View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by Stirling Online Research Repository

The Performance Assessment Framework: experiences and perceptions of NHSScotland

A Report to the Analytical Service Division, Directorate of Performance Management and Finance, Scottish Executive Health Department

March 2004

Dr Shelley Farrar
Dr Fiona Harris
Dr Tony Scott
Health Economics Research Unit

Professor Lorna McKee
Department of Management Studies
University of Aberdeen

EXECUTIVE SUMMARY

The Performance Assessment Framework: experience and perceptions of NHSScotland. *A Report to the Analytical Service Division, Directorate of Performance Management and Finance, Scottish Executive Health Department, March 2004.*

Dr Shelley Farrar[a], Dr Fiona Harris[a],and Dr Anthony Scott [a]
Health Economics Research Unit[a] and Professor Lorna McKeeDepartment of Management Studies[a], University of Aberdeen.

Introduction and study aims

The new Performance Assessment Framework (PAF) was introduced in NHSScotland in October 2001 and used in the annual NHS Board Accountability Reviews in 2002 and 2003. The PAF was assigned three objectives outlined in ***Our National Health:***

(*1)* *'Support and encourage sustained improvement in the performance of NHS Scotland by focussing on key measures in relation to health priorities.'*
(2) *'Reinforce and support the role of the 15 NHS Boards in managing the performance of their local NHS systems.'*
(3) *'Enable NHS Scotland to account systematically for its performance both locally and through the Scottish Executive to the Scottish Parliament and to the people of Scotland.'*

The success with which the PAF appears to be meeting those objectives forms the focus of this investigation. A key element determining how and whether the PAF affects the behaviour of decision-makers within the organisations and subsequently NHS Scotland performance is the perception of the PAF and the signals it generates. Thus it is important to determine what these perceptions and understandings are. It is necessary to capture these views in order to appreciate fully the impact of the PAF within the NHS in Scotland and to appraise its salience and power as a performance tool.

Methods

Three groups of stakeholders were interviewed: from NHS Boards, organisations within Boards and from the Scottish Executive Health Department. The same 'core' interview schedule was used for each group. This study covers the results for the first two groups. Each NHS Board was represented in the initial sample by an interview with every Board Chief Executive and a further five Boards were selected as depth case study sites where interviews were conducted with a wider range of staff. The five case study sites were chosen to provide a sample that reflected both the range of Health Board 'types' in Scotland and geographical spread. The study used a semi-structured interview schedule based around a series of questions relating to the development and implementation of the PAF, the Accountability Review, the choice of indicators, and the incentives in the system relating to the PAF. Fifty-four interviews were undertaken. All interviews were audio-tape recorded, transcribed, and anonymised prior to analysis by the research team.

Key findings and implications

1. General acceptability of performance assessment frameworks

Findings

- There was support for the use of performance assessment generally in the public sector.
- Support for the Scottish PAF *per se* was strengthened by the absence of league tables and its importance as a stimulus for discussion at the Accountability Reviews.

Implications

- In order to retain the high commitment of NHS Scotland, it is important to avoid the pitfalls of other similar systems, such as league tables and strong financial incentives.

2. The indicators

Findings

- Responses were mixed with respect to the scope and sensitivity of the indicators. Overall support was voiced but with clear reservations around some areas.
- General concern was raised with respect to the overload from the data collection and assessments and the risk that PAF might become an end in itself.
- There were differing views as to whether all indicators required improvement or were there to provide context against which other indicators can be viewed.
- Evidence of tension between the weights given to waiting times and financial performance indicators and those relating to health and equity emerged from the data. The challenge of capturing qualitative data was raised repeatedly and the PAF bias toward measuring only those aspects that could be easily enumerated.

Implications

- Refinement should continue to be undertaken in consultation with the NHS. Focus should be on improving what is currently there without adding to its volume.
- Greater clarity is required as to why some indicators are included in the PAF especially those relating to health and inequality and the differences in weight attached to the indicators should be made explicit.

3. Accountability, motivation and managerial performance

Findings

- The integration of the PAF into the Accountability Reviews and the transparency and inclusiveness of that process and dialogue was welcomed.
- All levels of staff interviewed felt that a key reward was the self-knowledge and external acknowledgement that they were helping to provide a good health service.
- There are no explicit incentives or rewards for the Boards associated with doing well on the PAF.
- The vulnerability of the Chief Executive posts is seen as an incentive to perform well on the PAF.
- Some Boards linked the PAF with performance related pay (PRP). The role of PRP as a means of recognition of good work appeared to be as important as the financial incentive *per se*.

- The Accountability Review letter was a key mechanism of feed back and recognition of good work and was valued by the NHS Boards.

Implications

- The climate of trust and open dialogue should be preserved.
- If rewards are attached to good performance, they should be designed with regard to the symbolism as well as any financial aspect.

4. PAF and leadership

Findings

- Different models of implementation are employed throughout Scotland and there seems to be no one single model for success though clear local as well as national leadership was important.
- NHS Boards which integrate the PAF into their management systems appear to find the process less burdensome.
- The respondents linked strong and effective leadership to effective implementation of the PAF.

Implications

- Mechanisms for the dissemination of good practice should be introduced.

5. Local and national accountability

Findings

- The current presentation of the data was reported as overly complex and inaccessible for the public (and indeed, some professionals) and the contextual information required for interpretation of the data is not available.
- The type of measures included in the PAF may not be meaningful or appropriate to public's needs.
- The PAF meets its objective of local accountability in a limited way and indirectly through the publication of the NHS Board's Accountability Review letters.

Implications

- The local accountability objective needs to be re-examined in terms of its laudability and, if this is confirmed, new means need to be established to increase local accountability.

Future research agenda

The limits of this study are governed by the time-scale in which it has been undertaken and while it answers a number of interesting questions it raises many new and related questions. Some are very closely related to the study described in this report and would build on the analysis using the existing data set. Other areas of suggested future research are quite distinct from the questions and methods used here. There are opportunities for illuminating and improving the Scottish system through comparison with other similar systems. Of key importance is what factors influence performance. This question can be tackled using qualitative and quantitative methods. Over time, quantitative methods will become more instrumental as longitudinal data sets become available.

Contents **Page**

1. Introduction and aims

The new Performance Assessment Framework (PAF) and accountability arrangements for Scotland were announced in ***Our National Health***[1] and given more detail in ***Rebuilding our National Health Service***[2] and the consultation document ***New performance assessment and accountability review arrangements for NHSScotland***[3]. The framework was introduced in NHSScotland in October 2001 and used in the annual NHS Board Accountability Reviews in 2002 and 2003.

The PAF was assigned three objectives outlined in ***Our National Health***. These are:

Objective 1. 'Support and encourage sustained improvement in the performance of NHS Scotland by focussing on key measures in relation to health priorities.'

Objective 2. 'Reinforce and support the role of the 15 NHS Boards in managing the performance of their local NHS systems.'

Objective 3. 'Enable NHS Scotland to account systematically for its performance both locally and through the Scottish Executive to the Scottish Parliament and to the people of Scotland.'

In accordance with the Scottish Executive Invitation to Tender 2002/04, the success with which the PAF appears to be meeting those objectives forms the focus of this investigation. Each of these objectives raises a number of questions and issues that, when combined with the issues raised in the literature, will form the basis of our investigation. In order to identify the requirements from the research remit, it is necessary to focus initially on what is meant by each of these objectives. Each objective is discussed below.

Objective 1. 'Support and encourage sustained improvement in the performance of NHS Scotland by focussing on key measures in relation to health priorities.'
In order for the PAF to work well, these individual indicators need to be accurate representations of the required outputs and outcomes. More broadly, the indicators must encapsulate the essence of a high performing NHS. A wide array of performance indicators has been included in the PAF under seven main headings.

Little systematic data exists about how key managers and clinicians perceive the implementation of PAF and it is timely to gather these insights at this stage in its operation. The aim here is to elicit views on the sensitivity and scope of indicators. It is not be our intention to examine each indicator individually but to gain a general impression and to note where particular concerns are highlighted with respect to specific indicators. The emphasis on a qualitative approach is important as it provides an opportunity to give voice to the key stakeholders who shape PAF locally. The aim here is not to judge objective improvement performance outcomes but rather to emphasise accounts and perceptions of the improvement process.

At the moment there are no explicit weights attached to indicators, which implies that they are all of equal importance. Anecdotal evidence suggests that the Scottish Executive may place greater weight on waiting time and financial targets, but Boards and their constituent parts may place more importance on other dimensions of

performance that are perceived to be relevant locally. If the PAF is to work well in guiding the service providers towards improved performance then the signals they receive need to be a clear representation of what the policy-makers are trying to achieve.

The 'support and encourage' element of the first objective of the PAF is crucial to its success. How does the PAF 'support and encourage' improved performance? The use of the PAF as part of each NHS Board's Accountability Review perhaps gives substance to the system by integrating the indicators into the management structure of NHS Scotland. What is the nature of this support and encouragement? An important issue here is the mechanisms that are being used to 'encourage sustained improvement in performance'. Although, currently, there are no explicit incentives attached to the PAF, there may be implicit rewards and penalties in terms of access to central funding, autonomy, serving on Scotland-wide committees and reviews, and linking executive pay to organisational performance.[4] The effect of the labour market for managers may also provide incentives to meet performance targets with career mobility and promotion directly or indirectly linked to PAF successes.[5] Each of these will be examined from the perspective of the stakeholders and other possible mechanisms that affect behaviour will be identified.

Objective 2. 'Reinforce and support the role of the 15 NHS Boards in managing the performance of their local NHS systems.'
What is the role of the PAF in monitoring and accounting for performance within NHS Boards? The PAF and Accountability Reviews operate at NHS Board level and performance assessment below Board level is the responsibility of the Board. The Unified NHS Board structure is further vertically integrating the NHS organisations within each Board. This will internalise the operational management role of NHS Trusts into Operating Divisions of the NHS Boards[6].

The Board has responsibility to respond to the objectives of the Scottish Executive whilst ensuring that the next line in the hierarchy, the service providers, responds to its own objectives. Of key importance in the successful operation of the PAF is the effectiveness of this line of responsibility, accountability and reward. Continuing the theme of the first objective, what mechanisms do the Boards have at their disposal to support and encourage improved performance? Does the PAF provide them with such a mechanism, and how does it operate?

Objective 3. 'Enable NHS Scotland to account systematically for its performance both locally and through the SE to the Scottish Parliament and to the people of Scotland.'
This raises questions about whether and how the PAF is being used to provide greater accountability. Does the PAF adequately represent the views and concerns of the public and Parliament and is the information available and accessible and in a form understandable by the health service users and public generally?

Turning now to the research approach used in this study, a key element determining how and whether the PAF affects the behaviour of decision-makers within the organisations and subsequently NHS Scotland performance is the perception of the PAF and the signals it generates. As suggested above, the way in which NHS organisations respond will be determined by how they perceive the PAF and its objectives. Thus it is important to determine what these perceptions and

understandings are. It is necessary to capture these views in order to appreciate fully the impact of the PAF within the NHS in Scotland and to appraise its salience and power as a performance tool.

In section two, background detail to the report is given. The next section presents the methods used to collect and analyse the data and considers the strengths and weaknesses of the methodology. The main findings from the interviews are presented in section four. The presentation of this section follows the structure of the interview schedule used in the data collection. Section five discusses the key findings under the headings of the three PAF objectives. Section six presents a list of policy implications and the last section considers areas of possible future research raised by this study.

2. Background

Scotland is far from alone in designing a Performance Assessment Framework to monitor and improve the performance of its health care system. Other governments around the world have introduced similar instruments, notably, in England but also in the USA and Canada. Their use is also apparent in other sectors in the UK through school league tables[7] and through the introduction of the Comprehensive Performance Assessment of Local Authorities in England[8]. The variety of settings in which performance assessment frameworks are used is indicative of the fact that they are not necessarily synonymous with a centrally planned health care system. A PAF is essentially a form of information and regulation which can be used within a market or non-market-based sector[9].

As one would expect given this variation in system setting, the production of such performance information is associated with a number of possible objectives:[10]

1. To secure or enhance accountability to funders and other stakeholders.
2. To identify areas of poor or under-performance and centres of excellence.
3. To help patients and purchasers of health care choose a provider.
4. To enable providers to focus on areas requiring improvement.
5. To provide epidemiological and other public data.

The Scottish PAF has all of these at the heart of its objectives with the exception of the third, which is more applicable to market-orientated system health care systems such as those of England and the USA. The Scottish system is also distinguishable from other systems by the lack of explicit financial or non-financial rewards and penalties attached to the performance assessment framework[a] and the absence of published performance league tables.

The Scottish system is based on an annual production and assessment of data. The seven areas of performance covered by the data are

1. Health improvement and reducing inequalities
2. Fair access to health care services
3. Clinical governance and effectiveness of healthcare
4. Patients' experience, including service quality
5. Involving public and communities
6. Staff governance
7. Organisational and financial performance and efficiency

The Information and Statistics Division of the Scottish Executive provide the 15 NHS Boards with their own PAF data in February of each year. The data can be divided into quantitative data and qualitative data in the form of assessments. The quantitative data is presented showing comparisons with previous years and with other NHS Boards. Boards then have an opportunity to review and discuss this information prior to an updated version of the data being published at the end of May. The data are used to inform the NHS Board Accountability Reviews, which take place for each Board during the following June and July[11].

[a] At the time of writing, a proposal to attach such incentives to the PAF is under consultation.

Despite the proliferation of performance assessment frameworks, there has been limited empirical evaluation of the effects of the introduction of such systems at the whole system level and our study attempts to address this deficit.

3. Methods

3.1 Data collection and analysis

In line with our aim of gathering rich insights from PAF 'implementers', three groups of stakeholders were interviewed: from NHS Boards, NHS organisations within Boards and from the Scottish Executive Health Department (SEHD). The same 'core' interview schedule was used for each group of stakeholders, to allow perceptions and key themes to be compared and contrasted. This study covers the results for the first two groups. The Scottish Executive interviews are used within this report as contextual data and for clarification purposes only.

The final scope of the interview sample and study approach was decided in consultation with the PAF Project Management Team at the SEHD. As in any qualitative study there is a trade-off between the scope and the depth of the analysis, in terms of the coverage of all NHS Boards versus the number of interviews to hold in each. The timescale was also a critical factor affecting scale of the project and overall sample size. Each NHS Board was represented in the initial sample by an interview with every Board Chief Executive and a further five Boards were selected as depth case study sites where interviews were conducted with a wider range of staff. In addition, interviews were conducted within the SEHD with key individuals who are primarily involved in the development of policy and the implementation of the PAF.

The five case study sites were chosen to provide a sample that reflected both the range of Health Board 'types' in Scotland and geographical spread. Criteria used in selection considered factors such as socio-economic status, 'remoteness' and 'rurality', population size, geographical size and geographical location within Scotland. The aim was to ensure a spread of experiences and views. To this end, we selected Shetland (remote island Board; sparse population, small Board population), Ayrshire and Arran (mix of high and low income areas as well as rural and urban populations), Greater Glasgow (urban, significant areas of deprivation, high population density, large Board population), Forth Valley (medium population, mixed rural and urban, mixed socio-economic characteristics) and Highland (small Board population, rural and remote).

Interviewees in case study sites were selected from both the acute and primary care sectors. The research design originally proposed eight interviews within each site. This was modified in several ways to take account of local circumstances. Firstly, because of the restricted number of senior managers involved in the PAF in Shetland, only five interviewees were selected from this Board. Secondly, an additional three interviewees were added to the Greater Glasgow sample to reflect the larger number of NHS Trusts within this Board. Finally, substitutions were made in response to intelligence gathered as fieldwork commenced.

Table 1 presents the professional groups originally selected for interview. Some interviewees were unavailable due to ill health and so some interviews were not arranged, one was cancelled by the interviewer due to ill-health and some were cancelled on the day due to the interviewees being unavoidably detained.

Of those who could not attend interviews due to unforeseen circumstances, one provided a substitute colleague with an excellent knowledge of the PAF. There were

only two refusals out of a total of 50 initially selected for interview, giving a very high response rate of 96 per cent.

Table 1 Interview sample by professional group

Professional Group	Proposed sample	Final sample
Chief Executive (NHS Board)	15	12
Deputy Chief Executive (NHS Board)	0	1
Chief Executive (NHS Trust)	9	7
Chairperson (NHS Board)	5	5
Director of Human Resources (NHS Trust)	5	5
Medical Director (NHS Trust)	4	3
Director of Nursing (NHS Trust)	5	5
Chair, LAMC G.P. Sub-committee	5	4
Other General Practitioner	0	1
Director of Public Health	1	1
Director of Patient Services	1	0
Planning, Policy, Performance & Statistics Personnel	0	7
Scottish Executive	4	3
Total	**54**	**54**

In order to compensate for those who were unavailable for interview, substitutes were selected: either arranged by those unavoidably detained, or by the research team. Given that the proposed sample did not include managers specifically assigned responsibility for the PAF, this enabled the sample to be widened in order to overcome this potential shortcoming of the study. These additional interviewees were selected for their in-depth knowledge of the PAF on the recommendation of NHS Board Chief Executives. The right hand column in Table 1 shows the final interview sample.

A semi-structured interview schedule was developed around a series of questions relating to the development and implementation of the PAF, the Accountability Review, the choice of indicators, and the incentives in the system relating to the PAF. The schedule focused on the perceptions of the PAF as it currently exists rather than trying to elicit 'what would work'. The questions were primarily about how the PAF is used and the effect that it has on decision-making. One core interview schedule was developed and then refined for four different constituent groups, for example, one was used for NHS Board members, an almost identical schedule was used for the NHS Trust employees, a third for primary care representatives and the fourth schedule was for the Scottish Executive interviews. The NHS Board members' interview schedule is reproduced in Appendix B.

The schedules were informed by the extensive literature review conducted at the beginning of the research and were piloted on the medical director of an acute hospital Trust. Comments were also sought from the PAF Project Management Group. Based on this feedback and experience, the instrument was adapted and streamlined for ease of use and several questions were added to explore both implementation and

accountability more thoroughly. In order to ensure that questions crucial to the research were both understood and reflected upon, the schedule included some repetition, although these questions were rephrased and linked to different sections.

Interviews were conducted by three researchers who maintained contact throughout the project in order to ensure that similar techniques were used. Regular feedback meetings were held to discuss emerging themes and to identify gaps in understanding that could be explored further in the interviews. By taking a dynamic approach to the interviews, the team gained the widest possible understanding of the PAF and its place within the assessment and monitoring of NHS Boards in Scotland.

All interviews were audio-tape recorded, transcribed, and anonymised prior to circulation within the research team. Analysis benefited from a team approach where regular meetings were held to discuss the themes drawn from the transcribed interviews. Second level interpretation of different aspects of the material was developed through team discussion, becoming refined through draft writing and further reflection. Illustrative quotes were selected from a broad range of interviews in order to represent both the majority view as well as to include a sense of the variation of opinions, experiences and indeed different Health Board types. In order to ensure anonymity, however, quotes are taken from across the whole range of interviews rather than simply the case study sites. For instance, any comments related to small Boards could have been taken from any of a number of individuals from Borders, Orkney, Shetland or the Western Isles. Furthermore, although there is much consensus within Boards, this is by no means total.

Qualitative research material provides a picture or representation of the field of study. The analysis develops this picture through putting together what is said by a range of individuals and where possible, placing an interpretative layer on top of this. Sometimes a major insight is gained from a single sentence uttered by only one interviewee, which may bring to the fore much that has simply been alluded to by others. For this reason, we have resisted the temptation to quantify our data; not least because the nature of qualitative interviews means that often the researcher is obliged to tailor the questions to the time available and therefore the information contained in each interview may vary. Where statements are made to offer the reader a sense of contrasting opinions or consensus, however, in order to maintain consistency, the following are adhered to:

A 'majority' of interviewees = more than 95 per cent
More than half = more than 50 per cent
A significant minority = less than but more than five
A small number = less than five

Throughout this report, strong endeavours have been made to ensure the anonymity of the interviewees. To this end, only NHS Board Chief Executives and NHS Trust Chief Executives are identified by occupation. The numbers of these individuals interviewed protects the respondents from identification. All other members of NHS Boards, including Chairpersons, are referred to as NHS Board members and all other interviewees from NHS Trusts are referred to as NHS Trust members. In some sections of the report, in order to illustrate the points been made, quotes from clinicians are distinguished from those of non-clinicians. These ‘clinicians’ might be

directors of public health, medical directors and nursing directors. In addition all interviewees are referred to as ‘he’.

Finally, the interview schedule was aimed at capturing a comprehensive overview of an extremely complex range of issues. This has enabled the research team to present a report that is wide in scope and depth. In only five months the research team conducted a literature review; organised and completed fifty-four interviews**;** had tapes transcribed then engaged in full analysis and report writing. The rich seam of analysis tapped into in this report indicates that many of the areas covered by the research could be fruitful areas of focus in their own right. There remains considerable scope for future analysis and extension of the themes uncovered at this exploratory stage.

3.2 Critique of methods

This sub-section briefly raises some of the weaknesses and strengths of the study. Firstly, while this study has provided an excellent snapshot of a wide range of NHS Boards and some depth on selected cases, some care has to be exercised in the generalisability of the findings. It has to be remembered that interviews in most Boards were largely with the ‘enthusiasts ‘ and the well-informed. Chief Executives in particular were able to speak eloquently and positively about the PAF system and many had been signed up to it at its inception. These respondents generally displayed leadership and high commitment toward measurement and could be persuasive in their accounts. While not exaggerating the robustness of PAF, they were able to see how it fitted with other target setting and assessment procedures that were ongoing. This they used to explain their comfort with PAF as an initiative describing it as consistent with other management practices.

Clearly such interviewees were motivated to present themselves as forward-thinking, trend-setters and as endorsing current measurement trends. Yet we did not feel that interviewees were merely presenting a managerialist ‘spin’. There did seem to be genuine conviction that the PAF system was working to good effect and threaded through good practice.

However, the integration of PAF into broader activity and keeping PAF in perspective was a methodological issue for the study. A number of respondents were concerned that the study itself exaggerated the status of PAF, giving it more significance that it really merited in the grand scheme of other target setting, regulatory and quality measurement activity. This message about PAF being unsensational, incremental and developmental needs to be kept to the fore and it should be stressed that it has different salience for different stakeholders.

Another aspect of this study is that it has concentrated on PAF as seen largely from the top teams in Boards and Trusts. This could be perceived as a limitation. For more insight into what performance measurement means a wider brief would be necessary.

Similarly there are questions to be addressed about how closely perception of effective PAF implementation and actual performance are linked. This study has not attempted this kind of analysis but it would be valuable to investigate whether those who have very favourable views on PAF are also high performers. A subsequent

study could select its case studies in terms of high and low PAF performance rather than the criteria used here of geography, size and socio-economic factors.

This study has hinted at a close connection between performance and leadership but did not set out systematically to assess different leadership and management styles or the integration of senior teams. This shortcoming could be addressed in any subsequent follow up study.

Common to many qualitative studies we have also to bear in mind that there may be dissonance between what people say and how they behave. There may also be the concern about independence of the researchers and issues of impartiality with respect to the study sponsors. We endeavoured to assure informants of academic independence and do not think this was a huge impediment to gaining authentic accounts. The team are highly experienced and sought to gain the confidence of all. The high level of co-operation was interpreted as a mark of salience in the topic and although some respondents did not expect to have much to say found themselves quite engaged with the subject.

One of the most challenging aspects of the research has been the time-scale. As we have noted there has not been scope to tie quantitative data and qualitative data together. We have not fully exploited the comparative cases to see what makes a difference. The depth of analysis across Boards has had to be fairly superficial at this stage and similarly we have not drawn firm conclusions on the strengths and weaknesses of different PAF approaches within cases. Within the remit all the initial objectives have been met but we would recommend developing the study further and some ideas are outlined below.

4. Key Findings

This section describes and summarises the key data elicited from the interviews. It follows the structure of the interview schedule reproduced in Appendix B. The interviewees varied in terms of their depth of knowledge of PAF from those leading in the PAF initiative to others more remotely or narrowly involved in only one aspect of the PAF, for example, staff governance. The responses elicited from the interviewees, therefore, varied in detail and richness in relation to the level of engagement and understanding of their PAF experiences.

4.1 Introduction

Assessing the performance of public organisations.
A question relating to this theme was asked in order to set the context for the remaining questions. The majority of interviewees expressed support for the principle of using performance assessment frameworks as a means of monitoring and improving performance in the public sector. Driving this support was a positive view (as opposed to an acceptance) that, given the large amounts of public money that were spent on the provision of public services (including health care), the organisations and individuals responsible for the decision-making should be accountable to the public. Furthermore, there must be transparency with respect to the use of public monies. This view of the need for accountability and measurement of performance was generally shared by managers and clinicians alike.

Although the majority of interviewees supported the approach, more than half also expressed reservations about the implementation and impact of the assessment. The two most common concerns were the trend towards an overload of assessment and measurement and the temptation for PAF to become an end in itself.

This second concern was expressed in two ways, each subtly different to the other. As one NHS Board member stated:

> '*What I am concerned about, of course, is the common industry in itself - we start feeding it rather than it feeding us'* (Interview 13).

And from a Trust Chief Executive:

> *'I think in the public sector there is now a view emerging that perhaps we have gone too far and that the targets themselves have become the end products rather than improvement in service*' (Interview 3).

Furthermore, one NHS Board Chief Executive warned that '*it* [performance assessment] *has created an industry and cost that is not commensurate with how the information is actually used at the end of the day*' (Interview 33).

Common to the majority of interviews, however, were positive comments to the effect that the current system was welcomed because it was more systematic than previous systems. It also complemented and extended what was already in place, rather than representing a sharp break with earlier monitoring systems.

Another Trust Chief Executive stated that, while the PAF adds value to the existing management systems, it needs to be regarded as a longer term project that is worth sticking with. This theme of persisting with the initiative was echoed by others.

Comparing the Scottish PAF with other systems, for example the English star system

More than half of the interviewees did not feel qualified to compare the Scottish and English systems. Of those responding, the majority preferred the Scottish system. In particular, they were not in favour of adopting league tables and the public use that was made of these in England. One interviewee, however, suggested that it could be useful to compare Health Boards of similar size and catchments. The suggestion was that rather than establishing a hierarchy, it could be useful for establishing a dialogue for the cross-fertilisation of ideas.

> '*I guess the difference is that the English Star System was used in a very public manner to drive a particular agenda in a particularly adversarial manner. The PAF has not so far in Scotland been used in that way because I think the cultural* [milieu of] *involving politicians and managers is a more integrated collegial one than exists in England*' (Interview 21, NHS Board Chief Executive).

The majority was also in favour of performance management as it was being applied in Scotland. The following illustrates this sentiment:

> '*I am reasonably optimistic about it. Perhaps not so much about the measures themselves but more the direction of travel in terms of trying to make it a partnership and trying to move forward together*' (Interview 3, NHS Trust Chief Executive).

4.2 Sensitivity and scope of the indicators

There were mixed reactions to the appropriateness of the indicators as a representation of the Boards' performance ranging from satisfaction with the instrument as it is through to recommendations for improvements.

It was felt that there was still room for improvement with respect to the adequacy of the performance indicators and that there were gaps in the coverage (or scope). Although there was some frustration that this was the case, there was an acceptance that the framework is a *'work in progress*' (Interview 5, NHS Board Chief Executive) with some refinement still needed.

In contrast, a common concern expressed by the interviewees was that there is an excessive number of indicators and that the numbers are growing year on year. Indeed one interviewee revealed that in the developmental stage of the PAF, it was intended that there should be '*a maximum of nine* [indicators]' (Interview. 5, NHS Board Chief Executive*).*

The positive aspect of the growth of the PAF is that it may be regarded as a 'living thing' which is dynamic and responsive to change. However, fears that it will continue to expand led to a significant minority of interviewees adopting phrases such as

'feeding the beast'. The notion of a greedy, consuming monster in danger of getting out of control was a frequently used metaphor, even by interviewees who were very positive about the framework.

Curiously, despite the concern with respect to the size of the PAF, more than half of the same interviewees recommended the addition of indicators for areas that are not covered by the current measures. Other respondents reported satisfaction with the range of indicators. This appeared to be associated with respondents who were confident in their management team's ability to subsume the PAF within their existing management structure.

More than half of all respondents highlighted that the PAF data on its own is misleading: this was considered particularly pertinent to small NHS Boards, although similar comments were gathered across the range of Health Board sizes.

> '*On its own without any contextual background it's potentially dangerous for a board area our size*' (Interview 22, NHS Board Chief Executive).

> '*So it's quite important to actually try to get behind the indicators to understand the basis of those indicators and how they might or might not apply in particular parts of our area*' (Interview 25, NHS Board member).

Similarly, some interviewees expressed the view that there was a temptation to measure things that can easily be measured and that the PAF does not allow for the assessment of outcomes. This means that it does not always capture change and improvement.

> '*the PAF measures areas where we can measure, it's often the things that are more difficult to measure that are important*' (Interview 3, NHS Trust Chief Executive).

> '*…because the service redesign indicators are very input driven … I mean it says something like how much do you spend…how much of your spend is dedicated to service redesign? But I think it needs to be more output focussed …I mean you could spend all you like on beds and redesign but its actually about the outputs, and if we take* [medical specialty] *as one of the outputs then we need to…Get that focus to be more outcome and output focussed* […] *because that is the bit that really makes the difference*' (Interview 11, NHS Trust member).

It was suggested that the PAF mainly illuminates things that management already knows about and although the potential utility of the instrument is acknowledged, it needs to be explored further:

> '*to be really useful a performance assessment system should tell me something that I don't know*' (Interview 3, NHS Trust Chief Executive).

Respondents pointed out that there is a danger that managers focus only on improving parts of the service that are currently measured in order to be seen to be outstanding rather than simply 'average'. Indeed it could be argued that NHS Boards performing

the best on the PAF might not necessarily have the highest quality of services. One interviewee described how his Board was setting a high target to be the best in Scotland on a particular service that was already adequate. He felt that this was to earn 'brownie points' with the Scottish Executive at the expense of the rest of the service. Furthermore he said that the service offered was '*making a rod for our own back'* (Interview 34) partly also because they did not have the complementary services for which demand would be generated.

Factors affecting whether Boards can meet targets

As might be expected, the majority of interviewees indicated that financial resources were one of the main things that affected whether Boards could meet their targets.

Another major concern was in the arena of recruitment and retention. A particular problem across the Boards is the lack of NHS dentists and a significant minority of interviews raised this as an example of something that is outwith their control and yet still measured within the PAF. Furthermore, this was raised as an example where change and improvement could be effected at the national level only through training more dentists.

Small Boards in particular face particular problems in recruitment and retention that often lead to the cost of employing consultant locums. A further problem is the difficulty of achieving compliance and co-operation from clinicians in referral centres, although they report excellent relationships with their own clinicians.

> '*Our visiting consultants and the clinicians and the clinical services we get from* [city], *we do have some problems in those areas and that is harder to have influence over and harder to have the same direct relationships because we don't manage those clinicians*' (Interview 32).

In the Health Improvement area of the PAF, there are several indicators which are viewed as partly beyond a Health Board's control and dependent on the involvement of other agencies and the socio-economic characteristics of the Board area.

Areas for improvement

A significant minority of respondents was also eager to include areas that were not covered. Although the aim of the interviews was to remain general with respect the appropriateness of the existing indictors, inevitably there was some discussion of specific indicators and areas of perceived weakness.

Health inequalities and health improvement were areas that were often cited as examples where the PAF failed to capture change and improvement. The quote below shows an appreciation of the difficulties faced by the PAF, acknowledging that they are endemic to the health care sector. In addition, there was evidence of a quite pragmatic view that while the PAF may not capture every nuance of the health sector, overall it does capture good and bad performance.

> '*I think* [the PAF Indicators] *give a fairly good snapshot of our performance. The difficulty I think isn't intrinsic to the PAF as it is to the nature of health care. For example, part of our board's performance is exemplified in our vision is to reduce health inequalities. By it's very nature that's a long term*

> *effort and the PAF's ability to track that in a year on year basis is inevitably more difficult. But we use the PAF as part of our accountability process and I am comfortable that in the long term it shows whether we're performing well or we are performing badly*' (Interview 21, NHS Board Chief Executive).

One interviewee was concerned that the health improvement and health inequality indicators are not sensitive to the efforts of the Boards to address them. Further, efforts to work with Local Authorities are not measured by the PAF. (See Appendix A: 3).

One NHS Board Chairperson commented that, since health improvement and health inequalities in Scotland were the worst in Europe, achieving an average score on the PAF was still far from ideal. He suggested that this was one area where the targets were simply not challenging enough, albeit agreeing with the majority of respondents who raised this that it must be assessed over the long term.

Staff Governance was another area felt to be neglected by the PAF:

> *'I think it* [staff governance] *needs to be more developed, and I think it needs to be given a higher level* …[of priority in the PAF]…' (Interview 45, NHS Trust member).

From another perspective, staff governance was still being developed and this area was seen to be improving:

> *'The HR site has really just been since last year with the staff governance, self assessment audit tool and this was the first year of the PAF against the audit tool. I think that that will be beneficial from next year onwards because at least you have got a benchmark of how you are continuing to perform'* (Interview 16).

Poor data collection techniques were highlighted as a particular problem in the health service. This was commented on by a small number of people who expressed concerns that there is no standardised method of data collection. The PAF, one person elaborated, was *'only as good as what it's fed'* (Interview 32).[b]

> '*You know, better clinical information systems seems to me will get us further along the route of capturing more of what goes on in ways that will be useful as management information - but we're a few years yet away from that*' (Interview 32).

Another person recommended that NHS managers take a step back and ask questions about what the PAF was intended for; refine it towards those objectives and also design information systems capable of gathering robust data that will not be questioned or regarded with suspicion at the local level. This could also address the replication of data collection, monitoring or auditing visits by outside agencies, perceived by many to be an ongoing problem. (See Appendix A: 2)

[b] See also Appendix A: 5

Primary care assessment was reported to be not as robust as other areas.

> '*They* [the PAF indicators] *focus on a set number of things which are based on things that we currently measure and I would say probably it reflects more about what happens in my* [Acute] *trust than happens in the primary care trust which is very…isn't really reflected at all*' (Interview 24, NHS Trust Chief Executive).

This was related to discussions that ranged across the interviews regarding the merits of various forms of assessment. While it was outwith the scope of the interviews to capture the fine details such as the merits of 'self' assessment versus the assessments performed by monitoring agencies, clearly there was some debate linked to the efficacy of what was referred to as 'softer measures'. This discussion is very much located in debates surrounding qualitative and quantitative data.

The majority of interviewees who raised the issue of Primary Care assessments were not in favour of the way that data was currently collected. They appeared to favour 'harder' measures, which was another way of referring to quantifiable indicators. The interesting dilemma embedded in these various discussions, however, was that while on the one hand 'hard data' was favoured, it was also clear from other parts of the interview that 'softer' data was essential in order to contextualise this. Similarly, it was also recognised that the areas that were subject to quantitative measures, were not necessarily always what interviewees felt to be the most important aspects of the service. Furthermore, it was clear that there were some areas that simply could not be captured in any meaningful way by quantitative measurement. It would appear then, that the challenge for the Scottish Executive is to develop a more robust form of qualitative data collection.

One NHS Trust member commented that the acute sector is much more driven by targets and adverse publicity than the Primary Sector because the latter is harder to measure: '*You name it, the acute sector lands everybody in it*' (Interview 43). Indeed a Primary Care Trust member elaborated:

> *'No I think they* [PAF indicators] *are much more…well they seem to be more orientated towards Acute Trusts and I think that is just the nature of the beast. I think its easier…because of the nature of the activity that occurs in the Acute Trusts where people are kind of in and out and through the door, then you are looking at activity which can be measured. Its much more difficult in the Primary Care Services, even where they are bed based because they are not based on specific interventions its much more difficult to produce comparative information and a lot of the work that takes place in the Primary Care Trusts which is around influencing and corralling and bringing about change in a very different kind of way to saying this is the target that we have got to achieve and this is…and how are we going to achieve it? It's much more difficult to do that in a Primary Care setting* (Interview 18).[c]

One interviewee suggested that financial performance in terms of 'unit costs' were not adequately represented in the framework.

[c] For further elaboration and examples from this interview see Appendix A: 6.

Some issues relating to small boards

Small NHS Boards encounter their own specific problems with the PAF indicators and also the difficulties experienced by larger boards are magnified for them. One of the major problems that they face is that some indicators are inappropriate for small boards since the numbers are so small that the PAF scores are meaningless:

> '*in some areas we could go from the best to the worst in the country or vice versa on the basis of three or four patients. So that shows that its not very sensitive for a small board area but we're okay with that as long as the contextual discussions around it take place and as long as its not used for other reasons than its currently being used*' (Interview 22, NHS Board Chief Executive).

In order to combat this problem, one interviewee suggested that it was more useful to examine morbidity rather than mortality:

> *'But what's much more meaningful is looking at a trend in the number of presentations at hospital where the primary diagnosis is cancer or stroke. And then looking at outcomes in terms of successful treatments and possibly looking at the admission rates and transfer rates and so on. Much of the work we did with the health plan is based on that, not death'* (Interview 31, NHS Trust member).

Despite these problems around small numbers, one interviewee said, '*the PAF was the trigger that made us look at, why is that up, why is that down?*' (Interview 19, NHS Board member). Common to other Boards (including large ones) was the feeling that although the PAF has some measurement issues to sort out, nevertheless it helps to 'focus' on particular issues.

NHS Board as level of data presentation

The majority of respondents agreed that the NHS Board level is the right level at which to collect data and implement the PAF. The arguments offered were that the Board is the site of strategic planning, the Trusts are being dissolved and senior managers in the Trusts already have positions of responsibility within NHS Boards.

> '*Yes, I think over all it is the right place but we just need to make sure that it's not seen as an isolated event that doesn't involve the rest of the system really*' (Interview 11, NHS Trust member).

The above quote, however, alludes to the warning that data should be disaggregated at the Trust level in order to help the Boards understand and respond to the information.

4.3 Relative importance of indicators

The question of 'what are the most important indicators?' produced a mix of responses. The majority said that 'waiting times' and 'finance' had to be priorities because that was one of the main things they were measured on. The answers emphasised indicators that had a high degree of public and political visibility. There does not appear to be disagreement with the need for financial performance to be

given priority. However the views on the weight given to waiting times were often negative, especially from the medical and nursing directors interviewed.

> *'..we didn't need the PAF to be understanding the political realities of waiting lists though I think they're disproportionate. So I understand why the waiting list stuff is there politically but I think its out of proportion to some of the other aspects of service actually'* (Interview 32).

One interviewee explained the problem with waiting times thus:

> *'We operate the performance assessment on the estimated waiting times across the board, without any assessment of clinical priority, without any assessment of demand versus need'* (Interview 34, NHS Trust member).

The lack of sophistication of waiting time as a key indicator was stressed as a concern. This was with respect to its failure to discriminate between different conditions in terms of clinical risk.

The majority of interviewees stated that waiting times and finance were a top priority because there was simply no choice in the matter and it was regarded as also being a top priority with the Scottish Executive. (See Appendix A: 4).

Managers also indicated that otherwise health improvement was their priority because the health of the local population should be their main concern. When questioned further, respondents usually acknowledged that this was also regarded as one of the top priorities of the Scottish Executive. There was also the suggestion that there is nevertheless not enough weight placed on this area and that more sensitive tools and data collection techniques need to be developed.

Clinicians often mentioned heart disease, cancer and diabetes as the headline (political) priorities. While there was general agreement that these are important, there was concern that other areas of clinical care are not necessarily subject to such close scrutiny by the service. A small number of all interviewees warned that there is the danger of targeting resources at the areas that are measured and measurable to the detriment of the rest of the service.

One NHS Board Chief Executive provided an incisive discussion of the relative importance of the PAF indicators in which all of the above came into play. (See Appendix A: 7). Although waiting times and finance were crucial, so too was health improvement. However, along with this was the recognition that the rest of the service was also important – with a high emphasis being placed on clinical governance and the quality of care. Although clinicians may be more inclined to be critical of waiting times and finance, nevertheless they too acknowledged the need to use resources effectively.

4.4 Changing behaviour, the Accountability Review and Incentives

PAF supporting and encouraging improved performance

There were different responses to the question of whether the PAF supported and encouraged improved performance. These ranged from total agreement to negative responses. Moreover, within any one Board, although there tended to be a shared ethos and approach to the PAF in general, there was not necessarily a consensus on whether or not the PAF supported and encouraged improved performance. For instance, within one Board, an interviewee responded negatively to the question of whether the PAF supported and encouraged improved performance. The interviewee explained this with reference to the lack of incentives within the system. This person felt that good performance was not financially rewarded while poor performers were often 'bailed out' with additional funding. (See Appendix A: 8a). Another interviewee from the same NHS Board responded positively, that the PAF was good for morale because it clearly shows areas of good performance.

> '*it gives you some idea of where you are sitting against other people. I suppose it goes part of the way and then its over to each health system to take that and make an environment where continuous improvement and improving across all of these areas is actually encouraged and supported and so I think it starts that process yes*' (Interview 11, NHS Trust member).

On reflection, part of this dissimilarity of views may be due to the respondents' interpretation of the question. The first interviewee was very supportive of the PAF in general and interpreted this part of the interview to be wholly about incentives while the second interviewee took a wider view of the expression 'encourage and support'.

Over half of the managers agreed that the PAF supported and encouraged improved performance.

This question of supporting and encouraging improved performance tended to elicit discussions of how the PAF is used to identify weak areas that need to be closely monitored throughout the year, in this way encouraging improved performance.

There were some concerns that the PAF only supports and encourages improved performance in areas that are measured.

One interviewee questioned the central role of PAF:

> *'PAF, yes it does help to improve performance but actually there's a whole lot of other powers and tools that we use to improve performance'* (Interview 28, NHS Board Chief Executive).

PAF and the Accountability Review

The majority of interviewees support the new Accountability Review process, which is regarded as being much less 'adversarial' than previously. It is seen now as more of a dialogue between NHS Board management teams and the Scottish Executive Accountability Review team.

This appears in part to be due to the introduction of the PAF into the process. Over half of the interviewees mentioned something to the effect that the PAF gives a clear structure to the accountability review and that the PAF scoring system allows management to come to the table prepared for the discussion of problem areas. Indeed one of the most positive aspects of the new system is, as one NHS Trust member expressed: *'by the time the PAF visit comes there shouldn't be any surprises'* (Interview 16).

However, the increased positive perception of the Accountability process was not entirely attributed to the integration of the PAF. The new style of leadership at the Scottish Executive Health Department was welcomed and appeared to have gained much support and this coincided with the introduction of the PAF.

> '*Yes and I don't think this is just about the PAF. I think this is also about the style of the folk at the executive but the accountability review is much more now about not having surprises. About understanding the areas for discussion and exchanging information prior to accountability review and then talking through issues that need to be talked through. So I think it has developed in that way over recent years. I think the PAF is part of that because it forms the bedrock of information but I think it's also a style thing as well*' (Interview 22).

In addition to the above, there are other factors which were reported to have contributed to making the Accountability Review a more positive experience. It is regarded as much more inclusive: firstly, because the review team now go to Boards rather than 'summon' them to Edinburgh as in the past; and secondly, because they include a wider range of personnel in each Health Board.

It must also be borne in mind that the PAF does not drive the entire Accountability Review, as one interviewee pointed out, '*the Accountability Review team are looking beyond I would say* […] *what is in PAF alone*' (Interview 11, NHS Trust member).

There was a mixed response to the question of whether the PAF changes the focus or direction of the Boards' activities or priorities. Major changes in priority, post-Review, appear to be minimal. This was partly attributed this to the fact that the PAF was directing them towards priorities which they would be addressing anyway.

Rewards and penalties associated with the PAF for Boards / Trusts

When looking at the responses regarding incentives and rewards more widely, it is clear that the majority of interviewees do not see any direct, tangible incentives within the system.

> *'There's no financial incentive, or resource incentive. Equally, unless something is dire there isn't any harsh penalty. So, there is no incentive associated with the PAF. It's more of a system to continually improve performance, but there isn't any hard incentive or penalty associated with it'* (Interview 41, NHS Trust Chief Executive).

A small number of interviewees suggested that there was a need to address what is perceived as the perverse incentives or inequitable situation at present where 'failing'

Boards are ‘bailed out’ with extra cash and those managing their finances well are not incentivised. (See Appendix A: 8a). However, at the same time it was appreciated that punishing Boards in difficulty by withdrawing funds or cutting their budgets was not a solution. Similarly, although recognition of a job well done is important, the majority of interviewees were not in favour of going down the ‘league-tables’ route.

One clear reward mentioned by over half of the respondents, was the Accountability Review letter from the Chief Executive of the SEHD. This was reported to be a valuable source of feedback to all of the personnel within a Health Board and a meaningful way of crediting staff for their efforts. In some cases, the letters are published in the local press, in others they are published on the Internet but in all cases the letter is widely circulated throughout the Trusts to all levels of staff. It was regarded as acknowledgement of a job well done that was highly appreciated. Furthermore, where Boards allocated specific targets or indicators as individual areas of responsibility, this meant that those responsible for good performance could also receive the praise of their peers.

For the small NHS Boards, recognition from the local population seemed to play a greater role (compared to the larger Boards) in motivating managers and for some, this seemed to rival the importance of the Health Department recognition. This was mainly due to their higher profiles in the local population than the equivalent figures in the larger (and perhaps more anonymous) Boards.

Some interviewees suggested that there was too much monitoring, which is particularly onerous for small Boards with low numbers of personnel. A significant minority of interviewees suggested that they would value increased autonomy as a reward for doing well. (See Appendix A: 9).

> '*I suppose I see* [earned autonomy] … *as a way of reducing the burden of inspections and assessments and that sort of stuff*' (Interview 32).

Increased autonomy took two forms in the interviews, both of which were seen as demonstrations of trust in the Boards by the Scottish Executive. The first was a reduction in the number of monitoring visits and the second was greater freedom in the allocation of spending by the Boards.

Junior doctors hours and compliance with this directive was raised as an example where failing to meet targets would result in severe penalties such as losing posts.

> '*if you think about penalties, one that we were waiting to get information as to whether it would apply, I suppose the whole thing about the new deal and junior doctors and how we are doing about getting junior doctors hours to be compliant. We have done a huge amount of work in the last year, its just phenomenal the kind of increase in compliance but we are still at kind of 85% compliance and there was always the threat that what would happen if you weren’t compliant by August 2003, is that you would have the post taken away from you*' (Interview 11, NHS Trust member).

Rewards and penalties for individuals

Performance-related pay was identified in the interviews as an explicit individual financial reward linked to the PAF that was used by some Boards. This was especially applicable in Boards which assigned individual responsibility for the seven areas of the PAF to senior managers, therefore naturally linking individual achievements to progress in their own PAF area.

However, the level of the financial incentives associated with this type of remuneration were not viewed as instrumental in affecting the level of effort exerted by staff in their work.

> '*I suppose you would then argue that the output of the performance pay by a number of people I don't think is as high as…we only got it circulated last week, and we were talking about an inflation uplift to pay ranges of 2.25% which is less than most other staff groups. So I think a lot of people will probably be feeling [that] individually I am not rewarded*' (Interview 11, NHS Trust member).

Interviewees were more inclined to talk about the individual reward of knowing that a job was well done and it was this sense of job satisfaction and achievement that mattered. (See Appendix A: 10a).

> *'I think what the NHS has been a wee bit remiss of in the past is acknowledging when folk are doing well, they are very committed and caring folk and I think that is the only benefit you want out of it really' (Interview 13, NHS Board member).*

Performance related pay appeared to be an explicit way in which the Board could acknowledge individual effort. It seemed to play a symbolic role in rewarding individuals.

Although the above comments on performance related pay could also be applied to the NHS Board Chief Executive, the main theme raised with respect to rewards and penalties for Chief Executives was job security. When one Chief Executive was asked what incentives there were in the system, the reply was:

> *'I guess the incentive is staying in a job, you know. NHS Chief Executives are, or being an NHS Chief Executive is not particularly good for your health, we don't last in them too long, it would seem'* (Interview 10).

Another respondent felt that it was only right that those in positions of power in NHS Boards should be removed from post if they were not delivering: particularly since they were responsible for public money and public services. (See Appendix A: 10b).

The perceptions, which emerged from the discussion in this section of the interviews, were that becoming the post of NHS Board Chief Executive was both a prestigious office and one that was risky. One interviewee reported that (to his knowledge) the average length of office was only two to three years and another that of a total of 15 Chief Executives of Scottish Health Boards, four had lost their jobs in the recent past.

Whether or not this is accurate, it does reflect a real perception of vulnerability of the position of Chief Executives in NHSScotland. (See Appendix A: 11a).

One interviewee spoke of the difficulties of managing such a large organisation. While they felt that a chief executive should not remain in post if they failed to meet the requirements, nevertheless it was felt that there was a certain element of luck involved. (See Appendix A: 11b). This was clearly illustrated in another interview where an NHS Board Chief Executive explained that something such as a death caused by clinical negligence, while outwith the direct control of the Chief Executive, could nevertheless potentially result in removal from post: an example of the ultimate accountability of NHS Board leaders. (See Appendix A: 11c). There appears to be a serious issue embedded in these narratives: while some senior managers are able to move sideways within the organisation, there is the problem of how to relocate them without losing their considerable talent to other sectors.

4.5 Implementation of the PAF

The majority of interviewees were very positive about the consultation process and the help that they received to implement the PAF. More than half also said that there was readily available ongoing help from the Health Department – either people would come out to the Board or were otherwise available to advise from a distance.

There were a small number of interviewees who were not positive about the consultation process, mainly associated with either a negative attitude towards the PAF, seeing it perhaps as a top-down initiative over which they could exert limited influence. For instance, one NHS Trust member explained:

> '*I didn't give a [care], and that's not being nasty, I just looked at it and thought great thing, fantastic. If the Trust signs up to it, as it will, then fine I'll do my bit. I didn't see as I could have any ability to change things ….*'

This sentiment can be linked to what may be regarded as a 'traditional' division between managers (or more precisely, 'management', 'finance' and 'business') and clinicians, which is explored further below. Equally it might symbolise the sense of disempowerment of those who feel distanced from the decision-makers at the Centre. The interviewee also revealed, however, that they were not necessarily opposed to the PAF *per se* but did not appear to feel any sense of ownership of the system.

Small Boards experienced different problems. One interviewee said that the presentation from the Scottish Executive team did not inform them beyond what they already knew. Furthermore, they emphasised the lack of sensitivity to and absence of technical expertise pertaining to small-scale data. One respondent describes his frustrations thus:

> '*So for instance we did the work on how much change in our numbers we'd have to get to see a change - a trend in line with the PAF targets for instance. We've done that work. I've never found anybody at the centre who either thought of the need to do that for smaller areas or could do it. So we present to the Scottish Executive something that says, "This is why this target is not*

meaningful for us because this is the number of events that we need to have in order to change our direction"' (Interview 32).

Management leadership style and its effect on the implementation of the PAF

There are clear signs from the accounts that respondents linked effective implementation of the PAF to strong and effective leadership. A particularly popular form of implementation is the creation of teams around groups of PAF indicators. This management configuration ensures that each senior manager has particular areas of responsibility. (See Appendix A: 12).

Over half of the interviewees stated that the PAF was integrated into strategic planning. For this reason, the majority of interviewees were unable to say how much time was committed to addressing the PAF, since it was embedded in management processes in such a way that they could not easily discriminate between discrete PAF and non-PAF activity.

> *'The way we've kind of used the PAF is we've used it in two ways. We've used it as a measuring tool to see how well are we doing. But we've also used the data from it to inform our planning activities. So we're kind of using it as an output thing but we're also using it as a performance measure. Which I think is probably the right way to use it. It's not either/or.'* (Interview 29, NHS Board Chief Executive)[d]

One interviewee, however, raised the concern that the current culture of monitoring and performance management could constrain creative local solutions:

> *'…can we built a safeguard for local innovation and local inventiveness? That worries me actually, because otherwise everybody's doing the same thing. The whole thing is moving forward in the same way'* (Interview 30, NHS Board member).

Integration and filtering down within the system

These interviews suggest that filtering down of PAF does not appear to go very far beyond senior management. However while overt knowledge of the PAF fails to travel far down the system, staff are in fact often dealing with issues connected to the PAF without necessarily knowing it. One interviewee stated that it was not necessary for staff on the 'frontline' of patient care to be aware of the PAF, just as there was no need for staff to understand the intricacies of 'management systems'. He elaborated,

> '[It's] *about knowing how we are doing and having a plan for improvement, it's all happening, maybe it doesn't matter that people don't know about the PAF per se*' (Interview 11).

Indeed, there are indications that the PAF may be an increased aid to management when it is more integrated and hence 'invisible' to those who do not deal with it in a managerial capacity.

[d] For further elaboration of the implementation of PAF and its link to planning, see Appendix A: 12c & 12d.

Managers and clinicians

It is difficult to say anything definitive regarding the attitudes of clinicians towards the PAF owing to the small number of interviewees, however some themes emerged from the data.

The majority of managers commented that they maintained excellent relationships with clinicians. However, it was clear from the broad range of interviews that although there was much in the way of partnership and positive relationships, nevertheless there were still areas of contention. As one NHS Board Chief Executive commented,

> *'There are tensions if you look at just waiting times. The clinicians say this is crazy… we shouldn't have these, and we aren't given adequate funding for it* […]. *But when you talk of the cost of the system, mathematically it doesn't balance. So, there are tensions, but these are good tensions* (Interview 33).

One Chief Executive, although reporting good relationships within that Board, also reported that one of the potential dangers was that if clinicians were not 'on board' they could act to the detriment of a manager.

> '*Now if you are a clinician in another area you might well think to yourself, why would we bother we'll spend money, we'll improve the service to our patients because that's what we're there for and if the chairman and chief executive get sacked it's a price worth paying*' (Interview 5).

With respect to the consultation process on the PAF, one clinician was antipathetic to the question of consultation, feeling he would have to comply whatever the outcome. Another clinician said that he was not in post when the consultations were ongoing; another speculated that few Nursing and Medical Directors had been involved in the consultation process: something that was possibly responsible for the fact that clinical governance and quality issues were often reported (across the whole range of interviews) as areas that were neglected in the PAF. These may be transitional outcomes relating to the early stage of PAF implementation and clinical staff would not be expected necessarily to be 'frontrunners'. Alternatively it may reveal that the depth of congruence or alignment between managerial and clinical cultures is overstated.

It appears from this research that these professional groups are supportive of the principle of accountability and indeed the majority also cautiously welcomes the PAF as a tool to enhance this. This is underscored by the previously sceptical clinician (Interview 43) who goes on to endorse PAF thus:

> '*No, I genuinely think it* [the PAF] *is valuable, but for me it doesn't affect my day to day behaviour, it doesn't affect the targets and the areas I see myself responsible for*' (Interview 43).

4.6 Local and national accountability

Local accountability

The interviewees were not especially positive or complimentary with respect to the PAF's success in terms of increasing local accountability. Over half of the respondents felt that it was too complex for the general public to understand, although one interviewee suggested that this was one way of ensuring that media interest was kept at bay.

> '*I struggled with it* [the PAF] *and I would have thought that given my background in* [professional area] *and very much working with statistics that I probably had a head start on a lot of people and I did struggle with it to be absolutely honest.* […] *So if you're just picking it up in a report or a newspaper and you're a member of the public you're just going to look at it and say, "What does that mean"?*' (Interview 19, NHS Board member).

The PAF nevertheless was perceived as playing an indirect role in enhancing local accountability since a significant minority of interviewees explained that information from the PAF is fed into the local health plan; made available through newsletters distributed with the local free press; published on Health Board websites and so on.

One of the concerns, which links into the problem of measurement and gaps in the indicators, is that the PAF does not provide the kind of information that is most meaningful to the general public. This is because the PAF fails to capture the experience of health service users.

> '[W]*e publish the accountability letter and the annual report and it goes to the board. I mean I think board members take that seriously. I'm not sure that the general public out there in* [Board area] *does because they judge the service on their experience last time they came to the hospital or what they think they're going to get out of their GP next time they go and see him and their expectations of what the service delivers isn't summed up necessarily in the PAF. I mean clearly it is in some things but not in others. You know, it doesn't capture the quality of experience that those people have…*' (Interview 32).[e]

A key mechanism through which the public is informed of Board performance is the publication of the Accountability Review letter. These letters are partially based around the PAF and do serve to place the PAF data into the context of the local situation in terms of the local NHS Board's performance over time and in relation to other Boards. However, investigation of the nature of the content of the published extracts and their impact would be required to determine whether this gives the public a balanced view of their Board's performance.

National accountability

As noted above, the need to contextualise the PAF data means that on its own the PAF can be misleading regarding the performance of a particular Board. As long as the PAF data is tied in with the Accountability Review, during which the data can be presented in terms of the local context then it plays a part in accountability but it does

[e] See also Appendix A: 15.

not contribute to this on its own except as something potentially misleading and damaging.

The problem for senior managers, however, is that Boards must also respond to political pressures both at national level and at the level of their local population through the pressures brought to bear by local Members of Parliament and the media. Attention may be brought to bear locally on things that do not arise in the PAF but nevertheless could become major issues that executives are obliged to respond to. Therefore there is a tension between accountability to the Parliament through the PAF targets and local accountability.

Some respondents expressed a fear that the PAF could become a political tool, easily expanded at the whim of politicians eager to monitor particular areas: particularly since interviewees were aware of and sympathetic to the political environment in which the initiatives were forged. Indeed one NHS Board Chief Executive went so far as to say,

> '*the department and the politicians are creating a rod for their own back. To set targets that may not be achievable* […] *that's bad news for everybody*' (Interview 33).

Any other comments

The respondents were given an opportunity at the end of the interview to raise any issues, which they considered important relating to PAF, but which had not been addressed by the schedule. The majority took this opportunity to reiterate their general support for the system. The quote below is indicative of these positive comments and highlights the need for persistence with the assessment tool:

> *'The only thing I would encourage is that we stick with it, because I think a lot of these things come and go because people perceive them not to be delivering what it is that they want and therefore politicians, or whatever, will want something else in place. I think from our experience in terms of performance management, you have to stick with a system in order to get people used to it, ownership, and that will take time because it's not something you can do overnight. It's almost a culture thing that does take time. So I would encourage the executive, or whatever, to stay with it and use it in a way that it links as much more of a tool that can be used systematically in the organisation. And not to give up on it, which there is a great temptation, having been involved in performance management systems around individuals. There is a great temptation to change the performance management system every two or three years because somebody either thought something else, but I think you need to stick with it if you are really going to try and improve performance. So, that would be my plea, if you like'* (Interview 41, NHS Trust Chief Executive).

5. Discussion

In this section we draw together the results to identify the key findings of the study in relation to the three objectives of the PAF which form the basis of this investigation. Each is briefly discussed in the context of existing related literature.

Before examining each of the objectives, it important to note from the results that the system of PAF is welcomed in principle by the NHS in Scotland though with some reservations. In addition to the evidence of support from the interview transcripts, the salience of the system is reinforced by the high response rate of the study. Further, this response rate adds weight to the findings here as a wide coverage of personnel and Boards was achieved.

*5.1 **Objective 1**. 'Support and encourage sustained improvement in the performance of NHS Scotland by focussing on key measures in relation to health priorities.'*

The wider literature on performance and incentives suggests that, of key importance to the successful working of the PAF is the sensitivity and scope of the indicators, as well as the mechanisms that are being used to 'support and encourage' improvement in performance. In an environment such as the NHS with its multiple objectives and outcomes and complex tasks, having strong incentives associated with a small number of short term performance indicators can cause problems such as myopia, narrow focus and gaming (e.g. the ratchet effect). The extent to which the PAF does and will suffer from these problems is not clear. If the incentives linked to the PAF are not strong and the PAF is mainly presented as a forum for discussion at the Accountability Reviews, the 'over-focussing' on particular indicators is less likely to cause such perverse incentives.

A balance needs to be achieved between, on the one hand, ensuring the wide scope of the indicators and, on the other, the burden of the data collection and qualitative assessments for the PAF and the Accountability Review. The data from the interviews confirmed that, for the PAF to work well, the indicators within it need to be accurate representations of the required performance and to encapsulate the essence of a good performing NHS. The overall view was that the PAF was quite burdensome, though this depended upon the extent to which the Boards integrated the PAF into the day-to-day management of the local health service. However, there was an appreciation that the provision and planning of health care is a complex undertaking and as such requires a complex performance monitoring system. It was widely believed that the PAF gave a good indication of a Board's performance. Despite this general acceptance, there seems to be a strong concern that any future developments of the system focus on its refinement. By refinement the respondents did not appear to suggest that the PAF should be reduced in data volume but that some existing indicators or new (i.e. substitute) indicators should be developed to more accurately reflect activity, effort and output.

Concern was raised with respect to myopia and over narrowing of focus of Boards energies and activities. A potential problem raised in the interviews was that yearly targets could constrain innovation and long term planning. When managers are forced to meet short term targets rather than take longer term views, some areas of the

service which are not monitored may suffer because of the need to allocate scarce resources to politically 'hot' areas. Similarly, the issue of how managers balance good performance on PAF indicators while encouraging innovation and creativity is an ongoing challenge of leadership. This was raised in two contexts. First, the risks associated with innovation, may be avoided by managers as the costs of failure are viewed as too great and second the energy and skills required to innovate may be lost as the incentives are to meet immediate targets not to examine opportunities for excellence. These problems are potentially exacerbated when the tenure of senior managers is tied into meeting specific targets.

Concern was expressed in the interviews with respect to the limited effect that the Boards have over some of the indicators. In particular, the ability of the PAF indicators to monitor change over time was less well supported by the respondents. Questions were raised with respect to whether they were sensitive enough to show changes in Board performance and policy over time. This was of particular concern with respect to the outcome measures for equity and also local health statistics which it was felt were not quickly amenable to interventions. It has been argued elsewhere in the literature[12] that only indicators over which the individuals have some control should be included. However, the importance of such an argument depends on the objective of the framework. If the aim is to stimulate discussion and a framework for interaction between the SEHD, NHS Boards and other public sector bodies that influence health, then the inclusion of indicators over which the NHS has little control may not be so destructive. However, the reason for their inclusion must be made explicit.

A further issue is the relative importance attached to the indicators and the effect that this has on the Boards' response to the PAF. At the moment there are no explicit weights, which implies that they are all of equal importance. Evidence from the interviews confirms anecdotal evidence that the Scottish Executive are perceived as placing greater weight on waiting time and financial targets, but that the Boards and their constituent parts may place more importance on other dimensions of performance such as health improvement or local issues.

An important issue under Objective 1 is that of the mechanisms used to 'encourage sustained improvement in performance'. The use of the PAF as part of each NHS Board's Accountability Review gives substance to the system by integrating the indicators into the management structure of NHS Scotland.

From the reading of policy documents, there are currently no explicit financial incentives attached to the PAF at an organisational level[f]. Similarly, from the interview data, there are few perceived implicit or perceived financial rewards and penalties for the NHS Boards. It was raised in the interviews that perverse incentives may arise from the actions of helping ailing Boards with extra resources. The most senior managers of the Boards appear to be subject to some personal rewards and threats in the form of performance related pay, job security and labour market positioning. These are discussed together with the effects of incentives on other individuals under Objective 2 below.

[f] This may change as noted in paragraph 20, chapter 4 of the White Paper 'Partnership for Care' and the recent SEHD consultation.

Of key importance to the Board, and thus the senior management of the Board, is the receipt of the Accountability Review letter. The interviewees appeared to be self-motivated to provide a good service and this letter was seen as important acknowledgement of the level of effort exerted by the Board.

Given the mixed response in the interviews as to whether PAF changes the overall direction of a Board, PAF may merely have a validatory role or a second interpretation is that it acts as an anticipatory or priming tool. It may help to critically raise awareness and promote problem sensing on a continuous basis. The first view implies that the PAF is having limited effect on behaviour. The second implies that it is affecting behaviour prior to the Accountability Review but perhaps with the knowledge that the Accountability Review and thus the requirement to demonstrate remedial actions in problem areas, lies ahead.

There appears to be some differences in the understanding of the overall objective of the PAF and the importance of the role it plays. Some Boards seemed happy with it as a framework for generating a dialogue at the Board Accountability Reviews and as a representation of overall performance. Other Boards seemed more concerned with its minutiae and whether it accurately reflects performance and the aspects of local health that the Boards can affect.

5.2 Objective 2. *'Reinforce and support the role of the 15 NHS Boards in managing the performance of their local NHS systems.'*

The PAF and Accountability Reviews operate at NHS Board level and performance assessment below Board level is the responsibility of the Board. The unified NHS Board structure has further vertically integrated the organisations within each Board internalising the operational management role of NHS Trusts into Operating Divisions of the Boards[13]. The Board has responsibility to ensure the appropriate response of these service providers to the messages from the PAF. The effectiveness of the mechanisms by which the Boards ensure that the service responds is key in the successful operation of the PAF. From the interviews, a number of mechanisms were perceived as affecting the degree to which individuals responded to the PAF. These were (not necessarily in order of importance) self-motivation to do a good job, acknowledgement of good performance, whether through performance related pay (PRP) or some non-financial mechanism, the nature of the leadership of the organisation and the management structure.

In the economics literature on incentives, financial incentives are often suggested as a way of increasing effort: the assumption underlying such an approach is that workers under a PRP will work harder than those on a fixed salary. Two questions are important. Do they matter to people and do they achieve the outcomes that the organisation wants? The interviewees' perceptions of financial incentives linking individual performance to the PAF depended on the Board in which they were working. PRP was used in conjunction with management systems where individuals are given responsibility for improvement in a group of PAF indicators. The interviewees who were rewarded in this way seemed happy with this approach under the proviso that their performance was placed in the local context and not crudely linked to movements in the indicators. Such a crude system was not employed by any

of the Boards. Indeed, the system employed appears to be a 'subjective performance evaluation' approach often recommended in the literature in situations where the range and types of tasks required of an employee are complex[14].

The marginal effect, which the PRP has on the income of the individuals, is quite small. Under such circumstances we might expect that the extra effort required of the employee to qualify for the extra payment may be deemed not worthwhile. However, those receiving the payments also emphasised the importance of peer respect. Thus the payments may act as an indicator or a marker that someone is performing well. We can deduce that, having this marker attached to a nominal PRP gives added weight to the mechanism as it imposes a cost on assigning good performance to an individual. Without PRP, the marker may lose its value to the recipients. However, we have very little data on this from the interviews and whether this is the case is an empirical question.

It is also important to understand what motivates individuals beyond the financial incentives that they face. An important distinction often made within the economics and psychology literature, with reference to the public sector, is that between 'intrinsic' and 'extrinsic' motivation. If individuals are motivated to employ effort to ensure that the organisation within which they work performs well or achieves its' objectives irrespective of any extra reward that they may receive for doing so, then the individuals are said to be intrinsically motivated. Extrinsic motivation occurs when an individual increases their effort to achieve organisational objectives in response to an incentive system. It has been hypothesised that where intrinsic motivation exists in an organisation, the introduction of incentives may act to crowd out the intrinsic motivation[15].

The respondents generally reported that they were motivated to provide a good health service and the best use of the public spending on health care was important to them. These findings are not surprising and in line with findings of other studies undertaken in public health care[16]. Given this, it is important to ensure that staff are aware of the value which is placed on their intrinsic motivation and that this aspect of the motivation of the providers of the service is not damaged. Relating the literature to these findings, it can be concluded that any further financial incentives added to the system should be done so with care and with attention to this hypothesis.

From the literature, the effect of the labour market and career concerns for managers may also provide incentives to meet performance targets, as managers will be concerned about their career prospects.[17] The interviews confirm that the role of the external labour market appears to be important in providing incentives for effort in the light of perceived job insecurity, especially for the Chief Executive. It is important to recognise that incentives for effort can exist in the absence of explicit pay for performance contracts through incentives in promotions, career concerns and self-motivation.

The data suggest that characteristics of management organisation, organisational culture and leadership influence the effectiveness of the PAF. It is difficult to elicit the direction of cause and precise nature of the interrelationship between these characteristics and organisational performance. Certainly, those Boards, which have integrated the PAF into their own management systems, seemed to feel that the PAF

was less burdensome. However, there appears to be no single model of good practice with respect to the internal implementation and integration of the PAF within the NHS Boards. For instance small Boards may benefit from a close-knit management and large Boards may benefit from a dedicated team with responsibility for individual areas of the PAF. Although no single model dominates as superior, and different models seem appropriate and effective in different settings, there are still opportunities to capture and present models of good practice around Scotland and perhaps to look wider afield at other systems. What is clear is that NHS Boards need to view the PAF as useful for its own purposes.

One of the issues under Objective 2 is how successful the internal communication and management of the Boards are at ensuring that the implications of the PAF are responded to within the Boards down to provider level. This applies to providers working within the hospital and within other health care settings such as primary care.

G.P.s deal with PAF 'issues' but may not necessarily have any direct knowledge of the PAF itself. Although activity within G.P.s' surgeries are clearly important to the Primary Care sections of the PAF, they are not always explicitly aware of how the efforts that they put into achieving improved breastfeeding rates, immunisations, and so on affect Primary Care targets within the PAF. Moreover, one of the problems is the system of G.P. incentives not complementing well the Board objectives. One example given, related to the immunisation rates

Issues arise in relation to the new G.P. contract, and fears that primary care could become less 'joined up' than before. Some interviewees expressed concern that they would lose their voice at the Board level because of the dissolution of the Primary Care Trusts. Although the G.P.s interviewed here clearly are aware that what they do has an impact on both performance in the Primary Care sector and admissions into Acute care, they noted that there was a problem of influencing strategic planning dialogues taking place across the Boards' services. Although G.P.s appear to have largely escaped the level of monitoring applied to other health service providers within the PAF, they are nevertheless subject to close scrutiny through, for instance, peer appraisal systems and benchmarking for Quality Practice Awards. They was also equivocacy about whether they would want to be more deeply implicated in PAF.

Another element of this internal communication is the relationship between managers and clinicians. Although this study did not include interviews with frontline clinical providers, it did include interviews with a small number of clinician-managers. Relationships between managers and clinicians in this study on the whole appear to be much more positive than anticipated given the 'traditional' tensions often described between the two: the majority of both professional groups acknowledge the necessity and value of working together to meet targets.

While clinicians interviewed here appear to be more open to criticising the PAF targets than 'managers', they are also aware of the necessity of meeting targets. (See Appendix A: 14). And while clinicians are not always as enthusiastically wedded to the assessment culture, it is clear that any simple distinction where managers 'managed' and clinicians ignored managerial realities no longer holds true. These clinicians appear to have been socialised in accepting some targets and measurement of activity. Performance Assessment seems to be becoming the norm within

organisational cultures and therefore is consistent with the activity of senior management teams. The depth of this awareness and consciousness raising, in terms of performance assessment, may however be restricted to an elite. One of the challenges that faces senior managers, the SEHD and clinical managers is how to engage broader tiers of medical staff in a dialogue that will change attitudes towards what has been regarded as the preserve of 'managers'. While both Medical Directors and Nursing Directors show an awareness that they must engage in management processes if they are to have decision-making power and influence within them, this awareness appears to be only gradually having an impact. Questions arise about how best to diffuse this orientation and mindset so that clinicians do not feel their clinical autonomy and judgement to be compromised or undermined by measurement diktat.

This data illustrates the complex ways in which NHS organisations are changing and new approaches are being adopted. As part of that, performance management culture appears to be infiltrating into the organisation of clinical care. (See Appendix A: 13c) Perhaps new ways of engaging with clinicians and involving them in target setting, service redesign and implementation need to be aggressively pursued.

5.3 Objective 3. *'Enable NHS Scotland to account systematically for its performance both locally and through the SE to the Scottish Parliament and to the people of Scotland.'*

Information on the PAF and the performance of individual NHS Boards is indisputably available within the public domain. The quantifiable indicators are available on the ISD web site by the Information & Statistics Division on behalf of the Scottish Executive Health Department[18]. However, that has to be qualified. From the interviews it was clear that although available, the data are is not necessarily accessible. It is clear from the data whether a Board has improved on its previous year's score. On the other hand, it would take some degree of sophistication in the reader to find out (or, indeed, to know that they need to find out) whether the improvement is absolute, compared with other Health Boards, the Scottish average or a target level. Furthermore, the information on the website is restricted to the quantitative measures and excludes the qualitative assessments. These qualitative assessments are also available on request from the SEHD but this is not stated as the case on the web pages.

The interviewees emphasised that, given the extent to which context is deemed necessary to interpret the data, it is questionable whether much valuable information can be gleaned from the web pages. Having said that, the fact that it is publicly available and allows the reader to explore and begin to ask questions is important. However, the objective of assisting in providing public accountability at the local level does not appear to be readily achieved by the PAF data or its presentation at the moment. Though of course, this view was gleaned without actually asking NHS patients or the public.

The main means by which the PAF enters the public domain at a local level is through its integration into the local health plans and also the publication of the Accountability Review letter by the Boards. This context allows a Board's performance with respect to the PAF to be described within context and the important aspects to the SE and the Board to be highlighted. However, these two formats do not necessarily address what

might be important to a particular individual or interest group trying to assess their own local health care services. These issues have been raised previously with respect to the UK and other health care systems such as that of the USA[19].

6 Policy implications

In this section, we present the authors' interpretations of the policy implications from the interview data in the light of our shared knowledge of managerial and economic issues in the Scottish NHS. The overall impression from the interviews was that the interviewees were happy to continue with the use of the PAF in Scotland. However, as stated earlier, this opinion was given subject to a wide variety of concerns. As a result, the policy recommendations below relate to the existing PAF and how it might better achieve its objectives rather than any radically different policies designed to replace the current system.

6.1 With respect to the indicators used within the PAF, refinement should continue to be undertaken in consultation with the NHS in Scotland. The focus should be on ways to change what is currently included in the PAF rather than adding to its volume. This may be done by replacing some indicators for ones that better capture the essence of an indicator or by refining existing indicators and recognising that its not just the NHS that can influence them. Furthermore, greater transparency and explanation is needed with respect to the rationale for the inclusion of the indicators.

6.1 The Scottish PAF differs from other performance assessment systems (in particular the English 'Star' system) in two main ways. It does not have strong financial or non-financial incentives attached to performance and it does not publish the data in the form of league tables. These two characteristics are important in securing high commitment from the people we interviewed and may be instrumental to the system's success. Any changes away from the current model should be undertaken with caution and the effects monitored.

6.3 We would not recommend introducing a strongly incentivised system. If rewards are to be attached to good performance, it may be the symbolism of the rewards and the way in which they are administered, which act as an incentive, rather than the financial aspect *per se*. This is in addition to the relationship between the PAF and the career structures of those implementing it. Further, a note of caution is offered with respect to the perception that 'underachieving' Boards are 'rewarded' with extra resources.

6.4 It would be helpful to revisit or restate the objectives of a policy initiative in order to ensure that it continues to be understood as it gains momentum and maturity. This will be especially important in the context of the new unitary Boards where the needs of primary care must be balanced with acute services and the relevance and implementation of PAF will apply to all.

6.5 Although no single model dominates as superior, and different models seem appropriate and effective in different settings, opportunities to capture and present models of good practice around Scotland and perhaps to look wider afield at other systems should be sought. In particular more needs to be understood about the importance of local management and leadership in the implementation process.

6.6 One of the big challenges that PAF faces is how to honour its objective to deliver local accountability. The Accountability Review letter is the main medium thorough which the public is informed. However, this is only a small aspect of the PAF. It may be worth considering whether the objective of PAF to increase local accountability is a laudable one and one which should be pursued. There may be alternative means of achieving this end, which would be more appropriate. To achieve it would require considerable work on the presentation of the PAF on the ISD web pages[17] and integration of these with the individual NHS Board websites. If this route is taken it may be fruitful to examine the approaches taken by other parts of the public sector.

7 Future research agenda

The limits of this study as already outlined above are governed by the time-scale in which it has been undertaken and while it answers a number of interesting questions it raises many new and related questions. Some of these have been formulated above and are reiterated briefly below. Some are very closely related to the study described in this report and would build on the analysis using the existing data set. Other areas of suggested future research are quite distinct from the questions and methods used here. Specific references within these proposals are not made to the English and other similar performance assessment systems. However, there are opportunities for illuminating and improving the Scottish system through comparison with and learning from other comparable systems.

7.1 Further investigation of this study's data set coupled with additional qualitative data would address the interesting issue of the differences in the perception of PAF between the different user groups, from the Scottish Executive to the frontline NHS staff and the public or consumer of health care.

7.2 This study has been able to draw out initial observations on the style of the implementation and integration of the PAF by the NHS Boards. Further analysis would enable the different models of good practice to be identified and disseminated. Such a study may benefit from examining a wider experience than that of Scotland.

7.3 Related to the above is the question of what is required to change a NHS Board which is perceived as being less successful into one which is perceived as a 'good performing NHS Board. For example, is it new leadership, a new management team, an increase in resources, training or something else?

7.4 Are there discrepancies between how Boards are perceived to be performing and how they are actually performing? Are the less successful Boards identified as such by performance on indicators or is it a matter of presentation by the organisations in question? Or conversely are the successful NHS Boards those which present themselves positively and 'play the game' and/or those which perform best on the performance indicators? Much more needs to be known about organisational culture and management and how these aspects link to performance

7.5 A question raised within the interview schedule was the perception of the influence that the NHS organisations have over the performance indicators. The question of attribution and influence could be addressed by more rigorous analysis examining evidence of a causal relationship between Board activity, other exogenous characteristics (such as local socio-economic factors) and Board performance. A systematic programme of analysis could address specific areas of concern for the NHS Boards and the SEHD.

7.6 There is scope to research whether PAF and similar methodologies create dysfunctional behaviour and perverse incentives that may lead to different outcomes to those intended by the policy makers?

7.7 As a longer series of data becomes available on the PAF, opportunities to answer questions using quantitative techniques with respect to its impact on NHS performance will become possible and will be crucial in analysing the effects of the policy.

7.8 Interviewees within this study suggested that relative performance in the PAF might affect an individual's future positioning in the job market and job mobility. Further investigation of the link between labour markets and the performance of NHS Boards would present a clearer picture of the implicit incentives in the NHS and help inform the need for future explicit incentives within the system. Comparisons between different professional groups (for example, hospital doctors and managers) might help inform the differences in importance attached to the PAF by different professional groups.

7.9 Further research is recommended on the extent to which the PAF is meeting its objective to 'increase local accountability' of the NHS. This would require investigation involving members of the public and local advocates for healthcare. A far-reaching study would question the feasibility of the objective and possible alternative ways of addressing this objective.

7.10 A key aspect of the perception of the PAF is the quality of the data collection and the methods of collection. Further work in this area to ensure consistency and quality between Boards would increase the credibility of the system. It will also be valuable to collect data over time and to assess how the new Board restructuring process impacts on PAF.

8. Acknowledgements

We are grateful to the NHS Scotland staff who gave generously of their time and hospitality in the completion of the interviews used to collect data for this report. The Health Economics Research Unit receives core support from the Chief Scientist of the Scottish Executive Health Department. We are pleased to have had the opportunity to work collaboratively across the College of Arts and Social Sciences and the Institute of Applied Health Sciences. The views in this report are those of the authors and not their funding bodies.

References

[1] Scottish Executive Health Department. *Our National Health. A plan for action, a plan for change.* December 2000.

[2] Scottish Executive Health Department. Rebuilding our National Health Service. May 2001.

[3] New performance assessment and accountability review arrangements for NHSScotland

[4] Scottish Executive Health Department Human Resources Directorate. *Appraisal arrangements for staff on executive pay ranges*. HDL(2002)664, 23 August 2002.

[5] Scott A and Farrar S. Incentives in Health Care. In: *Advances in Health Care*. Edited by A Scott, A Maynard and R Elliot. Wiley, Chichester, 2003.

[6] Scottish Executive Health Department. *A framework for reform: devolved decision-making. Moving towards single-system working*. HDL(2003)11, 7 March 2003.

[7] Herbert DT and Thomas CJ. School Performance, league tables and social geography. *Applied Geography*, 18, 3, 199-223, 1998.

[8] Audit Commission. *The Comprehensive Performance Assessment Framework for Single Tier and County Councils*, London, 2002.

[9] Walsh K. The rise of regulation in the NHS. *British Medical Journal*, 324, 967-970, April 2002.

[10] Nutley S and Smith PC. League tables for performance improvement in health care. *Journal of Health Services Research and Policy*, 3, 1, 50-57, 1998.

[11] Scottish Executive Health Department. Performance Assessment Framework. NHS HDL (2002)78, 1 November, 2002.

[12] Guiffrida A, Gravelle H and Roland M. Measuring quality of care with routine data: avoiding confusion between performance indicators and health outcomes. *British Medical Journal*, 319, 94-98, 10 July, 1999.

[13] Scottish Executive Health Department. *A framework for reform: devolved decision-making. Moving towards single-system working*. HDL(2003)11, 7 March 2003.

[14] Burgess S and Metcalfe P. *Incentives in organisations: a selective overview of the literature with application to the public sector*. Working Paper 99/016. Centre for Market and Public Organisation, University of Bristol, 1999.

[15] Frey BS. *Not Just for the Money. An economic theory of personal motivation*. Edward Elgar Publishing, Cheltenham, UK, 1997.

[16] Le Grand J Knights, knaves and pawns: health behaviour and social policy. *Journal of Social Policy*, 26, 149-170, 1997.

[17] Scott A and Farrar S. Incentives in Health Care. In: *Advances in Health Care*. Edited by A Scott, A Maynard and R Elliot. Wiley, Chichester, 2003.

[18] http://www.paf.scot.nhs.uk/paf/index.html at 22 December 2003.

[19] Davies HTO and Marshall MN. Public disclosure of performance data: does the public get what the public wants? *Lancet*, 353, 1639-1640, May 15, 1999.

Appendix A: Illustrative Quotes

1. Trust, monitoring and the quality of care issues not captured by existing monitoring systems:

'*So that's why I say I understand the principle of it - and if I was sitting at the centre and had to have some way of knowing the service other than getting better at hearing the reality of what local people within the service know... For instance if you go into a local service and you talk to local consultants then they'll tell you which clinician is … you know who they'd refer their own mother to amongst the geriatricians and those sorts of things… And you can only grab that [type of information] by active management I think. So if you're sitting far enough away from the local service and you want to measure stuff and you want to be able to ask a set of questions and get some sense of whether local management capacity can deal with the problems I accept that something like the PAF or the process around the PAF is a way of doing that. But we're still at the stage of having very imperfect indicators I'm afraid*' (Interview 32, NHS Board member).

2. Monitoring and replication of data collection

'*…sometimes you do feel as if hang on a minute we need to start from scratch, what are we going to be measured on and how can we have a more streamlined approach to it? I mean there was one week at the beginning of this year, tail end of last, where we had CNORIS in measuring us on a whole…particularly looking at risk and…but its got people issues in it, its got quality issues in it, its got service issues in it, we have the clinical standards board which was one of the bits of QIS which is now in there visiting that same week, we had…[…] …so the establishment of QIS has brought together a number of strands that were previously monitored separately so that is an improvement. But I think we have still got a way to go to kind of make sure that we aren't duplicating because people are busy enough and I think we need to get that right. I don't know if we have got that right yet*' (Interview 11).

3. Health improvement and the problems of capturing this in the PAF (Interview 33, NHS Board Chief Executive)

'Actually, if we are just looking at hitting targets, it doesn't reflect areas where, especially in health improvement, the energy is required, the creativity. I think particularly in health improvement because it is very long term … long period and therefore long term benefits before you can realise it… Because in spite of your efforts you cannot force the community to do certain things, they are actually out with your direct control. So, I think there is a real dichotomy and dilemma between a lot of the targets that are set and the indicators and the reality. I think we may well have to use some softer measures in parallel to show […] *the creativity and the energy and the sheer effort that has been put in, as opposed to just the out put. I think that would be very helpful.'*

Interviewer: Do you have any thoughts on how that could be captured?

'I think first of all, I know it is laborious, but to have some way for us to be very clear what are the activities and the intentions and those local targets… at least if the

department sees those details maybe it would give them a flavour. And not assuming no I've hit the target, but it's actually … it's still commendable what you have been doing. I think the other thing is it doesn't quite link up. Our current culture is to work in partnership with particular local authorities in health improvement, and again how do you capture what they are doing through the community plan? Because if they are also a health improvement organisation we are only capturing one, and maybe if we begin to join the two up together to reflect the joint effort as well as the joint responsibility we might have something that is much more meaningful in health improvement.'

4. Human Resources Issues

'Yes, if you look at the areas around, primarily I guess, either organisational performance in relation to finance or organisational performance in relation to waiting times and all that kind of stuff there is enormous amount of effort put into that. That backs up the view, that I think most Trusts have, which are probably three, real key objectives in the NHS in Scotland. One is that you have to work within your financial constraints, and you have meet your financial targets. The second is that you have to have your priorities around waiting times, and third is that you have to get it through the winter. If you do those three things then you've been pretty successful… Chief executives don't believe they are going to get sacked because they don't answer the question in the PAF field around the extent of which they met the leadership challenge on the back of race equality, but they do think that if they don't balance the books or they don't have a winter time target than they are in a valuable position.'

So, do you think that the staff governance areas should be more developed?

'Yes, absolutely. I think it needs to be more developed, and I think it needs to be given a higher level [of priority]... where the PAF, I think, really adds value to the system as a back up to the accountability review process. The extent of which it penetrates the Trust mechanism through Scotland, I think is quite limited. Because it is used to back up the accountability review process, it tends to be seen as a whole systems issue and therefore it's a matter more ... for Health Boards than for Trusts.'

Okay, so when you say whole systems you mean the NHS level rather than whole system as in the unified board?

'No, I think what I am meaning is that if there is a health economy, which in our case is [area H], within our Trusts and a Health Board, then the issues around the PAF really are primarily for Health Board and not for the Trusts, and only impinge on the Trusts to that extent that Chief Executives of the Trusts are in the room with the Chief Executives of the Health Board when the Scottish Executive are coming out to have the conversations around the Accountability Review. That's where it starts to have some impetus I suspect.

5. Problems with data quality

'The way numbers are collated and…most of the PAF comes from SMRs […] ISD information services, and that mostly comes from trusts and systems through what is called SMR data, its basically…we record our activity in a certain way around things like out patients, day cases and in patients. That is (a) I would suggest that we are not all recording that data in a consistent way and (b) we certainly don't…the system certainly doesn't describe the complexity of what we do. If you are involved at the local level in things like benchmarking (if I use that as an example, because the same data is kind of chopped down and used in lots of different ways.), you end up having lots of arguments with clinicians about whether the data is valid or not. So I think, if we are going to make this work, we have got to … improve the quality of the data that we [collect] and then … you wouldn't have arguments about consistency. I mean the thing is national pictures are really difficult because … we haven't got consistent ways of describing some things that happen, we haven't got consistent ways of delivering things' (Interview 24, NHS Trust Chief Executive).

6. Primary care indicators

'No I think they [PAF indicators] … *well they seem to be more orientated towards Acute Trusts and I think that is just the nature of the beast. I think it's easier…because of the nature of the activity that occurs in the Acute Trusts where people are kind of in and out and through the door, then you are looking at activity which can be measured. Its much more difficult in the Primary Care sector, even where they are bed-based, because they are not based on specific interventions. Its much more difficult to produce comparative information and a lot of the work that takes place in the Primary Care Trusts which is around influencing and corralling and bringing about change in a very different kind of way to saying this is the target that we have got to achieve and this is…and how are we going to achieve it? It's much more difficult to do that in a Primary Care setting.'*

Can you give me an example of one of these things?

'Well if you just take a kind of bed comparison for a start, then if you take acute beds in mental health as opposed to acute beds in general medicine or in surgical beds or whatever. You would say that someone going through a surgical intervention or a hip replacement, then the operation should take roughly X number of hours, I suppose there is a minimum and a maximum that they are likely to take and that the average length of stay is Y. If someone has an acute mental illness than its quite…you cannot say that the average length of stay for someone who has got manic depression will be X and the average length of stay for someone with schizophrenia will be Y because there are far more other factors that play into it and you have not got…you would have a drug regime or a […] therapy regime or whatever that you are going to use with the individual. Its not as simple as saying a broken hip, we will mend it, get the person back on their feet and out the door… But things like waiting lists yes you can say um…that there can be comparatives between waiting lists for acute care and waiting lists you know for paediatric, occupational therapy, or waiting lists for psychology or whatever, you can take raw data like that and make comparisons. But I think with beds … that is not an easy one. Equally can you say to a general practitioner I expect you to see X number of patients in X number of hours. Now the

GP contract, the new GMS contract has all the quality indicators, but they are not about activity, they are about the outcomes from patient care or patient interventions'. (Interview 18, NHS Trust Chief Executive).

7. Relative importance of the indicators

'The health improvement ones are important, but I do think we need to refine them further to be useful. I think the more crucial one is actually clinical governance, which is not featured as part of the PAF. We have other ways of vetting it, which comes through Quality Improvement Scotland, and old clinical standards, but I really think if we are into performance management there needs to be a single system to cover it all, because its all very well to say well are you able to hit the waiting time, well fine but what if you end up with very high morbidity rates as a consequence, and errors, and high suing rates. So, I don't think of the PAF in terms of performance, it's performance of outputs, but not of the quality of the service. As a patient I would be much more concerned when having my knee operation done that it's been done properly, I have been discharged appropriately, I've got the right drugs, so that the whole patient protection journey is there. The second area is missing – so I'm giving you more of the opposite end of the spectrum—its really some aspects of public protection which is about emergency planning and business continuity, there is no performance management of that side, it comes under more –I don't know if you are familiar with—CNORIS, which is the risk management system we all had previously to go through. So, in terms of performance management I would welcome a very clear system, encompassing all the streams that are crucial, so business continuity, clinical effectiveness and clinical governance, those are two not featured currently in the PAF. (Interview 33, NHS Board Chief Executive).

8. Supporting and encouraging improved performance

a) Negative response:
'No not at all. Because there is no reward for good performance, apart from the accountability review where you are commended for it, but there is no other tangible incentive. For staff in the front line, they are working under a lot or pressure hitting these targets, but they are not getting the funding, because the funding does not reward good people. The current funding . . . we try very hard every year in [Board B] to break even financially and that's the pain and needing to do a lot of things. Reward is given to the people who over spend; they get 'bail-out' money. There is totally, absolutely zero incentive for doing well…' (Interview 33, NHS Board Chief Executive).

b) Positive response:
Yes it does. It sharpens up…if you talk to some of our directors here, they will home in on what they see as key gaps or problems in services. What PAF does is it measures it for you much more accurately and puts it into perspective along with other indicators and that is vitally important, because given the range of things we cover in the NHS as you know, and given the professional and public and political priorities that folk have, the thing about PAF when you look at all the indicators, it really gives you a…not a league table but it reorders your priorities more accurately. And for example, if you took the one I mentioned about X [interviewee names an area of the service], normally […] health improvement is raised as a big issue that will

come at the board and the board say fine, compared to hip operations or knees or delayed discharges, that has slipped down the priority list. You see it in PAF it doesn't, it is a major implication, so I think that is what PAF does, I don't think it identifies anything unknown but I think it measures it and puts it in the proper balance along with other indicators, I think that is the value of PAF. I would be very concerned if PAF came up with something that our directors here had not highlighted. But it definitely on the national basis sharpens it. I welcome PAF; I do think it is a good development' (Interview 13, NHS Board member).

Accountability Review

'Yes, the reviews have become much more constructive and much more of a dialogue. I think the view Trevor Jones has taken, and I applaud him for this, is around openness and transparency. So that the Board and the Health Department coming to the Accountability Review have got an agreed pack of data, there have been lots of discussions going on between my staff and officials within the health dept about what are the key issues. So we'll all know what the issues are. So we can come to the table and have an open and honest dialogue. I think that has enormously helped. The Health Department know we're not going to spring surprises on them at the Accountability Review and we've built up a trust with the Health Department t that they're not going to do the same with us. I think that's hugely beneficial' (Interview 28, NHS Board Chief Executive).

9. Trust and monitoring

'*I'm torn because the burden of doing more and more of this takes away from the getting on and managing the problems in the service which is why I quite overall like more freedom to be getting on and managing the problems in the service but I understand that if I was at the centre I would be nervous about that as an approach. You have to have confidence in management capacity to be able to allow that freedom*' (Interview 32, NHS Board member).

'*If you could cut down on the inspections for say the next year,* […] *instead of coming annually we won't go for two years or three years. Because in a small board we spend so much time digging out information and being inspected. I'm using inspection but I suppose monitoring is the right word but that does take up a lot of time and that takes time away from managers who could be doing something more useful*' (Interview 19).

10. Rewards and penalties

a) *'I think people generally want to do a good job, and if you give them the resource and the commitment to do that and support them, then they will do that. The pay is nice to have on top of that, but I don't think it's the main driver, because the amounts of money are not so significant that they are going to dramatically change people's sense of whether they want to get up, you know. So, I think it's on the march, but it's one factor that will help, but I don't think we have the same level of incentives that are in other sectors if you were a real high performer in the organisation. I think there's an issue there about career developments things as well that you do want to have as talent, and perhaps use that and develop people in their careers and give*

them more rewarding fulfilling careers that maybe we haven't quite got to yet in the NHS' (Interview 41).

b) 'No notice required and no compensation given. Similarly, should the minister wish to dispense of your services … no notice will be given and no compensation will be paid. So we work on that kind of basis and I think that is the right way in a public appointment, because the sort of power we wield…not power, responsibility we carry and what we carry with it …. If you start going a bit off beam or off target, what is it they say nowadays off message, then the public interest of public safety and the public purse I think you have to go smartish.' (Interview 13, NHS Board member).

11. Job security

a) '…for the chief executive you would need to accept that's part of the risk and I'm not moaning about that. I'm really saying that, well I had a good track record I believe in my last job. Suppose I don't do well in this job, another organisation would say, "Well we've over-promoted him or we've put him in the wrong job, we'll pull him quietly and put him there". What happens in the health service is you get sacked. You get all over the press. You get people making statements about failure and then sometimes they try and help you behind the scene and come in somewhere else but that's a traumatic process to go through so I think there's a real issue there about how that's dealt with.' (Interview 5, NHS Board Chief Executive).

b) '*Well these are potentially high risk jobs, you know. Because you are the accountable officer and, if you are in an organisation, this organisation runs a budget of* [figure] *million, we employ* [X thousand] *people. The potential for things to go wrong is extremely high, you know, because a lot of things within NHS Board area are largely outwith the direct control of the Chief Executive. It depends on how clinicians treat patients or… whatever happens to be. But what we have to try and do is to ensure the governance of that and systems are in place or people are in place to conduct the work in a satisfactory manner. So it is difficult to keep on top of everything. Part of it is putting the right systems in place and having the right people but part of it is about luck as well.* […]*Yes, it is perhaps not as bad as I have made it out to be but there are certainly in my experience quite a number of people that have fallen on their swords.'* (Interview 10, NHS Board Chief Executive).

c) '[T]*here are* [number of employees] *in the NHS in* [area] *and at any given moment any one of them might be doing something that will get them sacked or if you're doing something so gross that the Health and Safety Executive will prosecute or something, there's nothing I can do about it'.* (Interview 6, NHS Board Chief Executive).

12 Implementing the PAF

a) 'The other way, in terms of promoting a very integrated culture, we concentrate on the culture rather than structural change by having Chief Executive portfolios. So, myself and the Trust Chief Executives each have a raft of portfolios where we have Chief Executive leadership and these would be in areas where we don't have a personal responsibility. So, for example, I am leading on X [interviewee names an area of service], which is a strictly a primary care trust responsibility, but that leadership means that I am driving the completion of the joint strategy with the local

authorities. I am actually leading the implementation group and if things go wrong in the process I have to make sure the trouble shooting happens. So I am not going to the line managers saying why are you doing this wrong, because that's the job of the primary care Chief Executive. But I still need to make sure the dialogue is taking place and if it's something between the primary and acute trust, I need to make sure the parties have had the dialogue and resolved it. Similarly, we have the primary care Chief Executive actually leading on the X [names another area of the service], whilst he doesn't manage those functions. So, this very kind of cross system leadership is a way to promote a very corporate integrated culture. That's the way the leadership style is moving in that integrated, team working, corporativeness, open and hopefully trusting relationship.' (Interview 33, NHS Board Chief Executive)

b) *'I think we've got a really good team, a culture where devolving responsibility, a team that's supportive. We're not going to hang people out to dry, we're not going to go after people as individuals when things go wrong. We seek to support individuals and the whole concept of having teams, being the senior management team or service teams, and we'll work with them, we'll manage them rigorously but we'll support them. Really PAF is one important factor in a whole range of things that people in the service need to deliver upon. There's a whole range of really important areas that aren't covered in any detail by the PAF that actually are probably more important to get right. So you take for example child protection. Major issue for the First Minister.* […] *It is of absolute importance that health and the council and all the agencies are working together to get child protection right. So in terms of the list of things that I think are absolute imperatives, must do, that's pretty high on my list. That does not feature in any way here, so PAF is important but it needs to be put into context'* (Interview 28, NHS Board Chief Executive).

c) 'Yeah [the PAF is integrated into our management system]*, this is a paper you might want to take away and have a look at. This shows how we're using performance information in* [area]*. So we've got the Director of Public Health's Annual Report, the PAF output, last year's performance, i.e. the things we had in the health plan and whether we did or didn't do them, and national requirements … What we've done is use all that to inform the health plan, to then inform the objectives for the different parts of the system. And then we use that to system performance manage and the linked individual's objectives. This describes here how we on a monthly basis take information back to the Board, the more detailed work the executives use, how we've fed the health plan into that, how we're doing on performance assessments measures. And it gives the reports we're using and how we're using them. So on the PAF for example, what we've done is we take each of the indicators and give ourselves a reading based on what it says. We don't alter what it says. So if we're in the upper bit we have a star and if we've got a problem we've got one of these marks to make you realise there's a problem. Then we chart the train so as it's steady, up, down, or what. So then after discussion we decide whether we think we need to be doing something about that, we define it as high, low or medium. And then we factor that into what's going into our health plan and what we're trying to do. So we're trying to use it to kind of be more informative and mean something.'* (Interview 29, NHS Board Chief Executive).

d) *'I think it's an essential building block in the Board's evolution in its Health Plan and its longer term aims for [Board area] and its longer term budget and planning.*

It's … part of the fabric of our decision-making process' (Interview 30, NHS member).

13. G.P.s and the PAF

a) *'Well I know very little about PAF, in my view most GPs don't know anything about it at all; they don't even know it exists. Um….I only know about it because I used to work as a part-time* [role] *and some aspects of coronary heart disease were interesting me at that time and I was made aware that there were some items within the PAF that were linked to coronary heart disease so I had a look at it on that basis, but it was pretty impenetrable.'* (Interview 27, G.P.).

b) *'One thing that I think is terrible is that there should be any connection between how much a G.P. is paid and whether a child is immunised and so I don't think there should be any targets at all and I don't think there should be any financial pressure put upon G.P.s to immunise more children than their parents are comfortable in doing.'* (Interview 27, G.P.).

14. Clinicians and managers

a) '*I have never bothered in the slightest with the PAF—that's something Chief Executives tend to get cheered and excited about; they're the only people who go and get praised, and quite frankly if you asked me what the leading areas in the PAF were, I wouldn't have a clue, and I wouldn't have a clue what the Health Board or the Trust against these actually is. The truth is, I'm probably involved in delivering a lot of these, but I don't bother with the PAF… I look at my own personal objectives and I look at objectives effectively set for me within the individual areas I am responsible for.*' (Interview 43).

b) '*As a doctor you never have any objectives, if you want a change you consult a contract. You don't have objectives you just do the job. If you have a waiting list then you just have to make sure you keep it under control and even if that consultant fails to do that he doesn't get any penalties, it's the chief executive that gets the penalties. You come from an atmosphere where objective setting is totally strange, you deliver good clinical, as best you can, and your real target is just to make sure patients are safe. When you come into management, you receive a series of objectives and I have to say I initially I was very, very cynical. I couldn't even write a set of objectives when asked to. Now I can, and I pay a lot more attention to whether I am writing achievable objectives for myself, and a lot more attention to the discussion I have with my chief executive about whether they are achievable and a lot more attention . . . initially as Medical Director before we got things organised you kind of … picked things up as you went along. You know you didn't have something you could strictly say was your responsibility. You might feel that if Doctors were heavily involved in it, then you kind of picked up. That has changed radically over a few years, down there are specific areas that you are responsible for and I feel a personal responsibility. If I failed in them, I would feel a real sense of failure, I might even pack in the job if I failed them. … I take on specific things and I know they are my responsibilities as Executive Director and I have to achieve the goals associated with these.* ' (Interview 43).

15. Local accountability

'So I think one of our criticisms of the PAF would be it's not terribly user friendly. It's really difficult for even NHS non-executive directors to get their heads around the various technical aspects of it. And the requirement to publish the PAF indicators in the annual report. Actually publishing it in a way that someone living in [town] *or* [town] *would be able to actually understand what this means….'* (Interview 28, NHS Board Chief Executive).

Appendix B: Schedule used for the NHS Board interviews

Personal details

Name:

Current post:

Time in post:

Previous post:

1. INTRODUCTION

1.1 A current trend in the public sector is to systematically assess performance of organisations. What do you think of the usefulness of this approach in general?

[Big general/ideological question to help place the other responses in context].

1.2. What do you think of the PAF compared to earlier attempts at managing performance in the NHS?

- *Purchaser-provider split*
- *The previous AR process*
- *Resource Management Initiative*
- *CRAG (clinical outcome indicators), etc?*

1.3 What do you think of the Scottish PAF compared to other systems, for example the English star system?

2. SENSITIVITY AND SCOPE OF THE INDICATORS

2.1 Do the performance indicators adequately represent your Board's performance? Are they a useful way of measuring performance?

- Appropriate/inappropriate
- Performance over time
- Change/improvement not covered by indicators?

2.2 As you probably know the PAF data is collected at the NHS Board level. Do you think this is the right level at which to collect data and implement the PAF?

- Trust level? - this what they do in England

2.3 What affects whether you can progress towards meeting the targets in the PAF?

- *resources*
- *factors beyond the board's influence [socio-economic, etc]*

- *other organisation*
- *too many targets*
- *variation within the Board?*

2.4 How would you describe your NHS Board in terms of location and socio-economic factors?

- *urban/rural/remote*
- *poor*
- *mixed*
- *small/large*

[prompt them re why they were chosen for close examination – is this how they see themselves?]

2.5 How would you describe your NHS Board in terms of the management leadership style (across your senior team)?

- *how does this affect the implementation of the PAF?*
- *how does the PAF affect the style?*

2.7 What are the relationships like between the managers and the clinicians in your Board?

- *are they affected by the PAF?*
- *do these affect the implementation of the PAF / hinder of help?*

3. RELATIVE IMPORTANCE OF THE INDICATORS

3.1 Which do you see as the most important indicators - from your Board's perspective/from the Scottish Executive's perspective?

- Is there a difference between the two? Why? Does this have any affect on the way that you respond to the PAF, to your Board?
- If they are the same, why?
    - *agreement*
    - *responding to incentives in the system*
    - *complying for other reasons*

4. INCENTIVES AND THE ACCOUNTABILITY REVIEW

4.1 One of the objectives of the PAF is to support and encourage improved performance. Does your experience of the PAF support this?

4.2 Were you involved in Accountability Reviews prior to the integration of the PAF? Has the integration of the PAF into the Reviews changed the nature of them?

4.3 What lessons (if any) came out of your accountability review and will this affect your activity in the coming year?

- *are there changes in priority/focus*
- *Examples*

4.4 How will you take these changes forward?

4.5 What effect (if any) is that likely to have on the rest of the service?

4.6 Is this what you as a Board would have chosen to focus on if it were not for the PAF and/or your accountability review?

- Did the accountability review change your direction or complement what you were doing anyway?

4.8 I'd like you to think about possible rewards and penalties associated with performing well or poorly on the PAF. Does the NHS Board experience any such penalties or rewards?

- Financial incentives/budgetary changes
- Non-financial incentives
- Explicit/implicit
- How do they work?
- How are they intended to work?
- Examples
- Opportunities/restrictions

4.9 What about for you as an individual? Are there rewards and penalties in the system for you which are affected by how well the board performs with respect to PAF?

- Financial incentives
- Non-financial incentives (e.g. promotion)
- Explicit/implicit
- How do they work?
- How are they intended to work?
- Examples

4.10 Are there any rewards or penalties associated with the PAF for other individuals within the Board or the Trusts?

- Financial incentives
- Non-financial incentives (e.g. promotion)
- Explicit/implicit
- How do they work?
- How are they intended to work?
- Examples

5. IMPLEMENTING THE PAF

5.1 How much input/guidance have you as a Trust been offered to help you to understand and implement the PAF?

- Where from (Scottish Executive, other Trusts, your NHS Board, peers)?
- Useful?
- What else could have been done to help?

5.2 The Scottish Executive carried out a consultation process on the PAF in 2001 and 2002.

- Did you take part?
- Did they seem to listen to you?
- Was this useful?

5.3 What steps has your NHS Board taken to implement the PAF? Plans for the future?

5.4 How does your Board intend to use the PAF?

- As a set of incentives
- As a set of instructions
- As a set of constraints/targets
- As a management tool which can be used internally within the Board?

5.5 Does the PAF influence decision-making within the Board? On a regular (weekly or monthly) basis?

5.6 How wide is the PAF's influence within the Board? Has it influenced its relationship with your Trusts or hospitals?

- How far does the PAF filter down and how does it do this?
- What mechanisms does the Board have available to it to ensure that it and its Trusts perform on the PAF, does it use them?

5.7 How much time is committed to addressing the PAF?

LOCAL AND NATIONAL ACCOUNTABILITY

6.1 One of the objectives of the PAF is to enable the NHS to be accountable to local people and to the Scottish Parliament. Do you think that it assists this aim and how does this accountability work for your Board?

FINALLY

7.1 Looking back at your achievements over the past year, can you tell me about one thing that you do well in this NHS board that other Boards could learn from?

7.2 Are there any aspects which you feel that we haven't covered? Any other comments which you would like to make about the PAF and the accountability review process?

7.3 Finally, how have you found taking part in this interview?

END