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King Edward's Hospital Fund for London

KING'S FUND CENTRE

PUTTING MEANING INTO MONITORING

A Report of a Conference held at the King's Fund Centre

on 7 November 1978

King's Fund Centre
126 Albert Street
London NW1 7NF

March 1979

PUTTING MEANING INTO MONITORING

Report of a Conference held on 7 November 1978

A variety of Oxford Dictionary definitions of the word 'Monitor', ranging from a type of battleship to a lizard, were put forward by speakers at this conference at the King's Fund Centre.
The conference Chairman, Cliff Graham, Assistant Secretary, Regional/Central Planning Division, DHSS, pointed out that this was one of the few aspects of the reorganised health service which was not well defined and had not been the subject of a departmental circular. The conference was to be welcomed as a contribution to that process of definition.

The use of the term in the health service or management context was usually taken to imply the development and establishment of certain standards of performance in a particular field, and a system to examine whether or not those standards had been met. The identification of adequate and realistic criteria against which to measure performance in health care was extremely difficult but attempts were being made in a number of areas.
The conference focused upon four projects which involved the monitoring of different aspects of the health care system.

1. The Wessex Regional Monitoring Exercise.

Mr Tony Pace, operational research officer to the Wessex Regional Health Authority, said that the Authority had decided, soon after reorganisation, that monitoring would be an important aspect of its work. A project had been set up to define monitoring and to establish a policy for its implementation. The project team had begun by building up a model of how the service operated, beginning with the primary input of money from the DHSS through to an output, or outcome, described as the 'state of health' (see Appendix 1).
This model distinguished the activities undertaken at Region and Area and tactical, operational and medical management.
The team had then gone on to define the sets of subjects which could be monitored, namely total resources (finance, manpower, buildings, stock, equipment), care groups, medical services (theatres, pathology, pharmacy etc.) and industrial services (CSSD, laundry, catering etc).
These subjects are fully listed in Appendix 2. The team's general

definition and objective in monitoring was agreed as:

> "To see that agreed standards are being maintained and that agreed plans are being carried out; and further to learn more about the behaviour and performance of the service and to use the knowledge obtained to amend, create or revise standards and objectives."

The responsibility for monitoring was seen as a compliment to accountability upwards in the health service. One officer was involved in monitoring the activities of another only if both agreed. The Wessex Region had distinguished between the process of monitoring and the process of planning in the achievement of its objectives, both in terms of time scale and in the documentation involved. Operational planning was the usual annual cycle of preparation of guidelines and plans covering all aspects of a District/Area's activities while monitoring was a less frequent excercise looking at specific and limited areas of activity in a measured and detailed way (see Appendix 3). Monitoring involved the setting of objectives or standards to be achieved while planning was concerned with the priorities for their achievement.

In Wessex, the actual process of monitoring involved the design of a programme defining methods of comparison (standards) for the activity being monitored, which was sent to the District for interpretation and comment. This was then passed back to the Area which added its own commentary; not suppressing the District interpretation but highlighting any areas of disagreement if they existed, and so back to Region. The discussion involved in preparation of the digest between the monitoring team and those being monitored was considered to be by far the most important part of the monitoring exercise (see Appendices 4 and 5 for definition of terms and details of the exercise). The application of the monitoring process was then described by Dr Robert Rowe, Specialist in Community Medicine (Information and Planning) who said that the system was bound to be invasive by alerting authorities to deviations from acceptable standards. It could therefore create antagonism, but the information produced could be extremely useful to those involved. A generally applicable system had been favoured in Wessex because it ensured that everyone had the same understanding of what was meant by monitoring, and because it provided a chanel of information which was complementary to the planning process in the establishment of priorities and the effecting of change.

The monitoring process had proved to be particularly valuable in the clinical field, where it had to be clearly distinguished from medical audit and based on epidemiological techniques and standard populations. Measures used in Wessex included the cancer register as an outcome measure for oncology, and the birth and still-birth rates for obstetrics. The provision of information made it possible to examine and compare other service outcomes and to create a real action learning situation for those involved. Many monitoring programmes are in process of development in Wessex. Amongst these, health-care monitoring now includes the regional medical specialities, dentistry, oncology, psychiatry, mental handicap and obstetrics and gynaecology. Teams were looking further and further into outcomes in participation with clinicians in the Districts.

2. Monitoring Standards of Clinical Performance

Professor Ian McColl, Prof. of Surgery, Guy's Hospital Medical School, introduced a most amusing and informative selection of slides illustrating the development of medical interest in clinical outcomes and the particular procedures currently used in Guys Hospital to measure standards of clinical performance.

The history dated back to Miss Nightingale's recommendation that there should be a register of operations and results, through the work of Graves and Godman in the early twentieth century and the establishment of the enquiry into maternal mortality, to the present day. During the early years of scientific medicine there had been considerable interest in outcome. More recently interest in process had tended to dominate but outcome studies were again beginning to become a focus of interest.

At Guys, clinical monitoring included the weekly multidisciplinary death and complications meeting, the use of problem orientated medical records (which are audited for completeness, although not clinical performance); surveys and controlled clinical trials which could bring dramatic changes in patterns of working even in Firms not directly involved in the survey or trial; consumer research using the King's Fund Patient Satisfaction Survey; unit review meetings which were held weekly in private to examine any unsatisfactory aspects of clinical work and to reach a consensus within the Firm on matters such as surgical techniques, conduct of ward rounds and the management of problem patients. Finally, there was the hospital review of resources committee which

reviewed the future of all patients who had been in an acute bed for more than 3 - 4 weeks.

Professor McColl said that while he was confident that the great majority of patients received excellent care, it was necessary to closely monitor the thoroughness of routine performance as well as the management of the unusual case. The measurement of the quality of routine care involved a systematic audit of:

the structure	-	the plant and organisation of the institution
the process	-	the activity undertaken by providers within the institution
the patient's contribution	-	factors such as obesity, smoking habits, etc.

Guys had obtained a King's Fund grant to enable it to look at the process stage by changing the system of medical notes and measuring whether or not this improved the quality of care. Trained clerks had recorded patient variables drawn from HAA, OPCS, case notes etc., on data-scan sheets in respect of patients admitted for treatment of peptic ulcers, removal of gallstones and repair of hernia. The management of patients before and after the introduction of new records had been recorded at Guys, and on the same dates at two other London teaching hospitals for control purposes. The study had found that not only had the management of patients improved over the period (measured in terms, for example, of the number of routine tests and procedures carried out on admission) but also that a large percentage of the variance related to the Firm a patient was admitted under.
A detailed and hand written analysis of his own performance in comparison to the overall performance of his colleagues with comments, was fed back to each surgeon. These were single copies and no surgeon was able to know what comments had been made to others.
Measures of outcome were particularly difficult. This involved areas such as the acceptable level of complications and measurement of how the surgeon dealt with them. Medical audit implied an educative examination within the profession of both process and outcome which was flexible and responsive to local needs, non-bureaucratic, non-invasive and non-disruptive.

Discussion

Discussion immediately highlighted the contrast between the Wessex approach which involved regional monitoring teams and the Guys approach which involved the consultants monitoring discreetly. A surgeon from Kent questioned how it was possible to find the time and the support

to undertake monitoring of the Guys type in a very hard pressed district hospital without King's Fund support. Professor McColl was clear that if a hospital was too busy to hold a weekly deaths and complication meeting, it was too busy and needed additional consultant posts. Resource allocation procedures included a redistribution of medical manpower, although there were clearly problems in the short term. The Kent District, for example, was unable to take up additional surgical sessions until it had more theatre time. Dr Rowe pointed out that Regional monitoring helped to demonstrate how hard pressed some people were and would assist the movement of resources.

Another questioner pointed out that the Wessex model did not take account of environmental health services provided by local authorities and Family Practitioner services. Mr Pace agreed that this was inevitable because these authorities had no interface with a Regional Health Authority. It was up to the Area to take account of these services in their community. It was not possible for the model to go beyond the services controlled by a Regional Authority, and it was recognised that many other services and factors such as housing, social services and education influenced outcomes. The NHS was by no means the most important factor in the state of the nation's health but it was not realistic to try and measure more than the service actually undertook. Asked about the place of preventive action in the measurement of health services, Professor McColl recognised the difficulties but suggested that the health service should be consistent in the message it presented and try to get it across to the largest audience possible; whether this was ensuring that patients in hospital were not allowed to smoke and were given a moderate diet including only wholemeal bread, or introducing discussion of the value of bran in the diet or rubella vaccination in programmes such as 'The Archers' and 'Crossroads'.

The Wessex team were then asked if they had attempted to monitor the industrial relations climate and standards. Dr Rowe said that there were literally thousands of areas of activity which could be looked at and they had started with ten. This did not include industrial relations. Monitoring was being undertaken in a very informal, participative and local way and it was strongly felt that to approach it in any other way could be a barrier to desirable outcomes.

The session closed with a number of questions on available information and its value in the measurement of quality of care. One speaker

suggested that a distinction should be made between deaths and discharges in statistical returns. The former was clearly an undesirable outcome from the patient's point of view and the latter needed to be looked at more closely to indicate the quality of life after discharge. There were outcome measures such as the Cancer Register, the HAA analysis of readmissions within a Region and general practice certification, but this data was not linked and examined in any useful way at the present time. Professor McColl was adamant on the need for flexibility and a fair and uniform data base. Both of these were compromised by RAWP. Clinicians needed to be able to refer patients to colleagues in other Districts for specialist treatment and the whole concept of catchment population ran counter to this. RAWP might be useful at Regional level but it could be penal at Area and District level. A new and more sensitive mechanism for allocation was needed to overcome this.

3. Nursing Management Audit

The place of monitoring in nursing management was described by Miss Juliet Moore, District Nursing Officer, South District, Kensington, Chelsea and Westminster AHA (T). Miss Moore had been involved with other nurses in her previous post in Doncaster in developing the Doncaster Series of Audits for the nursing service.

Miss Moore said that, although much had been written about monitoring and accountability little serious consideration had been given to the subject by the individual professions actually working in the health service. When accountability in nursing was discussed in any depth all clarity of concept diminished. Interpretation of the term caused difficulty and gave rise to three questions: who is accountable, to whom and for what acts?

What makes all these questions particularly difficult to answer are the conflicts of accountability involved. For example, it is possible that, in certain instances, accountability to one's patient may conflict with accountability to one's employer or to one's profession. From an idealistic point of view, most nurses would say that when such conflicts arise, the patient should be given first consideration, but such a stance may not always be practical or desirable.

Miss Moore said that some progress has been made in nursing and developments such as nursing audit and the nursing process showed a willingness by nurses to define and examine standards of practice and the quality of care given to patients.

Both in Britain and North America there has been interest in evaluating nursing performance. Checklists, interviews and patient opinion

surveys have all been developed and used. The objective of these is the provision of systems which will allow senior nursing staff to monitor the quality of care being given to patients. It was against this background that nursing audit was developed. In the United States a prominent exponent of nursing audit is Maria Phaneuf, and in Britain the initiative and development of nursing audit has come from Jan Smith (who recently retired from her post of Area Nursing Officer with Doncaster Area Health Authority) and the other three members of the Doncaster Management Audit Panel.

Management Audit can be defined as 'a methodical review over the whole range of nursing activity within a health district'. When one thinks about the total nursing service in a health district one is immediately aware of the multiplicity of activities which range from direct patient care in each specialty to the overall management of the nursing service. In order to ensure the accomplishment of all these activities, it is necessary first to clearly define the duties and responsibilities for which each nurse manager will be held accountable, and define standards of good management and nursing care practice.

The authors of the nursing audit series used job descriptions to form the basis of the audits for each grade of staff, and added defined criteria to establish an acceptable and agreed standard of care and good management practice. The foundation of each audit is a check-list of key questions which are posed in a way which demands a measured response - How much ? When ? How often ?. Therefore, it is possible to evaluate or gauge the effectiveness of the nurse as a manager, and her standards of nursing practice.

The Doncaster audits examined twelve areas of nursing management and practice, and these include such functions as :

Management structure and practice
Professional practice
Teaching responsibilities
Supporting services
Personnel management
Voluntary services
Public Relations

An audit was written for each grade of staff in the service divisions from state enrolled upward. One of the major distinguishing features of the Doncaster audit is that it is completed by the nurse herself, and when completed the nurse discusses it in detail with her superior

at audit interview.
This method of audit, enabled every level of nurse to influence the total picture. A senior nurse manager, is then in a position to bring this wide knowledge of service needs to the District Management Team so that in discussions on allocation of resources, the team is aware of the varying degrees of priority for care.

Within the audits of the Education Division, a standardised practice emerges ensuring that the highly individualistic people in Teaching Divisions are working to a similar pattern thus ensuring that the learner is less confused! Greater inter-communication has resulted because joint discussion of educational programmes, allocation of learners, clinical teaching and assessment are written into the documents.

In the audit documents, comments are invited on the various services directly and indirectly affecting the provision of care.
Linen supplies are always ready targets for criticism, but, from a series of audits a pattern can emerge showing that a deficiency in the linen service is in reality a failure in communication.
In implementing the audit system it is essential to have full discussion with other disciplines, so that the aims of audit are clearly understood and are not seen as a threat.

When completing an audit, the nurse has the opportunity to provide written comments on problem areas and to identify organisational and personal objectives. When the audit interview takes place, the nurse conducting the interview has had time to read the document, and is then in a position to discuss with the individual concerned the feasibility of solving the problems stated and a programme for achieving the objectives. It is thus possible to summarise all the problems arising in each Unit area and division, and to have information about what the staff feel the objectives of the organisation should be.

This feed-back of information is invaluable and ensures that the needs and thoughts of staff at all grades in the nursing profession are fed into the planning system. One of the major criticisms of the present nursing structure is that the needs of the bedside nurse are not considered by the so-called remote and uninvolved nurse managers. Delivery of care is the ultimate responsibility of all nurses no matter what grade they may be. Consultative processes are cumbersome and the nurse totally committed to bedside care can be disinclined to participate in meetings. Audit provides an opportunity for individual

participation in maintaining high standards of patient care and good morale amongst nursing staff. It is vital to accept that information is two-way in this exercise, and if such a system is not established then when the audits are completed for a second time, staff will be disillusioned.

The main objectives of nursing audit are to provide on-going self-monitoring of performance with a view to constant improvement in the standard of services to patients. An organisation should never remain static. It should sustain continuing growth and the value of audit is the motivation of the individual to this end.

Before the audit system was introduced a definitive measure of standards within the nursing organisation did not exist. The standards set within the audit were agreed within the known constraints of the organisation and applied throughout the health district.

In an ideal world all disciplines should engage in the audit process, and perhaps, in view of recommendations of the National Development Group for the Mentally Handicapped who advocate a decentralised structure and more autonomy for staff at every level, the development of a multi-disciplinary audit system should be considered.

However, those nurses who have introduced the Doncaster system of nursing audits, can say that it has proved to be of enormous value to the organisation as a whole, and has been well worth the effort involved.

In reply to questions, Miss Moore said that the original team had met weekly for three years to produce the full range of audit documents at Doncaster. This was followed by an intensive training programme before they were introduced, but staff accepted that it was an attempt to improve the organisation and wanted to know how they were getting on. The system could not over come problems of allocation of scarce resources but it did help managers to make the best use of the resources they had. Often the resource constraints did inhibit action on the problems identified by audit but management should not underestimate the ability of staff to understand the constraints if a proper explanation was given. Simply drawing attention to a problem and getting it discussed in the right place, could lead to improvement. The very audit process established agreed standards of care, staff ratios, ward practices and workload and everyone including the District Management Team understood this

baseline and what nursing management meant when they said that staffing or standards of care were falling below these agreed levels.

4. Planning Agreements with Clinical Teams

The final speaker, Mr I. Wickings, District Administrator, Brent Health District, distinguished between three types of monitoring - managerial or monitoring of one's own staff, self monitoring and external monitoring. There was no managerial relationship with most senior medical staff in the health service and it was therefore vital to provide the information to enable doctors to make informal and rational choices about their use of resources. The cost of the health service had trebled in real terms since 1951 while the number of deaths and discharges in relation to total population had doubled. There had been a hugh national increase in pathology and X-ray requests but there was no way of knowing whether these developments represented the best use of available resources. This raised the question whether, if doctors and nurses in ward teams had budgets, they would look at their expenditure more carefully and critically.

The DHSS had originally funded a project at the Westminster Hospital in which general wards had been matched into pairs and the staff in half the wards established as clinically accountable teams (CATS). Thus multidisciplinary teams involving consultants, the ward sister and, to a lesser extent, an administrator had been given a budget and defined accountability for part of the clinical service. The teams had met regularly and received detailed information on their expenditure and budget situation.

The budgets had three characteristics; they were unanimously agreed, ultimately open ended and publicly reported. They were described as 'Felt Fair Budgets'. They covered the use of resources such as CSSD, X-ray, pathology and pharmacy. One of the major costs of the project had been the facility to identify the consultant making such requests. The budget process had been accompanied by the use of a patient satisfaction survey and ward results compared to those in the hospital as a whole. The project at the Westminster Hospital had resulted in a levelling off in the pattern of annual growth in real terms, which had been running at between 5-6% per annum, and which continued at that rate nationally during the year. Small savings were made which were redeployed by teams; for example there was a reduction in requests for X-rays on the ward using mobile machines and in routine requests for X-ray in the coronary care and Intensive Therapy units. Money was put into the appointment of ward clerks and increased toilet accommodation on some wards - a point highlighted by the patient satisfaction surveys.

There had also been a two-day reduction in the average length of stay. Many of the improvements were apparent in the control group as well as within the designated(CAT); presumably because of the 'Hawthorne effect' and the greater awareness of the use of resources generated among staff in the hospital as a whole.

Mr Wickings went on to say that he was now in the process of introducing a similar system in the Brent Health District involving PACTs - Planning Agreements with Clinical Teams. These covered planned resource use, planned workload and planned developments, but, as at the Westminster, would be based on Felt Fair, open ended budgets. The Brent project was supported by a DHSS grant and had started with an increase in the provision of detailed information to consultants. Graphs had been used to present vacant bed days in conjunction with in-patient waiting list totals, death and discharges length of stay and the reattendance rate at outpatient clinics. The information was confidential to each consultant and no attempt was made to put any interpretation on it. Financial information related to total cost, cost per case and the cost of individual use of resources such as X-ray, pathology, physiotherapy and theatres.

A distinction was made between fixed costs which were non clinical costs and fixed costs in clinical areas that applied before a single patient was treated. There was very little concern about administrative interest in these fixed costs but the variable costs which were within the control of the doctor were another matter and examination of these might be interpreted as a threat to clinical freedom. This was being tackled by looking at the range of total cost per case for a given speciality or procedure and agreeing a reasonable high and low figure within which the team would operate. Management would only want to take resource useage up with the team if it went outside these agreed limits. A budget matrix presentation would be used to present information on total and unit costs in relation to agreements to the medical divisions and District Medical Committee. The management team would be open to negotiate change in the balance of service, reductions in cost and changes in the balance between fixed, hotel and treatment costs or hospital, community and FPC costs where this was possible.

Brent was at present at the provision of information stage and about to write round to consultants to ask what changes they envisage in treatment patterns and resources use, if any, and for proposals for dealing with problems such as waiting lists. The provision of information was permitting doctors to become informed political

negotiators and already had led to an improvement in bed occupancy and reduced length of stay and waiting lists. This appeared to be a device which allowed some external monitoring of the resource use of clinicians and which brought the District Management Team nearer to being able to ask questions such as "is the surgical service doing the job we want it to do?"

Discussion

The final discussion opened with a series of questions to Mr Wickings - Could the system apply to family practitioner and social services? How could comparisons be made between different firms who said they did different types of work? What was the role of planning teams? Did PACTs cover all therapy services, medical equipment etc?
Mr Wickings said that, currently, FPC involvement was limited. There was little information about what G.P.s actually did except those things covered by payment for item of service. Hospital Activity Analysis provided some information and the comparisons between work undertaken by firms but basically the system encouraged Divisions to make value judgements about the work being done and members' individual need for resources. PACTs encouraged wide debate about the use of resources and brought in G.P.s through the DMC and DMT. There were some indicators of G.P. use of resources such as comparative referral rates to outpatient clinics. PACTs were a tool for planning teams, but while at the Westminster all requests had been priced and teams charged for services used (an approach that had tended to turn the service departments into entrepreneurs), at Brent there would be functional and clinical budget holders and clinical budgets would be built up from the share of each functional budget they planned to use. The system was currently costing approximately £25,000 per annum but much of this was the clerical cost of recording names to identify all requests back to the consultant initiating them. This was covered by the project grant but the introduction of such a system in the other Districts would almost inevitably be in conflict with the aims of the Review of Management Costs exercise.

More general discussion followed on the value of monitoring both to managers at whatever level and to those directly involved in providing the service. It assisted managers to make the best use of resources and it made individuals feel more powerful by providing information about what they were doing and enabling them to influence their environment. The health service was always involved in a delicate balance between patient care and the employment aspects of its business and both were important. All the presentations had shown the crucial importance of monitoring by agreement, and although there

was a distinction between line management and clinical situations, the right to clinical freedom had to be kept separate from clinical responsibility for the use of health service resources.
Mr Pace said that the Wessex approach could apply to a manager, as well as external monitoring as defined by Mr Wickings. It could even apply to self monitoring if people made agreements with themselves. The main distinction was of course that managers could monitor with the addition of disciplinary control.

Summing up at the end of the day, the Chairman concluded that participants had reached an understanding of monitoring very similar to the definition now being used within the DHSS:

> "Monitoring is a systematic process of agreeing a range of measures of performance for specific activities so that actual performance can be measured against them over time, significant variations identified, and the need for management decisions demonstrated."

It was clear that statutory health authorities had a management right to question the activities of clinicians, just as the DHSS had a right to influence the activities of the authorities but these rights were usually exercised obliquely. Similarly there were a great number of norms and standards being promulgated which had no real force because they were not based on agreement with those actually providing the service. Agreement was beginning to come in areas such as mental handicap but generally managers were being called on to monitor without agreement. The development of mutually acceptable standards of performance was essential before the word 'monitoring' could be said to have any real meaning.

Shirley J. Hardy.
King's Fund Centre
March 1979.

Requests for further information about this conference or suggestions for further related activities should be directed to:

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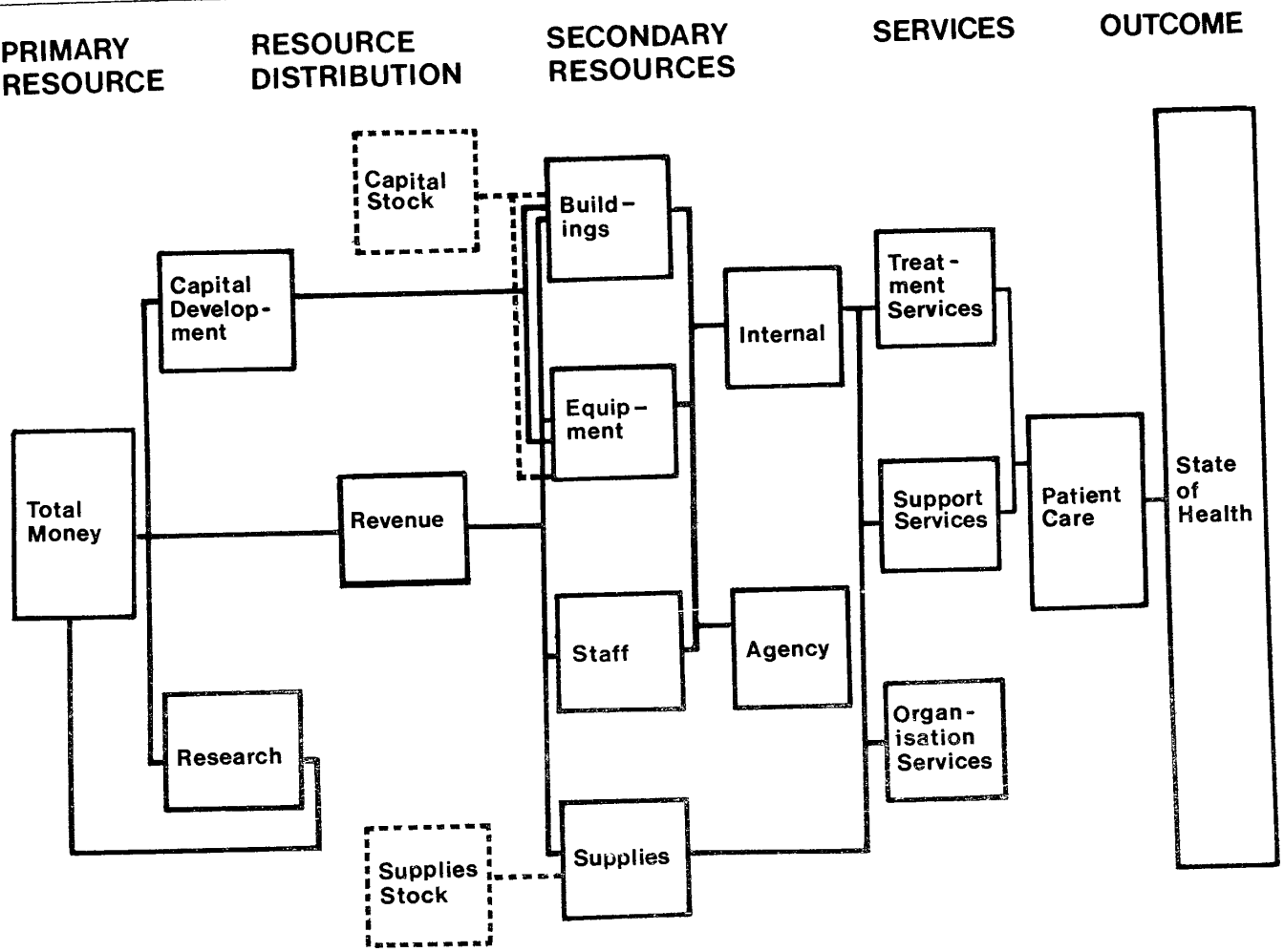
THE ORGANISATION OF THE HEALTH SERVICE



SLIDES USED IN PRESENTATION OF MONITORING

OUTLINE LIST OF SUBJECTS

TYPES OF SERVICE MONITORING

1. Total Resource Monitoring
2. Care Group Monitoring
3. Medical Services
4. Industrial Services

TOTAL RESOURCE

1. Finance
2. Manpower
3. Buildings
4. Equipment
5. Stock

CARE GROUPS

1. Services for Children
2. Services for the Elderly
3. Services for the Mentally Ill
4. Services for the Mentally Handicapped
5. Services for the Disabled
6. Maternity Services
7. Primary Care and Preventive Services
8. Acute Services:

a) General Surgery
b) Urology
c) Gynaecology
d) E.N.T.
e) Dental Surgery
f) Orthodontics
g) Orthopaedics
h) Paediatrics
j) Ophthalmology
k) Neuro Surgery
l) Neurology
m) Thoracic Surgery
n) Chest Diseases
p) General Medicine
q) Cardiology
r) Intensive Care
s) Dermatology
t) Radiotherapy
u) Infectious Diseases
v) Physical Medicine
w) V.D.
x) Rheumatology
y) Plastic Surgery
z) Nuclear Medicine

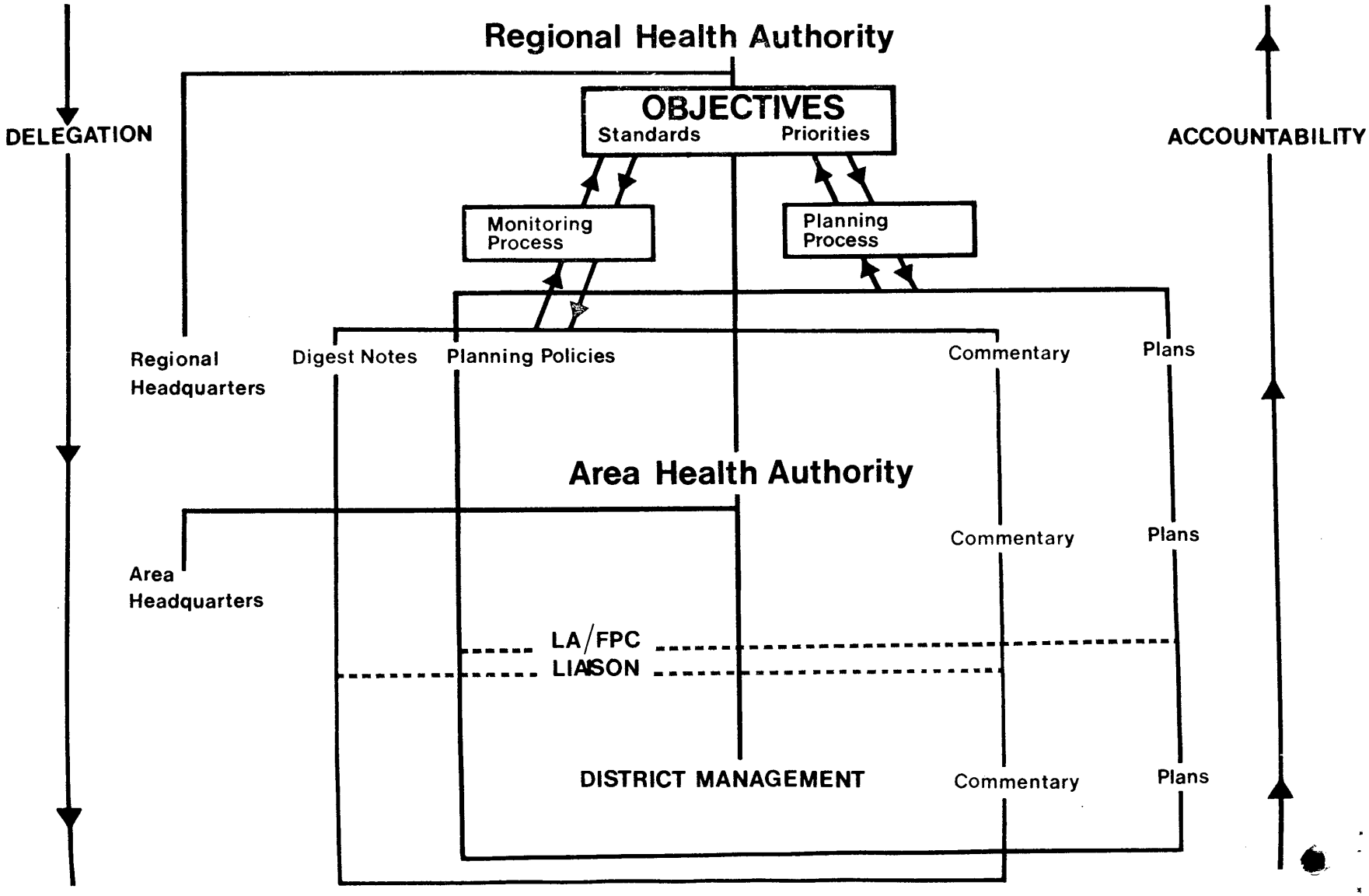
9. Accident and Emergency

MEDICAL SERVICES

a. Theatres
b. Pathology
c. Pharmacy
d. X-ray
e. Psysiotherapy
f. Speech Therapy
g. Hydrotherapy
h. Chemotherapy
j. Occupational Therapy
k. Artificial limb services
l. Chiropody
m. Blood Transfusion
n. Health Education

INDUSTRIAL SUPPORT SERVICES

a. C.S.S.D.
b. Laundry
c. Catering
d. Transport
e. Ambulances
f. Supplies
g. Domestic Services
h. Portering
j. Building & Engineering
k. Administration
l. Medical Records
m. Computer Services
n. Staff Support
p. Voluntary Services


Regional Health Authority
OBJECTIVES
Standards
Priorities
DELEGATION
ACCOUNTABILITY
Monitoring Process
Planning Process
Regional Headquarters
Digest Notes
Planning Policies
Commentary
Plans
Area Health Authority
Commentary
Plans
Area Headquarters
LA/FPC
LIAISON
DISTRICT MANAGEMENT
Commentary
Plans

DEFINITION OF TERMS

MONITORING – GENERAL OBJECTIVE

To see that agreed standards are being maintained and that agreed plans are being carried out; and further to learn more about the behaviour and performance of the service and to use the knowledge obtained to amend, create or revise standards and objectives.

A STANDARD IS:

A measurable level of performance or provision of some part of the service, which has been agreed with those who may be judged by it.

A DIGEST IS:

A selection of information relating to the activity which is being monitored, presented in a concise, standard form.

A COMMENTARY IS:

A concise statement interpreting the content of a digest, and recommending whether or not administrative or other action of some kind is indicated by the information in the digest. (According to the kind of activity being monitored, the commentary may be written by the monitor or by those who are monitored, or possibly by a third party). IN ANY EVENT, DISCUSSION OF THE COMMENTARY BY THE MONITOR AND MONITORED TOGETHER IS CONSIDERED TO BE THE MOST IMPORTANT PART OF THE MONITORING PROCESS IF IT IS TO BE OF POSITIVE AND CONSTRUCTIVE HELP TO THE MANAGEMENT OF THE SERVICE.

A PRIORITY IS:

A statement of the relative importance of particular standards or services.

A REVIEW IS:

An exercise to gather data so that management can learn about or watch the performance of the organisation.
No standards are used.

PERFORMANCE OF AN EXERCISE

THE PERFORMANCE OF A MONITORING EXERCISE

A. Set up the exercise
B. Design the monitoring programme
C. Execute the monitoring programme

A. SETTING UP A MONITORING EXERCISE

1. Select a subject (confirmed by R.H.A.)
1a. Appoint a monitoring officer
2. Appoint working team

B. DESIGNING THE MONITORING PROGRAMME

3. Sub-divide subject and select specific items
4. Define methods of measurement
5. Define methods of comparison (standards)
6. Define content and layout of Digest Cont.

N.B. Throughout these stages, all issues will be discussed with those to be monitored.

B. DESIGNING THE MONITORING PROGRAMME (Cont)

7. Prepare a draft monitoring programme containing:
   a) Identity of monitor and team
   b) Sub-divisions of topic to be monitored
   c) Digest layouts
   d) Standards and methods of comparison
   e) Programme timetable
8. Obtain agreement to draft programme through Consultation

C RUNNING A MONITORING PROGRAMME

9. Construct Digest and Prepare District Commentary
10. Prepare Area Commentary
11. Prepare Regional Commentary
12. Submit to R.H.A. and feed findings to the planners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