Monitor

Independent Regulator
of NHS Foundation Trusts

1 Working towards service-line management: a how-to guide

NEXT

Contents

Introduction

Introduction

About service-line management

Service-line management (SLM) is a combination of trusted management and business planning techniques that can improve the way healthcare is delivered. It was developed by Monitor for NHS foundation trusts, drawing on evidence from UK pilot sites and the experience of healthcare providers worldwide.

By identifying specialist areas and managing them as distinct operational units, SLM enables NHS foundation trusts to understand their performance and organise their services in a way which benefits patients and makes trusts more efficient. It also enables clinicians to take the lead on service development and drive improvements in patient care.

SLM provides the tools to help trusts identify and structure service-lines within their organisation, ensuring clear paths for decision making and accountability. It also builds a framework within which clinicians and managers can plan service activities, set objectives and targets, monitor their service's financial and operational activity and manage performance.

SLM relies on the production of timely, relevant information about each service-line, to enable analysis of the relationship between activity and expenditure for each service-line as well as showing how each service-line contributes to the overall performance of the trust. It also encourages ownership of budgets and performance at service-line level.

About this guide

Using checklists, practical tools and examples of good practice, this how-to guide sets out the processes and structures necessary to implement SLM within a trust setting.

It is recommended that trusts implementing SLM use this guide in conjunction with other documents in the *Working towards SLM* series (see page 150 for further details).

While it offers a framework for implementation, this guide does not offer a 'one-size-fits-all' approach. The examples it contains are all taken from healthcare providers that offer high value, high quality services, however each one runs its services in a slightly different way and with slightly different support mechanisms. Trusts are encouraged to tailor the fundamental SLM concepts so that they fit their unique circumstances, structure and culture.

The guide is structured around the following checklist of key SLM enablers (see next page):

Key enablers of SLM

Key enablers	"Check-list" of the important components
1 Organisation	☐ Defined **service-line structure** ☐ Defined service-line **leadership roles**, with integrated ownership of clinical, operational and financial performance ☐ Capability-linked, defined **decision rights** at each level (trust executive, service-line, and team)
2 Information support	☐ Relevant, timely information ☐ Patient level costing
3 Strategic and annual planning process	☐ Understanding of market and competitive position ☐ Defined three- to five-year strategy and annual objectives ☐ Action plan to deliver strategy ☐ Robust annual planning process ☐ Levels of autonomy linked to quarterly monitoring regime
4 Performance management	☐ Clear KPIs, targets and accountabilities ☐ Performance tracking ☐ Effective review meetings ☐ Good performance conversations ☐ Rewards and consequences for performance

Organisation

Service-line structure

Organisation – Servive-line structure

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3 Strategic and annual planning process	☐ Understanding of market and competitive position ☐ Defined 3-5 year strategy and annual objectives ☐ Action plan to deliver strategy ☐ Robust annual planning process ☐ Levels of autonomy linked to quarterly monitoring regime
4 Performance management	☐ Clear KPIs, targets and accountabilities ☐ Performance tracking ☐ Effective review meetings ☐ Good performance conversations ☐ Rewards and consequences for performance

Defining service-lines

Guiding principle: The NHS should move to a business unit structure, devolving autonomy to the front line, learning from how they have been applied in the commercial sector and translating the use to a hospital setting

	Principles	Questions raised at trusts
Service-line structure	• Service-lines should be defined using commercial business unit criteria • Where the service-line has the critical mass it should own the clinical infrastructure • Service-lines' objective functions should be defined by their intrinsic characteristics (e.g. revenue sourcing, financial and operational dependencies, service focus) • Service-lines should operate according to their objective function, with the majority as profit centres • A divisional layer should only be there when the value that it would add can be quantified	• How do we change the organisation? • How do we get there over time?
Roles	• There are different options for who and how service-lines are run; in all cases there should be a single point of accountability • Clinicians should have a prominent role in leadership • Leaders should exhibit competencies across people, quality, service and collaborative leadership	• How do we select service leaders? • How do we build capabilities? • How can we hold them to account?
Decision rights	• Decision rights should ensure service-lines are empowered to drive service performance • A control function should be in place to alter these decision rights according to performance	• Where should decision rights be held? • What are the conditions for having robust decision rights? • How can executive teams increase service autonomy in a controlled way?

Principles for structuring service-lines

Principle	From	To
Service-lines should be defined using commercial business unit criteria	"Our structure has evolved over time with directorates of varying sizes and remits"	"We have clearly defined service-lines based on robust criteria. Where the criteria has been conflicting we have made decisions as to how services are structured"
Where the service-line has the critical mass it should own the clinical infrastructure	"Our clinical support services are a mixture of centralised as a corporate function, centralised as a service-line and decentralised…we have never really questioned whether this is appropriate or not"	"Our clinical support services are structured according to their size, nature and user group – some are owned by the service-lines, others are centralised"…
Service-lines' objective functions should be defined by their characteristics	"All services have focused on trust requirements to deliver cost improvement initiatives…we haven't explored growth opportunities"	"Services have a clear objective function, based on the nature and characteristics of their service"…
Service-lines should operate according to their objective function, with the majority as profit centres	"All of our services are run as either service centres or cost centres – with control over their budget and cost base alone"	"Where we want services to focus on maximising their profits we have made them into profit centres with control over their profitability"…
A divisional layer should only be there when the value that it would add can be quantified	"We do not currently have a divisional layer and would like to explore whether it will improve our organisation"	"We do not currently require a span breaker and do not believe the value added by a divisional layer can be quantified to support it"…

NHS service-lines can be defined using commercial business unit criteria

Criteria	Commercial sector business units	NHS service-lines
Self-contained	• Discrete customer or products/services • Discrete finances • Discrete resources • Discrete assets and infrastructure • Minimal interactions outside of the business unit	• Discrete patient group • Discrete finances (profit and loss) • Discrete staffing group • Compatible infrastructure requirements • Can largely operate independently
Comparable size and complexity	• Resources • Cost • Revenue • Complexity	• Staff (consultant WTE) • Staff (total WTE) • Budget • Income • Complexity (high, medium, low)
Common measures of success	• Approaches and capabilities to success are common within the business unit • Independent planning and measurement of performance based on key measures of success (e.g. profitability, market position)	• Common KPIs and measurable outcomes (i.e. all elements of the service-line share a desired direction of travel) • The components of the service-line have the same objective function

Service-lines should be assessed against these criteria

Criteria	Service-line 1	Service-line 2	Service-line 3	Service-line 4	Service-line 5	Service-line 6
• Self contained: – Discrete patient group	✓	✓	x	✓	✓	✓
– Discrete finances (profit and loss)	✓	✓	✓	✓	x	✓
– Discrete staffing group	✓	✓	✓	✓	✓	✓
– Compatible infrastructure requirements	✓	✓	x	✓	x	✓
– Minimal interactions outside of the service-line	✓	✓	x	✓	✓	✓
• Comparable size – Staff (all WTE)	#	#	#	#	#	#
– Staff (consultants WTE)	# ✓	# x	# ✓	# ✓	# x	# ✓
– Budget (£m)	# ✓	# ✓	# x	# ✓	# ✓	# ✓
– Income (£m)	# ✓	# ✓	# x	# ✓	# ✓	# ✓
– Complexity (high/medium/ low)	L	M	H	M	H	L
• Common measures of success	✓	✓	✓	✓	✓	✓

Areas for review

- Assess service-lines against the business unit criteria
- Where service-lines do not meet the criteria conduct a more detailed review to assess:
  - Should the service be reduced in size / joined to another service in order to be a business unit?
  - Should the service be a cost centre or corporate function?
  - Are we confident the leadership can make it work?
- The criteria may conflict, requiring trusts to make trade-offs between which criteria should be overriding. When doing so they should think about the people who are leading and within the service and the priorities of the trust

Example 1: General surgery

	Criteria		Comments
Self-contained	• Discrete patient group	✓	• Requirements of the patient journey is common across the specialties within general surgery with pre-theatre assessment, anaesthetists, theatre time, recover and inpatient facilities • Relies on anaesthetists and theatre time support, with core consultants and nursing team as a discrete staffing group
	• Discrete finances (profit and loss)	✓	
	• Discrete staffing group	✓	
	• Compatible infrastructure requirements	✓	
	• Minimal interactions outside of the service-line	✓	
Comparable size and complexity	• Staff (all WTE)	#	• Where budgets include anaesthetics and theatre infrastructure it often moves into being a very large budget which can impact on "comparable size" General surgery fits the criteria to be a service-line
	• Staff (consultants WTE)	#	
		✓	
	• Budget (£m)	#	
		✓	
	• Income (£m)	#	
		✓	
		#	
	• Complexity (high/medium/low)	L	
Common measures of success	• Common measures of success	✓	• Common success measures with KPIs focused on theatre utilisation and operational efficiency measures as well as patient outcomes • Common objective to maximise profit through optimising the use of resources while improving quality of care and safety

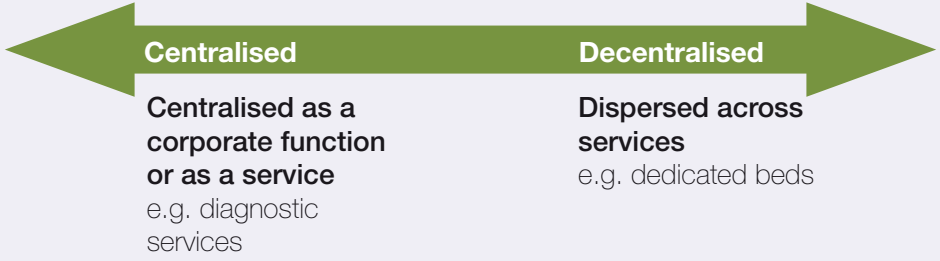
Example 2: Pathology services

	Criteria		Comments
Self-contained	• Discrete patient group	X	• Provides services to many patient groups, but with a common service – diagnostic tests
	• Discrete finances (profit and loss)	X	• Defining finances can be complicated as profitability is dependent on internal transfer pricing for trusts whose pathology service predominately services the rest of the hospital
	• Discrete staffing group	X	• High levels of interaction with other services
	• Compatible infrastructure requirements	✓	
	• Minimal interactions outside of the service-line	X	
Comparable size and complexity	• Staff (all WTE)	#	• Budgets are seldom comparable with other service-lines as large asset base for machinery
	• Staff (consultants WTE)	#	• External income is small
		✓	• Complexity will be dependent on the variety of diagnostic services that are offered
	• Budget (£m)	#	
		✓	
	• Income (£m)	#	Pathology does not fit all of the service-line criteria, but could still operate as one if deemed appropriate by the trust. The key success factor in doing so would be in transfer pricing and cross-service-line relationships
		✓	
	• Complexity (high/medium/low)	H	
Common measures of success	• Common measures of success	✓	• Common objective to optimise operational efficiency

Clinical support services

These can be either a centralised function or decentralised in services

Criteria	
Infrastructure	• Dedicated beds • Outpatient facilities* • Theatres
Services	• Diagnostic services • Rehabilitation • Allied health professionals

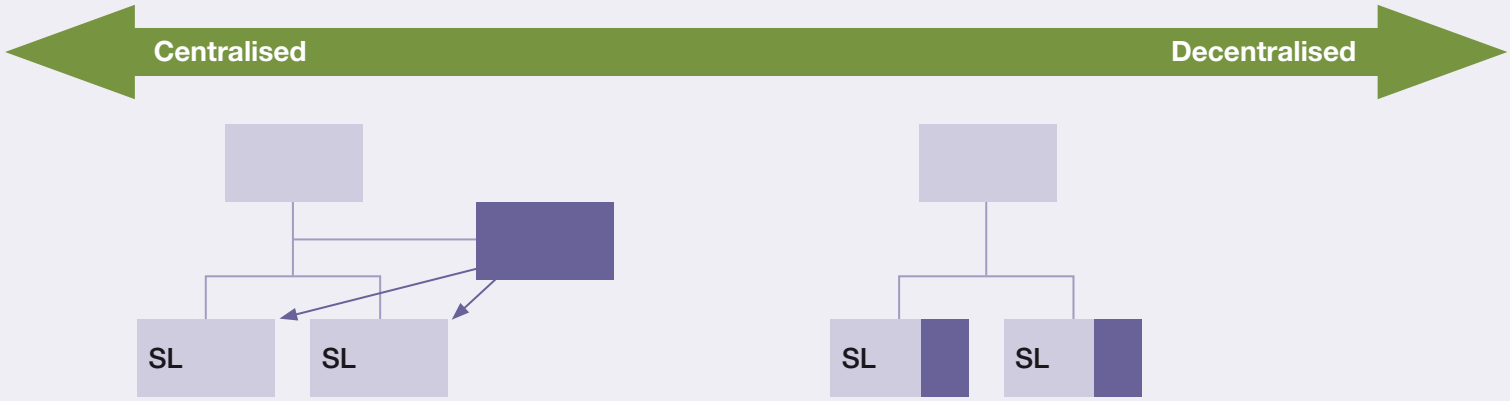


When reviewing where support services should sit it is important to assess:

- How many specialties use the support service?
- Who is the main user of the service? (% of activity)
- Can rules of engagement be set up to account for cross service-line use?
  - Can transfer prices be established?
  - Can income and cost be allocated according to where it is incurred?

* Including booking system, nursing and administrative staff

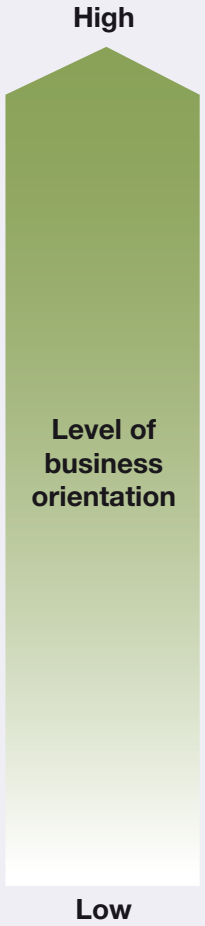
Where the service-line has the critical mass it should own the clinical infrastructure



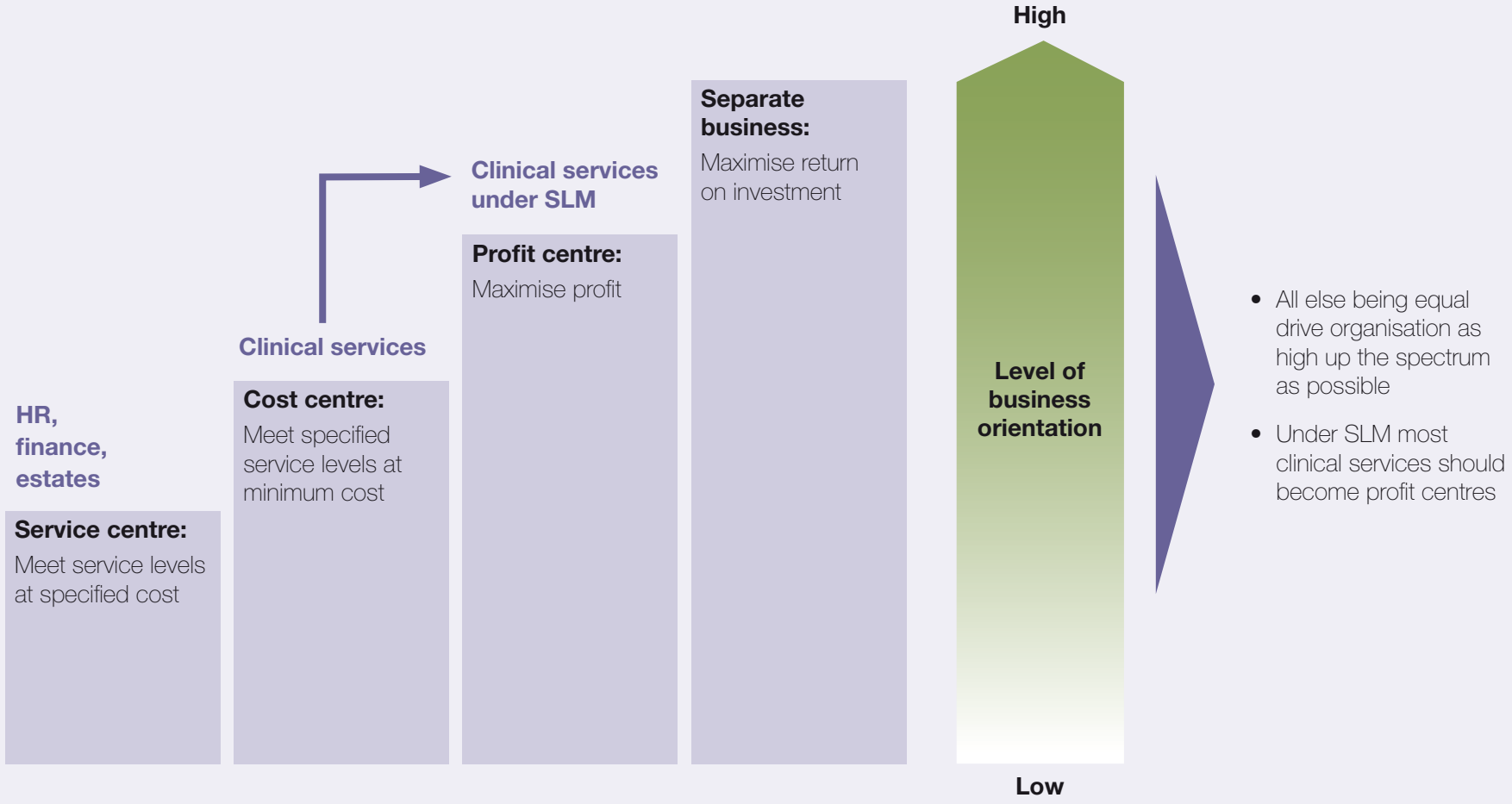
	Centralised	Decentralised
Pros	• Economies of scale maximised • Coordination across specialties, including best practice operations	• Greater service ownership increases incentive to maximise efficiency and utilisation • Function customised to requirements of the service
Cons	• Unclear ownership of service improvements • Potential loss of service innovations within specialties • Lower incentives for specialties to drive service improvements	• Scale may not be enough to ensure best use of cost base • Unclear ownership and accountability for targets that stretch over more than one specialty • Lack of coordination across services
Criteria for success	• Clear accountability for targets • Strong relationship with service-lines for both daily operations and service developments	• Service-line has enough activity to utilise and maintain the full resources of the support service • Inter service-line arrangements for sharing resources

Clarifying the objective function of the service-line to determine its business orientation

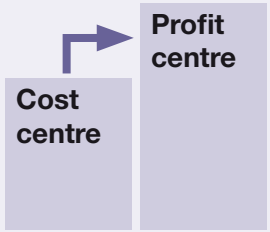
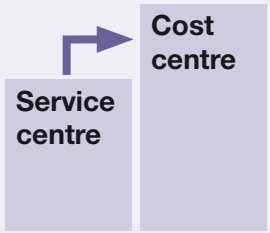
Service-line characteristics	Financial objective function
• Provide a competitive reputable service to distinct customers • Completely independent from trust, with no or few internal dependencies • Core focus is generating return on investment • Freedom to set strategic agenda and direction with no constraints	Maximise return on investment
• Majority of revenues come from external sources • Opportunity to increase market share and activity volumes • Strategic agenda required to be consistent with trust wide agenda • Management of service performance is driven by activity and income growth	Maximise profit
• Majority of service income is internal, with only a small proportion, if any, of direct external income • The main use of the service is requested and initiated by other services within the hospital (e.g. diagnostic tests requested by a consultant in another service, rather than direct patient access from other hospitals or primary care) • Management of service performance is driven by controlling costs and operational efficiencies	Meet specified service levels at minimum cost
• Run on services measures and local budget • Trust sets rules of engagement and cost/overhead allocation across the rest of the trust	Meet service levels at specified cost



Most services within a trust are currently service centres or cost centres



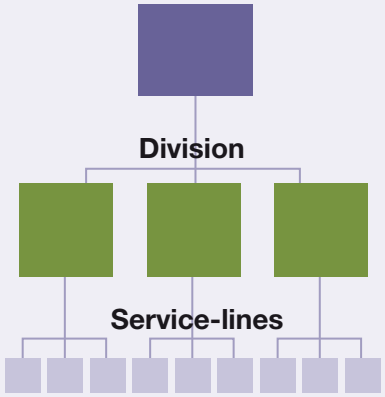
Service-lines should operate according to their objective function

	Objective function	Requirements	Rationale	Example service-lines
Move from cost centre to profit centre 	Maximise profit	• Revenue can be measured • Full profit accountability • Decision rights can be given that increase autonomy	• Enables profit to be calculated and controlled • Increases motivation to improve performance across: – Clinical and Quality – Operational – Financial • Improves decision making at the front line with understanding and links between all elements of the service, and provides the ability to make: – Revenue/revenue trade-offs – Revenue/cost trade-offs – Cost/cost trade-offs	• Surgery • General medicine
Move from service centre to cost centre 	Meet specified service levels at minimum cost	• Costs can be measured • External cost benchmarks are available • Need for cost/cost trade-offs	• Costs must be measurable to be controllable • Ensures that costs incurred in providing required service levels are of the right magnitude and that appropriate targets can be set • Provides a basis for controlling costs by considering knock-on implications of reducing/expanding services provided and balancing workload between different tasks	• Theatres • Pathology services

Divisional layers

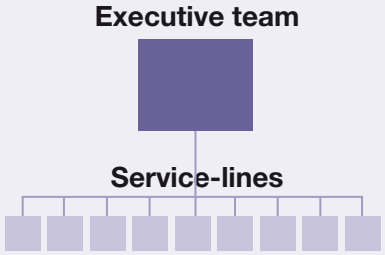
A divisional layer should only be there when the value that it would add can be quantified

Although often addressed, the existence of layers without clear value-adding roles is not always challenged strongly enough…



Characteristics

- Divisional layer aims to achieve a compromise between economies of scale and economies of specialisation
- Overcomes large spans of control
- Service-lines report to the division who in turn report to the executive team
- Little direct contact between the executive team and the service-lines



- Service-lines report directly to the executive team
- Facilitates high levels of presence and visibility of the executive team at the service level

…what would you have to believe to add a divisional layer?

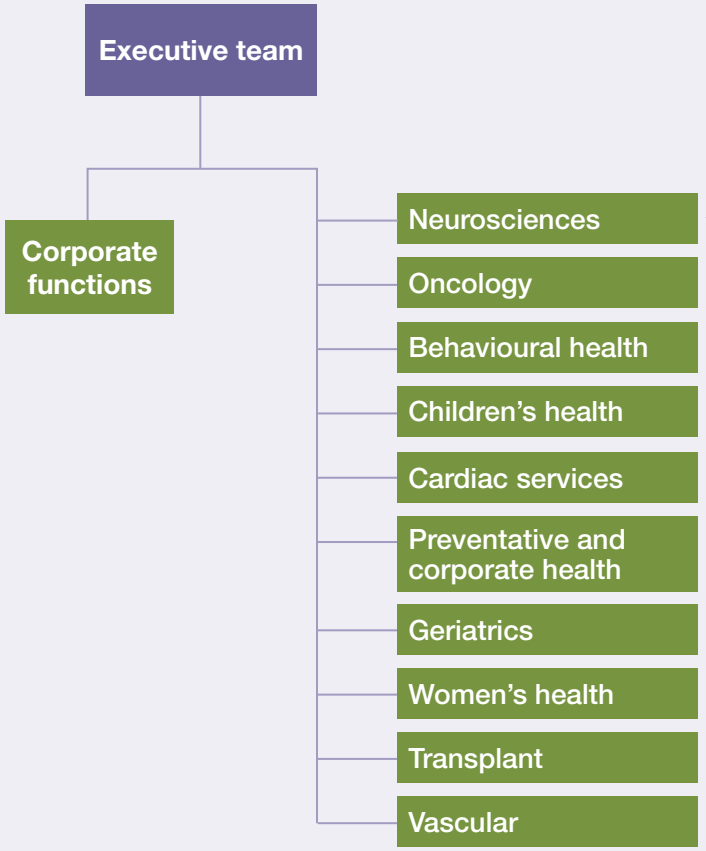
- A divisional layer will be an attractive post and attract high calibre candidates at recruitment
- The additional input will add enough value to justify the post, operational and coordination issues and this value can be both tested and quantified
- The executive team will have enough visibility of the service front line to facilitate devolution of autonomy
- The span of control of the services is too large* for a direct reporting line to the executive team and requires a “span breaker”
- There are specific skill gaps at the service level that a divisional layer can transitorily fill

* The span of control for leaders and managers of managers is advised to be between 1:10 and 1:20, where the role is primarily as coach and supervisor, providing guidance, oversight and problem-solving on an as-needed basis. Above 20 would require a ‘span breaker’

Example

Service-lines – U.S. hospital

This hospital is a fee for service structure and therefore the physicians are self employed.



Service-lines

Service-line director

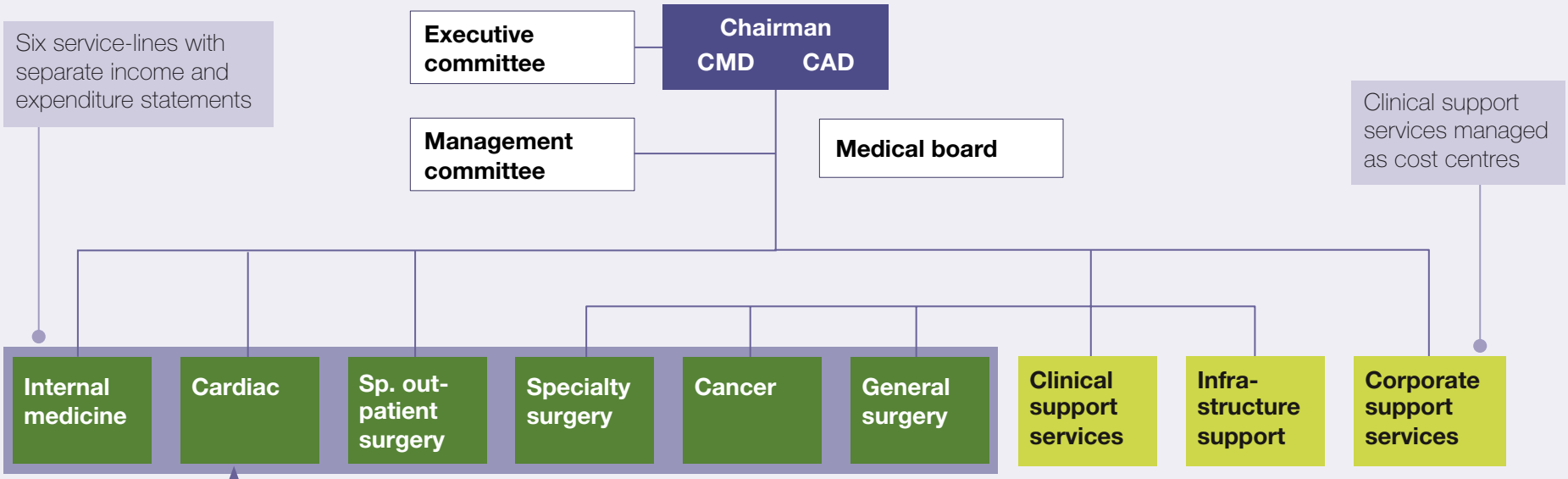
- Managerial role, accountable for the financial performance of the service-line (they have full profit and loss responsibility) and building and maintaining physician relationships within the service
- Work closely with physicians to build the service that is clinically required

Service line definition and creation relied on four principles

- **Flexible:** a single template would not work
- **Inclusive:** needs to involve all governance
- **Physician-led:** physicians determine leadership
- **Transparent:** information shared and used to form basis of strategic and business planning and performance

Example

Service-lines – Asian hospital



Service-lines

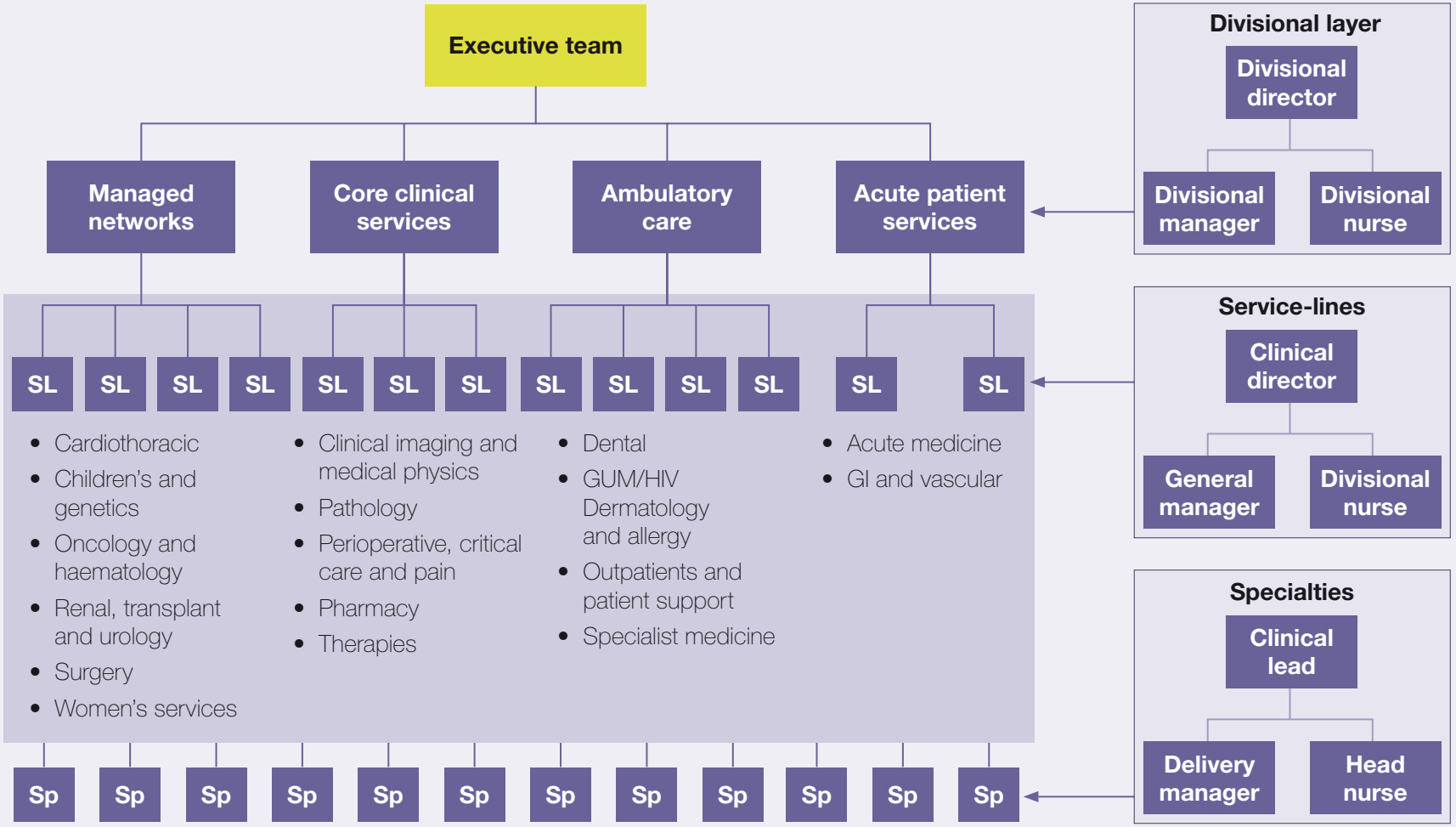
Clinical director

- clinical leaders, with support and input from general managers
- where the clinical complexity is low, general managers can take a larger role in two service leadership

- Leadership should be offered to clinicians who demonstrate clinical excellence and strong (potential for) leadership skills
- Incentives focus on supporting them in developing their services (resources, research, etc.)
- The clinical directors report directly to the chief medical director

Example

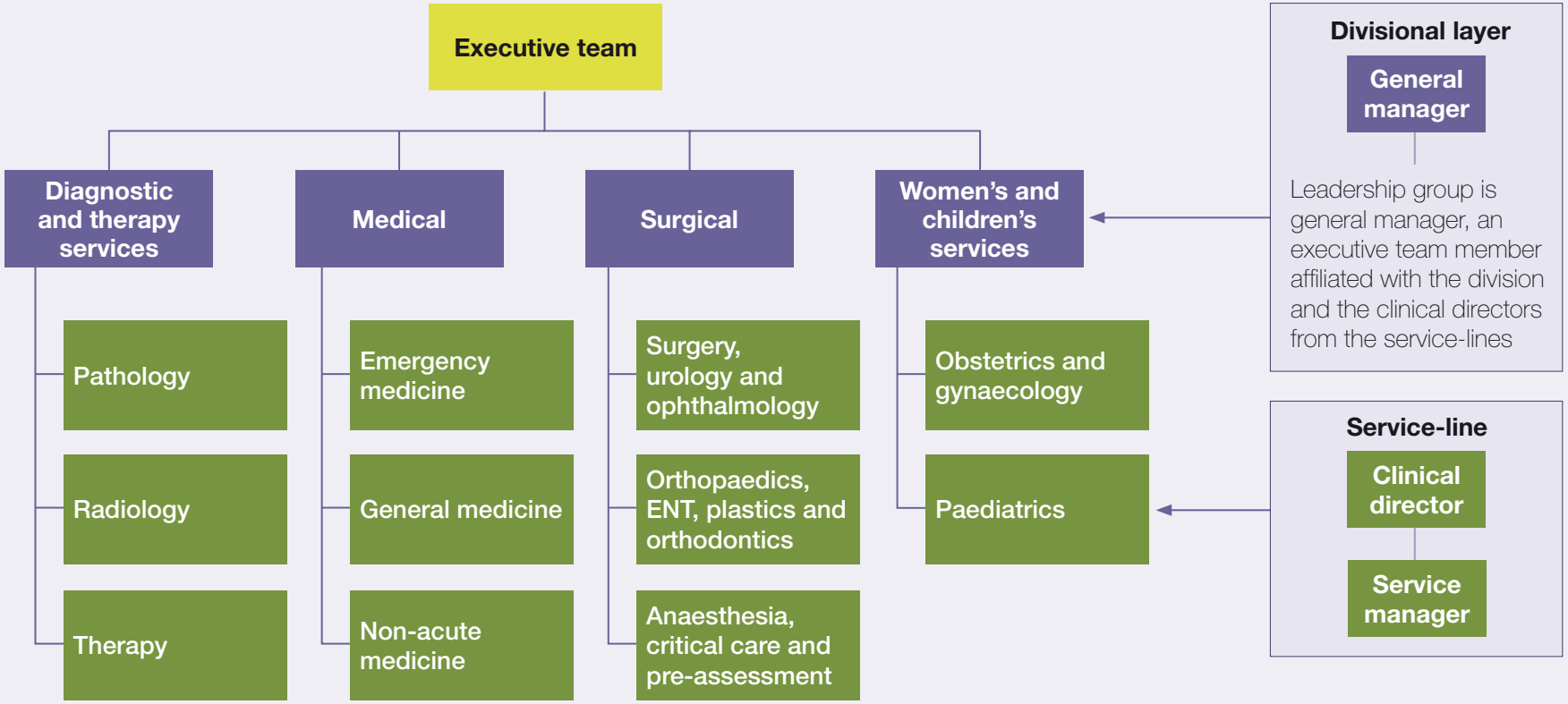
Divisional layer – UK teaching hospital



Illustrative

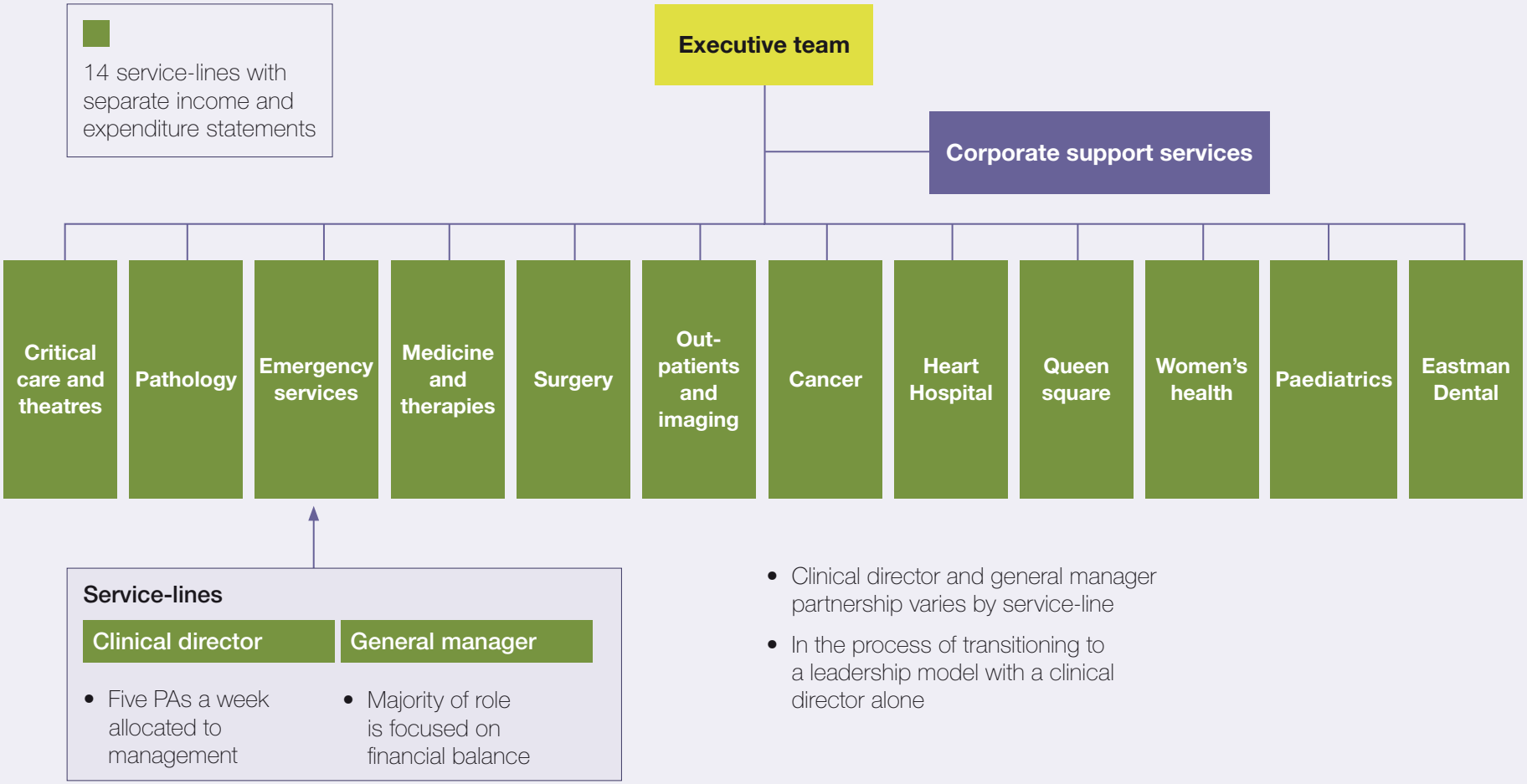
Example

Divisional layer – UK district general hospital



Example

No divisional layer – UK teaching hospital



Illustrative

Example

No divisional layer – UK district general hospital

Service-lines

Clinical director	General manager
• Define the service strategy • Patient care (with matron) • Consultant and clinical communication	• Support development of how to deliver strategy and business plans • Management delivery and expertise • Information transparency • Directorate-wide communication

- Leadership teams include matrons/lead nurses or other relevant senior staff (e.g. lead radiographer)
- Clinical directors are expected to take a prominent role in leadership
- General managers are expected to provide "business", including financial, expertise

Illustrative

Organisation

Roles

Organisation – roles

Guiding principle: The NHS should move to a business unit structure, devolving autonomy to the front line, learning from how they have been applied in the commercial sector and translating the use to a hospital setting

	Principles	Questions raised at trusts
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Roles	• There are different options for who and how service-lines are run; in all cases there should be a single point of accountability • Clinicians should have a prominent role in leadership • Leaders should exhibit competencies across people, quality, service and collaborative leadership	• How do we select service leaders? • How do we build capabilities? • How can we hold them to account?
Decision rights	• Decision rights should ensure service-lines are empowered to drive service performance • A control function should be in place to alter these decision rights according to performance	• Where should decision rights be held? • What are the conditions for having robust decision rights? • How can executive teams let go in a controlled way?

Roles

A summary

- The role of service-line leader needs to be developed to create clear accountability for the integrated clinical, operational, and financial performance of the service-line.
- The most important capability challenge for NHS foundation trusts in improving service-line management is engaging all of the service-line's clinicians to take responsibility for realising the clinical, operational and financial objectives of the service-line.
- There are multiple structural options available, the key is to ensure that there is a single point of accountability.
- Clinical engagement is a critical component of service-line leadership.
- A good service-line leader, clinical and managerial, exhibits leadership in four areas:
  - People leadership – taking responsibility for recruiting and developing clinicians and other staff members
  - Quality leadership – developing the service-line's quality, safety and efficiency
  - Service leadership – taking integrated responsibility for the service-line's performance along clinical, operational, and financial dimensions
  - Collaboration – working to maximise benefits for the whole trust rather than only their own service-line.
- Recruitment to service-line leadership posts needs to have a clear value proposition to attract high calibre candidates.
- For the service-line leader to prosper, significant training is required regardless of the service-line leader's background:
  - Clinical backgrounds need to demonstrate financial analysis, commissioning dynamics, and people leadership skills
  - Business backgrounds need to demonstrate ability to lead clinical efficiency development, understanding of commissioning dynamics, and people leadership skills.

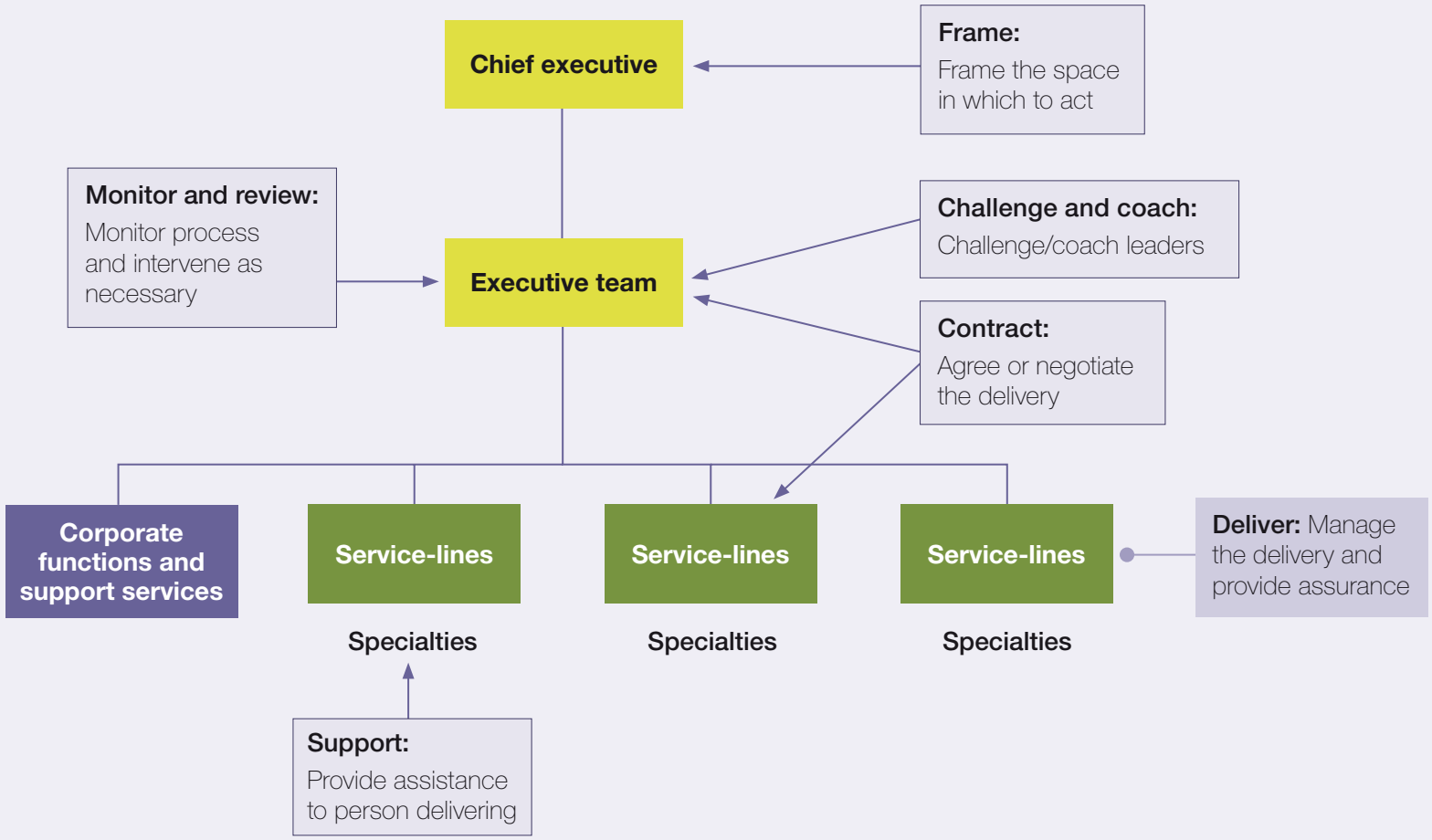
Roles

Principles

Principle	From	To
There should be a single point of accountability	"We have performance meetings and action lists but at the end of the day the executive team are accountable for delivering targets and financial stability"	"Accountability has been clearly defined throughout the organisation, with service-line leaders taking full ownership of the performance of their services"
Clinicians should have a prominent role in leadership	"General managers' role is to balance the books while (clinicians) get on with the work"	"Clinicians need to be integrally involved in service leadership to ensure the agenda strives to improve the quality of services to our patients"
Leaders should exhibit competencies across people, quality, service and collaborative leadership	"There are very few people who have the needed skill set and mind set today"	"We have a portfolio of training programmes in place, directly linked to up-skilling our staff across the four leadership dimensions"

Accountability

Accountability for delivering service performance at the service-line can be divided into sub components



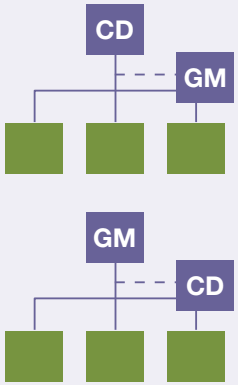
Single point of accountability for delivering tasks

Component	Description	Ideal number of people accountable
Frame Frame the space in which to act	• Provide context • Set limitations of role and provide policy frameworks	1
Contract Agree or negotiate the delivery	• Delegate the required task • Agree on the representation of the accountability (e.g. performance contract) • Agree on the specific performance required	2
Deliver Manage the delivery and provide assurance	• Act within the limitations to deliver the task • Take ownership for fulfilling the agreed on performance level • Exercise authority over relevant tasks and delegate sub tasks as appropriate • Report on delivery metrics as detailed by the performance contract	1
Support Provide assistance to person delivering	• Provide input where relevant • Assist with resources as required • Provide data to allow decision making	>1
Challenge and coach Challenge/coach leaders	• Provide real challenge on both performance and decisions made • Act as "coach" to the individual(s) accountable for delivery	>1
Monitor and review Monitor process and intervene as necessary	• Monitor and evaluate the efficiency of the process • At agreed on "triggers," orchestrate appropriate interventions • Identify risks to the agreed on performance levels	1

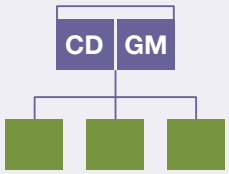
Typically, this is the person thought of as "owning the process"

Accountability can be single or dual point but needs to be clearly defined

Single leadership model



Partnership leadership model



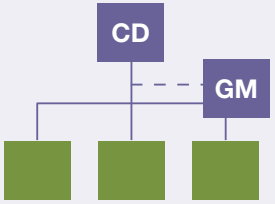
CD Clinical director
GM General manager

	Accountability	Condition for success
Single leadership model	• Clinical director is the single point of accountability for: – Financial performance – Operational performance – Clinical performance • General manager is the single point of accountability for: – Financial performance – Operational performance – Clinical performance	• Managerial support for clinical director • Sufficient time allocation in clinical director job plan • Skills and capability development for clinical director for financial and operational elements as required • Clear consequences for good/poor performance • Strong clinical input into decision making and direction of travel • Clinical director support for general manager • General manager well-respected by clinicians • Clear accountability for clinical governance and clinical operational performance
Partnership leadership model	• Partnership accountability for: – Financial performance – Operational performance – Clinical performance • Clinical director and general manager individually accountable for their behaviors within the partnership and successful working relationship	• Clear consequences for both clinical director and general manager for good/poor performance • Good working relationship within the partnership • Priorities for the service-line need to be agreed jointly • Clear description of how decisions will be made within the partnership • Arbitration mechanism in place for when there are disagreements between the two parties

Example

Single leadership model – U.S. academic medical centre

Single leadership model



Responsibilities: Clinical director

- Set strategic direction
- Service performance
- Actively engage and manage team
- Lead clinical quality delivery and initiatives
- Hire and fire clinical staff
- Substantial time allocated to leadership role

Responsibilities: General manager

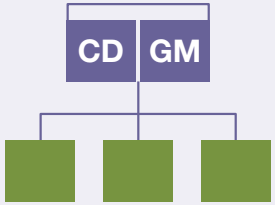
- Supporting role to clinical director (similar to chief financial officer – chief executive officer relationships)
- Project management
- Provide decision making support, information including performance reports, analysis and synthesis of key implications for clinical director
- Develop business cases
- Research feasibility and impact of proposals
- Hire and fire admin support

What are they held to account for?	• Clinical director is the single point of accountability for: – Financial performance – Operational performance – Clinical performance
How are they held to account?	• Reports to the chief medical officer on a monthly basis • Performance management regime • Removed from role if consistent poor performance
What are the benefits of this model?	• High levels of clinical engagement • Clinical focus and accountability for all aspects of service performance • Able to respond to changing demands more quickly as one ultimate decision maker • General mangers are very high calibre, often MBA backgrounds and specific expertise • Appropriate support to fulfill role, with business analysis, project management expertise and dedicated support from general manager

Example

Partnership leadership model – U.S. hospital

Partnership leadership model



Responsibilities: Clinical director

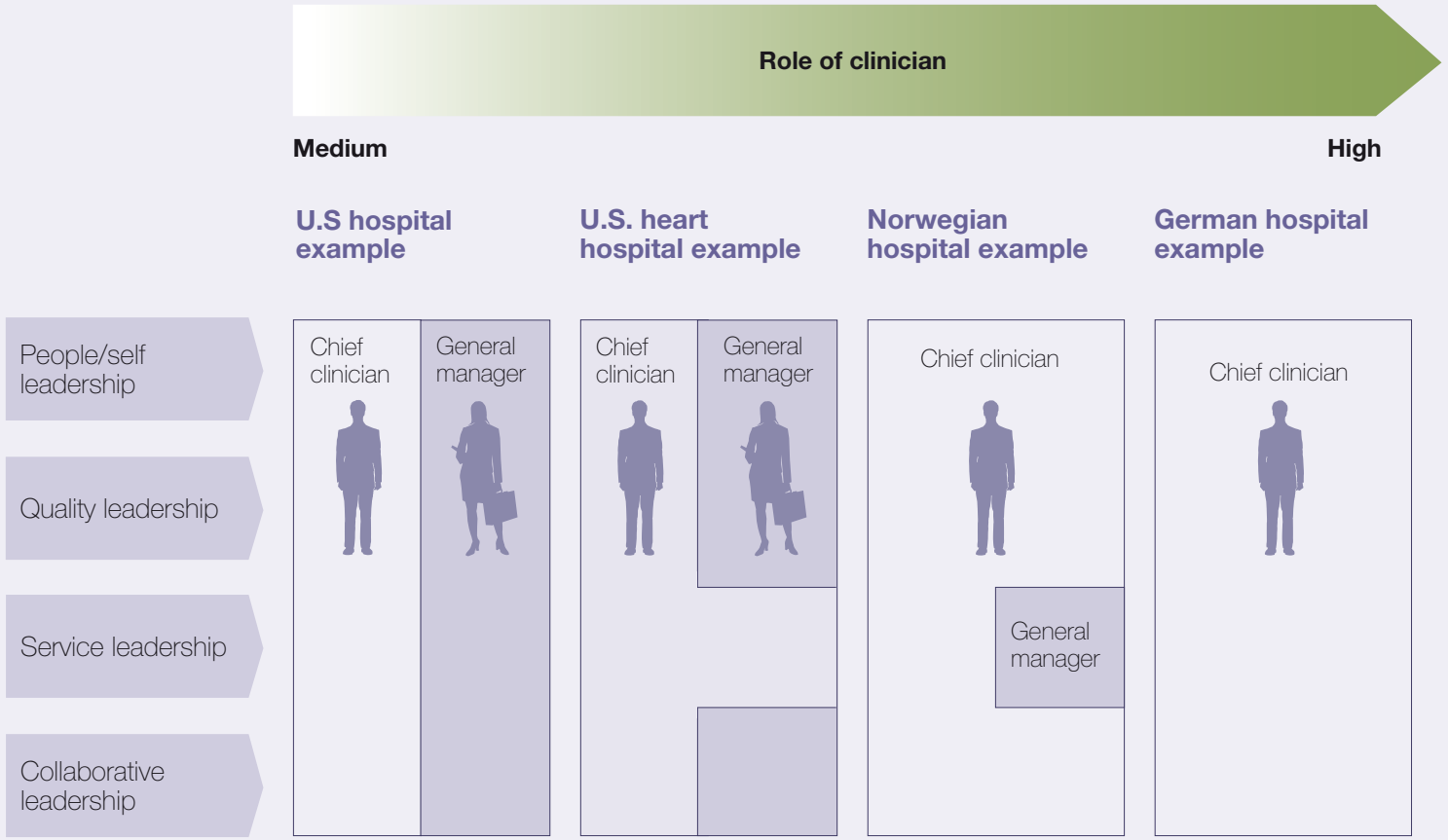
- Actively engage in quality improvement
- Select and empower leaders with shared vision
- Engage in collaborative practice
- Promote hospital through clinical innovation and outreach
- Time split between leadership role and clinical work

Responsibilities: General manager

- Include medical staff leaders in significant decisions
- Be transparent regarding finances and decisions
- Demonstrate appreciation for contributions
- Ensure well run hospital
- Improve access to clinical data and performance relative to benchmarks

What are they held to account for?	• Clinical director and general manager have partnership accountability for: – Financial performance – Operations including patient care, business processes and quality – Strategic planning and decision making – Performance review of section heads, administrative directors and managers
How are they held to account?	• Contract between hospital/managers and clinical leads outlining the responsibilities of each party • Performance management regime ensures compliance • Reward for good performance: – Autonomy – Protection – Entitlement
What are the benefits of this model?	• Provides diversity of skills and perspectives • Reduces over-dependence on individuals • Requires and facilitates strong communication • Ownership and accountability across professions

Clinicians play a prominent role in international service leadership models



A good service leader exhibits leadership capabilities in four areas

Dimension	What does this mean?
People/self leadership	• **Inspirational people leader** across professional boundaries • Helps others **perform their best** • Continuously aims for **self-development** • Is an effective **role-model**
Quality leadership	• Demonstrates outstanding **patient commitment** • Demonstrates commitment to **quality of care and outcomes** • Effectively prioritises **patient safety** • Ensures a positive **patient experience**
Service leadership	• Understands drivers of **financial performance** • Identifies and prioritises opportunities to improve **operational excellence** • Delivers service-specific **strategy and objectives**
Collaborative leadership	• Acts within the overall **interests of the trust** • Effectively communicates and **collaborates with other leaders** • **Engages the executive** as appropriate • Effectively **engages other stakeholders**

Please see Appendix A for detailed assessment tool

Common skills gaps and development needs across service leaders

	Clinical director	General manger
People/self leadership	• Continuously aiming for self-development • Coaching and developing team members	• Inspiring people across professional boundaries
Quality leadership	• Relying on nursing or administrative staff rather than leading initiatives to drive positive patient experiences	• Leading clinical efficiency development
Service leadership	• Understanding drivers of financial performance • Financial analysis • Understanding commissioning dynamics	• Understanding drivers of service performance • Understanding commissioning dynamics
Collaborative leadership	• Communicating effectively, internal and external	• Communicating effectively, internal and external

Developing service-line capabilities

Service-line capabilities can be realised through recruiting talent and developing current staff

	Description	Key requirements
Recruit	• Recruiting high performers fastest way to drive change • Recruiting to attract talent – Outsiders help calibrate talent and build confidence to replace low-performers – Helps attract other high-performers	• Know what you are looking for: people who are dedicated to your trust goals and possess the key characteristics for success • Know where to find the right candidates • Ensure recruiting activities and decisions are led by high performing members of the organisation • Set out the value proposition clearly and persuasively
Develop	• Retention and development of high-performers also critical – Calibrates and institutionalises new performance standard – Gets high-performers in pivotal positions and low-performers out	• Define and communicate the key capability requirements of the role • Assess individual against requirements and identify skill gaps • Create a training and development programme to address skill gaps • Regularly assess success and improvement

The key to successful recruitment is the value proposition

What excites people? What is it about a job that they really enjoy doing and motivates them? This is the "value proposition".

Survey conducted across clinical directors and general managers in four trusts

How successful do you think each of the following incentives would be in motivating you *personally* to become a service leader?

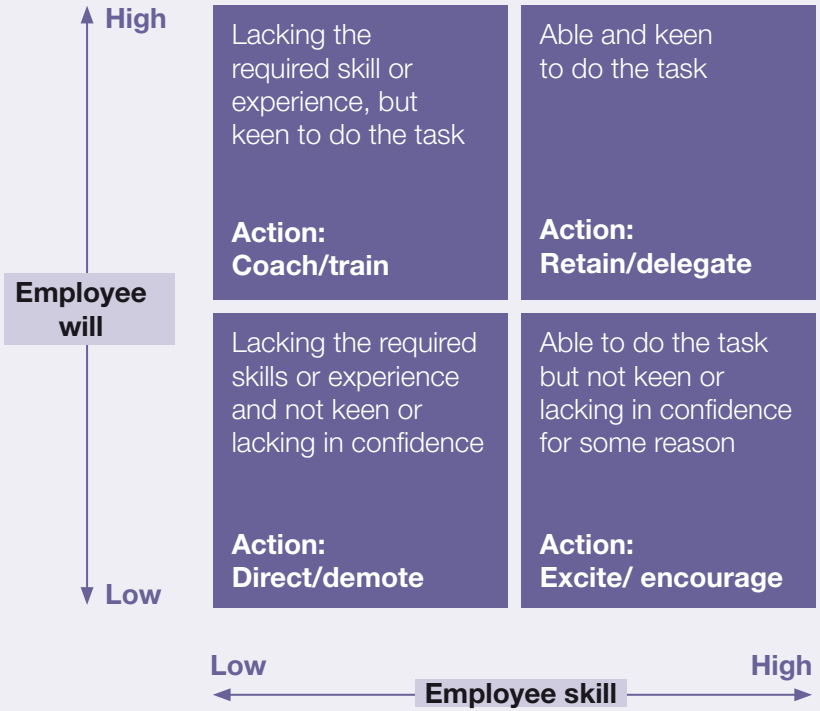
Define the "value proposition"

To attract talent there needs to be a value proposition that is tailored to the specific motivations of individuals

Developing current staff requires a clear understanding of their development needs

The "high skill/high will" concept refers to people's willingness to do something challenging and having the personal competencies to do those things. It is important to identify people with high skills/high will to develop as service-line leaders

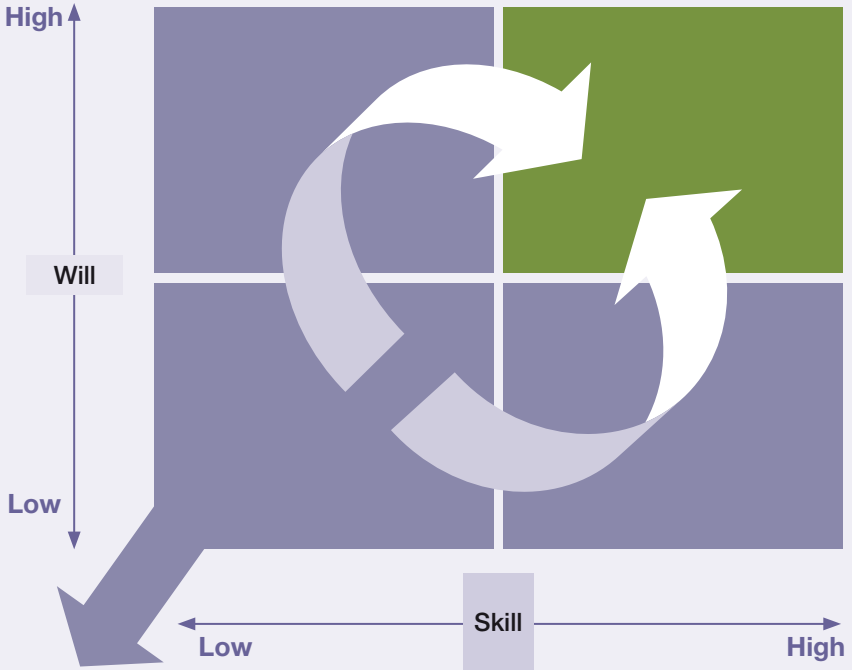
Skill/will matrix: to determine the current development needs of current staff



- Mapping the current members of the organisation on the matrix will help to determine the capability development programs that need to be put in place
- The devolution of decision rights should be linked to both the capability of the individual and the performance of the service-line

Important to clearly define “high will/high skill” and to link this with capability development programmes

The organisation should aspire to have service leaders with high will and high skill



- What are the ideal behaviours and competencies that would characterise high will and high skill?
- Once we understand where individuals are at present, how can we develop appropriate development programs to move towards all being in the top right?

Capability development should be tailored to needs

Input

Vision for creation, ownership and implementation of service improvements at service-line

Define future skill set

- Define future state of relevant skills and behaviours service leaders need to display to be successful

Assess current skill set

- Plan the communication ahead of the process and state why it is being done
- Assess present skills of target group in any of several ways:
  - Interviews with line managers and peers
  - Workshop with exec team
  - Self-assessment of target group
  - 360-degree evaluation
  - Observation

Prioritise skill gaps

- Define which skill gaps should be closed and when (e.g. all five or only the top three)
- Define hiring needs for large/hard to close skill gaps and for succession planning
- Define which skills are directly linked to decision rights

Design

- Design methodology for capability development
- Support:
  - Providing additional administrative support
  - Providing additional managerial/financial/information support (dedicated or pooled)
  - Mentoring/"sounding board"
- Development:
  - Coaching
  - Offering shadowing opportunities
  - Setting up ad hoc workshops
  - Creating courses with modules
  - External functional and leadership skills training courses

Organisation

Decision rights

Organisation – decision rights

Guiding principle: The NHS should move to a business unit structure, devolving autonomy to the front line, learning from how they have been applied in the commercial sector and translating the use to a hospital setting

	Principles	Questions raised at trusts
Service-line structure	• Service-lines should be defined using commercial business unit criteria • Where the service-line has the critical mass it should own the clinical infrastructure • Service-lines' objective functions should be defined by their intrinsic characteristics (e.g. revenue sourcing, financial and operational dependencies, service focus) • Service-lines should operate according to their objective function, with the majority as profit centres • A divisional layer should only be there when the value that it would add can be quantified	• How do we change the organisation? • How do we get there over time?
Roles	• There are different options for how service-lines are run and by whom; in all cases there should be a single point of accountability • Clinicians should have a prominent role in leadership • Leaders should exhibit competencies across people, quality, service and collaborative leadership	• How do we select service leaders? • How do we build capabilities? • How can we hold them to account?
Decision rights	• Decision rights should ensure service-lines are empowered to drive service performance • A control function should be in place to alter these decision rights according to performance	• Where should decision rights be held? • What are the conditions for having great decision rights? • How can executive teams let go in a controlled way?

About decision rights

What are decision rights?

Decision rights define who within the organisation has responsibility and, therefore, accountability for each part of the decision-making process

For decision-making processes, it is important to define…

- Who makes the initial recommendation
- Who is consulted during the process (e.g. has expertise and attends meetings to give guidance, or is required to provide supporting evidence/verification)
- Who makes the final decision?

Leaders should also understand…

- Who supports the process (e.g. with analysis)
- Who will be informed after the decision has been made

Why are decision rights important?

Benefits	
Higher performance	• People are clear about what decisions/processes they are responsible for and therefore deliver more consistently against targets
Increased management pace	• By increasing focus for individuals and clarifying who needs to be involved in reaching a decision, people are better placed to move quickly in their areas of responsibility
More accurate alignment of KPIs	• Enables accurate assignment of KPIs to individuals, based on areas they can actually effect, i.e. have decision making authority
Improved performance feedback	• By creating greater clarity about what people are and are not responsible for, managers and executives quickly know where to direct their feedback

Decision rights in SLM

- Clearly defined **decision rights** are crucial to enable service-line managers to deliver on their objectives and to empower them to take ownership of service performance.
- Clearly defined rights need to govern strategic, financial, operational and human resource decision making.
- The allocation of decision rights should be based on a clear framework, acting as a frame of reference for employees at all levels:
  - Decision rights concerning common, unambiguous decisions are defined in standard lists
  - In situations where the decision right is less common/unclear a framework for decision making can be used that takes into consideration the likelihood of a decision turning out to be wrong and the impact it would have.
- In the first instance, an assessment confirming that the right service-line management capabilities are in place is essential before decision rights are devolved.
- On an ongoing basis, levels of decision rights should be integrally linked to the performance management regime to ensure direct links between capabilities and the decision rights a service can have.

Principles underpinning decision rights

Principle	From	To
Decision rights should ensure service-lines are empowered to drive service performance	"The decision rights the different levels of the organisation have evolved over time… there are lots of decisions that we as an executive team don't need to be making"	"Service-lines feel empowered to make decisions that improve clinical, financial and operational performance"
A control function should be in place to alter these decision rights according to performance decision rights according to performance	"Our performance management structure does not link with our decision rights"	"The level of autonomy and the kind of decision rights our service-lines have are directly linked with the service and individual performance"

The four types of decisions

	Example decisions
HR decisions	• Replace consultant for an activity that may not be sustainable • Increase in overtime to cover additional work • Hire a temporary project manager
Financial decisions	• Vary budget between pay and non-pay • Lease purchase equipment from income • Adjust service price as a result of new developments • Replace dated equipment with new technology (value ~£1m)
Clinical and operational decisions	• Open beds temporarily to cope with emergency admissions • Close a ward due to infection outbreak • Condemn a piece of equipment • Decision to revise a discharge protocol
Strategic decisions	• Develop a cancer service against network view • Expand critical care unit • Develop new specialist surgery service

Define the "decision maker"

Starting with who should make the final decision and be the decision right owner can provide direction on who is really accountable

Process for assigning the decision maker

1. **What is the decision?**
2. **What is the risk?**
3. **How big is the impact?**
4. **What is the risk rating?**
5. **Who is the decision maker?**

- **Define the decisions**
  - HR
  - Financial
  - Clinical/operational
  - Strategic
- **What is the likelihood of an adverse event?**
  - Care quality
  - Contract risk
  - Trust employee relations
  - Reputation/external relationships
- **Is there a potential lack of alignment with the trust's direction?**
  - Overall trust strategy
  - Other divisions
  - Support services
- **How big an impact will the decision have?**
  - Recurring cost or revenue impact
  - One-off/investment cost impact
  - Support service impact
  - Ward, patient, staff impact
  - Reputation/external relations impact
- **Where does the decision fit in the matrix?**
  - Green
  - Amber
  - Red

  (See next page)
- **Who should be the decision-maker?**
  - Executive
  - Division
  - Service-line

Framework for determining decision rights

This table determines those decisions that have relatively low impact on a trust's overall performance to those that are mission critical. As the risk increases, there is a requirement for decisions to be taken at higher levels, up to and including the executive and board

Likelihood of adverse event occurring

- Care quality
- Contract risk
- Trust employee relations
- Reputation/external relationships and/or

Lack of alignment with rest of trust's direction

- Overall trust strategy
- Other divisions
- Support services

These two dimensions explained further on the next two pages

Risk assessment

Likelihood	1 Very low	2 Low	3 Moderate	4 High	5 Very High
5 Very High	G	A	R	R	R
4 High	G	A	A	R	R
3 Moderate	G	G	A	A	R
2 Low	G	G	A	A	A
1 Very low	G	G	G	G	A

Magnitude of impact of event/lack of alignment

- Recurring cost or revenue impact
- One-off investment cost impact
- Support service impact
- Ward, patient, staff impact
- Reputation/external relations impact

Decision right owner

Risk level	Appropriate decision right owner
Red risks	Trust executive/ chief operating officer
Amber risks	Clinical division (group of service-lines – only applicable in trusts with a divisional layer)
Green risks	Service-line

Example

Results of pilot discussions about decision rights owners (1 of 2)

The trust has agreed a risk profile for decision making and assessed the decisions in terms of impact and likelihood. It has allocated decision rights owners and given the risks a colour coding

	Example decisions	Assessment (1=low, 5=high) Impact	Likelihood	Appropriate decision right owner (highlighted) Service-line	Clinical division	Trust executive/ COO
HR decisions	• Replace consultant for an activity that may not be sustainable	2	1			
	• Increase in overtime to cover additional work	1	1			
	• Hire a temporary project manager	1	1			
Financial decisions • Revenue • Opex • Capex	• Vary budget between pay and non-pay	1	2			
	• Lease purchase equipment from income	3	2			
	• Adjust service price as a result of new developments	5	3			
	• Relocate equipment from one hospital site to another (value ~£1m)	3	3			
Clinical and operational decisions	• Open beds temporarily to cope with emergency admissions	2	3			
	• Close a ward due to infection outbreak	4	3			
	• Condemn a piece of equipment as non-servicable	1	1			
	• Decision to revise a discharge protocol	1	1			
Strategic and service development decisions	• Develop a cancer service against network view	4	5			
	• Expand critical care or neonatal intensive care unit	4	3			
	• Develop new specialist surgery service	4	4			

Example

Results of pilot discussions about decision rights owners (2 of 2)

This shows the analysis behind the risk ratings for some sample decisions.

Decision	Magnitude of impact	Likelihood of adverse event occurring/lack of alignment with rest of trust's direction	Decision right owner
Replace consultant for an activity that may not be sustainable	3 **Moderate** • Some financial impact if the revenue is not sustainable since staff will have to be paid for on a recurring basis regardless of whether there is volume or not	3 **Moderate** • In this case not certain that commissioners will continue to have these needs in the future	**Clinical division (group of service-lines)**
Increase in overtime to cover additional work, short term	1 **Very low** • Limited financial impact since this is a short term measure • Assuming additional work is agreed with commissioners	4 **High** • Will likely result in an increase in staff unit cost, in the short term	**Service-line**
Develop a cancer service against network view	4 **High** • Significant magnitude of loss if contract volume to support the expansion cannot be identified	5 **Very high** • Large risk that contract volumes may not materialise, based on network view	**Trust executive/COO**

Information support

Service-line management – information support

Key enablers	"Check-list" of the important components
1 Organisation	☐ Defined **service-line structure** ☐ Defined service-line **leadership roles**, with integrated ownership of clinical, operational and financial performance ☐ Capability-linked, defined **decision rights** at each level (trust executive, service-line, and team)
2 Strategic and annual planning process	☐ Understanding of market and competitive position ☐ Defined three- to five-year strategy and annual objectives ☐ Action plan to deliver strategy ☐ Robust annual planning process ☐ Levels of autonomy linked to quarterly monitoring regime
3 Performance management	☐ Clear KPIs, targets and accountabilities ☐ Performance tracking ☐ Effective review meetings ☐ Good performance conversations ☐ Rewards and consequences for performance
4 Information support	■ Relevant, timely information ■ Patient level costing

Service-line management information requirements

- Most widespread NHS practice is to operate within fixed budgets and analyse by spend against the budgets. However there is little or no analysis of expenditure linked to activity level to explain the observed spend against the budgets.
- In order to manage an organisation as a portfolio of service-lines with devolved autonomy, each service-line needs adequate financial and operational information, with a clear link between the two. This enables much more informed operational, as well as strategic, decisions to be taken.
- The first step to attaining the necessary level of financial detail, comparing income against expenditure, is provided by service-line reporting (SLR). This gives a statement of profitability at service-line level. Initially this is likely to be derived from reference costing information, but ideally over time should be developed to patient-level information and costing systems (PLICS).
- The time needed for change in people's mindsets will require parallel running of the old and new systems while the SLR/PLICS system is established, and the staff get used to using the information available in a meaningful way.
- PLICS systems can be developed in-house, but there are several established suppliers with off-the-shelf packages. Evaluation of these suppliers will ensure compatibility with the trust's legacy systems and will provide an opportunity to encourage clinical buy-in.

Service-line reporting (SLR) provides critical insight into service profitability

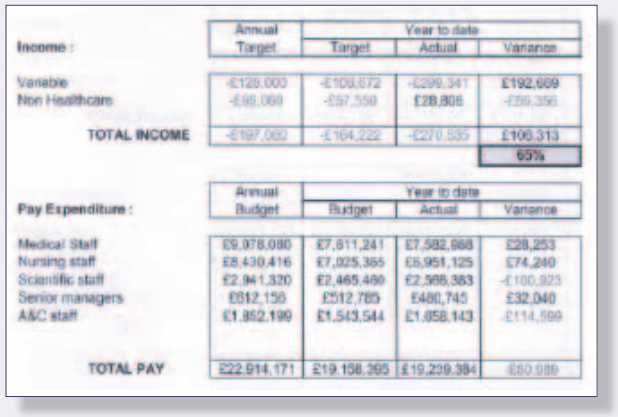
What it is	• Statement of profitability by service-line, including allocation of revenues and costs to service-line level • Driven by best available data: – top down allocation using reference costs plus revenue assignment – patient level costing – real time reporting
Benefits	• Ability to provide comprehensive overview of the economic contributions of individual service-lines making up overall portfolio • Catalyst for engaging clinicians in discussion about productivity • Enable linkage of operational drivers to financial performance • Can be used for budget setting and performance improvement
Requirements	• An executive sponsor with overall leadership accountability • A clinical champion • A lead for implementation from finance/data • Engagement of (at minimum) clinical directors and general managers • (Limited) time of clinicians to test key assumptions about allocations • New software/systems eventually desirable but not required at start
Key steps	• Gather available databases of information • Use unique patient key to allocate direct costs where possible (e.g. theatre, wards) • Use assumptions/allocation rules for whether direct assignment not possible • Review results and identify key questions to ask • Iterate

Linking operational and financial performance

Traditionally, operational performance and financial performance were seldom linked. Trust boards would take a finance report and discuss finance, and then take a performance report and discuss performance. They did not examine the correlation between output and the cost of delivering services. SLR attempts to ensure that financial and performance reports not only cross refer but are presented as a single operational performance reports package and are discussed accordingly, enabling trusts to better understand their service performance.

How performance reports are typically used

Financial report



Income :	Annual Target	Year to date Target	Actual	Variance
Variable	-£129,000	-£108,672	-£298,341	£192,669
Non Healthcare	-£68,060	-£57,550	£28,808	-£86,358
TOTAL INCOME	-£197,060	-£164,222	-£270,535	£106,313
				65%

Pay Expenditure :	Annual Budget	Year to date Budget	Actual	Variance
Medical Staff	£9,078,080	£7,611,241	£7,582,988	£28,253
Nursing staff	£8,430,416	£7,025,365	£6,951,125	£74,240
Scientific staff	£2,941,320	£2,465,460	£2,566,383	-£100,923
Senior managers	£812,156	£512,785	£480,745	£32,040
A&C staff	£1,852,199	£1,543,544	£1,658,143	-£114,599
TOTAL PAY	£22,914,171	£19,156,395	£19,239,384	-£80,989

> We check to see that costs are not wrongly allocated to us

> We use the finance reports to see whether we're within budget

> Sometimes we know from our wards what's increasing the cost and we'll discuss that with staff

Performance report

> The performance reports do not give us a good idea of how we're doing

> We use the performance reports to build business cases but not to manage the service each month

> The performance and finance reports are for different things – we keep them separate

The true cost of services

Many NHS trusts operate fixed budgets which do not contain unit cost transparency

Service-line monthly financial report

3.1 Income £341k over recovered, 373k favourable movement

- As mentioned above, income has been included for over-performance (£100k) and Paed liver disease drugs (£70k). The full year effect of this income is £170k and approx. £15k respectively

3.2 Pay £150k overspent, favourable movement of £40k

- Admin. and clerical staff (£19k under-spent year-to-date). This was £14k under-spent for the month. Bank and agency accruals are quite low
- Medical staffing (£6k overspent year-to-date). This was £28k under-spent in the month; Dr Smith was recharged to the medical school, and this totaled £20k
- Nursing staff (£121k overspent year-to-date). This was £9k under-spent for the month. Bank nursing was considerably lower than the trend to-date in NICU
- This may be due to an over-accrual in month 8 being balanced off; two wards had higher levels of bank than normal

4.1 Income

- Income is based on invoices raised to-date and excludes unbilled income
- The positive variance in income year-to-date of £541k is a reflection of the increased levels of activity over the past few months with the cardiac and women's and children's service-lines
- However, of significant note, is the number of bone marrow transplant cases performed in the current financial year thus far
- Also included is overseas visitors income of £100 year-to-date. Against which a provision of £170k has been made for doubtful debt.

Financial analysis focuses on spend against budget, rather than financial impact of operational decisions

Income is derived from level of activity, but no such link exists with expenditures

No fact base available to support qualitative understanding of cost drivers

No fact base available to support qualitative understanding of cost drivers

Operational issues and efficiency improvements are not considered in financial reports

Introducing patient level costing

Patient level costing enables trusts to better understand their service performance

Traditional accounting system

Cost **Cost centre**

- Traditional accounting systems allocate costs to expense categories (e.g. doctors' pay, drugs) and locations (e.g. cardiac service, Ward #1)

Patient level information costing system (PLICS)

Cost **Activities**

- Patient level costing allocates costs to HRGs (e.g. coronary bypass) and their components (e.g. theatre costs, nursing costs)

Practical benefits

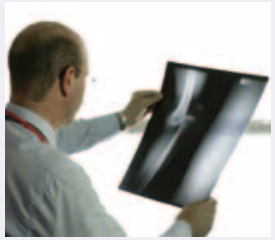
- Strategic insight into trust activity
  - Ability to challenge national tariff using robust cost data
  - Understanding of comparative attractiveness/profitability of services (portfolio management)
- Link operational and financial effectiveness and facilitate performance management
  - Total cost across all HRGs
  - Cost components of each HRG
  - Comparative costs of each component across clinicians, wards, and theatres

Patient level costing enables deeper analysis of service performance

What it is	• Costing by HRG down to the individual patient level • Driven by best available data on actual usage
Benefits	• Ability to identify variability in cost at the procedure and patient level • Improved ability to provide detailed input to setting national tariffs • Engages clinicians at an operational level • Can be used for on-going performance management/improvement
Requirements	• Software partner • A lead for implementation from finance/data • (Limited) time of clinicians to test key assumptions about allocations • Reasonably accurate doctor PA assignment data
Key steps	• Gather available databases of information • Use unique patient key to allocate direct costs where possible (e.g. theatre, wards) • Use assumptions/allocation rules for whether direct assignment not possible • Review results and identify key questions to ask • Iterate

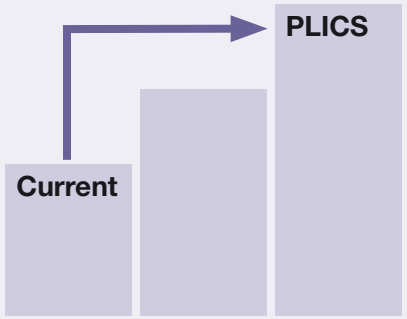
The benefits of patient level costing

Patient level costing facilitates understanding of the underlying drivers of financial performance

	From	To
Clinicians 	"I have no idea how finance relates to what I do"	"The reason the costs went up for X procedure was due to the new drug that reduces readmissions by Y%"
Managers 	"Our agency nursing costs have increased" "Our clinical supplies costs are under-budget"	"We've treated X% more patients than planned, which has caused higher usage of agency nurses" "Our case mix has changed and we are performing treatments that require less expensive supplies/devices"
Boards/Strategy/CEOs 	"We do not know which service-lines to focus on in order to achieve financial balance"	"We need to invest in building cardiac referrals since this is our most profitable service and we can build distinctiveness in it" "We choose to maintain world-class liver facilities, even though we incur losses in more complicated procedures"

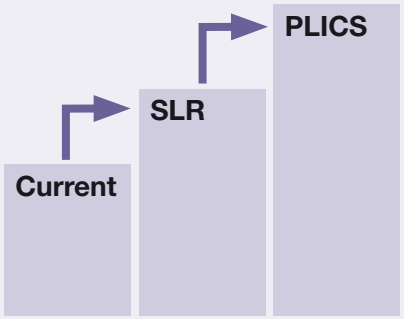
There are two options for implementing patient level costing

Option 1: Direct approach



- Implement a PLICS system from the ground up
- Engage clinician support during implementation to encourage early agreement on apportionment
- Service-lines learn to use the patient-level data with confidence from day one

Option 2: Step approach



- Develop SLR from current reference cost information so staff can learn to use indicative information for service decisions
- Move to PLICS once implementation is established, giving service-lines the next level of detail and reliability in their information

Example

A transition model to patient level costing implementation and integration

0-6 months

- Develop, agree and populate trust and service-line scorecards
- Continue to use current budget monitoring for performance management
- Evaluate PLICS system solutions and select preferred provider

- If employing SLR – improve information transparency by reporting income and expenditure by service-line where possible

6-12 months

- Balanced scorecard reporting by service-line used to monitor service performance and is refined as appropriate

- Supplement service information with SLR reports across all service-lines if applicable

- Focus on development and capability building of service-line leaders on the use of these new tools
- Develop, agree and implement scorecards for each specialty/ clinical team
- Budget-monitoring process continues
- Initiate implementation of PLICS system and use of profitability reports by patient and procedure, as available

12-18 months

- PLICS system is fully operational and drill down reports are universally used and understood by service leaders
- Planning and monitoring systems are based on patient-level costs and measures of operational performance
- Service leader has full accountability for the integrated performance of the service
- Scorecards are used throughout the trust (trust, service-line, specialty/team level) for performance management

Only applicable if implementing "Option 2: Step approach"

Evaluating PLICS systems providers

Providers of PLICS systems can be evaluated across four dimensions:

	Evaluation questions*
Functionality	• Does the solution provide a front end which is robust and easy to use? Is it web enabled? • Can the solution be used for on-going reporting and performance management (e.g. monthly, quarterly) by clinical teams? • Does the supplier develop allocation methodology engaging clinicians in your organisation?
Ease of implementation	• Does the supplier actively involve clinicians in development and implementation? • Is the IT system compatible with legacy clinical, management and finance systems? • Does the supplier have previous experience with the trust or other U.K. trusts?
Cost	• What is the up front price for installation of the IT solution? • Are there significant ongoing support costs? • How many internal FTEs will be working on implementation and ongoing support?
Timing	• When can the IT implementation begin? • When will the first reports be available? • Is sufficient time allowed for testing and roll out?

* See Appendix B for more specific questions and a list of providers

Example

Implementation of patient level costing in a German hospital network (1/3)

Report usage	Data collection
• Reports are created monthly by the medical controller and forwarded to the department heads • These reports are used as the cornerstone of fortnightly performance discussions between the CEO, all heads of departments and the medical controller • Combined with pathways, the tool allows accurate estimation of the cost of each pathway as part of the budgeting process	• Data is fed into the system monthly, half automatically, half manually • There are also manual updates that must be completed annually (e.g. percentages to allow appropriate allocation of overhead) • Data audit is an important stage of the process • Tool is flexible enough to allow system upgrades to be accommodated, and recently a SAP system was implemented
Allocation methodology	**Report content**
• The tool only costs inpatient cases • Nurses and doctors costs are allocated to patients based on length of stay • Low-cost consumables and drugs are also allocated based on length of stay • High-cost consumables are tracked and allocated directly to the consuming patient • Buy-in to the tool is high among clinicians and managers	• Reports are available at the hospital, service-line, pathway and individual level • Pathways are used as the basic unit of measurement, a 'recipe' for treating a patient with a certain diagnosis that may span a few HRGs • Reports separate out fixed and variable costs so that the effect of over-activity can be fully understood • Length of stay for each pathway is tracked to allow simple performance management on a more detailed level • Activity in the year to date in each HRG is included against the budgeted figure to allow clinicians and managers to track actual activity against commissioned activity

Example

Implementation of patient level costing in a German hospital network (2/3)

This shows the way service and financial information can be presented as a daily snapshot, showing average length of stay, the number of patients etc.

Example of service-line budgeting report

Overview of budget targets

Year: 2003
Hospital: Knappschaft Krankenhaus Bottrop
Care Group Internal Medicine

Diagnosis	Number	Tariff	Minimum cost	Maximum cost	Surplus (min)	Surplus (max)	LoS	Number of Patients
Pneumonia	2	2,053.18 €	1,298.96 €	1,960.45 €	754.22 €	92.73 €	7	148
Arrythmia	9	4,794.10 €	2,588.74 €	2,643.44 €	2,205.36 €	2,150.66 €	6	206
Myocardial Infarction	11	3,170.13 €	3,567.91 €	3,652.33 €	-397.78 €	-482.20 €	7	49
Syncope	8	1,568.75 €	1,406.50 €	1,649.93 €	162.25 €	-81.18 €	6	2
Ventricular Arrhythmia	7	1,787.12 €	3,304.94 €	3,504.04 €	-1,517.82 €	-1,716.92 €	7	45
COPD	3	2,100.87 €	1,034.02 €	1,380.77 €	1,066.85 €	720.10 €	6	179
Pacemaker	1	4,794.10 €	4,546.06 €	4,547.46 €	248.04 €	246.64 €	4	114
Heart failure	19	2,487.41 €	1,202.83 €	1,856.13 €	1,284.58 €	631.28 €	6	251
Comp. heart failure	10	1,611.42 €	2,041.12 €	3,512.67 €	-429.70 €	-1,901.25 €	5	94
Tumour diagnosis	5	1,483.41 €	1,466.27 €	2,273.97 €	17.14 €	-790.56 €	5	67
Decomp. heart failure	13	1,709.31 €	2,637.82 €	3,513.37 €	-928.51 €	-1,804.06 €	3	399
Diarrhoea	18	0.00 €	1,048.03 €	1,301.43 €	-1,048.03 €	-1,301.43 €	4	0
Total:		**4,449,845.97 €**	**3,860,468.10 €**	**4,944,720.46 €**	**589,377.87 €**	**-494,874.49 €**		**1927**
Average:		**2,309.21 €**	**2,003.36 €**	**2,566.02 €**	**305.85 €**	**-256.81 €**		

Example

Implementation of patient level costing in a German hospital network (3/3)

Example of detailed cost breakdown for a pathway

Detailed Costs

Pathway: Ventricular arrhythmia

Service

Service provider: **Internal medicine outpatients**

Dimension	Service	Total cost	Variable cost	Points	Direct costs
2	Physical examination	69.14 €	4.86 €	260	0.00 €
2	Abdominal ultrasound	95.73 €	6.73 €	360	0.00 €
Sum of services provided:		**164.86 €**	**11.59 €**	**620**	**0.00 €**

Service provider: **Base costs inpatients**

Dimension	Service	Total cost	Variable cost	Points	Direct costs
9	Inpatient base costs	530.92 €	88.11 €		0.00 €
Sum of services provided:		**530.92 €**	**88.11 €**	**0**	**0.00 €**

Service provider: **ECG**

Dimension	Service	Total cost	Variable cost	Points	Direct costs
2	ECG	14.16 €	0.18 €	253	0.00 €
Sum of services provided:		**14.16 €**	**0.18 €**	**253**	**0.00 €**

Service provider: **Respiratory function tests**

Dimension	Leistung	Total cost	Variable cost	Points	Direct costs
2	Holter monitor	42.50 €	0.56 €	800	0.00 €
2	Cardiac echo	37.18 €	0.49 €	700	0.00 €
Sum of services provided:		**79.68 €**	**1.05 €**	**1500**	**0.00 €**

Example

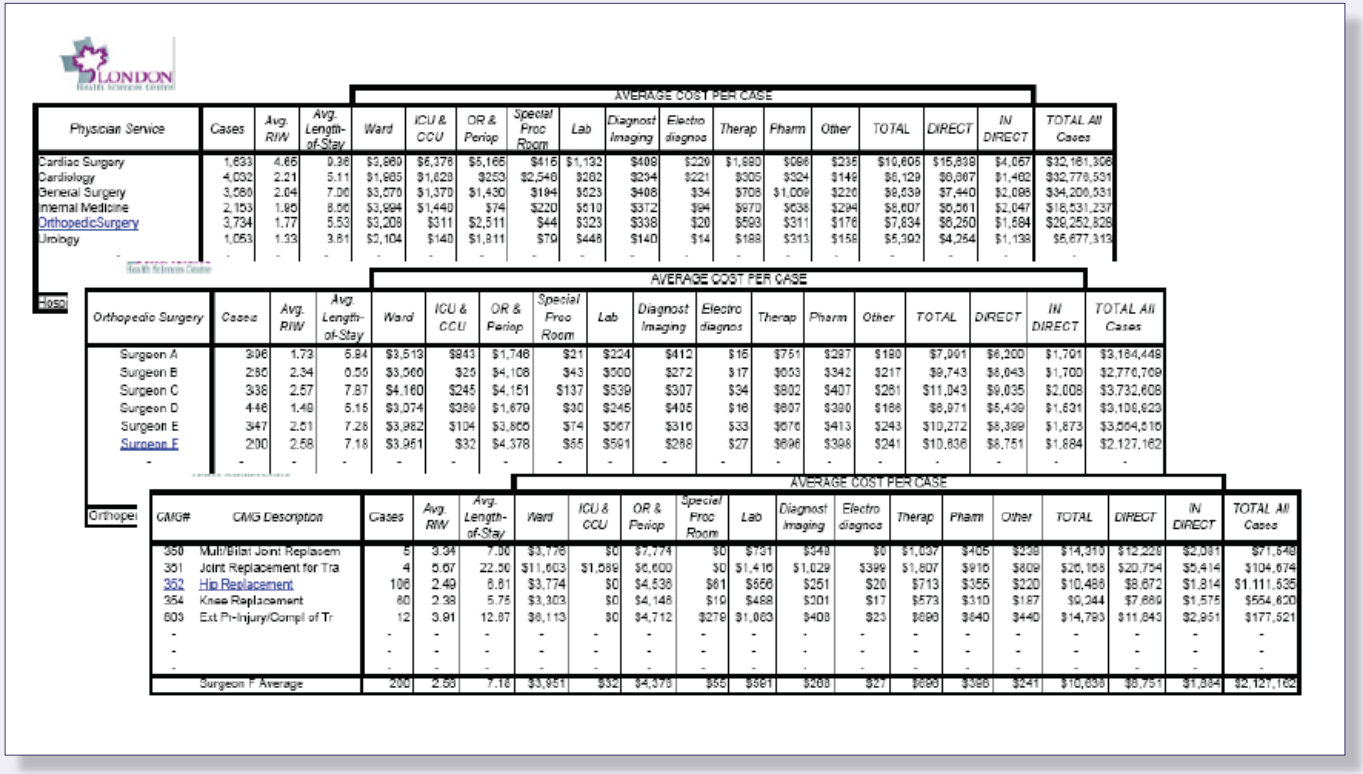
Implementation of patient level costing in a Canadian teaching hospital (1/3)

Report usage	Data collection
• The report was not initially used in conjunction with performance management or decision support ("90% under-utilised"), but uptake increased with time • Only half a dozen people within the organisation started using it regularly and it was only used for strategic reasons: – to contract with local payers – to influence the tariff and funding policy • The report is delivered to service-lines and specialties using a digital desktop but the steep learning curve and the once-a-year report generation impeded initial uptake	• Reports are created annually by plugging in the data into the patient level costing system • Data from the general ledger and from activity databases are downloaded every month and then audited (for the generation of reports, half of the time spent is on auditing the data). Data cleaning is a significant task
Allocation methodology	**Report content**
• Allocation is very precise: – drugs and consumables are allocated direct to patient – nursing costs are allocated based on resource utilisation with patients graded on a 1–6 scale by a nursing management tool at least once every 24 hours • Physician costs are not included (they are paid separately under the Canadian system) • Inpatient stays, day surgery and ER visits are under the scope of the costing system (outpatients added soon) • For the costs of individual diagnostic tests, a national workload system is used which estimates the relative resource utilisation of different tests • The view in the hospital is that you cannot get too detailed on the allocation methodology and that there is no trade-off against the effort required	• The hospital uses a separate reporting system software solution • Report content allows aggregation at any level, from service and specialty level, down to individual patients • Reports at the patient level give itemised bills down to individual items (e.g. individual drugs) in very impressive detail • Length of stay information is given for every DRG (i.e. HRG) to allow management on a lower level

Example

Implementation of patient level costing in a Canadian teaching hospital (2/3)

Examples of drill-down reporting by service, surgeon and procedure



AVERAGE COST PER CASE

Physician Service	Cases	Avg. RIW	Avg. Length-of-Stay	Ward	ICU & CCU	OR & Periop	Special Proc Room	Lab	Diagnost Imaging	Electro diagnos	Therap	Pharm	Other	TOTAL	DIRECT	IN DIRECT	TOTAL All Cases
Cardiac Surgery	1,633	4.65	9.36	$3,860	$6,378	$5,166	$416	$1,132	$408	$229	$1,880	$696	$235	$10,605	$15,838	$4,057	$32,161,306
Cardiology	4,032	2.21	5.11	$1,685	$1,628	$253	$2,546	$262	$294	$221	$305	$324	$149	$6,129	$8,867	$1,462	$32,778,531
General Surgery	3,560	2.04	7.00	$3,576	$1,370	$1,430	$194	$523	$408	$34	$708	$1,008	$220	$8,539	$7,440	$2,098	$34,206,531
Internal Medicine	2,153	1.85	8.66	$3,994	$1,440	$74	$220	$510	$372	$94	$870	$638	$294	$8,607	$6,561	$2,047	$18,531,237
OrthopedicSurgery	3,734	1.77	5.53	$3,208	$311	$2,511	$44	$323	$338	$20	$593	$311	$176	$7,834	$6,250	$1,584	$29,252,828
Urology	1,053	1.33	3.81	$2,104	$140	$1,811	$79	$448	$140	$14	$188	$313	$156	$5,392	$4,254	$1,138	$5,677,313

AVERAGE COST PER CASE

Orthopedic Surgery	Cases	Avg. RIW	Avg. Length-of-Stay	Ward	ICU & CCU	OR & Periop	Special Proc Room	Lab	Diagnost Imaging	Electro diagnos	Therap	Pharm	Other	TOTAL	DIRECT	IN DIRECT	TOTAL All Cases
Surgeon A	396	1.73	5.84	$3,513	$843	$1,746	$21	$224	$412	$16	$751	$287	$186	$7,991	$6,200	$1,791	$3,164,448
Surgeon B	280	2.34	6.55	$3,560	$25	$4,108	$43	$500	$272	$17	$653	$342	$217	$9,743	$8,043	$1,700	$2,776,769
Surgeon C	336	2.57	7.87	$4,160	$245	$4,151	$137	$539	$307	$34	$802	$407	$281	$11,043	$9,035	$2,008	$3,732,608
Surgeon D	446	1.49	5.15	$3,074	$389	$1,679	$30	$245	$405	$16	$607	$380	$186	$8,971	$5,439	$1,531	$3,106,623
Surgeon E	347	2.51	7.28	$3,982	$104	$3,866	$74	$567	$316	$33	$676	$413	$243	$10,272	$8,399	$1,873	$3,564,616
Surgeon F	200	2.58	7.18	$3,951	$32	$4,378	$55	$591	$268	$27	$696	$398	$241	$10,836	$8,751	$1,884	$2,127,162

AVERAGE COST PER CASE

CMG#	CMG Description	Cases	Avg. RIW	Avg. Length-of-Stay	Ward	ICU & CCU	OR & Periop	Special Proc Room	Lab	Diagnost Imaging	Electro diagnos	Therap	Pharm	Other	TOTAL	DIRECT	IN DIRECT	TOTAL All Cases
350	Mult/Bilat Joint Replasem	5	3.34	7.00	$3,776	$0	$7,774	$0	$781	$349	$0	$1,697	$405	$228	$14,310	$12,228	$2,081	$71,548
351	Joint Replacement for Tra	4	5.67	22.50	$11,603	$1,589	$6,600	$0	$1,416	$1,029	$389	$1,807	$916	$809	$26,158	$20,754	$5,414	$104,674
352	Hip Replacement	106	2.49	6.81	$3,774	$0	$4,536	$61	$556	$251	$20	$713	$355	$220	$10,486	$8,672	$1,814	$1,111,536
354	Knee Replacement	60	2.38	5.75	$3,303	$0	$4,148	$19	$488	$201	$17	$573	$310	$187	$9,244	$7,669	$1,575	$554,620
603	Ext Pr-Injury/Compl of Tr	12	3.91	12.67	$6,113	$0	$4,712	$278	$1,063	$408	$23	$893	$840	$440	$14,793	$11,843	$2,951	$177,521
	Surgeon F Average	200	2.58	7.18	$3,951	$32	$4,378	$55	$591	$268	$27	$696	$398	$241	$10,836	$8,751	$1,884	$2,127,162

Example

Implementation of patient level costing in a Canadian teaching hospital (3/3)

Example of patient level reporting of costs

CMG#	CMG Description / MR Physician (T2)	ICD10 Code#	Most Responsible Diagnosis/Principal Procedure	Full Cost
352	Hip Replacement Dr. Ben Casey	T84.03 1.VA.53.LA-PN-Q	Mech complication of hip Impl int dev hip joint-op	**$11,532**

Encounter #	IP/ER	PIN#	Age	Sex	RIW	Excl	Plx	LOS	AdmDate	DischDate	RIW Funding Credit
701762784	ER	30582296	72	F	2.8248	TYP	3	8	13-May-02	21-May-02	$12,395

Dept#	Dept Desc	Service Item (Orderable) Description	Qty	Date	DirLabor$	DirSuppl$	DirO'hd$	FixIndir	D+ITotal $'s
52401	**Patient Food Services**								
		Meal Day	7.1	21-May-02	96.70	91.01	32.44	45.79	265.93
	Total Cost for Patient Food Services				**$97**	**$91**	**$32**	**$46**	**$266**
Total Cost for MIS F/C *711952000*					**$97**	**$91**	**$32**	**$46**	**$266**
12035	**Nursing-Orthopaedics**								
		Medicus Type 2	10.1	13-May-02	96.96	4.29	8.39	38.87	148.50
		Medicus Type 2	24.0	14-May-02	229.71	10.17	19.87	92.08	351.84
		Medicus Type 2	8.9	15-May-02	85.28	3.78	7.38	34.19	130.62
		Medicus Type 3	15.1	15-May-02	216.64	9.59	18.74	86.84	331.83
		Medicus Type 3	16.1	16-May-02	230.43	10.21	19.94	92.37	352.94
		Medicus Type 4	7.9	16-May-02	174.79	7.74	15.12	70.07	267.72
		Medicus Type 3	24.0	17-May-02	344.56	15.26	29.81	138.12	527.76
		Medicus Type 2	13.0	18-May-02	124.81	5.53	10.80	50.03	191.17
		Medicus Type 3	11.0	18-May-02	157.35	6.97	13.61	63.08	241.01
		Medicus Type 2	24.0	19-May-02	229.71	10.17	19.87	92.08	351.84
		Medicus Type 2	24.0	20-May-02	229.71	10.17	19.87	92.08	351.84
		Medicus Type 2	16.4	21-May-02	156.78	6.94	13.56	62.85	240.13
	Total Cost for Nursing-Orthopaedics				**$2,277**	**$101**	**$197**	**$913**	**$3,487**
Total Cost for MIS F/C *712207200*					**$2,277**	**$101**	**$197**	**$913**	**$3,487**

Strategic and annual planning

Service-line management – strategic and annual planning

Key enablers	"Check-list" of the important components
1 Organisation	☐ Defined service-line structure ☐ Defined service-line leadership roles, with integrated ownership of clinical, operational and financial performance ☐ Capability-linked, defined decision rights at each level (trust executive, service-line, and team)
2 Strategic and annual planning process	☐ Understanding of market and competitive position ☐ Defined three- to five-year strategy and annual objectives ☐ Detailed and quantified action plan to deliver strategy ☐ Robust annual planning process ☐ Levels of autonomy linked to quarterly monitoring regime
3 Performance management	☐ Clear KPIs, targets and accountabilities ☐ Performance tracking ☐ Effective review meetings ☐ Good performance conversations ☐ Rewards and consequences for performance
4 Information support	☐ Relevant, timely information ☐ Patient level costing

Service-line strategy and annual planning:
a summary

- Historically, service-lines often inherited targets they didn't agree with as a result of top-down driven strategic/annual planning and targets.
- Service-lines should develop their own strategies since they are best positioned to identify their specialties' opportunities and threats and their impact on the trust's future performance, and to encourage their staff to focus their efforts better and feel greater accountability.
- Service-line strategy should be derived from the service-line's two- to three-year vision, which should in turn align with the trust's vision.
- Once the strategy has been clearly defined, it should be translated into specific short term strategic objectives in the annual planning process.
- Service-lines own their annual plans, although they should be created through executive level guidance and bottom-up plans to reach agreed-upon targets and objectives.
- Service-lines must have a detailed understanding of their current performance (clinical, financial and operational) and external market factors (demand growth, competitive position, etc) in order to develop a two- to thee-year strategy and translate it into annual strategic objectives. This includes robust forecasting of demand and competition to identify the best growth options.
- A robust action plan (with clear responsibilities, milestones and monitoring) should be developed to support the agreed annual strategic objectives.
- At the end of each year, objectives should be reviewed and refreshed to ensure that the long-term strategy can be ultimately achieved within the agreed time frame.

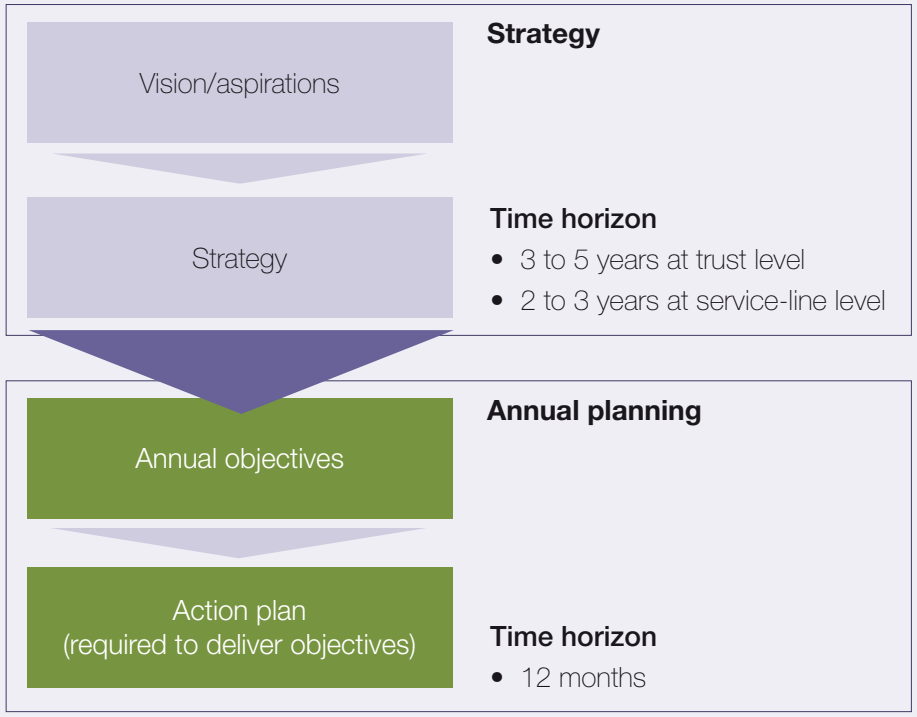
Changing behaviours

In order to capture the benefits of strategy and annual planning, trusts will need to change some behaviours

From	To
• No formal service-line strategy • Service-line annual plans primarily developed by management, with variable levels of clinical input	• Service-lines develop their own clear strategic objectives, aligned with the trust's vision.
• Service-line targets not cascaded to specialty level	• Service-line targets clearly cascade to specialty level and take into account each specialty's position and priorities
• No formal action plans to deliver strategy at service-line level	• Detailed action plans with leads, impact and risk assessment, milestones and progress tracking process
• Last year's budgets are "rolled over" to the following year	• Budgets are built bottom-up with strong clinician engagement • Targets are based on a detailed understanding of current performance, strategic objectives and appropriate external benchmarks

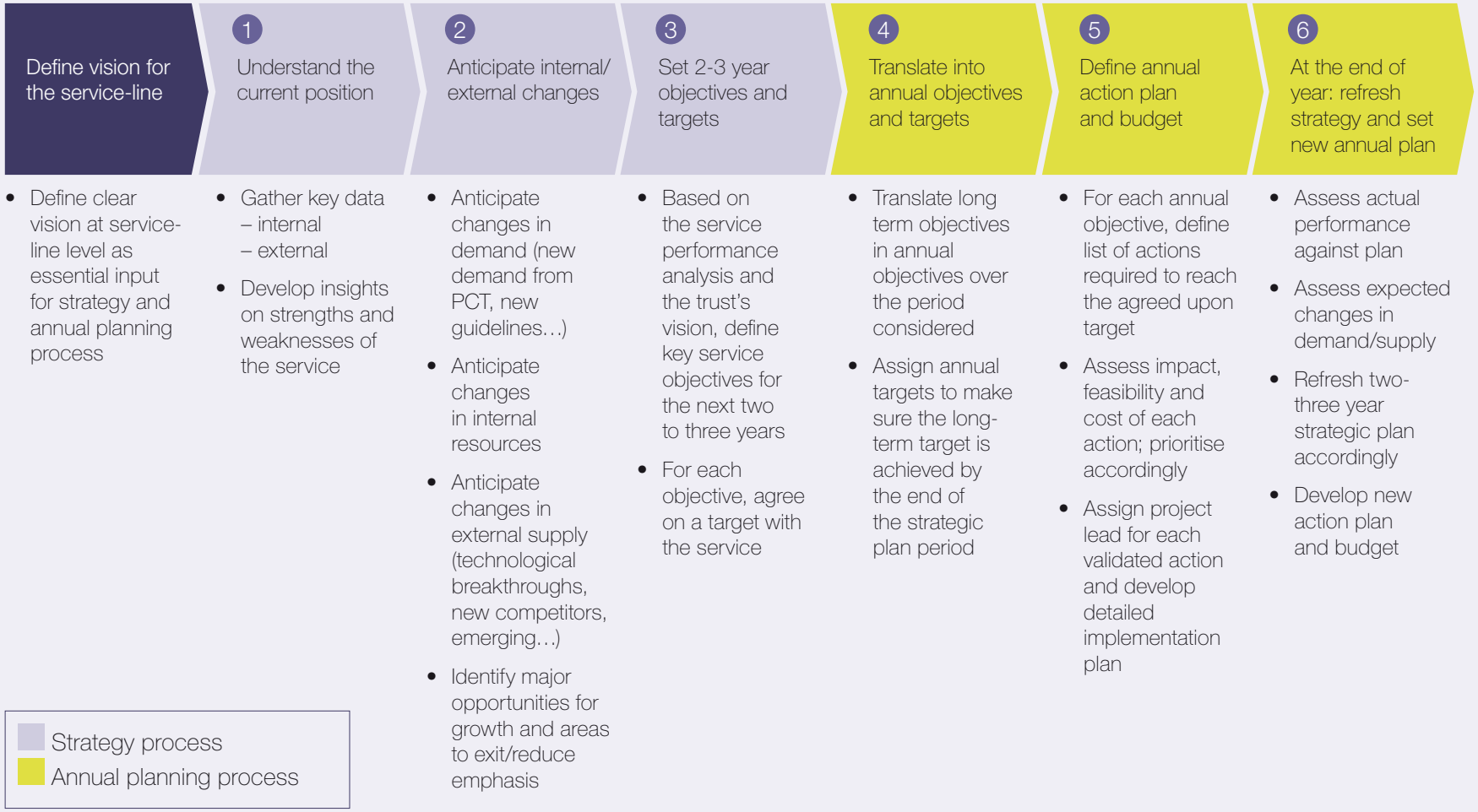
Translating vision into action

Strategy and annual planning are tools for translating vision into action in the medium and long term



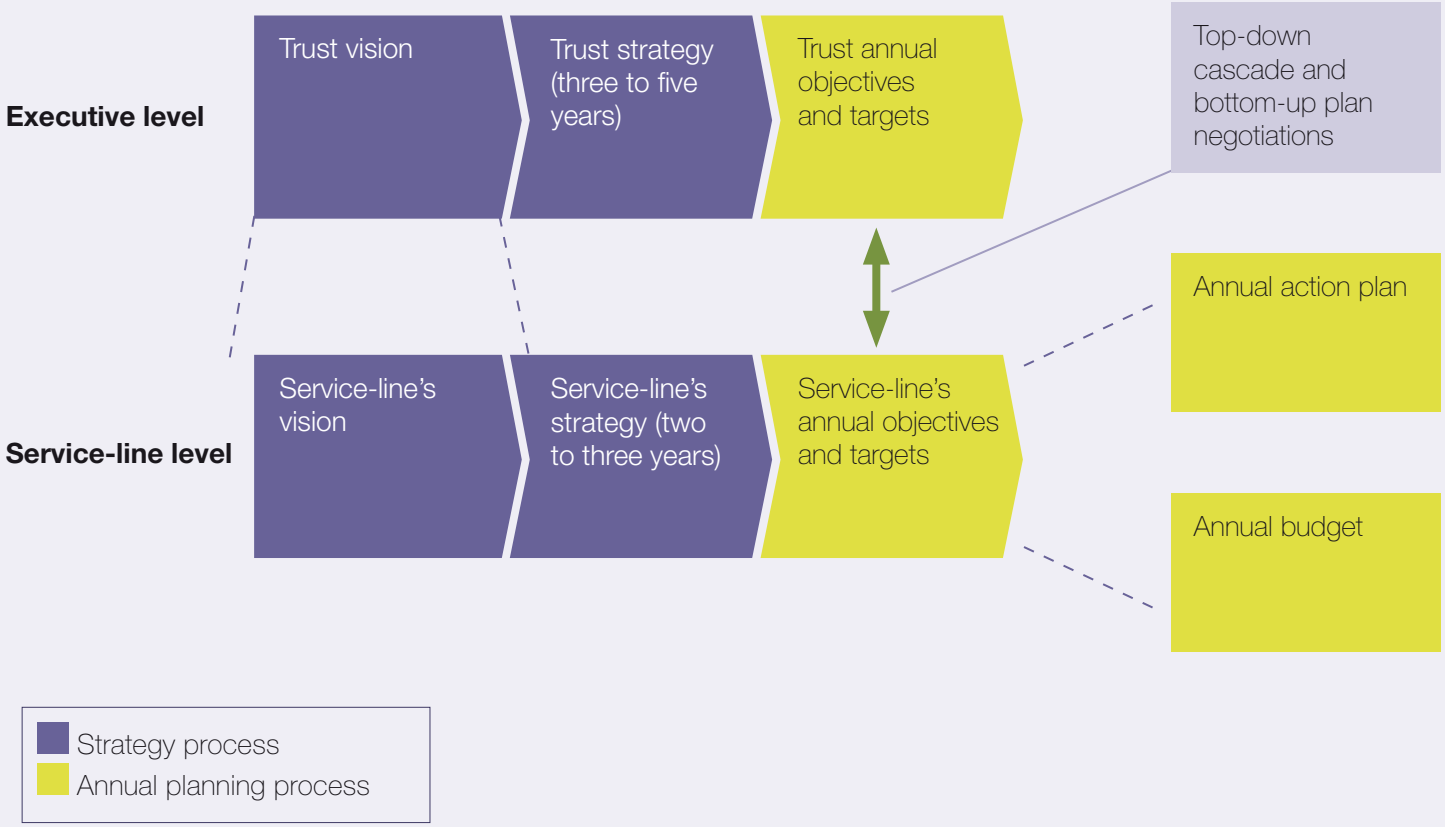
A six-step approach

Developing service-line strategy and linking it to the annual planning process is a six-step approach



Preparation for the six steps

First, a vision for the service-line should be defined. The service-line's vision should be driven by trust's vision, while objectives and targets should result from constructive negotiation.



Example

A service-line's vision

This illustrative example is from the ophthalmology service of an NHS foundation trust

Trust vision is to:

- Provide services in a timely way in line with clinical priorities and national waiting times standards
- Maintain financial balance
- Meet national guidance for the quality of provision of service

The ophthalmology service aims to:

- Provide excellent and comprehensive clinical care for the population we serve
- Maintain status as the provider of choice for the local population
- Maintain a firm financial basis for the service
- Continue to meet national standards for care (clinical and waiting times)
- Continue to develop an outstanding workforce that is equipped to provide high quality eye care to patients

Step 1& 2

Understand the current position and anticipate external/internal changes

Performance	• What is the operating, financial, and quality performance of the service-line? • How does this compare to relevant national benchmarks?
Demand	• What is the catchment area for the service? • How will demand for services change over time? • How much of the additional demand could the service-line capture and deliver?
Competition	• Who are the major competitors? • Is our market share rising or falling? • How are we positioned relative to competitors?
Financial	• What is the relative attractiveness of different specialties within the service-line? • What are the major threats and opportunities?

- Which are our more valuable services in strategic and financial terms?
- Which are our least attractive services in terms of performance and outlook?
- What should we do about this? e.g.
  - protecting and/or developing most valuable services
  - addressing market pressures and performance issues (quality, operating, financial) in least attractive services

Step 1 & 2

Understand the current position and anticipate external/internal changes (cont)

Analysis of current performance and potential improvement can be used to model future financial performance

Performance

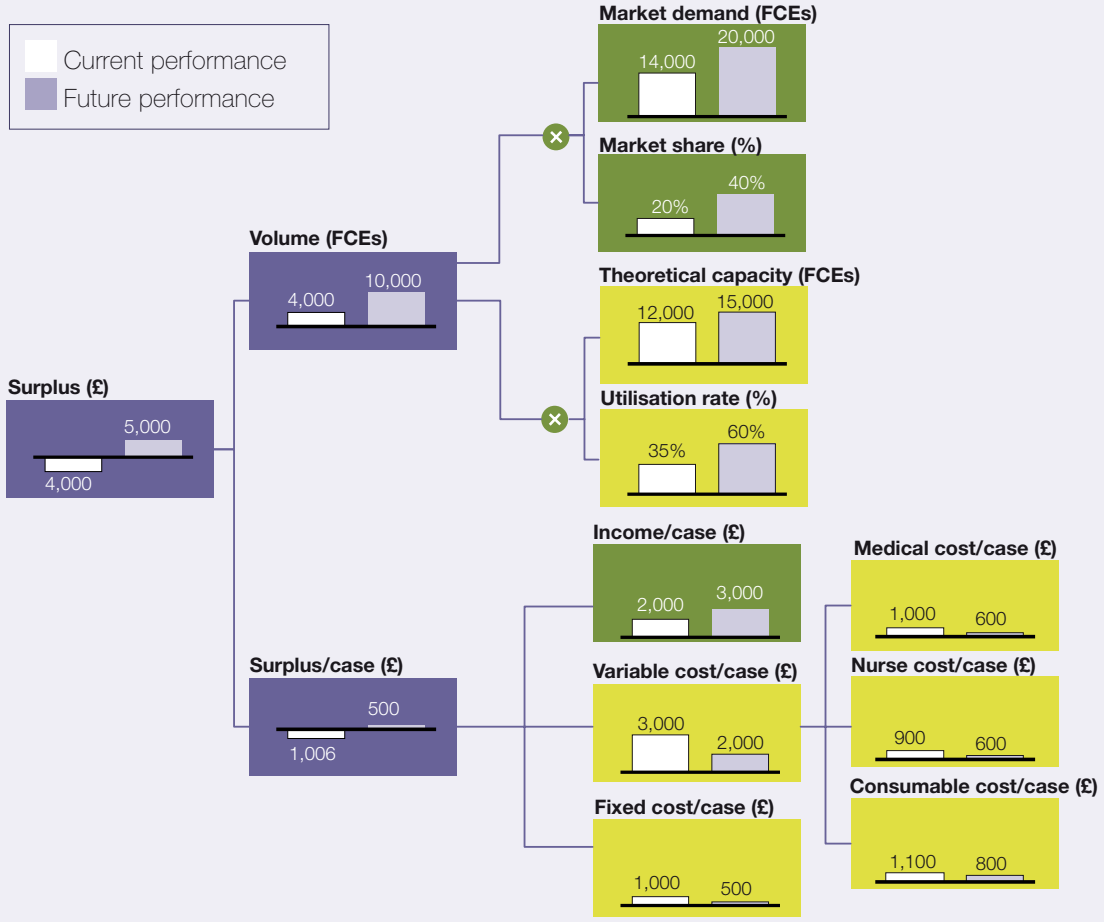
- In a fixed-price environment, service viability is largely determined by operating performance
- Break down the sources of costs (medical pay, nursing pay, non-pay, etc.) into their main operational drivers (FCE per WTE, ALOS, etc.)
- Identify and prioritise areas for improvement

Demand and competition

- Identify areas/specialties where the trust could potentially increase market share or lose activity to other providers by assessing:
  - Demand for healthcare services within trust's catchment area
  - Strength of competition for those services
  - Competitive position of the trust
- Consequently assess and manage capacity constraints (physical and staff) and optimise the use of resources

Financial

- Service strategy should be based on a sound understanding of the impact of each service on the profitability of the trust
- Trusts need to attain a balanced mix of services that will ensure financial viability



Step 3

Set 2-3 year objectives/targets (cont)

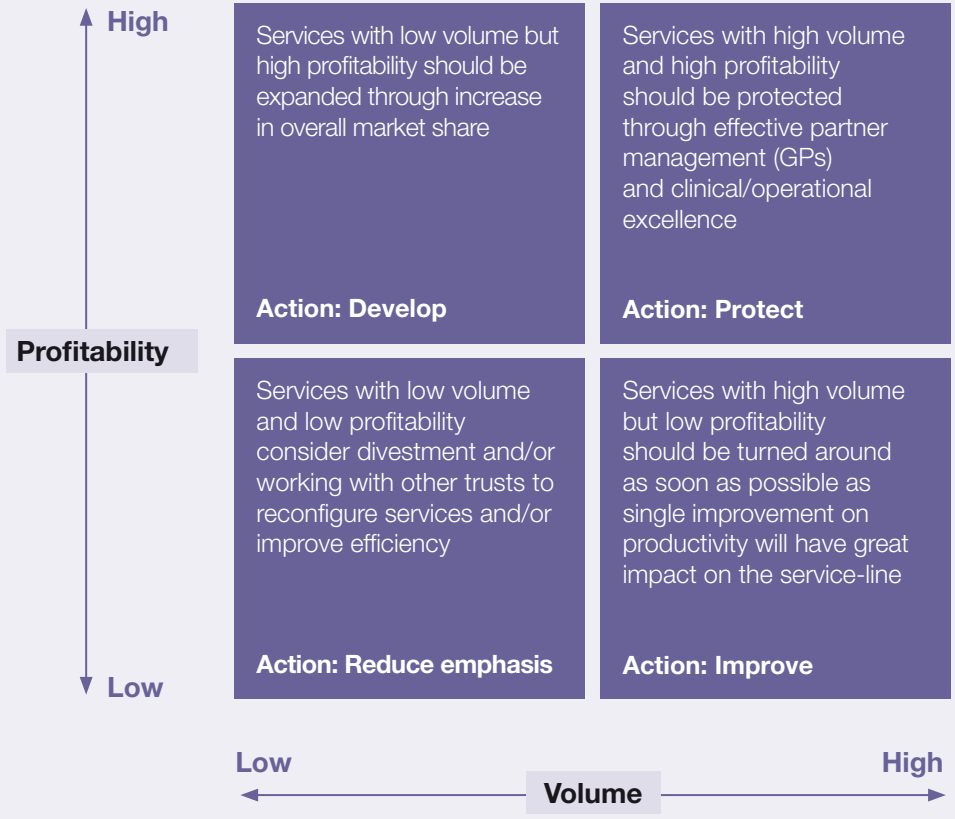
A method for generating strategic options.

Action	Key tasks and analyses	Purpose
Define the service-line's vision	• Determine the service-line's aspirations	• Ensure clinicians' views on the future outlook and future direction of the service-line are addressed
Determine main strategic direction	• Assess the implications of the information collected (service performance, market position, clinical and activity/financial outlook) for the future of each service	• Ensure the insights and analyses of the previous stage directly inform the trust's imperatives for the service portfolio
Generate strategic options	• Identify the initial set of potential options to meet the selected strategic direction • Translate each option into a coherent set of strategic initiatives with expected impact on the service-line	• Ensure that agreed strategic direction get translated into a set of concrete options for the service-line • Ensure that each proposed option is translated into a specific action plan

Step 3

Set 2-3 year objectives/targets (cont)

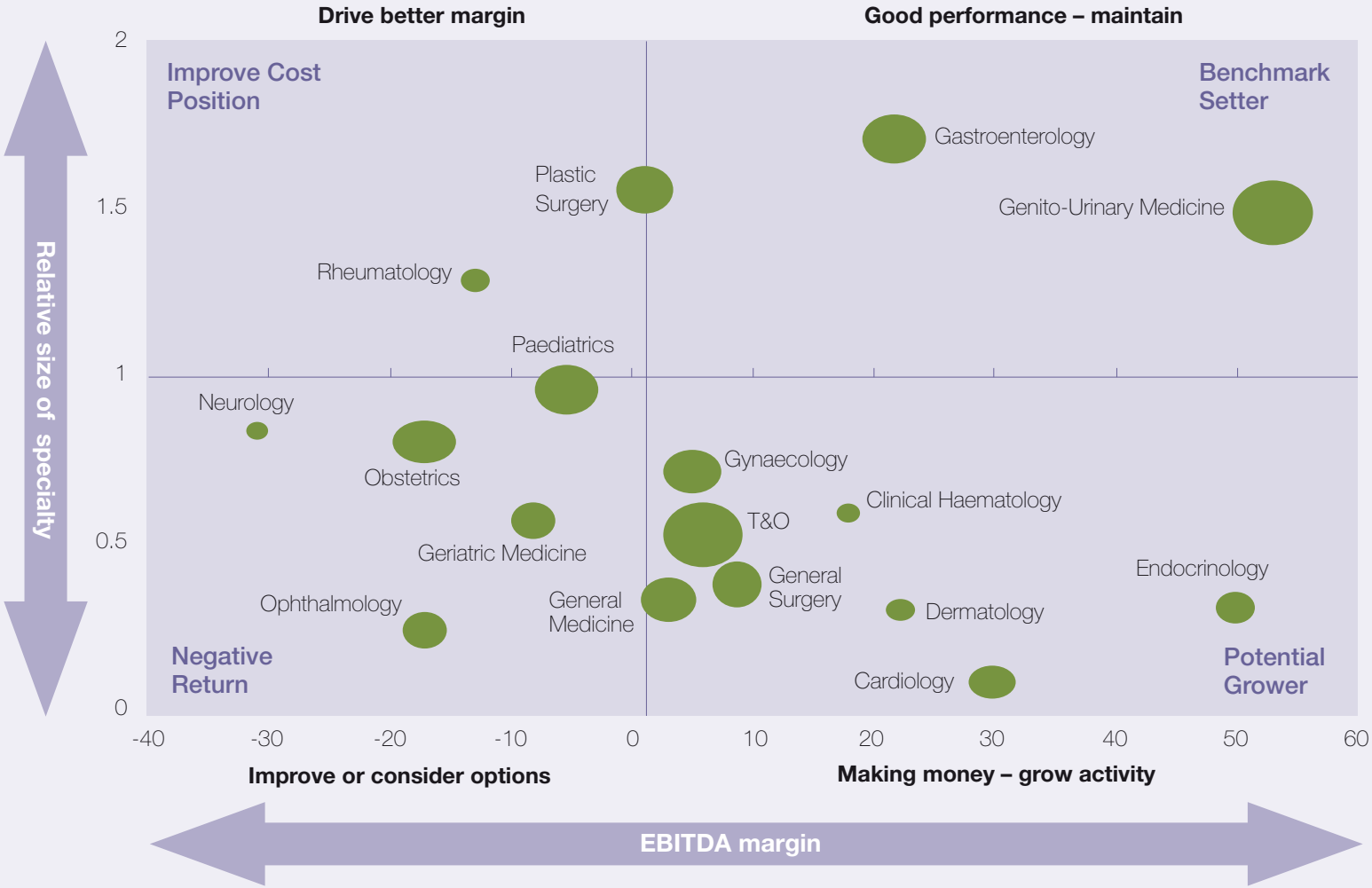
Services can be positioned in a strategic portfolio matrix to help define options.



Step 3

Set 2-3 year objectives/targets (cont)

Diagnostic tool for analysing service portfolio performance promoted by Monitor.



Step 3

Set 2-3 year objectives/targets (cont)

How to evaluate the options.

Action	Key tasks and analyses	Purpose
Evaluate economic potential of proposed options	• Analyse economic implications of different strategic options using marginal contribution approach	• Determine the I&E impact of the initiative by estimating its impact on activity/revenues and costs over the next five years
Evaluate operational implications and feasibility	• Evaluate options against clinical/quality criteria • Analyse implications on capacity and resources • Assess feasibility and implementability for prioritisation	• Test the potential clinical impact/risks of the options with clinicians in order to eliminate unacceptable ones • Test the impact of the initiative on the organisation, the workforce, the trust estate (beds and theatres), and required capital investment • Eliminate clinically or operationally unfeasible options, and determine the implementation risk and timing for the remaining ones
Select preferred option	• Select options on the basis of prior evaluation of impact, timing, and investment/resource requirement, and test overall financial impact by updating the financial forecasts as required • Consequently agree on specific initiatives to pursue for the next two to three years	• Check that the overall financial impact of the selected options meets trust's requirements • Gain broad agreement from senior management and clinicians on the way forward for the service-line

Step 3

Set 2-3 year objectives/targets (cont)

Example of strategic plan output.

Trust's vision and targets for the service-line

Service-line's vision

Strategic objectives
Key objective 1
Key objective 2
Key objective 3
Key objective 4
Key objective 5

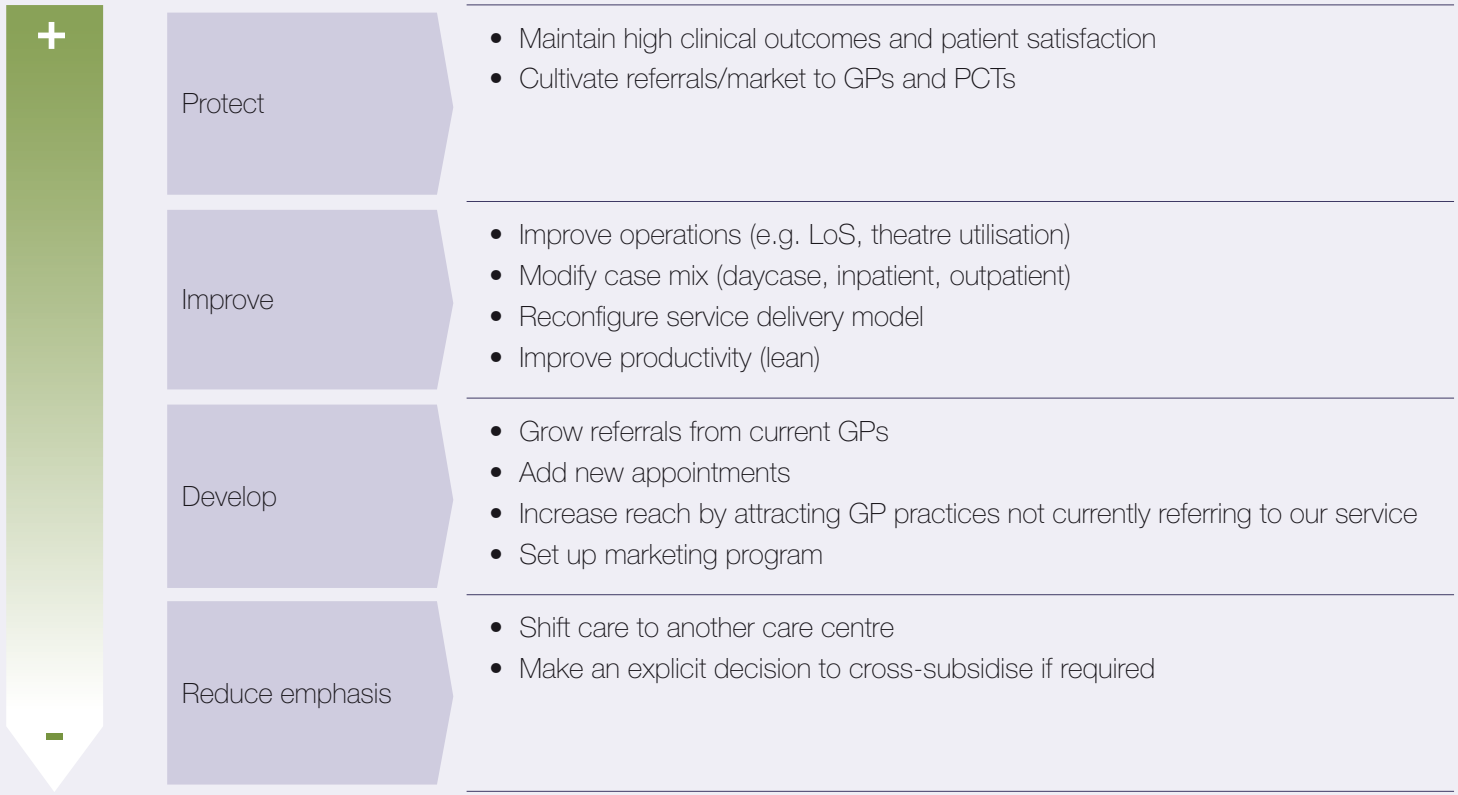
Benefits
Patient care
Financial
Staff
Other

Main risks
Demand
Supply
Other

Step 4

Translate into annual objectives and targets

Translating strategic option into annual objectives is key to drive action at service-line level.



Step 4

Translate into annual objectives and targets

Translating strategic option into annual objectives is key to drive action at service-line level.

Approach	Description	Benefits	Is this approach appropriate?
Limit based	• Targets are set based on the limits of the system (e.g. if operating theatre late starts were eliminated) • Targets need to be updated only when the system changes	• Highlights specific operating issues • Drives rapid pace of improvement	• Can we identify the areas we need to change to improve our performance? • Do we know how the suggested changes will affect the performance indicators of the service? • Is the analysis practical and easy to understand?
Aspiration based	• Targets are based on aspirations of the team • Often derived from internal or external benchmarks	• Stretches people and encourages to think creatively about how to close the performance gap	• Are external or internal benchmarks available? • Are comparisons to benchmark groups (e.g. other trusts) valid? • Do we need to adjust benchmark figures to make them comparable to our measures?
Capability based	• Targets are set based on the current capabilities of people, i.e. if they were working at their demonstrated best, what would output be? • Targets need to be updated frequently as capabilities improve	• Drives improvement at a manageable pace	• Do we see variations in our own performance over time? • Are benchmarks not comparable or unavailable? • Can we agree on a target which is achievable but stretching?

Step 4

Translate into annual objectives and targets (cont)

Examples of each target setting approach.

	KPI	Current performance	Target	Methodology
Limit based	• Theatre utilisation rate (knife to skin)	• 50%	• 65%	• Ask what would the utilisation rate be if we – eliminated late starts – reduced turn-around time from 35 to 10 minutes – reduced early finishes by a third
Aspiration based	• Average length of stay	• 6.2 days	• 5.3 days (top quartile target)	• Compare trust level figures to that of the peer group of comparable hospitals • Set a preliminary target of beating the peer group average for each service-line • Case mix adjust appropriately
Capability based	• Average length of stay	• 6.9 days	• 6.2 days	• Check service-line capabilities with general managers and clinical directors • Suggest that each service-line and specialty improve according to their current position (e.g. for those who perform better than the peer average, achieve top quartile performance) – differential target based on capability to deliver

Step 5

Define annual action plan and budget (cont)

Implementation plan example for an Ophthalmology service

Example of objective
• Refocus of emergency care into planned urgent clinics and away from the emergency department (ED)

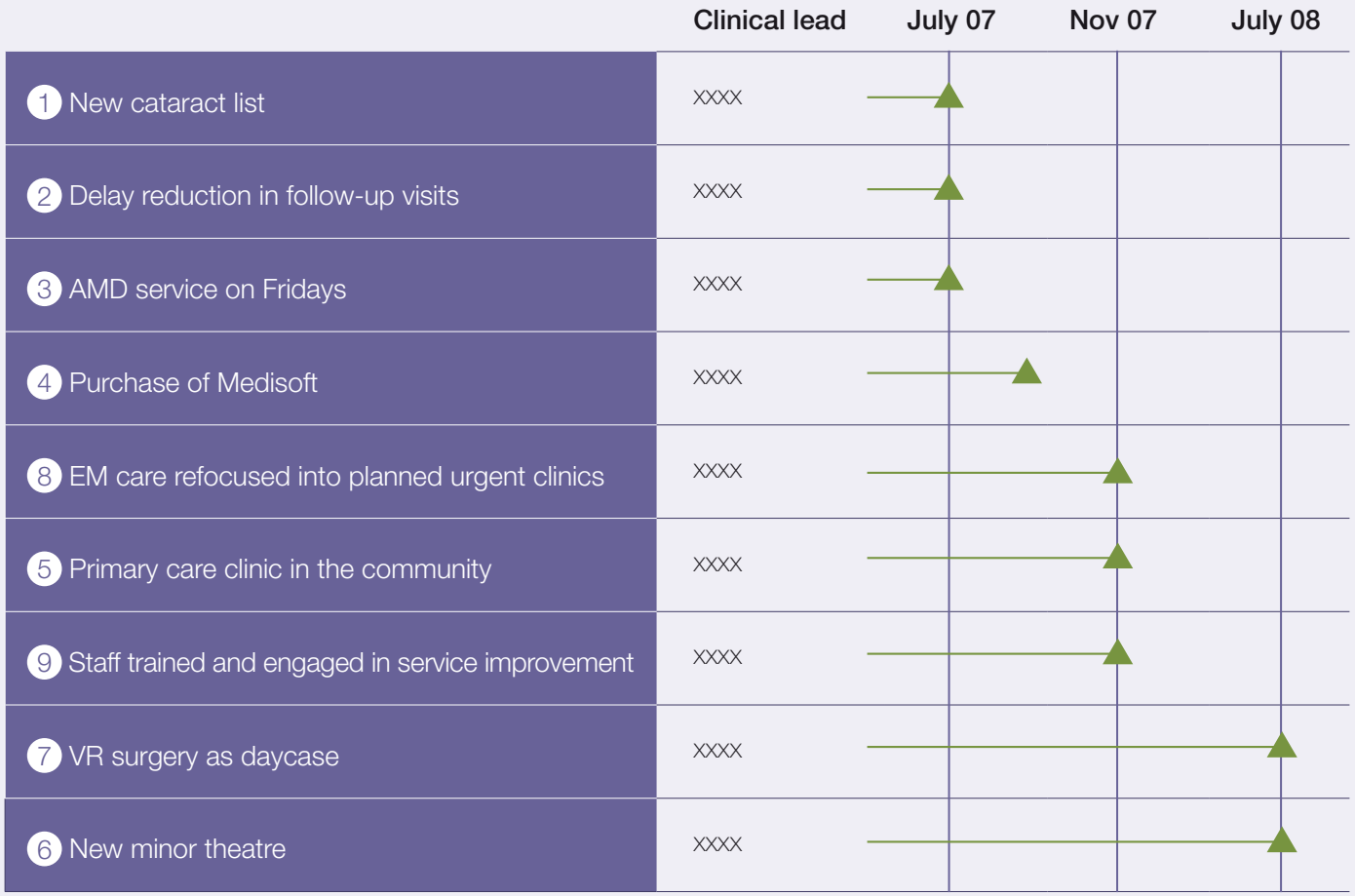
Key components
• Establishment of urgent access clinics and telephone triage service for emergency eye patients • The pathway of care for these patients will need to be refocused away from ED and towards urgent clinics • In order to achieve this the current ED open access service will need to cease and become led by ED doctors as is the case with other clinical services

Resources needed	
Workforce	• Change in responsibilities • Training of ED staff • Appointment of sufficient staff to run triage system and primary care clinics
Estate	• Potential need for new room for community clinics
IT	• Potential telemedicine link to community practitioners to allow remote diagnosis/ appropriate triage
Finance	• Appointment of new staff for triage and primary care clinics

Step 5

Define annual action plan and budget (cont)

Implementation plan example – each objective has a lead for follow-up and an agreed target date for completion.

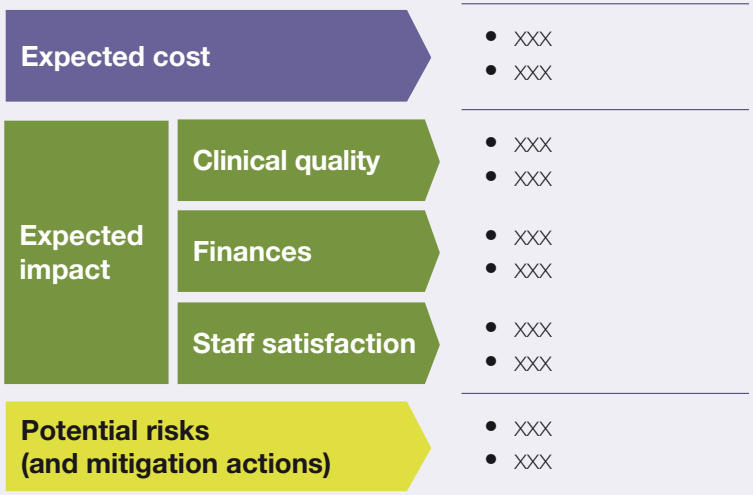


- Clinicians engaged in defining the objectives and setting the targets
- Agreed upon milestones for coming three, six and twelve months
- All objectives followed up by clinical leads, from action planning to implementation

Step 5

Define annual action plan and budget (cont)

Each objective needs to be quantified in terms of costs and expected impact, and risks should be assessed.

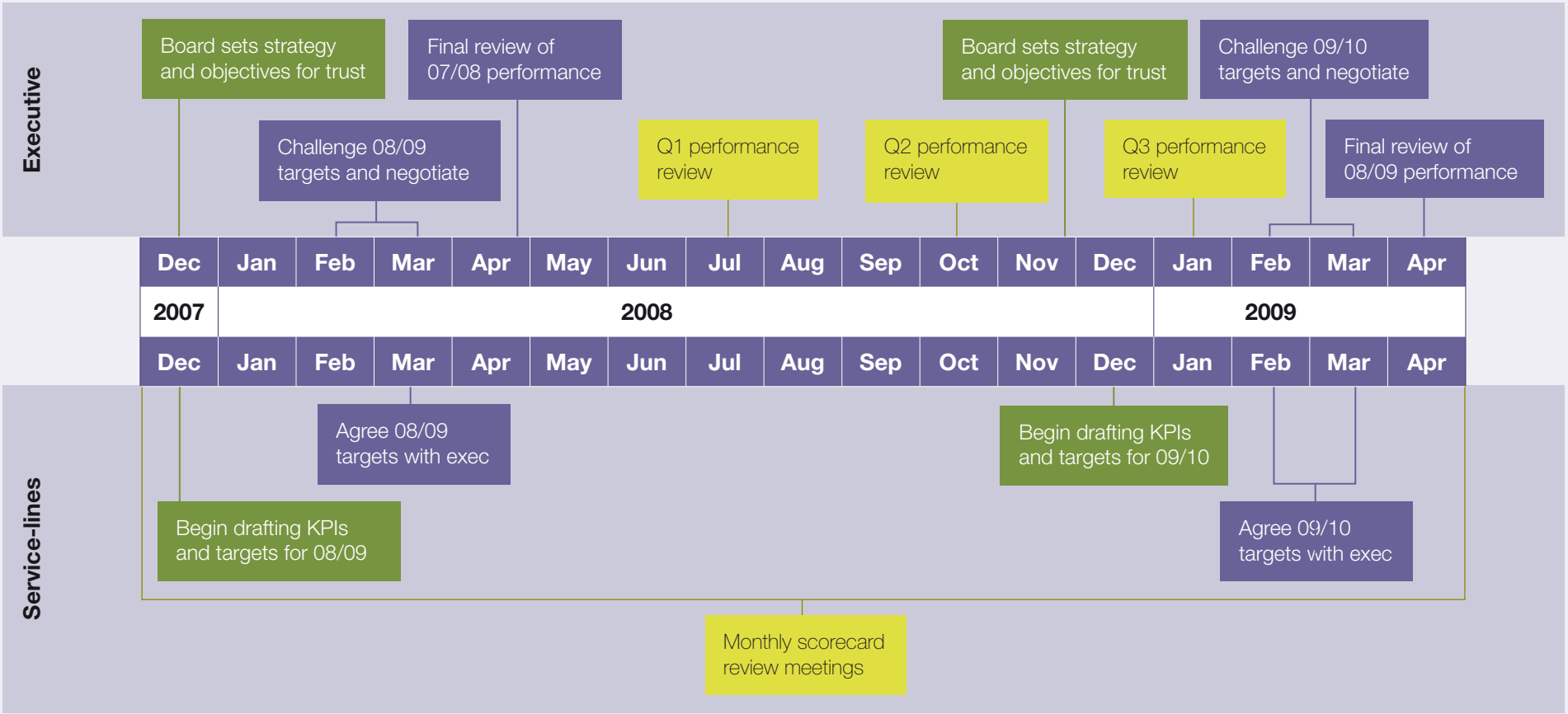


Illustrative

Step 6

At year end refresh strategy and set new annual plan

A clear and robust annual planning cycle needs to be in place to effectively assess past performance and refresh the service-line's strategy. This timeline illustrates the actions needed at board and service level to produce, agree and publish the annual plan, pulling out key activities and key dates on that time continuum.



Step 6

At year end refresh strategy and set new annual plan (cont)

Sufficient time needs to be allocated for the process to allow for relevant input, syndication, communication and buy-in.

▲ Meetings ● Reports

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Comments
Formal planning sessions • Leadership off-site • Three year strategy • Annual operating plan (AOP) • HR plan (HRP)	▲				▲					▲		▲	• Set corporate direction; • Three-year view • Operating unit/functional-level; Conduct in group meeting • Present and discuss plan/ targets; finalise AOP/scorecards for November senior staff meeting
Performance management • Scorecard review • Mid-year CEO review • Monthly scorecard reports	●	●	▲ ●	●	●	▲ ▲ ●	●	▲ ●	●	▲ ●	●	●	• Working sessions to "run the company" • Mid-year review includes AOP and HRP
Divisional meetings • Senior staff • Management board • Operating committees	▲ ▲	▲ ▲	▲ ▲	▲ ▲ ▲	▲ ▲	▲ ▲	▲ ▲	▲ ▲	▲ ▲	▲ ▲	▲ ▲ ▲	▲ ▲	• Agenda driven (held if necessary)
Corporate level meetings • Board of directors meeting • Earnings release/analyst calls • Annual analyst meeting	▲	▲ ▲		▲	▲		▲	▲		▲	▲		• Annual shareholder meeting in May

Earning autonomy

Successfully meeting agreed targets in the balanced scorecards should enable service-lines to earn autonomy

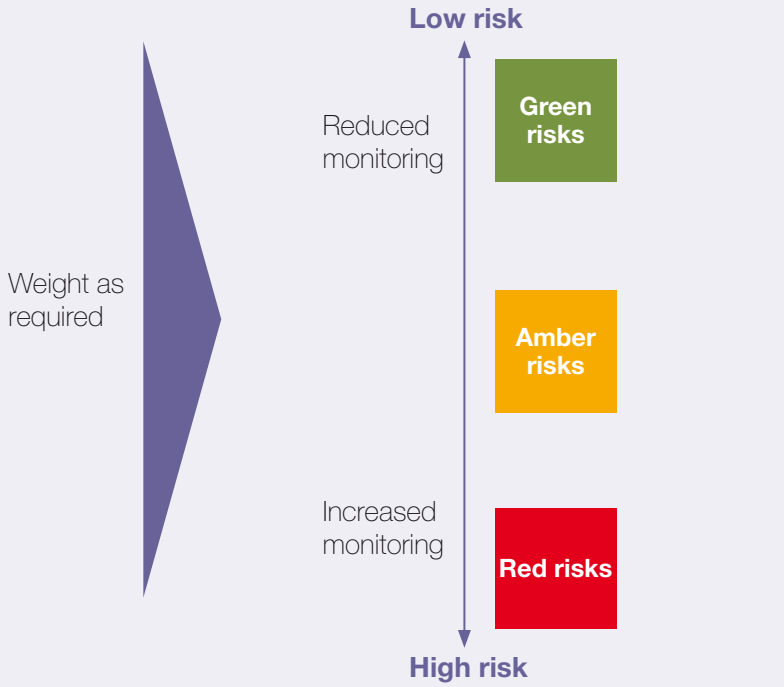
Service-lines are assessed for appropriate levels of devolved decision making. Implicit in this is also the requirement to analyse the impact of things going wrong and how this might affect individual teams, the service-line, directorate or the whole trust. To assess the risk, use the assessment framework outlined on page 52.

Balanced scorecard

Service-line performance scorecard

Financial / growth	Efficiency
Ensuring we have the overhead we need to invest in our services	Using our resources in an efficient way by working smarter
Quality	**Staff**
Providing the best quality of care to our patients	Keeping our staff motivated and providing them with the support needed

Degree of autonomy earned – dependent on performance



Determining executive involvement

Risk ratings for service-lines can be used to determine appropriate levels of executive involvement

	Low risk service-line	Medium risk service-line	High risk service-line
Frequency	Once every one to two months	Once a month	Once a month, or more frequently if needed
Length	One- to two-hour meeting	Two- to three-hour meeting	Half-day meeting
Content	• Service-line management (SLM) describes performance against key targets – If deviations from plan, SLM qualitatively explains plan to get back on track	• SLM describes performance against key targets and progress on actions agreed in previous meetings • If deviations from plan, SLM needs to describe in detail – root causes – actions for how to get back on track	• SLM describes performance against key targets and progress on actions agreed in previous meetings • If deviations from plan, SLM needs to describe in detail – quantified impact of each root cause – actions for how to get back on track – estimated impact from each action – who is responsible for each action

Questions to be considered when implementing or optimising service-line annual planning

Organisation	• What autonomy/decision rights are we prepared to concede to service-lines? • What are the respective roles of our clinical leads and general managers in making decisions about the management of service-lines? • What incentives (financial or otherwise) will we provide to service-lines to drive performance (at individual or group level)? • What is required from human resources?
Strategic and annual planning process	• To what extent/how do we use information about profitability to make decisions at the service or trust level (e.g. investment decisions, service developments, strategic moves)? • How do we ensure service-line plans are linked to overall trust objectives? • What should be the EBITDA targets for the different services? • To what extent will we explicitly use some services to cross-subsidise others? • Who needs to be involved in the annual planning process at the service-line level?
Performance management	• How will the board use service-line reporting information to manage the trust and individual service-lines? • How will we track service-line performance against initiatives? • What organisational culture changes are required to support the new approach?
Information support	• What information and standardised reports are required to facilitate the use of profitability in the management of service-lines? • How often do we need to see information on profitability (as opposed to budgets)? • What systems are needed to produce the required information in a timely manner? • What analytical capability is required to support service-line reporting?

Performance management

Service-line management – performance management

Key enablers	"Check-list" of the important components
1 **Organisation**	☐ Defined **service-line structure** ☐ Defined service-line **leadership roles**, with integrated ownership of clinical, operational and financial performance ☐ Capability-linked, defined **decision rights** at each level (trust executive, service-line, and team)
2 **Strategic and annual planning process**	☐ Understanding of market and competitive position ☐ Defined three-to five-year strategy and annual objectives ☐ Action plan to deliver strategy ☐ Robust annual planning process ☐ Levels of autonomy linked to quarterly monitoring regime
3 **Performance management**	■ Clear KPIs, targets and accountabilities ■ Performance tracking ■ Effective review meetings ■ Good performance conversations ■ Rewards and consequences for performance
4 **Information support**	☐ Relevant, timely information ☐ Patient level costing

What is a performance management system?

What is a performance management system?

A set of tools and processes that create transparency and accountability around the progress against specific initiatives and objectives within an organisation.

The tools and processes are usually embedded in a regular "rhythm" of reporting and reviews conducted by senior management and ultimately tied to the talent management process.

A well-functioning performance management system is an essential component of effective service-line management.

What does a performance management system offer?

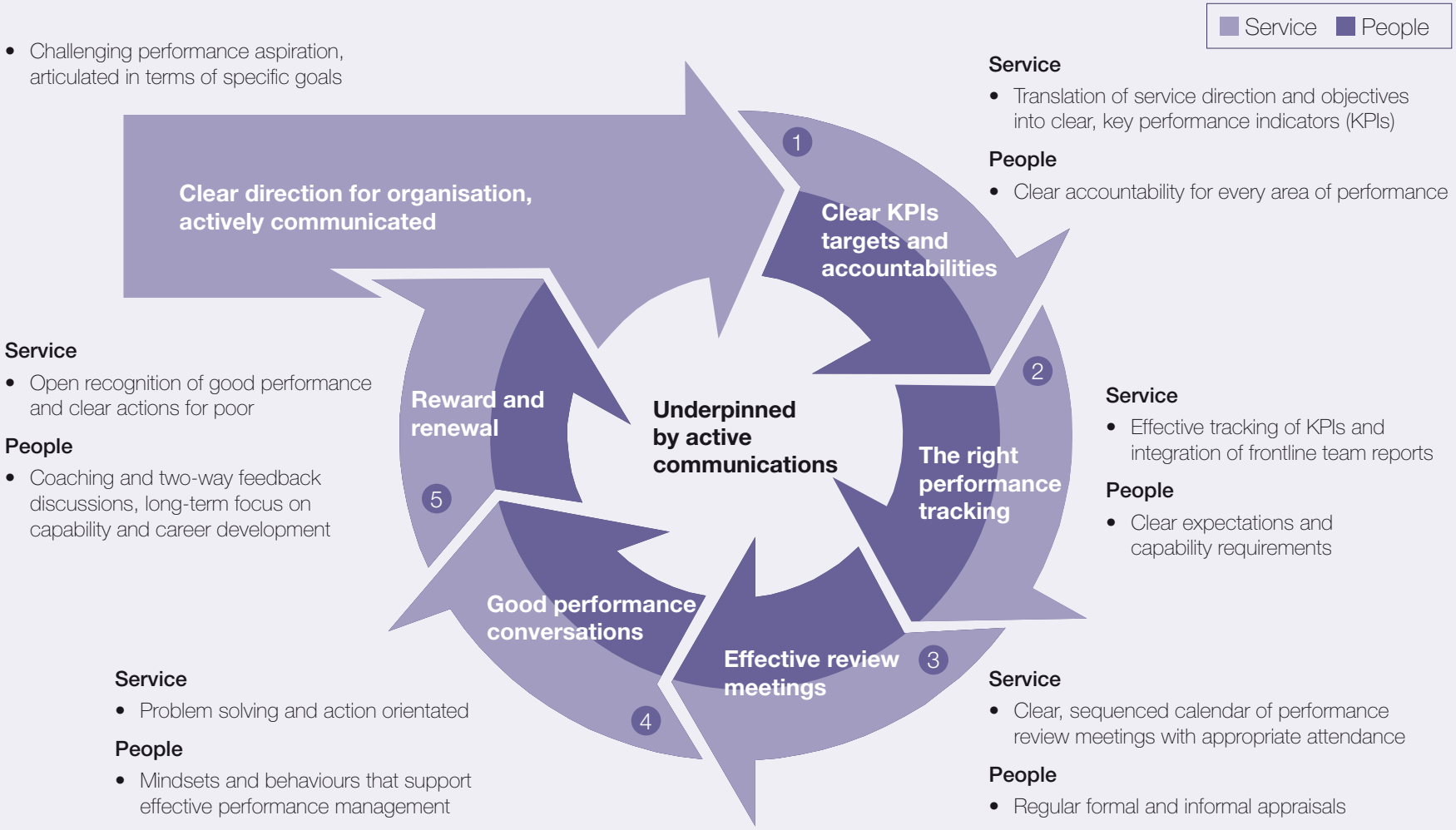
- Links strategy, objectives and targets to ensure delivery
- Focuses senior management on key metrics for performance
- Creates accountability for performance
- Enables more active professional development/coaching and a fairer process for career advancement
- Allows senior management to intervene on a fair basis when performance is substandard
- Increases the organisation's customer focus
- Promotes effective resource allocation
- Allows for effective and timely decisions in response to market and regulatory changes

More about performance management

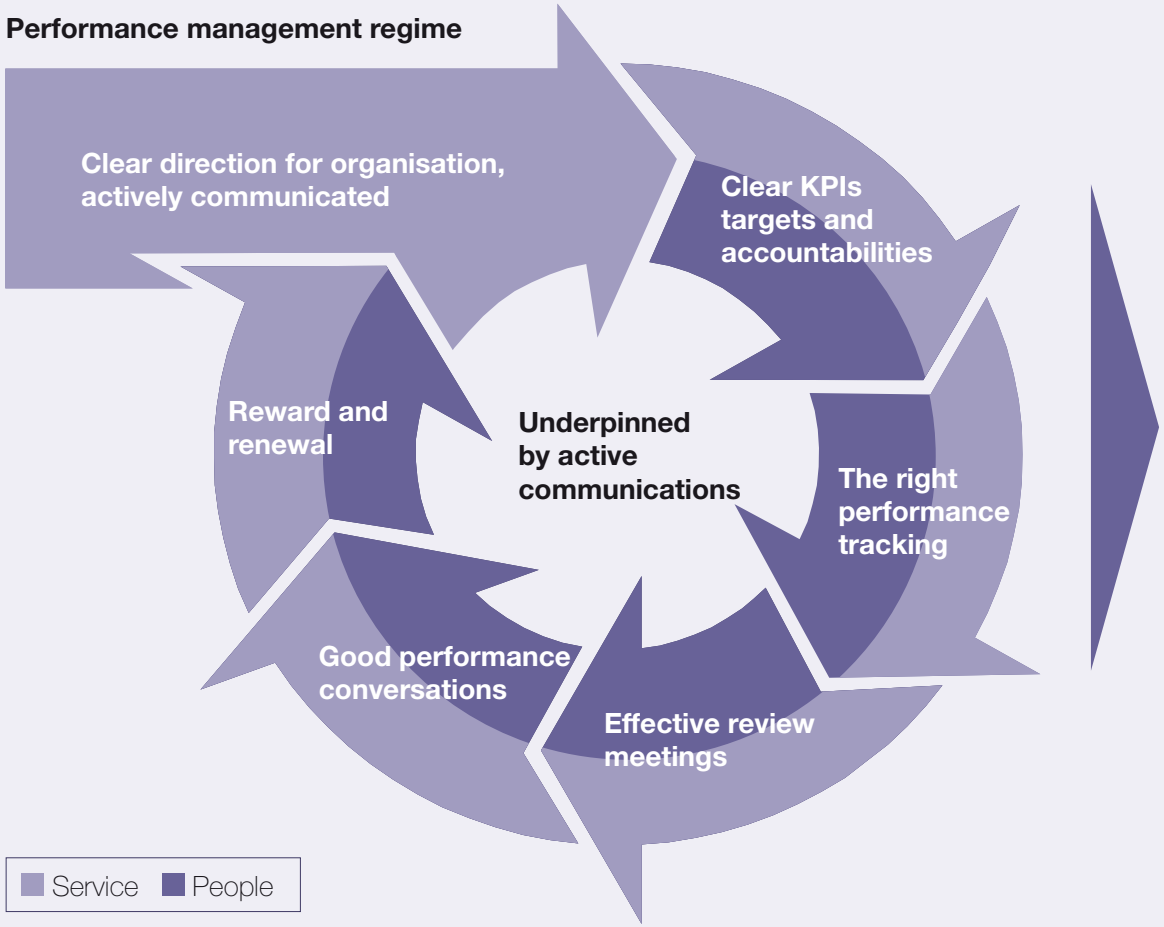
- Performance management is a set of tools and processes that create transparency and accountability around the progress against specific objectives within an organisation.
- The first step in a robust performance management regime is establishing clear KPIs, targets and accountabilities. KPIs and targets should be balanced across clinical, operational, financial and staff dimensions.
- The overall KPIs and targets for the trust should be established by the board of directors, and individual service-lines should develop their own KPIs and targets within this context. These are usually agreed as part of the annual planning cycle.
- Once KPIs and targets are established, it is imperative that they are tracked and monitored regularly. Trusts will need to ensure they have both the appropriate IT infrastructure and human resources to track performance.
- Regular performance reviews at all levels in the trust are necessary to drive performance improvement. These should be regular, scheduled meetings with clear terms of reference.
- The mindsets of participants is critical during performance reviews. Performance conversations should focus on identifying root causes rather than symptoms, and participants should be focused on how performance can be improved rather than casting blame or challenging the data and methodology.
- It is important to reinforce desirable behaviours with rewards and consequences for performance. Incentives should be team as well as individually based, and should always be tied to performance.

The components of a performance management system

The assessment of the performance of individuals and the performance of the service as a whole are inextricably linked. A trust goes through the same process whether assessing individual or service performance, setting targets, ensuring the means to measure them are in place, setting out rewards and targets and so on.



This guide focuses on the service elements of performance management



Service: What is the service performance?

- What KPIs (service specific and trust wide) should be tracked?
- What performance level will trigger concern for each of the core components:
  - financial
  - operational
  - clinical
- How will frequency and level of monitoring and the decision rights of a service-line be altered accordingly?

People: What are the capabilities of the service leaders?

- What performance level will trigger concern?
- How can it be managed?
- What action should the trust take to build and maintain capabilities?
- How will frequency and level of monitoring and the decision rights of a service-line be altered accordingly?

Changing behaviours

To capture the benefits of performance management, trusts will need to change some behaviours

	From	To
1 **Clear KPIs targets and accountabilities**	• Targets are externally driven • Too many metrics with no clear prioritisation • No clear disaggregating of top level metrics to lower level drivers	• Targets are set internally and linked to objectives • Clear relationship between trust-level and service-level metrics
2 **The right performance tracking**	• Key performance data not readily available • Data often has a time lag or is out of date • No explicit 'mapping' of data requirements to support performance management process	• Trust and service-specific objectives are clearly linked to scorecards and KPIs • Data is robust, timely and credible
3 **Effective review meetings**	• Performance calendar focused on performance reviews between executive team and directorates	• Performance review meetings at team and service-line level feeding into executive reviews
4 **Good performance conversations**	• Team performance reviews focus on information dissemination rather than problem solving • Information used to support conversations is inconsistent	• Performance reviews focussing on performance improvement • Open, honest development dialogue and feedback
5 **Reward and renewal**	• No tangible rewards or consequences for performance at individual or team level	• Clear incentives (penalties) in place for good (poor) performance at team and individual level • High performers are recognised and developed

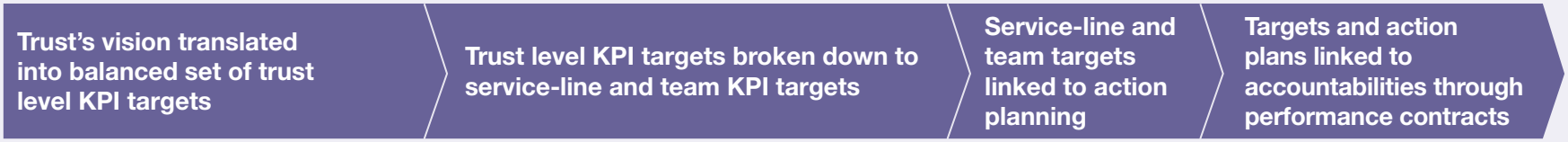
1. Clear KPIs, targets and accountabilities

There are minimum requirements for clear targets and accountabilities, but local flexibility is also important

Things to do	Minimum requirement	What you should define
Trust vision should be translated into a measurable set of KPIs	• KPIs are a direct reflection of the trust's vision and objectives • KPIs are simple, measurable, actionable, result-oriented and timely • KPIs are linked to scorecards • Manageable number of KPIs (no more than 15)	• Specific KPIs which cascade from trust vision and goals
KPIs should be balanced	• KPIs should cover clinical, financial, operational and staff dimensions of performance	• Specific categories for scorecards linked to trust goals • Weightings applied to different KPIs
Trust-level and service-line level KPIs should be aligned	• A clear process for trust-level KPIs to cascade down • Ownership of development and prioritisation of service specific KPIs at service-line level	• Timeline and process for negotiation and agreement of final KPIs
Targets for KPIs should be set through annual planning process	• Clearly defined annual planning process • Targets agreed before beginning of new financial year • Top-down cascade of objectives and bottom-up development of KPIs	• Specific planning process • Individual service-line targets

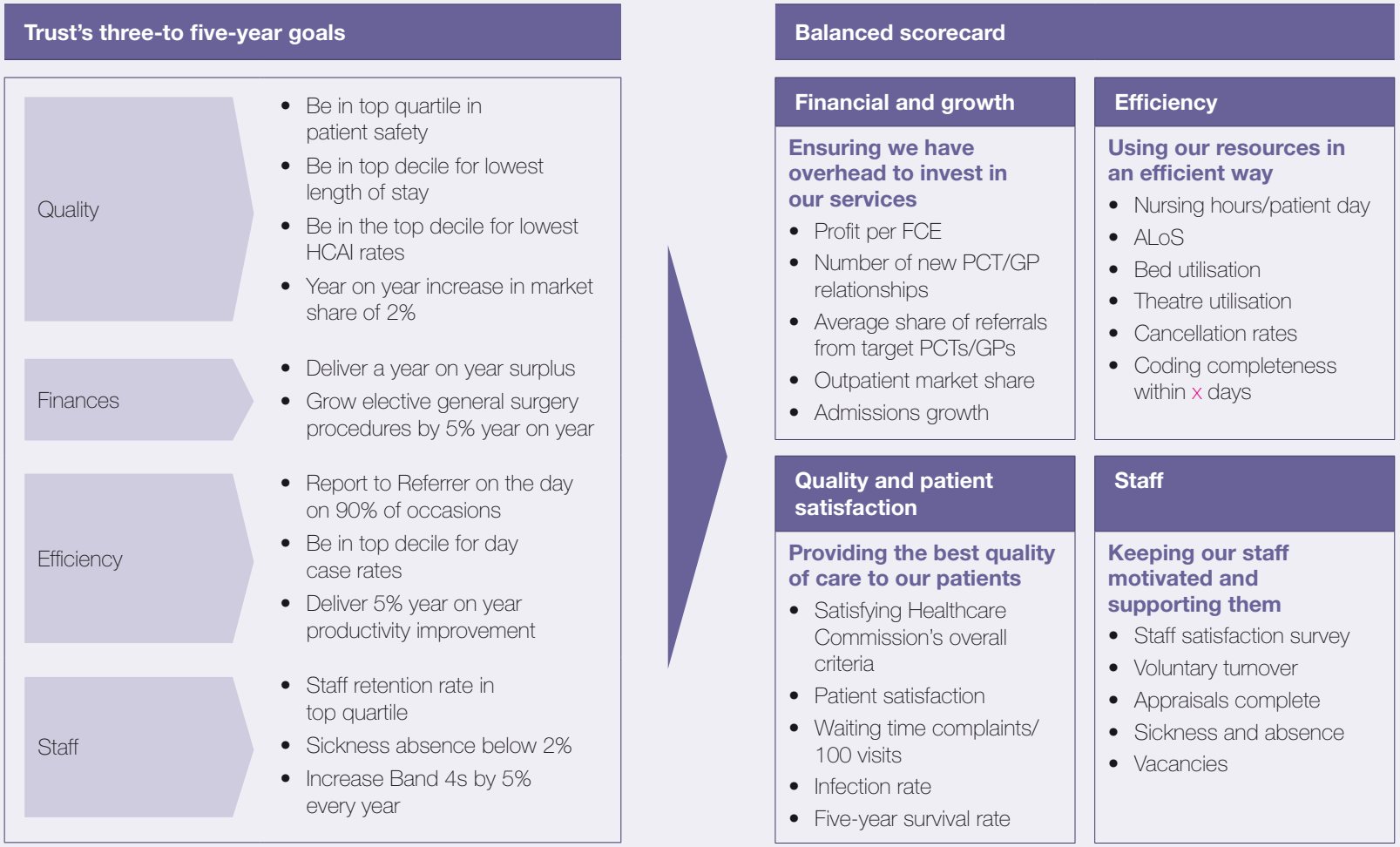
1. Clear KPIs, targets and accountabilities (cont)

There are four key success factors in creating clear targets and accountability



1. Clear KPIs, targets and accountabilities (cont)

The trust's strategic objectives should drive a balanced scorecard of KPIs



Illustrative

1. Clear KPIs, targets and accountabilities (cont)

KPIs need to be SMART – simple, measurable, actionable, result-oriented and timely

KPIs should define the critical elements of success…

…and each be SMART in their own right

Simple	• Does it have a clear definition? • Is it straightforward to understand? • Can it be easily generated without complex calculations?
Measurable	• Is it easy to measure? • Do we have or can we collect the data required? • What source would the data come from? • Can it be benchmarked against other teams or outside data?
Actionable	• Can the team responsible for it actually influence it? • Do we understand what drives the measure? • Can we take steps that will effect the measure?
Results oriented	• Is it relevant to the team as a whole? • Does it support the next level or KPIs and help organisation deliver on the overall goals? • Is it aligned with the objectives of the organisation?
Timely	• Can it be measured at a frequency that will allow us to solve problems and track success? • When will we measure it?

Limit the number of KPIs at any level

- Use not more than 15–25 KPIs
- Between two and four is the realistic number that any team can proactively manage at a time

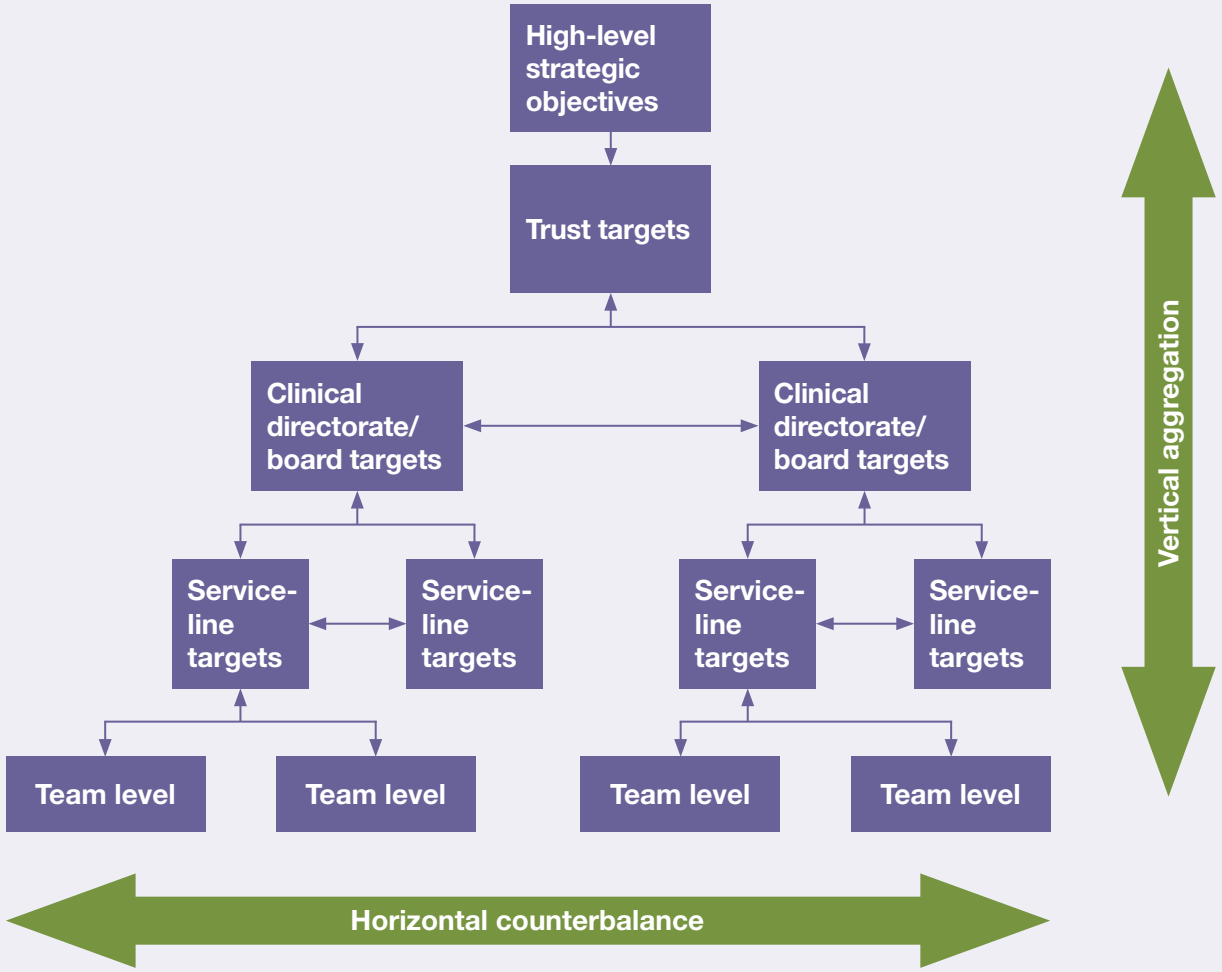
1. Clear KPIs, targets and accountabilities (cont)

KPIs should be clearly defined

Category	KPI	Definition	Units
Operational efficiency	Average length of stay	• (Discharge time – Admit time) for elective and non elective episodes/ total number of spells. Includes partial days and day-cases. To be tracked at the department-level	Days
	Day-of-surgery admission rate	• Number of patients admitted on the day of their surgery/total number of elective spells. To be tracked at the department level	Percentage
	Theatre utilisation rate	• Sum of anaesthetic hours (excluding overruns), surgical hours (excluding overruns) and turnaround hours/total available theatre hours	Percentage
	Nursing hours per patient day	• Total number of nursing hours worked divided by occupied bed days	Hours per day
Financial efficiency	Gross margin	• Department operating profitability, defined as (income-cost)/income	Percentage
	Cost per bed day	• Total bed costs divided by the number of occupied bed days. Bed costs to include ward nursing, direct costs and other staff and non-staff costs on the wards	£
Patient	Overall satisfaction rating	• From an ongoing patient survey conducted at discharge: percentage of patients rating the overall level of care as excellent or very good	Percentage
Quality of care	Infection control	• Number of positive cases of MRSA, Vancomycin-resistant enterococci and clostridium difficile toxin/total admissions	Percentage
	Patients mobilised within 15 hours of surgery	• Percentage of patients mobilised within 15 hours of surgery	Percentage
Staff capability and satisfaction	Voluntary turnover	• WTEs left voluntary divided by total number of WTEs	Percentage

1. Clear KPIs, targets and accountabilities (cont)

Trust-wide KPIs should be translated into service-line KPIs



Targets are disaggregated through the organisation and KPI hierarchy so that delivery of targets at each level ensures delivery of targets at the level above

Teams can be prevented from taking action that compromises another team's targets, as this will also compromise their manager's targets

1. Clear KPIs, targets and accountabilities (cont)

Service-line KPIs should be owned by the service and agreed with the trust

Example of an orthopaedics service performance scorecard

Financial and growth

Ensuring we have the overhead we need to invest in our services

- Contribution margin
  - – cost/spell
  - – income/spell
- Activity numbers

Efficiency

Using our resources in an efficient way by working smarter

- Theatre utilisation rate
- Late theatre starts
- Nursing hours per patient day
- Cancellation rate
- ALoS
- Day of surgery admission

Quality and patient satisfaction

Providing the best quality of care to our patients

- Infection rates
- Re-admission rates
- Number of complaints
- Clinical incidents
- Mortality
- Overall patient satisfaction

Staff

Keeping our staff motivated and providing them with the support needed

- Training attended
- Sickness and absence by staff group

- Service-line KPIs should be aligned with trust KPIs (as service-line objectives are aligned with trust's objectives) but should be set by the service-line
- As many people as possible from the service-line should contribute to setting the KPIs
- Doctors, nurses, managers and others can prioritise the most relevant KPIs for the service-line once they understand the drivers of performance in their service-line

2. The right performance tracking

There are minimum requirements for performance tracking, but local flexibility is also important

Things to do	Minimum requirement	What you should define
Ensure data is robust, timely and credible	• The trust is able to collect relevant data for each KPI • Data input is robust and credible and syndicated with clinicians • Sufficient IT resource in place for regular and timely reporting	• Exactly how data is collected and stored • Quality control systems for data input • Choice of IT provider
Produce simple and user-friendly reports	• Clear reports on trust and service level KPIs • Reports 'sense-checked' for user friendliness • Reports should be consistent and accessible to all decision-makers in the trust	• Formatting for reports • Methods of delivery
Ensure necessary analytical support	• Dedicated analytical resources to answer specific queries and support root-cause problem solving	• What is the most appropriate organisational level for analytical support (service versus trust level)

2. The right performance tracking (cont)

Key success factors for effective performance tracking

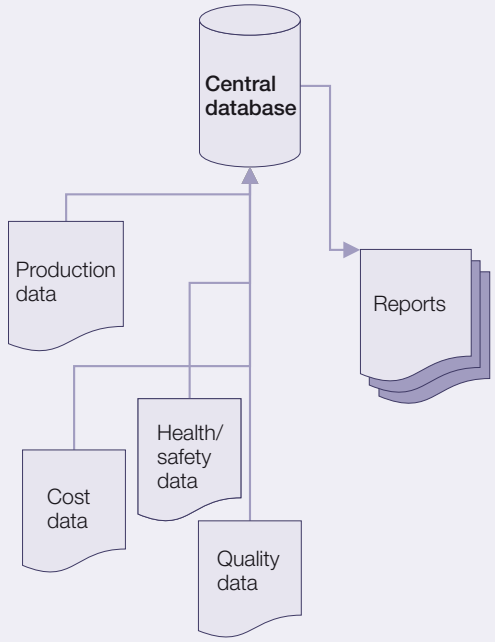
1 Develop and use efficient data collection processes

Automatic collection

Semi-automatic collection

Manual collection

2 Develop a data storage and management solution



3 Report service-line performance using hierarchy of reports with consistent format

Trust level

Service-line level

Team level

2. The right performance tracking (cont)

A very simple tool can be developed to track KPIs

KPIs are grouped into trust's strategic priority themes

Units in which KPI is measured

Targets are agreed with trust exec

COCH Orthopaedics scorecard

Area	Metric	Units	Target	Last month	This month	Status	Trend
Quality	Infection rates	percentage	X%				Better
	Readmission rates	percentage	X%				Same
	Number of complaints	number	Y				Same
	Clinical incidents	number	Y				Worse
	Mortality	percentage	X%				Worse
	Overall patient satisfaction	percentage	X%				Same
Efficiency	Theatre utilisation rate	percentage	X%				Better
	Late theatre starts	percentage	X%				Better
	Nursing hours per patient day	hours	N				Better
	Cancellation rate	percentage	X%				Worse
	ALOS	days	D				Same
	Rate of Day of Surgery Admission	percentage	X%				Better
	New : Follow-up ratio of Outpatient visits	percentage	X%				Better
Finance	Profitability by specialty	£000s	£TT,000				Worse
	Achievement of plan	percentage	X%				Better
	Underlying performance	percentage	X%				Same
	Financial efficiency	percentage	X%				Better
	Activity numbers	number	N				Same
Staff	Training attended	percentage	X%				Same
	S&A by staff group	percentage	X%				Better

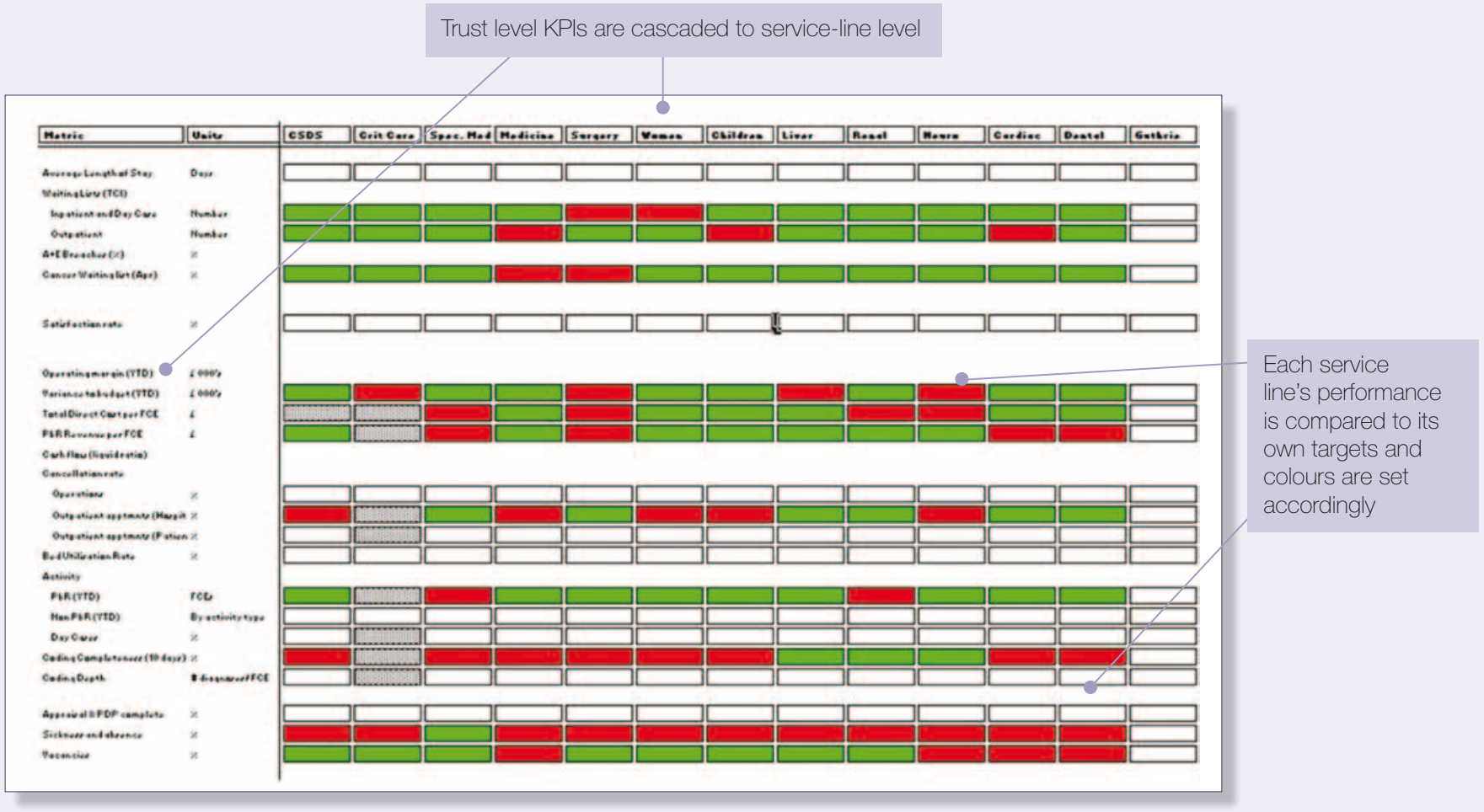
Red and green indicates if the service-line is doing better or worse than the target for the month

Trend indicates if KPI has improved or worsened during the last month. (status might be green even if performance is deteriorating)

Comparing this month's and last month's figures helps to understand last month's trend

2. The right performance tracking (cont)

A ‘heatmap’ can give the executive a quick overview of performance across the trust



Illustrative

Example

Targets are linked to specific initiatives and investments in the planning process

Clearly specify target and linked initiatives

Theatre operating hours: 2,254
Total T&O available hours: 4,508

	Current average	Base target	Stretch target
Utilisation (%)	50	60	65
Time not operating	2,254	1,803	1,578
Hours gained		451	676
Cost of non-op time	714,654	571,724	500,258
Est. cost savings (£)		**142,931**	**214,396**

- Implement all-day lists
- Assign anaesthetists/nursing staff to clinicians
- Provide doctors incentives to drive theatre utilisation (e.g. assign slots based on productivity, allocated dedicated staff)
- Provide consultants with information on their utilisation
- Implement process improvements to reduce delayed starts
- Ensure clinicians call for patients

Define owner with single-point point accountability

Key owner:
Ms. XXXX XXX

Estimated date of completion of initiatives:
DD-MM-YYYY

Key milestones:
1. XXXXXXX
2. XXXXXXX
3. XXXXXXX

Integrate into performance contract

Linking targets and accountabilities

Targets and action plans should be linked to accountabilities through performance contracts

Key components of a performance contract within a health care context.

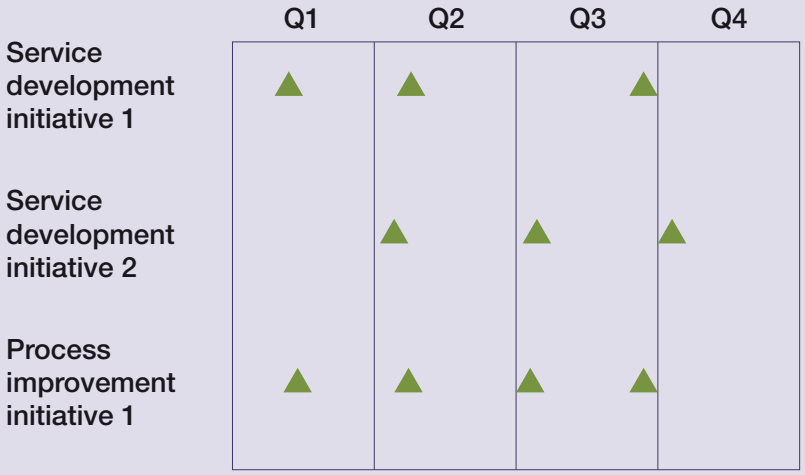
KPIs

- A "balanced scorecard" of approximately six to eight metrics covering both hospital wide and service-line specific targets:
  - key outputs (clinical, research and teaching)
  - quality standards (e.g. MRSA rates)
  - operational standards (e.g. length of stay)

Resources

- Detailed budget
- Capital and IT expenditure
- Consultant appointments
- Staff establishment
- Space

Initiatives with key milestones



Commitment to operate within trust policies and process standards

- For example:
  - patient record return times
  - deadlines for staff appraisal
  - communications

Comment

- Degree of freedom to deploy resources needs to be agreed (e.g. can service-lines flex establishment numbers within budget ceilings?)
- Some process standards may need to be incorporated in KPIs (e.g. where a service-line has a particularly poor record)

Example

Service-line leader performance contract

Service performance targets

Area	Metric	Last year	Target
Quality	Infection rates		X%
	Clinical incidents		Y
	Overall patient satisfaction		X%
Efficiency	Theatre utilisation rate		X%
	ALOS		D
Finance	Contribution margin		X%
	Activity numbers		N
Staff	Turnover		X%

Personal development targets

Dimension	Specific goals
People leadership	
Quality leadership	
Service leadership	
Collaborative leadership	

Executive lead

Signature Date

Service-line leader

Signature Date

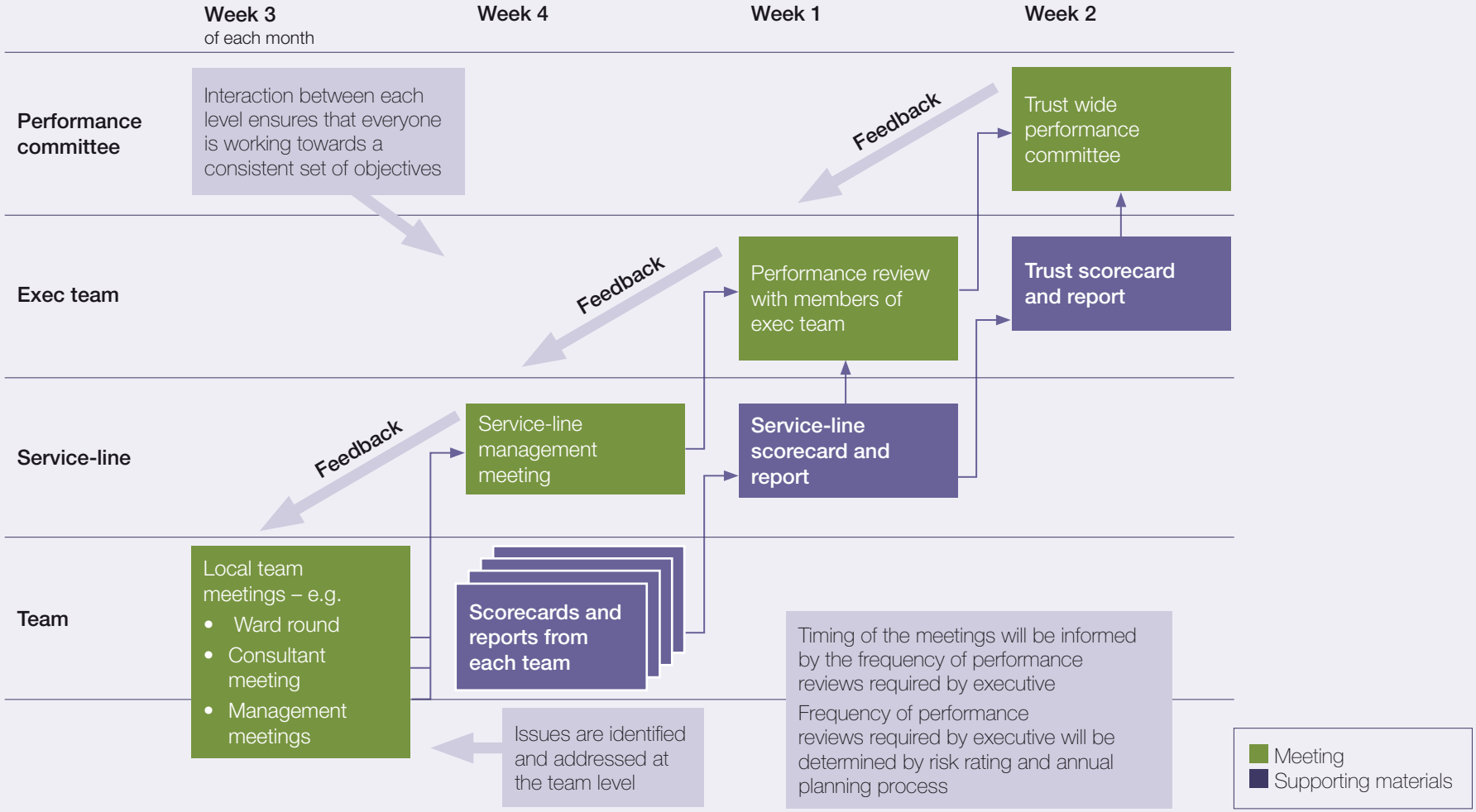
3. Effective review meetings

There are minimum requirements for review meetings, but local flexibility is also important

Things to do	Minimum requirement	What you should define
There should be a clear and consistent sequence of meetings	• Review intervals consistent with performance report cycles • Intervals between reviews at and between each level sufficient to allow actions to have some effect before topic is reviewed again • Meetings support bottom-up actions which facilitate continuous improvement	• Specific schedule for performance review meetings at every level
There should be clear terms of reference for meetings	• Up-to-date definition of each meeting including objectives, attendees, agenda, inputs/outputs	• Detailed terms of reference for each review meeting

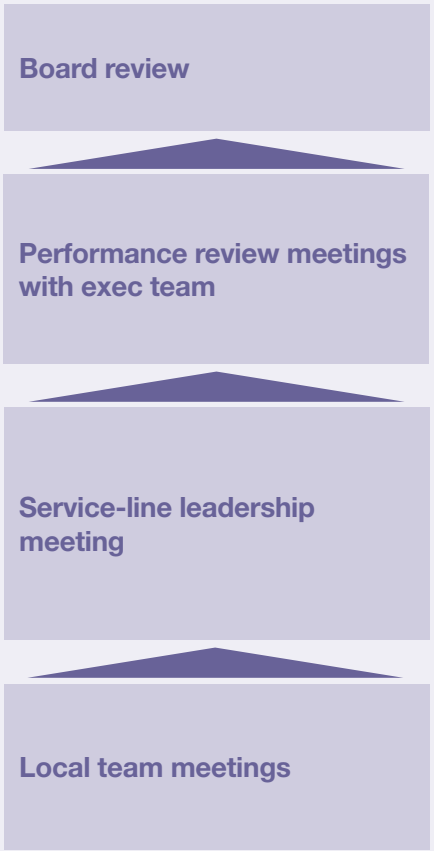
3. Effective review meetings (cont)

This diagram shows the series of meetings within a month and the actions required for each. It describes the process by which information is generated, assumptions are challenged and feedback given within the monthly cycle. Where a trust has multiple service-lines each service-line's scorecard is aggregated into a single scorecard for the executive and board.



3. Effective review meetings (cont)

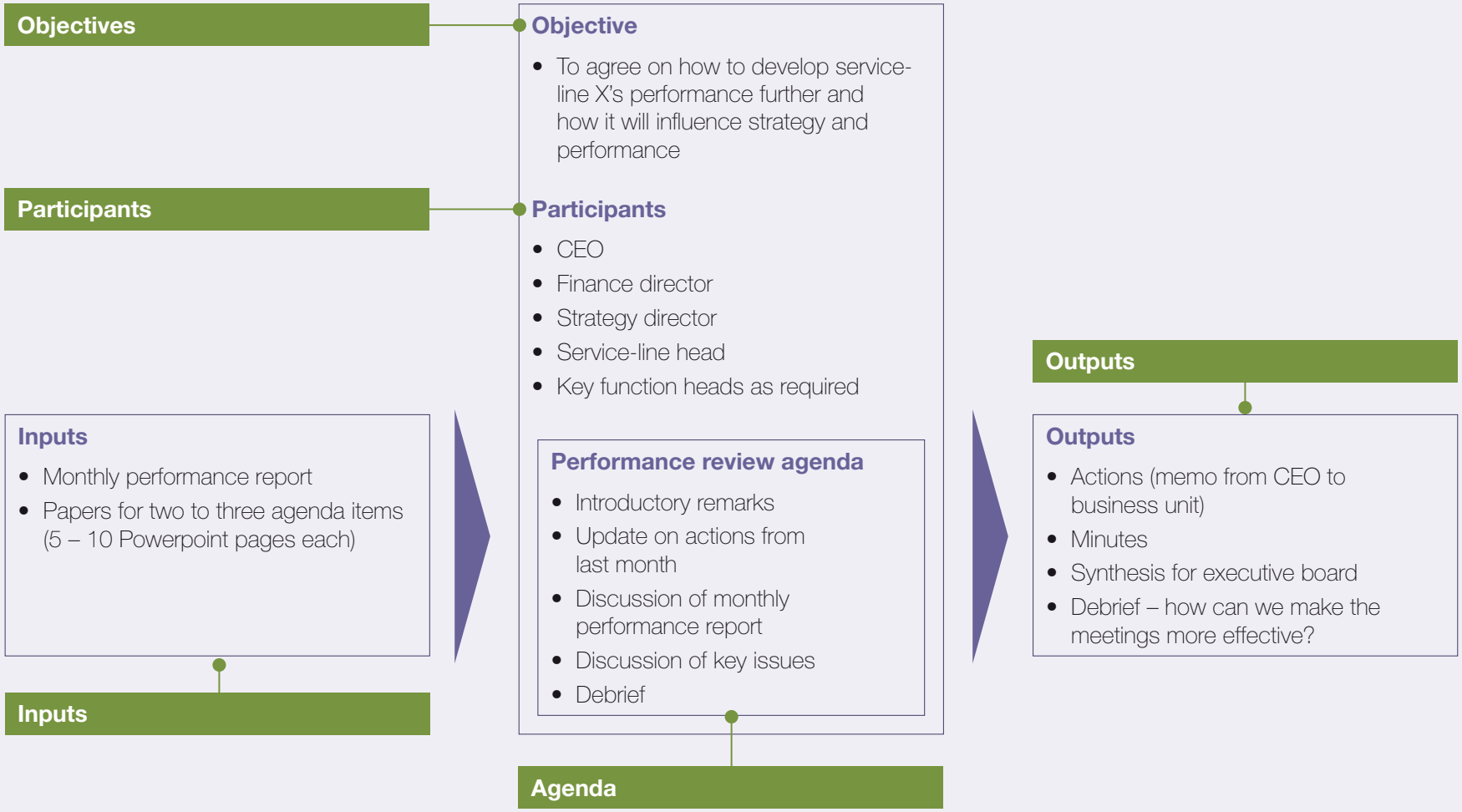
The objectives and scope of the meetings is different



	Frequency	Attendees	Objective
Board review	Bi-monthly	Executive and non-exec directors	• Review hospital operational performance, challenge and problem solve actions being proposed to address problems • Address cross-functional issues
Performance review meetings with exec team	Frequency dependent on risk rating	Service-line clinical director, service-line general manager, medical director, director of nursing and operations	• Follow-up on agreed actions • Review service-line situation, challenge and problem solve actions being proposed to address problems • Develop integrated view of hospital performance including identifying cross-service-line issues
Service-line leadership meeting	Monthly	Service-line clinical lead, service-line general manager, service-line head nurse	• Follow-up on actions agreed at last meeting • Review current situation, challenge and problem solve actions being proposed to address problems within teams • Agree integrated view of current service-line performance and any issues needing to be resolved at next level
Local team meetings	Monthly	Various, e.g. ward staff, nurse management, consultants	• Understand main drivers of performance and come up with actionable steps to improve under performance • Maintain daily services and ensure all operational issues are addressed • Agree key messages for service-line leadership team

3. Effective review meetings (cont)

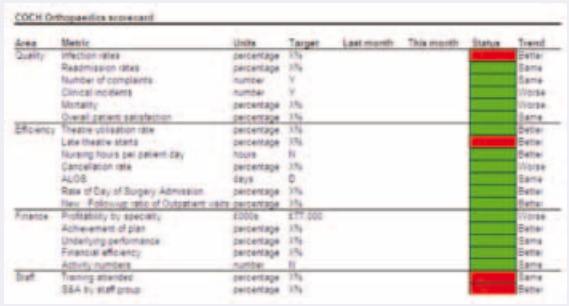
Effective performance review meetings should have clearly defined terms of reference



3. Effective review meetings (cont)

To hold a good meeting the chair has to ask the right questions in order to understand and challenge performance

Based on solid facts…



…ask the questions in a solution-focused way

What is happening?	• What are the gaps to target? • Are any trends causing concern?
Why?	• What has happened to cause the performance gap? • Do we understand the true root causes? • Do we need to investigate further to really understand the problem?
What needs to be done?	• Do we need to take any short term containment action? • What needs to be done to correct the problem and prevent this happening again? • Will these actions completely resolve the problem or do we need to do any additional things to close the gap?
Who is going to do it?	• Who will take responsibility for completing the action? • Does the owner need support from any of the other team members?
When is it going to be done?	• Is it a priority action? • What is the deadline for completion? • When are the intermediate milestones?
How is progress to be tracked?	• Will it be solved immediately or is it necessary to use a T-card?

4. Good performance conversations

There are minimum requirements for performance conversations, but local flexibility is also important

Things to do	Minimum requirement	What you should define
The meeting format, participants and roles should be established in advance	• Purpose and nature of meeting should be agreed in advance • Participants are well prepared • Participant roles (time-keeping, chairperson, note-taker, etc) are defined	• Nature of specific meetings (evaluation versus coaching, status update versus problem solving) • Exact requirements and design options for meetings
Participants need to understand the right behaviour and mindsets	• Participants are focused on root causes rather than symptoms • Participants are focused on performance solutions rather than challenging the data/methodology • Participants adopt a collaborative approach – "facing reality together" • Meeting is inclusive – all participants have a say	• The best way to engage people and develop these behaviour
Meetings should focus on solutions	• Prioritise areas of improvement based on relative value of closing gap • Solutions address gaps and root causes and are prioritised based on implementation time, effectiveness, and costs	• Specific agendas for meetings

4. Good performance conversations (cont)

Clear terms of reference for the meeting help to create focused and constructive discussions

	Example	Principle to apply
Why?	• Ensure that actions agreed at the previous meeting were taken and evaluate success of these actions • Outline key three to four issues (e.g. red KPIs or declining trend) for the department overall and understand how teams can help addressing these • Review each team's performance and proposed actions (help with solutions, where needed) • Agree on key messages to be highlighted at the performance review with ops director	• Ensure all participants understand the objectives of the meeting
Who?	• CD/DM ➔ Chair and challenge • Team lead(s) ➔ Report/take minutes • Finance manager ➔ Support • Other clinicians, as required ➔ Attend • Info analyst, as required ➔ Attend	• Target your communication to the audience • Ensure the relevant people attend or are represented
What?	• Service-line scorecard for the month (with supporting data) • Service-line report from the previous month • Reports from current and previous month from each team • Scorecards for the current month from each team • Financial unit cost report	• Understand the key agenda points you would expect to cover
How?	• Departmental report and agreed actions with clarity of responsibility/timescale	• Share the information in the shortest possible time and with enough time to make the change • Send the information as pre-read where possible • Focus the agenda on problem solving and getting in put rather than on reports • Could the objectives be met without having a meeting?

4. Good performance conversations (cont)

Example of meeting preparation for a performance review with service-line and executive team

Before the meeting

- Review actions from previous meeting
- Review and understand the scorecard:
  - Which of the indicators are red?
  - What has driven this performance level?
  - What can be done to address it?
- Establish the service line's biggest successes and what has worked well
- Establish clear objectives for the meeting
- Write a prioritised agenda
- Gather facts and input onto all items
- Collect supporting information where relevant

During the meeting

1. Progress on issues agreed last time
2. Focus the conversation on problem-solving around key performance aspects
3. Corrective action and new opportunities
4. Deep dive on agreed issues
5. Actions and answers next meeting
6. Debrief – what did and did not work well?

After the meeting

- Ensure summary of meeting and action plan is circulated to all meeting participants
- Send summary to service-line teams celebrating successes and highlighting next steps/action plan
- Work with team members as applicable to complete actions
- Review progress against action plan regularly

4. Good performance conversations (cont)

Actions must be clearly defined in terms of ownership and time

Actions must have…
• …a single owner
• …a deadline
• … a clear definition of success
• …an explicit reporting mechanism
• …authority transfer
• …understanding and commitment

Say this…	…not this!
"John, take this as an action"	"So, people, that report will be finished, right?"
"By the end of next Thursday"	"We just need to get it done"
"This should improve theatre utilisation by 5–10%"	"That should do the job"
"We will review this action at the next meeting"	
"Get Paula and Richard to help you, and anyone else you need"	"Do what you gotta do"
"So, John, what was your action?"	"Everybody clear? Great"

Actions, agreed owners and timelines should always be recorded to allow follow up. Common tracking mechanisms are:

- minutes from the meeting
- team report

4. Good performance conversations (cont)

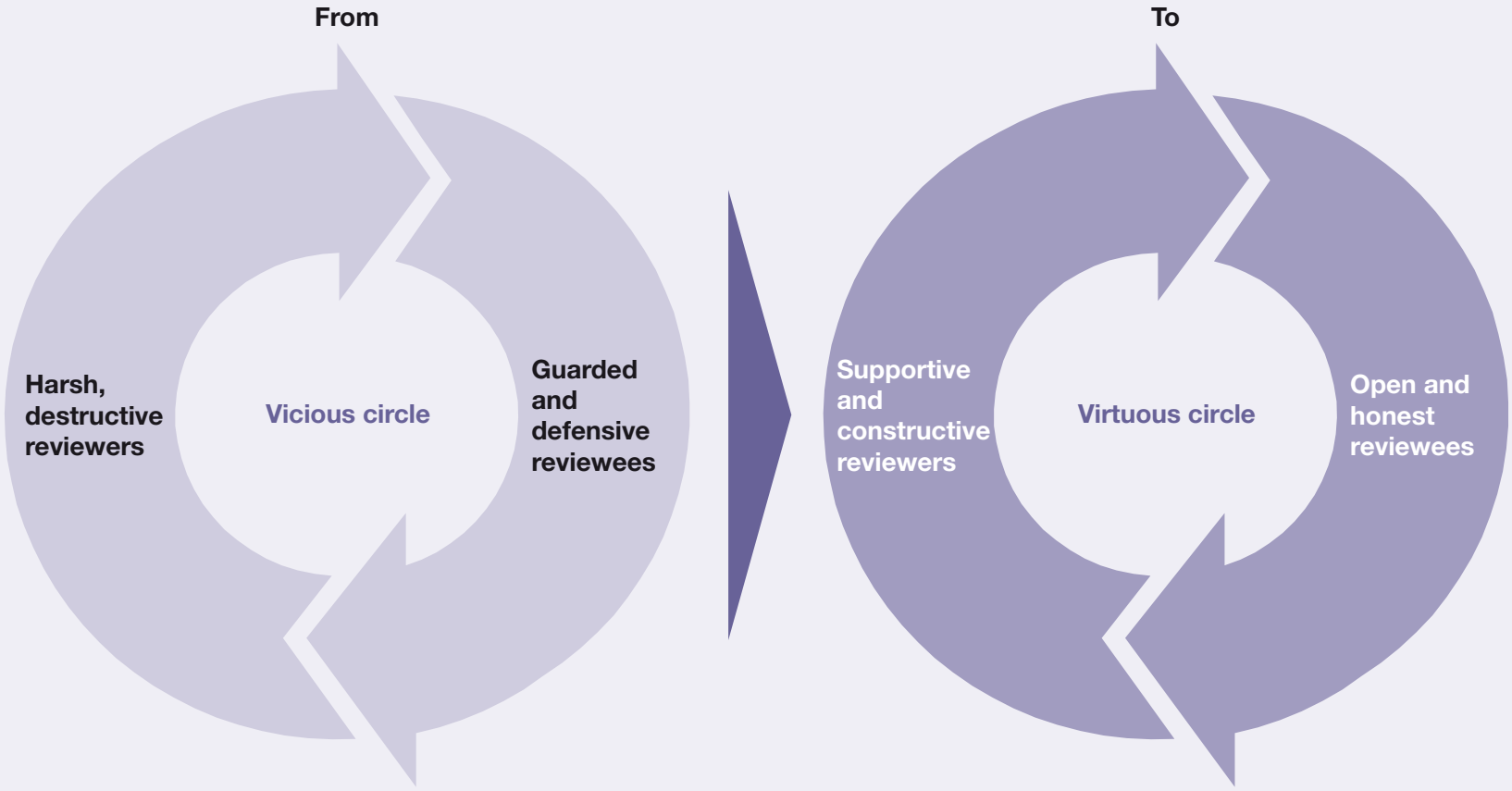
Constructive feedback steps

Constructive feedback is key to continuous performance improvement and self-development

Giver (e.g. clinical director)		Receiver (e.g. consultant)
Describe concrete **observation**	1	**Listen** without interrupting
Explain **effects** on you/others/the meeting	2	Avoid arguing or defending
Pause and listen for clarifying questions	3	**Probe** to ensure you understand
Give concrete **suggestion** on what you would do differently	4	**Thank** the giver

4. Good performance conversations (cont)

Individual skills, mindsets and behaviours in meetings should reinforce a continuous improvement mentality



As negative behaviours are often quite a natural response to performance conversations, instilling positive behaviours requires a cultural change

4. Good performance conversations (cont)

It is important to review the effectiveness of meetings to make continuous improvements

Agenda

The agenda is:	Yes	No
1. Prioritised	☐	☐
2. Received by all participants 24 hours in advance	☐	☐
3. Presented by chair at start of meeting with invitation to suggest changes to content/order	☐	☐
4. Used during meeting to keep discussion on track	☐	☐

Positive and constructive approach

	Volunteer	Nominated
1. People volunteer vs. are nominated for actions (use boxes to count occurrences of each)	𝍸	II

	Yes	Partly	No
2. All participants contribute		☐	☐
3. 'Quiet' participants brought into discussion		☐	☐
4. Respect shown for all ideas even where others disagree		☐	☐

Action focus

	Yes	Partly	No
1. Chair starts discussion with perspective on month's performance	☐	☐	☐
2. Root cause(s) of problems are identified	☐	☐	☐
3. Practical solutions that will address most or all of the problem are identified	☐	☐	☐
4. At least 80% of meeting is spent *identifying* or *solving* real operational problems	☐	☐	☐
5. Data and other non-operational issues are logged for off-line resolution, with all actions having an owner and timeline	☐	☐	☐
6. Participants have taken steps ahead of the meeting to obtain relevant input to make time spent at the meeting more productive	☐	☐	☐
7. Actions agreed at previous month's meeting are followed up	☐	☐	☐
8. Issues and actions for meeting report are recapped after discussion of each issue using report format (issue/action/who/when)	☐	☐	☐
9. Report-writer recaps main points in report at end of meeting	☐	☐	☐
10. Meeting starts and finishes on time	☐	☐	☐

5. Reward and renewal

There are minimum requirements for rewards and consequences, but local flexibility is also important

Things to do	Minimum requirement	What you should define
Rewards and consequences should be linked to performance	• Transparent links between performance and consequences • Incentives designed to encourage behaviours you want to promote	• Specific packages of financial and non-financial rewards and consequences
Team as well as individual rewards	• Rewards and consequences which promote good team behaviours and recognise whole team contributions to the success of service-lines	• Balance between team and individual rewards
Collaborative approach to ensure trust cohesion	• Trust has considered balanced mechanisms to avoid silos	• Specific incentives for trust-wide outlook

5. Reward and renewal (cont)

Performance against scorecards will drive incentives, which should be individual as well as team-based

What to incentivise (service-line scorecards)

Financial

Financial indicators – e.g.

- EBITDA
- Cost per spell
- Revenue per spell

Operational

Indicators of operational efficiency – e.g.

- Nurse hours per patient day
- Theatre utilisation
- Length of stay
- Outpatient DNA rates
- Includes key targets

Clinical quality and patients

Indicators that will impact longer term sustainability and strategy – e.g.

- Re-admission rates
- Patient satisfaction
- Healthcare Commission compliance

People/workforce

Indicators of organisational structure, employee productivity, skills, and motivation – e.g.

- Voluntary turnover
- Sickness and absence
- Staff satisfaction

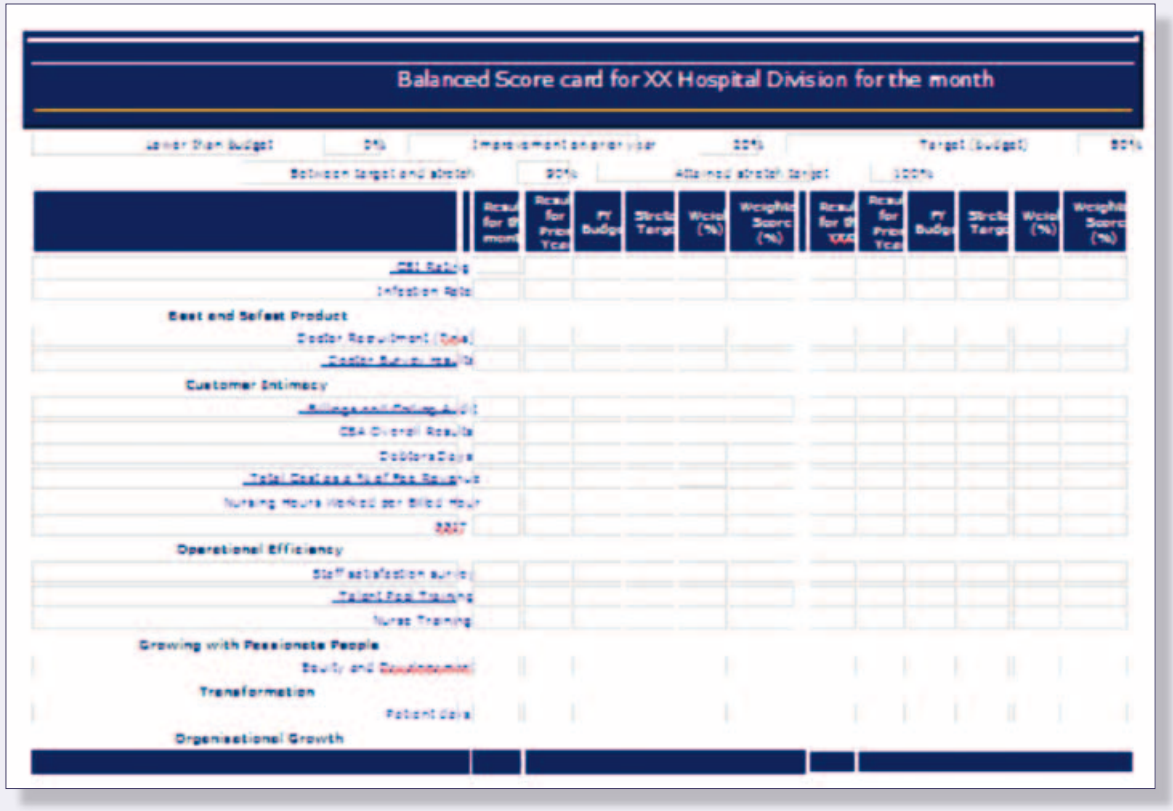
How and who to incentivise

	Non-financial	Financial
Individual	• "Star performer" development schemes (e.g. mentoring) • Additional annual leave • Development/project management opportunities • Preferential access to surgery lists	• Bonuses • Excellence awards (may be clinical, financial or operational) • Performance-based pay • Saturday lists
Service-line	• Further autonomy in decision-making • Control over budgets and profit and loss • Performance transparency • Preferential access to theatre slots	• Surplus retention (proportional to achievement of objectives)

5. Reward and renewal (cont)

A best practice example showing individual balanced scorecards linked directly to incentives

Balanced scorecard linked to strategic priorities

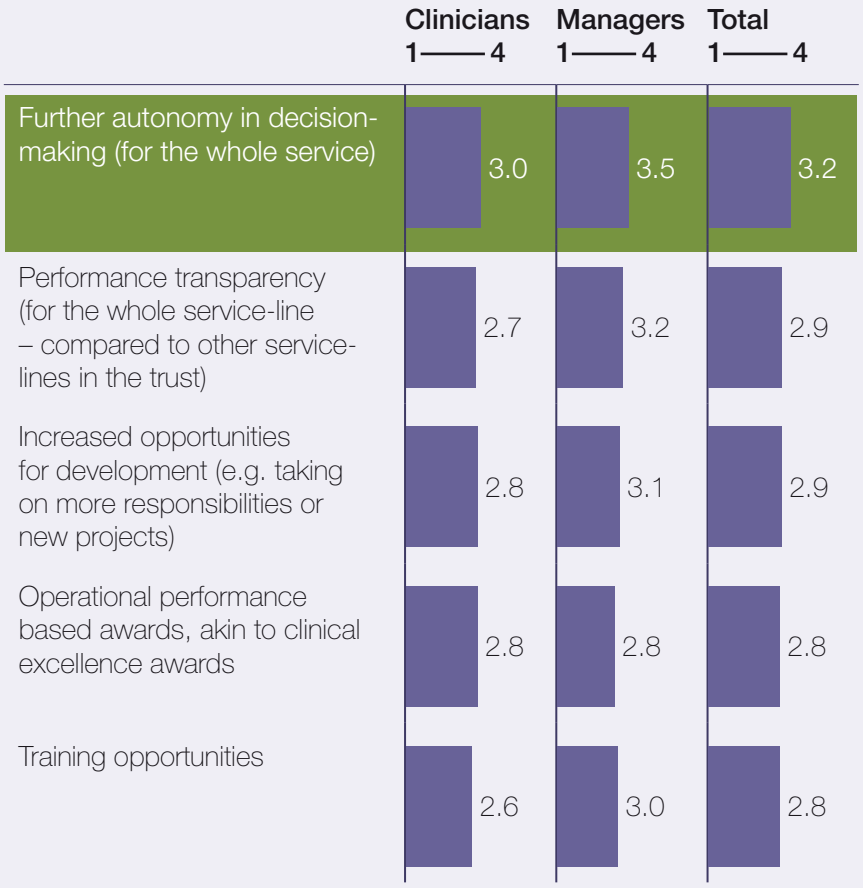


- Each individual has their own scorecard
- Executive team scorecards shared on intranet
- Incentives are linked directly to performance of group and individual
- Group must achieve 60% on scorecard before any incentives are triggered
- Individual performance drives personal incentives

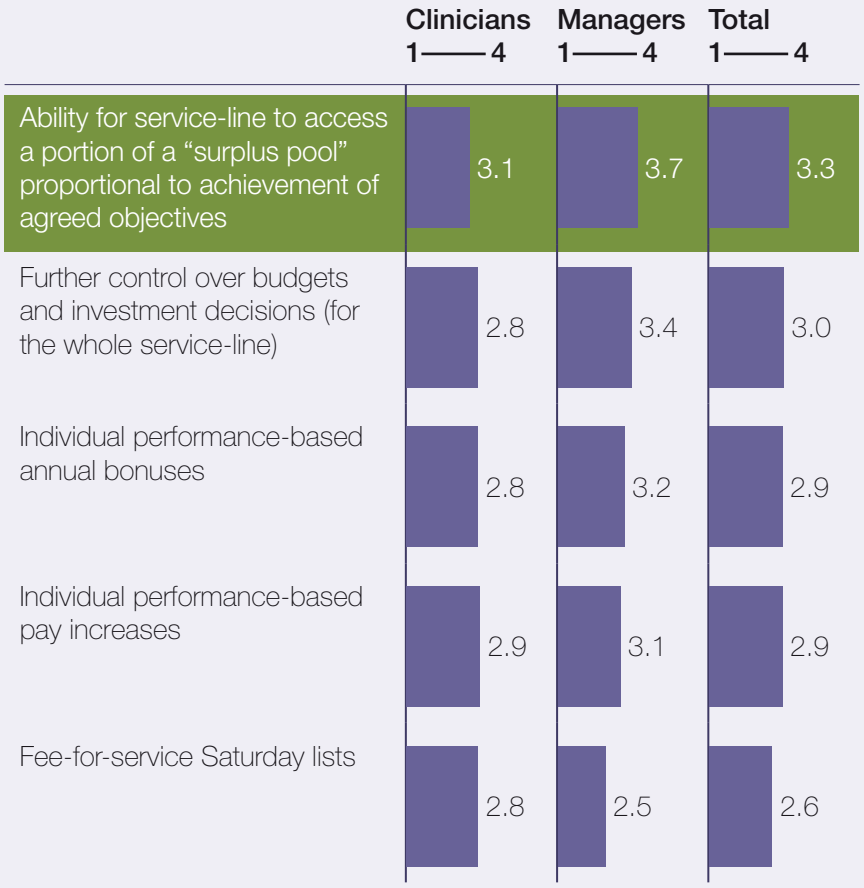
5. Reward and renewal (cont)

The ability to reinvest surpluses and increased autonomy provide the greatest incentives in the service-line

Top 5 non-financial incentives*



Top 5 financial incentives*



*Based on a survey of 39 clinical directors and general managers across four NHS FTs, with 1 as "not motivating" and 4 as "extremely motivating"

5. Reward and renewal (cont)

There are many barriers to implementing incentives, but there are also ways to overcome them

	Potential barriers	Options for overcoming them
Cultural	• Perception of incentives as a threat to public sector ethos • Perception of incentives as incompatible with team working • Perception that incentives may not be fair	• Educate staff on what incentives mean (e.g. not just cash bonuses) • Explain potential for team or individual incentives based on team performance • Ensure scorecards are clear and performance base for incentives are transparent
Structural	• Constraints of the NHS – what room does an NHS foundation trust have for manoeuvre? • Developing a solution when different roles and individuals have different motivators • Pace of change • Trade unions	• Decide if trust should be a change-leader • Start somewhere (e.g. team rather than individual incentives?) • Communication and training – ongoing • Engage early
Financial	• Overall cost to trust • Non-profitable service-lines also need to be incentivised	• Top-slice budget (e.g. performance fund) • Ensure incentives are tied to relative performance rather than absolute profitability

5. Reward and renewal (cont)

Using a phased approach to implementation will facilitate the introduction of incentives

Clinician example

Establish transparency

- Identify progressive and influential clinicians
- Jointly design a set of measures to track productivity by clinician
- Engage clinicians in the measure design and solicit input on continuous improvement
- Design appropriate peer groups
- Measure medical productivity and make information available to clinicians

Introduce non-financial incentives

- Set goal for medical productivity
- Design non-financial incentives (e.g. theatre slots, secretarial support, capital allocations)
- Measure clinician's performance against benchmark for period of time (e.g. three months)
- Test non-financial incentives and report
- Incorporate goals in development programs

Introduce financial incentives

- Measure salary against productivity and benchmarks
- Design financial incentives plan
- Measure clinician performance against the benchmark and report hypothetical results
- Phase 1: implement for clinicians performing above benchmark
- Phase 2: complete roll-out to others after grace period (e.g. six months)

Key messages

- Clinical engagement is critical in developing incentives
- Multiple non-financial incentives options can be explored first
- Organisational changes might be required to drive incentives through medical management
- Individual goal/ targets will need to be aligned with service-line strategy and goal

5. Reward and renewal (cont)

A US hospital uses non-financial incentives to motivate physicians

Area	What this means	Examples
Recognition	• Ensuring peers and others recognise success	• Published lists of top performers • Internal and external communications (e.g. newsletters, portraits, videos) • Parking spaces • Catering
Convenience	• Successful doctors have preferential access to hospital resources	• Preferential scheduling • Dedicated teams in theatres • Consistent nursing teams • Patients co-located
Additional support	• Successful doctors are supported with their own interests (e.g. research)	• Dedicated physician's assistant (e.g. junior doctor) • Research technician • Medical writer/editor and photographer to support submissions to journals and publishing papers

5. Reward and renewal (cont)

A Norwegian hospital's divisional managers are motivated to perform by peer pressure

Clear transparency of financial results…

	Årsbudsjett	Budsjettert hittil	Akkumulert avvik fra budsjett: Inntekt	Kostnad	Resultat
Kliniske enheter	3 114 872	2 206 226	41 406	-119 953	-78 547
BARNEKLINIKKEN	293 985	215 383	7 713	-8 078	-366
HJERTE- OG LUNGEKLINIKKEN	530 359	390 053	19 537	-24 384	-4 846
KIRURGISK KLINIKK 1	265 629	196 107	3 764	-8 424	-4 666
KIRURGISK KLINIKK 2	268 146	197 033	19 329	-39 681	-20 352
KREFTKLINIKKEN	469 053	345 708	-6 107	-13 209	-19 317
KVINNEKLINIKKEN	161 822	119 358	-1 421	-2 232	-3 653
MEDISINSK KLINIKK	418 905	307 370	-1 001	-11 207	-12 208
NEVROKLINIKKEN	373 403	275 630	-2 979	-8 180	-11 160
SPESIALSYKEHUSET FOR REHABILITERING	332 589	247 684	2 511	-4 557	-2 046
Medisinsk service enheter	1 082 484	796 328	13 624	-17 434	-3 810
ANESTESI- OG INTENSIVKLINIKKEN	326 329	240 997	897	-14 934	-15 932
BILDEDIAGNOSTIKK OG INTERVENSJONSKLINIKKEN	214 106	157 179	5 876	-892	5 017
KLINIKK FOR KLINISK SERVICE	78 751	58 065	988	497	1 485
LABORATORIEKLINIKKEN	316 500	231 029	1 365	1 369	2 734
OPERASJON 3	31 771	23 465	0	396	396
PATOLOGIKLINIKKEN	114 931	84 690	6 304	-3 904	2 400
Forskningsenheter	253 268	186 444	2 375	4 967	7 342
INSTITUTT FOR KREFTFORSKNING	89 663	65 782	6 663	-4 250	2 613
INTERVENSJONSSENTERET	21 780	16 149	-276	2 396	2 120
KREFTREGISTERET	92 743	67 857	-5 143	3 934	-1 209
MEDISINSK INFORMATIKK	29 829	21 417	42	2 382	2 424
SENTER FOR KOMPARATIV MEDISIN	8 177	6 047	606	252	858
S. FOR PASIENTMEDARK. OG SYKEPLEIEFORSK.	11 077	8 191	223	314	537
Administrative enheter	1 007 367	723 249	2 983	-737	2 246
Avskrivninger og sentrale poster	403 775	324 155	81 929	47 374	129 304
Resultat aksjeselskaper	124 884	96 166	6 662	-12 845	-6 181
RESULTAT	5 988 649	4 419 566	148 964	-98 627	50 341

Contribution versus plan compared for all service-lines

...results in strong peer pressure to perform

> Nobody wants to be bottom of the class – everyone wants to be the star student.
>
> **Head of cardiac clinic**

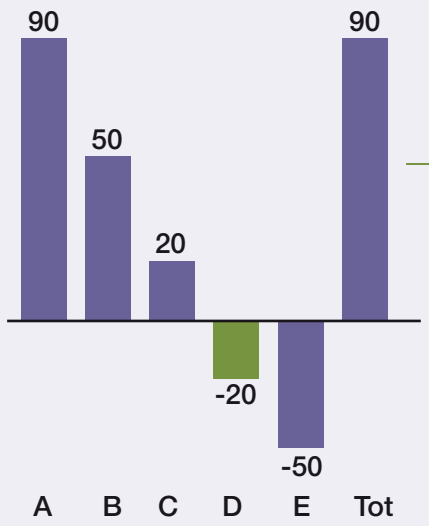
While financial incentives form a powerful motivational tool, peer ranking goes to the heart of professional pride

5. Reward and renewal (cont)

A German hospital's divisions retain earnings based on relative profit contribution

Identify financial results | **Aggregate profits** | **Allocate profit pool (for reinvestment) back to service-lines based on their share of profit contribution**

Contribution margin
£m



Service-line

Profit pool

Strategic investments

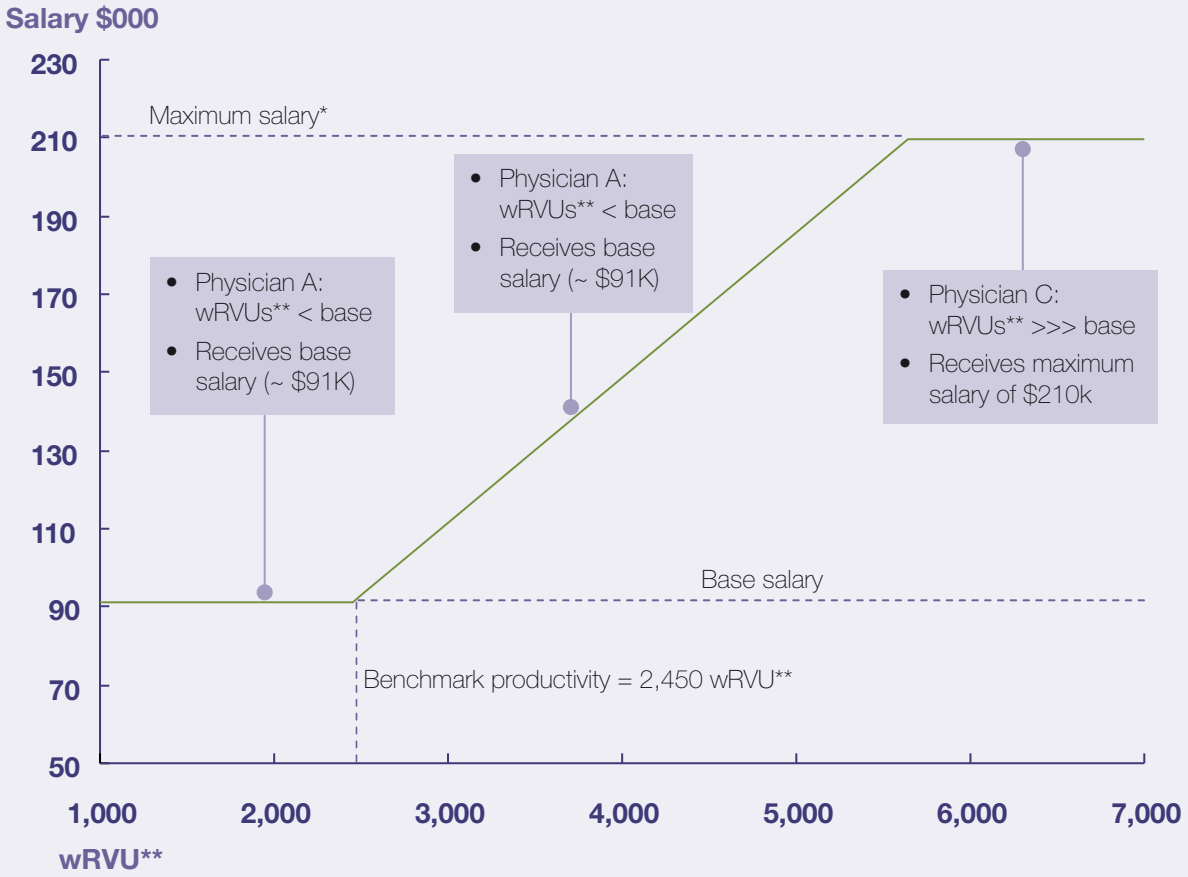
Corporate overhead costs support

SL	Contri-bution £m	Contri-bution share % of tot	Allocation of profit pool £m
A	90	56	56% x 20 = 11
B	50	31	31% x 20 = 6
C	20	13	13% x 20 = 3
	160	100	20

5. Reward and renewal (cont)

An example showing U.S. clinic's clinicians with a variable pay component based on productivity

Illustrative example: Salary outcomes for three different clinicians at a U.S. paediatric clinic



* The maximum salary is capped at the MGMA 90th percentile to comply with Stark and IRS regulations

** Weighted relative value units, represent the resources to perform a particular medical service

Appendices

A: service leader capability tool

Service leader capability assessment tool:

1. People/personal leadership

Dimension	1	3	5
1. Inspirational leader of people across professional boundaries	• Does not inspire others in service-line • Does not command respect from clinical, nursing and management/administrative staff • Fails to provide clarity and direction – does not demonstrate a clear vision for their service-line • Manages through control	• Commands respect from those who share own professional background • Effectively asks for support from others in service-line for inspiring those from different professional backgrounds • Effectively articulates expectations to others • Leads through clear metrics and goals	• Inspires people from all different professions in service-line • Commands respect from all professional backgrounds • Is sought out by others when problems arise • Mobilises energy and commitment of staff members • Provides clear vision and framework within which others can succeed • Encourages innovation and improvement from others
2. Helps others perform their best	• Does not identify strengths and weaknesses of others • Demonstrates avoidance of difficult or challenging behaviours • Is not prepared to tackle performance issues with individuals	• Holds performance conversations with others when required (ad-hoc) • Offers coaching and feedback to others informally • Raises difficult issues to individuals or service-line teams	• Has regular performance conversations with individuals from all professions in the service-line • Identifies strengths and weaknesses in others and makes suggestions for improvement • Is prepared to challenge the status quo and push for improved performance at an individual level • Deals with difficult issues head-on
3. Continuously aims for self-development	• Does not consider the impact of their behaviour on others • Finds reasons for disregarding feedback from others	• Aware that own behaviour has an impact on others • Reflects on own behaviour and makes adjustments based on observation or feedback	• Regularly solicits feedback from others • Understands own strengths and limitations and is prepared to ask for help and act on the feedback of others
4. Is an effective role-model for others	• Is not seen to display behaviours expected from others	• Often displays behaviours expected of others, but sometimes seen to communicate mixed messages	• 'Walks the talk' – actively displays the behaviours expected from others

Service leader capability assessment tool:

2. Quality leadership

Dimension	1	3	5
1. Demonstrates outstanding patient commitment	• Does not perceive patient care to be central to their role • Delegates patient relationships to others	• Recognises the need to put patients at the centre of their service-line • Responds to overall if not individual patient needs and concerns • Encourages others to implement patient satisfaction improvements	• Seen to 'go beyond the call of duty' to put patients at the centre of their work (e.g. addresses individual issues and complaints in a committed and timely manner) • Regularly engages with patients in the care of their department (e.g. regular ward walk about)
2. Demonstrates commitment to quality of care and outcomes	• Leaves clinical excellence to clinical governance leaders and medical staff • Reviews clinical performance only as part of mandated clinical governance processes	• Engages in clinical governance and understands their role in managing clinical excellence and patient safety in the service-line • Uses scorecards and information provided on clinical performance to drive through change across service-line (individual and team) • Makes use of benchmarking where available to improve clinical quality	• Drives innovation in clinical excellence • Rewards clinical excellence • Uses scorecards and information provided on clinical performance to drive through change across service-line (individual and team) • Instigates improvements to clinical performance on an ongoing basis • Proactively seeks out benchmarking and other internal and external resources to improve clinical quality
3. Effectively prioritises patient safety	• Fails to build robust relationship with nursing teams to ensure best practise is in place • Does not properly engage with remedial action where serious untoward incidents (SUIs) occur	• Maintains reasonable relationships with nursing teams on wards • Remedies SUIs as and when they arise	• Builds outstanding relationships with nursing teams on wards • Engages in thorough diagnostic when SUIs occur and takes active preventative measures to mitigate against future incidents • Uses scorecards and information effectively to continuously improve patient safety
4. Ensures a positive patient experience	• Leaves patient experience to nursing staff • Does not concern self with non-medical aspects of patient experience	• Recognises their responsibility in ensuring patient experience is positive	• Takes active responsibility for ensuring patient experience is positive • Actively engages with nursing staff to look for improvement opportunities

Service leader capability assessment tool:

3. Service leadership

Dimension	1	3	5
1. Understands drivers of financial performance	• Demonstrates little understanding of or interest in financial performance • Relies on others to make financial decisions	• Understands the relationship between financial performance, operational improvement and clinical quality • Demonstrates a clear understanding of the key drivers of financial performance in their service-line (with appropriate support and information)	• Understands the relationship between financial performance, operational improvement and clinical quality • Demonstrates a clear understanding of the key drivers of financial performance in their service-line (with appropriate support and information) • Uses these drivers to instigate change and operational improvement
3. Identifies and prioritises opportunities to improve operational excellence	• Identifies opportunities only through annual planning cycle	• Regularly identifies quantifiable opportunities to improve operational excellence • Implements new opportunities as they arise	• Regularly identifies quantifiable opportunities to improve operational excellence • Takes a strategic view of opportunities – is able to prioritise them and make trade-offs between them
4. Delivers service specific strategies and objectives	• Day-to-day management focused on 'fire fighting' rather longer term performance achievement	• Shows determination to meet targets set in annual plan • Regularly tracks performance and delivery against plan and makes required adjustments as needed	• Understands overall strategic vision for service-line • Sets stretching goals as well as annual plan objectives • Proactively overcomes obstacles to achieving goals and objectives

Service leader capability assessment tool:

4. Collaborative leadership

Dimension	1	3	5
1. Acts within the overall interests of the trust	• Is unable to balance the needs of the service-line with the needs of the trust • Rarely engages in trust-wide issues	• Understands the needs and objectives of the trust beyond own service-line • Engages in trust-wide issues as required to deliver results in own service-line	• Fully engages with the strategy and objectives of the trust and ensures the strategy and objectives of the service-line are aligned with these • Is able to effectively balance the needs of the service-line with the needs of the trust • Understands priorities of other departments and how these impact on own service-line
2. Communicates and collaborates effectively with other leaders in the trust	• Communicates with other service-lines only as mandated by trust • Does not seek opportunities to work in partnership or • Is over-involved in the detailed running of other service-lines	• Engages positively with other service-line leaders in partnership working when asked • Shares information with other service-line leaders as required • Inputs appropriately into other service-lines without needing to be involved in decision-making	• Works effectively with other leaders in the trust to create a cohesive leadership team • Creates opportunities for service-lines to learn from one another • Inputs appropriately into other service-lines without needing to be involved in decision-making
3. Engages executive as appropriate	• Escalates all responsibility up to executive team or • Does not sufficiently involve executive team/share information	• Appropriately involves executive team in majority of service-line decisions	• Appropriately involves executive team in service-line decisions • Earns executive's trust and autonomy
4. Effectively engages with other stakeholders (GPs, PCTs, social services, internal customers)	• Does not proactively manage communications with stakeholders beyond the service-line	• Understands the broader context of stakeholders in their service-line • Communicates effectively with external stakeholders when clearly required to do so	• Understands the broader context of stakeholders in their service-line • Initiates and regularly updates communications with external stakeholders • Regularly solicits feedback from external stakeholders on how the service-line is performing

Appendices

B: Questions to evaluate a candidate PLICS system

Questions to evaluate a candidate PLICS system (1 of 2)

	Evaluation questions
Technical	• What is the core data base used within the system? • Can you demonstrate the ease at which systems interfaces are created? • Is there any limitations in terms of size for data files for integration within the system? • How open is their black box – i.e. business intelligence/interface?
Ability to engage clinicians	• Tracking resources to patients – Relevant variables: (wards/nursing, medical, theatre, pharmacy, prostheses, any other) – Explain the ability of your system to accept input at various levels of granularity* – Explain how you deal with different levels of patient acuity – Explain how you cope with inadequate/non-existent data feeds (highly important) – Can you drill down into this systematically? • Comparability – Can your systems produce reports for comparability* (by procedure, by types of procedure, by patient age or other demographic – Can these reports be also produced by clinician – e.g. procedure by clinician comparison? – What patient level reports have you actually provided to clinicians? *
Costing standards	• What/how complex are any algorithms underpinning the costing methodology? • What clinical costing standards do you use in your system? * • How flexible is your system in using differing standards for different cost elements? • What is your ability to reconcile back to the general ledger? • How do you handle W.I.P.?
Ability to inform tariff	• Are you able to group patients to HRG?* • How would you go about providing a feed of the cost of individual patients by HRG?

* Please demonstrate or provide written examples

Questions to evaluate a candidate PLICS system (2 of 2)

	Evaluation questions
Ease of use	• How user-friendly is your report writer? Is there a need for an external system report writer? • Can you demonstrate the ease at which knowledge of the system can be transferred and users can become self sufficient in costing studies?
Experience	• How long has your product been on the market ? • How many hospitals have implemented your system? • In which countries has your system been implemented? • What experience do you have of talking to clinicians and managers about current performance and future opportunities, and how did you convince them of your argument? • How long you think it will take to properly implement the system?
Commitment to market/resource/ capacity	• What resources do you intend to commit to this market ? • What are the ongoing system support capabilities of your company? • What are the ongoing training/knowledge transfer capabilities of your company? • Can we have some tangible evidence of this please?
Other	• How can we assess your financial stability?

Further information about SLM

This guide is one of a series of documents produced by Monitor to help NHS foundation trusts implement SLM. All of these guides can be found on Monitor's website www.monitor-nhsft.gov.uk/slm

- ***Working towards service-line management: a how to guide* – this guide sets out the processes and structures necessary to implement SLM within a trust setting;**
- *Working towards service-line management: organisational change and performance management* – this guide looks at ways in which service-line reporting (SLR) can be used as a motivational tool and to influence;
- *Guide to developing reliable financial data for service-line reporting: defining structures and establishing profitability* – this guide helps foundation trusts move towards service line reporting and describes how some of the obstacles to SLR can be overcome;
- *Working towards service-line management: a toolkit for presenting operational service-line data* – this guide describes a range of service-line reporting (SLR) tools and shows how they can be used to present data to encourage informed decision making; and
- *Working towards service-line management: using service-line data in the annual planning process* – this guide shows how SLR data can be incorporated into a trust's business planning cycle.

To help implement SLM, Monitor – working in conjunction with various external organisations – can offer a comprehensive package of support, specifically tailored to individual needs, both in terms of cost and relevance. The support routinely includes consultancy and advisory services, board level diagnostics, individual coaching, strategic goal setting and the opportunity to join learning sets. For more information contact slm@monitor-nhsft.gov.uk

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