



# Using the Public Sector Scorecard in public health

Using the  
Public Sector  
Scorecard

Max Moullin

*Sheffield Hallam University, Sheffield, UK*

John Soady and John Skinner

*Sheffield Primary Care Trust, Sheffield, UK*

Charles Price

*European Commission Directorate-General for Health and Consumer  
Protection, Luxembourg*

John Cullen

*University of Sheffield, Sheffield, UK, and*

Christine Gilligan

*Sheffield Hallam University, Sheffield, UK*

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## Abstract

**Purpose** – This paper seeks to describe an application of the Public Sector Scorecard (PSS) to Sheffield's Stop Smoking Service.

**Design/methodology/approach** – The paper uses the PSS, an integrated service improvement and performance measurement framework for the public and voluntary sectors. The PSS shares the key advantages of the Balanced Scorecard in ensuring that performance measures reflect all aspects of an organisation's performance and have clear links to the organisation's strategy. In addition its structure and methodology, with more emphasis on service user involvement, working across organisational boundaries, process mapping, service improvement, and risk management, provide many additional benefits to organisations in the public and voluntary sectors. The study incorporated service user workshops with over 100 service users and a series of meetings with a reference group containing staff, service users and other key stakeholders.

**Findings** – The paper concludes that the PSS has many benefits both in improving a public health service and in aligning its strategy, processes and performance measures both with one another and with the requirements and expectations of service users and other key stakeholders.

**Originality/value** – The paper will be of use to anyone interested in integrating strategy, service improvement, and performance measurement whether in public health or in other public or voluntary organisations.

**Keywords** Public health, Balanced scorecard, Performance measures

**Paper type** Research paper



## Introduction

This paper describes an application of the Public Sector Scorecard (Moullin, 2002) to Sheffield NHS Stop Smoking Service. The Public Sector Scorecard (PSS) is an integrated service improvement and performance measurement framework for the public and voluntary sectors, based on the Balanced Scorecard. Prior to the study, it had been used in a variety of settings including a UK National Health Service (NHS)

modernisation taskforce (Moullin, 2004b) and a cross-governmental taskforce on ethnic minority employment, but had not been used in public health.

Sheffield NHS Stop Smoking Service provides free citywide support for people who wish to stop smoking. Its main focus is on providing stop smoking programmes run by trained health professionals. This is based on research evidence (Raw *et al.*, 1999), which demonstrate that people are more successful in stopping smoking if they quit with specialist help and support. While these programmes had proved very successful in getting people to quit, the Stop Smoking Service wanted to ensure that more people benefited from the service, to improve the service for users, to work more closely with other NHS staff and contracted-out providers of the stop smoking service, and to develop a better set of performance measures. In order to address these issues – and at the same time provide a forum for assessing the benefits of applying the PSS in public health – a joint project was set up between Sheffield West Primary Care Trust, which runs the service on behalf of the city, and Sheffield Hallam University, partially funded by the Sheffield Health and Social Research Consortium.

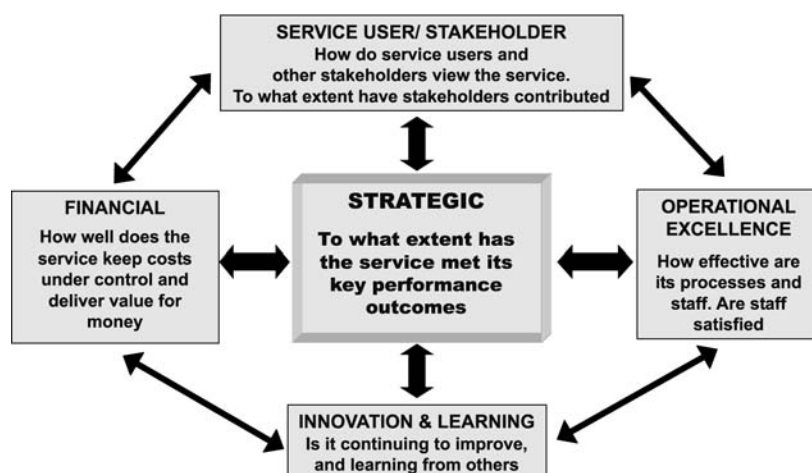
### **The Public Sector Scorecard**

The Public Sector Scorecard is an integrated service improvement and performance measurement framework designed for the public and voluntary sectors (Moullin, 2002). It aims to improve the service and to ensure that an organisation's strategy, processes and performance measures are all aligned with each other and reflect the needs and expectations of service users.

The PSS adapts the Balanced Scorecard (Kaplan and Norton, 2001) to the culture and values of public and voluntary sector organisations. While the balanced scorecard has been used successfully in many public sector organisations (Wisniewski and Dickson, 2001; Martin *et al.*, 2002; Radnor and Lovell, 2003; Niven, 2003), there are certain difficulties in its use for such organisations. In particular the architecture, language and methodology of the balanced scorecard – with the primary emphasis on financial results – very much reflect its private sector origins. Indeed Gambles (1999) says that "... in its usual form, it (the scorecard) is clearly not suitable for the vast majority of the public sector".

The architecture of the PSS is illustrated in Figure 1. The main changes compared with the balanced scorecard are the addition of a "strategic perspective" focussing on the organisation's progress against its main objectives and key performance targets, and the explicit mention of service users and stakeholders (Moullin, 2004b). The PSS also has a number of differences in methodology, with more emphasis on service user involvement, working across organisational boundaries, process mapping, service improvement, and risk management – all of which are highly relevant to public sector organisations and their clients. It also takes into account the eight essentials of performance measurement (Moullin, 2004a):

- (1) Use a balanced set of measures.
- (2) Make sure you measure what matters to service users and other stakeholders.
- (3) Involve staff in determining the measures.
- (4) Include both perception measures and performance indicators.
- (5) Use a combination of outcome and process measures.
- (6) Take account of the cost of measuring performance.



**Figure 1.**  
The Public Sector  
Scorecard

- (7) Have clear systems for translating feedback from measures into a strategy for action.
- (8) Measurement systems need to be focussed on continuous improvement, not a blame culture.

The PSS extends the concept of the “golden thread” of performance management (Audit Commission, 2001) which is useful in evaluating public sector organisations. The idea is that “golden threads are present if objectives, targets and performance indicators are consistent throughout the different levels from Central Government to single organisations” (Micheli *et al.*, 2005). However while a golden thread is an essential part of good performance management, it does not guarantee it. For example the UK Department of Health, the National Health Service, a Strategic Health Authority, and a hospital maternity unit might have an effective golden thread with all performance measures aligned. However if these measures ignore the wishes of women or their partners regarding the facilities provided, staff attitudes, or the choices available to them, then it is not an effective system. The PSS extends the golden thread concept to ensure that measures are aligned not only between the different levels, but also with the requirements and expectations of service users (Moullin, 2006).

### How the Public Sector Scorecard works

Like the Balanced Scorecard, the Public Sector Scorecard is a flexible framework, adaptable to the needs of the organisation. It has a high degree of involvement from service users and other stakeholders and typically it will involve the ten stages given in the following list:

- (1) *Think SERVICE USERS.* Work closely with service users to identify their requirements and expectations of what would constitute good service. A user workshop is recommended.
- (2) *Think PERFORMANCE MEASURES.* Identify appropriate performance measures for each objective within the five perspectives of the strategy map.

The outputs of stage 3 will also be useful here. Make it clear to participants that this is just an initial attempt at this, which will be refined later.

- (3) *Think STAKEHOLDERS*. Get feedback from other stakeholders, including: government, funding bodies, carers, and staff on their requirements and views of the service.
- (4) *Think PROCESS*. Identify the main processes involved in delivering the service and look at them in turn. Process mapping may be useful here. For each process, identify the main objectives and possible performance measures, consider how the processes can be improved to deliver improved performance. Try to streamline these processes to eliminate activities that do not add value.
- (5) *Think SUCCESS*. Form a reference group (or steering group) including senior managers, staff, service users and other stakeholders. Identify what a successful service or organisation would look like. This could be depicted in a “success map” (Neely *et al.*, 2002; Moullin, 2004b).
- (6) *Think CULTURE and PEOPLE*. While looking at processes, discuss how the culture of the organisation, its staff and partners affect the process and how this too can be improved. Staff-only workshops would also be useful to listen to the main issues affecting staff and how the organisation could take into account their views to improve leadership and the service to users and other key stakeholders. Their views on how existing performance measures have affected their behaviour would also be of use here.
- (7) *Think STRATEGY*. Re-examine the organisation’s strategy, vision, values, mission etc, ensuring that they are focussed on the needs of service users and other key stakeholders. The extent of this stage will depend on how recently and how comprehensively the organisation has developed these aspects. Translate the strategy into a “strategy map”, showing the organisation’s main aims and objectives under each of the five perspectives of the PSS. While undertaking this analysis, the five headings of the scorecard will serve as a prompt to identify further aspects that may have not been considered previously.
- (8) *Re-think STRATEGY and PROCESS*. The previous three stages will have generated debate about how to achieve the organisation’s objectives and there will be further refinement of the strategy map, and the processes required to achieve the strategy.
- (9) *Think RISK*. Identify, with the reference group and others as necessary, the main risks to the service under each of the five perspectives and how they might be managed. Incorporate this analysis – and in particular the top-level risks and the main processes used to manage them – into the strategy map.
- (10) *Re-think PERFORMANCE MEASURES*. The changes in the objectives given in the strategy map will need to be reflected in the measures chosen. This stage will also involve considering the practicalities in obtaining the performance measures, including their likely reliability, how they will be seen by staff, and users, and whether they add value. You may need to be fairly brutal in reducing the number of measures.

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For many organisations, it will be highly beneficial to “cascade” the scorecard to individual departments. This will involve each department developing its own version of the PSS setting out its contribution to the overall targets for the organisation. It will also involve dialogue between individual departments and the team developing the overall scorecard to make sure that the strategies of the organisation reflect the realities of individual departments and of service users.

The PSS can also be used across organisational boundaries. Within the NHS for example it can be used for a care pathway encompassing all services a patient may encounter on their “patient journey” which frequently crosses the boundaries between primary and secondary care and may involve people from other agencies including social care. Another example is in preventing substance abuse, where it would be preferable to use the scorecard initially for a citywide group looking at reducing dependence on drugs and cascade the scorecard down to individual agencies. In this way, the use of the scorecard can involve all organisations working – or at least talking – together. It also has specially designed interactive software SYSCORE (Costa, 2005), developed by InfoQuality.

The PSS also has interactive software developed by Infoquality (Costa, 2005), which depicts visually the relationship between the strategy map and performance measures. It also shows progress against targets, highlighting areas that are above and below target.

### **Using the PSS for the Sheffield NHS Stop Smoking Service**

The first stage of this action research project involved inviting all clients who had made any form of contact with the Sheffield NHS Stop Smoking Service in the preceding 18 months to one of three two-hour workshops. Altogether over 100 current or previous service users attended, with as would be expected greater representation from people who had quit smoking compared with those that did not. Comments from users were obtained on their initial contact with the service, the support programmes, and follow-up support after the programmes had finished. Users were then asked, both individually and in groups, to put suggestions for improvements on “post-its” which were placed on flip charts. The final stage was to give each participant a number of “sticky stars” to vote for the suggestions they thought would be most useful. This together with the richness of the discussion provided good background for the rest of the study.

A reference group was then set up to steer the project. A key consideration in deciding the membership of this group was to ensure that the project not only included staff and service users, but also reflected the need to work across organisational and professional boundaries. The group therefore included managers and staff of the service, eight service users, midwives, a dentist, a hospital consultant, pharmacists, and representatives of the Strategic Health Authority and Primary Care Trusts. The first meeting of the reference group included two group activities, one focussing on strategy inviting groups to complete the sentence “A successful stop smoking service would ...” and the other identifying relevant stakeholders and their likely expectations of the service. With regard to the latter, stakeholders were analysed in three ways. First, service users with different needs were analysed. These included pregnant women, teenagers, people from different cultural and religious backgrounds, people with mental health needs, shift workers, and people in socially disadvantaged

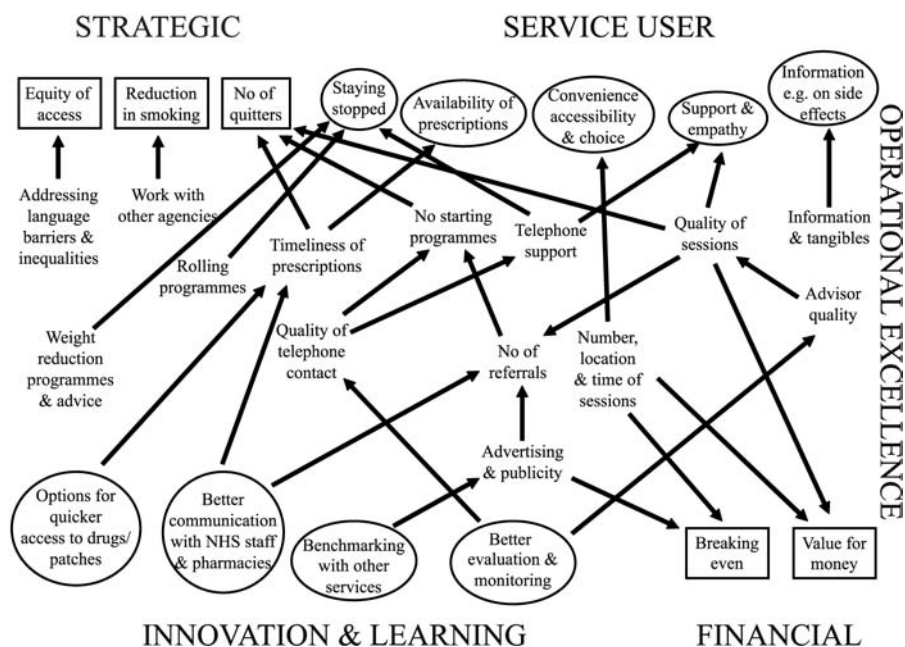
neighbourhoods. Second, service user needs were identified at different stages, for example on first contacting the service, when they first go to sessions, ex-smokers, those who achieve their quit date but later relapse, and those who do not manage to set a quit date. Finally, other groups with an interest in the service were identified. These included relatives and carers, referring GPs, dentists and consultants, other NHS professionals, Surestart, Smoking Advisors, the NHS, and Department of Health.

While this reference group meeting was seen as very successful, some NHS staff said that they were reluctant to share any frustrations with the service when users, who are their customers, were present. It was felt useful therefore to have a couple of NHS staff-only workshops before the next Reference Group Meeting. The first meeting of this Stakeholder Group focussed on the main desired outcomes of the service, the processes that need to be in place to meet these outcomes, how these processes could be improved, and the main issues affecting staff. The second meeting focussed on building a strategy map. This involved discussing the priorities for improving the service to deliver the desired outcomes. In addition this meeting identified the various risks under each of the five PSS perspectives, together with some strategies for addressing them. These NHS Stakeholder Groups were useful in developing better relationships between Stop Smoking Service staff and other professionals. While in retrospect, little that was said at these meetings would have been problematical with users present, they did free members to say what was on their mind without worrying about being negative or inappropriate. On reflection, however, one such meeting may have sufficed with users invited to the second of these meetings.

The draft strategy map and risk assessment were then shared with users at the second reference group meeting and several useful additions were incorporated. This meeting also included two group activities: one addressing the question “what information they would need to assess how well the stop smoking service is doing”, and the other on “ten questions to go in a user questionnaire”. While the theory of the PSS and the balanced scorecard is that measures should be derived direct from the strategy map, it was decided to calibrate the process by looking at performance measures in isolation. Differences between these measures and those that would be derived from the strategy map were highlighted by the facilitator after the meeting so that they – and the strategy map – could be refined accordingly at the next reference group meeting.

The final version of the strategy map is shown in Figure 2. This depicts the service’s main objectives under the five perspectives of the PSS. The main strategic objectives were increasing the number of people quitting smoking, reducing smoking prevalence in Sheffield, and ensuring equity of access in terms of gender, deprivation, age, etc. With respect to service users, it wished to be seen as offering a choice of convenient accessible programmes offering support, empathy and information, while also ensuring that prescriptions are available when required and that support for quitters is ongoing once the programmes are finished. The map also shows the main financial objectives – to offer value for money and to break even – together with the main processes needed to achieve the various outcomes and those areas that the service should focus on under the innovation and learning perspective.

As an illustration of how the strategy map works, users said that one of their problems was obtaining prescriptions for nicotine patches or drugs when they needed them. The timeliness of getting prescriptions, a key objective in the operational



**Figure 2.**  
Strategy map for Sheffield  
NHS Stop Smoking  
Service

excellence perspective, has a link not only to this particular service user requirement but also to the number of people quitting smoking. To make real progress here, the reference group identified that they needed to come up with quite radical options for speedier access, along with better communication with NHS staff and pharmacies – both of which are in the innovation and learning perspective.

Following the discussion at the reference group meetings, the performance measures were finalised with the managers and staff of the service to take on board the cost and difficulty of getting reliable data. For example there was considerable discussion on how to measure user satisfaction with ongoing support for people who have stopped smoking at the time the programmes finish. Some of this support involves diverting users to national helplines so it is difficult to find this information directly. Previous surveys have had poor response rates and tend to be biased towards people who have continued to be non-smokers, rather than those who subsequently smoke again.

The principal measures chosen under each perspective are shown in Figure 3. Further detail was provided (though not shown here) showing targets for the various measures where appropriate, how these measures relate to the objectives in the strategy map, and the main initiatives the service intends to use to improve performance with regard to the relevant measure.

### Benefits to the Stop Smoking Service

From the standpoint of the NHS stop smoking service the public sector scorecard approach was of particular benefit in three key areas. First, the minimum dataset specified by the Department of Health for local stop smoking services is designed to

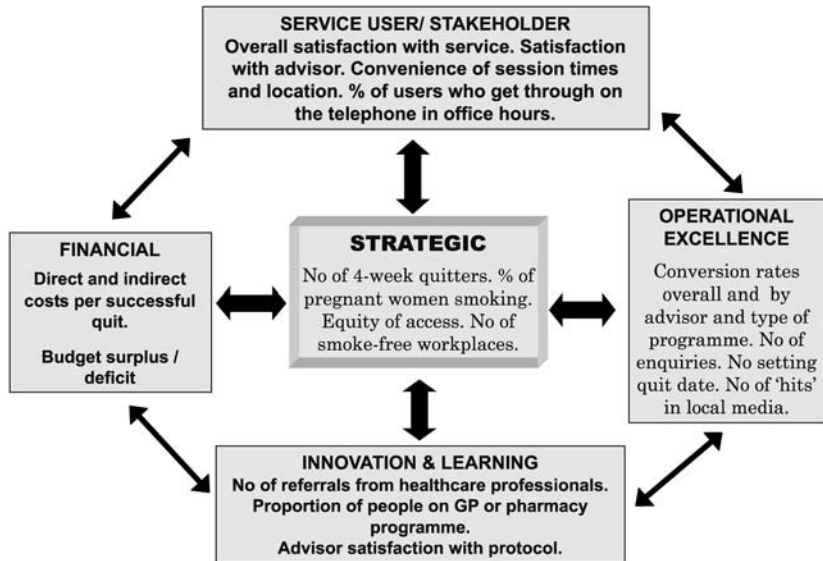


Figure 3.  
Summary of proposed  
performance measures

meet the requirements of monitoring nationally set targets and focuses purely on high-level outputs. This study enabled a broad and balanced portfolio of metrics to be identified relating to key parameters that impact directly on the effectiveness and experience of delivery. Second, the emphasis on service user input is consistent with the service development ethos of the NHS. The result is that the metrics portfolio reflects the user experience of provision and the accessibility of the various components in the make-up of the service package, for example medication. Finally, the strategy map captures a useful strategic overview of the key interrelationships, and demonstrates how the measurement and monitoring opportunities relate to the whole system view.

It is difficult to isolate improvements made as a result of the project from other activities aimed at improving the service. However, innovations during the period of the study included a better schedule of support programmes at stated times and convenient locations, together with better processes and links with GPs and pharmacies to reduce delays in users getting appropriate medication. During the period of the study, the annual number of users stopping smoking more than doubled, and the service also achieved the main government target for Stop Smoking Services, i.e. the number of people who had quit smoking for four weeks through the Stop Smoking Service (performance against plan).

### Conclusions

The Public Sector Scorecard has proved to be an effective framework for ensuring that strategy, processes and performance measures of Sheffield NHS Stop Smoking Service are aligned, not only with each other but with the requirements and expectations of service users and other key stakeholders. The collaborative working between managers and staff of the service, service users and other key stakeholders, together with an external facilitator, was another positive aspect. It also played a part in

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identifying a number of service improvements and in the achievement of certain targets. A key challenge for the future is sustaining these benefits in the context of organisational change.

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### Corresponding author

Max Moullin can be contacted at: [m.moullin@shu.ac.uk](mailto:m.moullin@shu.ac.uk)