The Whittington Hospital NHS

NHS Trust

Service Line Reporting

Comments and Observations

assista

Introduction

The issues raised in this report are based wholly on the information provided by the Trust in the interviews we conducted. The scope of our work does not include confirming the accuracy or robustness of the information so presented, although we will normally gain some assurance as to these through our challenge of the Trust throughout the process. The findings and recommendations presented in this report are made entirely for the purpose of comment and do not provide assurance to the Trust, the SHA, the DH or to any other party as to the likelihood of success of the Trust in fully implementing Service Line Reporting. Furthermore, although we aim to be comprehensive in our commentary, given the timeframe for our review the issues raised should not be regarded as exhaustive.

This report is prepared for the purposes of supporting the Trust in its development of Service Line Reporting. No responsibility is accepted in relation to any member of the Trust Board or its staff in their individual capacity, or to any third party.

Executive Summary

This report follows on from Assistaqs free consultancy at The Whittington Hospital NHS Trust and addresses the key risks in implementing Service Line Reporting. The report is split up into different sections looking at the current position the Trust is in, the views expressed by the stakeholders we interviewed and our proposed solutions including advice on how Assista could contribute in a way which complements the Trustqs existing resources. The analysis is largely based on our interpretation of statements made by various members of the Trustqs staff during the free consultancy day.

In completing the report we focused on key areas of interest:

How to engender wider clinical and operational engagement?

How SLR sits within the management accounts reporting structure?

What are the ±ewardsqof SLR?

Current Position

1.1 SLR is reported quarterly to the Trust Board in an Excel format. It is underpinned by Power Health Solutions, a PLICS package.

1.2 The Trust has identified twenty-five Service Lines.

1.3 Power Health Solutions has been linked with the Trustqs feeder IT systems and consequently only 15% of costs apportioned on a top down basis.

1.4 At the Wittington SLR is focused on contribution, with a target of 30% for each Service Line.

1.5 Progress so far has been achieved with a three person team in the finance directorate assisted by an external support person from Power Health Solutions.

1.6 SLR reconciles back to the ledger on expenditure.

1.7 There is a separate IMT directorate.

1.8 The Trust uses SLAM for income monitoring.

Views Expressed

2.1 The Trust has made good progress so far, especially in the areas of data collection and analysis. At a high level all stakeholders welcome the concept of SLR. However, until now the project has been largely finance driven with little involvement from the operational managers or the clinical staff.

2.2 This situation appears to have arisen because of concerns around data accuracy and issues over credibility. The danger in these circumstances is that SLR will be implemented without clinical involvement leading to it not becoming embedded in the wider organisation.

2.3 It was clear in the interviews we carried out that different stakeholders had quite different perceptions as to what SLR represented to them and the benefits it would bring them. The operational managers and clinicians see it as just one tool amongst many and, therefore, the challenge for the Trust is to take these viewpoints and meld them into one coherent whole.

2.4 The operational managers all commented on how they wanted to use SLR as an aid in their business planning, particularly around putting together business cases. They also all stressed the need for ±real timeqdata. To change behaviour they need to act as quickly as possible.

2.5 There was a degree of cultural maturity in that they accepted there was a trade off between data accuracy and the speed of information available. This touches on one of the central concepts of SLR, namely that it is an iterative process and that it will take time and constructive feedback to get information in an accurate, useable format.

2.6 As mentioned in 2.3 above there was clearly a perception that SLR sits within a wider reporting/monitoring system. This has been the experience in early adopter trusts where a ±dashboardqapproach is taken. The general managers also mentioned utilization rates and competitor information. They hoped that SLR would become a good pointer for housekeeping, for example checking that billing had been done correctly.

2.7 A related issue raised was what information and reporting systems could be discontinued if SLR was fully implemented? This very much ties in with not overloading people with data and, in consequence, ensuring that there is a high utilization rate.

2.8 There was no common consensus on how general managers and clinicians wanted to see data, but they all agreed there had to be some form of drill down without having to go back and ask the finance department for additional information. Many of the stakeholders also wanted personal interaction with the finance directorate and this chimes in with our previous experience; there will be a degree of ±hand holdingqas users familiarise themselves with SLR.

2.9 The clinical perspective was slightly different from the operational managers and focused on softer issues. There were concerns about the image that the finance directorate creates for itself in as much as there has to be a move away from the perception of ±cost cuttingq towards working in partnership with other staff groups. Finance directorate staff also have to be intellectually robust enough to properly engage consultants. There was an acknowledgement that there can be a degree of defensiveness on the part of some clinicians looking to ±protect their patchq

2.10 Clinicians take a value perspective that links into the financial side. Their focus is very much on new treatments and how to manage the benefits. This in turn means that their viewpoint is constantly moving forward and they believe itqs the job of the finance directorate to map this journey and follow at the same pace.

2.11 There was a feeling that if SLR could be linked to clinician training records and appraisals there would be far more interest.

2.12 A practical problem for the consultant body is that it is often the more junior doctors that are making resource allocation decisions, for example ordering pathology tests. These staff also need to understand SLR and be shown its benefits.

Proposed Solutions

3.1 The Trust has done a lot of work on SLR, but for the project to succeed it needs much wider engagement with various staff groups and a clear strategic plan on what outcomes it wants to achieve. This plan must have clinical and Board ownership.

3.2 Our solutions would be as follows: **An implementation group should be set up as a sub committee of the Trust Board**. Ideally the Medical Director should be the chairman of this group to encourage clinical involvement. It should also include some operational managers, consultants, the Finance Director and a senior person from IMT. The number of people in the group should be limited to a maximum of ten and it should meet once a month. The outcomes it wants to achieve should be debated and clearly set out at the beginning of the process

and there should be a definite timescale attached. Assista has undertaken this work for other trusts and would be able to devise and test suitable discussion papers and also run the administration of the group.

3.3 One of the main aims of the implementation group should be to decide on what to do after SLR has been implemented. There is a natural progression towards Service Line Management, but this throws up many more questions: should Service Lines be able to keep a proportion of their surplus? How much should decision making be devolved down the organisation in an evidence based culture? Assista would be able to advise the implementation group on these issues and suggest areas to concentrate on.

3.4 The existing technical group chaired by the Assistant Director Finance should continue to meet and report into the implementation group.

3.5 **A defined engagement process should be set up with clinicians and operational staff**. Similar to the interviews carried out for this report, this would begin to create the feedback loop needed for successful SLR implementation. Assista would be able to carry out these interviews and relay the results to the implementation group. An independent organisation would be in a better position to undertake this process.

3.6 **SLR Roadshows should be hosted throughout the Trust for all staff groups**. These would set out the basic concepts behind SLR and how they benefit all staff. Assista has run these types of events for other trusts and we have templates that are easily understandable.

3.8 **On going progress articles should be placed in 'The Link'**. These should highlight milestones and any successes achieved. They should focus more on human interest stories rather than the technical work involved. Assista would be able to write these articles.

3.9 **SLR and traditional management accounts must run in parallel**. The finance department should produce a coherent reporting pack that is credible in the eyes of the end users. There needs to be a reconciliation between SLR and the ledger. It's difficult to comment in more detail on this technical work without looking at the outputs produced so far. However, there are areas of work that could be undertaken that would complement the work done already. For instance, one area that Assista could immediately look at would around producing Service Line information on non Service Line areas, such as radiology. We could produce a price list based on the total recovery of last year's costs. Applying this to 2008/09 activity would then show a surplus/deficit on radiology, stimulating a debate on the relative efficiency of the department. This links into the larger question touched on in 3.3 above of what the Trust should do with the surplus it makes and how to correctly reward good performance. Essentially this is a decision for the implementation group, but Assista would be able to facilitate that discussion by highlighting the approach taken in other trusts.

3.10 To carry out the work highlighted above would take us two to three days a week, depending on the timescale agreed by the implementation group in 3.2 above. In project work we follow a PRINCE 2 methodology, agreeing outcomes and a proposed timetable with our clients. A major focus of our work is how we hand over projects so that information and learning is not lost to the organisation when we leave. We stay in contact with our clients after projects have ended and do not charge for further ad hoc enquiries/advice.

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