the graphs and tables in the report – put comments alongside the graphs*
11. *Don't be afraid to challenge and raise questions*
12. *Focus on action, not measurement*
13. *Use simple language that can be understood easily*
14. *Look forward as well as back*
15. *Check consistency of comments between different parts of the report, such as activity and finance*

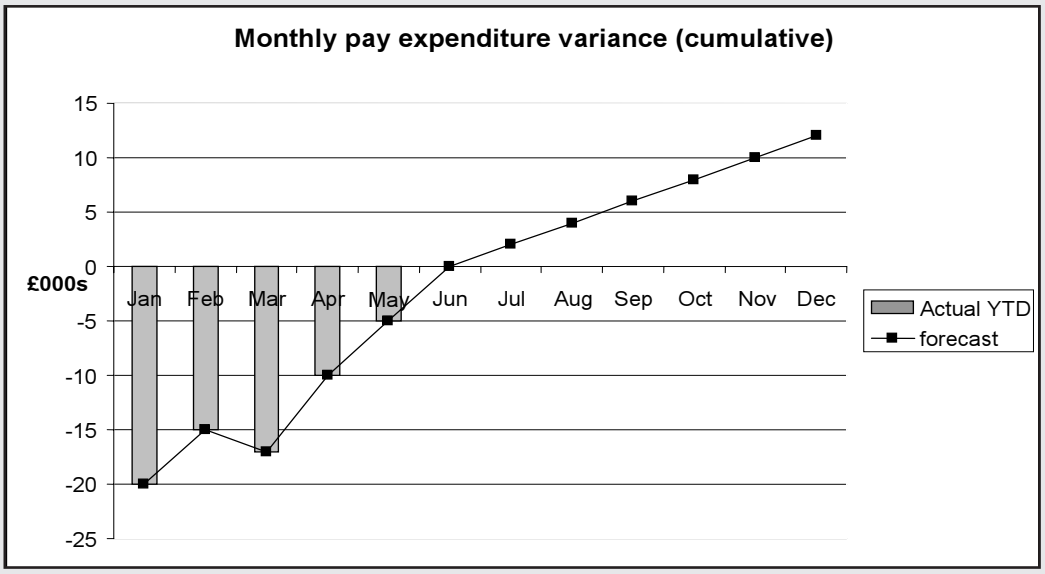
There are a number of different types of graphs that can be used to convey information, but the most useful are probably bar charts, and line graphs where values are plotted over time. Both these types of chart can be used to show more than one set of data, thereby allowing easy comparisons. Having more than one set of data together on one graph makes it easy to see the similarities and the differences. These two methods can be combined on one chart, for example by using bars to represent the value of the measure and a line to show the target. Different types of information need different types of graphs.

If used wisely, colour can enhance the presentation and make the report easier to read. However it is important that colour is not used to cope with too much complexity and disguise the fact that too much information is being presented. A good indication that a chart is too complex can be that it is impossible to understand in black and white.

Different types of analyses can be built into the graphical presentation:

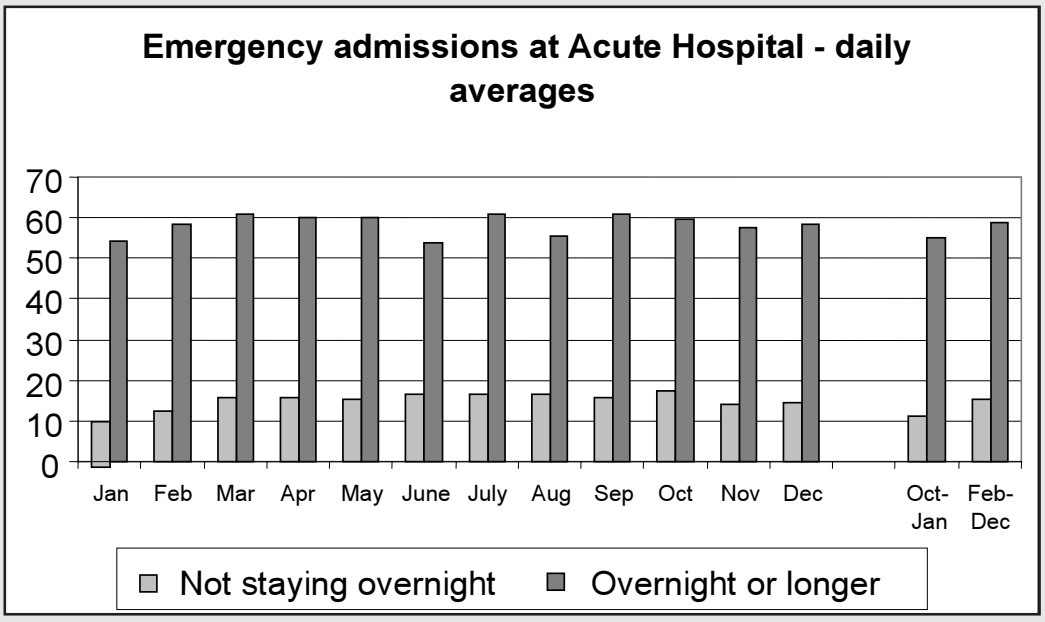
- *Using trends and forecasts*
  The absolute value of an indicator does not convey a great deal of information on its own. However, when an analysis is included which shows the trend over time or a forecast into the future, significantly more can be told about whether action is required to correct a deteriorating performance. Trend analysis can also help to explain a large variance.

A model for board reporting - continued



- *Statistical analyses*

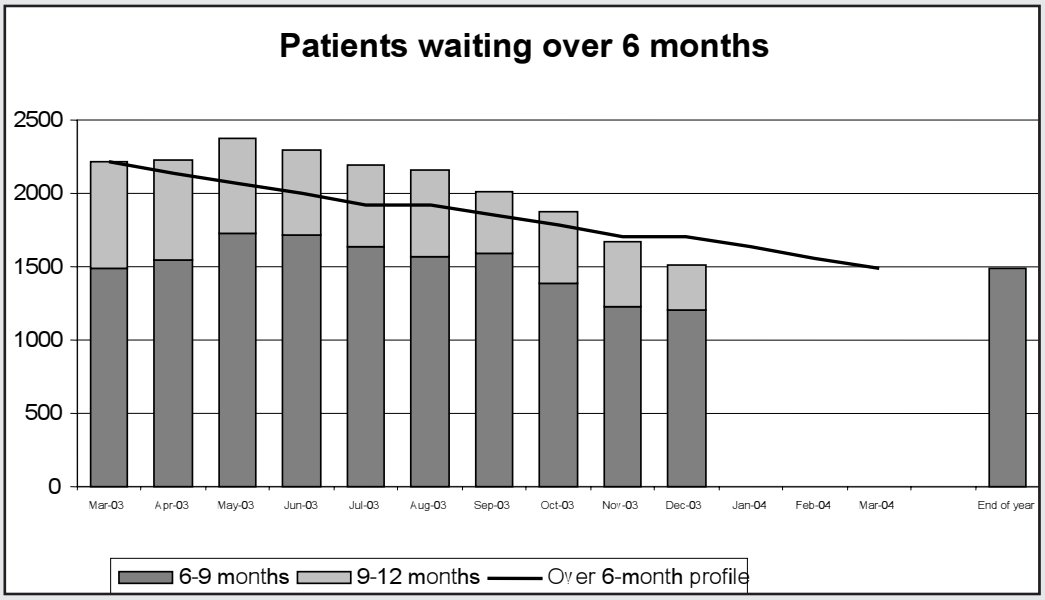
  The use of simple statistical techniques may sometimes be helpful in explaining performance. For example, an average of emergency admissions over time may be more helpful in demonstrating the overall pattern than a simple chart of daily levels in which one-off exceptional occurrences can be distracting.



A model for board reporting - continued

- *Early warning signals*

  Well-designed charts and analysis can give early warnings of a need to take corrective action, by using trends and target lines plotted alongside actual performance. A particular example of this is the use of statistical process control techniques and control charts, where performance is plotted on a chart on an ongoing (almost real-time) basis with pre-determined limits which trigger action when they are exceeded.



- *Balanced Scorecard*

  The Balanced Scorecard has been described earlier. As has already been explained, this can be an effective tool, but its use is limited without an understanding of cause and effect relationships between variables.

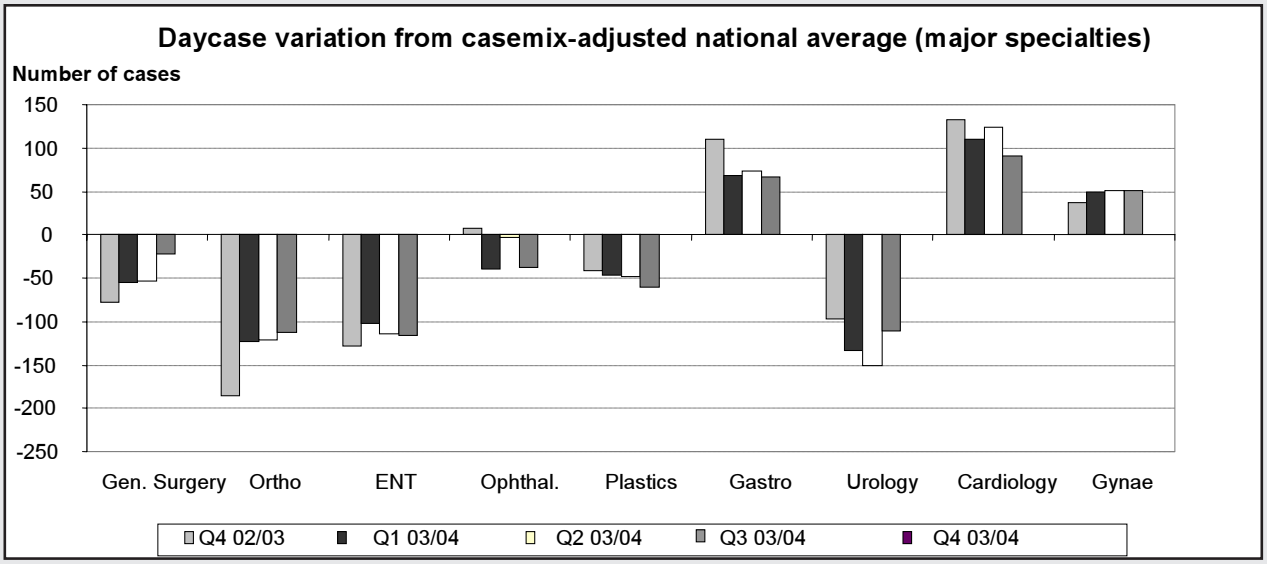
- *Traffic lights*

  Traffic lights systems are employed increasingly in NHS organisations. They can be valuable tool for drawing attention to problem areas and triggering action and can be used in conjunction with a Balanced Scorecard system (see the example summary report shown previously). However they only show the absolute value of an indicator at a point in time.

A model for board reporting - continued

- *Using benchmarks*

  The use of benchmarks, comparing the organisation's performance to that of similar ones, can be very useful in adding understanding of how well the organisation is performing (see the following example). Inevitably benchmarking information will be available less frequently (normally quarterly or annually) than the organisation's own information which is available monthly.



- *Linking indicators*

  One indicator is often linked to or dependent on another, or several different factors can contribute to the same top-level performance measure. By including linked indicators on the same chart or alongside one another, the dependencies can be demonstrated and accounted for in the interpretation. An example of two linked indicators is medical outliers and delayed discharges.

A model for board reporting - continued

What makes an effective finance report?

As finance managers, many readers of this guide will have at least the responsibility for contributing to the finance section of the report. All the general principles apply to the finance section as to any other part of the report. In particular:

- The finance section of the report should be focused. A good report will summarise the issues and highlight the overall position, making use of graphs and charts to replace lengthy tabular information where appropriate.

- Activity data should be linked to the financial performance, and variances should be calculated and explained. The report should integrate non-financial and financial reporting.

- The report should show period and cumulative positions in financial balance with variances against budget highlighted. Trend analysis should be included and full-year projections should be updated based on judgement and not just extrapolation.

- There should be comparisons with the plan for the year and the previous year.

- Appropriate use should be made of graphs, colour-coding and clear chapter headings.

- The report should avoid technical finance terms where possible, and explain them where their use is unavoidable.

THE ACTION PLAN

A plan detailing corrective actions being taken and any decisions required of the board and associated risks should be included on a single sheet. Actions should cover strategic issues and relate to what the board needs to discuss. They should either be in priority order or in the order in which the issues appear in the main part of the report. Responsible persons and timescales need to be clearly identified for each action .

CONSIDERATION OF FUTURE DEVELOPMENTS

The final section of the report should look at changes anticipated in the future and their impact on the organisation, particularly where the effect of the change is expected to be at a strategic level. The report should give an account of the emerging issues, the risks or opportunities presented and any actions that need to be considered as a consequence.

Chapter 4: Future developments in the NHS

The NHS is an organisation which is constantly changing. Every major development is likely to have some impact on the reporting requirements. This final section considers the changes currently on the horizon and their likely impact on the reporting of performance to boards. None of these developments will change the fundamental principles of effective reporting, but may change the key performance indicators.

Foundation Hospitals

The first Foundation Hospitals came into existence in April 2004. Although their independence will mean that their formal accountability is to a different body, independence does not mean less responsibility and they will still be part of the national framework of standards and accountable to commissioners and the local population. Indeed there may be greater involvement from the local community and a wider spread of stakeholders. This is likely to lead to greater visibility of board reports and there will be greater pressure to make them more effective and understandable. In addition, as previously mentioned, regulators will expect to see highly effective Board reporting to enable boards to fulfil their responsibilities in managing the Trust as an independent entity. Foundation Hospitals will also be subject to the impact of payment by results earlier.

Payment by Results

The new funding flows in the NHS will inevitably mean greater risks for all organisations. This will mean that all performance information, including that reported to boards, will need to be more robust. If the new system works as intended, it will force change and mean that to be successful organisations will need a much better understanding of their performance. There will be a need for better demand management and therefore improved activity monitoring, with a resultant change in the key performance indicators for the organisation.

Standards for better health

The proposals for changes to the national standards for the quality of healthcare are likely to influence the performance indicators boards consider, as the external standards by which organisations are measured will be different. However again the fundamental principles will still apply.

APPENDIX 1 - CIMA/HFMA research project on NHS performance management and reporting Questionnaire on Board reporting (sent 2003)

Please enter X in every box that applies.

e.g. if you regularly use traffic lights to monitor whether anyone waits more than 12 months for an inpatient admission and this forms part of a balanced scorecard, you would fill in the first line of access as 'Maximum wait 12 months'

Target Description	Target Description	2002/3	2003/4	2004/5	Information reported:		When reported:			How reported:		Traffic lights (red, amber, green)	Narrative (where significantv ariances)	Is this part of your balanced scorecard?
		Target Date	Target Date	Target Date	Actual	Forecast	Monthly	Quarterly or bi-monthly	By exception	Numbers	Graphs			
Finance														
Financial balance (Trust income and expenditure, PCT balance against revenue resource limit)	Statutory duty	Target is pre-2003												
Level of cash releasing savings achieved		Local												
Drug expenditure		n/a												
Agency staff expenditure		n/a												
Capital expenditure against capital resource limit	Statutory duty	Target is pre-2003												
Cash flow against cash limit	Statutory duty	Target is pre-2003												
Balance sheet		n/a												
Aged debtors		n/a												
Performance against the public sector payment policy		Target is pre-2003												
Access														
Inpatient Waiting														
Maximum wait 12 months	LDP	31.03												
Maximum wait 9 months	LDP		31.03											
Reduce 6 month waiters by 40% against 31.3.03 baseline	LDP		31.03											
Maximum wait 6 months	LDP			31.12										
Reduce 6 month waiters by 80% against 31.3.03 baseline	LDP			31.03										
Reduce overall list size	LDP			31.03										
Maximum wait 3 months	LDP													
Outpatient Waiting														
Maximum wait 21 weeks	LDP	31.03												
Maximum wait 17 weeks	LDP		31.03											
Maximum wait 13 weeks	LDP			31.12										
Reduce number of 13 week waiters	LDP		31.03											
A&E														
Maximum wait of 12 hrs from decision to admit (trolley wait)	Star Ratings	Before												
90% wait less than 4 hrs from arrival to admission, transfer or discharge	Star Ratings	31.03												
100% wait less than 4 hrs from arrival to admission, transfer or discharge for Trusts who have completed the ESC	LDP		31.03											
100% wait less than 4 hrs from arrival to admission, transfer or discharge for Trusts who have not completed the ESC	LDP			31.12										
Maintain target of at least 75% response rate within 8 minutes for all ambulance category A emergency calls	Star Ratings													
Primary Care														
Offer all patients access by a single telephone call through NHS Direct to out-of-hours primary care medical services	LDP			31.12										
Ensure 100% of patients who wish to do so can see a primary health care professional within 1 working day	LDP			31.12										
Ensure 100% of patients who wish to do so can see a GP within 2 working days	LDP			31.12										

APPENDIX 1 - continued
Questionnaire on Board reporting - continued

Target Description	Target Description	2002/3	2003/4	2004/5	Information reported:		When reported:			How reported:				
		Target Date	Target Date	Target Date	Actual	Forecast	Monthly	Quarterly or bi-monthly	By exception	Numbers	Graphs	Traffic lights (red, amber, green)	Narrative (where significantv ariances)	Is this part of your balanced scorecard?
Booking														
80% booking of daycases	LDP	31.03												
100% booking of daycases	LDP		31.03											
Two thirds first outpatient appointments pre-booked	LDP		31.03											
Two thirds elective inpatient appointments pre-booked	LDP		31.03											
Cancelled Operations														
If an operation is cancelled on or after day of admission, the patient will be re-admitted within 28 days or, if this is not possible, will be offered the option of treatment at a hospital of their choice.	Star Ratings		1.04											
Cancer														
Maximum wait of 14 days from urgent GP referral to specialist appointment	Star Ratings /LDP	Before 02-03												
Maximum wait of 31 days from Urgent GP referral to 1st Treatment, Leukaemia, Testicular & Children's cancer	LDP	Before 02-03												
Maximum wait of 31 days from diagnosis to 1st treatment for Breast Cancer	LDP	Before 02-03												
Maximum wait of 1 month from diagnosis to treatment for all cancers	LDP			31.12										
Maximum wait of 2 months from urgent referral to treatment for all cancers	LDP			31.12										
Reduce the rate of smoking among manual groups, contributing to the national target of reducing the rate from 32% in 1998 to 26%, with 800,000 smokers successfully quitting at the 4 week stage	LDP													
Extend breast screening to all women aged 65-70	LDP		31.12											
CHD														
Two week wait for Rapid Access Chest Pain Clinics	LDP	31.03												
Set local targets to make progress towards the NSF goal of maximum 3 month wait for angiography														
Maximum 3 month wait for revascularisation by 2005, or sooner				31.03										
Revascularisation: % of elective patients treated within 9 months	Star Ratings													
Increase by 10% each year the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help.	LDP		31.03	31.03										
Percentage of eligible patients treated with thrombolysis within 30 minutes of hospital arrival	Star Ratings													

APPENDIX 1 - continued
Questionnaire on Board reporting - continued

Target Description	Target Description	2002/3	2003/4	2004/5	Information reported:		When reported:			How reported:				
		Target Date	Target Date	Target Date	Actual	Forecast	Monthly	Quarterly or bi-monthly	By exception	Numbers	Graphs	Traffic lights (red, amber, green)	Narrative (where significantv ariances)	Is this part of your balanced scorecard?
Mental Health														
Reduce the duration of untreated psychosis to a service median of less than 3 months, (individual maximum less than 6 months) and provide support for the first three years for all young people who develop a first episode of psychosis	LDP		31.12											
Offer 24-hour crisis resolution to all eligible clients	LDP			31.12										
Deliver assertive outreach to the 20,000 adult patients with severe mental illness and complex problems who regularly disengage from services	LDP		31.12											
Increase breaks available for carers and strengthen carer support and networks to the benefit nationally of approximately 165,000 Carers of people on CPA	LDP		31.12											
Improve mental health care in prisons so that all prisoners with severe mental illness have a Care Plan (approximately 5000 prisoners nationally)…	LDP		31.03											
….and ensure appropriate use of secure and forensic facilities , contributing to the national target of moving 400 patients from high secure hospitals	LDP		31.12											
Older People														
All assessments of older people will begin within 48 hours of first contact with social services and all assessments will be completed within four weeks, and 70% within two weeks	LDP			31.12										
Following assessment, all social services for older people should be provided within four weeks, and 70% of services within two weeks	LDP			31.12										
All community equipment for older people (aids and minor adaptations) provided by social services will be delivered within seven working days	LDP			31.12										
Each year there will be less than 1% growth in emergency hospital admissions and no growth in re-admissions	LDP		31.03	31.03										
Emergency readmissions to hospital within 28 days of discharge following a stroke, as a percentage of live stroke discharges (age and sex standardised)	Star Ratings													
Emergency readmissions to hospital within 28 days of discharge following treatment for a fractured hip, as a percentage of live hip fracture discharges (age and sex standardised)	Star Ratings													
Percentage of patients whose transfer of care from hospital was delayed	Star Ratings													
80% of people with diabetes to be offered screening for early detection of diabetic retinopathy in a systematic programme which meets national quality standards	LDP													
Children														
Paediatric outpatient did not attends rates	Star Ratings													
Emergency readmission to hospital within 7 days of discharge for children as a percentage of live discharges for children	Star Ratings			31.03										

APPENDIX 1 - continued
Questionnaire on Board reporting - continued

Target Description	Target Description	2002/3	2003/4	2004/5	Information reported:		When reported:			How reported:				
		Target Date	Target Date	Target Date	Actual	Forecast	Monthly	Quarterly or bi-monthly	By exception	Numbers	Graphs	Traffic lights (red, amber, green)	Narrative (where significantv ariances)	Is this part of your balanced scorecard?
Patient Experience														
Improve the 5 key dimensions of the patient's experience as evidenced by increasingly positive local annual survey results, and other patient focused performance indicators, including those developed for the star ratings system. Agree, implement and jointly monitor local improvement plans as a result of surveys, with Patient Forums, as they come on stream during 2003	LDP		31.12											
Strengthen accountability to local communities through improved engagement with them, as evidenced by annual Patient Forum reports to the Commission for Patient & Public Involvement in Health, and annual publication of a patient prospectus covering local health services	LDP													
Outpatient/A&E survey - Better Information, more choice	Star Ratings													
Outpatient/A&E survey - Clean, comfortable, friendly place to be	Star Ratings													
Outpatient/A&E survey - Building relationships	Star Ratings													
Outpatient/A&E survey - Safe, high quality, co-ordinated care	Star Ratings													
Outpatient/A&E survey - Access & Waiting	Star Ratings													
Percentage of written complaints for which a local resolution was completed within 20 working days	Star Ratings													
Percentage of written complaints for which a local resolution was completed within 20 working days	Star Ratings													
Set local target to contribute to national target to reduce the value of NHS building backlog maintenance by 25%	LDP		31.12											
Whole hospital score, including cleanliness, formulated against Patient Environment Action Team (PEAT) visits	Star Ratings													
Infection control - Self-assessment scores by standard/criteria	Star Ratings													
Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia: Improvement score	Star Ratings													
Introduce bedside TV and telephone systems in every major hospital	LDP		31.12											
Eliminate Nightingale wards for older people	LDP		31.03											
Compliance (as at 31 December 2002) with objectives set to support the elimination of mixed sex accommodation in general wards	Star Ratings													
Introduce ward housekeepers in hospitals....	LDP		31.12											
....and appoint modern matrons to all remaining posts	LDP		31.03											
Health Inequalities														
Deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focussing especially on smokers from disadvantaged groups.	LDP		31.03	31.03										
Deliver an increase of 2 percentage points per year in breastfeeding initiation rate, focussing especially on women from disadvantaged groups	LDP		31.03	31.03										
Achieve agreed local conception reduction targets while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter in line with national targets	LDP													

APPENDIX 1 - continued
Questionnaire on Board reporting - continued

Target Description	Target Description	2002/3	2003/4	2004/5	Information reported:		When reported:			How reported:				
		Target Date	Target Date	Target Date	Actual	Forecast	Monthly	Quarterly or bi-monthly	By exception	Numbers	Graphs	Traffic lights (red, amber, green)	Narrative (where significantv ariances)	Is this part of your balanced scorecard?
Contribute to a reduction in death rates from CHD of at least 25% in people under 75 compared to 1995-1997, targeting the 20% of areas with the highest rates of CHD.	LDP			31.12										
Contribute to a reduction in cancer death rates of at least 12% in people under 75 compared to 1995-1997, targeting the 20% of areas with the highest rates of cance	LDP			31.12										
Achieve the target of 70% uptake in influenza immunisation in people aged 65 years and over, targeting populations in the 20% of areas with the lowest life expectancy	LDP													
Clinical Focus														
Level of compliance against Clinical Negligence Scheme for Trusts (CNST) risk management standards	Star Ratings													
Deaths within 30 days of surgery for heart bypass operation, (which includes deaths in hospital and after discharge)	Star Ratings													
Deaths within 30 days of selected surgical procedures (which includes deaths in hospital and after discharge)	Star Ratings													
Emergency readmission to hospital following discharge, as a percentage of live discharges	Star Ratings													
Summary measure of Hospital Episode Statistics (HES) data quality for NHS trusts with in-patient activity	Star Ratings													
Drugs														
Increase the participation of problem drug users in drug treatment programmes by 55% against 1998 baseline	LDP		31.12											
Reduce drug-related deaths by 20% against 1999 baseline	LDP		31.12											
Improving Working Lives														
Achieve IWL standard practice status	Star Ratings	31.03												
Responses from NHS-employed staff opinion survey on satisfaction with employer	Star Ratings													
Percentage of junior doctors complying in full with the New Deal on Junior Doctors' Hours	Star Ratings													
Percentage of consultants who have completed annual appraisal as set out in Advanced Letter AL (MD) 05/01, including the appraisal meeting and signing off their personal development plan	Star Ratings													
The amount of time lost through absences as a percentage of staff time available for directly employed NHS staff	Star Ratings													

APPENDIX 1 - continued
Questionnaire on Board reporting - continued

Target Description	Target Description	2002/3	2003/4	2004/5	Information reported:		When reported:			How reported:				
		Target Date	Target Date	Target Date	Actual	Forecast	Monthly	Quarterly or bi-monthly	By exception	Numbers	Graphs	Traffic lights (red, amber, green)	Narrative (where significantv ariances)	Is this part of your balanced scorecard?
Workforce														
Increase the number of nurses employed by the NHS by 20,000 (from a 2000 baseline)...,														
Increase the number of consultants by 7,500 and the numbers GPs by 2,000 by 2004 (from a 1999 baseline)		31.12												
Iincrease the number of GPs and Consultants employed by the NHS by 10,000 by 2005 (from a 2000 baseline)														
increase total numbers of cardiologists to 685 and cardiothoracic surgeons to 217, enabling single handed cardiologist posts to be eliminated		31.12												
Increase the number of therapists and scientists employed by the NHS by 6,500 (from a 1999 baseline)		31.12												
Plan to achieve increase of 30,000 in the number of therapists and scientists employed by the NHS (from a 2001 baseline)				31.12										
Increase the number of health care assistants employed by the NHS by 27,000 (from a 2002 baseline)														
Expand MH workforce by: 1,000 new graduate workers in primary care; 500 community MH "Gateway" workers; 700 more staff to support carers; 300 prison in-reach staff; 400 staff to support secure step-down		31.12												

APPENDIX 2

CHECKLIST FOR ASSESSMENT OF SAMPLE BOARD REPORTS

Organisation:
Date of board report:
Contact in organisation:

Report reviewed by:

Does report meet criteria for a good report? Scale 1-4: poor, acceptable, good practice, excellent. Is report clear?
Does it focus on areas of key strategic importance?
Is it easy to identify areas of good, OK and poor performance?
Does it identify reasons for poor performance or where performance has changed?
Does it include trend analysis?
Does it make use of different methods of presentation e.g. graphs to display trends, diagrams?
Does it include financial and non-financial indicators?
Does it include clinical indicators?
Is the information timely?
Does the report include a clear, concise summary (5 pages or less)

Total score

Other comments

In your opinion, is this a good report? If so, why?

Are there any particularly useful features of this report?

APPENDIX 3

ANALYSIS OF RESULTS FROM QUESTIONNAIRE AND REVIEW OF REPORTS

The following results are summarised by organisation type.

Acute NHS Trusts

Of the 90 responses 28 returns were from acute NHS Trusts.

General themes.

- Financial Balance (Trust Income and Expenditure (I&E), PCT balance against revenue resource limit) actual position was reported in 82 per cent of the sample. 78 per cent produced a year–end forecast.

- The achievement of Access targets was reported in over 75 per cent of the sample, largely the 12 month and nine month inpatient waits and the 21 week and 17 week outpatient target.

- Other popular reporting themes (greater than 60 per cent of the sample) were A&E 12 hour waits, achievement against the Capital Resource Limit, the Cost Improvement Programme target and drugs spend.

- Graphs were used by 57 per cent of the sample to report the waiting time position.

- The Balanced Scorecard approach was used in around a third of the sample, largely reflecting finance and access performance.

Specific areas

- *Finance*

  Financial Balance and capital spend, together with a forecast, were the most commonly reported areas and were reported by more than 70 per cent of the sample. These are generally reported monthly and was presented using numbers supported by a narrative rather than graphically. Less than 50 per cent of the sample reported the balance sheet. Again, where reported this tended to be displayed using numbers.

- *Access*

  Inpatient and Outpatient Waits were reported in around 80 per cent of the sample. The reporting cycle to the Board was roughly 2/3rds:1/3rd in favour of monthly reporting. Acute Trusts tended to use a combination of presentation format covering tables of numbers, charts and traffic lighting with a narrative. Forecast performance was reported only in around 25 per cent of the sample.

APPENDIX 3 - continued

- *A & E*
  The 12 hour trolley wait and 90 per cent waiting less than 4 hours were the key measures used. The questionnaire results showed 54 per cent and 64 per cent of the sample reporting these areas respectively using a full range of reporting measures, largely on a monthly basis.

- *Primary Care*
  These areas featured very little in the reporting of this sample; the same is the case for Health Inequalities. On the surface, and particularly to finance staff in acute trusts, this might be expected given the nature of acute trust responsibilities. However, in understanding the nature of demand for services from PCTs, some monitoring and performance reporting of PCTs and their make-up would be beneficial.

- *Booking*
  Around one third of sample reported on this area and most tended to produce monthly numbers.

- *Cancelled Operations*
  Surprisingly less than half of the sample reported to the Board, but of those reporting most tended to report monthly using numbers and traffic lights.

- *Cancer*
  Only around a half of the sample reported some cancer measure, and of these, it was mostly on a monthly basis and again using number and traffic light formats.

- *Coronary Heart Disease (CHD)*
  A third of the sample focused predominantly on the 2 week access to rapid access chest pain clinics – largely actual numbers reported monthly and allocated a traffic light category.

- *Mental Health*
  There was minimal reporting of these indicators, with around 10 per cent monitoring these targets on a monthly basis.

- *Older People*
  Readmission rates were monitored in around 40 per cent of the sample. This also links to the areas of Clinical Focus.

- *Patients' experience*
  Only a third of respondents picked up any measures across the range of measures in the survey relating to patients' experience of service delivery. The most popular was monitoring complaints response times, which rises to 60 per cent of the sample.

Primary Care Trusts

36 responses were from PCTs.

General themes

- Only 75 per cent of the sample reported Financial Balance on a monthly basis.

- In Board reports, graphs were primarily used in 50 per cent of the responses to report in-patient waiting times and 44 per cent for out patient waiting times.

- Traffic light highlighting was used in over 40 per cent of the sample.

- The Balanced Scorecard framework was used to place performance indicators in 22 per cent of the responses. The following indicators were reported by most of the sample using a scorecard:
  - *Financial Balance against revenue resource limit,*
  - *Maximum In Patient Wait 9 Months*
  - *Maximum Out Patient Wait 21 weeks*
  - *A&E Maximum 12 Hour wait from decision to admit*
  - *A&E 4hr wait from arrival to admit, transfer or discharge*
  - *Primary Care access to Healthcare professional / GP < one day / two days*
  - *Cancer Maximum wait of 14 days from referral to specialist appointment*
  - *Percentage of written complaints locally resolved within 20 days.*

APPENDIX 3 - continued

Specific areas

- *Finance*
  Financial balance (Revenue, Drug Expenditure and Capital spend against resource limit) was included in 90 per cent of the sample. Most (75 per cent) also included the level of cash releasing savings achieved and Performance against public sector payments policy. In nearly two thirds of the responses the balance sheet, cash flow and aged debtors were not reported.

- *Access*
  More than 80 per cent reported access targets, particularly actual performance against the maximum nine month in-patient and 17 week out patient targets.

- *A & E*
  The 4 hour wait from arrival to admit, transfer or discharge was reported by 63 per cent with the 12 hour trolley wait and 8 minute ambulance response also reported by 38 per cent.

- *Primary Care*
  63 per cent of reported access to healthcare professionals / GP.

- *Booking*
  Only 22 per cent of the sample reported the percentage of electronic booking.

- *Cancelled Operations*
  Only 27 per cent of the sample reported against this target.

- *Cancer*
  Over 60 per cent reported both the wait for cancer referrals and diagnosis to treatment of breast cancer.

- *CHD*
  Only 27 per cent of the sample reported against these targets.

- *Older people*
  Over 30 per cent reported Emergency readmission for stroke / hip fractures and the Percentage of patients with delayed discharge.

- *Patients' Experience*
  50 per cent reported their response to complaints. Most other targets were not reported by the sample.

- *Improving Working Lives*
  More than 50 per cent of the sample reported both time lost through absence and achievement of Improving Working Lives practice status.

Mental Health Trusts

Five returns were from mental health trusts.

General themes

- Very few graphs were used in the reports to Boards. Numbers with supporting narrative was the usual form of presentation.

- Almost all finance targets/duties were reported on an actual basis with forecast on a monthly basis with the exception of one trust which reported only three of the targets (one area reported monthly and the other two by exception).

- There was little consistency in what was reported even in the specific mental health section where only one organisation reported fully on those targets. The targets were consistent, however, in this section in that they were reporting quarterly rather than monthly.

- Five areas were not reported by any trust (Cancer, CHD, Children Health Inequalities and drugs).

- Generally the indicators were not used in a Balanced Scorecard framework or with traffic light systems with any consistency.

- Very little attention was given to Improving Working Lives, Patients experience and Workforce.

APPENDIX 3 - continued

Specific areas

- *Finance*

  Two Trusts did not report every target in the Finance section of the survey. The first omitted agency staff expenditure and level of cash releasing savings, and the second focused on only financial balance, capital expenditure and performance against the public sector payment policy.

- *Access*

  Only two Trusts reported access. One reported both inpatients and outpatients, actual and forecast, on a monthly basis and the other reported actual outpatients only, on a quarterly basis.

- *A & E*

  Only one Trust reported some targets, actual and quarterly.

- *Mental Health*

  Only one trust completed all six targets in this part of the survey and it focused on actual by exception only. Three trusts reported on three out of the six targets (including Deliver Outreach, improve breaks for carers and improve mental health in prisons). Three trusts used these targets on their Balanced Scorecard. Only one of the trusts did any forecasting.

- *Older people*

  Only one trust reported on these indicators, and it reported on three out of the eight targets - emergency hospital admissions and re-admissions, emergency re-admissions to hospital following a stroke, and delayed transferred. These were reported quarterly on an actual basis.

- *Patients' Experience*

  Only three reported on indicators in this area. All were reported quarterly. However, the only measure that was not reported by any of the respondents was the introduction of bedside TV and telephone systems in every major hospital. No organisation had these indicators on their Balanced Scorecard.

- *Clinical Focus*

  Only one trust reported on this area.

- *Improving working Lives*

  Four trusts reported on this issue but only two reported it on their Balanced Scorecard. Two of the four responded on all five areas. Interestingly these were not the ones, which reported it on the Balanced Scorecard. All four reported actual figures on a quarterly basis with little narrative.

- *Workforce*

  Only one reported three of the eight targets although the last one specifically relates to mental health.

Ambulance NHS Trusts

10 responses were from Ambulance Trusts.

General Themes

- Whilst eight Ambulance Trusts supported their reports with graphs only three of these were used to compare financial information.

- Financial targets were reported monthly in all 10 Trusts. However two Trusts did not report cash flow in any way. Only one Trust included forecasts.

- Only one Trust used a traffic light system. This was only for overall financial balance.

- Seven used a Balanced Scorecard approach, whilst only one indicated that their emergency response rate (star rating) was included on the Scorecard.

- Only five reported using age debtors in their reports. The timings varied from monthly through to by exception within the five reporting this.

- The only areas reported on were Finance, A&E, Patient Experience and Improving Working Lives.

APPENDIX 3 - continued

Specific Items

- *Finance*

  All of the trusts reported financial balance both actual and forecast, monthly and use numbers. They also reported capital expenditure monthly, using numbers and narrative.

- *A&E*

  Only five Trusts reported on A&E in any way. As this includes response times it is of significance and is also a star rating. Only two reported this as part of their Balanced Scorecard.

- *Patients' experience*

  All reported in this area to differing time-scales but all on an actual only basis. Infection control was used in only one although this would be considered a relevant star rating. Five Trusts included the reporting as part of their Balanced Scorecards.

- *IWL*

  Nine Trusts reported in this star rated area. All reported just on an actual basis with the exception of one Trust which also forecast time lost through absences. All reports varied in time-scales reported on and depth. Six Trusts included the reporting as part of their Balance Scorecards.

Strategic Health Authorities

Four responses were from SHAs.

General themes

- All reported actual and forecast I&E for their patch.

- Three reported against the main access targets.

- Two regularly reported on cancer, mental health, or other NHS Plan targets.

- One included workforce in their normal performance reporting on an exception basis.

- The Balanced Scorecard did not appear to be the basis for their performance reporting.

- Two recorded the performance on local resolution of complaints on an exception/ annual basis and one SHA also reported its activities for strengthening accountability to local communities, outpatient/A&E survey results, performance on infection control, MRSA improvement and elimination of nightingale wards for older people.

Specific areas

- *Finance*

  All reported actual and forecast I&E, two on a monthly basis and two on a bi-monthly or quarterly basis.

  Two reported actual and forecast level of cash savings achieved, one monthly and one on a quarterly basis.

  One reported monthly actual agency staff expenditure and three reported capital expenditure against capital resource limit on a monthly or bi-monthly basis (two actual and forecast and one just forecast information).

  Only one reported drug expenditure for their patch.

  One reported performance against the public sector payment policy.

  Two used narrative to support numbers and one used traffic lights.

APPENDIX 3 - continued

- *Access*
  Two reported all access targets bar inpatient maximum wait of three months. Both used traffic lights but only one used graphs.

  One focused on inpatient maximum wait 12 months (by exception) and monthly reporting of maximum wait nine months, reduction of six month waiters by 40 and 80 per cent and outpatient maximum waiting targets.

  One covered only one maximum wait target for in and outpatient groups respectively and used graphs.

- *A&E*
  All reported selected A&E targets. The only single target reported by all is 90 per cent wait less than four hours from arrival to admission.

- *Primary Care*
  Three reported key performance targets in relation to Primary Care with one using traffic lights.

- *Cancer*
  Two reported on cancer. One focussed on monthly actual and forecast reporting of referral wait to specialist from GP, reducing the rate of smoking and increasing breast screening and the others focussed only on all the maximum wait targets.

- *Mental Health*
  Of the two that reported on performance in relation to mental health, the targets used were reduction in duration of untreated psychosis, 24 hour crisis resolution and outreach services.

- *Older People*
  All reports selected targets around older people and one used supporting narrative and traffic lights.

- *Drugs*
  One reported on drug treatment programmes and the reduction of drug related deaths.

- *Workforce and IWL*
  One reported on most of the targets related to workforce performance and two reported on targets on improving working lives (all by exception or bi-monthly or quarterly).

APPENDIX 4
CIMA/HFMA research project on NHS performance management
Suggested performance indicators

The following grid shows suggestions for performance indicators

Some have been identified as key and which are suggested should be reported every month.
The other indicators are those from which secondary indicators would be selected.

Suggested key indicators
Key dependent on circumstances

		Hospital Trusts		Ambulance Trusts	Care Trusts	PCT	SHA
		Acute	Mental Health				
Finance							
Financial balance (Trust income and expenditure, PCT balance against revenue resource limit)	Statutory duty	*	*	*	*	*	*
Level of cash releasing savings achieved		*	*	*	*	*	*
Drug expenditure		*	*	*	*	*	*
Agency staff expenditure		*	*	*	*	*	*
Capital expenditure against capital resource limit	Statutory duty	*	*	*	*	*	*
Cash flow against cash limit	Statutory duty	*	*	*	*	*	*
Balance sheet		*	*	*	*	*	*
Aged debtors		*	*	*	*	*	*
Performance against the public sector payment policy		*	*	*	*	*	*
NICE directives - related expenditures		*	*	*	*	*	*
Access							
Inpatient Waiting							
Number waiting more than 12 months	LDP	*			*	*	*
Number waiting more than 9 months	LDP	*			*	*	*
Number waiting more than 6 months	LDP	*			*	*	*
Number waiting more than 3 months	LDP	*			*	*	*
Length of wait (appropriate target)		*			*	*	*
Overall list size	LDP	*			*	*	*
Reduce overall list size	LDP	*			*	*	*

NB care trust - depends whether commissioning services and on services covered.

		Hospital Trusts		Ambulance Trusts	Care Trusts	PCT	SHA
		Acute	Mental Health				
Outpatient Waiting							
Number waiting more than 21 weeks	LDP	*	*		*	*	*
Number waiting more than 17 weeks	LDP	*	*		*	*	*
Number waiting more than 13 weeks	LDP	*	*		*	*	*
Length of wait		*	*		*	*	*
A&E							
Maximum wait from decision to admit (trolley wait)	Star Ratings	*			*	*	*
% waiting less than 4 hrs from arrival to admission, transfer or discharge	LDP	*			*	*	*
% calls responded to within 8 minutes for all ambulance category A emergency calls	Star Ratings			*	*	*	*
Max response time for all ambulance category A emergency calls				*	*	*	*
Primary Care							
% of patients who wish to do so seeing a primary health care professional within 1 working day	LDP				*	*	*
% of patients who wish to do so seeing a GP within 2 working days	LDP				*	*	*
Max wait for GP appointment					*	*	*
Booking							
% booking of daycases	LDP	*			*	*	*
% of first outpatient appointments pre-booked	LDP	*	*		*	*	*
% of elective inpatient appointments pre-booked	LDP	*	*		*	*	*
Cancelled Operations							
% patients admitted within 28 days of operations cancelled on or after day of admission	Star Ratings	*			*	*	*
Number of operations cancelled on or after day of admission		*			*	*	*
Cancer							
Maximum Days waited from urgent GP referral to specialist appointment	Star Ratings /LDP	*			*	*	*
Maximum days waited from Urgent GP referral to 1st Treatment, Leukaemia, Testicular & Children's cancer	LDP	*			*	*	*
Maximum days waited from diagnosis to 1st treatment for Breast Cancer	LDP	*			*	*	*
Maximum wait from diagnosis to treatment for all cancers	LDP	*			*	*	*
Maximum wait from urgent referral to treatment for all cancers	LDP	*			*	*	*
Rate of smoking among manual groups	LDP				*	*	*
% of all women aged 65-70 receiving breast screening	LDP				*	*	*

APPENDIX 4 - continued

		Hospital Trusts		Ambulance Trusts	Care Trusts	PCT	SHA
		Acute	Mental Health				
CHD							
length of wait for Rapid Access Chest Pain Clinics	LDP	*			*	*	*
length of wait for angiography		*			*	*	*
length of wait for revascularisation		*			*	*	*
Revascularisation: % of elective patients treated within 9 months	Star Ratings	*			*	*	*
% of people suffering from a heart attack who receive	LDP	*			*	*	*
Percentage of eligible patients treated with thrombolysis within 30 minutes of hospital arrival	Star Ratings	*			*	*	*
Mental Health							
Mean duration of untreated psychosis	LDP		*		*	*	*
Maximum duration of untreated psychosis	LDP		*		*	*	*
% of young people who develop a first episode of psychosis provided with support for the first three years			*		*	*	*
% eligible clients receiving 24-hour crisis resolution	LDP		*		*	*	*
Increase in carers receiving breaks	LDP		*		*	*	*
% prisoners with severe mental illness having a Care Plan	LDP		*		*	*	*
Older People							
% assessments of older people begun within 48 hours of first contact with social services	LDP	*			*	*	*
Following assessment, % older people receiving social services within four weeks	LDP	*			*	*	*
Following assessment, % older people receiving social services within two weeks		*			*	*	*
% older people receiving community equipment (aids and minor adaptations) provided by social services within seven working days	LDP	*			*	*	*
growth in emergency hospital admissions	LDP	*			*	*	*
level of re-admissions		*			*	*	*
Emergency readmissions to hospital within 28 days of discharge following a stroke, as a percentage of live stroke discharges (age and sex standardised)	Star Ratings	*			*	*	*
Emergency readmissions to hospital within 28 days of discharge	Star Ratings	*			*	*	*
Percentage of patients whose transfer of care from hospital was delayed	Star Ratings	*			*	*	*
% of people with diabetes offered screening for early detection of diabetic retinopathy in a systematic programme which meets national quality standards	LDP				*	*	*

		Hospital Trusts		Ambulance Trusts	Care Trusts	PCT	SHA
		Acute	Mental Health				
Children							
Paediatric outpatient did not attends rates	Star Ratings	*			*	*	*
Emergency readmission to hospital within 7 days of discharge for children as a percentage of live discharges for children	Star Ratings	*			*	*	*
Patient Experience							
level of complaints		*	*	*	*	*	*
local annual survey results	LDP	*	*	*	*	*	*
Outpatient/A&E survey results	Star Ratings	*	*	*	*	*	*
Percentage of written complaints for which a local resolution was completed within 20 working days	Star Ratings	*	*	*	*	*	*
Percentage of written complaints for which a local resolution was completed within 20 working days	Star Ratings	*	*	*	*	*	*
Reduction in the value of NHS building backlog maintenance	LDP	*	*	*	*	*	*
Whole hospital score, including cleanliness, formulated against Patient Environment Action Team (PEAT) visits	Star Ratings	*	*				
Infection control - Self-assessment scores by standard/criteria	Star Ratings	*					
Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia: Improvement score	Star Ratings	*					
% hospital beds with bedside TV and telephone systems in every major hospital	LDP	*					
Number of Nightingale wards for older people	LDP	*	*				*
Level of mixed sex accommodation in general wards	Star Ratings	*	*				*
Number of wards with ward housekeepers in hospitals….	LDP	*	*				*
…level of modern matrons in all available posts	LDP	*	*				*
Health Inequalities							
proportion of women continuing to smoke throughout pregnancy	LDP	*			*	*	*
breastfeeding initiation rate	LDP				*	*	*
death rates from CHD in people under 75	LDP				*	*	*
cancer death rates in people under 75	LDP				*	*	*
uptake of influenza immunisation in people aged 65 years and over	Star Ratings				*	*	*
Clinical Focus							
Level of compliance against Clinical Negligence Scheme for Trusts (CNST) risk management standards	Star Ratings	*	*		*	*	*
Deaths within 30 days of surgery for heart bypass operation, (which includes deaths in hospital and after discharge)	Star Ratings	*			*	*	*
Deaths within 30 days of selected surgical procedures (which includes deaths in hospital and after discharge)	Star Ratings	*			*	*	*
Emergency readmission to hospital following discharge, as a percentage of live discharges	Star Ratings	*			*	*	*
Summary measure of Hospital Episode Statistics (HES) data quality for NHS trusts with in-patient activity	Star Ratings	*					

APPENDIX 4 - continued

		Hospital Trusts		Ambulance Trusts	Care Trusts	PCT	SHA
		Acute	Mental Health				
Drugs							
Level of participation of problem drug users in drug treatment programmes	LDP	*	*		*	*	*
Use of antibiotics					*	*	*
Number of drug-related deaths	LDP	*	*		*	*	*
Improving Working Lives							
Achievement level of IWL standard practice status	Star Ratings	*	*	*	*	*	*
Responses from NHS-employed staff opinion survey on satisfaction with employer	Star Ratings	*	*	*	*	*	*
Percentage of junior doctors complying in full with the New Deal on Junior Doctors' Hours	Star Ratings	*	*				
Percentage of consultants who have completed annual appraisal as set out in Advanced Letter AL (MD) 05/01, including the appraisal meeting and signing off their personal development plan	Star Ratings	*	*				
The amount of time lost through absences as a percentage of staff time available for directly employed NHS staff	Star Ratings	*	*	*	*	*	*
Workforce							
Turnover of workforce		*	*	*	*	*	*
Vacancy levels		*	*	*	*	*	*

APPENDIX 5

Bibliography and links to key publications

Governing the NHS: A guide for NHS Boards
NHS Appointments Commission,
June 2003
www.doh.gov.uk/governingthenhs/

Delivering Excellence in Financial Governance
Dept of Health,
March 2003
www.doh.gov.uk/financialgovernance/index.htm

Achieving Improvements through Clinical Governance: A Progress Report on Implementation by NHS Trusts
National Audit Office,
September 2003
www.nao.gov.uk/publications/nao_reports/02-03/02031055.pdf

Delivering the NHS Plan
Dept of Health,
April 2002
www.doh.gov.uk/deliveringthenhsplan/index.htm

Corporate Governance: Improvement and trust in local public services
Audit Commission,
October 2003
ww2.auditcommission.gov.uk/static/pdf/CorporateGovernance.pdf

Targets in the public sector
Audit Commission,
September 2003
www.auditcommission.gov.uk/Products/AC-REPORT/B02E376A-01D5-485b-A866-3C7117DC435A/Targets_briefing.pdf

Towards an integrated organisational framework of hospital performance
Aston Business School research paper,
July 2000
http://research.abs.aston.ac.uk/working_papers/0018.PDF

Measuring "goodness" in individuals and healthcare systems
Pringle et al,
BMJ 28 Sept 2002,
vol. 325 p704ff
http://bmj.com/cgi/reprint/325/7366/704.pdf

Measuring the performance of health systems
Mulligan et al,
BMJ 22 July 2000,
vol. 321 p191ff
http://bmj.com/cgi/reprint/321/7255/191.pdf

Improvement, expansion and reform: the next 3 years
Priorities and Planning Framework 2003 – 2006
Dept of Health,
2002
www.doh.gov.uk/planning2003-2006/improvementexpansionreform.pdf

Achieving First-class Financial Management in the NHS
Audit Commission,
April 2004
www.auditcommission.gov.uk/Products/NATIONAL-REPORT/94A993DA-FBD8-4ec1-9340D73489AEE86B/FinanceinNHS_Report.pdf

CIMA guides/ briefings
(available from the Knowledge Bank on www.cimaglobal.com):
Setting effective performance indicators in a best value environment

Latest trends in corporate performance measurement

Performance management in executive agencies

Performance Reporting to Boards: A Guide to Good Practice

The Balanced Scorecard – an overview

HFMA, Suite 32, Albert House, 111 Victoria Street, Bristol BS1 6AX.
Tel: 0117 9294789 Fax: 0117 9294844 E-mail: info@hfma.org.uk Website: www.hfma.org.uk
Registered with the Charity Commission of England and Wales: No. 1012713

CIMA, 26 Chapter Street, London SW1P 4NP.
Tel: 0207 6635441 Fax: 0207 6635442 E-mail: cima.services@cimaglobal.com Website: www.cimaglobal.com