THE SCOTTISH OFFICE

NHS:
MEL (1993) 30

National Health Service in Scotland
Management Executive

St. Andrew's House
Edinburgh EH1 3DG

Dear Colleague

PATIENT'S CHARTER: ANNUAL REPORTS

Summary

1. The Patient's Charter contained a commitment that all hospitals and other health units would publish annual reports with effect from this April. This letter contains guidance on the minimum information that we expect such reports to contain. It also encourages Health Boards to focus their annual reports on their achievements as purchasers and specifies the minimum information in that all Boards' reports should contain.

Action

2. Board General Managers and Trust Chief Executives should ensure that their annual repots contain the information outlined in annexes A and B respectively.

3. This circular should be copied to Unit General Managers.

Introduction

4. The Patient's Charter said (on Page 11)

> "From April 1992, all hospitals and other Health Units will publish annual reports setting out information about the Unit's activity, quality of service and finances over the past year."
>
> "From April 1992, more data will be published about the comparative performance of individual hospitals and other Health services."

5. In addition there is a statutory obligation on Trusts under the National Health Service Trusts (Membership and Procedure) (Scotland) Regulations 1991 to produce an annual report.

6. These reports are intended to inform the public and staff, as well as other interested parties such as GPs, local authorities, local health councils etc, about the performance of the Unit or Trust. They are not intended to be the primary mechanism for the purchaser to monitor performance against the contract; that will require separate and more detailed arrangements and more frequent reporting.

12 March 1993
(reissued August 1994)

~~Addressees~~

For action:

General Managers,
Health Boards

General Manager,
State Hospital

Chief Executives,
and Chief Executives -
designate, NHS Trusts

For information

General Manger,
Health Education
Board for Scotland

General Manager,
Commons Services
Agency

To be copied to Unit
General Managers for
action

~~Enquiries to:~~

Health Board Reports

7. All Health Boards have published local Charters setting out their commitments to their residents, reflecting the national commitments in the Patient's Charter; are developing local health strategies to explain in detail what they see as the health needs of their local population and their purchasing strategy to meet these needs; and are publishing their contracts with providers specifying what, where and how they are purchasing the requisite health care. In future the main purpose of annual reports will be to report to local residents on the Board's performance in the past year against these 3 documents setting out their intentions. The annual report also provides a convenient vehicle each year for publicising improvements to Charter commitments, given that we are not asking Boards to rewrite and republish Charters annually; or other important steps towards the achievement of the local health strategy, such as developments in care in the community.

8. The annual report should be aimed at the general public locally, rather than specialists, and its language and styling should reflect this. A degree of local diversity will be desirable, but it is important that all annual reports by Boards cover the same core content, reflecting the core content of charters, local health strategies and contracts. Annex A lists the core content for annual reports by Health Boards. Directors of Public Health currently produce separate annual reports and I expect them to continue to do so.

NHS Trusts and Directly Managed Units

9. I attach at Annex B a list of the minimum information that I consider should be included in the annual reports published by Directly Managed Units and Trusts. However, I stress that this is a minimum requirement. The publication of the annual report gives Trusts and Units the opportunity to demonstrate what they have achieved against the contracts they entered into with purchasers. I therefore encourage Unit General Managers and the Chief Executives of Trust to extend their reports beyond the minimum information in the attached Annex B. A good example of the kind of additional information that might be included in Unit and Trust annual reports would be progress with existing staff development initiatives and plans for the future.

10. In considering the scope and presentation of annual reports please bear in mind that the audience for the annual report is not just those who use the services provided by the Unit or Trust but also the staff who work in them. The annual report is an important opportunity to get over to staff exactly how much is being achieved. I hope that you will utilise the opportunity to the fullest extent. Please also bear in mind the main audience for these reports will not necessarily understand NHS jargon; it will therefore be important to present information in a non-technical, easily-understood form and in a way that presents the NHS as a coherent whole rather than as rival purchasers and providers.

11. The annual report will also fulfill the requirement contained in the White Paper "Competing for Quality" to publish annually information on the outcome of existing market testing initiatives and plans for the future; and information on other ways efficiency is being improved.

12. Each Trust and directly managed unit should publish a single annual report covering all their constituent hospitals and other facilities. They may at their discretion publish further reports covering individual hospitals or other component of their service. Where the decision is to have individual reports for individual components of Trusts or units, I would want those reports to contain at least the minimum information in the attached Annex B relating to the performance of the Unit or Trust as a whole.

Involvement of the Management Executive

13. Please let me have a copy of the report just prior to publication. I and my colleagues will be interested to read it; and we may well want to offer some thoughts on good practice which can be considered for future annual reports. But we do not wish to see the reports in draft. However, if you think that the report is likely to be controversial it would be helpful to have advance warning so that we can ensure that Ministers are properly briefed in advance. The publication timetable is for you to decide.

Comparative Performance of Hospitals Etc

14. The Patient's Charter said that more data would be published about the comparative performance of individual hospitals and other Health services. I hpoe to write again in the near future about the detailed arrangements and definitions to be applied.

DON CRUICKSHANK

ANNEX A

CORE CONTENT FOR ALL HEALTH BOARD ANNUAL REPORTS

* performance against commitment to consult local people about health needs

* performance against health status targets in Charter

* performance against commitment to provide practical help toward healthier living

* volume of activity by specialty and by provider, broken down for inpatients, day cases and outpatients

* performance against inpatient/day case waiting time guarantees to residents -

  . for hip replacements
  . for knee replacements
  . for cataract operations
  . for geriatric assessment
  . for other locally selected treatments
  . 18 month longstop guarantee

* numbers and percentage of residents waiting

  . less than 3 months
  . 3-12 months
  . 12-18 months
  . more than 18 months

  by specialty. (For future years, percentage change from the previous year should also be included.)

* performance against outpatient waiting times targets in Charter; and against commitment to give explanation after 30 minutes

* expenditure by main care programme: trend and forecast

* numbers of complaints dealt with by Health boards as purchasers (broken down by category as in GEN(1992)27), performance against response times targets in Charter, and action taken

* performance against quality standards in contracts

* names, responsibilities and contact address/telephone number of Board members and senior staff

* total emoluments of senior staff (including Board members) shown in broad bandings with Board General Manager and Chairman separately identified. This should not identify the salaries etc paid to individuals except for the Chairman and General Manager. (amplified as far as board members are concerned by Annex 3 of MEL(1994)80)

* plans for improved Charter commitments for coming year.

* number of GP fundholders; percentage of population covered and global budget allocated to GP fundholders.

ANNEX B

CORE CONTENTS FOR ANNUAL REPORTS OF NHS TRUSTS AND DIRECTLY MANAGED UNITS

1. Activity

Actual performance on the following should be assessed against that specified in contracts with each major purchaser and with GP fundholders taken together:-

1.1 Volume of activity purchased broken down by specialty and by into in-patients, day patients and out-patients

1.2 Performance against out-patient targets

1.3 Waiting lists by specialty and percentage change over previous 12 months

1.4 Performance against general and specific waiting time commitments for in-patients and day patients

1.5 Waiting times by specialty with percentage change over 12 months for:

- numbers waiting less than 3 months
- numbers waiting between 3 and 12 months
- numbers waiting over 12 months
- numbers waiting over 18 months

1.6 Number and percentage of operations cancelled by specialty.

2. Quality

2.1 How patients, staff, GPs and others are involved in improving standards

2.2 Performance in handling complaints from patients dealt with by the Trust/Unit (including numbers, category, response time and action taken)

2.3 Results of User Surveys, SHAS Reports etc.
Significant planned developments to improve quality

2.4 Performance against contract specifications for each purchaser.

3. Finance and Efficiency

3.1 Balance sheet and a clear statement of the accounting policies on which it is based

3.2 Income and Expenditure Account analysed by functional cost, activity or specialty

3.3 Cash flow statement

3.4 Significant changes in contracts or assets and liabilities

3.5 Finance performance information, expressing comparisons for the Trust/DMU against national averages and/or averages of similar types in key areas of cost eg activity, expenditure on staff groups etc.

3.6 Total emoluments of senior staff (including clinical staff and Board members) shown in broad bandings with Chief Executive and Chairman separately identified. This should not identify the salaries etc paid to individuals except for the Chairman and Chief Executive. (amplified as far as board members are concerned by Annex 3 of MEL(1994)80)

3.7 Areas to be market tested in the current and forthcoming year

3.8 An account of the outcome of market testing for the year of the report

3.9 Other plans to improve efficiency of the Board and of its providers; and the results of previous initiatives

3.10 Progress with equal opportunities

DECLARATION OF INTERESTS AND REGISTER OF INTERESTS

1. This guidance is intended to help Health Boards and NHS Trusts to comply with the Codes' requirement for the declaration of board members' interests, and the maintenance of a register of interests.

2. The requirements contained in Regulations governing the declaration of chairmen and board directors' pecuniary or other interests in the course of conducting NHS business remain in force. Amendments to Regulations are under consideration to give statutory force to the aspects of the Codes dealing with declaration of interests.

Declaration of interests

3. The Codes require board members to declare interests which are relevant and material to the NHS board of which they are a member. All existing board members should declare such interests. Any board members appointed subsequently should do so on appointment.

4. Interests which should be regarded as "relevant and material" are:

a. directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

b. ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c. majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;

d. a position of authority in a charity or voluntary body in the field of health and social care;

e. any connection with a voluntary or other body contracting for NHS services.

If board directors have any doubt about the relevance of an interest, this should be discussed with the chairman.

5. At the time board members' interests are declared, they should be recorded in the board minutes. The minutes containing information about the interests of board members should be drawn to the attention of the Health Board's or Trust's internal and external auditors. Any changes should also be declared within 4 weeks of the change occurring, and recorded in board minutes.

6. Board members' directorships of companies likely or possibly seeking to do business with the NHS and other significant interests should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7. During the course of a board meeting, if a conflict of interest is established, the board member concerned should withdraw from the meeting, and play no part in the relevant discussion or decision. This goes further than the present Regulations and should be reflected in Standing Orders.

Register of interests

8. Health Boards and NHS Trusts should maintain a formal Register of members' interests. The Register should be made publicly available, on request, in the offices of the Board or Trust.

9. The Register should include details of all directorships and other relevant and material interests which have been declared by chairmen, executive and non-executive board directors, as defined in paragraph 4. These should be kept up to date by means of an annual review of the Register in which any changes to members' interests declared during the preceding 12 months should be incorporated.

10. Health Boards and NHS Trusts should take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

Any enquiries concerning this guidance should be directed to:

Rob Walker
Room 181
Directorate of Corporate Affairs
NHS Management Executive
St Andrew's House
Edinburgh
EH1 3DG

Tel: 031 244 3469

NHS Management Executive
August 1994

PUBLICATION IN ANNUAL REPORTS OF INFORMATION ABOUT THE REMUNERATION OF BOARD MEMBERS

Introduction

1. This guidance is intended to help Health Boards and NHS Trusts to comply with the requirement that they publish in the annual report information about the remuneration of chairmen, general managers/chief executives, executive and non-executive directors. It provides a definition of remuneration for this purpose and sets out the minimum requirements for presentation of information in annual reports.

Effective Date of Requirement to Publish

2. The requirement to publish remuneration information is effective from 1 April 1994. This guidance should therefore be put into effect for the 1993/94 financial year.

3. The requirements set out in this guidance are additional to those in the Scottish Accounting Manual for Annual Accounts of Scottish Health Service Boards and the NHS Trusts Manual For Accounts; and replace the relevant provisions of MEL(1993)30 regarding the content of Annual Reports.

Definition of Remuneration

4. For the purposes of publication in the annual report, remuneration should be defined as all payments made to or on behalf of the chairman, general manager/chief executive, executive or non-executive directors by the NHS body of whose board he or she is a member. Payments will include:

a. basic gross salary or fee
b. performance related pay
c. employer's share of pension contributions actually paid in the year
d. the monetary value of benefits in kind (taken from P11D), and
e. expenses allowances, where these are subject to income tax.

Presentation of Information in the Annual Report

5. The following information should be shown in the annual report:

a. separately for each position, the total remuneration of (a) the chairman, (b) the highest paid director and (c) the general manager/chief executive (where he or she is not the highest paid director). Each should be broken down for the relevant year into:

(i) the total of basic salary (or fee), any performance-related pay, geographical allowance etc; if paid only highest paid director.

(ii) employer's share of pension contributions actually paid; and

(iii) the total of expenses allowances where these are subject to tax (including any payments on recruitment or termination e.g. relocation or severance), and the monetary value of taxable benefits in kind (taken from P11D);

b. the levels of remuneration of all other executive and non-executive directors - presented as the number of directors within bands of remuneration. The bands should be graduated at £5000;

c. an aggregate total of all taxable benefits (including any payments on recruitment or termination e.g. relocation or severance) paid to all executive and non-executive directors.

Any enquiries concerning this guidance should be directed to:

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NHS Management Executive
August 1994

PATIENT'S CHARTER: ANNUAL REPORTS

MEL(1993)30 is reissued as part of the Corporate Governance package.

Its provisions relating to publication of the remuneration of board members are amplified by Annex 3 of this package.

Any enquiries relating to this guidance should be directed to:

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Tel: 031 244 2557

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