Monitor

Independent Regulator
of NHS Foundation Trusts

5 Working towards service-line management:

using service-line data in the annual planning process

NEXT

Contents

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. The first step to achieving the necessary level of detail is the move to service-line reporting (SLR), which provides the foundation for an SLM framework of performance management and strategic annual planning.

About this guide

The use of service-line reporting (SLR) data in the annual planning process is a crucial part of service-line management (SLM), enabling trusts to improve their efficiency and the quality of their financial governance. This guide explains how trusts can work towards this, using examples and principles gained from working with pilot trust.

For trusts to gain the full benefits of using SLR within their planning, they need to ensure that the supporting infrastructure is in place. This includes accurate costing systems, including if appropriate patient level costing systems and reports, an appropriate organisation structure and established decision rights. These elements are covered in the *How-to guide* and in more detail in the *Guide to developing reliable financial data for service-line reporting: defining structures and establishing profitability.*

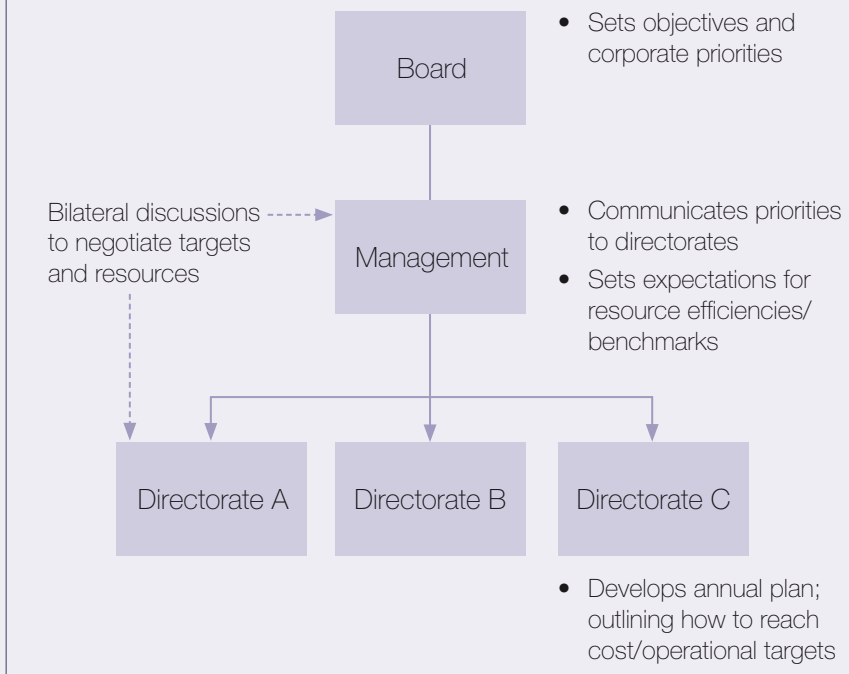
This guide is not a comprehensive annual planning kit, but shows how SLR data can be incorporated into a trust's business planning cycle. The approach complements rather than replaces existing methods of strategic analysis that trusts may be using in their planning process, such as SWOT, competitor or trend analysis.

Using SLR to inform annual planning

Existing NHS planning processes

Typical NHS annual planning is top down and focused on cost targets

Illustration of typical NHS annual planning process



Characteristics of current annual planning

- Board reviews previous year's performance and agrees on corporate objectives and priorities
- Goals/objectives are typically applied uniformly across services (e.g. 5% cost reduction)
- General managers own the planning process, with limited clinical engagement
- Independent of the budgeting process: budgets reset several times a year
- Not linked to performance management of individuals and/or groups
- Operational/quality targets driven by external bodies; financial emphasis on cost reduction

Source: Interviews with trusts; public documents

Improving NHS planning processes

A review of best practice suggests there is an opportunity to improve NHS planning

Characteristics of good annual planning	Assessment	Comments
Reflects organisation's top-down financial and operational goals		• Overall direction set by boards and communicated down through organisation
Involves the right people to create plans that are deliverable and which have impact		• Owned by general managers with limited or no engagement with clinicians
EBITDA focus at service-line/specialty; not just cost or revenue		• Strong emphasis on costs and cash
Uses long-term corporate objectives (e.g. three to five year strategic plan) to define concrete yearly objectives specific to service-line		• Goals typically applied uniformly through organisation (e.g. 5% cost reduction)
Focuses on a balanced approach integrating financial, quality, and service-level objectives		• Typically include externally-mandated targets focused on quality and patient experience
Directly links to budget and performance management processes		• Budgeting process independent of annual planning; sometimes reset several times per year to account for overspends or changes in activity

Strong use of best practice within NHS
Practice sometimes used; room for improvement
Practice not typically used within NHS

Source: Interviews with trusts; review public planning documents

Bringing SLR data into the process

SLR provides valuable and essential information for annual planning. The planning process is outlined in steps A to F below, with the corresponding SLR input also shown

Annual planning process		Objectives	Input from service-line reporting
Understand current position	A Set top-down direction	Identify top-down goals (e.g. three to five year strategic objectives, EBITDA targets)	• Service-line EBITDA margins
	B Review current state	Assess current performance (financial, operational, clinical) • Examine trends • Identify strengths, weaknesses	• Accurate costing and activity information by service-line – Income and expenditure – e.g. point of delivery, service-line, HRG – Patient-level data to explore variances
Set goals	C Agree on goals	Agree on performance goals • Quality, profitability, productivity, access, patient satisfaction, etc.	• Break down of costs into component operational drivers (e.g. £/bed day, theatre cost/hr) to quantify challenges/opportunities • Link of operational and financial objectives
	D Agree on budgets	Agree on budgets • Operational • Capital	• Budgets based on actual activities
Implement changes	E Agree on actions	Agree on plan to achieve goals • Prioritised initiatives • Identified genuine accountabilities and timelines for delivery	• Prioritisation based on financial and operational impact • Engagement of clinicians and finance managers to ensure buy-in
	F Track performance	Identify and monitor key performance indicators to ensure goals achieved	• Identified performance reports specific to each service-line • Individual and group performance goals

The benefits of using SLR in annual planning

Benefits	Lessons from pilot/interviews
1 Significantly Increased engagement of clinicians	• Using SLR allows clinicians to realise the relative size of operational challenges and strategic opportunities • Benchmarking clinician/trust performance motivates clinicians to create stretch targets • Involving clinicians increases their confidence that patient quality remains central to any new initiatives • Allows clinicians to play a significant role in discussions about service re-design
2 Improved understanding and prioritisation of the factors that influence profitability	• Service-line data provides transparency to real factors influencing performance • Ability to drill down by HRG, point of delivery, etc enables service-lines to draw new insights to their performance
3 Quantification of operational challenges to allow general managers, financial managers, and clinicians to prioritise improvement efforts	• Quantification of challenges and opportunities provides a fact-base to enable general managers and clinical leads to engage in informed debate • Quantifying impact of initiatives generates buy-in to the prioritisation of key initiatives
4 Development of clear and quantifiable goals linking financial and operational objectives	• Link between operations and finance allows clinicians to see clearly how their behaviour influences the financial performance of their service-line

'I used to be against targets, but these are better – they are our goals so we will want to achieve them.'

Clinician

'This will be better for everyone – consultants, patients, and management.'

General manager

'We've known theatre utilisation has been an issue – we just didn't know how much it was costing us.'

General manager

'Previously the team would have just tried to hire more people; understanding the financial implications made them innovate new solutions to an old problem.'

Finance director

'Seeing that she was consistently over average operating time and cost of this extra time made one physician radically change her operating procedures to get to target.'

Chief administrative officer

Source: Interviews; pilots

Sample processes for using SLR in annual planning

Sample work plan for annual planning

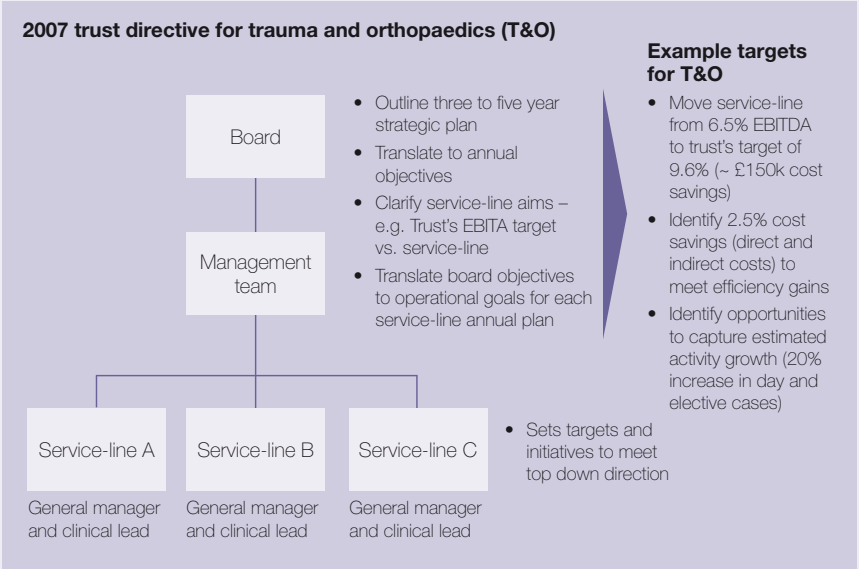
A 10 day pilot allowed clinical and non clinical staff to see how SLR could improve annual planning

Sample work plan for SLR pilot*

Activity	Days 01	02	03	04	05	06	07	08	09	10	Related step in guide
Describe top-down service-line goals (e.g. EBITDA target) • Review strategic objectives of board and externally mandated targets											A
Review current financial performance • Provide basic financial training to working team (e.g. financial systems, EBITDA) • Review service-line financial performance; compare against EBITDA targets, identify key sources of loss/profitability • Test data with clinicians and general managers, re-run data as necessary											B
Identify priority areas for annual plan • Brainstorm top-down and bottom-up operational opportunities • Agree top priorities based on financial and operational input											C
Assess scope of opportunity • Identify reasonable internal and external benchmarks to quantify the scope of opportunity • Apply financial information to cost the size of the challenges and the opportunity											C
Agree targets and identify next steps • Agree targets; compare against top-down directive to identify gap • Identify key players that need to be engaged to move initiatives forward											C

*Needs to be repeated across all service-lines; does not include time for building specific action plans or incorporating into budgets

Step A
Set top-down direction



Suggested approach:

1. Agree on the board's approach for managing service-lines, including approach for goal setting and rewarding services
2. Translate three to five year plan into specific service-line yearly objectives; include financial, operational, and clinical objectives
3. Quantify and effectively communicate goals for each service-line
4. Communicate expectations to service-line staff as part of annual planning process and review/reinforce with monthly/quarterly performance updates

Core questions to answer:

- What are our three to five year strategic objectives? How does this translate to yearly service-line goals?
- Will we set expectations as "best possible" targets; or set minimum target to be achieved (trust-wide and/or service-line specific)?
- What are the operational targets we need to deliver?
- How will we set targets for our consistently low performers, top performers, and what discretionary pay and performance rewards should we have?

Why is it important?

- Ensures service-lines are aligned to overall direction of trust
- Maps three to five year plan to yearly, service-line-specific objectives

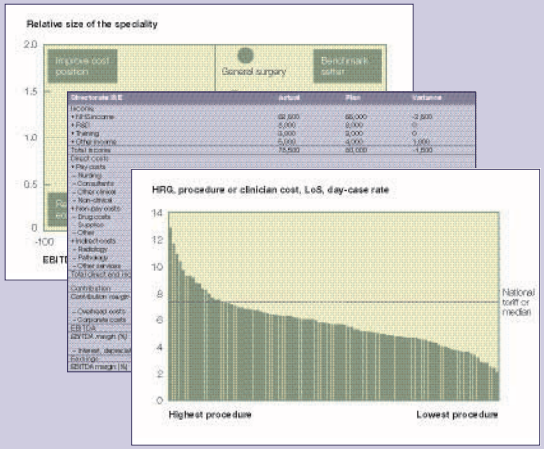
Available resources:

- Trust's three to five year strategy, with identified yearly goals
- Externally mandated targets (operational, financial, clinical quality, etc.)
- Portfolio matrix to identify current service-line positions against target

Step B

Review current state – understand the financial position

Analysing performance through service-line reports to understand areas of concern



Priority areas of focus identified through deep-dive

- Theatres, prosthesis, and pay are largest cost areas
- Non-electives make a large negative contribution and performance gap compared to benchmarks
- HRG 17 is large volume, but negative contributor
- Large variation exists in clinician costs per spell, especially related to prosthesis costs

Suggested approach:

1. Provide basic financial training to clinicians and general managers based on new service-line reporting tools
2. Compare service-line EBITDA against target; quantify the gap
3. Analyse I&E, variance analysis, etc. to identify key cost areas; sources of positive/negative contribution
4. Test cost information with clinicians and general managers; confirm data seems valid and reliable; re-run specific analysis as necessary
5. Agree top three to five priority areas of focus

Core questions to answer:

- What is the current performance of my service-line compared to target?
- What are the costs of running my service-line? What costs are indirect versus direct?
- Are there any significant variances in these costs by particular points of delivery or HRGs?
- What are my top three to five priority areas for this planning cycle?

Why is it important?

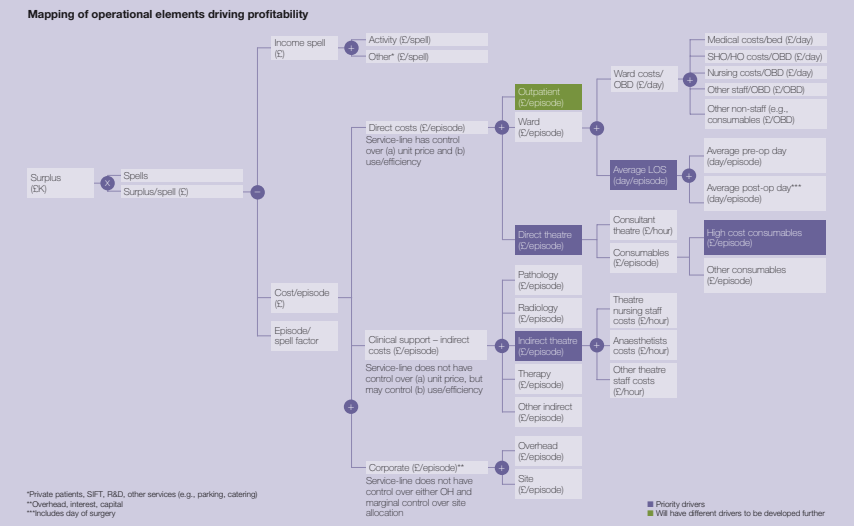
- Focuses initiatives on largest cost areas and identifies areas that are positively or negatively contributing to service-line financial performance
- Provides ability to better understand what is causing positive and/or negative contribution at service-line

Available resources:

- Internal costing systems
- Monitor guide: *Working towards service-line management: a toolkit for presenting operational service-line data*

Step B

Review current state – quantify the factors influencing profitability



Suggested approach:

1. Work with financial managers and costing system team to map operational factors influencing profitability
2. Use I&E and interviews to prioritise which operational elements are biggest influencers of profitability
3. Tailor map to each service-line; prioritise relevant cost areas
4. Identify and prioritise what operational elements are contributing to costs
5. Using costing information, generate a cost per spell figure in each operation

Core questions to answer:

- What are the operational factors influencing my profitability?
- What are my largest cost areas? Which of these are direct? Indirect?
- What is the cost per spell for each of the operational elements?

Why is it important?

- Links financial and operational metrics; facilitates dialogue between financial and operational teams
- Apportions costs per spell for key cost drivers
- Demonstrates how change in income or cost influences EBITDA

Available resources:

- Internal costing systems
- Interviews with clinicians; support services teams
- External benchmarks: industry research, Foundation Trust Network, interviews with other trusts

Step C

Agree on goals – identify scope for improvement

Measuring performance against benchmarks to scope opportunity

1. Reduce ALOS – non-electives

	Current	National average	Internal goal – reduce 1 day	Top performer
Non-electives (average length of stay)	6.5	3.2	5.5	2.1
Variance days		(3.3)	(1.0)	(4.4)

2. Improve theatre utilisation*

	Current	Peer group data, published	Best practice in literature review
Orthopaedics %	52	64	73
Variance %		12	21

*Theatre utilisation defined as actual hours/planned available

3. Reduce prosthesis costs

	Goal A	Goal B	Goal C
Estimated savings % of total costs	10	25	40

Suggested approach:

1. In cross-functional forum, use financial data and operational experience to identify list of improvement initiatives
2. Select priority areas and compare trust performance against identified benchmarks (internal/external targets)
3. Assess variances from targets to identify potential size of opportunity
4. Agree list of priorities with clinicians and general managers

Core questions to answer:

- What are our top improvement areas based on input from operations and finance?
- For each of these, what are the appropriate benchmarks to assess improvement potential?
- What is our baseline performance against targets?

Why is it important?

- Identifies scope of improvement opportunities
- Facilitates prioritisation based on potential size of opportunity
- Aligns general manager, clinicians, and finance managers on key priority areas

Available resources:

- Top-down targets: What savings/operational targets does the trust need to achieve (e.g. EBITDA 15%, average length of stay top quartile performance)?
- Bottom-up approaches: external benchmarking data, internal benchmarking data (consultant to consultant comparisons; service-line comparisons), bottom-up sizing of opportunities (e.g. measurement of waste)

Step C

Agree on goals – specific key improvement initiatives

Agreeing targets and identifying initiatives

Sizing of opportunity

Theatre utilisation

	Current*	Goal 1	Goal 2	Goal 3
Utilisation %	50	60	65	75
Hours gained		451	676	1,127
Est. cost savings**		142,931	214,396	357,327

*To be defined during as-is assessment.
**Based on % of current costs

Potential ideas

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

Action planning

Key owner:	Kay Smith
What can we measure:	Theatre utilisation*
Target timeline :	– "As is" analysis to identify required action (March 20) – Phase I implementation (April 24)

Organisational requirements

- Audit of current processes to understand scope of opportunity
- Involvement of anaesthetists, nurses, assistance in problem solving
- Commitment of project resources to drive process

Suggested approach:

1. Allocate financial measure to achieving target (e.g. cost/bed day); ensure financial measures pass "reasonableness" test with finance and clinical team members
2. Facilitate brainstorming sessions with clinicians and general managers to identify initiatives to move service-line to target
3. Identify organisation support required to deliver initiative
4. Prioritise initiatives (e.g. size of impact, ease of implementation)

Core questions to answer:

- What is the size of the operational and financial impact of achieving identified target?
- What are the operational improvement initiatives that would deliver targets?
- What would be required from the organisation to deliver these initiatives?

Why is it important?

- Sizes impact of potential initiatives
- Captures improvement ideas from clinicians and general managers

Available resources:

- Internal interviews with consultants
- Discussion with general managers, financial managers, and clinicians
- External research on best practices

Step C

Agree on goals – negotiate and agree

Identifying initiative and goals

Initiative name	Agreed goal	Estimated savings* £	Estimated savings* resources	Key ideas**
ALOS non-electives	• Reduce ALOS of all non-electives by 1 day	150 – 170K	~1,000 bed days	• Ensure one person is driving discharge process • Improve discharge functions • Ensure access to theatre for all fit non-electives within 1 day of admittance
Theatre utilisation**	• Improve theatre utilisation by 10%	140 – 220K	~300 hours	• Diagnose current utilisation • Work with different groups to improve culture • Implement best practices
Prosthesis	• Reduce prosthesis costs by 10% through increased visibility of prices and reduced waste	100 – 140K		• Postprothesis costs to inform clinicians • Reduce waste
Day of surgery admittance	• Ensure 100% fit patients admitted day of surgery	80 – 120K	~400 bed days	• Improve resources/processes to ensure notes/x-rays are properly managed • Facilitate ability of clinicians to see patients in pre-assessment
Sub total		**470 – 650K**	EBITDA shift to 8.9 – 9.2%	

Note: A number of other initiatives (e.g. growth, nursing productivity) may exist but have not been sized as part of this exercise.
* Estimates only; based on cost/bed day e.g., medical, nursing, administration, and other direct pay costs.
**Sample only; other ideas discussed recorded in T&O pilot document, finalise action plan still to be determind.
*** Theatre utilisation improvements require current state diagnostic

Suggested approach:

1. Facilitate fact-based discussion around reasonable targets to be delivered by service-line
2. Syndicate goals with clinicians, finance group, general managers
3. Agree on who is responsible, how frequently progress will be assessed, and what the consequences will be for hitting or missing targets

Core questions to answer:

- What is a reasonable stretch target for our service-line to achieve within the next year?
- Who will be required to facilitate/deliver these targets?
- Who is ultimately accountable within the business unit for delivery of targets?

Why is it important?

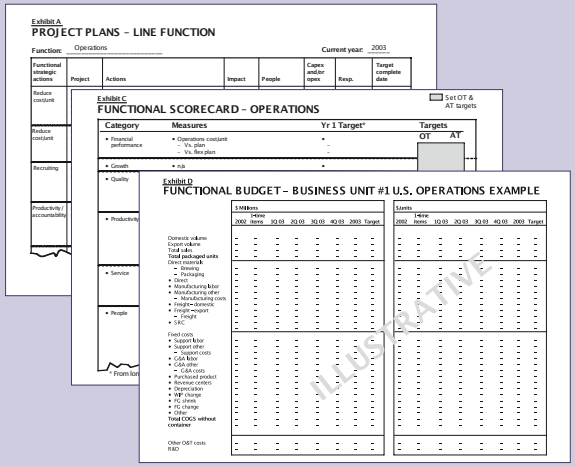
- Ensures right resources are aligned
- Creates organisational buy-in at all levels
- Creates ownership of the process

Available resources:

- Trust's management/specialty discussions

Step D
Agree budgets

Using private sector best practice: aligning budgets with annual planning and performance management



Tightly integrated business planning cycle (e.g. annual plans, budget, and performance management) ensure strategic focus and organisation alignment

Suggested approach:

1. Financial manager to translate annual plan to budget; continue to syndicate with clinicians and general managers
2. Ensure budgets clearly link activity with costs; requires new focus from previous cost-target budgeting approach
3. Finance/strategy/planning groups to review and ensure fit with overall trust annual planning objectives and available resources

Core questions to answer:

- How do our annual initiatives translate to quarterly and monthly budget requirements?
- How do our estimated activity and costs translate to budget?
- Can we use annual planning to assess incremental spend and effectiveness of existing spend?
- What are the required business cases for one-off investments, evaluated by return on investment?

Why is it important?

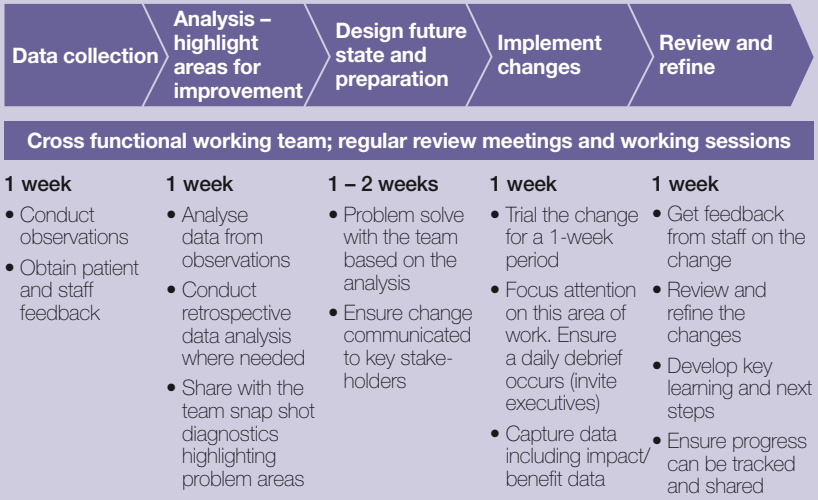
- Quantifies agreed goals into measurable outcomes to be achieved over the course of the next year

Available resources:

- Initiatives listed in service-line annual plan

Step E
Agree on actions

Defining plan to improve theatre utilisation



Suggested approach:

1. Prioritise initiatives based on potential size and ease of implementation
2. Agree on overall plan
3. Syndicate with central planning/finance teams to ensure no contradiction with overall plans and/or shared resources

Core questions to answer:

- What specific actions will be taken to deliver results?
- Who are the key people that need to be involved?
- What milestones will be achieved?
- What resources will be required?

Why is it important?

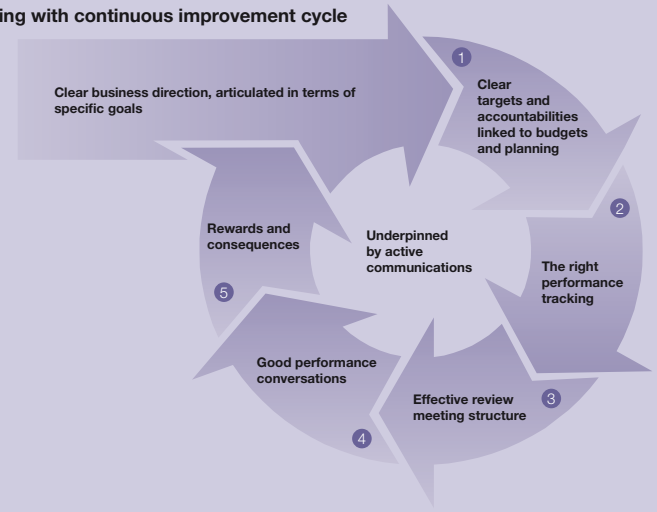
- Translates agreed goals into actions with clear owners, accountabilities, and milestones

Available resources:

- Internal interviews with consultants
- Performance indicator group data
- Discussion with general managers, financial managers, and clinicians

Step F
Track performance

Integrating with continuous improvement cycle



Suggested approach:

1. Work with clinicians, front-line staff, and general managers to design effective performance framework
2. Align agreed initiative goals to overall key performance indicators of service-line (group and individual)
3. Ensure proper reports are generated and distributed to key decision makers and front-line staff to inform day-to-day operations
4. Engage in regular review meetings to discuss performance
5. Identify proper rewards and consequences for meeting or not meeting agreed initiative targets

Core questions to answer:

- How do our annual planning initiatives translate into key performance indicators for each service-line and/or individual?
- How will we track and communicate this information (process, timing, reports, etc.?)
- What are the rewards and consequences of effectively delivering or not delivering service-line goals?

Why is it important?

- Ensures individuals and/or teams are incentivised to deliver agreed objectives
- Provides right information to inform decisions of front-line staff and managers (clinical, general, financial)

Available resources:

- Detailed advice available in Monitor's *Working towards service-line management: organisational change and performance management*

Key enablers for SLR in annual planning

Pilot findings

Key enablers for SLR in annual planning

	Description	Evidence from pilot/interviews
Clinical engagement	• **Engaging clinicians** in the annual planning process builds the alignment required to drive change and is essential if meaningful targets are to be set and pan-organisational corporate strategies established	• Providing tools to size the cost of operational inefficiencies created basis for fact-based debate between clinicians and general managers to identify priority areas • Focusing on issues relevant to the day-to-day operations of clinicians provided ability to link the operational and financial objectives of the trust • Building target/goals from the bottom-up ensured that clinicians and general managers were confident that they were focusing on the right improvement areas
Organisation infrastructure	• Ensuring the **board sets direction** for how SLR is managed within the trust is essential for setting overall strategic framework for annual planning process	• The board setting the SLR strategy is necessary to ensure each service-line understands and is motivated to meet the board's expectations for annual performance (e.g. will each service-line be managed against individual targets or against general trust target? What are the consequences for underperforming service-lines?)
	• Identifying **clear incentives and performance management** regimes motivates staff to deliver the results identified during the annual planning process	• Ensure clinical leads' and general managers believe that their efforts to improve profitability will benefit their service-line (e.g. autonomy to reinvest portion of over-performance profits); patients (e.g. financial focus will not impede highest quality of care); and their individual goals (e.g. rewarded for delivering results) is important for driving behaviour change

Pilot findings

Key enablers for SLR in annual planning (continued)

	Description	Evidence from pilot/interviews
Organisation infrastructure (continued)	• SLR may require **new roles capabilities, and mindsets** throughout the organisation	• Using SLR information requires general managers and clinicians to develop a basic understanding of financial terminology and concepts (e.g. EBITDA) • Shifting mindsets to focus on service-line profitability requires new training, role definitions, and incentives at all levels of the organisation • Identifying the process owner for driving use of service-line reporting in annual planning may be required, especially in the first phase of this new approach • Providing analytical support to clinicians and general managers ensures they are focusing on the right information at the right time
IT system and reports (financial and operational)	• Data must be available in a format that enables individual service-lines to **analyse performance in greater depth** (e.g. by HRG, patient, point of delivery, etc.) • **Accessing reliable and valid operational (e.g. performance benchmarks) and financial information** is important in identifying and prioritising initiatives for service-line annual plans	• Facilitating the ability of clinicians and managers to drill down into data to understand what is driving current performance and to understand how proposed changes will impact EBITDA performance allows their service-line to create greatest impact • Ensure clinical leads' and general managers to identify the right level of and timing of information/ reports ensures that they have access to necessary decision-making tools • Providing access to relevant internal and external benchmarks provides valuable mechanisms to define the scope of improvement opportunities

Pilot findings

Questions to consider when implementing service-line annual planning

	Key information input
Service-line leadership and organisation structure	• 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?
Service-line strategy	• How or to what extent do we use information about profitability to make decisions at 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?
Annual planning process	• Will all service-lines be expected to achieve the same EBITDA target? • 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?
Financial reporting	• 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?
Service-line performance management	• How will the board use SLR 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 this new approach?

Appendix A: Glossary of terms

Appendix A
Glossary of terms

These definitions can be customised for your trust. The important thing is to ensure clear and consistent definitions across your trust which are understood by everyone who uses the data.

Term	Meaning
Contribution	A measure of operating performance that excludes overheads. It shows the "contribution" made toward covering the overheads of the business
Cost line	A breakdown of costs by groupings of general ledger items (e.g. pay, non-pay)
Direct cost	Costs which are directly controlled by the service-line (e.g. consultant and nursing costs and drugs)
EBITDA	Earnings before interest, tax, depreciation and amortisation. It is used as meaningful measure of operating performance, particularly the ability to generate cash
I&E	Income and expenditure. This is the detailed breakdown of the profit and loss statement to derive contribution, EBITDA and net income
Indirect cost	Costs that are incurred by service-lines but controlled by shared service centres (e.g. clinical support services such as pathology, radiology, theatres, some ward costs (such as food and linen, etc)). Typically, service-lines can control their demand for these services but not the unit cost. This is a slightly different definition from the NHS costing manual, which defines direct costs as the cost that can be directly related to one service-line, indirect costs as the costs that can be related to a group of specific service-lines and overhead costs as the costs that cannot be linked to specific service-lines
Net income	The amount remaining when all expenses are deducted from income
Overhead costs	Costs that are not related directly to the type and quantity of services provided, such as site and corporate overhead costs
POD	Point of delivery (e.g. elective/day-case, non-elective, outpatient)

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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