Whittington Health NHS

ITEM: 18
DOC: 15

Trust Board Meeting

DATE:	28th March 2012

TITLE:	Service Line Report (SLR) – Month 10 2011/12

SPONSOR: Richard Martin, Finance Director	**REPORT FROM:** Guy Dentith, Head of Finance

PURPOSE OF REPORT:
The purpose of this report is to provide an overview of the Trust's SLR performance for Month 10 of 2011/12.

EXECUTIVE SUMMARY:

This report shows service line performance for Month 10 of 2011/12 by division, as calculated from the patient-level information and costing system (PLICS) – showing both contribution and profitability.

The SLR information is calculated from a combination of actual costs and income, allocated at patient level, together with top down apportionments of the community costs/income. Consistent with previous months the report covers performance two months in arrears due to the timing of activity being fully coded on the Trust's information systems.

In addition, it provides an update on the current role of PLICS/SLR data within the Trust and future objectives.

PROPOSED ACTIONS: The Trust Board is asked to:

•**Note**: The 2011/2012 M10 financial performance of service lines as reported in the Appendices.
•**Note**: The proposed next steps for embedding SLM in the organisation in section 2.3.
•**Discuss**: The proposed options around setting a new target contribution margin.

APPENDICES:
The following appendices have been included for further understanding of the monthly position:
- **Appendix 1** shows the summarised income and expenditure Trust position split by division.
- **Appendices 2-4** show the detailed SLR position within each division disaggregated by service line.
- **Appendix 5** shows Trust wide service line performance in the portfolio matrix.
- **Appendix 6** provides detail on the key costs and apportionment methodologies underpinning the SLR information.
- **Appendix 7** proposes and explains three options around a new target contribution reflecting reference cost averages.

DECLARATION:

In completing this report, I confirm that the implications associated with the proposed action shown above have been considered – any exceptions are reported in the Supporting Information:

Implications for the NHS Constitution, CQC registration
Financial, regulatory and legal implications of proposed action
Risk management, Annual Plan/IBP
Moving Ahead – how does this report support any of the Trust's 5 Strategic Goals

1. Month 10 SLR Report

1.1. Headline Observations

The overall Trust contribution margin has reduced by 1.1% to 19.6% compared with the 20.7% reported in month 9.

This most significant reason for this is due to reclassification of costs in line with the latest Department of Health costing guidance. Costs relating to providing patient services such as health records, infection control, blood transfusion services, domestics and portering which were previously classified as overheads are now classified as indirect costs.

This adjustment only redistributes costs within each service line, therefore it does not affect the bottom line profitability of a service. The only service line where the contribution margin is materially affected by this reclassification is Clinical Haematology where there contribution is 12.4% in month 10 compared to 26.8% reported in month 9. This is due to £500k costs related to the blood transfusion service being reclassified as and indirect cost in line with the guidance.

It is worth noting that using the previous costing methodology, there has been a 0.4% increase in month 10 in the contribution margin to 21.1%.

Figure 1: M10 divisional summary

Division	Income (£000's)	Direct and Indirect Costs (£000's)	Contribution Margin (%)	Overhead Costs (£000's)	Profit Margin (%)
Integrated Care and Acute Medicine	90,877	73,518	19.1	17,186	0.2
Surgery and Diagnostics	60,300	45,250	25.0	12,909	3.6
Women, Children and Families	72,682	61,178	15.8	14,258	-3.8
Trust Total	**233,859**	**179,946**	**19.6**	**44,354**	**-0.2**

Integrated Care and Acute Medicine

The overall contribution margin for this division is 19.1% which is a decrease from the month 9 position of 20.2% consistent with the impact of the new costing guidance. Similar to previous months, significant positive contributors are the Respiratory Medicine, Acute Medicine and Community service lines. Within Respiratory medicine both outpatient attendances and emergency inpatients provide the greatest contribution to the service's profitability.

As indicated in the month 9 board paper, a review of the relevant pain management staff time relating to the treatment of acute pain patients was carried out and costs apportioned accordingly. This has resulted in an improved contribution margin of -8.4% compared to -16.9% previously reported in month 9. Further work around the relative cost of theatre minutes may further improve the Pain Management contribution margin in future months.

There has been a 14.4% reduction in the Clinical Haematology contribution to 12.4% from the 26.8% reported in month 9. This is due to £500k costs related to the blood transfusion service being classified as indirect costs in line with the latest costing guidance as described in section 1.2.

Surgery and Diagnostics

In line with changes to cost classification, the overall contribution margin for this division is 25.0% which is the highest divisional margin, but a reduction from the month 9 reported margin of 26.8%. All of the 11 Service lines are generating a contribution towards the Trust's overheads with a total year to date divisional contribution of £15m. Drilling down to the service lines (shown in **Appendix 3**) the highest net contributing services include ENT, Ophthalmology, Dermatology, Critical Care and Direct Access diagnostics.

Women, Children and Families

This division generates the lowest contribution margin of the three divisions at 15.8%. However, excluding the impact of the new costing guidance, the month 10 contribution margin is 16.8% which is an increase from the month 9 report which showed a divisional contribution margin of 16.2%. A key contributory factor to this is the work undertaken by the operational mangers and the business planning team to reapportion radiology costs to take account of the imaging work done by gynaecology and obstetric staff.

As shown in **Appendix 4** all of the service lines are generating a contribution towards the Trust's overheads. The service line contribution of Paediatrics is the highest within the division at 28.8%. This is mainly due to Outpatients and non elective work.

Following the integration of Haringey children's services the Community service line is the largest in terms of income/expenditure and has generated a cumulative year to date £7.4m contribution towards the Trust's corporate overheads.

1.2. Key progress

Subsequent to the February SLR Board report key progress has been made in the following areas:

- Costing improvements to adhere to national standards.
- Development of contribution margin targets based on a national average reference costs.
- Development of a cost component and apportionment report for divisional/operational leads to aid better understanding of SLR costs.
- Further refinement of Qlikview drill down contribution reports with web based access provided to divisional/operational leads.

This progress is further detailed in section 2.2.

1.3. Financial reconciliation

As described in figure 2 the total expenditure in the SLR report is £4.3m lower than that reported in the month 9 finance board report, whilst income is £5.6m lower. This difference, as detailed in figure 3, is due to two elements; income which is not under the control of service lines (e.g. payroll shared service SLA, staff accommodation income) being netted off within the overhead expenditure figures and the exclusion of income/expenditure relating to prior year performance, which is not relevant for patient level costing in this year.

Figure 2: Reconciliation to Month 10 Board Report

	Income	Expenditure	Surplus/(Deficit)
Month 10 Board Report	£229.5m	£228.6m	£0.9m
M1-10 SLR values	£223.9m	£224.3m	-£0.4m
Difference	**-£5.6m**	**£4.3m**	**-£1.3m**

Figure 3: Reconciling differences

Reconciling Item	Income	Expenditure
Corporate income netted off from overhead expenditure	-£4.4m	£4.4m
Prior year income/expenditure	-£1.2m	-£0.1m
Difference	**-£5.6m**	**£4.3m**

2. Enabling Service Line Management (SLM)

2.1. Overview

Under the new divisional structure it is important that the roll-out of SLM and using it to develop Whittington Health as a business is a priority.

The objectives of Service Line Management (SLM) are to:

- Understand the performance of the Trust's business units in SLR.
- Identify examples of best practice in high-performing service lines, that can be implemented in other areas of the Trust.
- Focus on productivity gains and improved quality to help create surpluses for reinvestment and enhance the patient experience.
- Improve clinical and operational management engagement in business planning and financial management.

2.2. Ongoing Progress

As previously stated in section 1.2, subsequent to the January SLR Board report key progress has been made in the following areas:

Costing improvement and national standards

The Whittington Health SLR information is calculated and underpinned by the Trust's patient-level information and costing system (PLICS). Our PLICS system is currently undergoing a comprehensive review whereby the fundamental costing assumptions and apportionments are being refreshed to reflect analysis and feedback from SLR users. Following feedback from operational leads an explanatory guide has been produced (**Appendix 6**) which details the main cost drivers and the apportionment methodology in order to enable understanding of how PLICS allocates the main areas of cost.

In addition to this review, the costing methodologies and reporting mechanisms have been evaluated to ensure they are consistent with national clinical costing standards issued by the Department of Health. In implementing the costing changes to align our system with the DH guidance, costs relating to providing patient services such as health records, infection control,

blood transfusion services, domestics and portering which were previously classified as overheads are now classified as indirect costs.

This adjustment only redistributes costs within each service line, therefore it does not affect the bottom line profitability of a service. The benefits of adhering to the national standards include the ability to externally benchmark our data with other acute providers and ensuring we adopt national costing best practice.

Contribution margin analysis

The target contribution margin for all service lines is currently set at 30%. A review of this target percentage has been undertaken to assess if it would be more appropriate to set a specific target for each service line to ensure that challenging yet realistic goals are set to incentivise optimal performance.

The 2010/11 reference costs information recently published by the Department of Health has been used by the business planning team to determine an expected cost base for each service line. This has been used to reverse engineer a service line contribution which should reflect a target based on the national average cost for each service line.

The analysis has been used to generate three potential contribution margin options as detailed in **Appendix 7** with advantages/drawbacks listed for Trust Board discussion and approval. The three options provided are calculated as follows:

1) The current service line performance and contribution adjusted equally across each service line to generate a 1% surplus in line with Monitor requirements and the Trust's Long Term Financial Model.
2) Using the HRG/POD level reference costs information to determine an expected cost base therefore calculate a target service line contribution. This was then normalised to remove large variation, with a 10% 'ceiling' and 'floor' target percentage applied relative to the average, and adjusted to ensure the overall 1% surplus is generated.
3) Using a target achievement of a reference cost index of 100 indicating that our costs are brought in line relative to the national average. This target is also normalised using a 10% 'ceiling' and 'floor' target percentage relative to the average.

Training provided

A range of training sessions haven been delivered over the previous few months:

1) Training on SLA Key Performance Indicators (KPI's) the Trust has agreed with commissioners, delivered to groups of Consultants and operational managers.
2) Guidance on Service Line Reporting performance delivered at the divisional Board meetings.
3) One to one training on the Qlikview 'drill down' reports described above to divisional and operational leads.

All training sessions have received positive feedback and further sessions will be delivered in the coming months. Additionally, as the Trust-wide suite of Qlikview reports is finalised, training tools will be distributed on the Trust intranet to allow for remote training.

2.3. Next steps

Following the above progress the next steps are proposed to ensure the PLICS/SLR data is utilised to fully support effective SLM:

1. Designated operational/clinical leads for each service line are to be provided with a custom package of web based access to the SLR financial performance information and key metrics.

2. Continued implementation of a programme of training for users of the reporting software through face-to-face or virtual teaching aids.

3. The finance business planning team develop further reports in conjunction with the divisional leads and operational managers to ensure the divisions have the information they require to run their services as efficiently and effectively as possible.

4. Ensure an ongoing programme of information validation to improve data quality and accuracy of PLICS costing. This consists of several key objectives:

    - Ensure clinicians/managers understand the key messages from the information supplied.
    - Ensure the Trust adheres to national clinical costing standards.
    - Ensure the divisions own their data i.e. if there appears to be an error within the data the emphasis is on the division to identify the issue and ensure it is rectified.
    - Drive focus on materiality – what are the key issues affecting profitability e.g. what are the significant cost drivers.

5. Integrate the costing of community services at patient level wherever possible to enable drill down and analysis of profitable services/patient pathways.

6. In the medium term develop a comprehensive performance dashboard with information on quality/patient experience to ensure a balanced scorecard approach is taken and costs aren't driven down to the detriment of the quality of the services provided.