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## A Pragmatic Assessment of the Balanced Scorecard: An Evaluation for use in a NHS Multi-Agency Setting in the UK

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**A PRAGMATIC ASSESSMENT OF THE BALANCED SCORECARD: AN EVALUATION OF A NEW PERFORMANCE MANAGEMENT SYSTEM FOR USE IN A NHS MULTI-AGENCY SETTING IN THE UK**

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**ABSTRACT**

Despite worldwide popularity, Balanced Scorecard (BSC) usage in local public sector NHS organisations is rare. This paper conditionally outlines grounds supporting such usage. In particular, the BSC's contribution to improved accountability needs emphasising, and underlying conceptual concerns with the BSC system and its implementation pitfalls require full consideration. Full customisation of the system for NHS usage, is then possible. Finally, to minimise organisational resistance, a streamlined BSC implementation approach is recommended. In the short-term, reasons why NHS organisations could still be induced by pragmatic concessions from Central Government / Strategic Health Authorities to implement the BSC, are also outlined.

## INTRODUCTION

The Balanced Scorecard (BSC) has quickly gained popularity since its introduction in the early 1990s. It has transcended geographical, sector, and organisational boundaries to such an extent that the British Government is now openly heralding its 'Balanced scorecard approach' to managing the (NHS) National Health Service (Department of Health, 2001a). However, despite this enthusiasm, the BSC is not currently widely used at a local organisational level within the NHS. In addition, despite the publication of generic templates and a number of case studies to facilitate the successful design / implementation of initial scorecards, (Kaplan & Norton, 1996 and Olve et al, 2000) the failure rate for BSC implementations is claimed to be high. (Neely & Bourne, 2000). Indeed, the originators of the BSC have openly acknowledged that some scorecards will fail (Kaplan & Norton, 2001).

This paper will therefore critically evaluate the case of need for a full application of the BSC within the Bradford Health sector, paying particular attention to the factors that may facilitate successful BSC adoption within the UK health sector. It will also outline insights from a NHS perspective into the relevance of the particular factors that Kaplan and Norton identify as key for successful BSC implementation. That is the avoidance of key: transitional issues, design failures, and process failures when implementing the BSC.

## THE BSC AND ITS POTENTIAL RELEVANCE TO NHS ORGANISATIONS

### The BSC System - In a Nutshell

The BSC is briefly defined as a management framework that: "…. translates an organisation's mission and strategy into a comprehensive set of performance measures that provides the framework for a strategic measurement and management system". (Kaplan & Norton, 1996, p2).

When the system is fully deployed the BSC seeks to ensure that the drivers of long term performance 'breakthrough' are identified and aligned. In practice, this is taken to mean that ultimately an organisation's mission and strategy is linked to action, which results in positive tangible operational outcomes. However, though there has been significant research conducted on the BSC's relevance to a range of private and public sector organisations across international boundaries (Kaplan & Norton, 1996, & 2001, and Olve et al, 2000, Simons 2000) little work has been performed in relating the BSC to UK Public Sector NHS organisations.

**Bradford Health Economy and its Need for Performance Improvement**

In 1999/2000 an awareness of the BSC's claims to produce performance improvement prompted the newly formed Bradford Health Action Zone (HAZ) to fund this project, in order to evaluate whether the BSC could be productively employed within the Bradford health economy on a multi agency basis. Bradford was one of the 11 first wave HAZs. These organisations were specifically formed by the Government in April 1998 to "blaze the trail" in "finding new ways to tackle health problems and reshape local services.... in areas of pronounced deprivation and poor health". (Page 77, Secretary of State for Health, 1997). Therefore faced with this challenging remit, Bradford HAZ's interest in evaluating whether the BSC system could assist them in their new role, is unsurprising.

At a local level their task of improving health and health care services was, and is, considerable. For example, in Bradford Health Authority's (HA's) bid to achieve HAZ status its population was estimated at 486,000, with a minority ethnic population of circa 19 %. It was also the 4th most deprived Health Authority area in England outside London, based on the Jarman index. (Bradford Health Authority, 1998).

So, in brief, such is the need for significant improvement in health and health care services within the Bradford health economy, that if any Performance Management System (PMS) could be clearly demonstrated to offer the potential, both in theory and practice, to assist meeting this challenging agenda - it would be of key interest to all NHS organisations in the sector.

**AN ASSESSMENT OF THE RELEVANCE OF THE BSC TO THE BRADFORD HEALTH ECONOMY.**

**General Approach**

The following activities were undertaken to assess the BSC's potential benefit to NHS organisations:

Firstly, a theoretical assessment of the BSC's compatibility with the underarching principles of the 'new NHS' was conducted, as first set out in 1997 and subsequently amended and expanded in the first ever NHS National Plan to be issued since its formation in 1948 (Secretary of State for Health, 1997 & 2000). In short, this exercise unequivocally confirms the BSC system's theoretical value to NHS organisations. In particular, the NHS's stated need for improvement in 3 key areas: service efficiency, patient / public accountability, and staff involvement (Secretary of State, 1997, and 2002) could potentially be particularly well served by an appropriate application of the BSC system. Then, once the potential value of the BSC system within the NHS was confirmed on a theoretical basis, 'strawman' BSC's were developed at multi agency HIMP and organisational PCT level, as ultimately only confirmation of the BSC's benefits in practice has any 'real' significance. Indeed, this approach has been usefully deployed to assess the BSC's potential in other new areas of application as demonstrated by the work of Turner (1999).

Once the 'strawman' BSCs had been developed, two organisations decided to proceed with the BSC: the multi agency HIMP Steering Group decided to use the BSC on a pilot basis, and one of the Bradford Primary Care Trusts (PCTs) resolved to fully implement the BSC system as its main strategic PMS of choice. However, valuable as these steps were in confirming the BSC's positive potential to be deployed within NHS organisation's this evidence was assessed as being inconclusive on two main grounds. Firstly, the HA based HIMP's demise was announced by the Government (Department of Health, 2001b) before the BSC could be implemented, and secondly though 1 PCT had voluntarily decided to implement the BSC after assessing the system's potential, no other organisation within the Bradford health sector had reached this same conclusion. Therefore, in order to clarify these mixed signals concerning the BSC's potential to be successfully deployed by NHS organisations, a series of focus groups was conducted with all the main organisations within the Bradford health sector.

Focus groups were held with all the main public sector organisations within the Bradford health sector that either provided or commissioned health care and personal social services. These bodies comprised: Bradford Health Authority, 4 PCTs, 2 Hospital (i.e. secondary care) Trusts, and Bradford Metropolitan District Council (MDC). In all 46 people attended the 8 focus groups, with attendance determined on the basis of natural sampling (Hussey & Hussey, 1997). The range of people who attended the focus groups, in terms of functional job focus, seniority, and the views they willingly expressed - suggests that the focus groups that were held were not afflicted by bias to any significant or discernable degree. Of the 46 people who attended the focus groups approximately 22 % were front line clinicians (i.e. Consultant Medical Staff / General Practitioners (GPs) 7 %, Clinical Lead Nurses 15 %) and circa 22 % were either Chief Executive Officers or Executive Directors. The remaining 56 % of focus

group attendees were drawn from management posts at all levels, and from all areas, within each organisation, and came from both clinical settings and central departments (such as performance management and information technology). Detailed notes were maintained for all 8 focus groups and audio recordings were made and transcribed (verbatim for contributors) for 7 of the focus groups. Data was subsequently coded and analysed, based on applying an interpretative research approach, originally outlined by Radnor (2002). The results of this process are the main source of information that is used during the remainder of this article.

**Summary of The Focus Group Findings**
From the focus group sessions four main conclusions could be reached:

Firstly, regardless of their pre-existing knowledge of and exposure to the BSC system, individuals from all backgrounds and at all levels within each of the organisations could quickly identify many of the potential benefits from adopting the BSC system, that Kaplan and Norton (1996 & 2001) themselves highlighted. These can be briefly classified into two main groups: the high level fundamental reasons that lead organisations to adopt the BSC system in the first place, and in particular the detailed benefits that organisations expect to experience once the BSC system is fully deployed.

These detailed organisation level benefits are set out fully in the works of Kaplan and Norton (1996, & 2001) and Olve et al (2000). That is the BSC's perceived contribution in terms of: clarifying and obtaining consensus about strategy, communicating strategy throughout the organisation, aligning departmental and personal goals to strategy, linking strategic objectives to long term targets and annual budgets, identifying and aligning strategic initiatives, enabling periodic / systematic reviews, providing (double loop) feedback to assist learning / strategy development and, translating better strategic alignment into 'better results'.

Secondly, despite widespread recognition of the requirement for improved PMSs, and the BSC's potential to meet this need, this did not automatically lead to acceptance of the BSC as a preferred solution for this problem. Focus group contributors could also see potential problems as well as benefits with the BSC system, along with difficulties with implementing the BSC system. Without significant clarity to deal with both of these areas, 7 out of 8 of the organisations where the focus groups were held are still expected to persevere with attempts to improve their own localised PMS solutions.

Thirdly, even those organisations who were most cautious over their assessment of the net value that adoption of the BSC system could bring, would be willing to suspend their reservations and adopt the BSC on pragmatic grounds, if a number of conditions were met.

Lastly, based on the preceding observations, it is clear that a number of factors need to be addressed if the BSC system is to be perceived as a credible, realistic, PMS option within NHS organisations in general, and within the Bradford PMS in particular. In brief, these can be summarised as follows:

- The BSC's ability to contribute to the significant and expanding need for greater accountability in service planning and delivery must be emphasised. The BSC's ability to contribute to efficiency improvements is well publicized and known, but the claims of BSC advocates regarding the system's contribution to efficiency improvements must not be allowed to distract from, and overpower, the BSC system's potential contribution to promoting improved accountability in service delivery.

- The fundamental conceptual concerns with the BSC expressed in the focus groups must be addressed, preferably directly on an issue-by-issue basis, or at worst through applying pragmatic measures at least.

- If people's fundamental concerns with the BSC system are not addressed, minor solutions to implementation problems are rendered largely irrelevant.

- Based on the focus group feedback and the experience of assisting the one PCT in Bradford who are actively implementing the BSC system as their local PMS of choice, it is clear that the generic approach to BSC implementation outlined by Kaplan & Norton in (1996) and re-confirmed as having general validity in (2001) - must be heavily customised. If not, the very process of implementing the BSC will also become itself a strong barrier to the BSC being accepted.

Each of these factors will now be addressed in some detail in turn.

## FACTORS NEEDED FOR BSC PMSS TO BE ACCEPTED AS A FEASIBLE NHS OPTION

### The BSC Must Not Be Promoted Or Treated As A Panacea

Though the BSC's claims to generate 'breakthrough' (efficiency) improvements for organisations is clearly made and therefore widely understood, this creates several main problems for its adoption within the Bradford health sector.

Firstly, the highly noticeable lack of caveats to highlight that the correlation between BSC adoption and better results (financial or otherwise) does not necessarily imply causation, seriously undermines the BSC systems general credibility (Kaplan & Norton, 2001). Clinicians in particular who are accustomed to the rigour of quantitative research (such as to be found in Randomised Controlled Trials etc) immediately see these omissions as signalling a major flaw in the soundness of the BSC methodology, that it is difficult to counter. This can be illustrated by focus group interventions such as the following:

"Well that's not scientific, is it! ........ It's just a way of doing it. Is it evidenced based? Have we demonstrated that the balanced scorecard actually delivers better financial balance, better clinical outcomes, better feelings of involvement?!".

In addition, the over-emphasis placed on the BSC 's role in generating 'breakthrough' efficiency based improvements, appears to distract from the BSC's ability to contribute to improved accountability arrangements for service delivery and planning. This is unfortunate, because this is likely to be one of the key areas where the BSC can make its greatest contribution to NHS and other public sector organisations. For example, the Audit Commission (1999) has reminded all public sector organisations in general terms, that PMSs are needed to modernise Government services not only through improved economy, efficiency, and effectiveness in service delivery, but also to reinforce accountability, so that organisations are clearly held to account for the resources they use, and the outcomes achieved.

Though the public sector NHS based organisations within the Bradford health sector are generally aware of this requirement and have catered for this need to various degrees within their internal PMSs, few (if any) are currently equipped to cope with the expanded and more explicit need for accountability that has arisen since the Government published its response to the 'Bristol inquiry' i.e. the wide ranging investigation into the scandal of unnecessary children's deaths from cardiac surgery (Department of Health, 2002) and then its latest plans for 'shifting the balance of power' in the NHS from provider concerns to front line staff and patients (Secretary of State for Health, 2002). In this context, observations made in the focus groups such as the following are truly significant:

"Yeah, you're right its just that we don't document it that way (second voice: "Yeah, yeah") I mean we place a huge emphasis on the involvement of workforce, public and patients all the rest of it, and again we may not capture it particularly well........".

Increasingly, accountability concerns can no longer be considered an 'optional extra' and lightly discounted so as to retain current PMSs that are performing poorly in this area, but are retained because of their perceived contribution to efficiency. In future, NHS organisations need PMSs that can contribute in a comprehensive manner in both areas, and the BSC appears to be a potential system to meet this need. Indeed this is well demonstrated by the eventual consensus reached in one focus group where it was concluded that the BSC could potentially offer them little if any benefit over their current systems in terms of generating (efficiency based) performance improvement, but that:

"...it [i.e. the BSC system] could be useful, because actually when I.... I agree entirely, most of this we are already doing - but I don't think that we've got it down that we're doing it, actually as part of a strategy, policy or anything. And we've already covered.... like we said we've got more people in PMS, and we know exactly what we are trying to do by PMS, but nowhere is it in writing...we don't have a written PMS strategy. You know, so in away, this could be helpful to us, because it might help us put stuff down which is going on, so that when people come - either because they are 'badging' us, or to find out what is going on, we can actually demonstrate ......".

### Fully Address The Conceptual Barriers To Adopting The BSC

Within the Bradford health sector focus group contributors not only quickly identified the potential benefits of BSC adoption for themselves, they also identified a number of conceptual difficulties with the system, and pitfalls with the implementation process. Though there is some guidance available to assist those with BSC implementation difficulties (including Kaplan & Norton, 2001, Olve et al, Roest, 1997) there is

scarce coverage of how to handle some of the key practical concerns which stem from the fundamental assumptions at the heart of the BSC. Valuable as the former guidance is, guidance on the latter topics would be arguably of greater significance - as failure to resolve these issues means that organisations are unlikely to proceed to the BSC implementation stage in the first place. Besides, once organisations have embarked upon the implementation process, there is evidence to suggest that they are likely to have both the incentive and the expertise (though not necessarily the resources) to devise or find localised solutions themselves to meet most of the implementation problems they encounter.

In particular the fact that the BSC's potential benefits are reliant on a deterministic assumption about the business world (Palmer and Parker, 2001) and a reliance on the rational goal model that correlates goal conformity and collaborative management practices (Dinesh & Palmer, 1998), should not be a problem. At face value NHS organisations are obliged to share such assumptions (Secretary of State for Health, 2000). However, 'realists' within the health service can be dissuaded from using a PMS that seems to demand such idealised conditions in which to work, as the following focus group contributor noted:

"But quite apart from that, we've actually got conflicting priorities, because they are going down one line in wanting theirs, we're going down another, and you'll never get agreement. Therefore trying to get sort of balanced priorities that we all agree with, that work back up into a pyramid for the health economy - I don't think would work"

Similarly, the widespread uncompromising need for full collaborative working practices to implement the BSC is not seen as 'realistic' or valuable option as another focus group contributor noted:

"I mean I think it would be possible to develop something [i.e. a BSC], but if its what it should be, which is actual people on the ground having a say in what goes into that, I think it's a massive piece of work and I'm not sure what value we actual get out at the end of the day. I suppose its just because I've seen a number of different performance management frameworks used in the NHS in various settings, and sometimes it appears like more effort goes into it than what comes out at the end of the day".

**Strengthen The Analysis of BSC Implementation Pitfalls**

In practice, it is likely that the BSC system has to be adapted to fit less than ideal circumstances, so it is important that these issues are openly discussed and assessed and parameters for 'flexibility' evaluated, so that prospective BSC adopters can gain sufficient confidence to implement the BSC. However, at the moment the coverage of BSC implementation 'pitfalls' (Kaplan & Norton, 2001) appears to imply that BSC failure is often due to the ignorance or incompetence of managers who have spurned 'orthodox' BSC design and process issues. Little if any coverage is paid to supplying guidance to managers who are knowingly seeking to adapt an idealised BSC model to fit the operational environment they are working in. Though BSC failures are universally put down by Kaplan & Norton (2001) to departures from BSC 'orthodoxy' (analysed into convenient categories of: 'transitional issues', 'design failures', and 'process failures') no evidence is supplied to confirm that BSC 'successes' have eschewed some of these same departures from the basic BSC model, in order to gain the results that are attributed to them through use of the BSC system.

In fact though a number of BSC 'pitfalls' are covered by Kaplan & Norton (2001) the treatment of their fundamental causes is largely un-addressed, and in total this guidance appears to offer few practical insights for NHS organisations that are seeking to implement the BSC. So, for instance - though it is widely recognised that the BSC takes a considerable input of time and other resources to implement and then maintain (Gautreau and Kleiner, 2001), Kaplan & Norton (2001) seek merely to emphasise that the generic approach to implement the BSC can now be shortened by 50 % since 1996, to 8 weeks in 2001. However, more importantly as Dinesh & Palmer highlight (1998), the time and complexity involved in developing the BSC is arguably the main cause of partial BSC adoption. This in turn is likely to be a main factor in most BSC failures that result from the 'BSC pitfalls' identified by Kaplan & Norton, such as lack of senior management support, and the inappropriate use of external consultants to implement the BSC etc. In practice, the BSC system is ill served by the attempts to present it as 'all things to all people' (i.e. comprehensive in coverage, yet speedy and low on resources to implement). For NHS organisations in particular, the time / resource implications should not be the over-riding concern. With accountability correctly factored

into the implementation cost benefit equation, the BSC's potential capacity to create excessive 'bureaucracy' is transformed into meaningful audit trails, and managers are able to rationalise the high resource demands required by BSC adoption as follows:

" I think you're right, there are going to be additional resources around doing this, but it isn't the balanced scorecard that's causing this, we would have to do it anyway - we would have to be doing performance management for PMS, we would have to be doing performance management for the PCT - the balanced scorecard in itself doesn't generate extra work that we would have to do, anyway".

Finally from observing the efforts of the PCT to implement the BSC, it is clear that an organisation once committed to the BSC concept will quickly seek out pragmatic solutions to implementation pitfalls that they encounter. For example, the BSC adopting PCT had approximately 200 core strategic objectives in its Business Plan, of which 97 were Government 'imposed' or derived 'Must Do' requirements. In order to whittle these down to a number of targets that can sit on a top level BSC they resolved to prioritize, filter and ultimately summarise their 'true' Must Do' targets, whilst still remaining alert to dangers such as:

"...the one thing I fear is that because we are having to summarise the targets, you then get a target that doesn't really say anything because its so general because it's a summarisation of lots of other things that it doesn't actually focus your mind, and its isn't very sensitive therefore, and I think that will be the art in actually implementing it......."

In addition, following the Government's first announcement of major NHS reform (Department of Health, 2001b) PCTs gained an expansion in their functions and powers from 1/4/2002. Whilst some PCTs saw this change as a reason to consolidate their position, one PCT in Bradford took an alternate view and decided to implement the BSC because:

".....I think where we're different is in our information systems - we haven't got any really, we've got bits and bats around so we've actually got an information strategy being worked up, and so I suppose different from other organisations where they might be quite comfortable with their information systems and their thinking - then why should we unpick these to do this? We're seeing this as giving us a framework for creating a management information structure".

**Introduce Pragmatic Concessions To Facilitate BSC Implementation**

However, in reality, without addressing the fundamental concerns of those who are reluctant to implement the BSC, it is clear that all the NHS organisations in the Bradford health economy could be persuaded to implement the BSC as their PMS of choice, if the following conditions were met / arranged by the new Strategic Health Authority or preferably the Department of Health itself:

- The fullest possible implementation of the BSC was 'arranged' on a Bradford District basis as a minimum, to enable cause and effect resource changes highlighted by the BSC system to be actioned across organisational boundaries. The management style used to implement the BSC would however, have to minimise the risk that this approach could be seen as 'top down' imposition of a PMS.

- The BSC would have to be explicitly used, and seen to be used, as a means of rationalising existing performance management workloads, with no parallel running of systems.

- The BSC would have to incorporate as many good elements of existing local PMSs as consistent with the BSC model, to encourage staff to transfer 'loyalties' from their current systems.

- Additional resources, other than that transferred from PMSs rendered redundant by the BSC itself, are needed - not only to backfill front line staff so that they can take part in the process as appropriate, but also more importantly to signal senior NHS support for the system.

- To minimise additional workload associated with BSC implementation, the BSC process will need to be explicitly linked / embedded in the Business Plan review process. This will invariably render the generic BSC approach advocated by Kaplan and Norton (1996 and 2001) largely redundant.

**Deploy A Simplified Generic Approach To Facilitate BSC Implementation**

The simplified use of a generic BSC will be required in order to make the BSC process acceptable, not only in terms of resource input but also in terms of cultural compatibility.
A number of reasons support this viewpoint.

Firstly, presumably because the NHS workforce is atypical in terms of its high proportion of qualified / skilled staff (Wanless, 2001) there would be resistance to any template approach to the BSC which stresses both 'what to do' and 'how to do it', as the following focus group quote demonstrates:

"I'm not sure if General Practice is different to any other mode of delivery of the service but, people don't like being told what to do. People like to be involved in developing a vision and given the resources to go away and deliver that vision..........".

Secondly, senior clinicians often have a dual management role, and so taking front line clinicians in particular away from their everyday roles to attend seminars and working groups to develop the BSC is not a realistic option. Not only would it foster resentment, but also national staff shortages are such that backfill cover may be difficult to arrange on an adequate basis. Lastly, by linking the BSC process into an existing set of arrangements, such as the Business Planning cycle, this would enable the BSC process to be 'piggy backed' to some extent, and so minimise its additional resource requirements for implementation.

In reality, providing the BSC is linked with an appropriate up to date strategic Business Plan, just 8 steps should be required to implement the BSC, to ensure optimum levels of involvement and ownership. In each case, the streamlined methodology would emphasise detailed definitions of the output requirements of each stage, but would avoid any prescriptive measures to detail 'how' these outputs would be required. If top managers do not have the 'core' skills to obtain the necessary involvement and ownership of the BSC concept at the onset, it is unlikely that they will have the required 'nous' to appropriately maintain the BSC system once it has been implemented. Therefore, in these circumstances, it would arguably be in the organisation's best interests if the BSC implementation process suffered a 'short death,' rather than for the organisation to suffer from the long drawn out 'death' of a poorly implemented, partial BSC solution, that was purporting to be its main strategic PMS. In brief, the core streamlined generic approach to optimise local ownership and involvement with BSC implementation would focus on the following basic steps:

1) Establish a sound strategic foundation (i.e. SMART based, Department of Health, 2001a).
2) Produce a multi dimensional strategic summary (i.e. by BSC perspective).
3) Set BSC SMART objectives for each BSC perspective.
4) Determine measures for each objective included on the BSC.
5) Relate objectives through cause and effect linkages.
6) Set SMART targets for each measure in the BSC.
7) Identify strategic initiatives to deliver BSC targets.
8) Establish monitoring and review schedules for the BSC and its outputs.

**CONCLUSIONS**

The experience of the Bradford health sector suggests that the BSC is a feasible PMS solution (both in theory and practice) to generate improved performance management in UK health settings.

However, in the majority of cases if the BSC to be considered a feasible PMS option a number of fundamental issues will need to be addressed. Firstly, the BSC's contribution to improved accountability will need to be emphasised, explored and demonstrated. Fundamental concerns at the heart of the BSC system itself and those that underpin implementation pitfalls, will also need to be addressed in order to facilitate pragmatic adaptation of the basic BSC model to the NHS environment. In addition, to avoid creating barriers to the BSC from the onset, a simplified generic approach to BSC adoption should be used which maximises local flexibility. But in the short-term absence of detailed research to address all these concerns, it is likely that many NHS organisations could be induced by pragmatic concessions from the Department of Health or possibly the Strategic Health Authority to adopt the BSC system.

Future research within the BSC field is especially required to explore the nature and extent to which the basic BSC model can be legitimately adapted and customised, before it loses its essential essence. At present pioneering attempts to adapt the BSC to real life situations are liable to be simply branded as 'BSC pitfalls to avoid', should they be unfortunate enough to fail in their attempts. Hopefully, a greater balance can be reached in future, where the boundaries of legitimate BSC adoption and practice are known and respected, but where organisational need to explore and experiment with customised BSC adaptations will also be acknowledged and supported. Finally, by way of warning - failure to substantiate and customise the BSC system in this manner may well have serious adverse

implications for some organisations if the BSC is adopted in its current form, as the following focus group quotation highlights:

"I hope the NHS doesn't touch it [i.e. the BSC system] with a barge pole. I think it will be positively counter productive, I think the NHS has got to get a grip of manpower and personnel. And if it comes down from on high - the front line troops are knackered, and they need supplies and provisions not missives from headquarters in Berlin, because they're on the Eastern Front with the snow, and the whole thing sucks".

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