

The intelligent board

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Dr Foster Intelligence is an independent organisation that undertakes research and analysis and provides information about the quality and availability of health services. Launched in 2006 as a joint venture between Dr Foster and the Health and Social Care Information Centre, Dr Foster Intelligence aims to set a new standard in information for health and social care providers and their users.

The Dr Foster unit at Imperial College London is directed by Professor Sir Brian Jarman, a former member of the Bristol Royal Infirmary Inquiry, and Dr Paul Aylin, an expert witness at both the Bristol and Harold Shipman Inquiries.

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For further information on the Dr Foster Intelligence or Ethics Committee, visit www.drfoosterintelligence.co.uk or contact Jake Arnold-Forster on 020 7330 0400.

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Foreword

Effective boards depend on having the right information at the right time. That information needs to be focused on the right issues, pitched at the right level of detail and presented clearly. These may be obvious truths, but they are nevertheless very significant challenges for the new NHS and I firmly believe we must take action now to meet them. This report seeks both to provoke debate and offer practical proposals. What we seek to offer is not a prescription, but a starting point for discussion and development.

In this report, the steering group has developed a view on the minimum set of information an acute trust board should have if it is to be effective in its role. We found it striking that in too many areas this basic information set is simply not currently available within the NHS in a timely, comparable or reliable form. This should provoke debate and action among board directors: Are you tracking what your patients think? Do you have information on the income and costs associated with each “business unit” in your trust? How do you compare with “competitor” trusts? In addition, those who collect data centrally should also consider the questions and implications arising from this work, as they have a key role to play in ensuring the existence and availability of the base data for comparison. The next step is for boards and specialists such as Dr Foster to work together to ensure that the base data is properly analysed, presented and interpreted for and by NHS boards.

The fact that not all of the required information is currently available should not deter boards from working to achieve the production of the required information in an acceptable format within a reasonable timescale. To manage effectively without it is not possible.

I am grateful to colleagues in Monitor, the Healthcare Commission and the NHS Confederation as well as individual trusts who gave up their time to contribute to this project, and to Dr Foster for sponsoring it. I see this as the start of a significant piece of developmental work and I hope others will join us in this challenge.

Sir William Wells

A handwritten signature in blue ink, appearing to read 'Will Wells', written in a cursive style.

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Background

In its work with the NHS, Dr Foster has found that increasing numbers of trusts were facing similar challenges in identifying and meeting the information needs of their boards. Dr Foster therefore invited Sir William Wells to convene a group of leading NHS figures, executive and non-executive, to consider these issues and act as steering committee for the development of this report.

Board-level information needs are being driven by advances in medical care and developments in health policy that are changing the environment for clinicians and managers. Some of the key policy drivers are:

- Payment by Results
- Practice-based commissioning
- Waiting targets
- Choice
- Foundation status and the creation of governors and members
- Changes in commissioning structures
- Regulatory compliance – including the need to take account of patient and stakeholder views
- Public health targets
- Clinical governance.

As a result of this rapidly changing environment, those who are charged with the governance of NHS organisations have an increased need for good-quality, timely information – to set strategic direction, to oversee progress towards strategic goals and to monitor operational performance.

Every member of the board needs sufficient information at a high enough level to be confident that the organisation is well run, but not so much information that it becomes difficult to tell what is important. This is as true for executive directors as it is for non-executives. NHS boards are unitary in nature and it is increasingly recognised that non-executives are not simply there to “referee a game being played by the executives” but to share fully in collective responsibility. Executives, too, need to be equipped to play their role fully and to contribute to oversight of areas beyond their own sphere of responsibility. On the best boards, constructive challenge is not seen as the preserve of non-executives; executive colleagues are expected to provide each other with challenge too.

How the steering group worked

The steering group involved:

Sir William Wells

Chairman, NHS Appointments Commission (Chairman)

Bill Moyes

Chairman, Monitor

Marcia Fry

Head of Operational Development, Healthcare Commission

Peter Mount

Chairman, NHS Confederation and Central Manchester and Manchester Children's Hospital NHS Trust

Alan Howarth

Chairman, Royal Surrey County Hospital NHS Trust

Sir Miles Irving

Chairman, The Newcastle upon Tyne Hospitals NHS Trust

Cally Palmer

Chief Executive, The Royal Marsden NHS Foundation Trust

The group has considered what information the boards of NHS acute trusts need in order to discharge their function properly. The group also considered how that information is best delivered, how frequently it should be updated and the extent to which organisations should support their boards in understanding the information they are given. The group has met three times to steer the project, which has been supported by Dr Foster.

The group has focused on the information requirements of boards of acute and mental health trusts in the first instance. The next phase of work will focus on the information that the boards of strategic health authorities and primary care trusts need.

This report

This report presents a set of principles and model framework for structuring information to support strategy development and oversight of business delivery and effectiveness. It also suggests practical ways in which boards might use the framework proposed.

The report is structured as follows:

- The Information Challenge: discussion of the growing pressure on boards to raise their game and the need to improve the information they receive and how they use it.
- Intelligent information for the board: some key principles that should govern information for the board, together with a proposed framework and minimum data set for reviewing trust performance, supporting decision-making and considering strategy.
- Putting the framework into practice: improving the structure of agendas for the board; developing a “dashboard” of routine performance indicators; informing the annual cycle of board meetings.

Annex 3 contains the results of an analysis of the board agendas and papers from 14 acute and mental health trusts, which informed the group’s deliberations.

This report is being made freely available and is also available from www.drfoosterintelligence.co.uk and www.appointments.org.uk.

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The information challenge

Governance – the changing context

The past decade or so has seen ever-increasing interest in the effectiveness of governance across all sectors, prompted not only by high-profile business failures but also in the public sector by concerns about integrity, independence, accountability and recognition of the growing complexity of effective public service provision. The foundations of good practice were laid down in the Cadbury Report back in 1992 and developed by Greenbury, Hampel, Turnbull and more recently Higgs (2003). Alongside the Nolan principles of public life, the recommendations of these reports have also to a large extent been extended to public bodies, including through the Good Governance Standard for Public services in 2004.

In the NHS, the creation of the Appointments Commission in 2001 signalled a renewed emphasis on the quality of governance and the role of non-executive directors, following up with *Governing the NHS – a guide for NHS Boards* in 2003. Progress continued with the development of the concept of integrated governance, which set out the challenges clearly in terms of how boards work and how they can best add value. *Standards for Better Health* has since described the parameters of performance that boards must oversee – while the Healthcare Commission’s annual health check has placed the onus firmly on boards to assure themselves of compliance and continuous improvement.

All of this has brought into sharp focus the critical role of boards in enabling and ensuring that organisations deliver their objectives and are accountable to their stakeholders for their performance. To quote from *Governing the NHS*:

“Good governance is an essential springboard for modernisation. Getting it right not only enables staff to do a good job. More critically, it leads to better patient care and enables boards to demonstrate proper accountability to local people for the safe running of their health service.”

Boards at the forefront of modernisation work recognise that they need to ask themselves a different set of performance questions from those traditionally asked.

Monitor’s consultation in early 2006 on the draft NHS Foundation Trust Code of Governance similarly reinforces these messages, describing effective corporate governance as a fundamental cornerstone for success.

Boards of directors, and in particular chairs and non-executives, are having to raise their game to meet greater expectations. As a result we have seen:

- Sharper definition of the roles and responsibilities of the chair, executive and non-executive directors.
- More rigorous skills-based recruitment processes and independent appointment of non-executives.
- Greater emphasis on the robustness of internal control systems.
- Increased requirements for transparency and accountability mechanisms.
- Streamlining of board size, committee structures and processes.
- More attention being given to reviewing the performance of boards and individual board members.
- Ever-increasing pressure for the right information, presented in the right way and available at the right time, without overloading board members.

“Non-executive directors should satisfy themselves that they have appropriate information of sufficient quality to make sound judgements. Information must be provided sufficiently in advance of meetings to enable non-executive directors to give issues thorough consideration and must be relevant, significant and clear. Some stressed the dangers of data-overload, which could lead to important issues being overlooked.”

Higgs (2003)

This need for better information is fundamental – and is the focus of our endeavour here.

The role of the NHS board

The board has collective responsibility for:

- Adding value to, and promoting the success of, the organisation.
- Providing leadership to the organisation within a framework of prudent and effective controls.
- Setting strategic direction, ensuring management capacity and capability, and monitoring and managing performance.
- Safeguarding values and ensuring the organisation’s obligations to its key stakeholders are met.

As outlined in the Higgs’ report and again in Governing the NHS, non-executives’ specific duties include the following:

- Constructively challenging and contributing to the development of strategy.
- Scrutinising the performance of management in meeting goals and standards, and monitoring the reporting of performance and service quality.
- Satisfying themselves that financial information is accurate and that internal systems and controls are robust and defensible.
- Ensuring the board acts in the best interests of the public and other stakeholders and is fully accountable for the services provided and the public funds used.

The chair has a particular duty to ensure that board members are provided with timely, accurate and clear information in order to fulfil their duties, as well as facilitating effective contributions from non-executives to the board.

Intelligent information

Good governance is underpinned by intelligent information, which enables the board to:

- Set an appropriately challenging, but achievable, strategic direction.
- Identify the strategic issues that require discussion or decision, and distinguish these issues from operational detail.
- Provide constructive challenge.
- Make sure that tax payers are receiving value for money.
- Identify trends in performance.
- Enable comparisons with the performance of similar organisations.
- Understand the needs, views and experiences of users and non-users from all backgrounds and communities.
- Make sure that users are receiving a high-quality service.
- Anticipate the potential impact of key policy, technological and socioeconomic developments.
- Assure themselves that the organisation is complying with standards and other regulatory requirements.

Information overload

A frequent complaint is that directors suffer from information overload. In too many cases, quantity wins out over quality when it comes to board papers. Moreover, the habit of responding to issues with a request for more information is widespread. Using information intelligently means that boards need to address these issues. They need to distinguish between:

- Issues that need to be reported routinely to the board at a certain level of detail.
- Issues that need to be reported only if there is demonstrably a problem, for example, where performance significantly diverges from that achieved by peer trusts.
- Issues that change relatively slowly and that should therefore be looked at only on a quarterly or six-monthly basis.

Conclusion

It is this group's contention that many NHS organisations have some way to go if they are to live up to the challenge of intelligent information that supports and enables effective governance both in terms of oversight of current performance and the setting of strategic direction. The content and presentation of the information provided to boards therefore needs to be reviewed. This report seeks to encourage boards to address this issue and to support them in so doing.

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Intelligent information for the board

Boards play a crucial scrutiny role, but they really add value to their organisations through their strategic role. It follows that boards should arrange their time together so as to dispatch their operational oversight tasks as efficiently and thoroughly as possible, thus enabling a strong strategic focus. A good rule of thumb is that boards should aim to spend around 60% of their time on strategic matters. This is a challenge for many boards. This section aims to help boards meet this challenge by proposing some key principles they should adopt, together with a framework for structuring key elements of their agendas.

Principles

Strategic information for the board should:

- Be structured around an explicit set of strategic goals.
- Show trends in performance in terms of finance and business development, quality and the experience and satisfaction of patients.
- Provide forecasts and anticipate future performance issues.
- Encourage an external focus.

Information about operational performance should:

- Provide an accurate and balanced picture of current and recent performance – including financial, clinical, regulatory and patient perspectives.
- Focus on the most important measures of performance – and highlight exceptions.
- Be appropriately standardised in order to take account of known factors that affect outcomes, such as the age and deprivation profile of patients.
- Enable comparisons with the performance of similar organisations.

All information should:

- Be clearly and simply presented, including graphic overviews as well as brief commentary.
- Be updated in a timely manner.
- Direct the board's attention to significant risks, issues and exceptions.
- Provide a level of detail appropriate to the board's role.

Ideally, directors should be able to access key information about trust contemporary and historical performance online, off the premises and in between meetings. While this is not currently possible in all trusts, the group believes that trusts should work towards this.

The key tests of the success of any information resource for the board will be the extent to which it:

- Prompts relevant and constructive challenge.
- Supports informed decision-making.
- Is effective in providing early warning of potential financial or other problems.
- Develops all directors' understanding of the organisation and its performance.

A framework for considering strategy and operational performance at board level

This group proposes that boards should make a clear distinction between strategic and operational matters, focusing their attention on a limited number of key aspects of each. The proposed framework seeks to fulfil a number of important purposes:

- Supporting boards to make more efficient and effective use of information – and to spend more time on strategic matters.
- Structuring the process of formulating strategy, shaping plans and reviewing progress.
- Enabling a balanced focus when scrutinising current and recent operational performance.

This framework is flexible enough to:

- Balance the crucial ingredients of success in financial, operational and quality terms.
- Cover the perspectives of patients, commissioners, clinicians and managers, along with regulatory requirements.
- Allow trusts to select and modify those indicators that are most relevant to them in light of their own particular strategic priorities and/or trends and issues in their own performance.

Proposed minimum data sets

Regular strategy discussions should, as a minimum, focus on:

- Market and business development – in the context of patient choice and Payment by Results, boards increasingly need to think in terms of understanding their trust's markets, analysing the competition and developing the trust's business. They also need to be anticipating the needs of patients in their community.
- Key trends and forecasts in relation to key aspects of trust performance: finance (resources and HR capacity to deliver), efficiency, patients' experiences, clinical quality.
- Future developments in terms of policy, technology and other changes in the external environment, and their potential impact.

Foundation trust boards will also need to take into account the views and advice of their governors, the needs of the members and the wider community, and on longer-term direction.

Routine oversight of operational performance should focus on exception reporting in terms of current and recent performance against target and peer benchmarks in relation to:

- Finance, including: income and expenditure, cash flow and gross margin.
- Efficiency, including: length of stay, day-case rates, theatre and diagnostic utilisation rates, and drug prescriptions.
- Workforce, including: headcount and salary bill, turnover, use of agency staff, sickness and diversity.
- Patients' experiences, including feedback from patients, relatives and GPs on: staff attitude, responsiveness, communication and involvement in decisions, and cleanliness.
- Clinical quality, including: mortality, readmission rates, infection, serious untoward incidents, litigation and claims.
- Access and targets, including: waiting-time targets and the developmental and public health targets.

These proposed minimum data sets are described in more detail in the tables overleaf. They list the key issues and indicators that the steering group would hope to see covered in an information resource for an acute trust board, together with a brief commentary on each.

Some of this information is readily available, with the application of appropriate analysis, presentation and interpretation, from existing national data sets. For example, existing commercially available tools can provide comparative data on a number of quality and efficiency measures, including mortality, length of stay and readmission rates. The key data source for such analyses are the England-wide hospital episode statistics (HES) routinely collected and updated via the NHS' Nation Wide Clearing Service (NWCS). Market intelligence, such as which practices are referring which patients to which trusts, is available to support more strategic discussions. It is also possible now to generate quite sophisticated mapping analyses of health needs by linking geodemographic, consumer lifestyle and health data sets.

On the other hand, much financial management data is collected only at a local level and, inevitably, in different formats. It is also questionable whether many trusts have good information at sufficient detail to produce accurate cash-flow forecasts and to calculate gross margins. The same is true of information on patients' satisfaction and outcomes: beyond the national patient survey programme, not enough trusts collect such data routinely, and where they do, different formats and frequencies limit its value for comparative purposes.

Nevertheless, the steering group is clear that nothing proposed in these minimum data sets is out of reach in the short to medium term.

Intelligent information for board strategy discussions – the minimum data set

Strategy

Issue	Indicators	Source	Comments
Market and business development	<ul style="list-style-type: none"> Referral rates by diagnosis/ procedure from local GPs to the trust and to competitor trusts Assessments of local health needs 	Available now using Patient Administration Systems (PAS) and Nation Wide Clearing Service (NWCS)	<p>Trusts should understand referral patterns by specialty to their and neighbouring trusts. It is helpful to examine referral patterns by diagnosis or procedure and for selected time periods and geographical areas. It is also important to check that a trust is receiving all the referrals that it potentially could receive. For instance, a local GP may have concerns about a particular service offered by the trust and start to send referrals to a competitor. There are tools that can help trusts with this task.</p> <p>Boards will also want to receive structured analyses of competitor trusts and private sector providers from time to time, as well as briefings on the key players across the local health economy.</p> <p>Neighbourhood analysis can identify local groups that have a lower than expected uptake of the trust’s services. A combination of health data and other census-based and lifestyle data can enable these groups to be reached. Various tools enable trusts to explore their local geodemographic structure. Projected changes in local geodemographics might require a new service or an existing one to be reconfigured. Boards should review such analyses at least annually. Foundation trust boards will also receive input from governors on community needs and views.</p>
Key trends and forecasts	<p>Trends in income and expenditure against budget</p> <ul style="list-style-type: none"> Projected activity growth by trading centre Cash-flow forecast over 6, 12 and 24-month horizons 	May be locally available from trusts’ financial systems and Patient Administration Systems (PAS)	<p>Most NHS financial projections are poor and trusts should work to improve expertise in this area. The key issue is to be able to anticipate income and expenditure both at the end of the current year and for future years – and to avoid the common practice of recasting the budget at regular intervals throughout the year. This group strongly recommends that only one formal mid-year budget re-forecast exercise should be undertaken.</p> <p>Trusts must ensure that their activity data is entered in a timely manner. This is a significant problem in some trusts. A trust’s waiting list is, in effect, its order book. Trusts should ensure that waiting-list records are detailed enough to provide an estimate of future income. Significant issues arising from this analysis should be reported to the board.</p>
Trusts’ own strategic objectives	Locally defined		Trusts need to identify indicators to monitor progress against their own strategic objectives, with the board reviewing progress at least every six months.
Key external developments			Trusts need to monitor and evaluate policy, technology and other changes in the external environment, and provide the board with periodic assessments of their potential strategic risks and opportunities.

Intelligent information for board discussions of operational performance – the minimum data set

Finance

Issue	Indicators ¹	Source	Comments
Income and expenditure	<ul style="list-style-type: none"> • Performance against budget 	Available from trusts' financial systems	Variance should be reported against the original budget position – with one mid-year recast of the budget. Reports should also include a financial risk analysis.
Cash flow	<ul style="list-style-type: none"> • Total cash flow • Cash flow by “trading centres” (eg, directorates) 	May be locally available from trusts' financial systems – income and cost data	Foundation trust status and Payment by Results requires trusts, perhaps for the first time, to pay close attention to their cash flow. Many trusts have not yet developed robust techniques for establishing cost. Foundation trusts will be leading the way here, given the focus of Monitor's compliance framework. Trusts will also want to have regard to Monitor's financial risk rating indicators, including EBITDA achieved/margin and liquidity ratio (days).
Debtors	<ul style="list-style-type: none"> • Value of 30, 60 and 90-day debtors 	May be locally available from trusts' financial systems	The importance of cash flow will require trusts to manage debtors much more actively than they have in the past. Though this should be routinely monitored by trust finance departments, trust boards have seldom been kept up-to-date on these values.
Gross margin	<ul style="list-style-type: none"> • Gross margin by “trading centres” 	May be locally available from trusts' financial systems	Defined as revenues less cost of services, expressed as a percentage or as the ratio of gross contribution to sales revenue. This is a new concept to most trusts and is a measure of productivity. Trusts will have to improve productivity continually in order to survive.

¹ Trend values should be monitored for all these indicators and exceptions reported to the board.

Important note for all indicators

All the suggested indicators should be calculated monthly where possible, although clearly some information cannot be updated so frequently, for example, surveys in the national patient survey programme. Statistical Process Control (SPC) should be used to identify if any month is an outlier. Trend information should be reviewed as well as current performance data in relation to each key indicator. Directors should also be presented with high-level summaries, showing only indicators that differ significantly from the norm.

Efficiency

Issue	Indicators ²	Source												
Length of stay	1. Total length of stay <ul style="list-style-type: none"> • (Pre-operative) length of stay • Length of stay of people not discharged to their usual address • Number of delayed discharges by “trading centre”, procedure, patient group 	Available now using Patient Administration Systems (PAS) and Nation Wide Clearing Service (NWCS).												
Day-case rates	<ul style="list-style-type: none"> • Number of patients treated as a percentage of total number patients by procedure. As a minimum, trusts should monitor day-case rates for the following procedures identified in 10 High Impact Changes: <table border="0" style="margin-left: 20px;"> <tr> <td>- Inguinal hernia</td> <td>- Cystoscopy /TUR bladder tumour</td> </tr> <tr> <td>- Varicose veins</td> <td>- Arthroscopy meniscectomy</td> </tr> <tr> <td>- Termination of pregnancy</td> <td>- Excision of Dupuytren’s Contracture</td> </tr> <tr> <td>- Cataract</td> <td>- Myringotomy/grommets</td> </tr> <tr> <td>- SMR</td> <td></td> </tr> <tr> <td>- Extraction of wisdom teeth</td> <td></td> </tr> </table> 	- Inguinal hernia	- Cystoscopy /TUR bladder tumour	- Varicose veins	- Arthroscopy meniscectomy	- Termination of pregnancy	- Excision of Dupuytren’s Contracture	- Cataract	- Myringotomy/grommets	- SMR		- Extraction of wisdom teeth		Available now using PAS and NWCS.
- Inguinal hernia	- Cystoscopy /TUR bladder tumour													
- Varicose veins	- Arthroscopy meniscectomy													
- Termination of pregnancy	- Excision of Dupuytren’s Contracture													
- Cataract	- Myringotomy/grommets													
- SMR														
- Extraction of wisdom teeth														
Theatre utilisation	<ul style="list-style-type: none"> • Theatre utilisation defined as the actual number of theatre hours used divided by the scheduled theatre hours • Number of operations performed • Number of cancelled operations for non-clinical reason on day of surgery 	May be locally available from theatre information system and PAS.												
Diagnostic utilisation	<ul style="list-style-type: none"> • Diagnostic services utilisation rate • Patient recall rate for inadequate/incomplete/incorrectly performed investigation/procedure 	May be locally available from diagnostic management information systems.												
Augmented care utilisation	<ul style="list-style-type: none"> • Number of ICU episodes • Number of high-dependency care episodes • Average occupancy 	May be locally available; some are also available using PAS and NWCS.												
Drug prescription	<ul style="list-style-type: none"> • Total cost of prescription by month • Mean cost of prescription per finished constant episode (FCE) 	May be locally available via hospital pharmacy systems and PAS.												

² Trend values should be monitored for all these indicators and exceptions reported to the board. For length of stay and day-case rates, comparative information is also available for benchmarking purposes.

Comments

Most PAS systems will automatically calculate length of stay. However, it is difficult to interpret. For example, is a long length of stay caused by poor discharge or long pre-operative or pre-treatment length of stay? Moreover, a trust with a short length of stay may have poor outcomes.

Comparison with other acute trusts or mental health trusts is possible, given access to national data, enabling monthly reports by exception. However, it is important to compare like with like. The patient's diagnosis, co-morbidities, age and gender have all been shown to affect length of stay. There are a number of methodologies that enable these factors to be taken into account so that trusts can be compared.

The report should highlight particular types of patients where the length of stay was longer than expected.

Shifting work from an inpatient to a day-case setting has been found to be one of the most effective ways of increasing hospital capacity. The Audit Commission and NHS Modernisation Agency have jointly published a list of procedures that could potentially be carried out as day cases. For these procedures, it is worthwhile comparing your trust's performance with others.

The report should highlight procedures where the percentage of patients treated as day cases is significantly below the national average. An expanded list of procedures can be found at http://www.modern.nhs.uk/home/key/docs/10_High_Impact_Changes.pdf

Not all trusts currently have a theatre information system, making national benchmarking difficult. Therefore, it is currently only possible to make local comparisons.

It should be noted that utilisation rates will differ according to specialty and purpose of the theatre session. For instance, sessions reserved for emergency cases (known as CEPOD lists) will normally have a lower utilisation rate than other lists.

The report should highlight consultants where the utilisation rate or number of late starts was higher than their peers. Mental health trusts could look at bed occupancy as an alternative measure.

Data quality on data via NWCS in this area is currently considered poor.

Management reporting tools for diagnostic services are not well developed. Waiting times for diagnostics are reported in the access section.

Analysis is possible at trust level, but may require data to be linked from different systems (typically the pharmacy and PAS systems). It is hoped that some national comparison should be available in 2006.

Ideally, trusts should also be developing measures of waste and over-prescribing.

Workforce

Issue	Indicators ³	Source	Comments
Headcount and salary bill	<ul style="list-style-type: none"> • Total headcount • Total WTE • Gross salary bill 	May be locally available from trusts' HR systems	Many NHS staff work part-time. Therefore, when comparing trusts it is important to consider not only gross headcount but also whole-time equivalents.
Use of agency/bank	<ul style="list-style-type: none"> • Total cost by month and area 	Should be locally available from trusts' HR/ financial systems	Sudden increases in agency/bank staff can provide early warning of problems.
Sickness	<ul style="list-style-type: none"> • Number of people off long term by area • Number of days lost to short-term sickness by area 	Should be locally available from trusts' HR systems	Like staff turnover, this is an important measure of the "health" of an organisation.
Vacancy	<ul style="list-style-type: none"> • Number of vacancies by area 	HR system	Many trusts, especially those in London, have problems recruiting certain categories of staff with key skills.
Staff turnover	<ul style="list-style-type: none"> • Number of leavers by area 	HR system	The number of leavers is an important measure of the "health" of an organisation. Problems are associated with too-high and (arguably) too-low staff turnover.
Diversity	<ul style="list-style-type: none"> • Staff ethnic mix compared with population served 	HR system	Like all employers, trusts have a legal responsibility not to discriminate against particular groups. As public bodies, they also have statutory duties to promote racial equality.

³ Trend values should be monitored for all these indicators and exceptions reported to the board

Patients' experiences

Issue	Indicators	Source	Comments
Patients' experiences/ outcome and satisfaction	<p>Patients and relatives, eg:</p> <ul style="list-style-type: none"> • Staff attitude and responsiveness • Treated with respect • Communication, involvement in decisions • Cleanliness <p>GPs, eg:</p> <ul style="list-style-type: none"> • Referral process • Timeliness of results • Communication 	Available now from the national survey programme and trusts' own surveys	<p>The NHS patient survey programme focuses on a small number of areas each year, eg, A&E and outpatients in 2004/5 and inpatients in 2005/06. These enable comparison across trusts and are considered in the Healthcare Commission's annual healthcheck. PEAT measures are also helpful.</p> <p>Trusts should, however, also be surveying the satisfaction levels of patients, their relatives and GPs on a regular, even continual basis. Good practice from the private sector, being adopted in some trusts, suggests that feedback surveys should contain few questions and be administered on discharge. Possible examples of such satisfaction surveys are attached in Annex 2 to this report.</p> <p>Rarer and more challenging is the practice of gathering information on patient-assessed outcomes, although tools such as SF-36® and EQ-5D are reasonably well established and used in the private health sector.</p> <p>As a minimum, quarterly reports to the board should highlight trends in satisfaction.</p>
Complaints	<ul style="list-style-type: none"> • Number of complaints by specialty/ directorate/ patient group • Number of complaints returned by the Healthcare Commission as unresolved 	Should be available now from trusts' own systems	<p>Quarterly reports to the board should highlight trends, together with an analysis of issues raised, actions taken and lessons learnt.</p> <p>The percentage of complaints unresolved within 20 days should be included only if the trust is in breach of the target.</p>

Clinical quality

Issue	Indicators ³	Source	Comments
Mortality	<ul style="list-style-type: none"> Standardised mortality rates using a technique such as CUSUM by specialty 	Available now using Patient Administration Systems (PAS) and Nation Wide Clearing Service (NWCS)	<p>The outcome of every stay in hospital is sent to the NWCS. However, a patient's chance of dying is very strongly influenced by their age, gender and what is wrong with them. Therefore, it is important to standardise for these factors when comparing different trusts.</p> <p>Mental health trusts could look at suicides of inpatients or within three months of discharge.</p>
Readmission	<ul style="list-style-type: none"> Standardised readmission rates using a technique such as CUSUM by specialty 	Available now using PAS and NWCS	<p>Readmission data is collected nationally by the NWCS, enabling trusts to compare themselves with other trusts. Like mortality, it is important to standardise readmission rates before making such comparisons.</p> <p>Mental health trusts could look at psychiatric readmissions for particular age groups, eg, adult or older people.</p>
Infection	<ul style="list-style-type: none"> Number of hospital acquired infections per 1,000 bed days 	Available via local systems and Department of Health data	<p>Since 2001, trusts have had to report MRSA and certain other infections. The Department of Health publishes a table that compares trusts' performance in terms of MRSA bacteraemias (bloodstream infections) per 1,000 hospital bed days. However, both a delay in publishing this data and some definition/ measurement issues make it difficult to use this data to compare trusts.</p>
Serious untoward incidents	<ul style="list-style-type: none"> Number of serious untoward incidents — by area and seriousness 	Available via local systems and National Patient Safety Agency (NPSA)	<p>Serious untoward incidents are potentially avoidable events, which either harmed the patient or resulted in a near miss. Information about serious untoward incidents is collected nationally by the NPSA. For reasons of anonymity, the NPSA tends to draw general lessons from serious untoward incidents rather than publish comparisons that trusts can use as a benchmark. The board should also receive analyses of issues raised, actions taken and lessons learnt.</p>
Litigation and claims	<ul style="list-style-type: none"> Number of outstanding claims Trends and forecasts of amounts paid out 	Should be available via trust legal system, eg, Datex. NHSLA data	<p>Details about amount paid out should be presented in a way that does not breach patient confidentiality.</p>

³ Trend values should be monitored for all these indicators and exceptions reported to the board. For mortality and readmission rates, comparative information is also available for benchmarking purposes. Some limited comparative information is available on untoward incidents and litigation.

Access and targets

Issue	Indicators ⁴	Issue	Comments
Waiting-time targets	<ul style="list-style-type: none"> • Any breach of NHS waiting time targets for: <ul style="list-style-type: none"> - Outpatients - Inpatients - Diagnostics - Cancer targets • Progress towards 18-week target • Number of patients waiting more than four hours in A&E 	Available from Patient Administration Systems (PAS) and diagnostic systems	From December 2008, trusts must ensure that no patient waits more than 18 weeks from GP referral to treatment. Currently, many trusts' computer systems are not able to monitor this patient journey. Until the systems are improved, trusts should devise local ways of monitoring progress towards this target.
Mental health targets	<ul style="list-style-type: none"> • Number of patients accessing services such as assertive outreach • Numbers of patients receiving a copy of their care plan 	Available from trust Local Delivery Plan data	Mental health trusts will require separate sources of information to track performance against their targets and monitor access to local services.
Developmental/ public health targets	<ul style="list-style-type: none"> • Substantially reduce mortality rates from heart disease and stroke, and related diseases • Substantially reduce mortality rates from cancer • Substantially reduce mortality rates from suicide • Reduce health inequalities • Reduce adult smoking rates • Tackle the underlying determinants of ill health and health inequalities by halting the year-on-year rise in obesity among children under 11 • Reduce the under-18 conception rate • Improve health outcomes for people with long-term conditions • Increase the participation of problem drug users in drug treatment programmes • Secure sustained national improvements in NHS patient experience • Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible • Achieve year-on-year reductions in MRSA levels • Diversity and equality targets relating to both staff and patients 	Some available using Nation Wide Clearing Service (NWCS). Rest gathered locally and by Department of Health	<p>One of the key challenges is that many of these targets are shared across the health economy; nevertheless, boards need to track their trust's contribution to target achievement.</p> <p>Mortality, emergency admissions and figures on the treatment of patients with long-term conditions are measurable. Standardisation is possible, as is comparison, given access to the data and the ability to carry out standardisation analysis. The challenge is putting this data in the context of the local health economy/population. The full list of targets for acute and mental health targets can be found at http://ratings2006.healthcarecommission.org.uk/Indicators_2006Nat/Trust/Overview/PT_overview.asp</p>

⁴ Trend values should be monitored for all these indicators and actual or potential breaches reported to the board. Trusts should also forecast their likely year-end position. Comparative information may be available locally via strategic health authorities, and periodically on a national basis via DH.

4

Putting the framework into practice

This section outlines a number of proposals to help boards achieve the twin goals of:

- Using intelligent information according to the proposed principles.
- Maximising the time they devote to strategic matters while delivering their operational oversight role efficiently and effectively.

The group has identified three opportunities for putting the framework into practice:

- Improving board agendas to focus attention on performance, priorities and future strategy.
- Developing a board “dashboard” that would lend itself to online access and presentation, enabling key issues to be highlighted and allowing “drill-down” to more detailed information.
- Reviewing the annual cycle of board meetings to ensure boards organise their time to focus on the right issues at the right time.

Improving board agendas

Board agendas too often follow a traditional template, structured around separate reports from each director, together with a number of policies and business cases for approval. Such agendas do not explicitly respond to the integrated governance agenda, nor the good practice that the board’s agenda and information requirements should be driven by the key strategic issues for the organisation. Moreover, such agendas do not always help to free up board time to focus on their important strategic role, a common concern among boards as found by the NHS Confederation’s research published in June 2005, *Effective Boards in the NHS?*

Board agendas should be structured so as to address the distinct but related matters of strategy and operational performance as discussed in the previous section. While every meeting should contain both strategic and operational items, at different points in the annual board cycle different aspects could receive greater emphasis according to the:

- Availability and relevance of data on some issues, for example, quarterly or annually.
- Priorities and issues for the individual trust.
- Importance of focusing in depth on certain business critical services from time to time.
- Key events, including the development of the business plan, approval of the accounts, the declaration to the Healthcare Commission and, for foundation trusts, submissions to Monitor.

As a way of demonstrating these proposals, Annex 1 contains 2 example agendas developed in line with the proposed principles and framework, together with a brief commentary on the information that would be needed to support key items.

With the aim of maximising board time and attention on strategic matters and key performance issues, boards should also on a regular basis critically review:

- Delegation limits and the levels at which business cases come to the board for approval.
- Whether and which policies must come to the board for approval.
- Whether they can adopt the “consent agenda” technique for dealing with routine and/or non-controversial items, so they are grouped and approved together at the end of the meeting.

Finally, directors should be encouraged to ask the “frequently un-asked questions” in relation to key agenda items. These might include, for example:

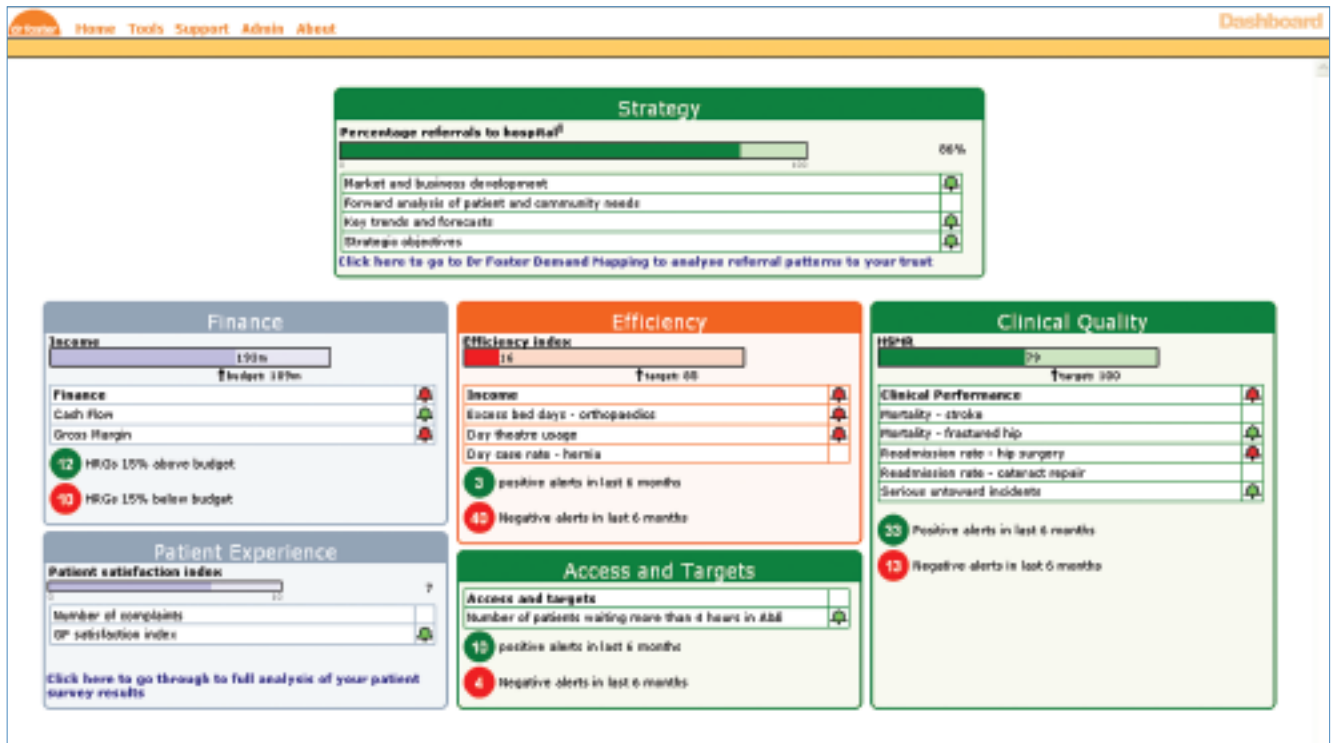
- What is our current performance in the context of our strategy?
- How is it likely to change in the future – given current trends and external changes that might affect performance?
- How do we compare with our peers on each aspect of performance – locally and nationally?
- What are the key risks to the cash-flow forecast?
- How much could we save if we reduced length of stay to the national average?
- Do we know enough about the experiences of patients, how and why they vary and whether they are improving or not? If not, why not?
- How many preventable deaths are there in our hospital?
- Where do we need to make the biggest changes in order to progress towards the 18-week target?
- What effect do we expect patient choice to have on services in this trust?
- In which areas should we be exploiting our competitive advantage?

Improving the presentation of information for boards

Taking into account the principles put forward earlier in this report, the aim must be to develop ways of presenting intelligent information on each aspect of strategy and operational performance, maximising the use of routinely collected data, appropriately cleaned, linked and standardised – while also allowing individual trusts to adapt the framework to their own needs and input their own data where appropriate.

A mock-up dashboard tool

The graphic below indicates how the “front page” of an online dashboard tool could look, highlighting performance against selected key indicators. This sort of tool could be interrogated online, allowing the user to “drill down” to trend graphs, peer comparisons and relevant forecasts, for example. It could also be used to generate content for hard-copy board reports. [copyright Dr Foster]



Reviewing the annual board cycle

Most boards agree forward agenda plans, responding to one of the key integrated governance recommendations that boards must review and clarify their trust's strategic purpose, and ensure that board agendas are integrated with a fully established annual cycle of business. The principles and performance domains described earlier can help to inform this cycle, incorporating routine reviews of performance using the “dashboard” and twice yearly strategy sessions. Boards may choose to focus on different aspects of performance at successive meetings in order to focus more on, for example, patient experience issues or periodic scrutiny of core-standards compliance.

To illustrate the group's thinking, a possible annual cycle of board meetings is set out below. This is proposed merely as a “straw man”, which boards might discuss and adapt. The key message is that boards should explicitly discuss how they allocate their time, not only within a given meeting but over the period of the board's year. In particular, boards should schedule not only one annual strategy awayday, but also a mid-year meeting devoted to reviewing progress against strategic plans.

A note on committees

Though this project has focused primarily on the work of the board, the group's discussions extended to the question of committees. The recommendation of this group is that the number of committees that include non-executives should be minimised. Committees of the board should therefore be limited to:

- Audit Committee
- Remuneration Committee
- Foundation trusts will also have a Nominations Committee and may need to establish a dedicated Investment Committee.

Reports from other executive committees should be limited to matters of strategic importance and integrated into the recommended framework, using the consent agenda where appropriate.

Possible annual board cycle

	April	May	June	July	
Strategy	Review any issues arising from monitoring of: - markets and business development - key trends and forecasts	Mini board awayday Review progress on strategy	Review any issues arising from monitoring of: - markets and business development - key trends and forecasts	Review any issues arising from monitoring of: - markets and business development - key trends and forecasts	
Operational performance	Exception reports on: - Finance - Efficiency - Access and targets Quarterly report on patients' experiences In-depth review: clinical quality	Exception reports on: - Finance - Efficiency - Patients' experiences - Clinical quality - Access and targets	Exception reports on: - Finance - Efficiency - Patients' experiences - Clinical quality - Access and targets	Exception reports on: - Finance - Efficiency - Clinical quality - Access and targets In-depth review: patients' experiences	
Risk	Exception report on key risks	Review and update risk register	Exception report on key risks	Exception report on key risks	
Regulatory	FTs – quarterly report to Monitor	FTs – sign off annual plan for submission to Monitor	NHSLA report	Sign off accounts, statement of internal control and annual report FTs – quarterly report to Monitor	
Other	Approve register of seals Approve register of directors' interests Approve changes to standing orders and SFIs	Agree forward agenda plan Board self-assessment, including review of committees and working groups		Annual report on infection control Annual report on research and development	

September	October	November	January	February	March
Review any issues arising from monitoring of: - markets and business development - key trends and forecasts	Board awayday Review strategic priorities in context of changing needs and wider external developments Budget re-forecast	Review any issues arising from monitoring of: - markets and business development - key trends and forecasts	Review draft annual plan and budget	Review any issues arising from monitoring of: - markets and business development - key trends and forecasts	Agree annual plan and budget
Exception reports on: - Patients' experiences - Clinical quality - Access and targets In-depth review: finance and efficiency	Exception reports on: - Finance - Efficiency - Clinical quality - Access and targets Quarterly report on patients' experiences	Exception reports on: - Finance - Efficiency - Patients' experiences - Clinical quality - Access and targets	Exception reports on: - Finance - Efficiency - Clinical quality Quarterly report on patients' experiences In-depth review: access and targets	Exception reports on: - Finance - Efficiency - Patients' experiences - Clinical quality - Access and targets In-depth review: staff survey report/plan	Exception reports on: - Finance - Efficiency - Patients' experiences - Clinical quality - Access and targets
Exception report on key risks	Exception report on key risks	Review and update risk register	Exception report on key risks	Review board assurance framework	Exception report on key risks Sign off annual audit plan
	FTs – quarterly report to Monitor	Sign off annual audit letter	FTs – quarterly report to Monitor		Healthcare Commission declaration of performance against standards
Annual reports on health and safety, radiation protection, fire safety					

Appendices

- Annex 1** Sample board agenda
- Annex 2** Examples of possible patient, relatives and GP feedback surveys
- Annex 3** An analysis of current practice

Annex 1

Sample board agendas

Puddlesham Hospitals NHS Trust

**Meeting of the Trust board to be held at the Puddlesham Country Club
on 7 October 2006 at 10am**

Board awayday agenda

- 1. Chairman's welcome and note of apologies**
- 2. Minutes of the previous meeting**
- 3. Matters arising**

4. Strategic review

4.1 Market and business development

Strategic questions: How well is the Trust positioned in its market? How is it performing compared with competitors? Which areas of business are developing most/least strongly?

Information set to include:

- *Trend analyses of referral rates by diagnosis, procedure, specialty and by GP practice – as well as comparing these referral patterns with neighbouring and competitor trusts.*
- *Areas where the Trust was failing to achieve its expected number of referrals.*
- *Any major changes in referral patterns or trends.*

Availability of information: trusts should be able to fill in this section within the next six months.

Other information required will include:

- *Overview of key players in local health economy and analysis of competitor trusts.*
- *Commentaries on issues underlying referral patterns and trends.*

Availability of information: trusts should be able to provide this now.

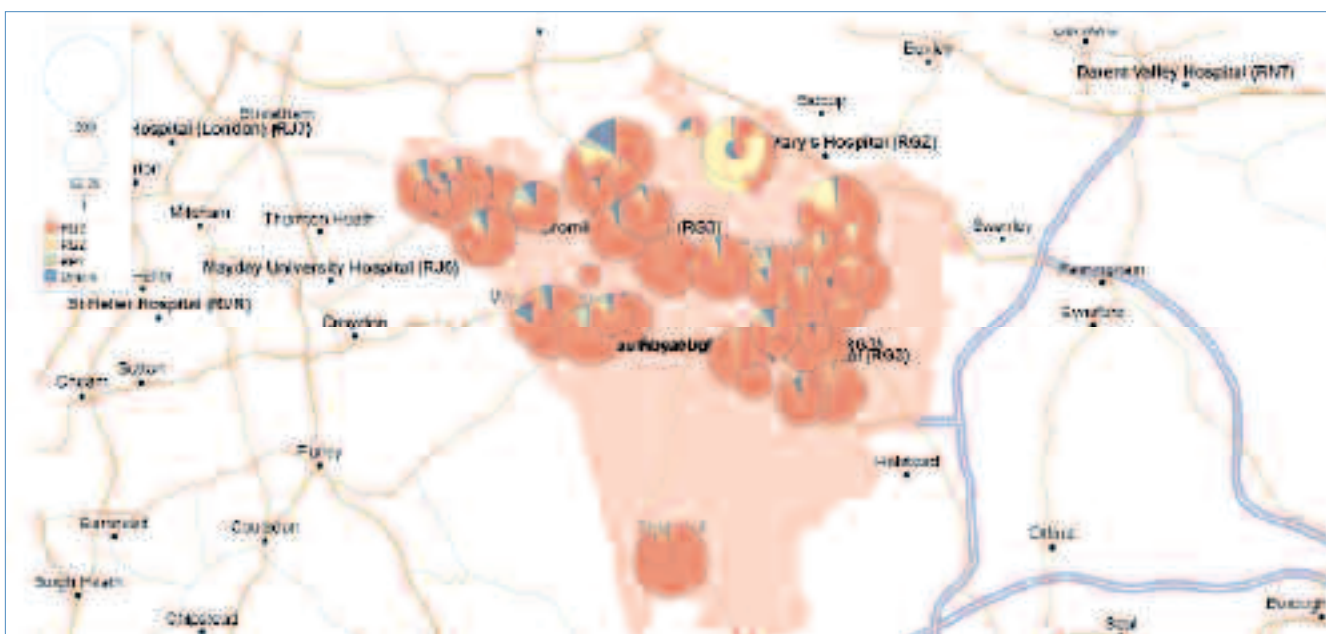
4.2 Forward analysis of patient and community needs

Strategic questions: What do we know about the health needs of our local community and how they are changing? What will this mean for the services we provide – whether new services are to be developed or existing services reconfigured?

Information set: analyses of local community in terms of key geodemographic factors, data on hospital admissions and the health needs that can be inferred from this.

Availability of information: tools exist for trusts to carry out this analysis.

For instance, the pie charts in the map below show where GPs are referring urological patients in this PCT area for a particular Trust. Red segments are where patients are being referred to the Trust and other colours represent competitors. It can be clearly seen that the Trust is losing market share in the north of this PCT area.



4.3 Key trends and forecasts

Strategic questions: What income, expenditure and cash flow do we anticipate across key areas of our business – by year end, for the next two to three years? From our routine oversight of operational performance, in which aspects do we have particular strengths on which to build and weaknesses to address?

Information set: graphic presentations, with commentary as necessary:

- Projected activity growth by trading centre.
- Cash-flow forecasts.
- Selected trends/forecasts relating to stronger/weaker aspects of performance re: finance, efficiency, patients' experiences, clinical quality, access/targets.

Availability of information: provided trusts have established approaches to costing and have some expertise in forecasting methodology, this information should be available now.

4.4 External developments in terms of policy, technology and other changes in the environment

Strategic questions: What changes to the environment in which we operate should we be anticipating in the coming one to three years? What impact could they have on our

ability to achieve our goals? What might they mean for the way our services are configured?

Information set: brief report, based on regular horizon-scanning, together with analysis of possible impact.

Availability of information: trusts should be able to provide this now.

5. Patients' experiences – quarterly report

Strategic questions: Are we delivering on our goals in the eyes of our customers? What do their perceptions and experiences tell us about the priorities we should be setting? Where do we need to do better?

Information set:

- *Trend analyses of feedback from patients, relatives and GPs on key aspects of satisfaction – by patient group, by trading centre.*
- *Trend analyses of complaints (issue, process and outcome) – by patient group, by trading centre.*
- *Commentary on underlying issues.*

Availability of information: trusts should have complaints information readily available. Most trusts have limited up-to-date information on patient satisfaction – implementing a patient feedback system and building a robust and usable data set could take up to a year.

6. Future strategy

Building on the data presented and discussions in the earlier part of the meeting, directors would now discuss and develop a draft framework of strategic goals and operational priorities.

7. Operational performance – by exception

Exception reports should, if necessary, highlight any significant areas of current concern in the following areas:

- *Finance*
- *Efficiency*
- *Clinical quality*
- *Access and targets*
- *Other key risks.*

Where possible, this information should be presented graphically.

8. Any other business

Ideally, this should be limited to urgent business notified to the chair or board secretary in advance of the meeting.

Puddlesham Hospitals NHS Trust

**Meeting of the Trust board to be held in the Trust boardroom
on 12 June 2006 at 2pm**

Agenda

- 1. Chairman's welcome and note of apologies**
- 2. Minutes of the previous meeting**
- 3. Matters arising**
- 4. Update on strategic issues**

Information set:

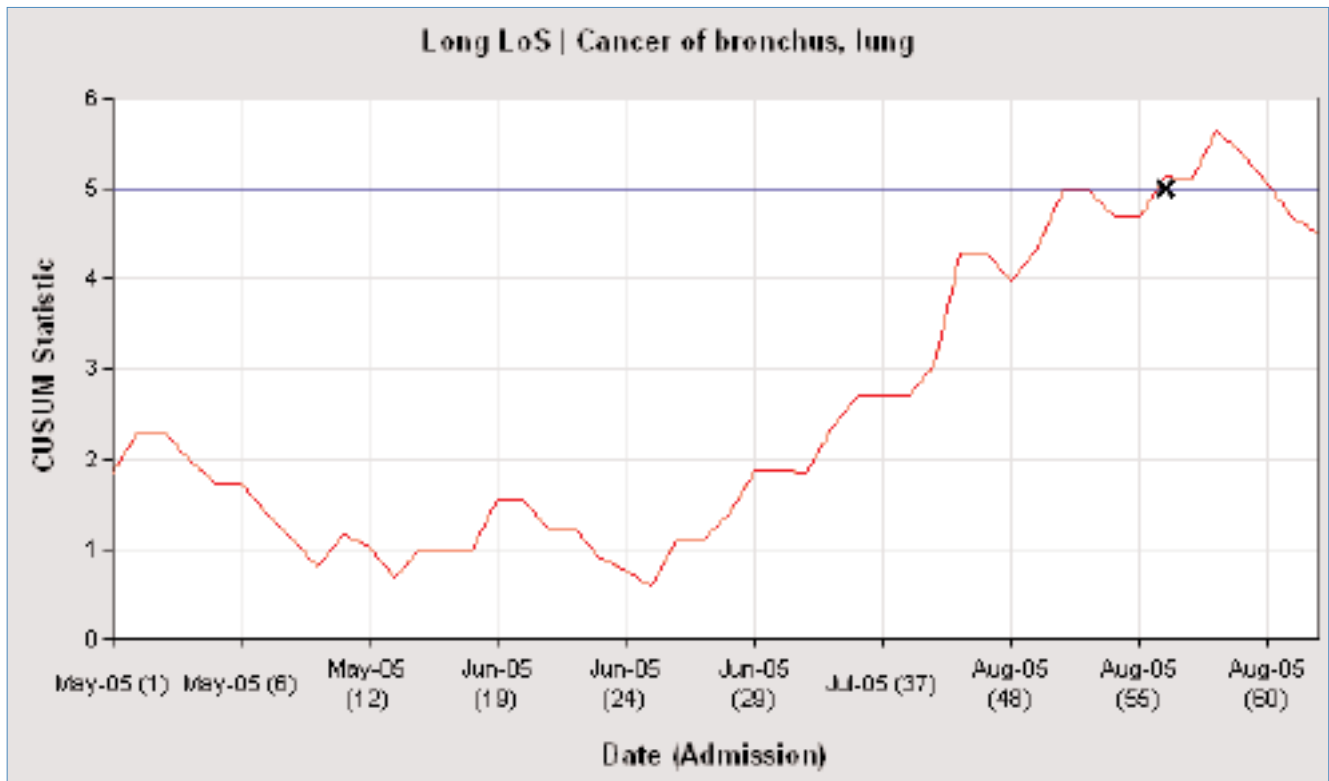
- *Market and business development: update on changes in referral patterns.*
- *Trends and forecasts: latest cash-flow forecasts.*
- *Any other locally defined strategic indicators.*

5. Operational performance

Information set: exception reports should highlight any concern in the following areas.

Where appropriate, this information should be presented graphically:

- *Finance*
- *Efficiency*
- *Patients' experiences*
- *Clinical quality*
- *Access and targets*



For example, Efficiency

The graph above uses a statistical technique called CUSUM to compare length of stay with other trusts after standardisation for age, gender and deprivation. A steadily worsening length of stay can be seen between June 2005 and August 2005. The graph was obtained using data from NWCS and a benchmarking package available to all NHS trusts from Dr Foster Ltd.

CUSUM plot comparing the Trust's length of stay for patients with cancer of bronchus with other trusts.

6. Annual report on infection control

7. Any other business

Ideally, this should be limited to urgent business notified to the chair or board secretary in advance of the meeting.

Annex 2

Examples of possible patient, relatives and GP feedback surveys

Five-question Patient Feedback Form⁶

In this survey we are trying to find out more about the quality of care you received during your stay in hospital. This is so we can continuously improve the care we provide. The survey should only take a minute or two of your time.

Your participation in this survey is voluntary.

If you choose not to take part in this survey, it will not affect the care you receive from the NHS in any way. If you do not wish to take part, or you do not want to answer some of the questions, you do not have to give us a reason.

Your answers will be treated in strictest confidence.

Q1. Were the staff friendly and sensitive to your needs?

Always Most of the time Sometimes Seldom

Q2. Were the staff quick to respond to your/your family's needs?

Always Most of the time Sometimes Seldom

Q3. Was your privacy and dignity respected?

Always Most of the time Sometimes Seldom

Q4. Were you/your family kept informed about your condition/treatment?

Always Most of the time Sometimes Seldom

Q5. Did we exceed your expectations?

Always Most of the time Sometimes Seldom

Five-question Relatives' Feedback Form

In this survey we are trying to find out more about the quality of care your relative received during their stay in hospital. This is so we can continuously improve the care we provide. The survey should only take a minute or two of your time.

Your participation in this survey is voluntary.

If you choose not to take part in this survey, it will not affect the care you or your relative receive from the NHS in any way. If you do not wish to take part, or you do not want to answer some of the questions, you do not have to give us a reason.

⁶Source: Patient Focus keypad system developed by CFS Europe and in use across a number of private hospitals

Your answers will be treated in strictest confidence

Q1. The hospital was clean when I visited

Strongly agree Agree Unsure Disagree Strongly disagree

Q2. I found it easy to park when I visited

Strongly agree Agree Unsure Disagree Strongly disagree

Q3 The visiting hours were appropriate

Strongly agree Agree Unsure Disagree Strongly disagree

Q4 I was informed about decisions in my relative's treatment

Strongly agree Agree Unsure Disagree Strongly disagree

Q5 The ward staff treated me with courtesy and respect

Strongly agree Agree Unsure Disagree Strongly disagree

Five-question GP Feedback Form

In this survey we are trying to find out more about the quality of care your patient received during their stay in hospital. This is so we can continuously improve the care we provide. The survey should only take a minute or two of your time.

Your participation in this survey is voluntary.

Your answers will be treated in strictest confidence.

Q1 The hospital referral process was easy to use

Strongly agree Agree Unsure Disagree Strongly disagree

Q2 Your patient received the best possible treatment

Strongly agree Agree Unsure Disagree Strongly disagree

Q3 Test results were returned to you on time

Strongly agree Agree Unsure Disagree Strongly disagree

Q4 The discharge summary contained all the information you needed

Strongly agree Agree Unsure Disagree Strongly disagree

Q5 The discharge summary was sent to you on time

Strongly agree Agree Unsure Disagree Strongly disagree

Annex 3

An analysis of current practice

Dr Foster undertook an analysis of board papers from 14 NHS trusts across England. These included mental health, acute, specialist and foundation trusts of varying size. The results, summarised below, informed the group's deliberations.

The aim was to look at the range of current practice in terms of the way board agendas and papers were constructed, focusing on papers in three areas: finance, performance and clinical governance, looking at the length of papers, content (including information sources) and frequency of reporting. The analysis took in only one set of papers for each trust, so is a snapshot of current practice.

Mental health trusts (x3)

General comments

- Length of papers ranged from 80-240 pages.
- Papers tended to be longer than for other trust types.

Finance

- All three trusts have monthly finance reports.
- Two trusts had short reports (only three pages) with one-page summaries of key figures (expenditure and income with variance from budget by department), plus short text overview of key issues by directorate.
- One trust had a 13-page overview of its overall financial position, spending in localities, capital programme overall position and public sector payment performance information.

Performance

- One trust had lengthy separate reports on developments in two of its services in the past month, plus a report of workforce figures, but no activity data.
- Others had integrated performance reports with balanced scorecard-style performance against key performance indicators, including clinical indicators, patient experience and staffing data.
- One trust also had PALS, complaints and incident reports on its agenda.

Clinical governance

- No specific monthly clinical governance papers – just six-monthly or annual reports.
- Clinical governance committee minutes included in one trust's papers (other trusts may not have had a meeting to report from that month).
- One trust had a verbal clinical governance update.
- Performance reports included information on clinical activity.

Foundation trusts (x3)

General comments

- Length ranges from 120-170 pages.
- Some trusts discussed the majority of agenda items in private.

Finance

- All have monthly finance reports.
- Longer than reports for other trust types.
- Typical example: 21 pages, including:
 - overall financial position
 - income and expenditure
 - capital programme
 - balance sheet
 - cash flow
 - working capital facility
 - long-term borrowing ratios
 - activity.

And nine pages of tables on financial performance in these areas.

Performance

- Ranged from six-page operational activity report with figures and text on in/outpatient activity, waiting lists and emergency care
- To 31 pages of performance against key performance indicators, workforce activity figures, information on quality (complaints, cancelled operations, PALS activity) and progress with corporate objectives.

Clinical governance

- No specific monthly update on clinical governance and few items on the agendas.
- One trust had minutes of its clinical governance committee on the agenda.
- Performance reports included information on clinical activity.
- One trust had an update from the medical director.
- One trust had a couple of reports on services (domestic violence strategy note and breast screening programme).

Large acute trusts (x3)

General comments

- Length ranged from 105-140 pages.
- Size of acute trust did not seem to relate to length of papers.

Finance

- All trusts had monthly reports.
- Reporting ranged from ten-page text and chart summary of:

- income and expenditure
- performance against budgets by department
- financial plan and forecast overrun
- external financing limit
- overspend areas and directorate action plans
- To 38 pages with text on key issues and risks, income and expenditure, NHS depreciation, donated asset depreciation, interest receivable, trust debt remuneration, retained surplus/deficit, balance sheet, creditors' analysis, cash and cash invested, debtors' analysis, stock, capital resource limit, external financing limit and cash management. It included text and 19 pages of charts and graphs on these areas.

Performance

- One trust had no monthly performance reporting item – a specific paper on performance in the hospital's sexual health clinic was included.
- Of the two trusts that had performance reports, one was a three-page summary of in/outpatient and emergency activity and waiting list performance.
- The second was a longer report including information on:
 - key targets
 - clinical and patient focus
 - capability and capacity focus
 - inpatient and day-case activity information

And graphs/tables on:

- outpatient activity
- A&E activity
- list of clinics with waiting times over 13 weeks
- workforce report (eight pages – sickness absence, bank and agency staff expenditure, plus update on agenda for change).
- Two trusts did not include workforce information.

Clinical governance

- No specific clinical governance items.
- Two trusts had clinical governance committee minutes on the agenda.
- Report from nursing or medical director on two trusts' agendas.
- There were a number of clinical governance items scattered throughout the agendas, for example: detailed report on performance and issues in the hospital's sexual health clinic, business case to establish clinical learning centre.

Small acute trusts (x3)

General comments

- Ranged from 90-160 pages. Size of trust did not seem to relate to length of papers.

Finance

- All trusts had monthly reports.

- Two trusts had short reports – just an overview of income and expenditure issues by department. One trust had a more detailed report (18 pages) of performance against budget and workforce information.

Performance

- All reports about ten pages with traffic-light indicators of performance against key targets, for example: waiting lists, admissions, attendances, finished consultant episodes, delayed transfers, cancelled operations, trolley waits, bed occupancy.
- Two trusts reported workforce information.

Clinical governance

- No specific section on clinical governance – but items scattered through the agendas, for example, one included performance against clinical governance KPIs in the chief executive's report, another had four items relating to clinical governance within the agenda. Minutes of clinical governance committee included on one agenda.

Specialist trusts (x2)

General comments

- Length ranged from 140-330 pages.

Finance

- Both had monthly 13-page reports covering areas such as:
 - income and expenditure
 - capital expenditure
 - cash and borrowing
 - better payment practice code
 - balance sheet.

Performance

- Examples of information included in reports:
 - access and cancer plan targets
 - action plan for the Local Delivery Plan
 - waiting-list information
 - cancelled and rebooked operations
 - activity information
 - internal performance data.

Clinical governance

- One trust included monthly report on clinical governance – information on overall trust's activity, PALS, complaints, medical negligence claims, clinical incidents, other incidents, infection control, cancellation rates, inpatients' satisfaction survey. Clinical governance committee minutes were included on the other trust's agenda.

Key references

Chapter 2

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