Guide to Implementing Service-Line Management

Service-line management was developed for the NHS by Monitor, the Independent Regulator of NHS Foundation Trusts

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Guide to Implementing Service-Line Management
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Service-line management was developed for the NHS by Monitor, the Independent Regulator of NHS Foundation Trusts. The Guide to Implementing Service-Line Management is the latest in Monitor’s series of publications showing how managing by service lines can be implemented in a health setting:

- **Guide to Developing Reliable Financial Data for Service-Line Reporting** describes how to generate the information needed for income and expenditure reporting at service-line level through a seven-step process;
- **Toolkit for Presenting Service-Line Reporting Data** comprises six analysis tools which can be customised to present service-line financial data;
- **Getting the Most Out Of Service-Line Reporting: Organisational Change and Incentive Based Performance Management** acknowledges the important role of clinical and operational engagement in successfully devolving decision-making to the frontline, and describes systems and structures that can used to motivate and influence to improve performance and productivity; and
- **Getting the Most Out Of Managing Service Lines: Using Service-Line Reporting in the Annual Planning Process** shows how the service-line infrastructure can be used in the annual planning process to improve the efficiency and quality of financial governance and shows how this approach complements other strategic analysis.

The Guide to Implementing Service-Line Management shows how the use of robust service-line reporting structures and information enables service-line management, where each service line is managed as a business unit by frontline staff, and explores how to implement this.
Service lines and service-line management: an overview

• Service-lines are an NHS foundation trust’s equivalent of a commercial company’s business units. They are the key units within which the trust’s services are delivered to patients, with discrete resources used to meet a related set of patient needs.

• The goal of managing an organisation as a portfolio of service lines is to enable the devolution of ownership to the front line - where the capabilities, information, and patient relationships reside that enable the trust to fulfil its overall objectives.

• Successful service-line management requires integrated ownership of clinical, operational and financial objectives and outcomes.

• Organisation structures need to be tailored to the characteristics and culture of the trust. Whilst there is not a common answer, there are multiple principles that can be followed.

• Trusts can define service lines using similar criteria to that used by commercial companies when defining business units. A balance needs to be struck between the advantage of too few versus too many service lines. The former may force unnatural groupings of activities, and put excessive demands on service-line leaders. The latter will place extra demands on planning and budgeting processes and on the trust executive’s capacity to engage with each service line individually as well as increasing overall management costs.

• The configuration of clinical support services needs to be tailored to the trust’s circumstance. Where service lines have critical mass of activity to support clinical services within their service lines, this should be facilitated.

• Although often addressed, the existence of layers without clear value-adding roles is not always challenged. Divisional layers should only be in place where the additional input will add enough value to justify the additional organisational complexity and cost of the post, and this value can be both tested and rigorously evaluated.
Service-line management

Key enablers

“Check-list” of the important components

1. Organisation
   - Defined service-line structure
   - Defined service-line leadership roles, with integrated ownership of clinical, operational and financial performance
   - Capability-linked, defined decision rights at each level (trust executive, service line, and team)

2. Strategic and annual planning process
   - Understanding of market and competitive position
   - Defined three- to five-year strategy and annual objectives
   - Action plan to deliver strategy
   - Robust annual planning process
   - Levels of autonomy linked to quarterly monitoring regime

3. Performance management
   - Clear KPIs, targets and accountabilities
   - Performance tracking
   - Effective review meetings
   - Good performance conversations
   - Rewards and consequences for performance

4. Information support
   - Relevant, timely information
   - Patient level costing
Service line management – the organisation

Key enablers

“Check-list” of the important components

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   - Defined service-line leadership roles, with integrated ownership of clinical, operational and financial performance
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2. Strategic and annual planning process
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   - Performance tracking
   - Effective review meetings
   - Good performance conversations
   - Rewards and consequences for performance

4. Information support
   - Relevant, timely information
   - Patient level costing
Guiding principle: The NHS should move to a business unit structure, devolving autonomy to the front line, learning from how they have been applied in the commercial sector and translating the use to a hospital setting.

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

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

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Service line 1</th>
<th>Service line 2</th>
<th>Service line 3</th>
<th>Service line 4</th>
<th>Service line 5</th>
<th>Service line 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self contained</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Discrete patient group</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Discrete finances (profit and loss)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Discrete staffing group</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>- Compatible infrastructure requirements</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
</tr>
<tr>
<td>- Minimal interactions outside of the service line</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Comparable size</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Staff (all WTE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Staff (consultants WTE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Budget (£m)</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>- Income (£m)</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>- Complexity (high/medium/low)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common measures of success</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

• Assess service lines against the self contained criteria

- Discrete patient group
- Discrete finances (profit and loss)
- Discrete staffing group
- Compatible infrastructure requirements
- Minimal interactions outside of the service line

• Assess service lines against the comparable size criteria

- Staff (all WTE)
- Staff (consultants WTE)
- Budget (£m)
- Income (£m)
- Complexity (high/medium/low)

• Common measures of success

• Where service lines do not meet the criteria conduct a more detailed review to assess

- Should the service be reduced in size / joined to another service in order to be a business unit?
- Should the service be a cost centre or corporate function?
- Are we confident the leadership can make it work?

• The criteria may conflict, requiring trusts to make trade-offs between which criteria should be overriding. When doing so they should think about the people who are leading and within the service and the priorities of the trust.
## Example 1: General surgery

### Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discrete patient group</td>
<td>• Requirements of the patient journey is common across the specialties within general surgery with pre-theatre assessment, anaesthetists, theatre time, recover and inpatient facilities</td>
</tr>
<tr>
<td>Discrete finances (profit and loss)</td>
<td>• Relies on anaesthetists and theatre time support, with core consultants and nursing team as a discrete staffing group</td>
</tr>
<tr>
<td>Discrete staffing group</td>
<td>• Where budgets include anaesthetics and theatre infrastructure it often moves into being a very large budget which can impact on “comparable size”</td>
</tr>
<tr>
<td>Compatible infrastructure requirements</td>
<td></td>
</tr>
<tr>
<td>Minimal interactions outside of the service line</td>
<td></td>
</tr>
</tbody>
</table>

### Comparable size and complexity

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Value</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff (all WTE)</td>
<td>#</td>
<td>• Common success measures with KPIs focused on theatre utilisation and operational efficiency measures as well as patient outcomes</td>
</tr>
<tr>
<td>Staff (consultants WTE)</td>
<td>#</td>
<td>• Common objective to maximise profit through optimising the use of resources while improving quality of care and safety</td>
</tr>
<tr>
<td>Budget (£m)</td>
<td>#</td>
<td></td>
</tr>
<tr>
<td>Income (£m)</td>
<td>#</td>
<td></td>
</tr>
<tr>
<td>Complexity (high/medium/low)</td>
<td>L</td>
<td></td>
</tr>
</tbody>
</table>

### Common measures of success

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Value</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common measures of success</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
### Example 2: Pathology services

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

**Clinical support services**

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dedicated beds</td>
<td>• Diagnostic services</td>
</tr>
<tr>
<td>• Outpatient facilities*</td>
<td>• Rehabilitation</td>
</tr>
<tr>
<td>• Theatres</td>
<td>• Allied health professionals</td>
</tr>
</tbody>
</table>

* Including booking system, nursing and administrative staff

**Centralised**
- Centralised as a corporate function or as a service
  - e.g. diagnostic services

**Decentralised**
- Dispersed across services
  - e.g. dedicated beds

**When reviewing where support service should sit it is important to assess**
- How many specialties use the support service?
- Who is the main user of the service? (% of activity)
- Can rules of engagement be set up to account for cross-service line use?
  - Can transfer prices be established?
  - Can income and cost be allocated according to where it is incurred?
Where the service line has the critical mass it should own the clinical infrastructure

**Pros**
- Economies of scale maximised
- Co-ordination across specialties, including best practice operations

**Cons**
- Unclear ownership of service improvements
- Potential loss of service innovations within specialties
- Lower incentives for specialties to drive service improvements

**Criteria for success**
- Clear accountability for targets
- Strong relationship with service lines for both daily operations and service developments

**Centralised**

**Decentralised**
- Greater service ownership increases incentive to maximise efficiency and utilisation
- Function customised to requirements of the service

- Scale may not be enough to ensure best use of cost base
- Unclear ownership and accountability for targets that stretch over more than one specialty
- Lack of coordination across services

- Service line has enough activity to utilise and maintain the full resources of the support service
- Inter service line arrangements for sharing resources
It is important to clarify the objective function of the service line to determine its business orientation.

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

- **Service centre:** Meet service levels at specified cost
- **Cost centre:** Meet specified service levels at minimum cost
- **Clinical services under SLM:**
  - **Profit centre:** Maximise profit
  - **Separate business:** Maximise return on investment

- **Level of business orientation**:
  - **High**
  - **Low**

- All else being equal, drive organisation as high up the spectrum as possible.
- Under SLM, most clinical services should become profit centres.
Service lines should operate according to their objective function

<table>
<thead>
<tr>
<th>Objective function</th>
<th>Requirements</th>
<th>Rationale</th>
<th>Example service lines</th>
</tr>
</thead>
</table>
| Maximise profit    | • Revenue can be measured  
                     • Full profit accountability  
                     • Decision rights can be given that increase autonomy | • Enables profit to be calculated and controlled  
                                          • Increases motivation to improve performance across  
                                          – Clinical and Quality  
                                          – Operational  
                                          – Financial  
                                          • Improves decision making at the front line with understanding and links between all elements of the service, and provides the ability to make  
                                          – Revenue/revenue tradeoffs  
                                          – Revenue/cost tradeoffs  
                                          – Cost/cost tradeoffs | • Surgery  
                                          • General medicine |

| Meet specified service levels at minimum cost | • Costs can be measured  
                                                   • External cost benchmarks are available  
                                                   • Need for cost/cost tradeoffs | • Costs must be measurable to be controllable  
                                                                  • Ensures that costs incurred in providing required service levels are of the right magnitude and that appropriate targets can be set  
                                                                  • Provides a basis for controlling costs by considering knock-on implications of reducing/expanding services provided and balancing workload between different tasks | • Theatres  
                                                                  • Pathology services |
A divisional layer should only be there when the value that it would add can be quantified

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

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

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

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

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

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

Six service lines with separate income and expenditure statements

Executive committee
Management committee
Chairman
CMD CAD
Medical board
Clinical support services managed as cost centres

Internal medicine
Cardiac
Sp. out-patient surgery
Specialty surgery
Cancer
General surgery
Clinical support services
Infra-structure support
Corporate support services

Service lines

Clinical director

- Clinical leader, with support and input from general managers
- Where the clinical complexity is low, general managers can take a larger role in the service leadership

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

Executive team

Managed networks
- Cardiothoracic
- Children’s and genetics
- Oncology and haematology
- Renal, transplant and urology
- Surgery
- Women’s services

Core clinical services
- Clinical imaging and medical physics
- Pathology
- Perioperative, critical care and pain
- Pharmacy
- Therapies

Ambulatory care
- Dental
- GUM/ HIV
- Dermatology and allergy
- Outpatients and patient support
- Specialist medicine

Acute patient services
- Acute medicine
- GI and vascular

Divisional layer
- Divisional director
  - Divisional manager
  - Divisional nurse

Service lines
- Clinical director
  - General manager
  - Divisional nurse

Specialties
- Clinical lead
  - Delivery manager
  - Head nurse
EXAMPLE divisional layer: UK district general hospital

Executive team

Diagnostic and therapy services
- Pathology
- Radiology
- Therapy

Medical
- Emergency medicine
- General medicine
- Non-acute medicine

Surgical
- Surgery, urology and ophthalmology
- Orthopaedics, ENT, plastics and orthodontics
- Anaesthesia, critical care and pre-assessment

Women’s and children’s services
- Obstetrics and gynaecology
- Paediatrics

Divisional layer
- General manager
  - Leadership group is general manager, an executive team member affiliated with the division and the clinical directors from the service lines

Service line
- Clinical director
- Service manager

ILLUSTRATIVE
EXAMPLE no divisional layer:
UK teaching hospital

Executive team

14 service lines with separate income and expenditure statements

- Critical care and theatres
- Pathology
- Emergency services
- Medicine and therapies
- Surgery
- Outpatients and imaging
- Cancer
- Heart Hospital
- Queen Square
- Women’s health
- Paediatrics
- Eastman Dental

Corporate support services

Service lines

<table>
<thead>
<tr>
<th>Clinical director</th>
<th>General manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Five PAs a week allocated to management</td>
<td>• Majority of role is focused on financial balance</td>
</tr>
</tbody>
</table>

• Clinical director and general manager partnership varies by service line

• In the process of transitioning to a leadership model with a clinical director alone
EXAMPLE No divisional layer: UK district general hospital

Executive team

Corporate functions

- A&E
- Elderly care
- Medicine
- Trauma and orthopaedics
- Surgery
- Specialist surgery
- Anaesthetics
- Obstetrics and gynaecology
- Paediatrics
- Imaging
- Pathology/pharmacy /therapies

Service lines

<table>
<thead>
<tr>
<th>Clinical director</th>
<th>General manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Define the service strategy</td>
<td></td>
</tr>
<tr>
<td>• Patient care (with matron)</td>
<td></td>
</tr>
<tr>
<td>• Consultant and clinical communication</td>
<td></td>
</tr>
<tr>
<td>• Support development of how to deliver strategy and business plans</td>
<td></td>
</tr>
<tr>
<td>• Management delivery and expertise</td>
<td></td>
</tr>
<tr>
<td>• Information transparency</td>
<td></td>
</tr>
<tr>
<td>• Directorate-wide communication</td>
<td></td>
</tr>
</tbody>
</table>

- Leadership teams include matrons / lead nurses or other relevant senior staff (e.g. lead radiographer)
- Clinical directors are expected to take a prominent role in leadership
- General managers are expected to provide ‘business’, including financial, expertise
Guiding principle: The NHS should move to a business unit structure, devolving autonomy to the front line, learning from how they have been applied in the commercial sector and translating the use to a hospital setting.

**Principles**

- Service lines should be defined using commercial business unit criteria.
- Where the service line has the critical mass it should own the clinical infrastructure.
- Service lines objective functions should be defined by their intrinsic characteristics (e.g. revenue sourcing, financial and operational dependencies, service focus).
- Service lines should operate according to their objective function, with the majority as profit centres.
- A divisional layer should only be there when the value that it would add can be quantified.

**Questions raised at trusts**

- How do we change the organisation?
- How do we get there over time?

---

**Service line structure**

- There are different options for who and how service lines are run; in all cases there should be a single point of accountability.
- Clinicians should have a prominent role in leadership.
- Leaders should exhibit competencies across people, quality, service and collaborative leadership.

**Roles**

- Decision rights should ensure service lines are empowered to drive service performance.
- A control function should be in place to alter these decision rights according to performance.

**Decision rights**

- How do we select service leaders?
- How do we build capabilities?
- How can we hold them to account?

- Where should decision rights be held?
- What are the conditions for having robust decision rights?
- How can executive teams let go in a controlled way?
Summary: Roles

• The role of service-line leader needs to be developed to create clear accountability for the integrated clinical, operational, and financial performance of the service line.

• The most important capability challenge for NHS foundation trusts in improving service-line management is engaging all of the service-line’s clinicians to take responsibility for realising the clinical, operational and financial objectives of the service line.

• There are multiple structural options available, the key is to ensure that there is a single point of accountability.

• Clinical engagement is a critical component of service-line leadership.

• A good service-line leader, clinical and managerial, exhibits leadership in four areas:
  — People leadership – taking responsibility for recruiting and developing clinicians and other staff members
  — Quality leadership – developing the service line’s quality, safety and efficiency
  — Service leadership – taking integrated responsibility for the service-line’s performance along clinical, operational, and financial dimensions
  — Collaboration – working to maximise benefits for the whole trust rather than only their own service line

• Recruitment to service-line leadership posts needs to have a clear value proposition to attract high calibre candidates.

• For the service-line leader to prosper, significant training is required regardless of the service-line leader’s background:
  — Clinical backgrounds need to demonstrate financial analysis, commissioning dynamics, and people leadership skills
  — Business backgrounds need to demonstrate ability to lead clinical efficiency development, understanding of commissioning dynamics, and people leadership skills.
### Principles: Roles

<table>
<thead>
<tr>
<th>Principle</th>
<th>From....</th>
<th>To....</th>
</tr>
</thead>
<tbody>
<tr>
<td>There should be a single point of accountability</td>
<td>“We have performance meetings and action lists but at the end of the day the executive team are accountable for delivering targets and financial stability”</td>
<td>“Accountability has been clearly defined throughout the organisation, with service-line leaders taking full ownership of the performance of their services”</td>
</tr>
<tr>
<td>Clinicians should have a prominent role in leadership</td>
<td>“General managers’ role is to balance the books while [clinicians] get on with the work”....</td>
<td>“Clinicians need to be integrally involved in service leadership to ensure the agenda strives to improve the quality of services to our patients”....</td>
</tr>
<tr>
<td>Leaders should exhibit competencies across people, quality, service and collaborative leadership</td>
<td>“There are very few people who have the needed skill set and mindset today”</td>
<td>“We have a portfolio of training programmes in place, directly linked to upskilling our staff across the four leadership dimensions....”</td>
</tr>
</tbody>
</table>
Accountability for delivering service performance at the service line can be divided into sub components.

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

Typically, this is the person thought of as “owning the process”
A single point of accountability does not necessarily require a structure with a single leader.

**Single leadership model**

- **CD** (Clinical director)
- **GM** (General manager)

**Accountability**

- Clinical director is the single point of accountability for:
  - Financial performance
  - Operational performance
  - Clinical performance

- General manager is the single point of accountability for:
  - Financial performance
  - Operational performance
  - Clinical performance

**Conditions for success**

- Managerial support for clinical director
- Sufficient time allocation in clinical director job plan
- Skills and capability development for clinical director for financial and operational elements as required
- Clear consequences for good/poor performance
- Strong clinical input into decision making and direction of travel
- Clinical director support for general manager
- General manager well-respected by clinicians
- Clear accountability for clinical governance and clinical operational performance

**Partnership leadership model**

- **CD** (Clinical director)
- **GM** (General manager)

**Accountability**

- Partnership accountability for:
  - Financial performance
  - Operational performance
  - Clinical performance

- Clinical director and general manager individually accountable for their behaviors within the partnership and successful working relationship

**Conditions for success**

- Clear consequences for both clinical director and general manager for good/poor performance
- Good working relationship within the partnership
- Priorities for the service line need to be agreed jointly
- Clear description of how decisions will be made within the partnership
- Arbitration mechanism in place for when there are disagreements between the two parties

**CD – Clinical director**

**GM – General manager**
Single leadership model

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

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

---

**What are they held to account for?**
- Clinical director is the single point of accountability for
  - Financial performance
  - Operational performance
  - Clinical performance
- Reports to the chief medical officer on a monthly basis
- Performance management regime
- Removed from role if consistent poor performance

**What are the benefits of this model?**
- High levels of clinical engagement
- Clinical focus and accountability for all aspects of service performance
- Able to respond to changing demands more quickly as one ultimate decision maker
- General mangers are very high calibre, often MBA backgrounds and specific expertise
- Appropriate support to fulfill role, with business analysis, project management expertise and dedicated support from general manager

**How are they held to account?**
- Clinical focus and accountability for all aspects of service performance
- Able to respond to changing demands more quickly as one ultimate decision maker
- General managers are very high calibre, often MBA backgrounds and specific expertise
- Appropriate support to fulfill role, with business analysis, project management expertise and dedicated support from general manager
EXAMPLE Partnership leadership model: US hospital

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

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

What are they held to account for?
- Clinical director and general manager have partnership accountability for
  - Financial performance
  - Operations including patient care, business processes and quality
  - Strategic planning and decision making
  - Performance review of section heads, administrative directors and managers

How are they held to account?
- Contract between hospital/managers and clinical leads outlining the responsibilities of each party
- Performance management regime ensures compliance
- Reward for good performance
  - Autonomy
  - Protection
  - Entitlement

What are the benefits of this model?
- Provides diversity of skills and perspectives
- Reduces over-dependence on individuals
- Requires and facilitates strong communication
- Ownership and accountability across professions
Clinicians play a prominent role in international service leadership models.

<table>
<thead>
<tr>
<th>Required service-line leadership capabilities</th>
<th>Medium</th>
<th>Role of clinician</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>People / self leadership</td>
<td>Chief clinician</td>
<td>General manager</td>
<td>Chief clinician</td>
</tr>
<tr>
<td>Quality leadership</td>
<td>Chief clinician</td>
<td>General manager</td>
<td>Chief clinician</td>
</tr>
<tr>
<td>Service leadership</td>
<td>Chief clinician</td>
<td>General manager</td>
<td>Chief clinician</td>
</tr>
<tr>
<td>Collaborative leadership</td>
<td>Chief clinician</td>
<td>General manager</td>
<td>Chief clinician</td>
</tr>
</tbody>
</table>

U.S. hospital example

U.S. heart hospital example

Norwegian hospital example

German hospital example
A good service leader exhibits leadership capabilities in four areas

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

Please see appendix for detailed assessment tool
Common skills gaps and development needs across service leaders

**People / self leadership**
- Continuously aiming for self-development
- Coaching and developing team members

**Quality leadership**
- Relying on nursing or administrative staff rather than leading initiatives to drive positive patient experiences

**Service leadership**
- Understanding drivers of financial performance
- Financial analysis
- Understanding commissioning dynamics

**Collaborative leadership**
- Communicating effectively, internal and external

**Clinical director**
- Continuous aiming for self-development
- Coaching and developing team members

**General manager**
- Inspiring people across professional boundaries
- Leading clinical efficiency development
- Understanding drivers of service performance
- Understanding commissioning dynamics
- Communicating effectively, internal and external
Service line capabilities can be realised through recruiting talent and developing current staff

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

Survey conducted across clinical directors and general managers in four trusts

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

<table>
<thead>
<tr>
<th>Incentive</th>
<th>Clinical directors</th>
<th>General managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shape future of service</td>
<td>3.7</td>
<td>3.8</td>
</tr>
<tr>
<td>Learn new skills</td>
<td>3.3</td>
<td>3.3</td>
</tr>
<tr>
<td>Shape future of the trust</td>
<td>3.0</td>
<td>3.3</td>
</tr>
<tr>
<td>Career development</td>
<td>3.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Greater remuneration</td>
<td>3.0</td>
<td>3.1</td>
</tr>
<tr>
<td>Involvement with the trust at executive level</td>
<td>2.8</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Define the “value proposition”

To attract talent there needs to be a value proposition that is tailored to the specific motivations of individuals.
Developing current staff requires a clear understanding of their development needs.

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

<table>
<thead>
<tr>
<th>Employee skill</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee will</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Lacking the required skills or experience and not keen or lacking in confidence</td>
<td>Lacking the required skill or experience, but keen to do the task</td>
</tr>
<tr>
<td>Action:</td>
<td>Direct / demote</td>
<td>Coach / train</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>Able to do the task but not keen or lacking in confidence for some reason</td>
<td>Able and keen to do the task</td>
</tr>
<tr>
<td>Action:</td>
<td>Excite / encourage</td>
<td>Retain / delegate</td>
</tr>
</tbody>
</table>

- Mapping the current members of the organisation on the matrix will help to determine the capability development programs that need to be put in place.
- The devolution of decision rights should be linked to both the capability of the individual and the performance of the service line.
Important to clearly define ‘high will/high skill’ and to link this with capability development programmes

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

- What are the ideal behaviours and competencies that would characterise high will and high skill?
- Once we understand where individuals are at present, how can we develop appropriate development programs to move towards all being in the top right?
### Input
Vision for creation, ownership and implementation of service improvements at service line

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

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

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

### Design
- Design methodology for capability development
- Support:
  - Providing additional administrative support
  - Providing additional managerial / financial / information support (dedicated or pooled)
- Mentoring / “sounding board”
- Development:
  - Coaching
  - Offering shadowing opportunities
  - Setting up ad hoc workshops
  - Creating courses with modules
  - External functional and leadership skills training courses
Guiding principle: The NHS should move to a business unit structure, devolving autonomy to the front line, learning from how they have been applied in the commercial sector and translating the use to a hospital setting.

**Principles**
- Service lines should be defined using commercial business unit criteria
- Where the service line has the critical mass it should own the clinical infrastructure
- Service lines’ objective functions should be defined by their intrinsic characteristics (e.g. revenue sourcing, financial and operational dependencies, service focus)
- Service lines should operate according to their objective function, with the majority as profit centres
- A divisional layer should only be there when the value that it would add can be quantified

**Questions raised at trusts**
- How do we change the organisation?
- How do we get there over time?

**Roles**
- There are different options for how service lines are run and by whom; in all cases there should be a single point of accountability
- Clinicians should have a prominent role in leadership
- Leaders should exhibit competencies across people, quality, service and collaborative leadership

**Decision rights**
- Decision rights should ensure service lines are empowered to drive service performance
- A control function should be in place to alter these decision rights according to performance

**Where should decision rights be held?**
- What are the conditions for having great decision rights?
- How can executive teams let go in a controlled way

- How do we select service leaders?
- How do we build capabilities?
- How can we hold them to account?
• Clearly defined **decision rights** are crucial to enable service-line managers to deliver on their objectives and to empower them to take ownership of service performance

• Clearly defined rights need to govern strategic, financial, operational and human resource decision making

• The allocation of decision rights should be based on a clear framework, acting as a frame of reference for employees at all levels
  — Decision rights concerning common, unambiguous decisions are defined in standard lists
  — In situations where the decision right is less common/unclear a framework for decision making can be used that takes into consideration the likelihood of a decision turning out to be wrong and the impact it would have

• In the first instance, an assessment confirming that the right service-line management capabilities are in place is essential before decision rights are devolved

• On an ongoing basis, levels of decision rights should be integrally linked to the performance management regime to ensure direct links between capabilities and the decision rights a service can have
### Principles: Decision rights

<table>
<thead>
<tr>
<th>Principle</th>
<th>From….</th>
<th>To….</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision rights should ensure service lines are empowered to drive service performance</td>
<td>“The decision rights the different levels of the organisation have evolved over time…there are lots of decisions that we as an executive team don’t need to be making”….</td>
<td>“Service lines feel empowered to make decisions that improve clinical, financial and operational performance”</td>
</tr>
<tr>
<td>A control function should be in place to alter these decision rights according to performance</td>
<td>“Our performance management structure does not link with our decision rights”….</td>
<td>“The level of autonomy and the kind of decision rights our service lines have are directly linked with the service and individual performance” ….</td>
</tr>
</tbody>
</table>
**What are decision rights?**

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

**For decision-making processes, it is important to define....**

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

**Leaders should also understand...**

- Who supports the process (e.g. with analysis)
- Who will be informed after the decision has been made
## Why are decision rights important?

### Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher performance</td>
<td>People are clear about what decisions/processes they are responsible for and therefore deliver more consistently against targets</td>
</tr>
<tr>
<td>Increased management pace</td>
<td>By increasing focus for individuals and clarifying who needs to be involved in reaching a decision, people are better placed to move quickly in their areas of responsibility</td>
</tr>
<tr>
<td>More accurate alignment of KPIs</td>
<td>Enables accurate assignment of KPIs to individuals, based on areas they can actually affect, i.e. have decision-making authority</td>
</tr>
<tr>
<td>Improved performance feedback</td>
<td>By creating greater clarity about what people are and are not responsible for, managers and executives quickly know where to direct their feedback</td>
</tr>
</tbody>
</table>
There are four categories that decisions fall into

**Example decisions**

**Strategic decisions**
- Develop a cancer service against network view
- Expand critical care unit
- Develop new specialist surgery service

**Clinical and operational decisions**
- Open beds temporarily to cope with emergency admissions
- Close a ward due to infection outbreak
- Condemn a piece of equipment
- Decision to revise a discharge protocol

**Financial decisions**
- Vary budget between pay and non-pay
- Lease purchase equipment from income
- Adjust service price as a result of new developments
- Replace dated equipment with new technology (value ~£1m)

**HR decisions**
- Replace consultant for an activity that may not be sustainable
- Increase in overtime to cover additional work
- Hire a temporary project manager

**Define the “decision maker”**

Starting with who should make the final decision and be the decision right owner can provide direction on who is really accountable.
## Process for assigning the decision maker

<table>
<thead>
<tr>
<th>What is the decision?</th>
<th>What is the risk?</th>
<th>How big is the impact?</th>
<th>What is the risk rating?</th>
<th>Who is the decision maker?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the decisions</td>
<td>• What is the</td>
<td>• How big an impact</td>
<td>• Where does the</td>
<td>• Who should be</td>
</tr>
<tr>
<td>— HR</td>
<td>likelihood of an</td>
<td>will the decision have?</td>
<td>decision fit in the</td>
<td>the decision-maker?</td>
</tr>
<tr>
<td>— Financial</td>
<td>adverse event?</td>
<td>— Recurring cost</td>
<td>matrix?</td>
<td>— Executive</td>
</tr>
<tr>
<td>— Clinical/</td>
<td>— Care quality</td>
<td>or revenue impact</td>
<td>— Green</td>
<td>— Division</td>
</tr>
<tr>
<td>operational</td>
<td>— Contract risk</td>
<td>— Trust employee</td>
<td>— Amber</td>
<td>— Service line</td>
</tr>
<tr>
<td>— Strategic</td>
<td>— Trust employee</td>
<td>relations</td>
<td>— Red</td>
<td></td>
</tr>
<tr>
<td></td>
<td>relations</td>
<td>— Reputition/</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Reputition/</td>
<td>external relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>external</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>relationships</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is there a</td>
<td></td>
<td></td>
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<td>potential lack</td>
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<td>of alignment with</td>
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<td></td>
<td>the trust’s</td>
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<tr>
<td></td>
<td>direction?</td>
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</tr>
<tr>
<td></td>
<td>— Overall trust</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>— Other divisions</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>— Support</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(See next page)
### Risk assessment

<table>
<thead>
<tr>
<th>Likelihood of adverse event occurring</th>
<th>Care quality</th>
<th>Contract risk</th>
<th>Trust employee relations</th>
<th>Reputation/external relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very high</strong></td>
<td>G</td>
<td>A</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>G</td>
<td>A</td>
<td>A</td>
<td>R</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>G</td>
<td>G</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>G</td>
<td>G</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td><strong>Very low</strong></td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lack of alignment with rest of trust’s direction</th>
<th>Overall trust strategy</th>
<th>Other divisions</th>
<th>Support services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>High</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Very high</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Decision right owner

<table>
<thead>
<tr>
<th>Risk level</th>
<th>Appropriate decision right owner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Red risks</strong></td>
<td>Trust executive/chief operating officer</td>
</tr>
<tr>
<td><strong>Amber risks</strong></td>
<td>Clinical division (group of service lines – only applicable in trusts with a divisional layer)</td>
</tr>
<tr>
<td><strong>Green risks</strong></td>
<td>Service line</td>
</tr>
</tbody>
</table>

#### 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

These two dimensions explained further on the next two pages.
## Decision rights

### Example – results of pilot discussions about decision rights owners (1 of 2)

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

* Framework detailed further on following pages

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### Example – results of pilot discussions about decision rights owners (2 of 2)

<table>
<thead>
<tr>
<th>Decision</th>
<th>Magnitude of impact</th>
<th>Likelihood of adverse event occurring/lack of alignment with rest of trust’s direction</th>
<th>Decision right owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replace consultant for an activity that may not be sustainable</td>
<td><strong>3</strong> Moderate</td>
<td>• 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</td>
<td>Clinical division (group of service lines)</td>
</tr>
</tbody>
</table>
| 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 | 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 | Trust executive/COO |
| | **5** Very high | • Large risk that contract volumes may not materialise, based on network view |  |
### Example of risk assessment to determine decision maker at a pharmaceutical company (1 of 2)

#### Rough estimate of magnitude of total potential present value of revenues, costs, and investments

**Scoring**
- Rated low, medium, or high (1-3)
- Rating driven largely by potential to positively or negatively impact revenues
- Only very major costs and investments (e.g. new plant) sufficient for high rating on cost/investment basis alone

#### Degree of strategic, operational, legal/compliance/regulatory, and reputation risk (i.e., relative likelihood of an undesirable outcome)

**Scoring**
- Rated low, medium, high (1-3) on each of four dimensions
  - **Strategic/business volume risk**, e.g. revenue risks from current/future products
  - **Operational risk**, e.g. manufacturing risks, quality control risks
  - **Legal/compliance/regulatory risk**, e.g. FDA reactions
  - **Reputation risk**, e.g. negative public opinion leading to effects on capital markets, employees, customers
- Overall score taken as **highest rating across four dimensions**

---

<table>
<thead>
<tr>
<th>POTENTIAL VALUE</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (~ 1bn+)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium (~ 250mn+)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**ILLUSTRATIVE**
### Example of risk assessment to determine decision maker at a pharmaceutical company (2 of 2)

<table>
<thead>
<tr>
<th>POTENTIAL VALUE</th>
<th>DEGREE OF RISK</th>
<th>DECISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (~ 1bn+)</td>
<td>Low</td>
<td>Decide to build a new plant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rationale:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• High capital investment required</td>
</tr>
<tr>
<td></td>
<td>Medium (~ 250m)</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Medium</td>
<td>Set spend / mix ratio for customers for each brand</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rationale:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Changing customer mix is a key lever for growth</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Set monthly production targets for each brand</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rationale:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Targets set and reviewed regularly at all levels</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Low risk as full performance scorecard provides sense check</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Define which products should move from phase II to phase III</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rationale:</td>
</tr>
<tr>
<td></td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
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</tbody>
</table>

**Rationale:**
- Phase III products directly impact company’s future marketed product mix and revenue streams
- High risk to future strategic direction
- High capital investment required
- Medium risk driven by operational and supply/demand assessment
- Changing customer mix is a key lever for growth
- Medium risk of missed opportunities /underinvestment in key customer groups
- Targets set and reviewed regularly at all levels
- Low risk as full performance scorecard provides sense check
### Service-line management

#### “Check-list” of the important components

<table>
<thead>
<tr>
<th>Key enablers</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>- Defined service-line structure</td>
</tr>
<tr>
<td></td>
<td>- Defined service-line leadership roles, with integrated ownership of clinical,</td>
</tr>
<tr>
<td></td>
<td>operational and financial performance</td>
</tr>
<tr>
<td></td>
<td>- Capability-linked, defined decision rights at each level (trust executive,</td>
</tr>
<tr>
<td></td>
<td>service line, and team)</td>
</tr>
</tbody>
</table>

| Strategic and annual planning | - Understanding of market and competitive position                          |
|                              | - Clear two- to three-year strategy and relevant annual objectives          |
|                              | - Detailed and quantified action plan to deliver strategy                   |
|                              | - Robust annual planning process                                           |
|                              | - Levels of autonomy linked to quarterly monitoring regime                  |

| Performance management      | - Clear KPIs, targets and accountabilities                                  |
|                            | - Performance tracking                                                     |
|                            | - Effective review meetings                                                 |
|                            | - Good performance conversations                                            |
|                            | - Rewards and consequences for performance                                  |

| Information support        | - Relevant, timely information                                              |
|                            | - Patient level costing                                                     |
Summary: service-line strategy and annual planning

• Historically, service lines often inherited targets they didn't agree with as a result of top-down driven strategic/annual planning and targets

• Service lines should develop their own strategies since they are best positioned to identify their specialties' opportunities and threats and their impact on the trust’s future performance, and to encourage their staff to focus their efforts better and feel greater accountability.

• Service-line strategy should be derived from the service line’s two- to three-year vision, which should in turn align with the trust’s vision.

• Once the strategy has been clearly defined, it should be translated into specific short term strategic objectives in the annual planning process.

• Service lines own their annual plans, although they should be created through executive level guidance and bottom-up plans to reach agreed-upon targets and objectives.

• Service lines must have a detailed understanding of their current performance (clinical, financial and operational) and external market factors (demand growth, competitive position, etc) in order to develop a two- to thee-year strategy and translate it into annual strategic objectives. This includes robust forecasting of demand and competition to identify the best growth options.

• A robust action plan (with clear responsibilities, milestones and monitoring) should be developed to support the agreed annual strategic objectives

• At the end of each year, objectives should be reviewed and refreshed to ensure that the long-term strategy can be ultimately achieved within the agreed timeframe.
To capture the benefits of strategy and annual planning, trusts will need to change some behaviours

**From**

- No formal service-line strategy
- Service-line annual plans primarily developed by management, with variable levels of clinical input
- Service-line targets not cascaded to specialty level
- No formal action plans to deliver strategy at service-line level
- Last year’s budgets are “rolled over” to the following year

**To**

- Service lines develop their own clear strategic objectives, aligned with the trust’s vision.
- Service-line targets clearly cascade to specialty level and take into account each specialty’s position and priorities
- Detailed action plans with leads, impact and risk assessment, milestones and progress tracking process
- Budgets are built bottom-up with strong clinician engagement
- Targets are based on a detailed understanding of current performance, strategic objectives and appropriate external benchmarks
Strategy and annual planning are tools for translating vision into action in the medium and long term.

**Vision / aspirations**

- Strategy
  - Annual objectives
    - Action plan required to deliver objectives

**Time horizon**

- 3 to 5 years at trust level
- 2 to 3 years at service-line level
- 12 months
Developing service-line strategy and linking it to the annual planning process is a six-step approach

1. **Define vision for the service line**
   - Define clear vision at service-line level as essential input for strategy and annual planning process

2. **Understand the current position**
   - Gather key data — internal — external
   - Develop insights on strengths and weaknesses of the service

3. **Anticipate internal / external changes**
   - Anticipate changes in demand (new demand from PCT, new guidelines,…) 
   - Anticipate changes in internal resources 
   - Anticipate changes in external supply (technological breakthroughs, new competitors, emerging…)
   - Identify major opportunities for growth and areas to exit / reduce emphasis

4. **Set 2-3 year objectives and targets**
   - Based on the service performance analysis and the trust’s vision, define key service objectives for the next two to three years
   - For each objective, agree on a target with the service

5. **Translate into annual objectives and targets**
   - Translate long-term objectives in annual objectives over the period considered
   - Assign annual targets to make sure the long-term target is achieved by the end of the strategic plan period

6. **Define annual action plan and budget**
   - For each annual objective, define list of actions required to reach the agreed upon target
   - Assess impact, feasibility and cost of each action; prioritize accordingly
   - Assign project lead for each validated action and develop detailed implementation plan

At the end of year: refresh strategy and set new annual plan

- Assess actual performance against plan
- Assess expected changes in demand / supply
- Refresh two-three year strategic plan accordingly
- Develop new action plan and budget
The service line’s vision should be driven by trust’s vision, while objectives and targets should result from constructive negotiation.

- **Trust vision**
- **Trust strategy (three to five years)**
- **Trust annual objectives and targets**
- **Top-down cascade and bottom-up plan negotiations**

- **Service line’s vision**
- **Service line’s strategy (two to three years)**
- **Service line’s annual objectives and targets**

- **Annual action plan**
- **Annual budget**
Trust vision is to:

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

The ophthalmology service aims to:

- Provide excellent and comprehensive clinical care for the population we serve
- Maintain status as the provider of choice for the local population
- Maintain a firm financial basis for the service
- Continue to meet national standards for care (clinical and waiting times)
- Continue to develop an outstanding workforce that is equipped to provide high quality eye care to patients
A robust service-line strategy needs to be informed by rigorous analysis of the current situation

<table>
<thead>
<tr>
<th>Performance</th>
<th>Demand</th>
<th>Competition</th>
<th>Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What is the operating, financial, and quality performance of the service line?</td>
<td>• What is the catchment area for the service?</td>
<td>• What is the relative attractiveness of different specialties within the service line?</td>
<td></td>
</tr>
<tr>
<td>• How does this compare to relevant national benchmarks?</td>
<td>• How will demand for services change over time?</td>
<td>• What are the major threats and opportunities?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• How much of the additional demand could the service line capture and deliver?</td>
<td></td>
<td>• Which are our more valuable services in strategic and financial terms?</td>
</tr>
<tr>
<td></td>
<td>• Who are the major competitors?</td>
<td>• Which are our least attractive services in terms of performance and outlook?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Is our market share rising or falling?</td>
<td>• What should we do about this? e.g.</td>
<td>• Protecting and / or developing most valuable services</td>
</tr>
<tr>
<td></td>
<td>• How are we positioned relative to competitors?</td>
<td>— addressing market pressures and performance issues (quality, operating, financial) in least attractive services</td>
<td></td>
</tr>
</tbody>
</table>
Current performance and potential improvement help model future financial performance

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

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

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

<table>
<thead>
<tr>
<th>Action</th>
<th>Key tasks and analyses</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the service line’s vision</td>
<td>• Determine the service line’s aspirations</td>
<td>• Ensure clinicians’ views on the future outlook and future direction of the service line are addressed</td>
</tr>
<tr>
<td>Determine main strategic direction</td>
<td>• Assess the implications of the information collected (service performance, market position, clinical and activity/financial outlook) for the future of each service</td>
<td>• Ensure the insights and analyses of the previous stage directly inform the trust’s imperatives for the service portfolio</td>
</tr>
<tr>
<td>Generate strategic options</td>
<td>• Identify the initial set of potential options to meet the selected strategic direction</td>
<td>• Ensure that agreed strategic direction get translated into a set of concrete options for the service line</td>
</tr>
<tr>
<td></td>
<td>• Translate each option into a coherent set of strategic initiatives with expected impact on the service line</td>
<td>• Ensure that each proposed option is translated into a specific action plan</td>
</tr>
</tbody>
</table>
Services can be positioned in a strategic portfolio matrix to help define options:

- **Services with low volume but high profitability** should be expanded through increase in overall market share.
  - **Action**: Develop

- **Services with high volume and high profitability** should be protected through effective partner management (GPs) and clinical/operational excellence.
  - **Action**: Protect

- **Services with low volume and low profitability** consider divestment and/or working with other trusts to reconfigure services and/or improve efficiency.
  - **Action**: Reduce emphasis

- **Services with high volume but low profitability** should be turned around as soon as possible as single improvement on productivity will have great impact on the service line.
  - **Action**: Improve
# How to evaluate the options

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

**Trust’s vision and targets for the service line**

<table>
<thead>
<tr>
<th>Service line’s vision</th>
</tr>
</thead>
</table>

### Strategic objectives

<table>
<thead>
<tr>
<th>Key objective 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key objective 2</td>
</tr>
<tr>
<td>Key objective 3</td>
</tr>
<tr>
<td>Key objective 4</td>
</tr>
<tr>
<td>Key objective 5</td>
</tr>
</tbody>
</table>

### Benefits

<table>
<thead>
<tr>
<th>Patient care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
</tr>
<tr>
<td>Staff</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

### Main risks

<table>
<thead>
<tr>
<th>Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>
## Translating strategic option into annual objectives is key to drive action at service-line level

<table>
<thead>
<tr>
<th>Priority</th>
<th>Strategic option</th>
<th>Examples of annual objectives</th>
</tr>
</thead>
</table>
| +        | PROTECT          | • Maintain high clinical outcomes and patient satisfaction  
|          |                  | • Cultivate referrals / market to GPs and PCTs |
| -        | IMPROVE          | • Improve operations (e.g. LoS, theatre utilization)  
|          |                  | • Modify case mix (daycase, inpatient, outpatient)  
|          |                  | • Reconfigure service delivery model  
|          |                  | • Improve productivity (lean) |
| -        | DEVELOP          | • Grow referrals from current GPs  
|          |                  | • Add new appointments  
|          |                  | • Increase reach by attracting GP practices not currently referring to our service  
|          |                  | • Set up marketing program |
| -        | REDUCE EMPHASIS  | • Shift care to another care centre  
|          |                  | • Make an explicit decision to cross-subsidise if required |
## Choosing an approach to target setting will depend on the specific situation

<table>
<thead>
<tr>
<th>Approach</th>
<th>Description</th>
<th>Benefits</th>
<th>Is this approach appropriate?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Limit based</strong></td>
<td>• Targets are set based on the limits of the system (e.g. if operating theatre late starts were eliminated)</td>
<td>• Highlights specific operating issues</td>
<td>• Can we identify the areas we need to change to improve our performance?</td>
</tr>
<tr>
<td></td>
<td>• Targets need to be updated only when the system changes</td>
<td>• Drives rapid pace of improvement</td>
<td>• Do we know how the suggested changes will affect the performance indicators of the service?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Is the analysis practical and easy to understand?</td>
</tr>
<tr>
<td><strong>Aspiration based</strong></td>
<td>• Targets are based on aspirations of the team</td>
<td>• Stretches people and encourages to think creatively about how to close the performance gap</td>
<td>• Are external or internal benchmarks available?</td>
</tr>
<tr>
<td></td>
<td>• Often derived from internal or external benchmarks</td>
<td></td>
<td>• Are comparisons to benchmark groups (e.g. other trusts) valid?</td>
</tr>
<tr>
<td><strong>Capability based</strong></td>
<td>• Targets are set based on the current capabilities of people, i.e. if they were working at their demonstrated best, what would output be?</td>
<td>• Drives improvement at a manageable pace</td>
<td>• Do we need to adjust benchmark figures to make them comparable to our measures?</td>
</tr>
<tr>
<td></td>
<td>• Targets need to be updated frequently as capabilities improve</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Examples of each target setting approach**

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

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

## Key components

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

## Resources needed

### Workforce
- Change in responsibilities
- Training of ED staff
- Appointment of sufficient staff to run triage system and primary care clinics

### Estate
- Potential need for new room for community clinics

### IT
- Potential telemedicine link to community practitioners to allow remote diagnosis/appropriate triage

### Finance
- Appointment of new staff for triage and primary care clinics
Implementation plan example

Each objective has a lead for follow-up and an agreed upon target date for completion

1. New cataract list
2. Delay reduction in follow-up visits
3. AMD service on Fridays
4. Purchase of Medisoft
5. Primary care clinic in the community
6. New minor theatre
7. VR surgery as daycase
8. EM care refocused into planned urgent clinics
9. Staff trained and engaged in service improvement

<table>
<thead>
<tr>
<th>Clinical lead</th>
<th>July 07</th>
<th>Nov 07</th>
<th>July 08</th>
</tr>
</thead>
<tbody>
<tr>
<td>xxx</td>
<td></td>
<td></td>
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<tr>
<td>xxx</td>
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<td>xxx</td>
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<tr>
<td>xxx</td>
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<td></td>
</tr>
</tbody>
</table>

- Clinicians engaged in defining the objectives and setting the targets
- Agreed upon milestones for coming three, six and twelve months
- All objectives followed up by clinical leads, from action planning to implementation
Each objective needs to be quantified in terms of costs and expected impact, and risks should be assessed.

- Expected cost
  - XXX
  - XXX

- Clinical quality
  - XXX
  - XXX

- Finances
  - XXX
  - XXX

- Staff satisfaction
  - XXX
  - XXX

- Potential risks (and mitigation actions)
  - XXX
  - XXX
A clear and robust annual planning cycle needs to be in place to effectively assess past performance and refresh strategy.
Sufficient time needs to be allocated for the process to allow for relevant input, syndication, communication and buy-in.

Example from a transportation company

<table>
<thead>
<tr>
<th>Formal planning sessions</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Leadership off-site</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Three year strategy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Annual operating plan (AOP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• HR plan (HRP)</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Performance management

• Scorecard review
• Mid-year CEO review
• Monthly scorecard reports

Divisional meetings

• Senior staff
• Management board
• Operating committees

Corporate level meetings

• Board of directors meeting
• Earnings release/analyst calls
• Annual analyst meeting

ILLUSTRATIVE

- Reports
- Meetings

Comments

- Set corporate direction;
- Three-year view
- Operating unit/functional-level; Conduct in group meeting
- Present and discuss plan/targets; finalise AOP/scorecards for November senior staff meeting
- Working sessions to “run the company”
- Mid-year review includes AOP and HRP
- Agenda driven (held if necessary)
- Annual shareholder meeting in May
Successfully meeting agreed targets in the balanced scorecards should enable service lines to earn autonomy.

### Balanced scorecard

#### Service line performance scorecard

<table>
<thead>
<tr>
<th>Financial / growth</th>
<th>Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring we have the overhead we need to invest in our services</td>
<td>Using our resources in an efficient way by working smarter</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing the best quality of care to our patients</td>
<td>Keeping our staff motivated and providing them with the support needed</td>
</tr>
</tbody>
</table>

### Degree of autonomy earned – dependent on performance

- **Low risk**
  - Reduced monitoring
  - Weight as required
  - Green

- **High risk**
  - Increased monitoring
  - Red

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

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Low risk service line</th>
<th>Medium risk service line</th>
<th>High risk service line</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Once every one to two months</td>
<td>Once a month</td>
<td>Once a month, or more frequently if needed</td>
</tr>
<tr>
<td>Length</td>
<td>One- to two-hour meeting</td>
<td>Two- to three-hour meeting</td>
<td>Half-day meeting</td>
</tr>
<tr>
<td>Content</td>
<td>• Service-line management (SLM) describes performance against key targets — If deviations from plan, SLM qualitatively explains plan to get back on track</td>
<td>• SLM describes performance against key targets and progress on actions agreed in previous meetings — If deviations from plan, SLM needs to describe in detail — Root causes — Actions for how to get back on track</td>
<td>• SLM describes performance against key targets and progress on actions agreed in previous meetings — If deviations from plan, SLM needs to describe in detail — Quantified impact of each root cause — Actions for how to get back on track — Estimated impact from each action — Who is responsible for each action</td>
</tr>
</tbody>
</table>
Consequently, a number of questions need to be considered when implementing or optimizing service-line annual planning.

**Organisation**
- What autonomy/decision rights are we prepared to concede to service-lines?
- What are the respective roles of our clinical leads and general managers in making decisions about the management of service-lines?
- What incentives (financial or otherwise) will we provide to service-lines to drive performance (at individual or group level)?
- What is required from human resources?

**Strategic and annual planning process**
- To what extent/how do we use information about profitability to make decisions at the service or trust level (e.g. investment decisions, service developments, strategic moves)?
- How do we ensure service-line plans are linked to overall trust objectives?
- What should be the EBITDA targets for the different services?
- To what extent will we explicitly use some services to cross-subsidise others?
- Who needs to be involved in the annual planning process at the service-line level?

**Performance management**
- How will the board use service-line reporting information to manage the trust and individual service-lines?
- How will we track service-line performance against initiatives?
- What organisational culture changes are required to support the new approach?

**Information support**
- What information and standardised reports are required to facilitate the use of profitability in the management of service-lines?
- How often do we need to see information on profitability (as opposed to budgets)?
- What systems are needed to produce the required information in a timely manner?
- What analytical capability is required to support service-line reporting?
Service-line management

Key enablers

“Check-list” of the important components

1. Organisation
   - Defined service-line structure
   - Defined service-line leadership roles, with integrated ownership of clinical, operational and financial performance
   - Capability-linked, defined decision rights at each level (trust executive, service line, and team)

2. Strategic and annual planning process
   - Understanding of market and competitive position
   - Defined three- to five-year strategy and annual objectives
   - Action plan to deliver strategy
   - Robust annual planning process
   - Levels of autonomy linked to quarterly monitoring regime

3. Performance management
   - Clear KPIs, targets and accountabilities
   - Performance tracking
   - Effective review meetings
   - Good performance conversations
   - Rewards and consequences for performance

4. Information support
   - Relevant, timely information
   - Patient level costing
Summary: Performance management

- Performance management is a set of tools and processes that create transparency and accountability around the progress against specific objectives within an organisation.

- The first step in a robust performance management regime is establishing clear KPIs, targets and accountabilities. KPIs and targets should be balanced across clinical, operational, financial and staff dimensions.

- The overall KPIs and targets for the trust should be established by the board of directors, and individual service lines should develop their own KPIs and targets within this context. These are usually agreed as part of the annual planning cycle.

- Once KPIs and targets are established, it is imperative that they are tracked and monitored regularly. Trusts will need to ensure they have both the appropriate IT infrastructure and human resources to track performance.

- Regular performance reviews at all levels in the trust are necessary to drive performance improvement. These should be regular, scheduled meetings with clear terms of reference.

- The mindsets of participants is critical during performance reviews. Performance conversations should focus on identifying root causes rather than symptoms, and participants should be focused on how performance can be improved rather than casting blame or challenging the data and methodology.

- It is important to reinforce desirable behaviours with rewards and consequences for performance. Incentives should be team as well as individually based, and should always be tied to performance.
A well-functioning performance management system is an essential component of effective service-line management.

What is a performance management system?

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

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

What does a performance management system offer?

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

**Service**
- Challenging performance aspiration, articulated in terms of specific goals
- Open recognition of good performance and clear actions for poor
- Problem solving and action orientated

**People**
- Clear accountability for every area of performance
- Coaching and two-way feedback discussions, long-term focus on capability and career development
- Mindsets and behaviours that support effective performance management

**Clear direction for organisation, actively communicated**

1. **Clear KPIs targets and accountabilities**
   - Underpinned by active communications
   - The right performance tracking
   - Effective review meetings
   - Good performance conversations
   - Reward and renewal

2. **Service**
   - Translation of service direction and objectives into clear, key performance indicators (KPIs)

3. **Service**
   - Clear, sequenced calendar of performance review meetings with appropriate attendance

4. **People**
   - Regular formal and informal appraisals

5. **People**
   - Underpinned by active communications

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This document focuses on the service elements of performance management

Performance management regime

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

People: What are the capabilities of the service leaders?
- What performance level will trigger concern?
- How can it be managed?
- What action should the trust take to build and maintain capabilities?
- How will frequency and level of monitoring and the decision rights of a service line be altered accordingly?
To capture the benefits of performance management, trusts will need to change some behaviours

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

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

1. Trust’s vision translated into balanced set of trust level KPI targets
2. Trust level KPI targets broken down to service-line and team KPI targets
3. Service-line and team targets linked to action planning
4. Targets and action plans linked to accountabilities through performance contracts
# The trust’s strategic objectives should drive a balanced scorecard of KPIs

## Trust’s three- to five-year goals

<table>
<thead>
<tr>
<th>Quality</th>
<th>Balanced scorecard</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Be in top quartile in patient safety</td>
<td>Financial and growth</td>
</tr>
<tr>
<td>• Be in top decile for lowest length of stay</td>
<td>Efficiency</td>
</tr>
<tr>
<td>• Be in the top decile for lowest HCAI rates</td>
<td>Providing the best quality of care to our patients</td>
</tr>
<tr>
<td>• Year on year increase in market share of 2%</td>
<td></td>
</tr>
<tr>
<td>Finances</td>
<td></td>
</tr>
<tr>
<td>• Deliver a year on year surplus</td>
<td></td>
</tr>
<tr>
<td>• Grow elective general surgery procedures by 5% year on year</td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td></td>
</tr>
<tr>
<td>• Report to Referrer on the day on 90% of occasions</td>
<td></td>
</tr>
<tr>
<td>• Be in top decile for day case rates</td>
<td></td>
</tr>
<tr>
<td>• Deliver 5% year on year productivity improvement</td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td>• Staff retention rate in top quartile</td>
<td></td>
</tr>
<tr>
<td>• Sickness absence below 2%</td>
<td></td>
</tr>
<tr>
<td>• Increase Band 4s by 5% every year</td>
<td></td>
</tr>
</tbody>
</table>

## Financial and growth

### Ensuring we have overhead to invest in our services
- Profit per FCE
- Number of new PCT/GP relationships
- Average share of referrals from target PCTs/GPs
- Outpatient market share
- Admissions growth

## Efficiency

### Using our resources in an efficient way
- Nursing hours/patient day
- ALoS
- Bed utilisation
- Theatre utilisation
- Cancellation rates
- Coding completeness within x days

## Quality and patient satisfaction

### Providing the best quality of care to our patients
- Satisfying Healthcare Commission’s overall criteria
- Patient satisfaction
- Waiting time
- Complaints/100 visits
- Infection rate
- Five-year survival rate

## Staff

### Keeping our staff motivated and supporting them
- Staff satisfaction survey
- Voluntary turnover
- Appraisals complete
- Sickness and absence
- Vacancies

---

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

KPIs should define the critical elements of success . . .

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

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

© Monitor November 2007
### KPIs should be clearly defined

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

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

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.

Horizontal counterbalance

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

Example of an orthopaedics service performance scorecard

<table>
<thead>
<tr>
<th>Financial and growth</th>
<th>Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring we have the overhead we need to invest in our services</td>
<td>Using our resources in an efficient way by working smarter</td>
</tr>
<tr>
<td>• Contribution margin</td>
<td>• Theatre utilisation rate</td>
</tr>
<tr>
<td>– Cost/spell</td>
<td>• Late theatre starts</td>
</tr>
<tr>
<td>– Income/spell</td>
<td>• Nursing hours per patient day</td>
</tr>
<tr>
<td>• Activity numbers</td>
<td>• Cancellation rate</td>
</tr>
<tr>
<td></td>
<td>• ALoS</td>
</tr>
<tr>
<td></td>
<td>• Day of surgery admission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality and patient satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing the best quality of care to our patients</td>
</tr>
<tr>
<td>• Infection rates</td>
</tr>
<tr>
<td>• Readmission rates</td>
</tr>
<tr>
<td>• Number of complaints</td>
</tr>
<tr>
<td>• Clinical incidents</td>
</tr>
<tr>
<td>• Mortality</td>
</tr>
<tr>
<td>• Overall patient satisfaction</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping our staff motivated and providing them with the support needed</td>
</tr>
<tr>
<td>• Training attended</td>
</tr>
<tr>
<td>• Sickness and absence by staff group</td>
</tr>
</tbody>
</table>

• Service-line KPIs should be aligned with trust KPIs (as service-line objectives are aligned with trust’s objectives) but should be set by the service line

• As many people as possible from the service line should contribute to setting the KPIs

• Doctors, nurses, managers and others can prioritise the most relevant KPIs for the service line once they understand the drivers of performance in their service line
There are minimum requirements for performance tracking, but local flexibility is also important.

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

I. Develop and use efficient data collection processes
   - Automatic collection
   - Semi-automatically collection
   - Manual collection

II. Develop a data storage and management solution
   - Central database
   - Production data
   - Cost data
   - Health/safety data
   - Quality data
   - Reports

III. Report SL performance using hierarchy of reports with consistent format
   - Trust level
   - Service-line level
   - Team level
A very simple tool can be developed to track KPIs:

KPIs are grouped into trust’s strategic priority themes.

Units in which KPI is measured.

Targets are agreed with trust exec.

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

Comparing this month’s and last month’s figures helps to understand last month’s trend.

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

Trend indicates if KPI has improved or worsened during the last month. (status might be green even if performance is deteriorating.)
A ‘heatmap’ can give the executive a quick overview of performance across the trust.

Trust level KPIs are cascaded to service-line level. Each service line’s performance is compared to its own targets and colours are set accordingly.
### Clearly specify target and linked initiatives

<table>
<thead>
<tr>
<th></th>
<th>Current average</th>
<th>Base target</th>
<th>Stretch target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theatre operating hours:</strong></td>
<td>2,254</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total T&amp;O available hours:</strong></td>
<td>4,508</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Utilisation, %</strong></td>
<td>50</td>
<td>60</td>
<td>65</td>
</tr>
<tr>
<td><strong>Time not operating</strong></td>
<td>2,254</td>
<td>1,803</td>
<td>1,578</td>
</tr>
<tr>
<td><strong>Hours gained</strong></td>
<td></td>
<td>451</td>
<td>676</td>
</tr>
<tr>
<td><strong>Cost of non op time</strong></td>
<td>714,654</td>
<td>571,724</td>
<td>500,258</td>
</tr>
<tr>
<td><strong>Est. cost savings (£)</strong></td>
<td>142,931</td>
<td>214,396</td>
<td></td>
</tr>
</tbody>
</table>

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

### Define owner with single-point point accountability

- **Key owner:** Ms. XXXX XXX
- **Estimated date of completion of initiatives:** YYYY-MM-DD
  
- **Key milestones**
  1. XXXXXXX
  2. XXXXXXX
  3. XXXXXXX

### Integrate into performance contract
Targets and action plans should be linked to accountabilities through performance contracts

Key components of a performance contract within a health care context

KPIs
- A ‘balanced scorecard’ of approximately six to eight metrics covering both hospital wide and service-line specific targets:
  - Key outputs (clinical, research and teaching)
  - Quality standards (e.g. MRSA rates)
  - Operational standards (e.g. length of stay)

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

Initiatives with key milestones

<table>
<thead>
<tr>
<th>Service development initiative 1</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>∆</td>
<td></td>
<td>∆</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service development initiative 2</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>∆</td>
<td>∆</td>
<td>∆</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process improvement initiative 1</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>∆</td>
<td>∆</td>
<td>∆</td>
<td>∆</td>
</tr>
</tbody>
</table>

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

### Service performance targets

<table>
<thead>
<tr>
<th>Area</th>
<th>Metric</th>
<th>Last year</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Infection rates</td>
<td>X%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical incidents</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overall patient satisfaction</td>
<td>X%</td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td>Theatre utilisation rate</td>
<td>X%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ALOS</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Finance</td>
<td>Contribution margin</td>
<td>X%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Activity numbers</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td>Turnover</td>
<td>X%</td>
<td></td>
</tr>
</tbody>
</table>

### Personal development targets

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Specific goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>People Leadership</td>
<td></td>
</tr>
<tr>
<td>Quality Leadership</td>
<td></td>
</tr>
<tr>
<td>Service Leadership</td>
<td></td>
</tr>
<tr>
<td>Collaborative Leadership</td>
<td></td>
</tr>
</tbody>
</table>

### Executive lead

- Signature
- Date

### Service-line leader

- Signature
- Date

© Monitor November 2007
### Things to do

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

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

There should be a clear and consistent sequence of meetings

There should be clear terms of reference for meetings
The cascade of meetings allows for problem-solving and actions to be generated by the care groups.

Interaction between each level ensures that everyone is working towards a consistent set of objectives.

Timing of the meetings will be informed by the frequency of performance reviews required by executive. Frequency of performance reviews required by executive will be determined by risk rating and annual planning process.

Local team meetings – e.g. Ward round, Consultant meeting, Management meetings.

Scorecards and reports from each team.

Issues are identified and addressed at the team level.

Meeting
Supporting materials
### The objectives and scope of the meetings is different

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Attendees</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Board review</strong></td>
<td>Executive and non-exec directors</td>
<td>• Review hospital operational performance, challenge and problem solve actions being proposed to address problems&lt;br&gt;• Address cross-functional issues</td>
</tr>
<tr>
<td><strong>Performance review meetings with exec team</strong></td>
<td>Service-line clinical director, service-line general manager, medical director, director of nursing and operations</td>
<td>• Follow-up on agreed actions&lt;br&gt;• Review service line situation, challenge and problem solve actions being proposed to address problems&lt;br&gt;• Develop integrated view of hospital performance including identifying cross-service line issues</td>
</tr>
<tr>
<td><strong>Service-line leadership meeting</strong></td>
<td>Service-line clinical lead Service-line general manager Service-line head nurse</td>
<td>• Follow-up on actions agreed at last meeting&lt;br&gt;• Review current situation, challenge and problem solve actions being proposed to address problems within teams&lt;br&gt;• Agree integrated view of current service line performance and any issues needing to be resolved at next level</td>
</tr>
<tr>
<td><strong>Local team meetings</strong></td>
<td>Various, e.g. ward staff, nurse management, consultants</td>
<td>• Understand main drivers of performance and come up with actionable steps to improve under performance&lt;br&gt;• Maintain daily services and ensure all operational issues are addressed&lt;br&gt;• Agree key messages for service-line leadership team</td>
</tr>
</tbody>
</table>
Clearly define terms of reference for effective performance review meetings

**Objectives**
- To agree on how to develop service-line X’s performance further and how it will influence strategy and performance

**Participants**
- CEO
- Finance director
- Strategy director
- Service-line head
- Key function heads as required

**Inputs**
- Monthly performance report
- Papers for two or three agenda items (5-10 Powerpoint pages each)

**Performance review agenda**
- Introductory remarks
- Update on actions from last month
- Discussion of monthly performance report
- Discussion of key issues
- Debrief

**Outputs**
- Actions (memo from CEO to service line)
- Minutes
- Synthesis for executive board
- Debrief – how can we make the meetings more effective?
To hold a good meeting the chair has to ask the right questions to understand and challenge performance

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

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

## Example

<table>
<thead>
<tr>
<th>Why?</th>
<th>Principle to apply</th>
</tr>
</thead>
</table>
| • Ensure that actions agreed at the previous meeting were taken and evaluate success of these actions  
• Outline key three to four issues (e.g. red KPIs or declining trend) for the department overall and understand how teams can help addressing these  
• Review each team’s performance and proposed actions (help with solutions, where needed)  
• Agree on key messages to be highlighted at the performance review with ops director | • Ensure all participants understand the objectives of the meeting |

| Who? | | Chair and challenge  
Report/take minutes  
Support  
Attend  
Attend |
|------|-------------|-------------------|
| • CD/DM  
Team lead(s)  
Finance manager  
Other clinicians, as required  
Info analyst, as required | • Target your communication to the audience  
• Ensure the relevant people attend or are represented |

<table>
<thead>
<tr>
<th>What?</th>
<th>How?</th>
</tr>
</thead>
</table>
| • Service-line scorecard for the month (with supporting data)  
• Service-line report from the previous month  
• Reports from current and previous month from each team  
• Scorecards for the current month from each team  
• Financial unit cost report | • Departmental report and agreed actions with clarity of responsibility / timescale  
• Share the information in the shortest possible time and with enough time to make the change  
• Send the information as pre-read where possible  
• Focus the agenda on problem solving and getting in put rather than on reports  
• Could the objectives be met without having a meeting? |
Example meeting preparation: Performance review with service line and executive team

Before the meeting

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

During the meeting

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

After the meeting

- Ensure summary of meeting and action plan is circulated to all meeting participants
- Send summary to service-line teams celebrating successes and highlighting next steps / action plan
- Work with team members as applicable to complete actions
- Review progress against action plan regularly
### Actions result must be clearly defined in terms of ownership and time

<table>
<thead>
<tr>
<th>Actions must have…</th>
<th>Say this…</th>
<th>… not this!</th>
</tr>
</thead>
<tbody>
<tr>
<td>… a single owner</td>
<td>“John, take this as an action”</td>
<td>“So, people, that report will be finished, right?”</td>
</tr>
<tr>
<td>… a deadline</td>
<td>“By the end of next Thursday”</td>
<td>“We just need to get it done”</td>
</tr>
<tr>
<td>… a clear definition of success</td>
<td>“This should improve theatre utilisation by 5–10%”</td>
<td>“That should do the job”</td>
</tr>
<tr>
<td>… an explicit reporting mechanism</td>
<td>“we will review this action at the next meeting”</td>
<td></td>
</tr>
<tr>
<td>… authority transfer</td>
<td>“Get Paula and Richard to help you, and anyone else you need”</td>
<td>“Do what you gotta do”</td>
</tr>
<tr>
<td>… understanding and commitment</td>
<td>“So, John, what was your action?”</td>
<td>“Everybody clear? Great”</td>
</tr>
</tbody>
</table>

Actions, agreed owners and timelines should always be recorded to allow follow up. Common tracking mechanisms are:
- Minutes from the meeting
- Team report
Constructive feedback steps

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

Giver (e.g. clinical director)
- Describe concrete **observation**
- Explain **effects** on you/others/the meeting
- **Pause and listen** for clarifying questions
- Give concrete **suggestion** on what you would do differently

Receiver (e.g. consultant)
1. **Listen** without interrupting
2. Avoid arguing or defending
3. **Probe** to ensure you understand
4. **Thank** the giver
Individual skills, mindsets and behaviours in meetings have to reinforce continuous improvement mentality.

As negative behaviours are often quite a natural response to performance conversations, instilling positive behaviours requires a cultural change.
Review effectiveness of meetings to make continuous improvements

Agenda

The agenda is....

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

1. Chair starts discussion with perspective on month's performance  
2. Root cause 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

Positive and constructive approach

1. People volunteer versus are volunteered for actions (use boxes to count occurrences of each)  
2. All participants contribute  
3. ‘Quiet’ participants brought into discussion  
4. Respect shown for all ideas even where others disagree

<table>
<thead>
<tr>
<th>Volunteer</th>
<th>Volunteerled</th>
<th>Yes</th>
<th>Partly</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Box" /></td>
<td><img src="image2" alt="Box" /></td>
<td><img src="image3" alt="Box" /></td>
<td><img src="image4" alt="Box" /></td>
<td><img src="image5" alt="Box" /></td>
</tr>
</tbody>
</table>
There are minimum requirements for rewards and consequences, but local flexibility is also important.

<table>
<thead>
<tr>
<th>Things to do</th>
<th>Minimum requirement</th>
<th>What you should define</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rewards and consequences should be linked performance</td>
<td>• Transparent links between performance and consequences</td>
<td>• Specific packages of financial and non-financial rewards and consequences</td>
</tr>
<tr>
<td></td>
<td>• Incentives designed to encourage behaviours you want to promote</td>
<td></td>
</tr>
<tr>
<td>Team as well as individual rewards</td>
<td>• Rewards and consequences which promote good team behaviours and recognise whole team contributions to the success of service lines</td>
<td>• Balance between team and individual rewards</td>
</tr>
<tr>
<td>Collaborative approach to ensure trust cohesion</td>
<td>• Trust has considered balanced mechanisms to avoid silos</td>
<td>• Specific incentives for trust-wide outlook</td>
</tr>
</tbody>
</table>
Performance against scorecards will drive incentives, which should be individual as well as team-based

<table>
<thead>
<tr>
<th>What to incentivise (service-line scorecards)</th>
<th>How and who to incentivise</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial</strong></td>
<td><strong>Individual</strong></td>
</tr>
<tr>
<td>Financial indicators – e.g.</td>
<td>• “Star performer”</td>
</tr>
<tr>
<td>• EBITDA</td>
<td>development schemes</td>
</tr>
<tr>
<td>• Cost per spell</td>
<td>(e.g. mentoring)</td>
</tr>
<tr>
<td>• Revenue per spell</td>
<td>• Additional annual leave</td>
</tr>
<tr>
<td><strong>Operational</strong></td>
<td>• Development / project</td>
</tr>
<tr>
<td>Indicators of operational</td>
<td>management opportunities</td>
</tr>
<tr>
<td>efficiency – e.g.</td>
<td>• Preferential access to</td>
</tr>
<tr>
<td>• Nurse hours per patient day</td>
<td>surgery lists</td>
</tr>
<tr>
<td>• Theatre utilisation</td>
<td><strong>Service line</strong></td>
</tr>
<tr>
<td>• Length of stay</td>
<td>• Further autonomy in</td>
</tr>
<tr>
<td>• Outpatient DNA rates</td>
<td>decision-making</td>
</tr>
<tr>
<td>Includes key targets</td>
<td>• Control over budgets</td>
</tr>
<tr>
<td></td>
<td>and profit and loss</td>
</tr>
<tr>
<td></td>
<td>• Performance transparency</td>
</tr>
<tr>
<td></td>
<td><strong>Non-financial</strong></td>
</tr>
<tr>
<td></td>
<td>• Preferential access to</td>
</tr>
<tr>
<td></td>
<td>theatre slots</td>
</tr>
<tr>
<td><strong>Clinical quality and patients</strong></td>
<td><strong>Financial</strong></td>
</tr>
<tr>
<td>Indicators that will impact longer term</td>
<td>• Surplus retention</td>
</tr>
<tr>
<td>sustainability and strategy – e.g.</td>
<td>(proportional to</td>
</tr>
<tr>
<td>• Readmission rates</td>
<td>achievement of</td>
</tr>
<tr>
<td>• Patient satisfaction</td>
<td>objectives)</td>
</tr>
<tr>
<td>• Healthcare Commission compliance</td>
<td><strong>People / workforce</strong></td>
</tr>
<tr>
<td>Indicators of organisational structure,</td>
<td>• Surplus retention</td>
</tr>
<tr>
<td>employee productivity, skills, and</td>
<td>(proportional to</td>
</tr>
<tr>
<td>motivation – e.g.</td>
<td>achievement of</td>
</tr>
<tr>
<td>• Voluntary turnover</td>
<td>objectives)</td>
</tr>
<tr>
<td>• Sickness and absence</td>
<td>• Bonuses</td>
</tr>
<tr>
<td>• Staff satisfaction</td>
<td>• Excellence awards (may</td>
</tr>
<tr>
<td></td>
<td>be clinical, financial</td>
</tr>
<tr>
<td></td>
<td>or operational)</td>
</tr>
<tr>
<td></td>
<td>• Performance-based pay</td>
</tr>
<tr>
<td></td>
<td>• Saturday lists</td>
</tr>
</tbody>
</table>
Best practice example – individual balanced scorecards link directly to incentives

- Each individual has their own scorecard
- Executive team scorecards shared on intranet
- Incentives are linked directly to performance of group and individual
- Group must achieve 60% on scorecard before any incentives are triggered
- Individual performance drives personal incentives
### Top 5 non-financial incentives*

<table>
<thead>
<tr>
<th>Incentive</th>
<th>Clinicians</th>
<th>Managers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further autonomy in decision-making (for the whole service)</td>
<td>3.0</td>
<td>3.5</td>
<td>3.2</td>
</tr>
<tr>
<td>Performance transparency (for the whole service line – compared to other service lines in the trust)</td>
<td>2.7</td>
<td>3.2</td>
<td>2.9</td>
</tr>
<tr>
<td>Increased opportunities for development (e.g. taking on more responsibilities or new projects)</td>
<td>2.8</td>
<td>3.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Operational performance based awards, akin to clinical excellence awards</td>
<td>2.8</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>Training opportunities</td>
<td>2.6</td>
<td>3.0</td>
<td>2.8</td>
</tr>
</tbody>
</table>

### Top 5 financial incentives*

<table>
<thead>
<tr>
<th>Incentive</th>
<th>Clinicians</th>
<th>Managers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability for service line to access a portion of a ‘surplus pool’ proportional to achievement of agreed objectives</td>
<td>3.1</td>
<td>3.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Further control over budgets and investment decisions (for the whole service line)</td>
<td>2.8</td>
<td>3.4</td>
<td>3.0</td>
</tr>
<tr>
<td>Individual performance-based annual bonuses</td>
<td>2.8</td>
<td>3.2</td>
<td>2.9</td>
</tr>
<tr>
<td>Individual performance-based pay increases</td>
<td>2.9</td>
<td>3.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Fee-for-service Saturday lists</td>
<td>2.8</td>
<td>2.5</td>
<td>2.6</td>
</tr>
</tbody>
</table>

* Based on a survey of 39 clinical directors and general managers across four NHS FTs, with 1 as ‘not motivating’ and 4 as ‘extremely motivating’
There are many barriers to implementing incentives, but there are also ways to overcome them

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

Clinician example

Establish transparency

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

Introduce non-financial incentives

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

Introduce financial incentives

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

Key messages

- Clinical engagement is critical in developing incentives
- Multiple non-financial incentives options can be explored first
- Organisational changes might be required to drive incentives through medical management
- Individual goal / targets will need to be aligned with service-line strategy and goal
<table>
<thead>
<tr>
<th>Area</th>
<th>What this means</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition</td>
<td>• Ensuring peers and others recognise success</td>
<td>• Published lists of top performers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Internal and external communications (e.g. newsletters, portraits, videos)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Parking spaces</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Catering</td>
</tr>
<tr>
<td>Convenience</td>
<td>• Successful doctors have preferential access to hospital resources</td>
<td>• Preferential scheduling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Dedicated teams in theatres</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Consistent nursing teams</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patients co-located</td>
</tr>
<tr>
<td>Additional support</td>
<td>• Successful doctors are supported with their own interests (e.g. research)</td>
<td>• Dedicated physician’s assistant (e.g. junior doctor)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Research technician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical writer / editor and photographer to support submissions to journals and publishing papers</td>
</tr>
</tbody>
</table>
While financial incentives form a powerful motivational tool, peer ranking goes to the heart of professional pride.

Contribution versus plan compared for all service lines

"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.
German hospital’s divisions retain earnings based on relative profit contribution

<table>
<thead>
<tr>
<th>Identify financial results</th>
<th>Aggregate profits</th>
<th>Allocate profit pool (for reinvestment) back to service lines based on their share of profit contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution margin £m</td>
<td>Profit pool</td>
<td>Strategic investments</td>
</tr>
<tr>
<td>A  90</td>
<td>90</td>
<td>20</td>
</tr>
<tr>
<td>B  50</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>C  20</td>
<td>50</td>
<td>20</td>
</tr>
<tr>
<td>D  -20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E  -50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tot</td>
<td>160</td>
<td>140</td>
</tr>
<tr>
<td>Contribution share % of tot</td>
<td>Allocation of profit pool £m</td>
<td></td>
</tr>
<tr>
<td>A  56% x 20 = 11</td>
<td>A 90</td>
<td></td>
</tr>
<tr>
<td>B  31% x 20 = 6</td>
<td>B 50</td>
<td></td>
</tr>
<tr>
<td>C  13% x 20 = 3</td>
<td>C 20</td>
<td></td>
</tr>
<tr>
<td>Tot</td>
<td>100</td>
<td>20</td>
</tr>
</tbody>
</table>

German hospital’s divisions retain earnings based on relative profit contribution.
US clinic’s clinicians with a variable pay component based on productivity

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

<table>
<thead>
<tr>
<th>Salary ($000)</th>
<th>50</th>
<th>70</th>
<th>90</th>
<th>110</th>
<th>130</th>
<th>150</th>
<th>170</th>
<th>190</th>
<th>210</th>
<th>230</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base salary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum salary*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Physician A:** wRVUs** < base
  - Receives base salary (~ $91K)

- **Physician B:** wRVUs** > base
  - Receives base salary + bonus

- **Physician C:** wRVUs** >>> base
  - Receives maximum salary of $210k

Benchmark productivity = 2,450 wRVU**

* 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
# Service-line management

## Key enablers

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Strategic and annual planning process</th>
<th>Performance management</th>
<th>Information support</th>
</tr>
</thead>
</table>

### Organisation
- Defined **service-line structure**
- Defined service-line **leadership roles**, with integrated ownership of clinical, operational and financial performance
- Capability-linked, defined **decision rights** at each level (trust executive, service line, and team)

### Strategic and annual planning process
- Understanding of market and competitive position
- Defined three- to five-year strategy and annual objectives
- Action plan to deliver strategy
- Robust annual planning process
- Levels of autonomy linked to quarterly monitoring regime

### Performance management
- Clear KPIs, targets and accountabilities
- Performance tracking
- Effective review meetings
- Good performance conversations
- Rewards and consequences for performance

### Information support
- Relevant, timely information
- Patient level costing
• Most widespread NHS practice is to operate within fixed budgets and analyse by spend against the budgets. However there is little or no analysis of expenditure linked to activity level to explain the observed spend against the budgets

• In order to manage an organisation as a portfolio of service-lines with devolved autonomy, each service line needs adequate financial and operational information, with a clear link between the two. This enables much more informed operational, as well as strategic, decisions to be taken

• The first step to attaining the necessary level of financial detail, comparing income against expenditure, is provided by service-line reporting (SLR). This gives a statement of profitability at service-line level. Initially this is likely to be derived from reference costing information, but ideally over time should be developed to patient-level information and costing systems (PLICS)

• The time needed for change in people’s mindsets will require parallel running of the old and new systems while the SLR / PLICS system is established, and the staff get used to using the information available in a meaningful way

• PLICS systems can be developed in-house, but there are several established suppliers with off-the-shelf packages. Evaluation of these suppliers will ensure compatibility with the trust’s legacy systems and will provide an opportunity to encourage clinical buy-in
Operational performance and financial performance are seldom linked

How performance reports are typically used

Financial report

<table>
<thead>
<tr>
<th>Income</th>
<th>Target</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable</td>
<td>£123,000</td>
<td>£129,341</td>
<td>£6,341</td>
</tr>
<tr>
<td>Non Healthcare</td>
<td>£66,066</td>
<td>£68,806</td>
<td>£2,740</td>
</tr>
<tr>
<td><strong>TOTAL INCOME</strong></td>
<td>£197,666</td>
<td>£198,147</td>
<td>£481</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pay Expenditure</th>
<th>Budget</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Staff</td>
<td>£8,678,080</td>
<td>£7,811,241</td>
<td>£866,839</td>
</tr>
<tr>
<td>Nursing Staff</td>
<td>£8,430,416</td>
<td>£7,825,385</td>
<td>£605,031</td>
</tr>
<tr>
<td>Scientific Staff</td>
<td>£2,941,320</td>
<td>£2,695,250</td>
<td>£246,070</td>
</tr>
<tr>
<td>Senior Managers</td>
<td>£612,156</td>
<td>£612,785</td>
<td>£6,629</td>
</tr>
<tr>
<td>CEO Staff</td>
<td>£1,855,199</td>
<td>£1,543,544</td>
<td>£311,655</td>
</tr>
<tr>
<td><strong>TOTAL PAY</strong></td>
<td>£22,344,171</td>
<td>£19,158,358</td>
<td>£3,185,813</td>
</tr>
</tbody>
</table>

“We check to see that costs are not wrongly allocated to us”

“We use the finance reports to see whether we’re within budget”

“Sometimes we know from our wards what’s increasing the cost and we’ll discuss that with staff”

Performance report

“The performance reports do not give us a good idea of how we’re doing”

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

“The performance and finance reports are for different things – we keep them separate”
NHS trusts operate fixed budgets which do not contain unit cost transparency

### Service-line monthly financial report

**3.1 Income £341k over recovered, 373k favourable movement**
- As mentioned above, income has been included for over-performance (£100k) and Paed liver disease drugs (£70k). The full year effect of this income is £170k and approx. £15k respectively

**3.2 Pay £150k overspent, favourable movement of £40k**
- Admin. and clerical staff (£19k under-spent year to date). This was £14k under-spent for the month. Bank and agency accruals are quite low
- Medical staffing (£6k overspent year-to-date). This was £28k under-spent in the month; Dr. Smith was recharged to the medical school, and this totaled £20k
- Nursing staff (£121k overspent year to date). This was £9k under-spent for the month. Bank nursing was considerably lower than the trend to-date in NICU
- This may be due to an over-accural in month 8 being balanced off; two wards had higher levels of bank than normal

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

Traditional accounting system

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

Patient level information costing system (PLICS)

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

Practical benefits

- Strategic insight into trust activity
  - Ability to challenge national tariff using robust cost data
  - Understanding of comparative attractiveness / profitability of services (portfolio management)

- Link operational and financial effectiveness and facilitate performance management
  - Total cost across all HRGs
  - Cost components of each HRG
  - Comparative costs of each component across clinicians, wards, and theatres
Patient Level Costing facilitates understanding of the underlying drivers of financial performance

<table>
<thead>
<tr>
<th>Clinicians</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I have no idea how finance relates to what I do”</td>
<td>“The reason the costs went up for X procedure was due to the new drug that reduces readmissions by Y%”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Managers</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Our agency nursing costs have increased”</td>
<td>“We’ve treated X% more patients than planned, which has caused higher usage of agency nurses”</td>
</tr>
<tr>
<td>“Our clinical supplies costs are under-budget”</td>
<td>“Our case mix has changed and we are performing treatments that require less expensive supplies / devices”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Boards / Strategy / CEOs</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>“We do not know which service lines to focus on in order to achieve financial balance”</td>
<td>“We need to invest in building cardiac referrals since this is our most profitable service and we can build distinctiveness in it”</td>
</tr>
<tr>
<td></td>
<td>“We choose to maintain world-class liver facilities, even though we incur losses in more complicated procedures”</td>
</tr>
</tbody>
</table>
Service-line reporting (SLR) provides critical insight into service profitability

What it is

• Statement of profitability by service line, including allocation of revenues and costs to service-line level
• Driven by best available data:
  – top down allocation using reference costs plus revenue assignment
  – patient level costing
  – real time reporting

Benefits

• Ability to provide comprehensive overview of the economic contributions of individual service lines making up overall portfolio
• Catalyst for engaging clinicians in discussion about productivity
• Enable linkage of operational drivers to financial performance
• Can be used for budget setting and performance improvement

Requirements

• An executive sponsor with overall leadership accountability
• A clinical champion
• A lead for implementation from finance/data
• Engagement of (at minimum) clinical directors and general managers
• (limited) time of clinicians to test key assumptions about allocations
• New software / systems eventually desirable but not required at start

Key steps

• Gather available databases of information
• Use unique patient key to allocate direct costs where possible (e.g. theatre, wards)
• Use assumptions / allocation rules for whether direct assignment not possible
• Review results and identify key questions to ask
• Iterate
### What it is
- Costing by HRG down to the individual patient level
- Driven by best available data on actual usage

### Benefits
- Ability to identify variability in cost at the procedure and patient level
- Improved ability to provide detailed input to setting national tariffs
- Engages clinicians at an operational level
- Can be used for on-going performance management / improvement

### Requirements
- Software partner
- A lead for implementation from finance / data
- (limited) time of clinicians to test key assumptions about allocations
- Reasonably accurate doctor PA assignment data

### Key steps
- Gather available databases of information
- Use unique patient key to allocate direct costs where possible (e.g. theatre, wards)
- Use assumptions / allocation rules for whether direct assignment not possible
- Review results and identify key questions to ask
- Iterate
There are two options for implementing patient level costing

**Option 1: Direct approach**
- Implement a PLICS system from the ground up
- Engage clinician support during implementation to encourage early agreement on apportionment
- Service lines learn to use the patient-level data with confidence from day one

**Option 2: Step approach**
- Develop SLR from current reference cost information so staff can learn to use indicative information for service decisions
- Move to PLICS once implementation is established, giving service lines the next level of detail and reliability in their information
Example of a transition model to patient level costing implementation and integration

0-6 months

- Develop, agree and populate trust and service-line scorecards
- Continue to use current budget-monitoring for performance management
- Evaluate PLICS system solutions and select preferred provider
- If employing SLR - improve information transparency by reporting income and expenditure by service line where possible

6-12 months

- Balanced scorecard reporting by service-line used to monitor service performance and is refined as appropriate
- Supplement service information with SLR reports across all service lines if applicable
- Focus on development and capability building of service-line leaders on the use of these new tools
- Develop, agree and implement scorecards for each specialty / clinical team
- Budget-monitoring process continues
- Initiate implementation of PLICS system and use of profitability reports by patient and procedure, as available

12-18 months

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

Evaluation questions*

**Functionality**
- Does the solution provide a front end which is robust and easy to use? Is it web enabled?
- Can the solution be used for on-going reporting and performance management (e.g. monthly, quarterly) by clinical teams?
- Does the supplier develop allocation methodology engaging clinicians in your organisation?

**Ease of implementation**
- Does the supplier actively involve clinicians in development and implementation?
- Is the IT system compatible with legacy clinical, management and finance systems?
- Does the supplier have previous experience with the trust or other U.K. trusts?

**Cost**
- What is the upfront price for installation of the IT solution?
- Are there significant ongoing support costs?
- How many internal FTEs will be working on implementation and ongoing support?

**Timing**
- When can the IT implementation begin?
- When will the first reports be available?
- Is sufficient time allowed for testing and roll out?

* See Appendix for more specific questions and a list of providers
### Case example: Implementation of patient level costing in a German hospital network (1/3)

<table>
<thead>
<tr>
<th>Report usage</th>
<th>Data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Reports are created monthly by the medical controller and forwarded to the department heads</td>
<td>- Data is fed into the system monthly, half automatically, half manually</td>
</tr>
<tr>
<td>- These reports are used as the cornerstone of fortnightly performance discussions between the CEO, all heads of departments and the medical controller</td>
<td>- There are also manual updates that must be completed annually (e.g. percentages to allow appropriate allocation of overhead)</td>
</tr>
<tr>
<td>- Combined with pathways, the tool allows accurate estimation of the cost of each pathway as part of the budgeting process</td>
<td>- Data audit is an important stage of the process</td>
</tr>
<tr>
<td><strong>Allocation methodology</strong></td>
<td><strong>Report content</strong></td>
</tr>
<tr>
<td>- The tool only costs inpatient cases</td>
<td>- Reports are available at the hospital, service line, pathway and individual level</td>
</tr>
<tr>
<td>- Nurses and doctors costs are allocated to patients based on length of stay</td>
<td>- Pathways are used as the basic unit of measurement, a ‘recipe’ for treating a patient with a certain diagnosis that may span a few HRGs</td>
</tr>
<tr>
<td>- Low-cost consumables and drugs are also allocated based on length of stay</td>
<td>- Reports separate out fixed and variable costs so that the effect of over-activity can be fully understood</td>
</tr>
<tr>
<td>- High-cost consumables are tracked and allocated directly to the consuming patient</td>
<td>- Length of stay for each pathway is tracked to allow simple performance management on a more detailed level</td>
</tr>
<tr>
<td>- Buy-in to the tool is high among clinicians and managers</td>
<td>- Activity in the year to date in each HRG is included against the budgeted figure to allow clinicians and managers to track actual activity against commissioned activity</td>
</tr>
</tbody>
</table>
Case example: Implementation of patient level costing in a German hospital network (2/3)

Example of service line budgeting report

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number</th>
<th>Tariff (€)</th>
<th>Minimum Cost (€)</th>
<th>Maximum Cost (€)</th>
<th>Surplus (min) (€)</th>
<th>Surplus (max) (€)</th>
<th>LOS</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>2</td>
<td>2,053.18</td>
<td>1,298.96</td>
<td>1,960.45</td>
<td>754.22</td>
<td>92.73</td>
<td>7</td>
<td>148</td>
</tr>
<tr>
<td>Arrhythmia</td>
<td>9</td>
<td>4,794.10</td>
<td>2,588.74</td>
<td>2,643.44</td>
<td>2,205.36</td>
<td>2,150.66</td>
<td>6</td>
<td>206</td>
</tr>
<tr>
<td>Myocardial Infarction</td>
<td>11</td>
<td>3,170.13</td>
<td>3,567.91</td>
<td>3,652.33</td>
<td>-397.78</td>
<td>-462.20</td>
<td>7</td>
<td>49</td>
</tr>
<tr>
<td>Syncope</td>
<td>8</td>
<td>1,568.75</td>
<td>1,406.50</td>
<td>1,649.93</td>
<td>162.25</td>
<td>-81.18</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Ventricular Arrhythmia</td>
<td>7</td>
<td>1,787.12</td>
<td>3,304.94</td>
<td>3,504.04</td>
<td>-1,517.82</td>
<td>-1,716.92</td>
<td>7</td>
<td>45</td>
</tr>
<tr>
<td>COPD</td>
<td>3</td>
<td>2,100.87</td>
<td>1,034.02</td>
<td>1,380.77</td>
<td>1,066.85</td>
<td>720.10</td>
<td>6</td>
<td>179</td>
</tr>
<tr>
<td>Pacemaker</td>
<td>1</td>
<td>4,794.10</td>
<td>4,546.06</td>
<td>4,547.46</td>
<td>248.04</td>
<td>246.64</td>
<td>4</td>
<td>114</td>
</tr>
<tr>
<td>Heart failure</td>
<td>19</td>
<td>2,487.41</td>
<td>1,202.83</td>
<td>1,856.13</td>
<td>1,284.58</td>
<td>631.28</td>
<td>6</td>
<td>251</td>
</tr>
<tr>
<td>Comp. heart failure</td>
<td>10</td>
<td>1,611.42</td>
<td>2,041.12</td>
<td>3,512.67</td>
<td>-429.70</td>
<td>-1,901.25</td>
<td>5</td>
<td>94</td>
</tr>
<tr>
<td>Tumour diagnosis</td>
<td>5</td>
<td>1,483.41</td>
<td>1,466.27</td>
<td>2,273.97</td>
<td>17.14</td>
<td>-790.56</td>
<td>5</td>
<td>67</td>
</tr>
<tr>
<td>Decomp. heart failure</td>
<td>13</td>
<td>1,709.31</td>
<td>2,637.82</td>
<td>3,513.37</td>
<td>-928.51</td>
<td>-1,804.06</td>
<td>3</td>
<td>399</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>18</td>
<td>0.00</td>
<td>1,048.03</td>
<td>1,301.43</td>
<td>-1,048.03</td>
<td>-1,301.43</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>4,449,845.97</strong></td>
<td><strong>3,860,468.10</strong></td>
<td><strong>4,944,720.46</strong></td>
<td><strong>589,377.87</strong></td>
<td><strong>-494,874.49</strong></td>
<td></td>
<td><strong>1927</strong></td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td></td>
<td><strong>2,309.21</strong></td>
<td><strong>2,003.36</strong></td>
<td><strong>2,566.02</strong></td>
<td><strong>305.85</strong></td>
<td><strong>-256.81</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Example of detailed cost breakdown for a pathway

**Detailed Costs**

**Pathway:** Ventricular arrhythmia

<table>
<thead>
<tr>
<th>Service provider:</th>
<th>Internal medicine outpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dimension</strong></td>
<td><strong>Service</strong></td>
</tr>
<tr>
<td>2</td>
<td>Physical examination</td>
</tr>
<tr>
<td>2</td>
<td>Abdominal ultrasound</td>
</tr>
<tr>
<td><strong>Sum of services provided:</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service provider:</th>
<th>Base costs inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dimension</strong></td>
<td><strong>Service</strong></td>
</tr>
<tr>
<td>9</td>
<td>Inpatient base costs</td>
</tr>
<tr>
<td><strong>Sum of services provided:</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service provider:</th>
<th>ECG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dimension</strong></td>
<td><strong>Service</strong></td>
</tr>
<tr>
<td>2</td>
<td>ECG</td>
</tr>
<tr>
<td><strong>Sum of services provided:</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service provider:</th>
<th>Respiratory function tests</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dimension</strong></td>
<td><strong>Leistung</strong></td>
</tr>
<tr>
<td>2</td>
<td>Holter monitor</td>
</tr>
<tr>
<td>2</td>
<td>Cardiac echo</td>
</tr>
<tr>
<td><strong>Sum of services provided:</strong></td>
<td></td>
</tr>
</tbody>
</table>
Case example: Implementation of patient level costing in a Canadian teaching hospital (1/3)

**Report usage**
- The report was not initially used in conjunction with performance management or decision support ("90% underutilised"), but uptake increased with time.
- Only half a dozen people within the organisation started using it regularly and it was only used for strategic reasons:
  - To contract with local payors
  - To influence the tariff and funding policy
- The report is delivered to service lines and specialties using a digital desktop but the steep learning curve and the once-a-year report generation impeded initial uptake.

**data collection**
- Reports are created annually by plugging in the data into the patient level costing system.
- Data from the general ledger and from activity databases are downloaded every month and then audited (for the generation of reports, half of the time spent is on auditing the data). Data cleaning is a significant task.

**Allocation methodology**
- Allocation is very precise:
  - Drugs and consumables are allocated direct to patient.
  - Nursing costs are allocated based on resource utilisation with patients graded on a 1–6 scale by a nursing management tool at least once every 24 hours.
- Physician costs are not included (they are paid separately under the Canadian system).
- Inpatient stays, day surgery and ER visits are under the scope of the costing system (outpatients added soon).
- For the costs of individual diagnostic tests, a national workload system is used which estimates the relative resource utilisation of different tests.
- The view in the hospital is that you cannot get too detailed on the allocation methodology and that there is no trade-off against the effort required.

**Report content**
- The hospital uses a separate reporting system software solution.
- Report content allows aggregation at any level, from service and specialty level, down to individual patients.
- Reports at the patient level give itemised bills down to individual items (e.g. individual drugs) in very impressive detail.
- Length of stay information is given for every DRG (i.e. HRG) to allow management on a lower level.
Case example: Implementation of patient level costing in a Canadian teaching hospital (2/3)

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Cases</th>
<th>Avg. Length-of-Stay</th>
<th>Ward</th>
<th>ICU &amp; CCU</th>
<th>OR &amp; Pasip</th>
<th>Specialty Procs</th>
<th>Lab</th>
<th>Diagnostic Imaging</th>
<th>Electro-diagnosis</th>
<th>Therap</th>
<th>Pharm</th>
<th>Other</th>
<th>TOTAL</th>
<th>DIRECT</th>
<th>IN DIRECT</th>
<th>TOTAL All Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Surgery</td>
<td>1,513</td>
<td>4.86</td>
<td>$3,190</td>
<td>$6,299</td>
<td>$5,165</td>
<td>$165</td>
<td>$1,115</td>
<td>$403</td>
<td>$220</td>
<td>$1,180</td>
<td>$695</td>
<td>$225</td>
<td>$10,605</td>
<td>$16,659</td>
<td>$4,057</td>
<td>$22,161,306</td>
</tr>
<tr>
<td>Cardiology</td>
<td>4,032</td>
<td>2.21</td>
<td>$1,235</td>
<td>$6,248</td>
<td>$5,253</td>
<td>$2,542</td>
<td>$2,240</td>
<td>$221</td>
<td>$225</td>
<td>$1,600</td>
<td>$6,067</td>
<td>$1,402</td>
<td>$32,776,551</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Surgery</td>
<td>3,585</td>
<td>2.94</td>
<td>$3,579</td>
<td>$3,370</td>
<td>$1,425</td>
<td>$1,949</td>
<td>$912</td>
<td>$403</td>
<td>$179</td>
<td>$1,109</td>
<td>$226</td>
<td>$9,539</td>
<td>$7,440</td>
<td>$2,098</td>
<td>$15,806</td>
<td>$34,206,551</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>2,165</td>
<td>1.96</td>
<td>$3,004</td>
<td>$1,420</td>
<td>$741</td>
<td>$263</td>
<td>$916</td>
<td>$372</td>
<td>$54</td>
<td>$700</td>
<td>$658</td>
<td>$294</td>
<td>$8,807</td>
<td>$6,661</td>
<td>$2,147</td>
<td>$19,351,267</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>3,744</td>
<td>1.77</td>
<td>$3,200</td>
<td>$2,111</td>
<td>$444</td>
<td>$322</td>
<td>$355</td>
<td>$65</td>
<td>$511</td>
<td>$176</td>
<td>$7,004</td>
<td>$6,290</td>
<td>$1,504</td>
<td>$25,292,362</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic</td>
<td>1,005</td>
<td>1.53</td>
<td>$2,104</td>
<td>$1,811</td>
<td>$756</td>
<td>$448</td>
<td>$440</td>
<td>$146</td>
<td>$156</td>
<td>$950</td>
<td>$4,254</td>
<td>$1,156</td>
<td>$5,920</td>
<td>$3,877,312</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Surgeon A        | 300   | 1.93                | $3,190 | $2,249  | $211      | $224           | $412  | $12            | $151        | $291   | $180  | $1,791 | $2,144,498 |
| Surgeon B        | 200   | 2.05                | $3,200 | $2,084  | $229      | $224           | $412  | $12            | $151        | $291   | $180  | $1,791 | $2,144,498 |
| Surgeon C        | 350   | 2.67                | $4,160 | $245    | $1,515    | $133           | $34   | $800           | $261        | $11,043 | $9,035 | $2,098 | $3,732,605 |
| Surgeon D        | 449   | 1.48                | $3,074 | $245    | $1,078    | $330           | $405  | $130           | $100        | $6,671  | $5,439 | $1,351 | $10,000,620 |
| Surgeon E        | 247   | 2.51                | $3,004 | $2,245  | $744      | $567           | $343  | $876           | $413        | $10,772 | $8,300 | $1,773 | $5,864,518 |
| Surgeon F        | 250   | 2.06                | $3,921 | $32     | $437     | $505           | $591  | $225           | $277        | $906   | $396  | $241   | $10,696 | $8,751  | $1,945   | $2,127,102 |

<table>
<thead>
<tr>
<th>CMG #</th>
<th>CMS Description</th>
<th>Cases</th>
<th>Avg. Length-of-Stay</th>
<th>Ward</th>
<th>ICU &amp; CCU</th>
<th>OR &amp; Pasip</th>
<th>Specialty Procs</th>
<th>Lab</th>
<th>Diagnostic Imaging</th>
<th>Electro-diagnosis</th>
<th>Therap</th>
<th>Pharm</th>
<th>Other</th>
<th>TOTAL</th>
<th>DIRECT</th>
<th>IN DIRECT</th>
<th>TOTAL All Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>562</td>
<td>Multi-Inst Joint Replacement</td>
<td>1</td>
<td>2.04</td>
<td>$1,777</td>
<td>$1,005</td>
<td>$542</td>
<td>$525</td>
<td>$67</td>
<td>$10,777</td>
<td>$9</td>
<td>$5,439</td>
<td>$10,777</td>
<td>$4,842</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>561</td>
<td>Joint Replacement for Trac</td>
<td>4</td>
<td>2.04</td>
<td>$1,777</td>
<td>$1,005</td>
<td>$542</td>
<td>$525</td>
<td>$67</td>
<td>$10,777</td>
<td>$9</td>
<td>$5,439</td>
<td>$10,777</td>
<td>$4,842</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>563</td>
<td>Hip Replacement</td>
<td>100</td>
<td>2.04</td>
<td>$1,777</td>
<td>$1,005</td>
<td>$542</td>
<td>$525</td>
<td>$67</td>
<td>$10,777</td>
<td>$9</td>
<td>$5,439</td>
<td>$10,777</td>
<td>$4,842</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>564</td>
<td>Knee Replacement</td>
<td>60</td>
<td>2.04</td>
<td>$1,777</td>
<td>$1,005</td>
<td>$542</td>
<td>$525</td>
<td>$67</td>
<td>$10,777</td>
<td>$9</td>
<td>$5,439</td>
<td>$10,777</td>
<td>$4,842</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>565</td>
<td>Ext. Pelv/Injury/Comp of Tr</td>
<td>12</td>
<td>2.04</td>
<td>$1,777</td>
<td>$1,005</td>
<td>$542</td>
<td>$525</td>
<td>$67</td>
<td>$10,777</td>
<td>$9</td>
<td>$5,439</td>
<td>$10,777</td>
<td>$4,842</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon F Average</td>
<td>200</td>
<td>2.04</td>
<td>$1,777</td>
<td>$1,005</td>
<td>$542</td>
<td>$525</td>
<td>$67</td>
<td>$10,777</td>
<td>$9</td>
<td>$5,439</td>
<td>$10,777</td>
<td>$4,842</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Example of patient level reporting of costs

<table>
<thead>
<tr>
<th>Encounter # EPN# Age Sex Rnt Age LOS AdmDate DischDate</th>
<th>Full Cost $11,532</th>
</tr>
</thead>
<tbody>
<tr>
<td>701762784 30582296 72 F 2.8248 TYP 3 8 13-May-02 21-May-02</td>
<td>RIW Funding Credit $12,395</td>
</tr>
</tbody>
</table>

**Death**  **Date**  **Service Item (Orderable) Description**  **Orx**  **Date**  **DirLabor**  **DirSup**  **DirOth**  **FixIndr**  **D+ITotal $'s**

<table>
<thead>
<tr>
<th>52401  <strong>Patient Food Services</strong>  <strong>Meal Day</strong></th>
<th>7.1  21-May-02  96.70  91.03  32.44  45.79  265.93</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Cost for Patient Food Services</strong></td>
<td><strong>$97</strong>  <strong>$91</strong>  <strong>$32</strong>  <strong>$46</strong>  <strong>$266</strong></td>
</tr>
<tr>
<td><strong>Total Cost for MIS F/C 711952000</strong></td>
<td><strong>$97</strong>  <strong>$91</strong>  <strong>$32</strong>  <strong>$46</strong>  <strong>$266</strong></td>
</tr>
</tbody>
</table>

| 12035  **Nursing Orthopaedics**  **Medicus Type 2** 20.1  13-May-02  96.96  4.29  8.39  38.87  148.50 |
|---------------------------------------------------------------|--------------------------------------------------------|
| **Medicus Type 2** 24.0  14-May-02  229.71  10.17  19.87  92.08  351.84 |
| **Medicus Type 2** 8.9  15-May-02  85.28  3.78  7.38  34.19  130.62 |
| **Medicus Type 2** 15.1  15-May-02  216.64  9.59  18.74  86.84  331.83 |
| **Medicus Type 2** 16.1  16-May-02  230.43  10.21  19.94  92.37  352.94 |
| **Medicus Type 2** 7.9  16-May-02  174.79  7.74  11.12  70.07  267.72 |
| **Medicus Type 2** 24.0  17-May-02  344.56  15.26  29.81  138.12  527.76 |
| **Medicus Type 2** 13.0  18-May-02  124.81  5.53  10.80  50.03  191.17 |
| **Medicus Type 2** 11.0  18-May-02  157.35  6.97  13.61  63.08  241.01 |
| **Medicus Type 2** 24.0  19-May-02  229.71  10.17  19.87  92.08  351.84 |
| **Medicus Type 2** 24.0  20-May-02  229.71  10.17  19.87  92.08  351.84 |
| **Medicus Type 2** 16.4  21-May-02  156.78  6.94  13.56  62.85  240.13 |

**Total Cost for Nursing-Orthopaedics**  **$2,277**  **$101**  **$197**  **$913**  **$3,487**
| **Total Cost for MIS F/C 712207200** | **$2,277**  **$101**  **$197**  **$913**  **$3,487** |
Appendix
## Service leader capability assessment tool: 1. People/personal leadership

<table>
<thead>
<tr>
<th>Dimension</th>
<th>1. Inspirational leader of people across professional boundaries</th>
<th>2. Helps others perform their best</th>
<th>3. Continuously aims for self-development</th>
<th>4. Is an effective role-model for others</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>• Does not inspire others in service line</td>
<td>• Does not identify strengths and weaknesses of others</td>
<td>• Does not consider the impact of their behaviour on others</td>
<td>• Is not seen to display behaviours expected from others</td>
</tr>
<tr>
<td></td>
<td>• Does not command respect from clinical, nursing and management / administrative staff</td>
<td>• Demonstrates avoidance of difficult or challenging behaviours</td>
<td>• Finds reasons for disregarding feedback from others</td>
<td>• Often displays behaviours expected of others, but sometimes seen to communicate mixed messages</td>
</tr>
<tr>
<td></td>
<td>• Fails to provide clarity and direction – does not demonstrate a clear vision for their service line</td>
<td>• Is not prepared to tackle performance issues with individuals</td>
<td>• Aware that own behaviour has an impact on others</td>
<td>• ‘Walks the talk’ – actively displays the behaviours expected from others</td>
</tr>
<tr>
<td></td>
<td>• Manages through control</td>
<td>• Holds performance conversations with others when required (ad-hoc)</td>
<td>• Reflects on own behaviour and makes adjustments based on observation or feedback</td>
<td>• ‘Walks the talk’ – actively displays the behaviours expected from others</td>
</tr>
<tr>
<td>2.</td>
<td>• Inspires people from all different professions in service line</td>
<td>• Commands respect from those who share own professional background</td>
<td>• Regularly solicits feedback from others</td>
<td>• ‘Walks the talk’ – actively displays the behaviours expected from others</td>
</tr>
<tr>
<td></td>
<td>• Commands respect from all professional backgrounds</td>
<td>• Effectively asks for support from others in service line for inspiring those from different professional backgrounds</td>
<td>• Understands own strengths and limitations and is prepared to ask for help and act on the feedback of others</td>
<td>• ‘Walks the talk’ – actively displays the behaviours expected from others</td>
</tr>
<tr>
<td>3.</td>
<td>• Is sought out by others when problems arise</td>
<td>• Effectively articulates expectations to others</td>
<td>• Identifies strengths and weaknesses in others and makes suggestions for improvement</td>
<td>• ‘Walks the talk’ – actively displays the behaviours expected from others</td>
</tr>
<tr>
<td>4.</td>
<td>• Mobilises energy and commitment of staff members</td>
<td>• Leads through clear metrics and goals</td>
<td>• Is prepared to challenge the status quo and push for improved performance at an individual level</td>
<td>• ‘Walks the talk’ – actively displays the behaviours expected from others</td>
</tr>
<tr>
<td></td>
<td>• Provides clear vision and framework within which others can succeed</td>
<td></td>
<td>• Deals with difficult issues head-on</td>
<td></td>
</tr>
<tr>
<td>Dimension</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>-----------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>1. Demonstrates outstanding patient commitment</strong></td>
<td>• Does not perceive patient care to be central to their role</td>
<td>• Recognises the need to put patients at the centre of their service line</td>
<td>• Seen to ‘go beyond the call of duty’ to put patients at the centre of their work (e.g. addresses individual issues and complaints in a committed and timely manner)</td>
<td>• Takes active responsibility for ensuring patient experience is positive</td>
</tr>
<tr>
<td></td>
<td>• Delegates patient relationships to others</td>
<td>• Responds to overall if not individual patient needs and concerns</td>
<td>• Regularly engages with patients in the care of their department (e.g. regular ward walk about)</td>
<td>• Actively engages with nursing staff to look for improvement opportunities</td>
</tr>
<tr>
<td><strong>2. Demonstrates commitment to quality of care and outcomes</strong></td>
<td>• Leaves clinical excellence to clinical governance leaders and medical staff</td>
<td>• Engages in clinical governance and understands their role in managing clinical excellence and patient safety in the service line</td>
<td>• Drives innovation in clinical excellence</td>
<td>• Builds outstanding relationships with nursing teams on wards</td>
</tr>
<tr>
<td></td>
<td>• Reviews clinical performance only as part of mandated clinical governance processes</td>
<td>• Uses scorecards and information provided on clinical performance to drive through change across service line (individual and team)</td>
<td>• Rewards clinical excellence</td>
<td>• Engages in thorough diagnostic when SUIs occur and takes active preventative measures to mitigate against future incidents</td>
</tr>
<tr>
<td><strong>3. Effectively prioritises patient safety</strong></td>
<td>• Fails to build robust relationship with nursing teams to ensure best practise is in place</td>
<td>• Maintains reasonable relationships with nursing teams on wards</td>
<td>• Uses scorecards and information effectively to continuously improve patient safety</td>
<td>• Takes active responsibility for ensuring patient experience is positive</td>
</tr>
<tr>
<td></td>
<td>• Does not properly engage with remedial action where serious untoward incidents (SUIs) occur</td>
<td>• Remedies SUIs as and when they arise</td>
<td>• Uses scorecards and information provided on clinical performance to drive through change (individual and team)</td>
<td>• Actively engages with nursing staff to look for improvement opportunities</td>
</tr>
<tr>
<td><strong>4. Ensures a positive patient experience</strong></td>
<td>• Leaves patient experience to nursing staff</td>
<td>• Recognises their responsibility in ensuring patient experience is positive</td>
<td></td>
<td>• Recognises their responsibility in ensuring patient experience is positive</td>
</tr>
</tbody>
</table>
# Service leader capability assessment tool: 3. Service leadership

<table>
<thead>
<tr>
<th>Dimension</th>
<th>1. Understands drivers of financial performance</th>
<th>3. Identifies and prioritises opportunities to improve operational excellence</th>
<th>5. Delivers service-specific strategies and objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>• Demonstrates little understanding of or interest in financial performance • Relies on others to make financial decisions</td>
<td>• Regularly identifies quantifiable opportunities to improve operational excellence • Implements new opportunities as they arise</td>
<td>• Understands overall strategic vision for service line • Sets stretching goals as well as annual plan objectives • Proactively overcomes obstacles to achieving goals and objectives</td>
</tr>
<tr>
<td>3.</td>
<td>• Regularly identifies opportunities to improve operational excellence • Demonstrates a clear understanding of the key drivers of financial performance in their service line (with appropriate support and information)</td>
<td>• Regularly identifies quantifiable opportunities to improve operational excellence</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>• Day-to-day management focused on 'fire fighting' rather longer term performance achievement</td>
<td>• Shows determination to meet targets set in annual plan • Regularly tracks performance and delivery against plan and makes required adjustments as needed</td>
<td></td>
</tr>
<tr>
<td>Dimension</td>
<td>1</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>-----------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1. Acts within the overall interests of the trust</td>
<td>• Is unable to balance the needs of the service line with the needs of the trust</td>
<td>• Understands the needs and objectives of the trust beyond own service line</td>
<td>• Fully engages with the strategy and objectives of the trust and ensures the strategy and objectives of the service line are aligned with these</td>
</tr>
<tr>
<td></td>
<td>• Rarely engages in trust-wide issues</td>
<td>• Engages in trust-wide issues as required to deliver results in own service line</td>
<td>• Is able to effectively balance the needs of the service line with the needs of the trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Understands priorities of other departments and how these impact on own service line</td>
</tr>
<tr>
<td>2. Communicates and collaborates effectively with other leaders in the trust</td>
<td>• Communicates with other service lines only as mandated by trust</td>
<td>• Engages positively with other service-line leaders in partnership working when asked</td>
<td>• Works effectively with other leaders in the trust to create a cohesive leadership team</td>
</tr>
<tr>
<td></td>
<td>• Does not seek opportunities to work in partnership or</td>
<td>• Shares information with other service-line leaders as required</td>
<td>• Creates opportunities for service lines to learn from one another</td>
</tr>
<tr>
<td></td>
<td>• Is over-involved in the detailed running of other service lines</td>
<td>• Inputs appropriately into other service lines without needing to be involved in decision-making</td>
<td>• Inputs appropriately into other service lines without needing to be involved in decision-making</td>
</tr>
<tr>
<td>3. Engages executive as appropriate</td>
<td>• Escalates all responsibility up to executive team or</td>
<td>• Appropriately involves executive team in majority of service line decisions</td>
<td>• Appropriately involves executive team in service line decisions</td>
</tr>
<tr>
<td></td>
<td>• Does not sufficiently involve executive team / share information</td>
<td></td>
<td>• Earns executive’s trust and autonomy</td>
</tr>
<tr>
<td>4. Effectively engages with other stakeholders (GPs, PCTs, social services, internal customers)</td>
<td>• Does not proactively manage communications with stakeholders beyond the service line</td>
<td>• Understands the broader context of stakeholders in their service line</td>
<td>• Understands the broader context of stakeholders in their service line</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Communicates effectively with external stakeholders when clearly required to do so</td>
<td>• Initiates and regularly updates communications with external stakeholders</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Regularly solicits feedback from external stakeholders on how the service line is performing</td>
</tr>
</tbody>
</table>
Questions to evaluate a candidate PLICS system
(1 of 2)

Evaluation questions

Technical

- What is the core database used within the system?
- Can you demonstrate the ease at which systems interfaces are created?
- Is there any limitations in terms of size for data files for integration within the system?
- How open is their black box – i.e. business intelligence / interface?

Ability to engage clinicians

- Tracking resources to patients
  - Relevant variables: (wards / nursing, medical, theatre, pharmacy, prostheses, any other)
  - Explain the ability of your system to accept input at various levels of granularity*
  - Explain how you deal with different levels of patient acuity
  - Explain how you cope with inadequate / non-existent data feeds (highly important)
  - Can you drill down into this systematically?
- Comparability
  - Can your systems produce reports for comparability* (by procedure, by types of procedure, by patient age or other demographic
  - Can these reports be also produced by clinician – e.g. procedure by clinician comparison?
  - What patient level reports have you actually provided to clinicians? **

Costing standards

- What/how complex are any algorithms underpinning the costing methodology?
- What clinical costing standards do you use in your system? **
- How flexible is your system in using differing standards for different cost elements?
- What is your ability to reconcile back to the general ledger?
- How do you handle W.I.P.?

Ability to inform tariff

- Are you able to group patients to HRG?*
- How would you go about providing a feed of the cost of individual patients by HRG?

* Please demonstrate or provide written examples
### Evaluation questions

#### Ease of use
- How user-friendly is your report writer? Is there a need for an external system report writer?
- Can you demonstrate the ease at which knowledge of the system can be transferred and users can become self-sufficient in costing studies?

#### Experience
- How long has your product been on the market?
- How many hospitals have implemented your system?
- In which countries has your system been implemented?
- What experience do you have of talking to clinicians and managers about current performance and future opportunities, and how did you convince them of your argument?
- How long you think it will take to properly implement the system?

#### Commitment to market / resource / capacity
- What resources do you intend to commit to this market?
- What are the ongoing system support capabilities of your company?
- What are the ongoing training / knowledge transfer capabilities of your company?
- Can we have some tangible evidence of this please?

#### Other
- How can we assess your financial stability?