Monitor

Independent Regulator
of NHS Foundation Trusts

2 Working towards service-line management: organisational change and performance management

NEXT

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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 right organisation structure and the use of service-line data as a tool to manage performance are both vital in order to maximise the benefits of the service-line approach.

This guide can be used by trusts who have already put in place service-line reporting to gather financial and operational data. (See two additional documents in this series – *Working towards service-line management: a how to guide and Working towards service-line management: a toolkit for presenting service line data*).

It will suggest ways in which service-line reporting (SLR) can be used as a motivational tool and to influence:

- the organisational and management structure, decision ownership rights and personnel incentives within a trust;
- general processes and policies; and
- performance management targets and systems.

The document will take the reader through a number of steps, but it is not a definitive or prescriptive guide. Every trust is different and faces different challenges. The processes and tools that follow can be adapted to best suit each trust's individual circumstances.

The various issues covered in this guide include:

- organisational structure, with a particular focus on capabilities, decision rights and incentives;
- strategy and objectives;
- effective annual planning;
- the need for reliable information; and
- the benefits of effective performance management.

It will also focus on two key areas that have been highlighted by our research as posing the biggest challenge to trusts.

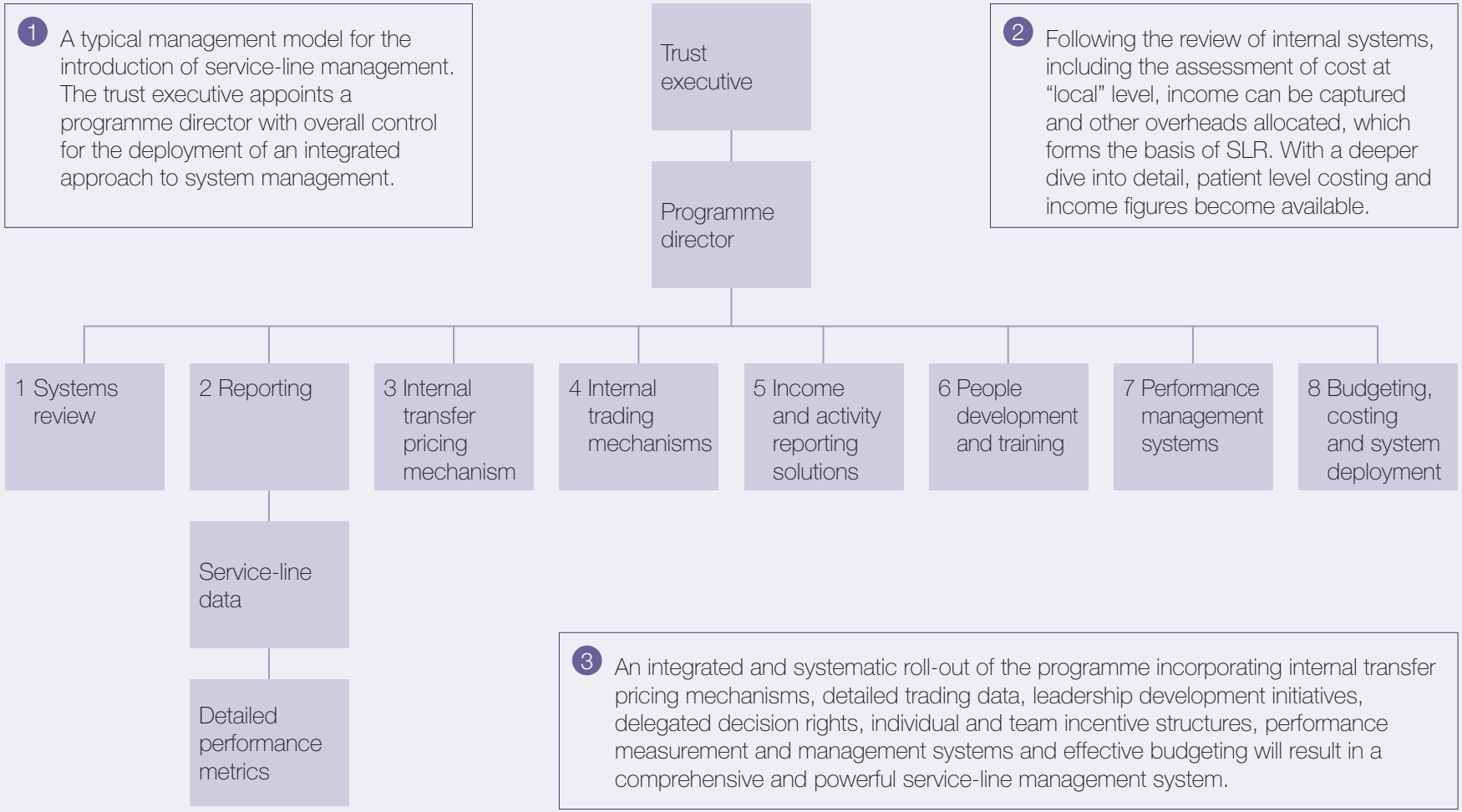
- Encouraging greater ownership of service-lines by clinicians, by building appropriate, autonomous levels of decision making aligned with incentives.
- Using effective performance management processes to measure improvements in output.

The second part of this guide examines some of the options available.

Background information

A model for high-level implementation of service-line management

1 A typical management model for the introduction of service-line management. The trust executive appoints a programme director with overall control for the deployment of an integrated approach to system management.

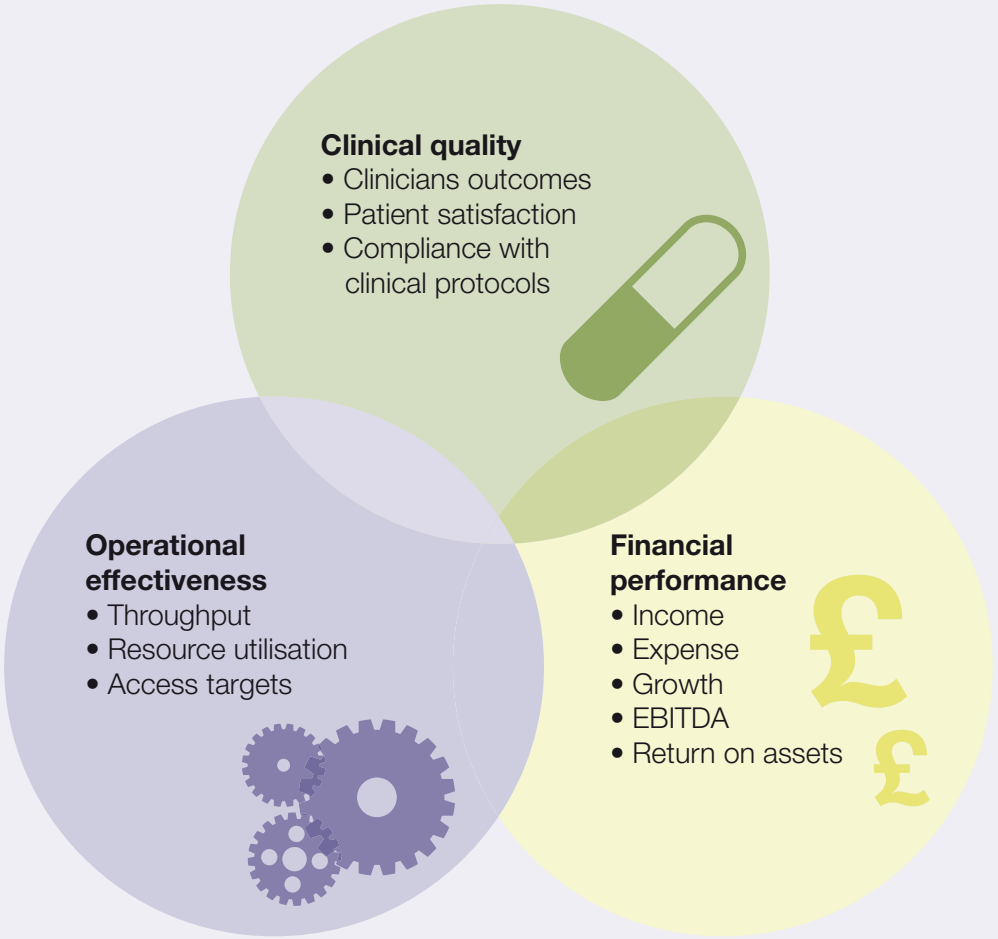


2 Following the review of internal systems, including the assessment of cost at "local" level, income can be captured and other overheads allocated, which forms the basis of SLR. With a deeper dive into detail, patient level costing and income figures become available.

3 An integrated and systematic roll-out of the programme incorporating internal transfer pricing mechanisms, detailed trading data, leadership development initiatives, delegated decision rights, individual and team incentive structures, performance measurement and management systems and effective budgeting will result in a comprehensive and powerful service-line management system.

Integrating ownership

Successful service-line management integrates the ownership of clinical, operational and financial outcomes



Five key enablers

The following five key operational and financial enablers are required for effective service-line management

Source: UK pilot discussions

What the enablers require in practice

Key enablers	"Check-list" of the important SLM components
1 Supporting organisational structure, capabilities, incentives, and trust-wide processes/policies	☐ Organisational structure with appropriately defined service-lines ☐ Clearly defined leadership roles at service-line level, with integrated ownership of clinical, operational and financial performance ☐ Trust executive body capable of supporting and developing service-line managers ☐ Well-defined, capability-linked, transparent decision rights at each level (trust executive, service-line and team) ☐ People development process that ensures that the capabilities needed are continuously renewed ☐ Incentive structures aligned with the trust's culture and re-enforcing performance ownership
2 Clear service-line strategy and objectives	☐ Simple, clear statement of aspirations and objectives over three- to five-year timeframe that inspires clinicians ☐ Action-oriented set of initiatives to deliver the objectives ☐ Practical process to develop/refresh strategy grounded in both internal understanding and external (market/demand) perspective
3 Effective annual planning process	☐ Coherent annual process to set service-line specific goals and budgets based on top-down and bottom-up processes to define quality, operational, and financial goals ☐ Budget developed from operational benchmarks (not "last year rolled-over") ☐ Plan for follow-up that enables early identification and mitigation of risks at service-line level
4 Reliable, relevant, accessible, and timely information	☐ All decision makers with access to relevant, timely information (financial, operational and quality) ☐ Financial information at procedure level (cost and profitability) based on activity-based costing ☐ Transparent internal and external benchmarks
5 Effective performance improvement system	☐ Performance tracking focus on a balanced set of targets for quality, operational efficiency, financial performance, safety, and staff satisfaction ☐ Performance accountability at each level formalised in individual performance contracts ☐ Effective performance reviews focusing on targets realisation, progress on agreed activities and agreement on new required actions and responsibilities ☐ Rewards for strong performance and fair consequences for poor performance

Organisational structures and leadership capabilities

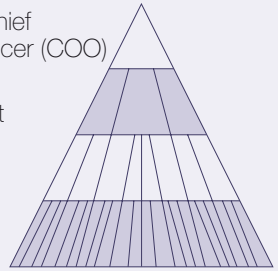
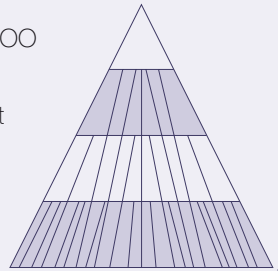
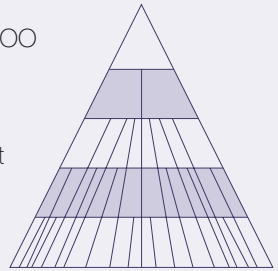
Organisational structures, capabilities, processes and policies

An overview

- Successfully managing a trust's service-lines means the trust has to address several organisational and trust-wide issues – **organisational structure, individual and team capabilities, autonomous decision rights, financial and non-financial incentives, and trust-wide processes and policies**.
- Identifying the most suitable **organisational structure** depends on the trust's starting point and vision for future growth and identifying the right type and number of service-lines:
  - too few service-lines may force unnatural groupings of activities and thereby undermine the operational and clinical efficacy of the exercise;
  - too many service-lines will place extra demands on any planning and budgeting processes and on the trust executives' capacity to engage with each service-line individually.
- The identification of **individual and team capabilities** and the ability to assess these capabilities in the light of organisational demands is of critical importance. Playing to existing strengths and highlighting operational needs in terms of new staff, new equipment or other infrastructure requirements will shape the potential gains to be made. Of particular importance is the role of the service-line manager or leader. This needs to be developed to create clear accountability for the integrated clinical, operational, and financial performance of the service-line.
- The allocation of **autonomous decision rights** should be based on a transparent framework:
  - decision rights for common, unambiguous decisions can be defined in standard lists;
  - in situations where the right to decide is less common or is unclear, a decision-making framework can be used. This reduces the likelihood and impact of a decision turning out to be wrong or being based on incorrect information.
- **Financial and non-financial incentive structures** that align the performance of the individual or team with the trust's goals and objectives reinforces the ownership of delivery and performance at every level.
  - the key dimensions of incentives are **what** to incentivise (quality, operational, or financial performance), **who** to incentivise (the individual, team, or service-line); and **how** to incentivise (monetary or non-monetary).
  - depending on the trust's cultural starting point and visions, a variety of incentives can be put in place. Different hospitals around the world successfully apply different combinations of incentives.
- **Trust-wide policies** translate the values of a trust into the way in which it conducts its business (particularly patient care, employee relationships, and external relationships). In the context of service-line management they are important to ensure that individual service-lines do not pursue activities that go against the values of the trust or damage the trust's "brand image".
- **Trust-wide processes** such as budgeting need to be clearly defined and based on feedback from service-lines so that they support rather than hinder the service-line's pursuit of their objectives.

Source: International best practice interviews and UK pilot discussions

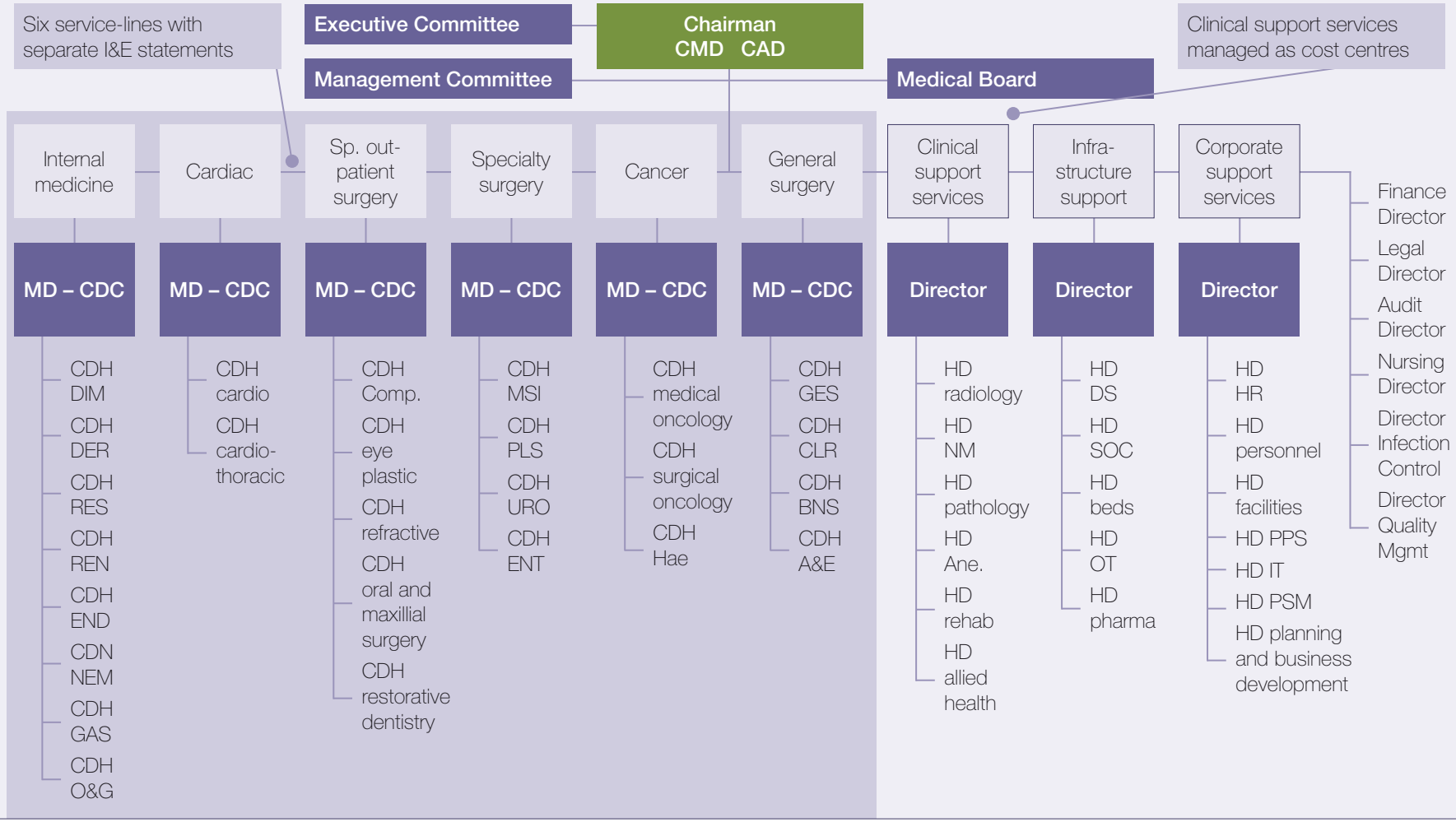
A range of options for organisation structure

	Key features	Benefits/risks	Option suitable if trust starting point is…
1 Trust exec/chief operating officer (COO) Service-line management Team leads Clinicians 	1. Low COO span of control (three to six service-lines (SLs)) 2. SL managers: One whole time equivalent (WTE) clinician + one admin support	+ Low overhead costs + Low risk of uncollaborative behaviour among SLs – Stretched SL managers (clinician cannot keep clinical work)	• …SL management capable of delegating decision-making to team level, as appropriate
2 Trust exec/COO Service-line management Team leads Clinicians 	1. High COO span of control (six to 15 SLs) 2. SL managers: 0.5 WTE clinician + one WTE admin support	+ Medium/low overhead costs – High risk of uncollaborative behaviour among SLs – Stretched COO, large span of control	• …COO capable of managing with a large span of control • …highly collaborative culture among SL managers
3 Trust exec/COO Division Service-line management Team leads Clinicians 	1. High COO span of control (six to 15 SLs) 2. SL managers: 0.5 WTE clinician + one WTE admin support 3. Extra management layer between COO and SLs	– High overhead costs due to extra management layer + Low risk of uncollaborative behaviour among SLs	• …SL management capability needs to be developed

Source: International best practice interviews and UK pilot discussions

Organisation structure

Hospital model with low span of COO control



Note: CDH = Clinical Department Head; CDC = Clinical Department Coordinator, MD = Medical Director; CMD = Campus Medical Director; CAD = Campus Admin Director; HD = Head

Source: International best practice interviews

Service-line management capabilities

A summary

- The most important capability challenge for NHS foundation trusts in improving SLM is engaging the service-line's clinicians in taking responsibility for realising the clinical, operational and financial objectives of the service-line.
- In the typical trust, the current division of leadership responsibility between clinical lead and general manager is a risk in realising the benefits of service-line management:
  - shared management may create polarised perspectives on the importance of quality and productivity;
  - lack of a single point of accountability for performance may lead to clinical leads and general managers blaming each other for poor performance.
- A good service-line leader exhibits leadership in four areas:
  - overall service-line leadership – taking total responsibility for the service-line's performance: clinical, operational, and financial;
  - people leadership – taking responsibility for recruiting and developing clinicians and other staff members;
  - entrepreneurship – developing the service-line's quality, safety and efficiency, to ensure profitable growth; and
  - collaboration – working to maximise benefits for the whole trust rather than only their own service-line.
- A service-line leader may come from either a clinical or business background and, if clinical, does not need to be the most senior or research-focused clinician in the service-line.
- A service-line leader needs to be well supported to succeed. The four most important areas of support are:
  - full support from top management, particularly medical director/CMO (especially important for junior clinical service-line leaders);
  - easily accessible, relevant financial reporting information;
  - service improvement support to help assess financial outcomes of clinical improvement initiatives; and
  - general administrative support.
- For the service-line leader to succeed, significant training is required regardless of the service-line leader's background:
  - those from a clinical background need to demonstrate financial analysis, commissioning dynamics, and people leadership skills; and
  - those from a business background need to demonstrate the ability to lead the development of clinical efficiency, an understanding of commissioning dynamics, and people leadership skills.
- International best practice hospitals typically use a chief clinician service-line leader who maintains overall responsibility for clinical, operational, and financial performance, with the support of general/financial managers and systems.

The importance of single-point accountability

Without single-point accountability in service-line leadership, the benefits of SLM may be held back

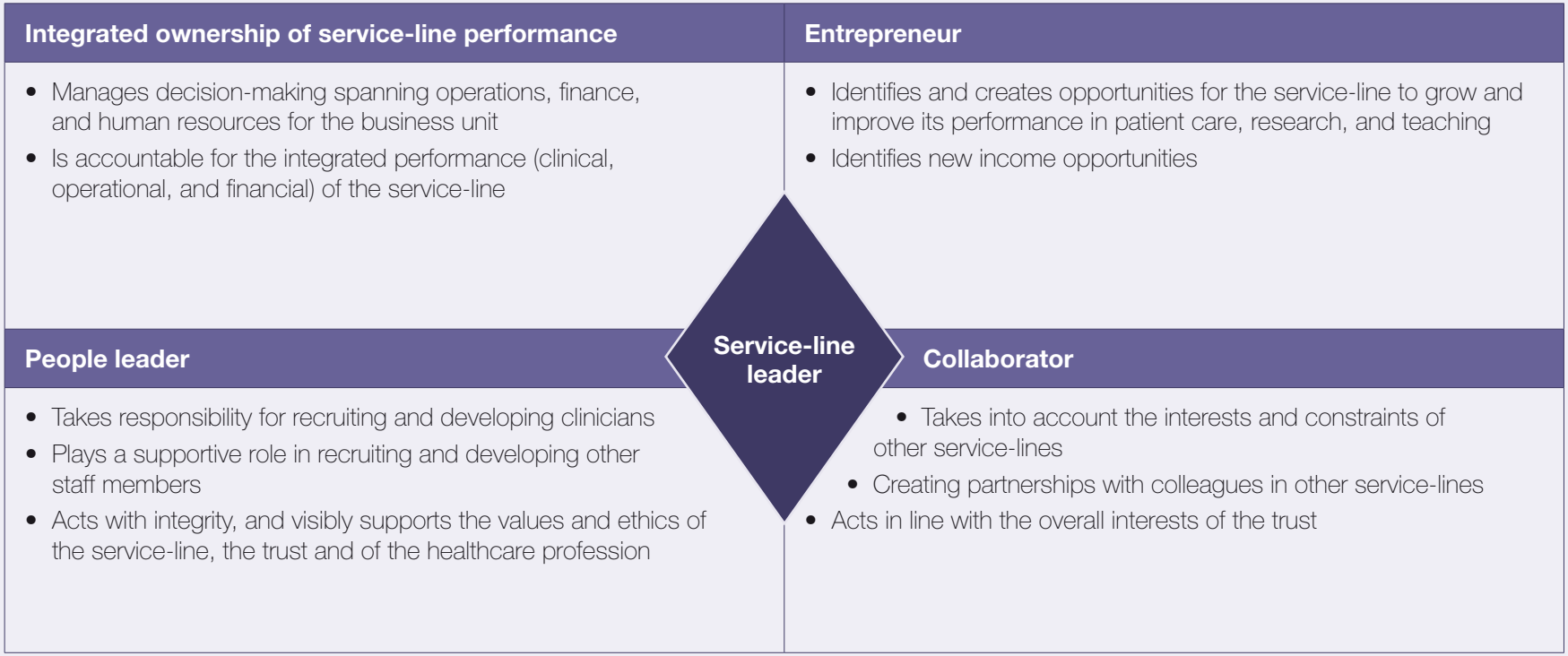
Joint service-line leadership roles	Typical responsibilities
Clinical leader (Dr.)	• Patient care, R&D, training, and/or teaching • Clinician/staff planning • Service development • Management of clinical efficiency programs • Collaboration with other units – clinical areas • Training and development of clinicians
Business leader (GM)	• Service development • Commissioner management • Budgeting and capacity planning • CIP management • Collaboration with other units – financial areas • Training and development of non-clinicians

- Shared management often results in lack of holistic responsibility for service-line operations
  - The structure creates opportunity for polarised perspectives on quality vs. value
- No single point of accountability for performance
  - Clinical lead can blame poor performance on poor planning/ financial management
  - GMs can blame poor performance on lack of clinician compliance with plans

Source: International best practice interviews and UK pilot discussions

Capabilities

What does it take to be a good service-line leader?



Source: International best practice interviews and UK pilot discussions

Capabilities

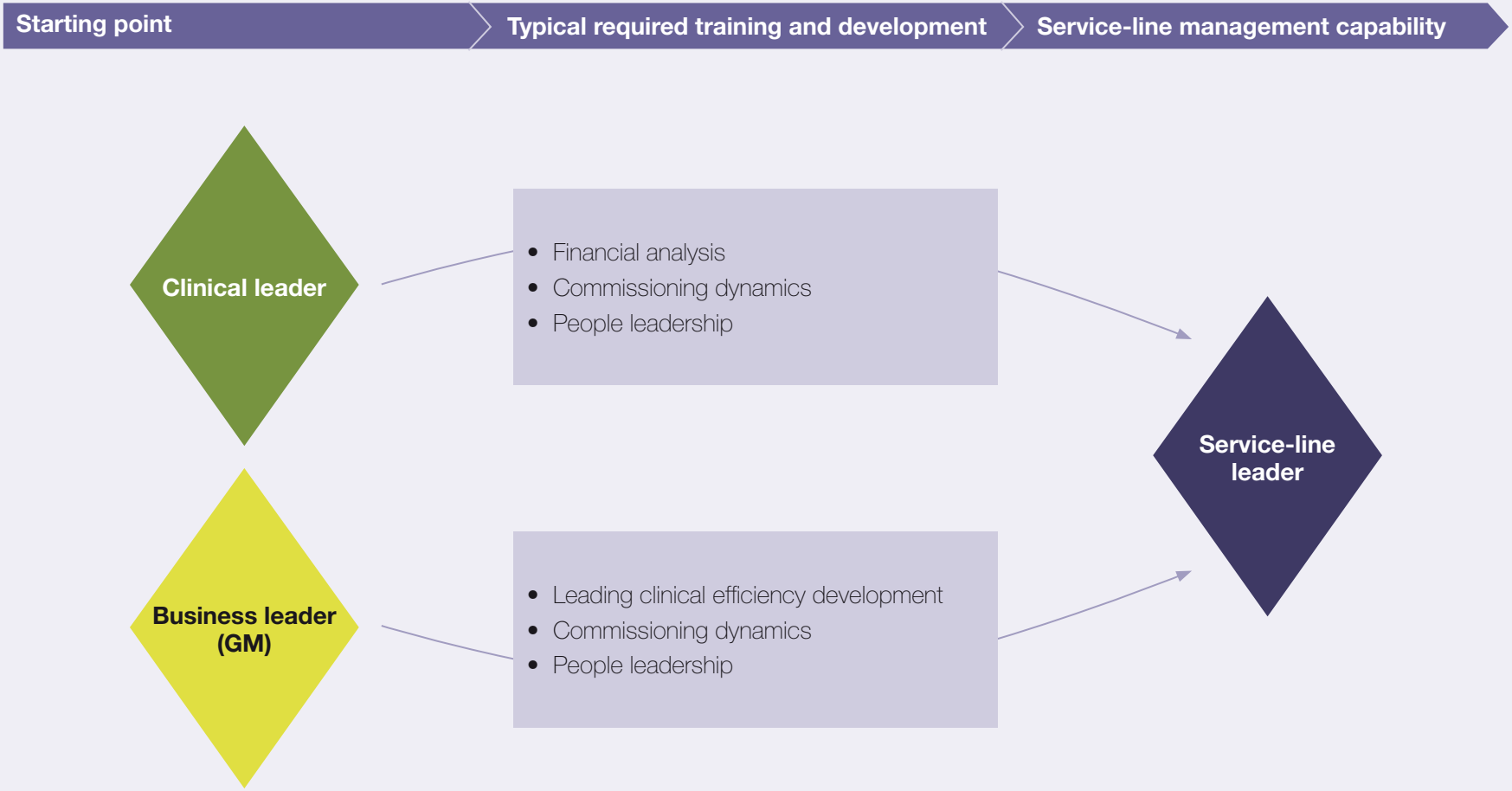
What is NOT required to be a good service-line leader?

A service-line manager does NOT need to…	Rationale
• …have a clinical background	• A non-clinician with sufficient understanding of clinical operations and credibility among clinicians can be a suitable service-line leader
• …have an academic business degree	• Aptitude for (and interest in) financial analysis is critical, but training (class room and on-the-job) can provide what the service-line leader is lacking in experience
• …be the most senior clinician in the service-line	• Leadership and entrepreneurial qualities are more important than seniority: – full support from medical director/top management important to confirm a junior service-line leader's authority
• …have the best research credentials	• A strong research focus is negative since it is very difficult to combine a dedicated research role with dedicated service-line leadership

Source: International best practice interviews and UK pilot discussions

Capabilities

What are the likely training requirements for a service-line leader?

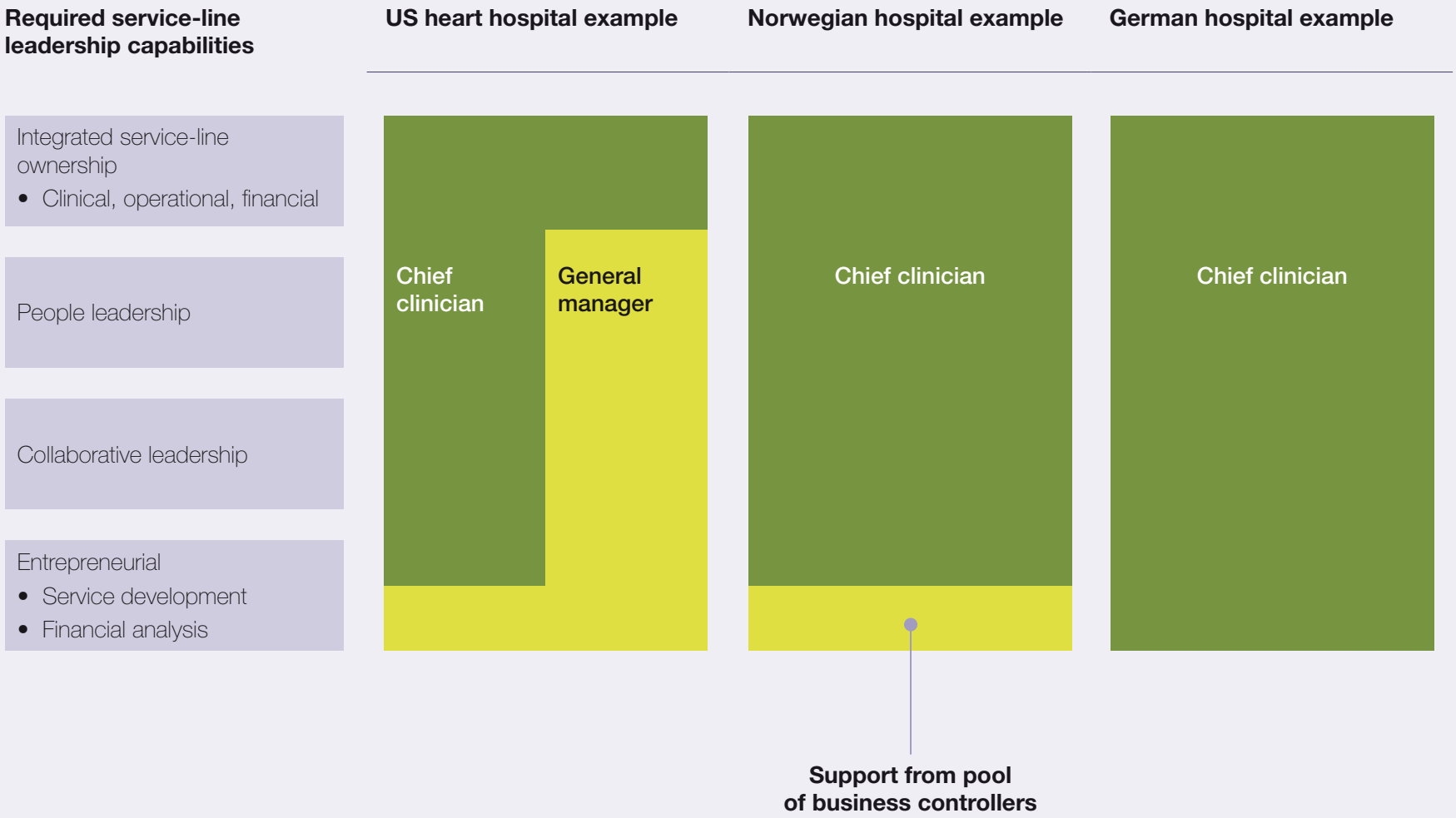


Source: International best practice interviews and UK pilot discussions

Capabilities

International models

International service-line leadership models typically have a clinician in charge of the service-line's integrated performance



Source: International best practice interviews and UK pilot discussions

Capabilities

Key insights from pilot discussions

Key insights	Quotes from clinicians and managers
• The established understanding that performance objectives can be pursued in parallel by different people in the service-line needs to be challenged	'GMs' role is to balance the books while (clinicians) get on with the work' **General manager**
• Making the transition to a structure with a single service-line manager responsible for the integrated performance of the service-line will take time	'There are very few people who have this skill set and mindset today' **Medical director**
• The "German example" of a chief clinician in charge of a service-line is not applicable in a UK context	'As manager of a service-line, I would not want to do all the fire-fighting and admin tasks myself – I need a right hand man who helps me take care of these things' **Clinical lead**

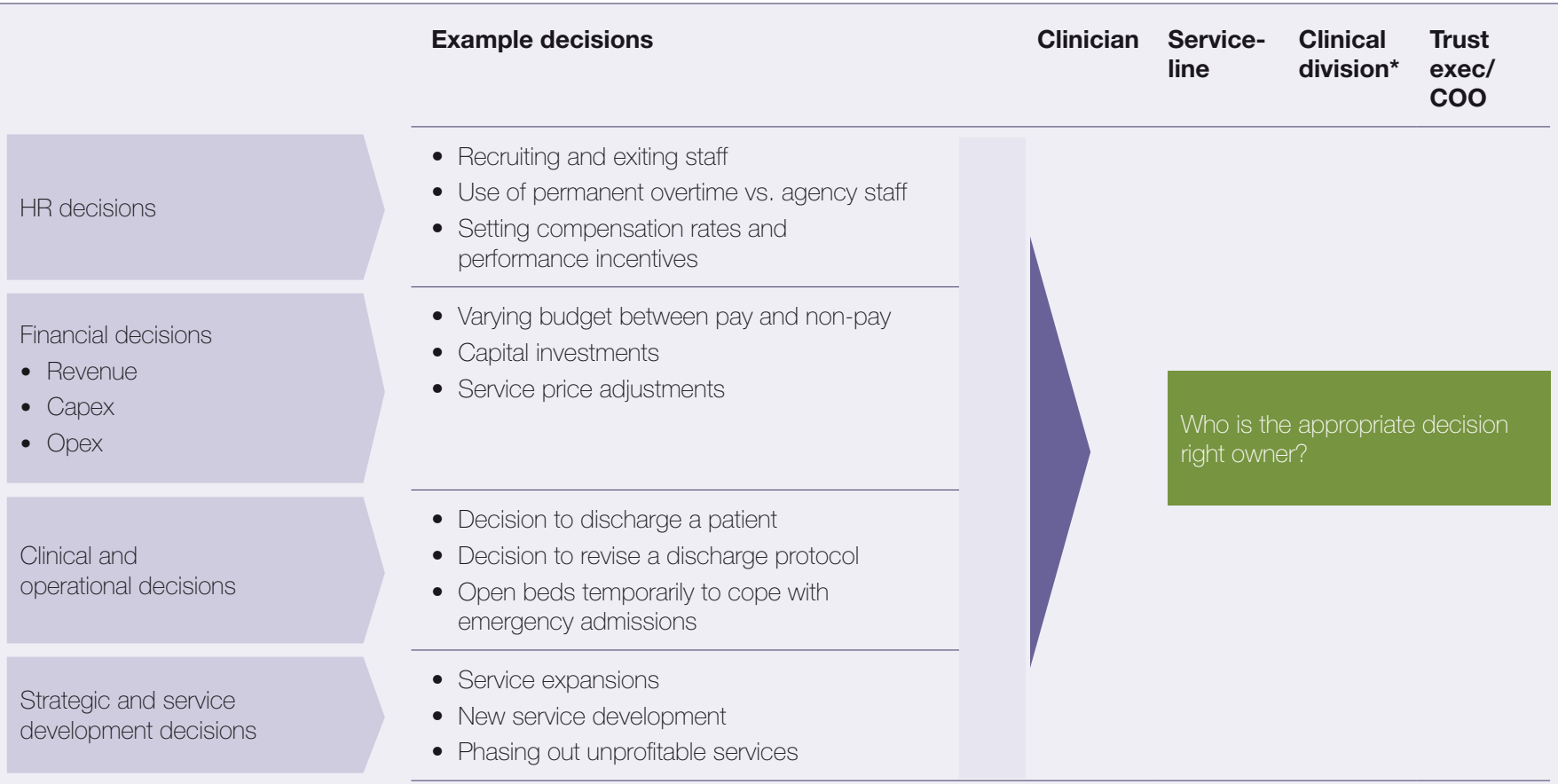
Source: UK pilot workshops and interviews

Decision rights

Introduction to decision rights

- Clearly defined **decision rights** are crucial to show that service-line managers can deliver their objectives. These defined rights need to govern strategic, financial, operational and human resource decision-making.
- It is essential to assess that the right SLM capabilities are in place before decision rights are devolved.
- The allocation of decision rights should be based on a clear matrix, acting as a frame of reference for employees at all levels:
  - decision rights concerning common, unambiguous decisions are defined in standard lists; and
  - in situations where the decision right is less common or is unclear, a framework for decision-making can be used to reduce the likelihood and impact of a decision turning out to be wrong or being based on incorrect information.
- After a decision has been taken, the decision owner needs to inform the rest of the organisation:
  - by staying informed about all important decisions, the rest of the organisation can be assured of the decision rights being applied accurately – and take action if they are not.

Decision rights need to be defined in four areas



*A grouping of service-lines – not applicable in all trusts
Source: International best practice interviews and UK pilot discussions

Capability assessment

It is important to conduct a capability assessment before determining decision rights

For example	Is service-line analysis able to…
Service-line strategy	…produce a strategic plan that links long-term objectives to a set of action-oriented initiatives? …demonstrate that its clinicians stand behind the strategic plan? …generate support from commissioners for service developments?
Annual planning and delivery	…create and follow an annual plan and budget that realises the business unit performance goals? …identify and mitigate revenue risks related to commissioning and operational risks? …understand the tariff structure and its implications for the service-line's revenues and profitability? …use sound judgement in applying decision rights?
Information	…understand financial and operational reporting, and use this information to manage accordingly? …translate the impact of changes in clinical operations into financial outcomes?
Performance improvement	…ensure that the service-line's staff are adequately trained, developed, held to account and incentivised to deliver the business unit's performance objectives? …hold effective performance dialogues to drive improvement and respond to trends and issues? …ensure appropriate staff are recruited and retained to carry out the business unit's functions?

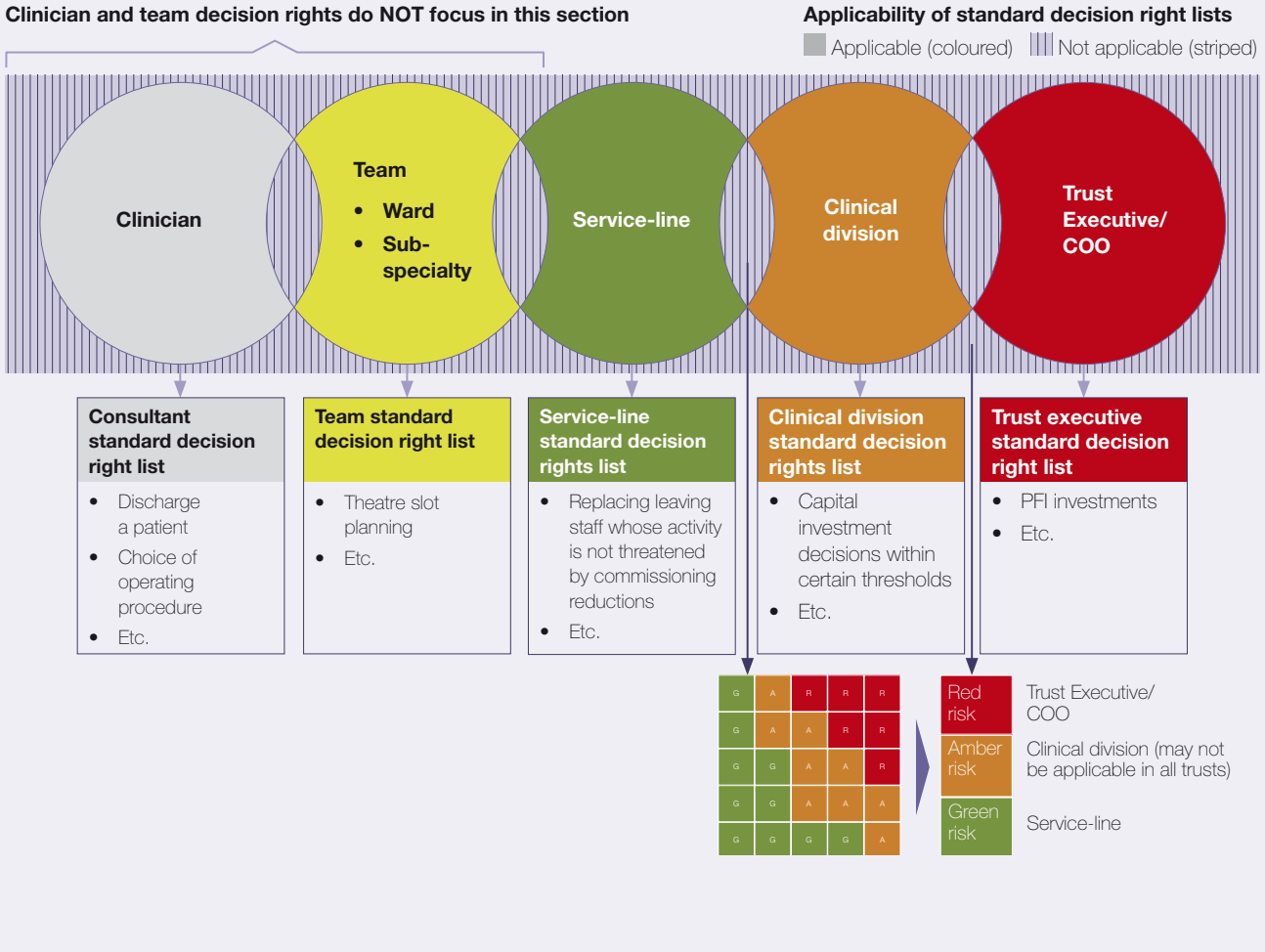
A business unit's management needs to have all these capabilities to allow devolution of autonomy

Source:

Determining decision rights

An example four-step methodology

1. Identify if the decision right is covered by standard decision right lists*
2. If applicable, then use standard decision right lists
3. When standard lists are not applicable, use decision rights framework to determine the owner
   - If required, consult relevant function – finance, HR etc.
4. Inform rest of organisation what decision has been taken



*The standard decision right lists need to be defined in a separate exercise

Source: UK pilot discussions

Example

A framework for determining decision rights

This example is for a trust with service-lines, clinical directorates and trust executive. The issue of alignment with the trust's overall objectives is explained further on the next two pages

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 are explained further on the next two pages

Risk assessment

Decision right owner

Risk level	Appropriate decision right owner
Red risks	Trust executive/ COO
Amber risks	Clinical division (may not be applicable in all trusts)
Green risks	Service line

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

Source: UK pilot discussions

Example

A framework to assess the magnitude of impact/ lack of alignment with a trust's interests

Preliminary example framework

Rating	Score	Recurring cost or revenue impact	Cost impact of one-off investment	Support service impact	Wards impact (number)	Patient impact (number)	Staff impact (number)	Reputation impact on external relationships
Very high	5	>£x (thousands)	>£x (thousands)	Requires step change in activity (investments equivalent to >x% or more of the support unit's current cost)	All or most service-lines' wards	>x	>x	Significant damage
High	4	£x (thousands) – £x (thousands)	£x (thousands) – £x (thousands)	Significant impact on support services (x-x% increase in activity/cost)	Several service-lines' wards	x-x	x-x	
Moderate	3	£x (thousands) – £x (thousands)	£x (thousands) – £x (thousands)	Some impact on support services (x-x% increase in activity/cost)		x-x	x-x	
Low	2	£x (thousands) – £x (thousands)	£x (thousands) – £x (thousands)	Marginal impact on support service use (<x% increase the service's activity/cost)	Only one service-lines' wards	x-x	x-x	
Very low	1	<£x (thousands)	<£x (thousands)	No impact on support services		<x	<x	No damage

Source: UK pilot discussions

Example

A framework to assess the likelihood of impact/ lack of alignment with a trust's interests

Preliminary example framework

		Likelihood of an adverse event				Lack of alignment with rest of trust direction		
Rating	**Score**	**Care quality**	**Contract risk (service development)**	**Trust employee relations**	**Reputation external relationships**	**Trust strategy**	**Impact on other divisions**	**Support services**
Very high	5	Significant risk of negative impact	Expansion not agreed with commissioners	Decision likely to have significant negative implications on the trust's relationships with one or more staff groups	Very high risk of an impact on external relations	Decision not aligned with trust strategy	Decision's implications certain to conflict in a negative way with other divisions current activities or plans	Very likely to require changes to support services capacity that are likely to increase further in the future
High	4		Expansion agreed with commissioners short-term, but long-term sustainability of contract uncertain					Very likely to require changes to support services capacity
Moderate	3					Decision relatively in line with trust strategy		
Low	2							
Very low	1	No risk of negative impact	Expansion agreed with commissioners for coming year and deemed sustainable in the long-term	No impact on the trust's relationship with any staff group	No risk of external relations impact	Decision completely in line with trust strategy	Activity does not conflict with other divisions' activities or plans	Impact on the business unit's support service use not likely

Source: UK pilot discussions

Results of pilot discussions

This shows the results of discussions in pilot trusts about decision rights owners

	Example decisions	Assesment (1=low, 5=high) Impact	Likeli-hood	Appropriate decision right owner (highlighted) Service-line	Clinical director-ate	Trust exec/ COO
HR decisions	• Replace consultant for an activity that may not be sustainable	2	1			
	• Increase in overtime to cover additional work	1	1			
	• Temporary employment of project manager	1	1			
Financial decisions • Revenue • Capex • Opex	• Vary budget between pay and non-pay	1	2			
	• Lease purchase ultrasound 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-serviceable	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			

*Framework detailed further on following pages
Source: UK pilot discussions

Results of pilot discussions about decision rights owners

Some examples

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 it is not certain that commissioners will continue to have these needs in the future	Clinical directorate (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 • Likely to 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 • Significant risk that contract volumes may not materialise	Trust executive/COO

Source: UK pilot discussions

Key insights from pilot discussions

Decision rights

Key insights	Quotes from the working team
• To avoid service-line managers, empowered with new decision rights, creating 'kingdoms' within the trust, they need themselves to be able to delegate decisions to the next (team) level	'This devolution is not about power, it's about performance… managers who take all decisions by themselves will not make the best decisions' **Medical director**
• Without sufficient, clearly defined decision rights, service-lines cannot be expected to take full responsibility for performance	'We can't be held accountable for our performance when we are not even allowed to replace staff vacancies as they arise – and have to employ expensive agency staff' **General manager**
• Besides clear autonomy/decision rights, communication of decisions to the next level of management and to peers is essential	'Without being kept in the loop about what is going on, I don't think (the trust's executive/COO) will be comfortable delegating any important decisions to service-lines' **Clinical lead**
• The role of functional support (e.g. finance, service development, human resources etc.) in decision making needs to be clarified	'(Finance and other support functions) should be consulted when necessary, but should not be the ones taking decisions instead of the service-line' **Clinical lead**

Source: UK pilot workshops and interviews

Effective performance improvement

More about performance improvement

A well-functioning performance improvement system is an essential component of SLM

What is a performance improvement system?

A set of tools and processes that create transparency and accountability in the progress made 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.

What does a performance improvement system offer?

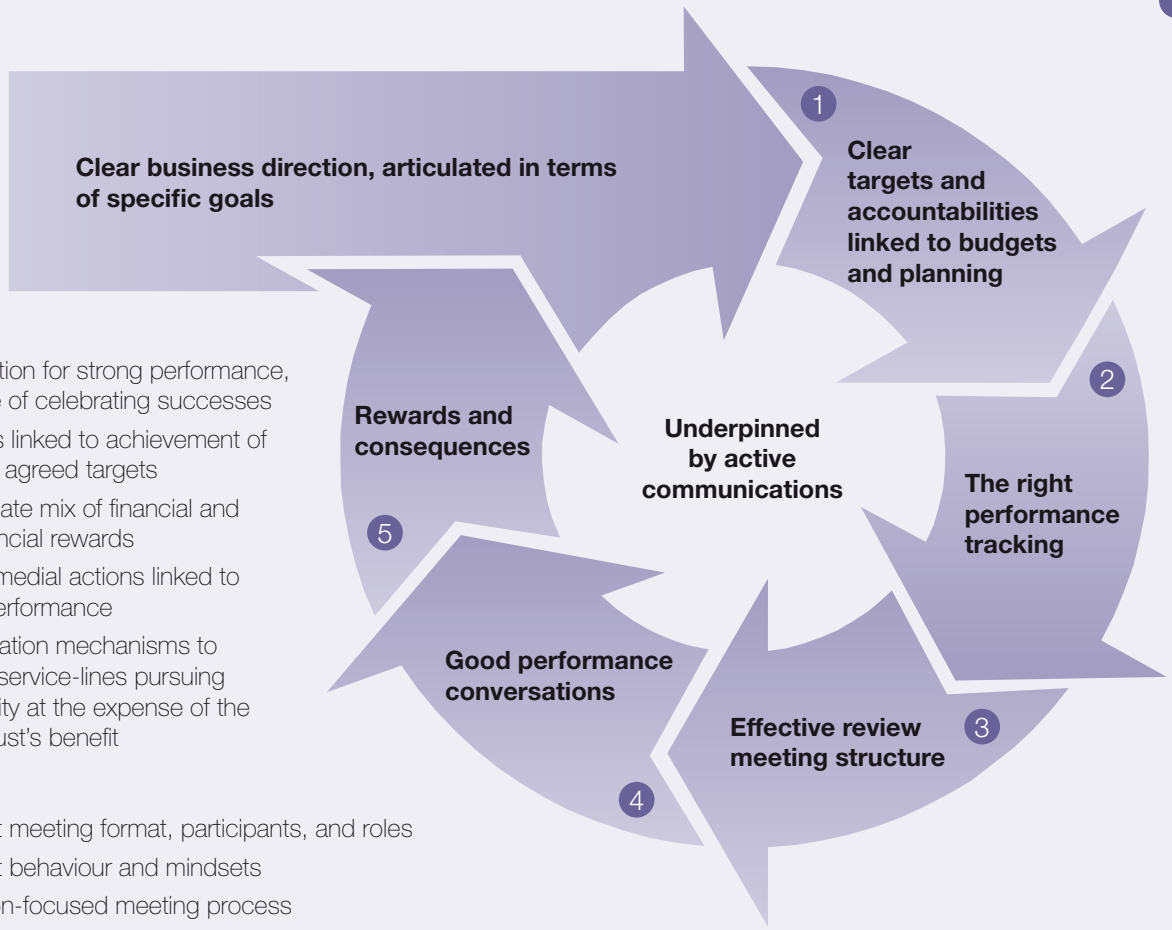
- Focuses senior management on key metrics for performance
- Creates accountability for performance
- Enables more active professional development/ coaching and a fairer process for career advancement
- Allows senior management to intervene on a fair basis when performance is substandard
- Increases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

Driving change

An effective performance improvement system is essential to drive change

Key enablers	"Check-list" of the important SLM components
1 Supporting organisational structure, capabilities, incentives, and trust-wide processes/policies	☐ Organisational structure with appropriately defined service-lines ☐ Clearly defined service-line leadership roles, with integrated ownership of clinical, operational and financial performance ☐ Trust executive capable of supporting and developing service-line managers ☐ Well defined, capability-linked, transparent decision rights at each level (trust executive, service-line, and team) ☐ People development process that ensures that the capabilities needed are continuously renewed ☐ Incentive structures aligned with the trust's culture and reinforcing performance ownership
2 Clear service-line strategy and objectives	☐ Simple, clear statement of aspirations/objectives over three- to five-year timeframe that inspires clinicians ☐ Action-oriented set of initiatives to deliver the objectives ☐ Practical process to develop/refresh strategy grounded in both internal understanding and external (market/demand) perspective
3 Effective annual planning process	☐ Coherent annual process to set service-line specific goals and budgets based on top-down and bottom-up processes to define quality, operational, and financial goals ☐ Budget developed from operational benchmarks (not "last year rolled-over") ☐ Plan for follow-up that enables early identification and mitigation of risks at the service-line level
4 Reliable, relevant, accessible, and timely information	☐ All decision makers with access to relevant, timely information (financial, operational, quality) ☐ Financial information at procedure level (cost and profitability) based on activity-based costing ☐ Internal and external benchmark transparency
5 Effective performance improvement system	☐ Performance tracking focus on a balanced set of targets for quality, operational efficiency, financial performance, safety, and staff satisfaction ☐ Performance accountability at each level formalised in individual performance contracts ☐ Effective performance reviews focusing on targets realisation, progress on agreed activities and agreement on new required actions and responsibilities ☐ Rewards for strong performance and fair consequences for poor performance

Five key components of an effective continuous improvement system



1
- Trust vision is translated into a balanced set of trust level KPI targets
- Trust-level KPI targets are broken down to service-line level KPI targets
- KPI targets are linked to specific initiatives and investments in the planning and budgeting process
- Each target and initiative is linked to accountabilities, formalised in performance contracts

2
- Efficient data collection processes
- Reliable data storage and management solution, that allows user-friendly access to the information
- Reporting of service-line performance using an hierarchy of reports with consistent format and frequency

3
- Clear and consistent sequence of review meetings
- Clear terms of reference for each performance review meeting

4
- The right meeting format, participants, and roles
- The right behaviour and mindsets
- A solution-focused meeting process

5
- Recognition for strong performance, a culture of celebrating successes
- Rewards linked to achievement of specific, agreed targets
- Appropriate mix of financial and non-financial rewards
- Clear remedial actions linked to under-performance
- Collaboration mechanisms to prevent service-lines pursuing profitability at the expense of the whole trust's benefit

Shifting mindsets and behaviours

Performance improvement needs to address the four key influencing factors to shift mindsets and behaviours across an organisation

1 Role modeling

'…I see superiors, peers, and subordinates behaving in the new way'

- Hold robust performance conversations
- Ensure rewards, consequences, and actions

2 Fostering understanding and conviction

'…I know what is expected of me – I agree with it, and it is meaningful'

- Establish clear metrics, targets, and accountabilities
- Create realistic budgets and plans
- Track performance efficiently
- Hold robust performance conversations
- Ensure rewards, consequences, and actions

3 Developing talent and skills

'…I have the skills and competencies to behave in the new way'

- Create realistic budgets and plans
- Hold robust performance conversations

4 Reinforcing with formal mechanisms

'…The structures, processes, and systems reinforce the change in behaviour I am being asked to make'

- Establish clear metrics, targets, and accountabilities
- Create realistic budgets and plans
- Track performance efficiently
- Hold robust performance conversations
- Ensure rewards, consequences, and actions

Effective performance improvement

1. Clear targets and accountability

Clear targets and accountability

An overview

Importance

- Clear targets and accountabilities are the foundation for an effective performance improvement system
- The trust's objectives are translated into specific targets and initiatives that in turn deliver single-point accountability

Key success factors

- The trust's vision is translated into a balanced set of trust level KPI targets
  - KPIs are defined to measure the critical elements of success
  - KPI targets are simple, measurable, actionable, result-orientated and timely
  - The most important trust level KPI targets are communicated widely and frequently in the trust
- Trust level KPI targets are broken down to service-line level KPI targets
  - KPI targets are linked up and down the trust's hierarchy so that if targets are achieved for all service-lines, the trust's overall objectives are achieved
- KPI targets are linked to specific initiatives and investments in the planning and budgeting process
- Each target and initiative is linked to accountabilities which are formalised in performance contracts

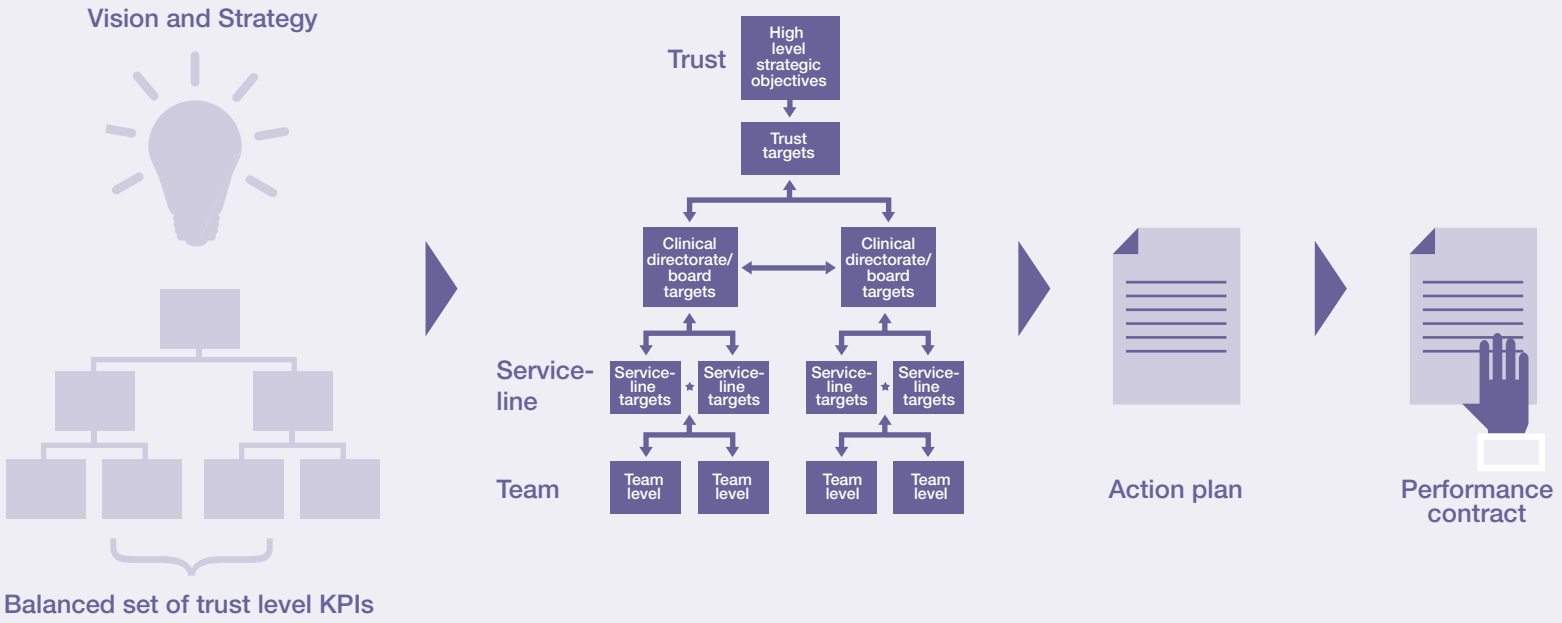
Four key success factors in creating clear targets and accountability

Trust's vision translated into balanced set of trust level KPI targets

Trust level KPI targets broken down to service-line and team KPI targets

Service-line and team targets linked to action planning

Targets and action plans linked to accountabilities through performance contracts



Source: International best practice interviews

Translating a trust's vision into a balanced set of trust-level KPI targets

KPIs should define the critical elements of success…

…provide a balanced view of performance…

…and each be SMART in their own right

Financial and growth

Financial indicators – e.g. Cost per spell or FCE

Clinical and administrative efficiency

Indicators of operational efficiency – e.g. ALOS

Clinical quality and patient satisfaction

Indicators that will impact longer term sustainability of the organisation – e.g. Quality of care

Employees

Indicators of employee skills and motivation – e.g. Voluntary turnover

Simple	• Clear definition • Straightforward to understand
Measurable	• Easy to collect required data • Reliable sources • Can be benchmarked
Actionable	• The responsible team understand and take control of key decisions
Results oriented	• Is aligned with trust objectives • Links with the next level of KPIs
Timely	• Can it be measured frequently enough to track success

Source: International best practice interviews

A critical success factor

Identifying a set of KPIs that reflect the trust's strategic objectives

Selected KPI examples used by reference hospitals

Financial metrics and growth

- Market share
- Cost/FCE (£)
- Revenue per FCE (£)
- Profit per FCE (£)
- Number of new PCT/GP relationships (#)
- Average share of referrals from target PCTs/GPs (%)
- Variance to budget (£)
- Number of "unique" patients/ members served
- Outpatient market share
- Admissions growth

Clinical and admin efficiency

- Nursing hours per patient day
- ALOS
- R&D productivity
  - – Successful funding requests (%)
  - – Publication pages (weighted number)
- Day case rate (%)
- Bed utilisation (%)
- Theatre utilisation (%)
- Cancellation rates (%)
  - – Appointments
  - – Operations
- Coding completeness within x days (%)

Clinical quality and patient satisfaction

- Satisfying the Care Quality Commission's overall criteria
- Teaching student satisfaction (survey based)
- Patient satisfaction (survey based) – e.g. % that would recommend/return
- Re-admission rate – e.g. within four weeks
- Waiting time for consultation (days)
- Complaints/ 100 visits (#)
- Infection rate (%)
- Five-year survival rate (oncology)

Employee satisfaction

- Staff satisfaction survey (%)
- Voluntary turnover (%)
- Appraisals complete (%)
- Sickness and absence (%)
- Vacancies (%)

- Trusts need to select the concise set of KPIs that reflect their business objectives
  - – Successful trusts typically find that 15 – 20 overall KPIs are sufficient
- It is important to strike a balance between KPIs
  - – Leading and lagging indicators of success; and
  - – Short-term outcomes (financial) and long-term success requirements (quality and patient/employee satisfaction)

Source: International best practice interviews

Best practice example

A balanced scorecard that translates strategic objectives into specific KPIs

Dimension	Strategic objectives	Measures
Clinical excellence	Consistently provide care that is free from adverse events and harm	Percentile CMS measures (equivalent to Care Quality Commission annual health check ratings)
	Consistently provide evidence based care that is effective and timely	% of clinical program and safety goals met
Service excellence	Improve positive patient perceptions of quality and extraordinary care	% of operating entities meeting their service excellence goals
		% of operating entities meeting their patient perception of quality goals
		Increase in the number of questions exceeding the national benchmark (national survey based)
		% of departments that provide extraordinary care
Operational effectiveness	Achieve an operating margin sufficient to meet community need	% of operating entities achieving supply chain savings
		% of operating entities achieving operating margin target
Employee engagement	Provide a work environment that attracts and retains the best service-oriented people, and results in an engaged workforce	% of operating entities increasing the Employee Commitment Index
		% of operating entities that achieve their physician satisfaction goal
		% of operating entities achieving a decrease in employee turnover – first year employees
Community stewardship	Provide and promote services and programmes to improve community health and provide access to all	Cost per case
		Cost of charity care

Source: International best practice interviews

Best practice example

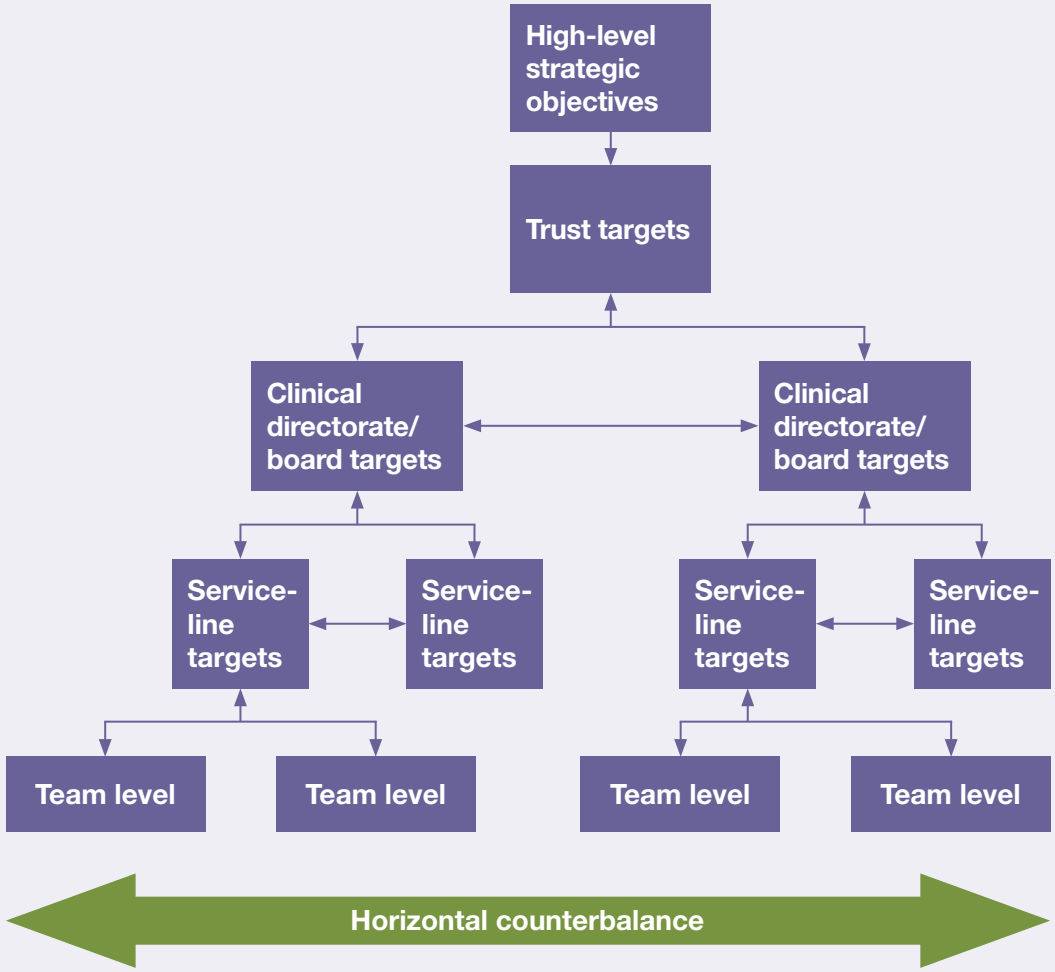
A balanced scorecard that translates key success factors into specific KPIs

Scorecard category	Key success factors	Key performance indicators	
Customer service	Patient satisfaction	Patient satisfaction survey	# of patient complaints
	Accessibility	Appointment availability	# of ED patients left w/o seen
Growth and quality	Operational efficiency	Average daily census	Red zone gridlock
		FTE per Adj. occupied bed	
	Service growth	# of ER visits	# of inpatient surgeries
		# of cardiac catheterisations	# of outpatient surgeries
	Quality clinical outcomes	Anti-emb. mid-high risk	Nosocomial infection rate
		AB utilisation for CAP	Decubitus ulcers rate
	Patient and staff safety	# of patient falls	
Workforce management	Quality of work life	Employee absenteeism rate	Vacancy rates/RN vacancy
Financial strength	Operating margin	Net operating margin	Days in A/R
		Days cash on hand	Days in A/P
	Revenue enhancement	ALOS	Clinical documentation
	Expense control	Collections as % of revenue	Volume of 3rd party denials
		Payor mix	Revenue from fundraising

Source: International best practice interviews

Best practice example

Trust-level KPIs are broken down to service-line level KPIs



Vertical aggregation

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

Source: International best practice interviews

Best practice 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 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

(See following pages for examples of performance contracts)

Source: International best practice interviews and UK pilot discussions

Best practice example

This shows how a US hospital links each initiative to KPI target improvements

Specific metrics targeted by each initiative

Specific owner for each initiative

Tear	Metric grouping	Metric	Initiative Grouping	Initiative	Ability to move metric (impact)	Time to impleme
CoC	Reduce average discharge time	reduce average discharge time	Alter rounding schedules	Evaluate opportunities to alter resident and attending rounding and academic schedules to allow for earlier patient discharges		
CoC	Reduce average discharge time	reduce average discharge time	Identify and prepare for anticipated discharges	Formalize communication process around anticipated and actual discharges (e.g., daily 4 PM rounds involving charge nurses and case management, flag anticipated discharges)	3	3
CoC	Reduce average discharge time	reduce average discharge time	Identify and prepare for anticipated discharges	Have night shift start discharge process on anticipated discharges (education, paperwork)	3	2
CoC	Reduce lag between patient discharge and next patient arrival	reduce lag between patient discharge and next patient arrival	Enhance bed control processes	Establish a twice daily bed control meeting	5	3
CoC	Reduce lag between patient discharge and next patient arrival	reduce lag between patient discharge and next patient arrival	Enhance bed control processes	Expand discharge and bed control process to include internal transfer of patients		
CoC	Reduce lag between patient discharge and next patient arrival	reduce lag between patient discharge and next patient arrival	Streamline room cleaning process (e.g., communication)	Redesign discharge and room-turn process (e.g., standardize communication process between ambassador/ housekeeping and bed control)*	5	3
CRM	Increase use of oral drugs where IV = po	Increase use of oral drugs where IV = po	Pilot IV to PO conversion	Piloting IV / PO conversion, leveraging nursing and case management	5	3
CRM	Reduce supply cost variability	reduce supply cost variability	Improve purchasing practices	Building cross-reference / substitution knowledge for largest spend items (in progress)	na	

Quantified expected impact by initiative

Clearly defined timeframe where applicable

Source: International best practice interviews

Linking targets and action plans to accountabilities through performance contracts

Key components of a performance contract within a healthcare context

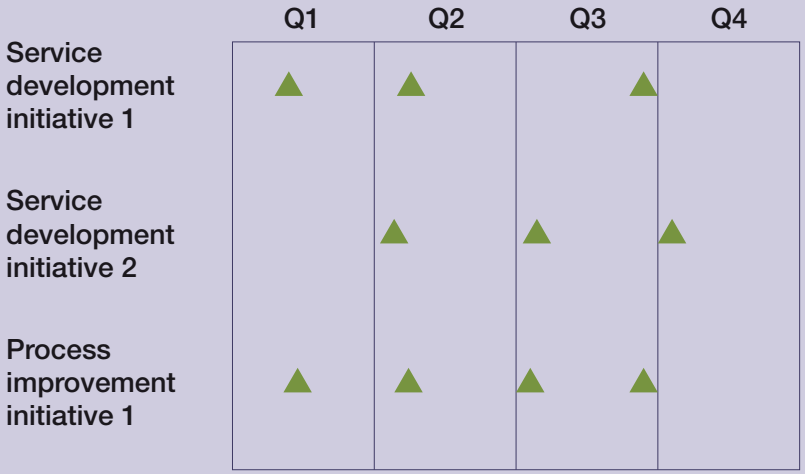
KPIs

- A "balanced scorecard" of ~6-8 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

- E.g.
  - 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

Source: International best practice interviews

Best practice example

Performance contracts are used extensively in other industries

Marketing company example

EMEA region marketing performance contract

Your commitment

Financial performance
- Operating expenditure, <£17m
- Capital expenditure, <£2m
- EBIT >£5m

Business objectives
- Launch product pilots by Q1 '04
- Build product marketing infrastructure Q2 '04

Organisation
- Recruit five market analysts Q1 '04
- Train 50% of team on Siebel
- Establish team satisfaction survey

Personal
- Demonstrate the firm's six key leadership skills
- Attend senior management training course

Our commitment
- Provide you with £17m of operating expenditure
- Provide you with £2m of capital expenditure
- Access to appropriate Firm resources

VP, Marketing, HQ

Marketing Manager, EMEA Region

Including both KPI targets and specific initiatives

Specifying resources available

Petroleum company example

Business unit management performance contract

Key financial targets	Targets
• Production (mboe/d)	• A
• Capital expenditure ($m)	• B
• Net income ($m)	• C
• Post tax cash flow ($m)	• D

Key business objectives
- Health&Safety: Build an organisation with an exemplary H&S culture that sets the industry standard for H&S performance in a new basin by end of year
- Exploration project x: Determine the scale of opportunity by end of year
- Financial: Meet the annual and quarterly financial targets. Establish a track record in cost control throughout the business unit by end of Q3

Resources: To realise the above Peer Group/Exploration Forum Targets, the above Business Unit Financials incorporate

	$m
• Exploration licenses	• A
• Exploration spend	• B
• Exploration G&G expense	• C
• Exploration write-offs	• D

Business Unit Leader

ExCo Member

Separating financial targets and business objective

Specifying resources available

Source: International best practice interviews

Effective performance improvement

2. The right performance tracking

The right performance tracking

An overview

Importance	• Ongoing tracking of KPIs is crucial to identifying worrying deviations from plan as well as enabling the celebration of successes where performance exceeds plan. A reliable stream of performance data enables the organisation to focus on the right areas of development and is also a requirement for having good performance-based conversations
Key success factors	• Efficient data collection processes • Reliable data storage and management solution, that allows user-friendly access to the information • Reporting of service-line performance using a hierarchy of reports with consistent format and frequency – Consistent format for all reports at trust, directorate and service-line-level reports (and further team/sub-specialty reports if possible) – Performance report includes upfront synthesis and key issues/topics requiring action and/or senior-level attention – All reports accessible for all decision makers in the trust

Three key success factors for effective performance tracking

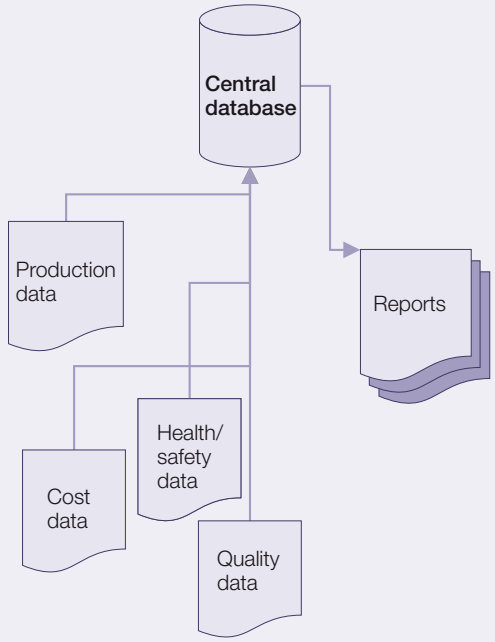
1 Develop and use efficient data collection processes

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

Source: International best practice interviews

Best practice example

A KPI tracking report with a user-friendly interface

Category	Metric	Units	Tracking frequency	Last year	Last month	This month	Target	Status	Trend
Financial/growth	Variance to budget	£000's	Monthly						Better
Financial/growth	Profit/FCE	£	Monthly						Better
Clin/admin efficiency	Average length of stay	Days	Monthly						Worse
Clin/admin efficiency	Activity, year-to-date (cases)	FCEs	Monthly						–
Clin/admin efficiency	Day case rate	%	Monthly						Worse
Clin/admin efficiency	Bed utilisation rate	%	Monthly						Worse
Clin/admin efficiency	Theatre utilisation rate	%	Monthly						Better
Clin/admin efficiency	10 days coding complete	%	Quarterly						Better
Clin/admin efficiency	Coding depth	Ratio	Monthly						Worse
Quality/patient	Readmissions (within 26 days)	%	Quarterly						Worse
Quality/patient	Infection control (year-to-date)	Cases	Quarterly						Worse
Quality/patient	Waiting target list	%	Monthly						Better
Quality/patient	Timely response to complaints	%	Monthly						–
Employee satisfaction	Appraisal complete	%	Quarterly						Worse
Employee satisfaction	Sickness and absence	5	Monthly						Better

Disguised targets and results

Targets reflect overall goals linked to three to five year strategy. Ties together operations, finances and/or quality

Same structure for overall trust scorecard for all service-lines

User-friendly tracking of status vs. target

Supporting pages for each indicator allows managers to drill down to understand root causes of issues

Source: International best practice interview example (simplified and sanitised)

Effective performance improvement

3. Effective review meeting structure

An effective review meeting structure

An overview

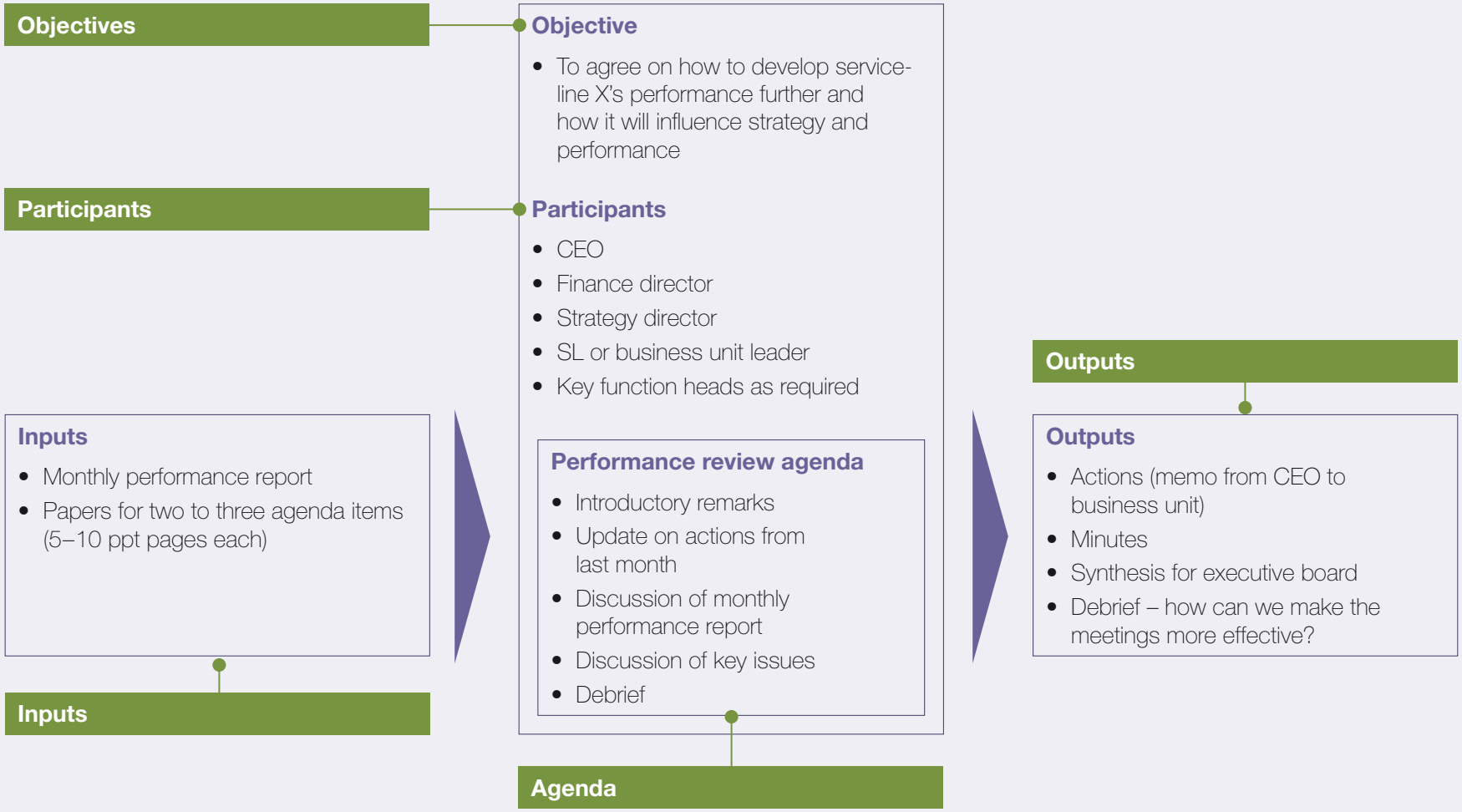
Importance

- Well-defined review meeting structure with clear objectives, duties and responsibilities is a key enabler of good performance-based conversations

Key success factors

- Clear and consistent sequence of review meetings
  - Review intervals consistent with performance report cycles
  - Intervals between reviews at each level sufficient to allow actions from one review to have some effect before the topic is reviewed again
  - Intervals between hierarchical reviews sufficient to allow meaningful integration of sub-teams and synthesis of overall status
- Clear terms of reference for each performance review meeting, providing written, change-controlled and up-to-date definition of each meeting. Elements of each meeting to comprise attendees, agenda, inputs and outputs

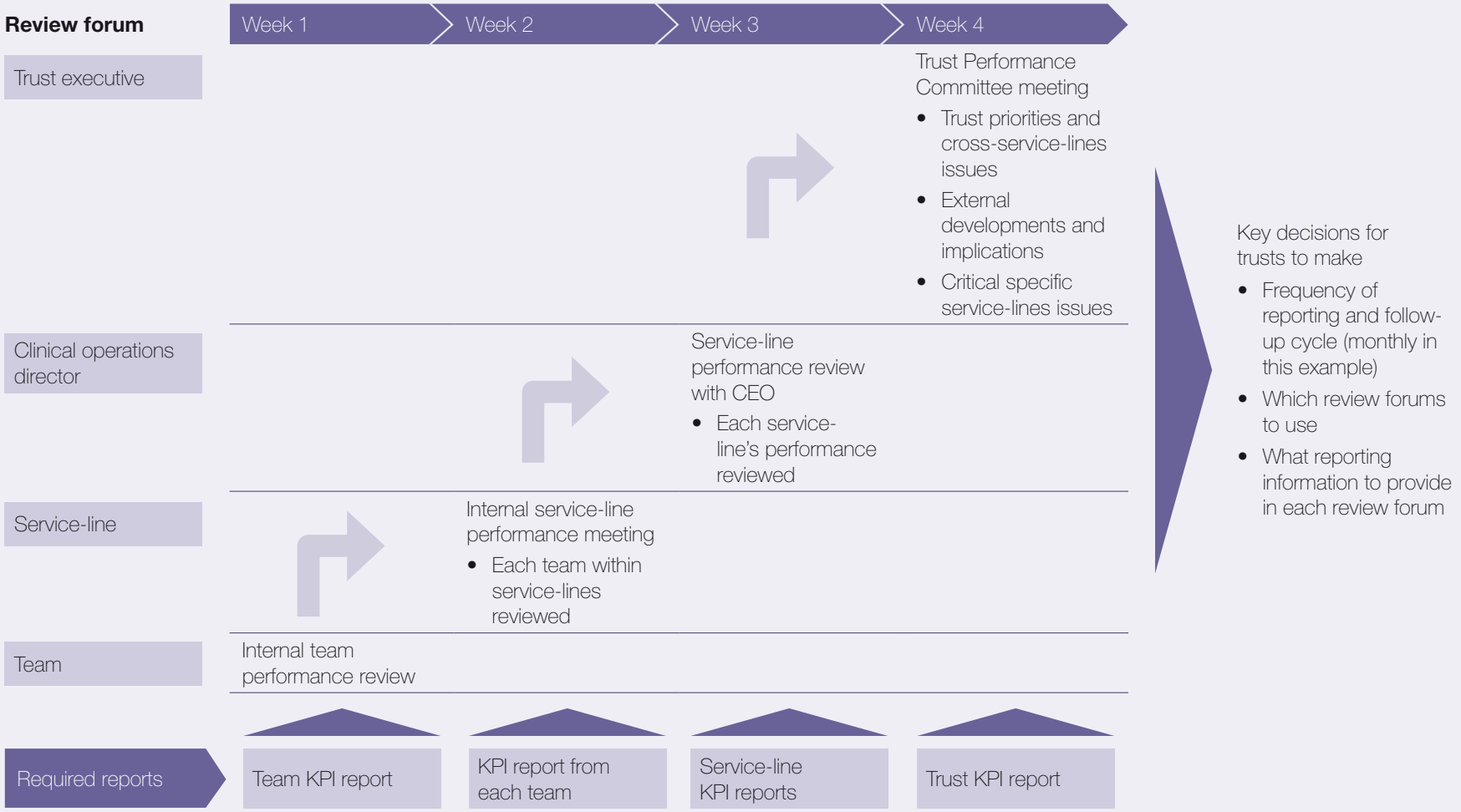
Defining the terms of reference for effective performance review meetings



Source: International best practice interviews

Best practice example

A sequence of clear and consistent review meetings



Source: International best practice interviews

Effective performance improvement

4. Good performance-based conversations

Good performance-based conversations

An overview

Importance	• Honest and creative performance-related conversations are the critical component of an effective performance improvement system. This is where managers and their team members have frank and open discussions and agree on realistic actions for improving performance and driving productivity
Key success factors	• The right meeting format, participants and roles – Agree beforehand on the type of meeting (e.g. status update vs. problem solving) – Ensure the right participants are there and that they are well prepared – Define participant roles (time-keeping, chairperson, note-taker, etc) • The right behaviour and mindsets – Focus on root-causes rather than symptoms – Challenge focus on content and solutions rather than data/methodology – Establish cumulative discussions over a series of review meetings, but with a well defined delivery schedule • A solution focused meeting methodology – Contextualise the issue; identify root causes; prioritise improvement areas; generate solutions; agree on realistic implementation plan

Three key success factors for effective performance conversations

1 The right meeting format, participants and roles

- Agree beforehand on type of meeting
  - Formal evaluation vs. informal coaching
  - Status update vs. problem solving
- Ensure the right participants are there
  - The relevant perspectives represented
  - No redundant participants
- Ensure participants are well prepared
  - Thorough review of pre-reading
  - Data issues addressed beforehand to enable focus on content and solutions in the meeting
- Define meeting roles
  - e.g. chairperson, timekeeper, note-taker, etc.

2 The right behaviour and mindsets

- Base discussion on facts whenever possible
- Focus on root causes rather than symptoms
- Focus on solutions to improve performance rather than challenging the data/methodology
- Establish cumulative discussions over a series of review meetings (vs. recurring discussions on "the usual topics")
- Adopt a collaborative approach – we are in this together; no reference to "them" or "the trust" – everyone is "the trust"
- Ensure meeting is inclusive – all participants must have a say and be heard

3 A solution-focused meeting methodology

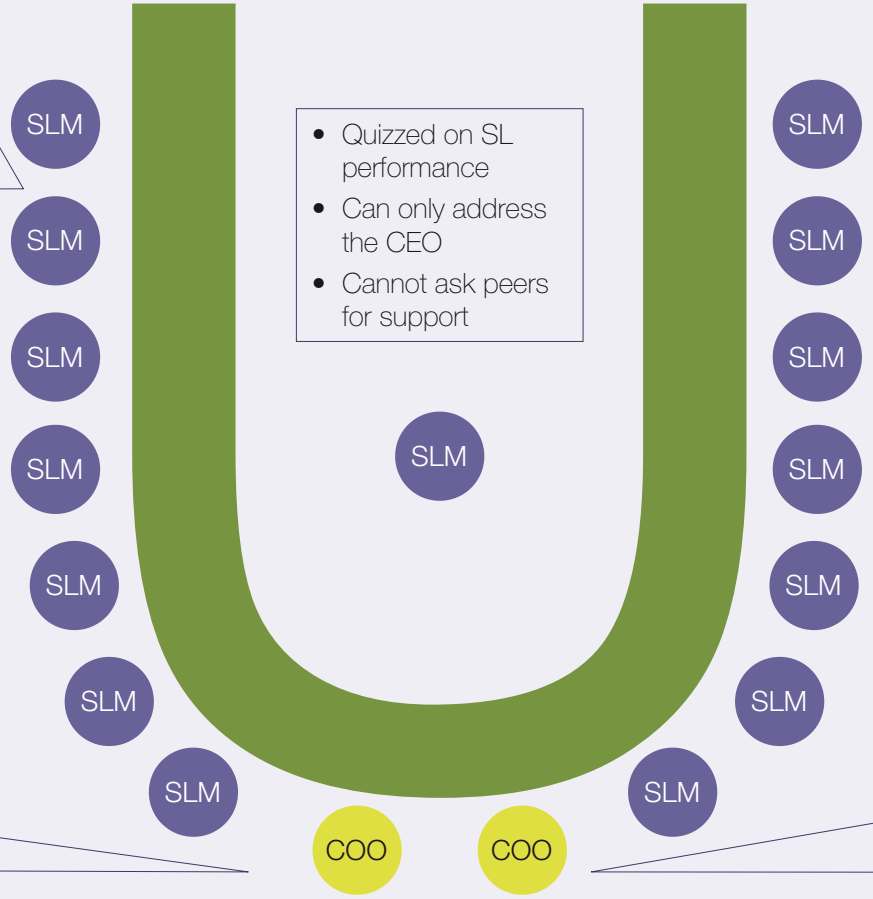
- Contextualise the issue
  - Background (e.g. what the issue is, and when was the action agreed)
  - What success would look like
  - Impact on performance
  - Key stakeholders
  - Constraints to consider
- Identify root causes
- Prioritise areas of improvement based on relative value of closing gap
- Generate solutions to address gaps and root causes and prioritise them based on implementation time, effectiveness, and costs
- Agree on realistic timeline, owners and milestones to close gaps
  - Critical to define a single-point accountabilty for all agreed actions – who is "on the hook"?
  - If there is no solution, acknowledge this, and reset targets and plans

Source: International best practice interviews

Best practice example

An example of well-defined meeting format, participants and roles

- All service-line managers (SLMs) present
- Their role in meeting is as observers
- "Seeing the performance challenge was a powerful development event, teaching SLMs their business, but also how to challenge their own people"



- Quizzed on SL performance
- Can only address the CEO
- Cannot ask peers for support

- Peer audience is aware they will be "on stage" at some point, and therefore this generates motivation to support one another
- CEO constructively criticises and/or praises SLMs, probing for potential performance improvements
- Reinforces sense of accountability
- SLMs realise that good financial and operational performance is rewarded and poor performance penalised

- COO has collected information on service-lines from "the shop floor"

'I review how their strategy is going …whether what we are saying is feasible…have they got some new ideas?…what's unfinished business?…what are the issues?'

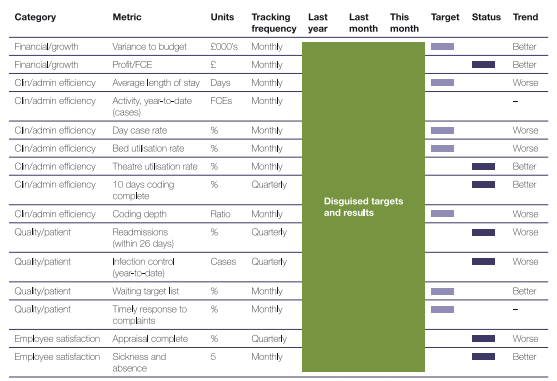
CEO

Source: International best practice interviews

Best practice example

A solution-focused sequence of review questions

Based on solid facts…



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Quality/patient	Timely response to complaints	%	Monthly						–
Employee satisfaction	Appraisal complete	%	Quarterly						Worse
Employee satisfaction	Sickness and absence	5	Monthly						Better

Disguised targets and results

…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 going to be tracked?

Source: International best practice interviews

Best practice example

A chair's preparation checklist to ensure effective review meetings

Before

- Write prioritised agenda based on scorecard and on-the-ground observation
  - Remember to consider reasons for good performance as well as problem areas!
- Identify meeting blockers and unblock them
  - Request inputs (facts, expertise) ahead of meeting that will enhance quality of discussion (e.g. ask relevant meeting participant to investigate problem area; invite guest attendee for specific agenda item)
- Send agenda, scorecard and last month's report to all meeting participants 24 hours ahead of meeting
- Spend five minutes writing an outline one-page report
  - Helps you focus the meeting on generating critical output; and you will have a ready-made introductory perspective to provide context at start of meeting

During

- Check all roles are covered (timekeeper, report-writer, issue-logger, process-checker, experts)
- Follow up on previous month's actions
- Present prioritised agenda and invite modifications and changes to order
- Give your brief perspective on main features of the month's performance, then start on most important topic
- Focus on the top three most important issues and spend the necessary time to really deal with them
- Focus the meeting on real operational issues. Take other issues (e.g. data) off-line
- Model good meeting behaviours
  - Thank people for good performance, for ideas and for volunteering to carry out an action point
  - Volunteer yourself when appropriate
  - Bring quiet attendees into discussion
- Recap report items as you go to help report-writer
- At end, invite report-writer to recap all report items

After

- Ensure report goes to coordinator of "next level" meeting on time
- Ensure report and issue log are circulated to all meeting participants
- Follow-up key actions one to two weeks ahead of next meeting

Source: International best practice interviews

Best practice example

Evaluating meeting effectiveness

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		

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			

Roles

Clear presence of:	Yes	No
1 Timekeeper		
2 Report-writer		
3 Issue-logger		
4 Process-checker		
5 Necessary expertise		

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			

Quote → effect notes (continue on separate page)

Sequence for giving feedback

1 Quote or observed action → 2 Effect on you (or perceived effect on group) → 3 Suggestion

Source: International best practice interviews

Effective performance improvement

5. Rewards and consequences

Rewards and consequences

An overview

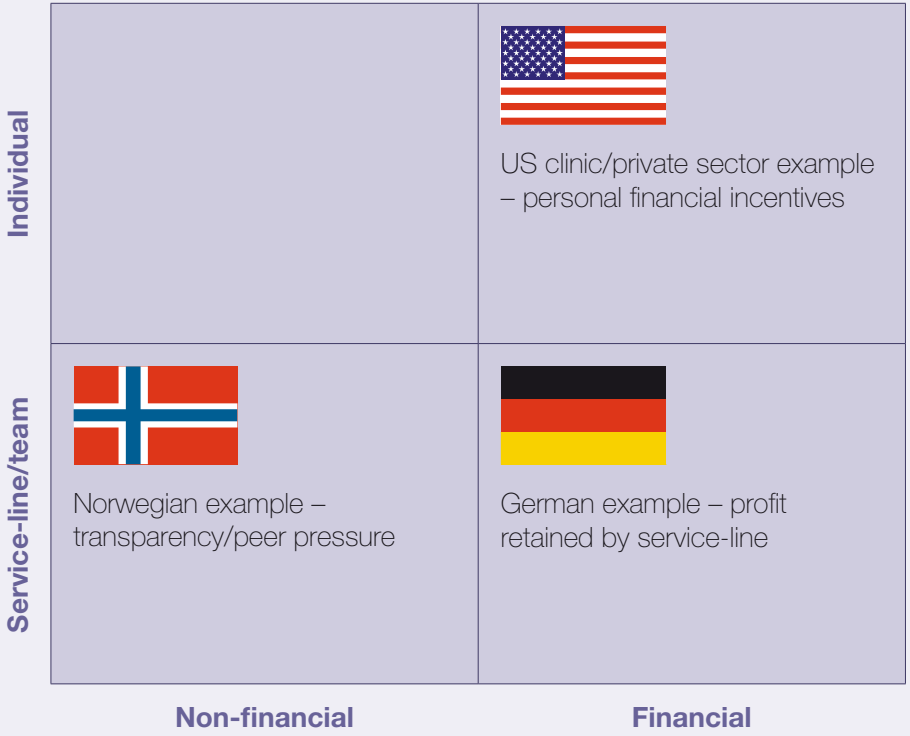
Importance	• Rewards based on actions and consequences and collaboration mechanisms are mission critical for success. Trusts need to encourage individuals to adopt behaviour patterns that deliver valuable and desirable outcomes for the organisation. Learn how to deliver the motivational challenge
Key success factors	• Recognition for strong performance, a culture of celebrating successes • Rewards linked to achievement of specific, agreed targets • Appropriate mix of financial and non-financial rewards • Under-performance linked to clear remedial actions • Collaboration mechanisms exist to prevent service-lines pursuing their profitability at the expense of the whole trust's benefit – the maverick player

Two key considerations in setting up a performance based incentive structure

What to incentivise

- Financial performance
  - % profitability
  - £ profitability
  - Achievement of financial targets
- Access (e.g. meeting 18-week targets)
- Quality
  - Re-admissions
  - Outcomes (e.g. mortality rates)
  - Infection rates
  - Patient satisfaction index (survey based)
- Staff satisfaction

Who and how to incentivise

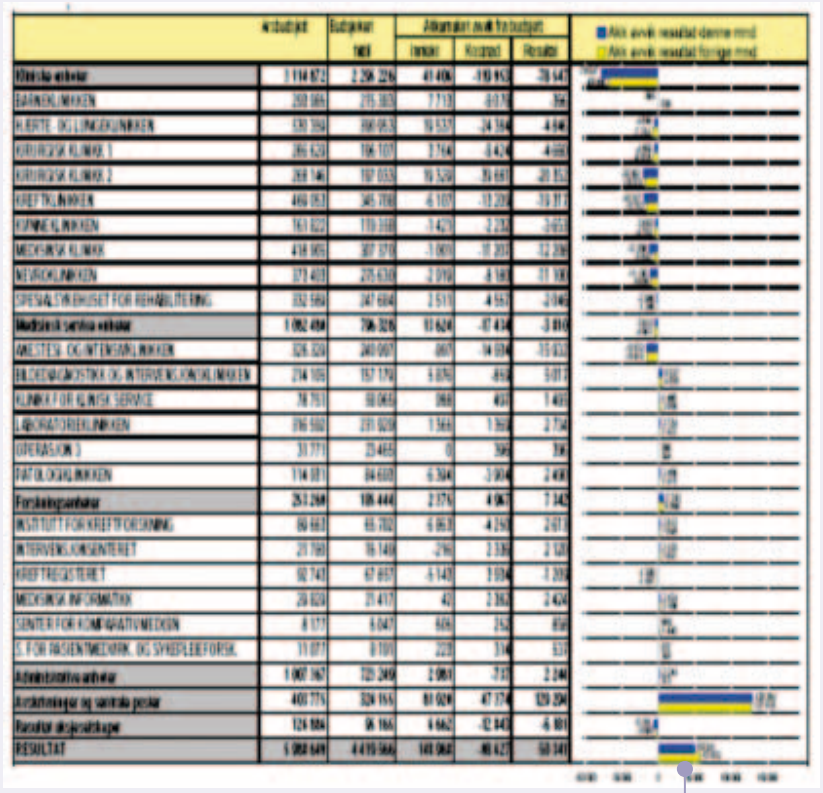


Source: International best practice interviews

Motivating through peer pressure

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

Clear transparency of financial results…



Contribution vs. 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

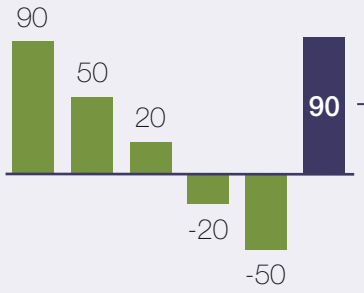
Source: International best practice interviews

Linking a service-line's earnings to its profit contribution

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

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

Contribution margin, £m



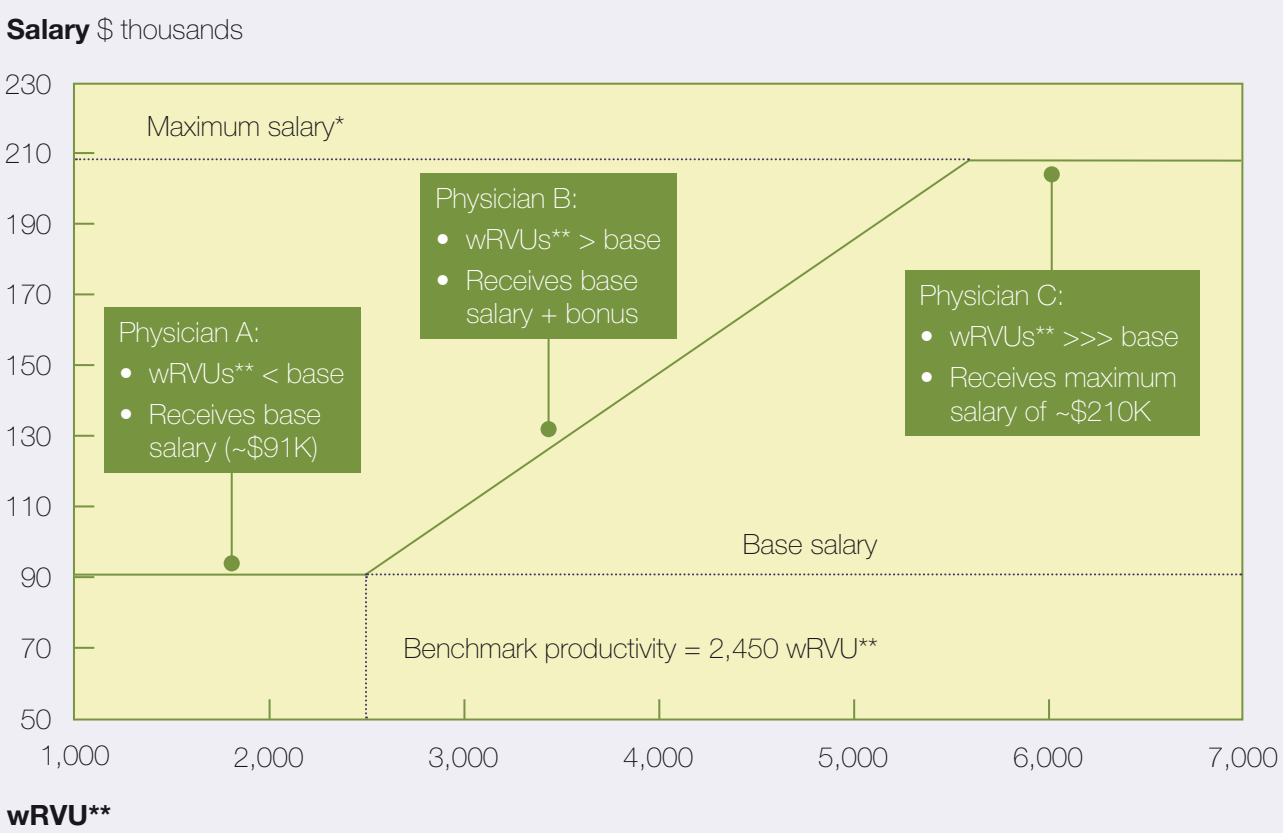
SL	Contribution £(m)	Contribution share (% of total)	Allocation of profit pool £(m)
A	90	56	56% x 20 = 11
B	50	31	31% x 20 = 6
C	20	13	13% x 20 = 3
	160	100	**20**

Illustrative data
Source: International best practice interviews

Linking pay and performance

Clinicians at a US clinic have a variable pay component based on productivity

Illustrative example: Salary outcomes for three different clinicians at a US pediatric clinic

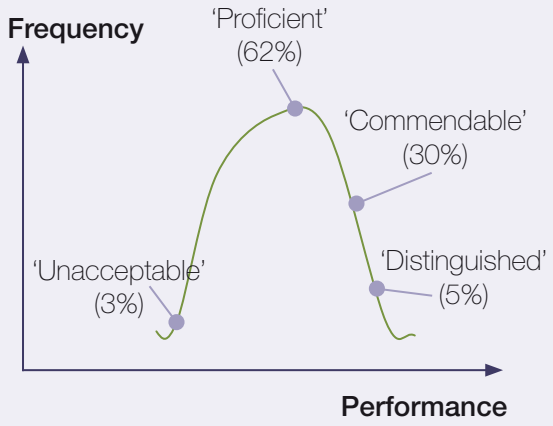


*The maximum salary is capped at the MGMA 90th percentile to comply with Stark and IRS regulations
**Weighted relative value units, represent the resources to perform a particular medical service
Source: International best practice interviews

Motivating through personal incentives

A US packaged goods company's product line managers are motivated by personal incentives

Review of results vs. goals	Performance rating	Rewards and consequences
• Each product manager has three to five financial goals, cascaded from corporate to product line, and one to three initiative related goals • Each product manager's goals and results known by the other product managers	• Financial and initiative-related results plus assessment on 11 leadership competencies combine into a performance rating with an expected distribution monitored by the corporate center	• Based on performance rating, each product manager is rewarded – Salary increase of 0% to 12%, – Cash bonus 25% to 75% of base salary – based half on individual performance, half on product division's financial result • Lowest ~5% of performers facilitated to exit the company



Source: International best practice interviews

The merits of different incentive schemes

Feedback from pilots

	A Norwegian hospital model: non-financial service-line incentives	B German: financial service-line incentives	C US clinic/private sector model: personal financial incentives
Examples of practices	• League table ranking of service-line profitability and quality	• Allowed to reinvest share of profits in service-line	• Clinician: variable pay or merit awards based on productivity • Service-line: management bonus set on the basis of service-line profitability target realisation
Pros	+ Encourages competition among service-lines + No extra costs	+ Encourages competition and supports resource allocation to areas where they are best put to use	+ Strong incentive for management to focus on profit contribution
Cons	– No financial impact on service-line – not as strong incentive?	– In cases where profitability is driven by tariff-misalignment, should not drive future investments if tariff corrections are expected	– Risk of increased overall costs with bonuses – Difficult to distinguish 'windfall' profitability from true performance driven profitability
Conclusion	• Suitable for trusts that do not make a surplus overall – Only if trust makes profit overall is it feasible for service-lines to retain profits	• Suitable for trusts that make a surplus overall, but feel individual performance incentives are a too aggressive way of encouraging profitability	• Suitable for trusts that want to be more aggressive in linking financial performance to compensation

Options A, B, and C can be combined

Source: UK pilot workshops and interviews

Key insights from the pilot sites

The applicability of performance improvement system in UK trusts

Key insights	Quotes from the working team
• Performance improvement system will bring increased engagement of clinicians in the trust's performance	'Even very small performance related rewards have achieved a tremendous impact on our clinicians' **Clinical lead**
	'The key is to link clinical and financial performance – if the system can do this it can create a huge impact on behaviour' **Clinical lead**
• Welcome approach to balanced performance tracking	'This will force us to look at quality and efficiency at the same time – the way financial and quality assessments run parallel tracks now prevents us from having meaningful discussions' **General manager**
	'Assessment on the basis of profitability…rather than (the current focus on) costs and activity is the way forward' **Clinical lead**
• Creating transparency of objectives and key performance measures for success is very helpful	'We need to start this by thinking through what the (strategic objectives) really mean in running the trust' **Director**
• A structured approach to review meetings is especially valuable	'There are a lot of good ideas for improvements from the teams that could be brought up if these review meetings were to focus on identifying solutions' **Clinical lead**

Source: UK pilot workshops and interviews

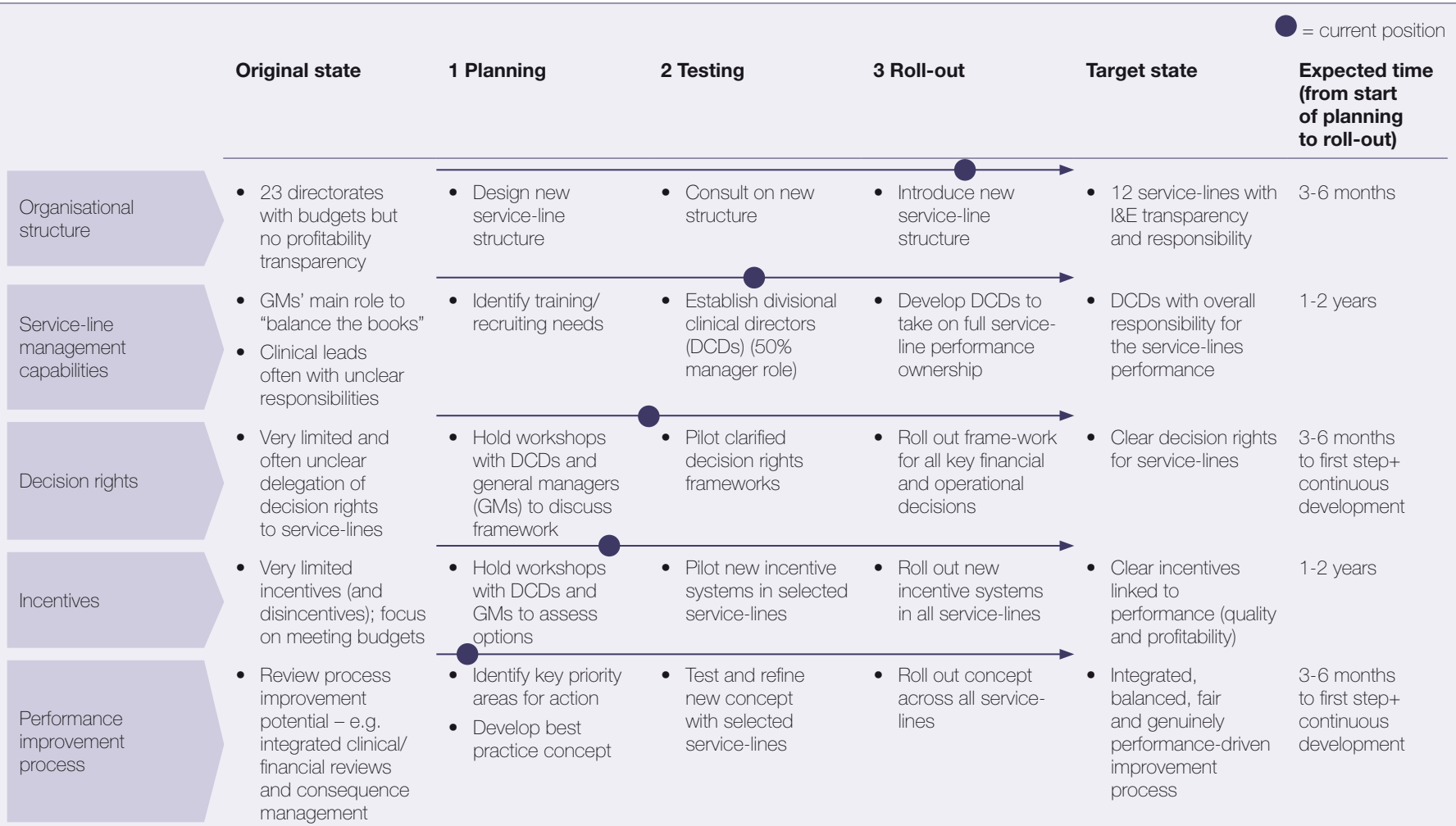
Key challenges in performance improvement

Key insights – key challenges are to…	Quotes from the working team
…obtain accurate data and meaningful metrics which are reliable and hence believable and what form the basis of detailed and constructive conversations between clinicians and non-clinical management	'It is difficult to measure many desired behaviours' **General manager**
	'We do not measure what is needed to drive performance' **Clinical lead**
	'There are very different opinions about how to balance financial and quality targets' **Clinical lead**
…achieve shared aspirations throughout the trust	'Clinicians are suspicious of any initiatives that may have an impact on the delivery of care' **General manager**
	'There is no responsibility for most metrics today' **General manager**
…integrate metrics and targets into performance improvement reviews	'No structured performance review processes for the divisions' **Director**
…link incentive systems to performance	'Different incentives required for different people – some ARE motivated by status and recognition others by financial rewards…others by a more balanced lifestyle' **Clinical lead**
…embed performance improvement in hospital culture – and creating demand for KPI information outside the finance department	'Performance reviews and the reporting cycle are not really linked today' **Clinical lead**

Source: UK pilot workshops and interviews

Overview of real pilot site implementation

This shows the key steps for organisational change, based on incentives, linked to decision rights and consequential actions



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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