

The Public Sector Scorecard

Max Moullin explains how a public sector scorecard can be used to measure and improve the performance of healthcare services

Summary

This article identifies how performance measurement can achieve the greatest number of benefits with the smallest number of drawbacks..

Keywords

Performance measurement, balanced scorecard, Public Sector Scorecard

IT IS often easy to criticise performance measurement in the NHS, but it is also important to appreciate why it is needed. As former New York mayor Rudy Giuliani says: 'Objective, measurable indicators of success allow governments to be accountable' (Giuliani and Kurson 2002).

The use of performance measures has also widened political debate. During UK general elections held before 2001, for example, information on nation-wide healthcare inputs, such as funds earmarked for services, was available but that on outputs, or outcomes, was not. Consequently, political parties promised only to outdo each other in spending. In the 2001 and 2005 elections, however, output measures such as waiting times had become available, so political debate could encompass what parties planned to achieve.

Performance measurement can also be an agent for change. Whatever one's doubts about the Department of Health's (DH) operational standards for England, its use of performance measures has had benefits, such as faster treatment for patients (Bevan and Hood 2006).

Measuring performance

Measuring performance in health and public services is understandably controversial. When done well, it can motivate staff to improve performance, and can 'reveal the true performance of the system and the impact of any changes in real time' (NHS Modernisation Agency 2004). When done poorly,

however, it can alienate employees and lead to a culture of blame in which staff meet targets at the expense of patient care.

Performance measurement has been defined as the process of 'evaluating how well organisations are managed and the value they deliver for customers and other stakeholders' (Moullin 2002).

It follows that, in performance measurement, measures and targets must be based on the outcomes that matter most to patients and carers. In identifying these outcomes, it is important to recognise that those who use specific services may have different requirements and expectations.

For example, patients at a GP surgery who think their needs are urgent are likely to be dissatisfied if they have to wait 48 hours for their appointments. On the other hand, those whose needs are less urgent are more likely to want appointments at times that suit their lifestyles.

In a study comparing the effectiveness of male and female GPs, McKinstry (2008) reports that the latter spend, on average, two minutes longer with patients than their male counterparts (2008).

The speed at which patients are handled is not an outcome measure, however, as can be verified by talking to any patient. Those who think that it should be might consider the case of a GP who, in taking two minutes less than colleagues, mistakenly refers a patient to an ear nose and throat (ENT) specialist rather than a specialist in infectious diseases.

In such a case, the GP, ENT and infectious diseases specialists involved will probably meet their targets but the patient's frustration, poor experience of health care and long wait, as well as the unnecessary additional costs incurred by the NHS, are unlikely to be identified by existing measures.

This example also illustrates the importance of measuring performance across organisational boundaries, which is particularly important in patient discharge, when the quality

of service received probably depends more on the collaboration of the different professionals involved than on their individual skills and abilities.

Hospital staff must work closely with pharmacies, GP practices, and social care to ensure that their combined performance measures, particularly concerning medication, care following discharge and dealing with delays, reflect patients' experiences.

To understand the extent of the difference between outcomes and outputs, and the need to look across departmental boundaries, two sources of data on hospital waiting times can be compared (Table 1).

In Table 1, the figures in the second column are the percentages of patients experiencing waiting times defined as the periods between referral and arrival at hospital (DH 2008a).

These times are important to patients, of course, but they do not tell the whole story. Patients can also wait for test results or to see several health professionals before their are referred to hospital, for example, or they may experience 'hidden' waiting times such as those between when they see their GPs to when their referral letters arrive at the hospitals.

In Table 1, the figures in the third column are the percentages of patients experiencing waiting times, as reported in the National Inpatient Survey (Healthcare Commission 2008).

These are derived from patients' responses to the question: 'Overall, from the time you first talked to your GP about being referred to hospital, how long did you wait to be admitted?' (Healthcare Commission 2008).

Integrating risk management

Risk management is often ignored when performance is monitored. However, identifying and addressing key risks are essential for any high-performing organisation and therefore any evaluation of performance without considering risk is incomplete (Moullin 2006).

Organisations that perform well against current measures but have not addressed major risks cannot be described as 'well-performing organisations'. Arguably, the lack of recognition of risk factors in the evaluation of performance was a major cause of the collapse in the banking sector.

In health care too, recognition of risk factors is important. For example, a public health programme that focuses on obesity might lead inadvertently to an increase in the prevalence of eating disorders.

Reliability It is important that those who develop performance measures take into account their likely reliability, how they will be perceived

by staff and users, and whether they add value to services. To meet these ends, the number of measures developed may have to be severely limited.

Performance measurement has become something of an industry in recent years, and careful consideration is needed to identify the cost and the value of particular measures.

In this context, 'you cannot manage what you do not measure' is an often quoted statement. It is important to remember, however, that measuring and managing are different, and that measures should not be devised simply to provide an illusion of good management.

Reporting The reporting of performance measures also requires careful attention. For example, one common practice in reporting is to aggregate the numbers of patients who rate services as, for example, 'good', 'very good' or 'excellent'.

Managers who aspire to excellence must take note of the proportions of patients who give these different responses. They should also record precisely what is measured and why, how frequently and by whom, and must identify who is responsible for co-ordinating action once the data becomes available.

Continuous improvement

Performance measurement in the NHS has been much criticised because it has produced a number of unintended consequences (Smith 1993, Bevan and Hood 2006).

Some responses of healthcare organisations to measures and targets are given in Figure 1.

These are often described as 'perverse effects' (Brooks 2007), but they are the predictable consequences of a top-down performance management culture that can lead people to abandon their professionalism and meet targets at the expense of service quality or patient interests.

Table 1 Hospital waiting times in England		
Hospital waiting times	Percentage of patients experiencing waiting times defined as the periods between:	
	Referral and arrival at hospital	Discussion of referral and arrival at hospital
Four months or less	93	64
Five or six months	7	15
More than six months	0	21
Department of Health (2008) and Care Quality Commission (2008)		

All performance targets are flawed, but some are useful (Moullin 2009). Arguably, therefore, the most important requirement of an effective performance management system is that it helps create a culture of continuous improvement rather than one of blame (Moullin 2004).

When setting targets, the DH must work closely with NHS Trusts to prevent staff from meeting targets at the expense of patient care. In particular, they must ensure that targets are linked clearly to patient care, and that they are seen as challenging but fair by individual trusts and their staff.

The Healthcare Commission has tried to address such issues in recent years by allowing trusts to mention 'extenuating circumstances' that might have affected their achievement of a target, and by gathering feedback from local stakeholders, including patient bodies, to corroborate data provided.

A culture of continuous improvement also requires organisations to act on the information they obtain to improve services by producing clear action plans and by designating the people who are responsible for achieving these. Through effective leadership they must create a climate in which people are encouraged to look for innovative solutions, analyse past performance and learn from other organisations.

The Public Sector Scorecard

One of the best ways for public and third sector organisations to measure their effectiveness is by use of the Public Sector Scorecard (PSS).

Adapted from the balanced scorecard, which is a strategic and performance measurement framework that has had considerable success in the private sector (Kaplan and Norton 2001), the PSS is

an integrated framework for quality management, service redesign and performance measurement.

It has been used in healthcare services in Saudi Arabia and South Africa, as well as in the UK, and is consistent with Lord Darzi's recommendation that 'NHS services must develop quality frameworks that combine relevant indicators, defined nationally, with those appropriate to local circumstances' (DH 2008b).

By using the PSS, healthcare organisations can ensure that their strategies, processes, organisational culture and performance measures are all consistent with the outcomes that matter to service users and other key stakeholders (Moullin 2002, Moullin and Soady 2008).

Use of the PSS focuses on the outcomes that matter to patients and other key stakeholders, the processes that deliver these outcomes, and the ability of healthcare organisations to provide the leadership and support required to ensure that processes work effectively.

Perspectives The PSS has seven 'perspectives' in three groups: 'capabilities', 'processes' and 'outcomes'. The first of these groups leads to the second and the second to the third (Figure 2).

There are three outcome perspectives:

- The strategic perspective reflecting key performance outcomes required by the relevant organisation.
 - The outcomes that matter most to service users and other key stakeholders.
 - The financial outcomes such as the achievement of value for money or the securing of funding.
- Only one perspective, operational excellence, relates to processes but it is key to ensuring that outcomes are achieved.

Figure 1 Responses of organisations to government measures and targets

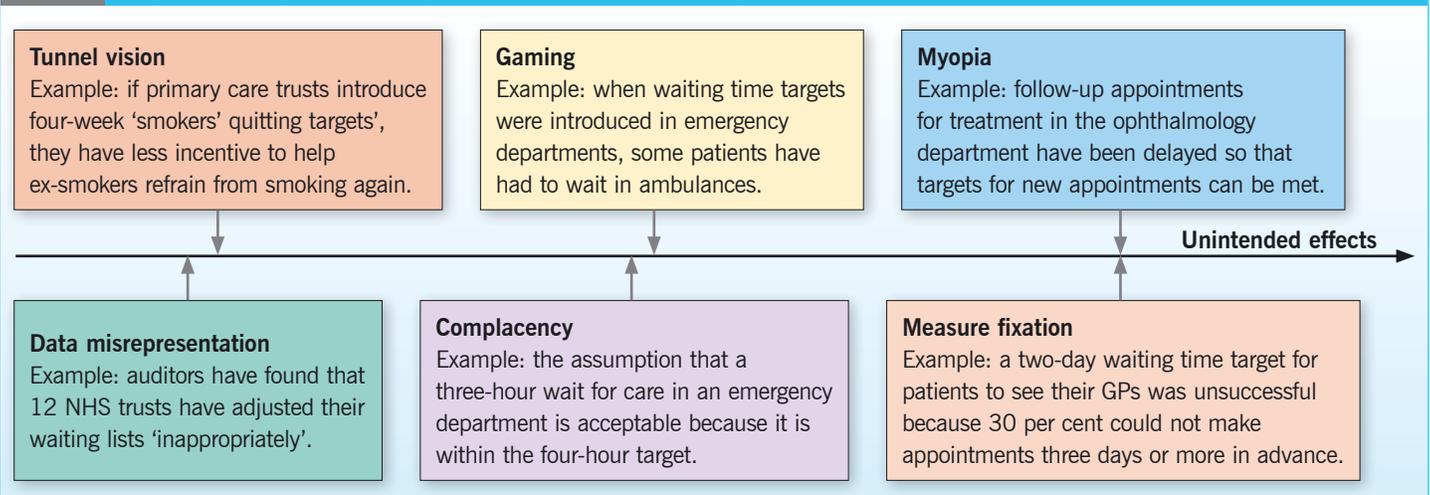


Figure 2 The seven perspectives of the Public Sector Scorecard



(Adapted from Moullin and Soady 2008)

The three capabilities are concerned with innovation and learning, effective leadership, and people, partnerships and resources, all of which are needed by organisations to enable their staff to achieve the required outcomes.

The PSS is a flexible framework and the seven perspectives can be ignored or changed according to the needs of the organisations, provided that, if used, they address outcomes, processes and capability as illustrated in the first column in Figure 2.

Stages A typical PSS application also involves seven stages (Figure 3.), of which the first three are clarifying outcomes, re-designing processes and addressing capabilities.

For example, a project aimed at improving hospital discharge arrangements would involve a series of workshops in which all relevant staff groups, senior health and social care managers, and former patients and carers take part.

The first stage usually involves identifying the outcomes required by patients and their carers, and their perceptions and expectations of quality services. They may also concern the key performance outcomes required by hospitals, GPs, social care services and the DH.

The second stage may involve workshops on the numerous processes associated with hospital discharge, including the involvement of patients and professional staff.

In these workshops, process maps may be used to highlight areas of duplication, processes that could be simplified or accelerated through, for example, better communication, and non-productive activities such as talking to patients who ring up because they have not received a service they were promised.

The third stage concerns what can be done to ensure that redesigned processes work smoothly.

This might involve extra resources for one particular area, better teamwork, improvements to staff morale, or ensuring that senior managers are available, supportive and receptive to new ideas.

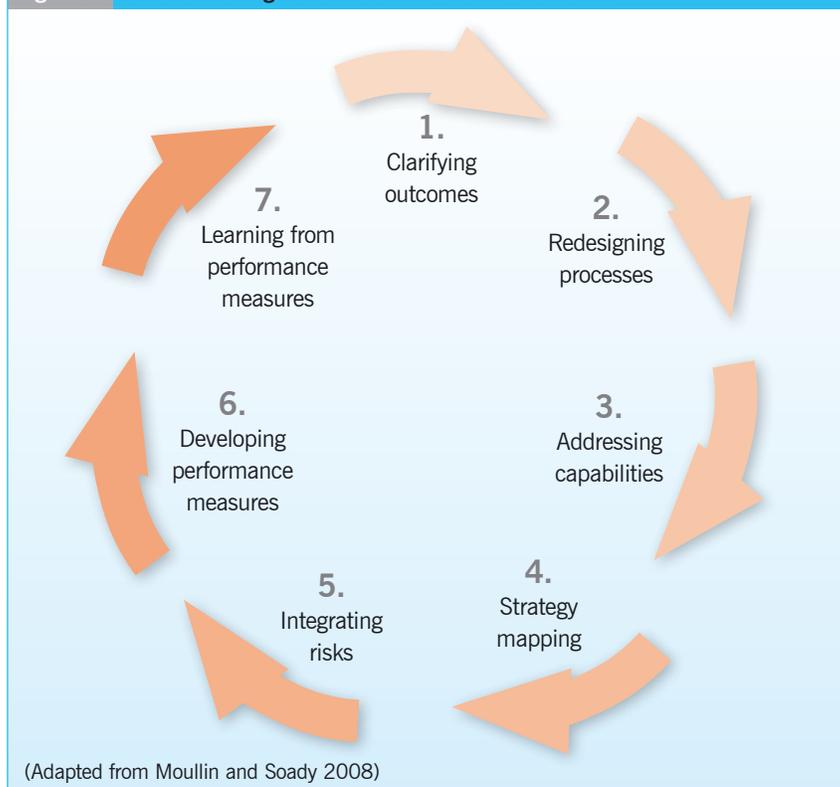
It might also mean addressing budgetary problems in which, for example, prescribing costs are passed between hospitals and GPs.

Strategy maps The links between outcomes, processes and capabilities are then illustrated in a strategy map, which is an important intermediate output of the PSS. According to Kaplan and Norton (2001) a strategy map 'describes how shareholder value is created from intangible assets'. When used with a PSS, however, it can be defined more simply as a depiction of the relationships between outcome, process, and capability elements.

Integrating risk management The next stage involves incorporating risk management into a strategy map by considering the reduction of a key risk as a desired outcome.

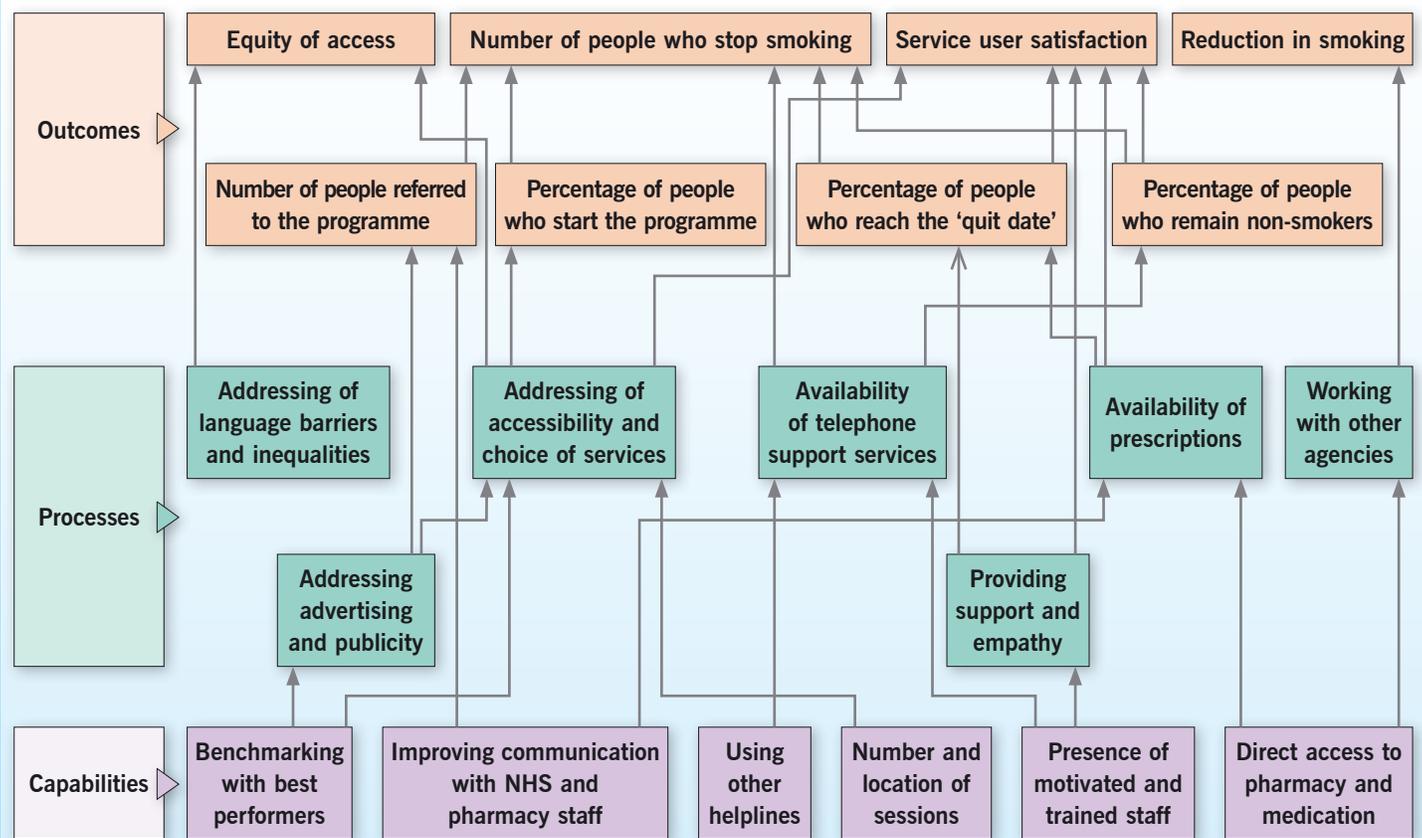
The processes by which risks are reduced, eliminated, or mitigated are then reviewed, together with organisations' abilities to develop risk-conscious cultures without stifling innovation. The results of these reviews are then added to the strategy map.

Figure 3 The seven stages of the Public Sector Scorecard



(Adapted from Moullin and Soady 2008)

Figure 4 Extract from a stop smoking service strategy map



(Adapted from Moullin and Soady 2008)

Developing performance measures Before finalising its performance measures, organisations should identify the main objectives and potential performance measures for each element of the strategy map. They should consider how staff and others are likely to respond to these measures and also examine issues of data collection and data quality.

A filtering process then takes place to ensure that the measures chosen are cost-effective and can provide value to the organisations concerned.

Learning Analysing and learning from performance measures provides insight into how well organisations perform in meeting their objectives for each of the elements on the strategy map, and into the activities that deliver these most effectively. This information is then used to clarify outcomes, and to identify how further improvement in processes and capability can be made so that the cycle can begin again.

Culture of continuous improvement

The aim of the PSS is to develop an organisational culture of continuous improvement.

This culture is created in three ways:

- By use of perception measures, such as questionnaires or focus groups to determine service-user satisfaction, and of specific indicators. This lets staff know that their work is judged on the levels of service user or stakeholder satisfaction it produces so that they become less likely to put targets before patients.
- By the direct involvement of staff, service users and other stakeholders in reference groups.
- By not simply relying on data. For example, if performance in a particular area is below target, staff can be invited to outline the circumstances in which achievement of outcomes has been made more difficult and to put together action plans to improve performance.

The Sheffield NHS Stop Smoking Service, in which healthcare professionals provide free, city-wide support for people who want to stop smoking, is an example of the PSS in action. The PSS study for this service began with user workshops involving more than 100 service users to identify their views on how a smoking-cessation service should be run.

The strategy map produced in these workshops shows the relationships between how the capability

aspects can lead, through the arrows, to more effective processes and better outcomes (Figure 4).

By using this map, four ways in which people can be helped to stop smoking were identified:

- Ensuring that more smokers are referred to the programme.
- Ensuring that a greater proportion of these smokers start the programme.
- Ensuring that more of those who start the programme reach the 'quit date' four weeks later.
- Ensuring that more of those who start the programme 'stay stopped'.

Service users identified that one key factor in improving satisfaction and getting more people to achieve their specified quit date was the prompt availability of prescriptions for nicotine patches or drugs once they had made the decision to quit.

A reference group, which included managers and service staff, eight service users, midwives, a hospital consultant and a pharmacist, reviewed the processes for timely receipt of prescriptions and identified some solutions including the direct access of service users to pharmacies, so that they bypass their GPs, and improvements in communication between staff at the smoking cessation service, the NHS and at pharmacies.

In putting these ideas into practice, the reference group chose three performance measures to keep track of progress:

- The time taken to obtain prescriptions.
- Service user satisfaction with the availability of prescriptions.
- The number of people who stop smoking.

According to John Soady, Health Improvement Principal at NHS Sheffield, the benefits of the PSS project include 'a broad and balanced portfolio of measures that impact directly on service delivery, greater focus on service user and stakeholder input, and capturing a useful overview of the key interrelationships'.

Managers who want to judge the success of their performance measures can answer these questions:

- Are users, staff and other stakeholders involved in the choice of measures?
- Do the measures relate clearly to the outcomes that matter to patients, carers and other stakeholders?
- Are measures of major risk factors included?
- Do the measures relate closely to the organisation's strategy?
- Do the measures address deficiencies in organisational capability and culture?
- Does the organisation involved have a transparent process for reporting and learning from measures that improve performance?
- Is there a culture of continuous improvement rather than culture of blame?

Conclusion

The PSS offers an excellent way of ensuring that service improvement and performance measurement focus on the outcomes that matter to service users, patients and other key stakeholders, as well as the processes that deliver those outcomes, and the organisational culture and capability to ensure that these are delivered and to support their staff.

Implications for practice

The most important aspect of performance measurement is the creation of management culture in which managers and staff focus on improving services, rather than a culture of blame. Without this, people will be rewarded for pursuing targets, instead of for improving services.

Further reading

For more information on the Public Sector Scorecard, including references, access www.shu.ac.uk/ciod/pss

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