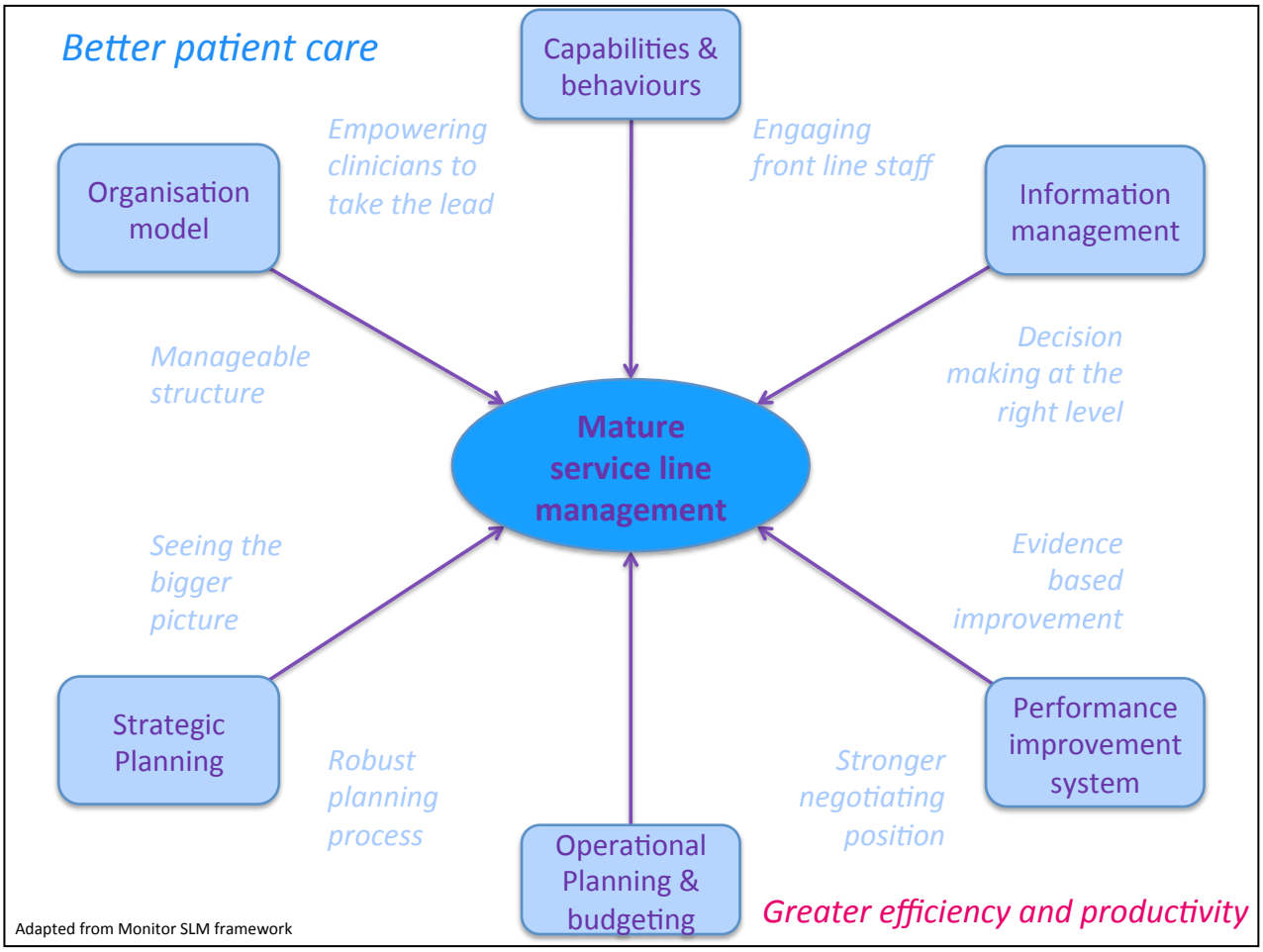


Service Line Management maturity at Sherwood Forest Hospitals

Prepared for: Peter Wozencroft, Director of Strategic Planning and Commercial Development

Prepared by: David Seymour, Director

15th October 2014

EXECUTIVE SUMMARY

The trust has had a form of Service Line Management (SLM) since 2007 and SLM forms a key part of the narrative of the current strategic plan. From the end of July to mid-October this year work has been undertaken to assess the maturity of the trust's service line management and develop a plan to move the trust towards best practice implementation. Key findings from the maturity assessment include:

- Implementation of service line management is 'partial' (level 2 implementation) across all four dimensions (organisational structure, strategy and planning, performance management and information management) used by Monitor to assess best practice (level 4) implementation.
- There were a large number of 'Don't know' responses to a self-assessment survey carried out as part of the work indicating significant understanding and awareness gaps even amongst senior leaders within the trust.
- Defined structure and use of incentives and consequences scored lowest of all the criteria, assessed as 'minimal implementation' by all respondents.
- The approach to service line management and the stage of development varies between divisions (particularly between Emergency Care & Medicine and Planned Care & Surgery).
- Recent "corporate disorganisation" has hampered development of service line management
- The importance of better implementation of service line management came through strongly in interviews: ***"it's fundamental to our future"***

Re-invigorating SLM should be synonymous with **'organising to deliver sustainability'** (rather than being viewed as meeting a Monitor expectation) and needs to involve the whole organisation (not just front line clinical services). It means changes to organisational structures and accountabilities, management processes (e.g., performance management, strategic and operational planning, risk management) and capabilities. It needs to be underpinned by better information flows that enable timely analysis and interpretation of data to drive action.

This report sets out a large number of recommendations and it is acknowledged that these come on top of recommendations and actions from recent reviews into governance arrangements and regulatory requirements. There is, therefore, a significant risk that this review fails to gain traction given everything else the trust is having to manage. To help kick-start implementation, three priorities for action over the next 6 months have been set out:

- Priority 1: Clarify organisation design by Christmas
- Priority 2: Get an improved performances management process in place by start of FY 2015/16 at the latest
- Priority 3: Stress test plans at performance unit level using expertise and experience from across the organisation by end of January 2015

The imminent arrival of the Head of Strategic Planning provides vital capacity to help co-ordinate and drive forward the priorities but additional investment, particularly in informatics, will also be required. The senior leadership of the trust will also have to invest time to resolve organisation design issues (such as how to manage the site-based requirements). In the medium term, investment in the development of the current and future leaders of performance units will be required to build the capacity of a clinically led organisation able to deal with the challenges of today and the opportunities of the future.

1. CONTEXT

1.1 BACKGROUND

The trust has had a form of Service Line Management (SLM) since 2007 and SLM forms a key part of the narrative of the current strategic plan which was approved by the board and submitted to Monitor at the end of June 2014. However, SLM is not yet embedded as 'the way we do business at SFH' and therefore its development needs to be part of the overarching implementation plan for the trust's strategy. To achieve this work was commissioned to:

1. Assess the maturity of the trust's service line management;
2. Develop a set of recommendations to form the basis of the forward work plan to bridge the gap between current SLM and the ideal future state;
3. Define what successful development of SLM looks like over 6, 12 and 24 month time horizons;
4. Define the potential support requirements for the next stages of the trust's SLM journey;
5. Develop a framework for assessing the relative performance of service lines and different treatment strategies to be adopted.

The work builds on the recent financial governance review by KPMG and current internal audit meetings with Non-Executive Directors. It also needs to be considered alongside related work on performance framework (Kevin Gallacher), role of the clinical service line leaders (Andy Haynes), refinements to SLR and implementation of PLICS[1], new PAS implementation, and enabling strategies such as recently published Organisational Development (OD) strategy. This report also draws on insights and approaches from other organisations who have implemented, or are in the process of implementing SLM.

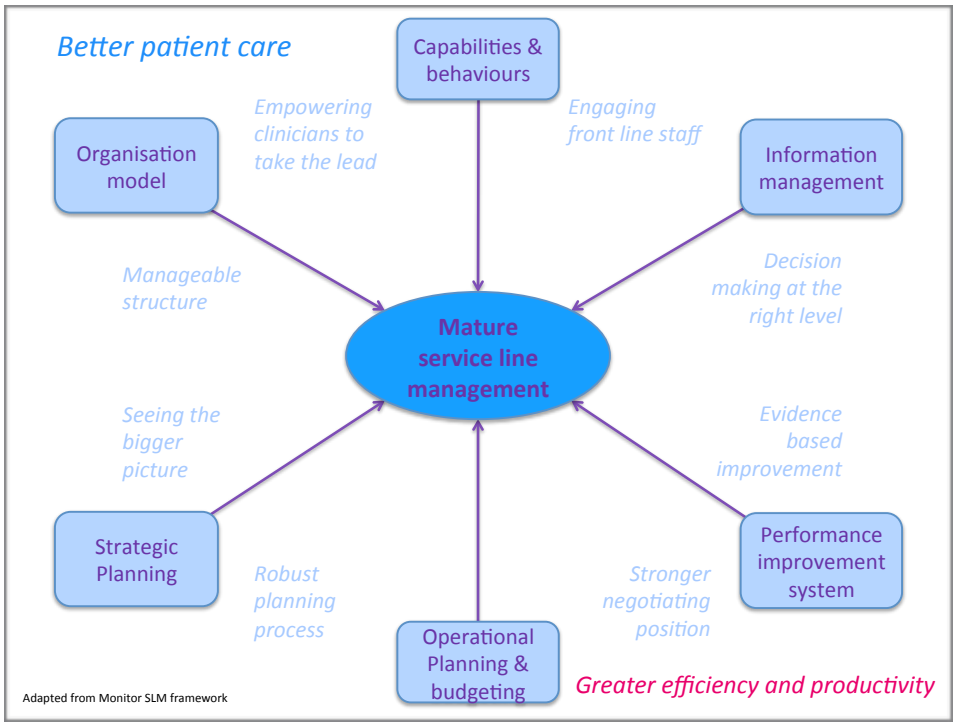
1.2 DEFINING WHAT GOOD LOOKS LIKE

There is a reasonable degree of coherence about what works for service line management (SLM) across the Monitor frameworks for SLM, the 2011 Kings Fund review of service line management implementation at seven NHS trusts, the 2012 publication by 2020 Delivery "The journey to Service Line Management: turning theory into practice", and other practitioner experiences such as those described on the 16 July 2014 HFMA webinar "How SLM/SLR will add value". As such it is possible to take a hypothesis driven approach to both the assessment of the trust's SLM maturity and the recommendations for the forward work plan.

A framework for mature service line management is set out below. In essence, service line management should reflect the vision, mission, values and strategy of the organisation and guide all aspects of organisation design - the structures and accountabilities, management and information processes, and capabilities and behaviours. It should affect all departments and functions within the trust, be they (clinical) service lines, clinical support services, non-clinical support services or corporate functions.

[1] Patient-level Information & Costing Systems

Monitor have also published a self-assessment framework which sets out four different levels of implementation (minimal, partial, significant and best practice) for 27 different criteria across Information Management, Strategy &



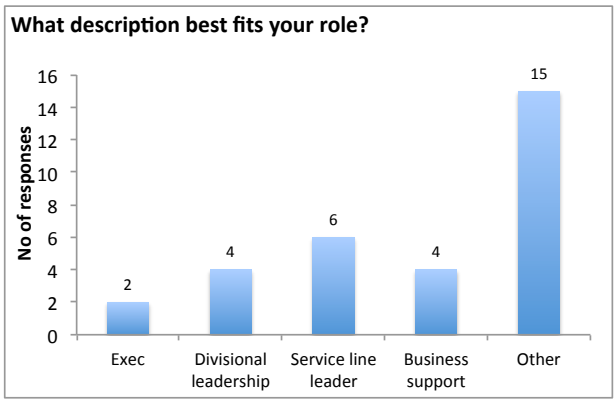
service line planning, performance management and organisational structure. This self-assessment was converted into an online survey and completed by 30 individuals in key roles across the trust. It forms an important part of the baseline assessment and summary findings are set out in section 2 and then interspersed through section 3 with observations from document reviews and interviews with divisional leaders and senior managers to provide a rounded view on the state of SLM implementation across SFH. The results have then been shared with Divisional Boards, Medical Managers and Nursing Care Forum, as well as the project steering group and Executive team. These groups have also provided additional input to help shape both the recommendations and the approach to implementation.

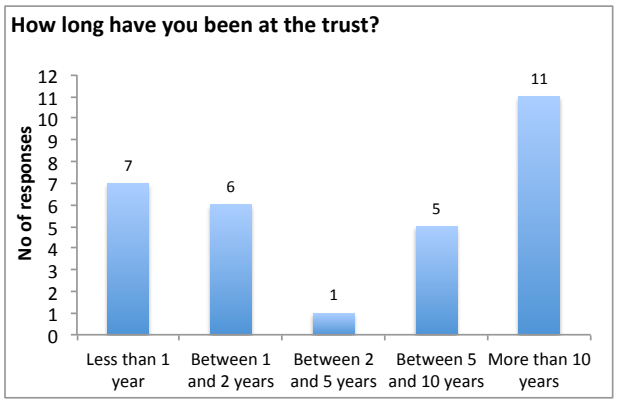
2. OVERVIEW OF SELF-ASSESSMENT SURVEY

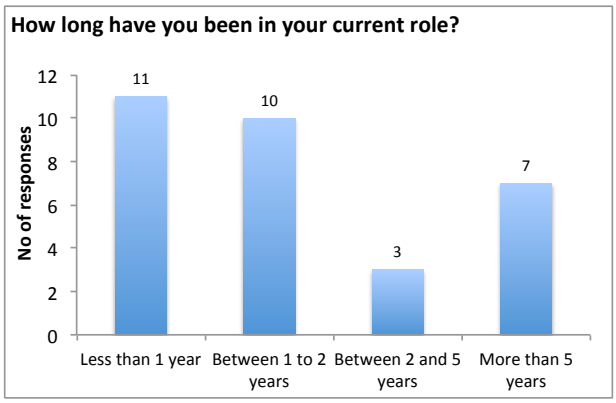
2.1 DEMOGRAPHICS OF RESPONDENTS

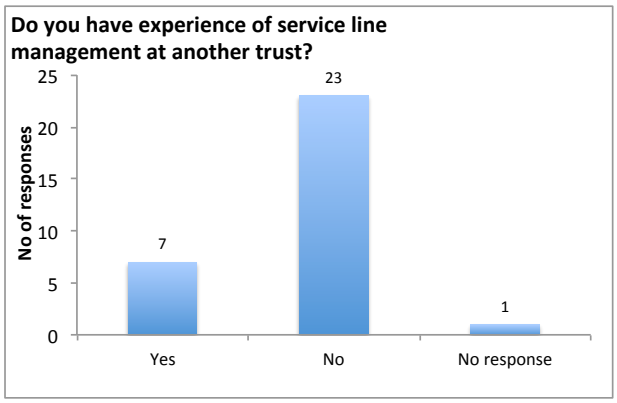
The Monitor self-assessment survey was undertaken by over 30 individuals in key roles across the trust and forms an important part of the baseline assessment. It is estimated that around 60 people were offered the opportunity to take the survey (either via direct requests or through Finance & Performance Managers) and although the overall sample size is relatively small, particularly when segmented into either role or tenure, there was a broadly consistent response to the assessment of progress with SLM implementation.

The charts below set out the 'demographics' of the respondents. Half of the respondents came from corporate support areas. Whilst a third of respondents had been at the trust for more than 10 years, two-thirds were within the first two years of a new role. Less than a quarter had any experience of service line management beyond the trust leaving over three quarters with no external benchmark of what good looks like elsewhere.

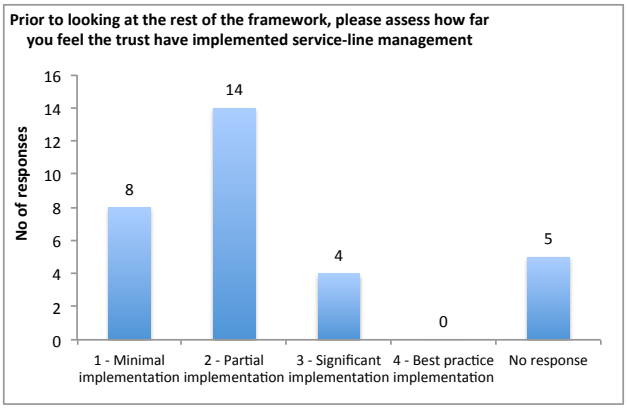




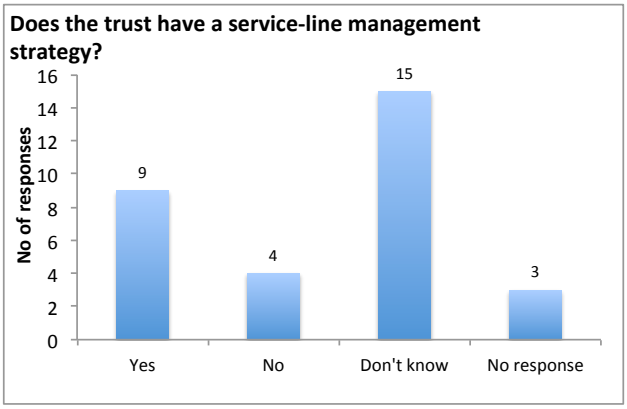




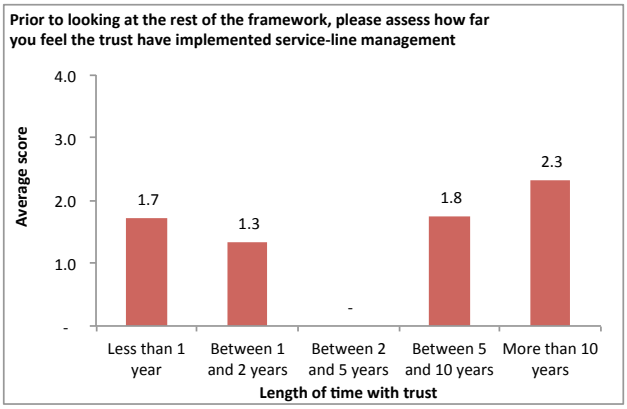
2.2 SUMMARY FINDINGS



Almost half of respondents assessed progress as 'partial implementation' (level two on a four point scale), with a quarter considering that the trust had only made minimal progress.



Most respondents were unable to answer 'yes or no' to whether the trust had a service line management strategy, highlighting a large communication gap



On average, those who have been at the trust more than 10 years viewed progress more positively than more recent arrivals.

It was also clear from both the survey and interviews that the approach to service line management and progress that had been made varied between divisions (particularly between Emergency Care & Medicine and Planned Care & Surgery).

Corporate 'disorganisation' was seen as holding back service line development with the ability of corporate services to support service lines negatively impacted by changes within Finance and other priorities (such as new PAS) within Information.

The importance of better implementation of service line management came through strongly in interviews e.g:

"it's fundamental to our future - people need to own it"; ***"its fundamental to informed decision making"***; **'it's vital"**

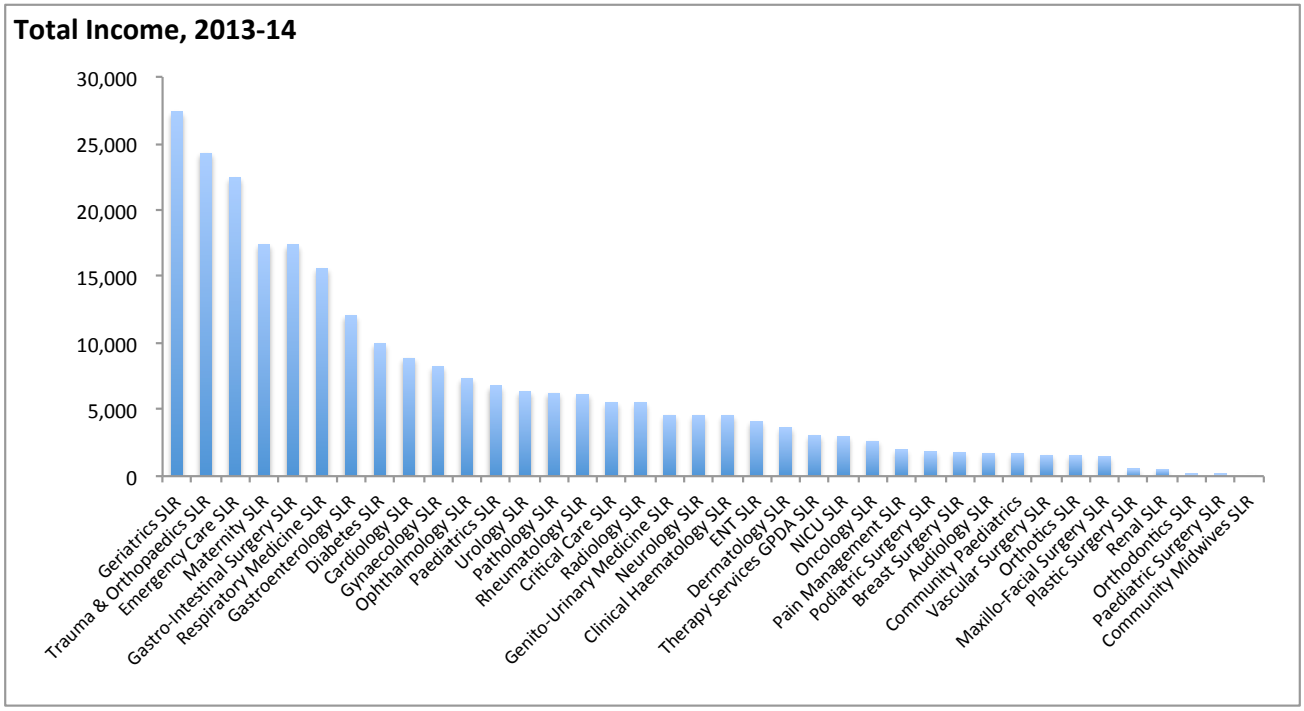
3. OBSERVATIONS AND RECOMMENDATIONS

This part of the document is structured around the four parts of the Monitor SLM self-assessment framework with sub-sections that group together related criteria of the framework. There are also links between the different parts - particularly between information management and performance management - and so there is some duplication of message and recommendation. Findings from the self-assessment survey have been incorporated into the relevant sections. Recommendations were developed to address the gaps highlighted by the work and provide the steering group with a potential way forward. To help kick start implementation, a sub-set of the recommendations below have been condensed into a set of design principles and three priority actions for the next six months (section 4).

3.1 ORGANISATION MODEL

3.1.1. Structure

The trust has defined 38 service lines[2]. These range in size from Geriatrics (£27m of income) to Community Midwives (without any allocated income).



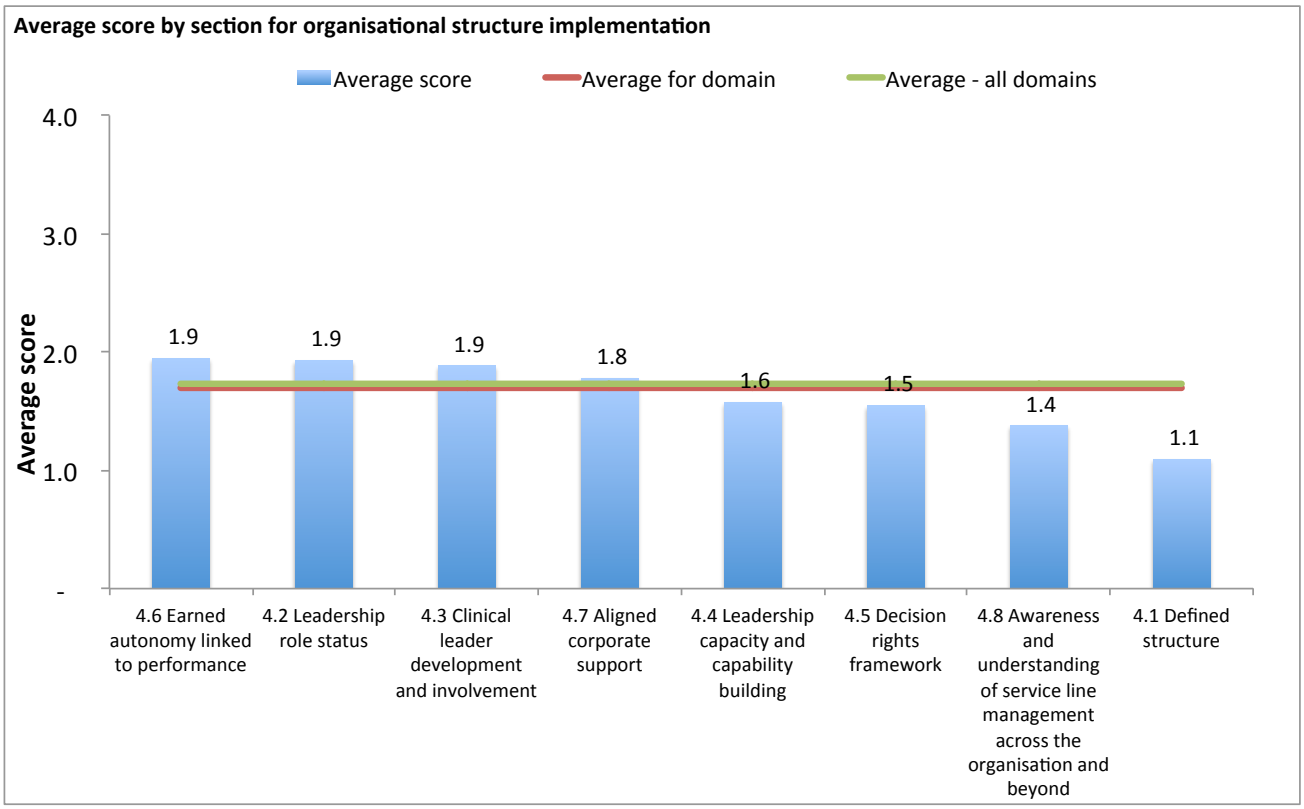
Whilst almost all income is disaggregated to service lines (a positive development), the Trust has not distinguished between 'service lines', clinical support services and corporate support services which leads to services such as Radiology and Pathology appearing as both 'SLR' units and 'indirect costs'. There are also indications that these 'SLR' units are not consistently treated as the main 'performance units' of the trust. The Finance SLR report provides data for service lines but only identifies accountable leaders at the 'Service Management team' level (which are the aggregation of between one and five 'SLR' units). Whilst there may be some synergies across the SLR units within an SMT, generally clinical service strategy, planning and performance management needs to

[2]based on the 2013-14 SLR reports

occur at the specialty level (and frequently at the sub-specialty, team or pathway level) in the first instance and so aggregation can be a barrier to this. The approach to managing at SLR or SMT level differs between Emergency Care & Medicine (who manage at individual service line level) and Planned Care and Surgery (where the SMT appears to be the dominant 'SLR' unit).

There also appears to be little substance in terms of resources directly linked to SLR units. Around £50m of direct costs have been defined, whilst indirect costs are £143m, overheads £80m (of which £63m is allocated in SLR reports) and ITDA costs of £7.5m (of which £6.7m is allocated). Twelve service lines (around 30%) have less than £100k of direct costs. From interviews this was a conscious design choice to have a consistent approach to direct costs such that contribution margins can be compared across all units. However, the result is that service lines are a financial construct rather than an operational unit with significant resources under their control. This is also reflected in the cost centre structure and budget delegations which do not appear to be in line with service line structures or accountabilities (for example Heads of Service generally do not have 'budget holder' status and costs centres are not aggregated into service lines).

Defined structure was also the lowest scored criteria within the self-assessment survey and It is not clear who (or



what) is the 'design authority' for the organisational structure and therefore at what level these structures (and any changes) have been agreed and signed off. It seems unlikely that the current structure has had significant board-level input.

Recommendations:

- Performance units should be defined across the organisation with a clearer separation between clinical service lines, clinical and patient support services and corporate and other support services (profit centres, service centres and cost centres).
- Each performance unit should control as much of the resource they require to deliver their services as possible. In some instances this may involve wards being included in service lines, in other cases they may remain a shared resource.
- The Service Management Team (SMT) layer should be removed unless there is a clear clinical or operational synergy that needs to be managed at that level rather than at divisional or service line level
- Each performance unit should have a named accountable lead but the overall level of management time and resource should be proportionate to the scale and complexity of the unit. This is likely to mean management resource being shared across performance units and a differentiated number of consultant PAs being agreed for medical staff leading performance units. It may also affect the amount of supernumerary time that non-medical senior clinical staff are allocated for leading performance units.
- The organisational structure (and leadership resourcing) should reflect the trust's strategic and transformation plan, involve conscious organisational design choices, and be developed in a transparent way. For example, it may be appropriate to develop a business unit for Ambulatory Care which draws in resource from a number of functional areas and services.

3.1.2. Leadership roles and development

The trust has a strong role model of a clinical leader able to "balance decisions across financial, operational, clinical and people dimensions"[3] in the current Medical Director who takes an active interest in service line performance. Whilst leadership role status scored relatively highly (albeit still averaging below 'partial implementation'), leadership capacity and capability was a low scoring criteria within the survey (see figure above). Comments from the survey and interviews highlighted the variability in clinical leadership at divisional, service management team and service line level. It appears to be further developed in Emergency Care & Medicine where a more selective process has been adopted and as a result the division have some gaps where they do not yet have a suitable individual. The allocation of PAs for leadership roles does not appear to be a barrier with 2 PAs (or a day a week) typically available at SMT level which could be re-allocated. However, there is not an agreed job description that is consistent across the trust, and relevant technical and behavioural training appears to be limited (under a third of respondents answered 'yes' to service line leaders having received training). Succession planning appears to take place informally in some areas but there was not a consistent view on how long heads of service appointments should (or do) last, or which clinicians could be considered for the post.

Recommendations:

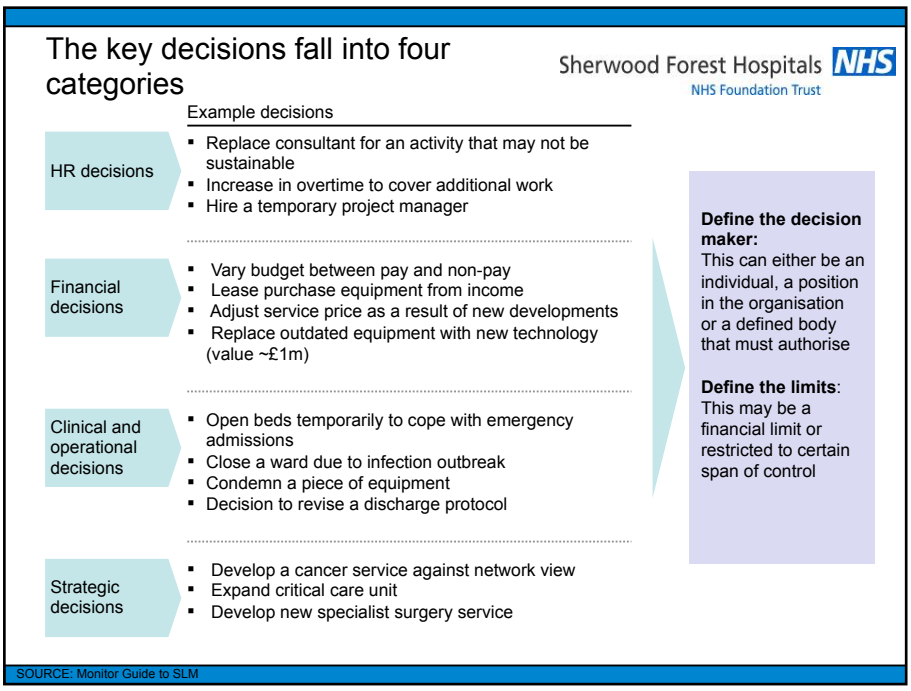
- Develop and agree a consistent job description for Head of Service role, incorporating a consistent approach to allocating 'non-clinical' time to the role (e.g., PAs, supernumerary time) - this work is underway through Medical Managers group.

[3] Monitor definition of 'best practice' implementation

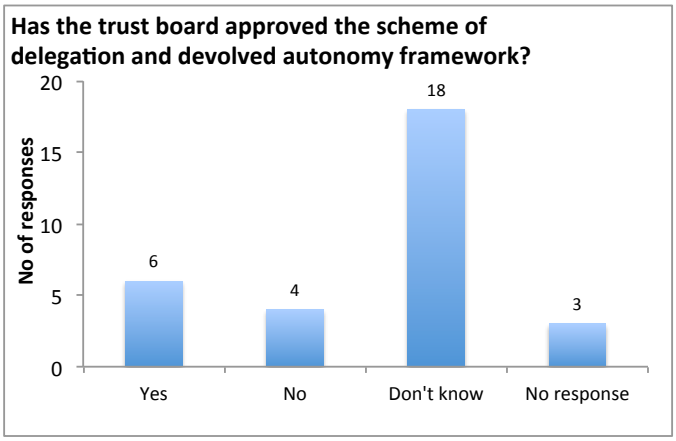
- Develop a trust wide succession plan for service line leadership teams (including doctor, nurse / other health professional, manager, Finance and HR)
- Develop a service line leadership team development programme, incorporating both development for individuals new in post and also refresher / CPD. This should include potential partnership arrangements to support staff development as service line leaders (e.g., exchange with NUH, other organisations, development courses supported by business schools or equivalent)

3.1.3. Decision rights, autonomy and assessment of performance / readiness

Monitor's guidance sets out the change to best practice implementation of SLM as "a shift from centralised decision making to holding service lines to account for clear expectations of performance, having granted greater degrees of autonomy and supported them in developing leadership capability."



Whilst some trusts have adopted a process similar to FT authorisation for their service lines to earn autonomy with the expectation that greater autonomy will be matched by increased accountability, there appears to be little or no definition of decision rights nor a plan for 'earned autonomy' within SFH. This is evidenced by the number of 'don't know' responses to the self-assessment survey question regarding a board approved scheme of delegation and devolved autonomy and the score for the level of implementation of the decision rights framework. Perhaps surprisingly there was a more positive response to 'earned autonomy linked to performance', although it should be highlighted that the average of all responses was still below partial implementation. Around half of all respondents felt service line leaders were accountable for performance, with the remainder answering either 'no', 'don't know' or not providing a response.



Developing the trust's approach to decision making, delegation and devolved autonomy will need to be led at board level and recognise the benefits, risks and constraints of moving towards greater autonomy within

SFH's context and current work on cost control. It will also need to reflect the role of the clinical divisions within the organisational structure and decision making process.

Recommendations:

SFH should embark on a Trust Management Board level process to:

- Define current approach to decision making
- Agree 'ideal state' for decision making assuming high performing and capable service line teams
- Agree the process and criteria to asses performance and capability of service line teams and why and how autonomy may be reversed given changes in performance or capability
- Agree additional benefits of earned autonomy (e.g., additional influence, reduced 'process')
- Agree how similar approach can be taken to support service units

3.1.4. Role of corporate and support staff

Monitor's best practice implementation states "nominated service line support from corporate services and SLAs in place for corporate services". The Finance & Performance Managers, HR business partners / service managers and Business support staff provide some allocated support at divisional and service management team level. This is continuing to be strengthened after the restructuring of Finance and other corporate staff coupled with high levels of staff turnover led to gaps and weaknesses in the corporate support for divisions and service lines (particularly Finance). "Corporate disorganisation" was given as one of the barriers to SLM implementation. Attendance at key service line meetings and follow up on issues were identified as two gaps to be addressed. There was also a lack of clarity about timescales and deadlines for providing information to support monthly performance cycle, and concern that Information are overstretched with new PAS deployment. There was also frustration that the actions of trust HQ sometimes inadvertently undermined service line management within divisions, such as arranging meetings during time protected for monthly performance reviews.

However, there was increasing confidence amongst the divisions that the situation was improving and expected to improve further but it was starting from a low baseline.

Recommendations:

- Current corporate support arrangements and expectations should be clarified for service lines, clinical support services and other support services. They should be clearly communicated to divisional and service line leadership teams who should have opportunity to feedback whether they are 'fit for purpose'.
- Corporate services should undertake a strategy and planning process similar to service lines and demonstrate to their internal 'customers' how they are working to meet their needs as well as deliver as cost efficient service as possible. This should include the degree of 'self-service' compared to 'serviced' service line management, backed up by appropriate training and technology.
- As far as possible future re-structuring of corporate functions and business support should be minimised and agreed posts should be filled by individuals on standard rather than temporary / short term contracts to provide greater continuity of support to performance units.

3.1.5. Communications

Level 4 implementation on this dimension is considered to be "all staff are aware of the shift to service line culture and understand the benefits of the new organisational structure"

Given SLM at SFH started seven years ago and has subsequently gone through periods of reduced focus and importance, it is not surprising that there are very mixed views about SLM and the trust's approach to it across the organisation. It was clear from the strategic planning work in May / June of this year that SLM is **NOT** the dominant thread of the organisational strategy. The number of blank responses to the survey, combined with 'Don't knows' and below average score for the specific communications criteria all highlight a very significant communications challenge that will need to be addressed as part of the implementation plan.

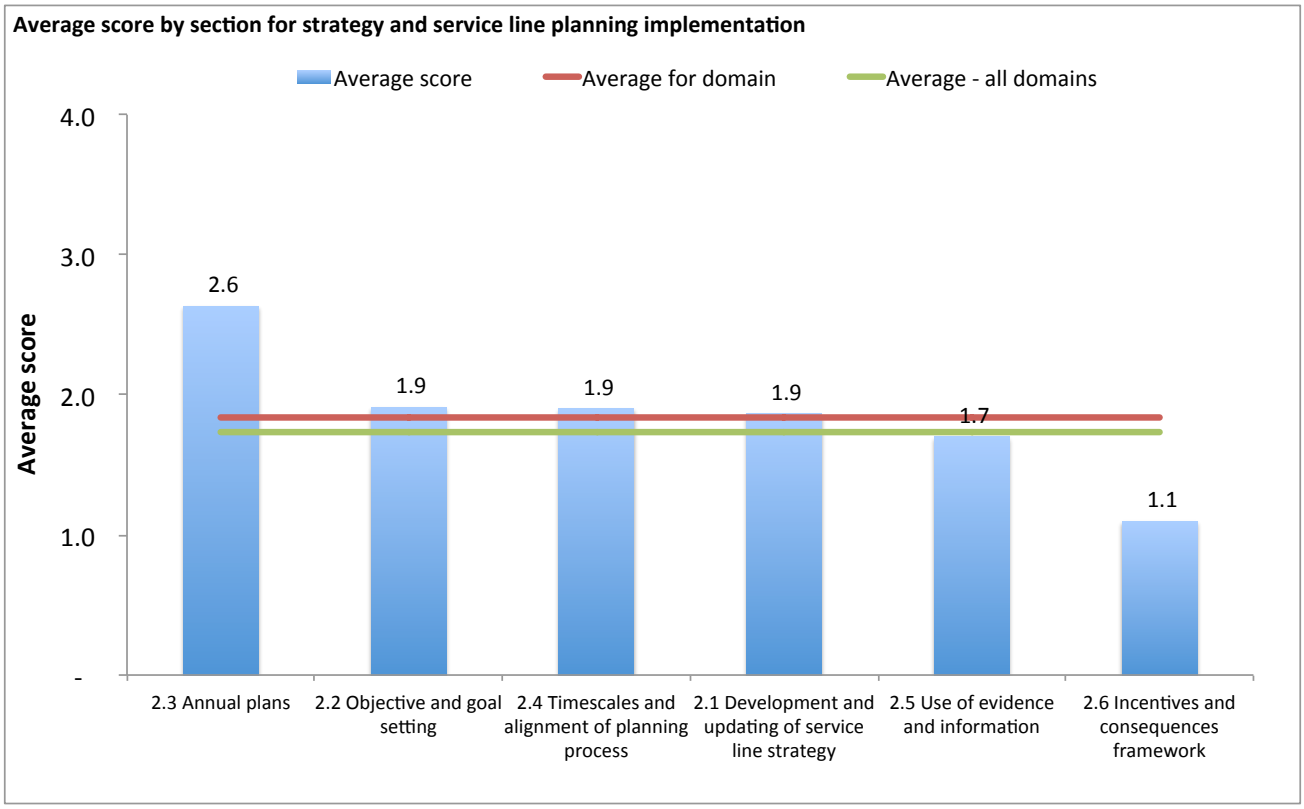
Recommendations:

- Devise a comprehensive communication strategy for re-invigorating SLM as part of 'organising to deliver the strategic plan' and include in regular communications across all media (e.g., highlighting 'good news stories' from service lines). This needs to be part of a coherent narrative grounded in the strategic direction for the trust which encompasses Quality for All, the Integrated Improvement Programme and other change / transformation initiatives.
- Ensure that how the trust runs itself (through SLM) is a core part of new staff induction

3.2 STRATEGY AND SERVICE LINE PLANNING

3.2.1. Strategy and planning

There was a reasonably consistent set of responses within the strategy and service line planning section of the self-assessment, with progress generally assessed as 'partial implementation' except for annual plans (more significant implementation) and incentives and consequences framework (minimal implementation).



Whilst the recent recent strategic planning process provided limited evidence of any documented service line strategies having been developed internally, discussions with divisional leaders indicate they do have 'strategies' they are pursuing with their services. Furthermore, annual plans at specialty level have been developed and this criteria was the highest scoring of all criteria within self-assessment. However, these plans "were not well evidenced based or tied into measurable KPI, finance or operational performance unless where addressing the trust ambitions".

Recent progress provides a solid base for involving leadership teams of performance units (service lines and support services) in the development of their strategies and plans in a holistic, evidenced based manner (rather than on a business case by business case basis) as part of the re-launch of SLM. It will deliver a better plan and also help teams to develop a shared understanding of their current service and how they would like it to develop given the external environment and their relative strengths and weaknesses. Evidence from other organisations suggests that it is likely to be a 2-3 year journey to improved strategic planning.

Recommendations:

- Develop and run a service line strategy and planning process through Q3 & Q4 2014/15 in readiness for 2015/16 (and beyond).
    - Process should start with Exec level guidance and expectations (essential goals and strategic objectives, use of available evidence to support assessment of threats and opportunities, team based problem solving of potential solutions), include some form of interim progress check and executive and peer based review of proposals. Process should also include support services from across the organisation.
    - Proposed strategy and planning process should lead seamlessly into annual budgeting and operational planning process in Q4 2014/15. This should set the operational targets and trajectories (across quality, safety, efficiency, financial and workforce) to be used as basis for 2015/16 performance management and improvement process and conclude before the start of 2015/16.
    - Process should include activity and capacity planning at clinical support service level and result in agreed levels of expected demand for e.g., theatre lists, beds, outpatient clinics, diagnostic tests and procedures, pharmacy issues and therapeutic input. It should also form basis of job planning for key staff.
    - Process should also be used to inform a transparent assessment of performance and capability of each performance unit and hence potential for earned autonomy
- Board should undertake a portfolio review of service lines to ensure alignment of service line plans with trust vision, mission and strategic plan

3.2.2. Financial plans and budgets

Analysis of the 2013-14 service line financial reports suggest that the largest SLR variances are a result of the approach to planning and allocation rather than actual performance and this will need to be rectified for 2015/16. As shown in table below, whilst the trust position was £1.6m better than budget, the aggregated SLR position showed a large negative variance of £11.7m - a difference of £13.3m - which was due to underspends across the reserves budgets. The main driver of this difference was overhead charges that were £0.5m higher than plan

for aggregate SLR but showed a near £10m better than plan position at trust level. This was almost entirely driven by 'other' costs (within the overheads category). Whilst variances for direct and indirect pay were (unsurprisingly) effectively the same, there was a net £3.1m difference in income with trust (including reserves budgets) showing a negative variance of £1.3m compared to service line aggregated negative variance (under recovery) of £4.4m. The difference at patient level income was even greater with the main difference being for 'Other contractual patient income'. These differences suggest the method for allocating reserves costs (and income) during budgeting process is different to the method used for 'actuals'. These sorts of differences undermine confidence in SLR reports and also mask performance related variances.

In addition, the absence of activity data and re-charging of support services at standard costs leads to difficulties in interpreting over (and under) spends. For example, radiology and pathology were both overspent as indirect costs (and under-recovered as service lines in terms of contribution margin). What is less clear is whether this was because they consumed more resource in delivering the 'planned' level of activity or whether the demand for diagnostic test was higher than budgeted which led to the overspend. Likewise Theatres were very slightly underspent as an indirect cost but given that elective income was below plan this may have been due to less activity through theatres requiring less resource, rather than good cost management and efficiency[4]. Ensuring that the plan and the financial budget reflect the planned activity levels at support service level (as well as service line level) and that this is reviewed in year should be a priority for 2015/16 plans.

Concern has also been raised about the accuracy of the approach to apportioning costs with a feeling that whilst a lot of work was done on this in the past this may not have kept pace with organisational changes and so may no longer be fit for purpose. At the very least there is a lack of understanding and perceived transparency about the methodology and when issues or questions are raised the feedback loop to Finance and back to service leaders is not completed in a timely fashion. There is no formalised 'issues' log or improvement plan for SLR methodology.

Line item	Trust position, £m	SLR aggregate position, £m	Reserve budgets, £m	Comments
Budget Profit / (Loss) position	**-23.3**	**0.94**	**-24.2**	Nearly £28m of cost reserves and £1.5m of income under recovery reserves offset by unallocated income targets of £5m
Income variance - patient	+1.2	-3.6	+4.8	Main difference is 'Other contractual patient income' with reserves recording income of £3.6m compared to a budget of -£1.5m
Income variance - non-patient	-2.5	-0.8	-1.6	Under recovery of income targets budgeted under reserves in services to other organisations and 'Other'
Direct costs variance	-1.9	-1.9	0	No reserves
Indirect costs variance	-5.3	-5.3	0	"Other" costs largest variance for SLR budgets
Overheads variance	+9.9	-0.5	+10.4	"Other" costs is main difference plus lower costs for corporate services reserves
ITDA variance	+0.2	+0.5	-0.3	Higher restructuring and depreciation charges in reserves
Sub-total variance	+1.6	-11.7	+13.3	Trust variance is positive due to improvements in reserves budgets, aggregate SLR shows a negative variance of £12m
Actual Profit / (Loss) position	**-21.7**	**-10.8**	**-10.9**	SLR cost centres picked up costs which may have been part of reserves without having budget adjusted

[4] These are intended as illustrative examples not a detailed analysis

Recommendation:

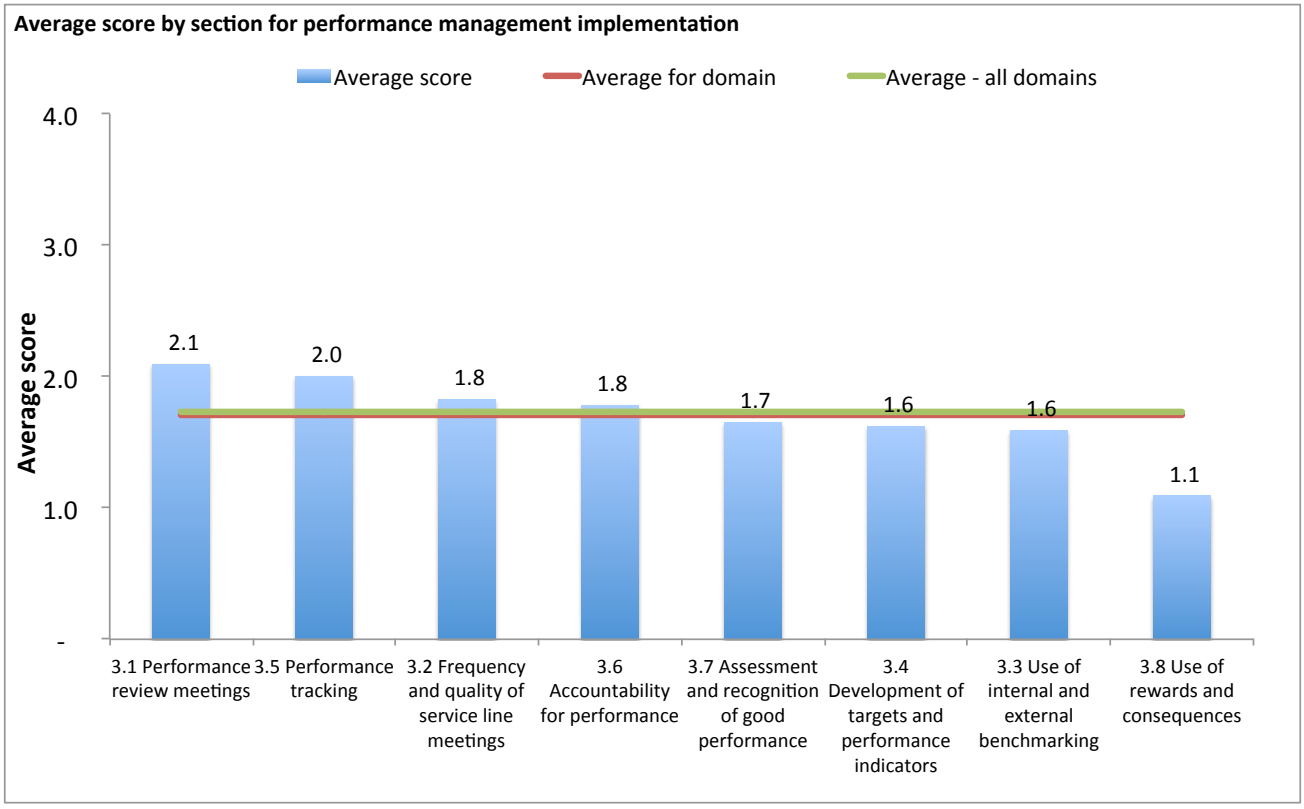
- Undertake a review of allocation and apportionment approach to ensure it is fit for purpose and consistent between budget and actuals
- Review cost centre mapping to ensure it aligns with service line structure
- Increase focus on activity and resource requirements within support services and include development of standard costs for key internal services as part of a move to increased transparency of financial performance and interaction of service lines and support services.
- Move towards managing service line financial performance against budgeted contribution margin (both absolute and % of income)

3.3 PERFORMANCE IMPROVEMENT

3.3.1. Performance review cycle and accountability

"Regular service specific performance meetings are the backbone of effective service line management."

There has been recent work on the performance management framework (presentation to Finance and Performance Committee on 17 Jul 2014), which included the approach to escalation based on RAG ratings of performance and the role of divisional performance meetings and Trust Management Board as level 1 and level 2 escalations. The presentation also highlighted the variable nature of one of the corner stones of SLM - effective service line performance meetings involving all relevant staff groups. In addition the need for "clearer understanding between contract performance, operational performance and their overlap" was identified.



Whilst there appears to be confidence in the escalation process, the focus now needs to be on the core performance review process and improving the effectiveness and consistency of this, particularly at service line level. Feedback from divisions indicates that too many meetings are either cancelled or do not have the right participants or information. The flow between trust, division, service management team and service line (and where appropriate team) requires further definition and consistency of approach. The sequencing of meetings (linked to when the necessary performance data is first available) is an important component, alongside the agenda, expected participants, style of interaction and follow up. The priority given to service line meetings needs to be increased to address concerns such as *"Service line meetings are held after divisional meetings and frequently cancelled as other corporate meetings are booked over pre-organised timings"*.

With effective meetings in place, further consideration can be given to how rewards and consequences can help motivate teams to deliver improved performance (question related to rewards and consequences was assessed as least developed in the self-assessment).

Recommendations:

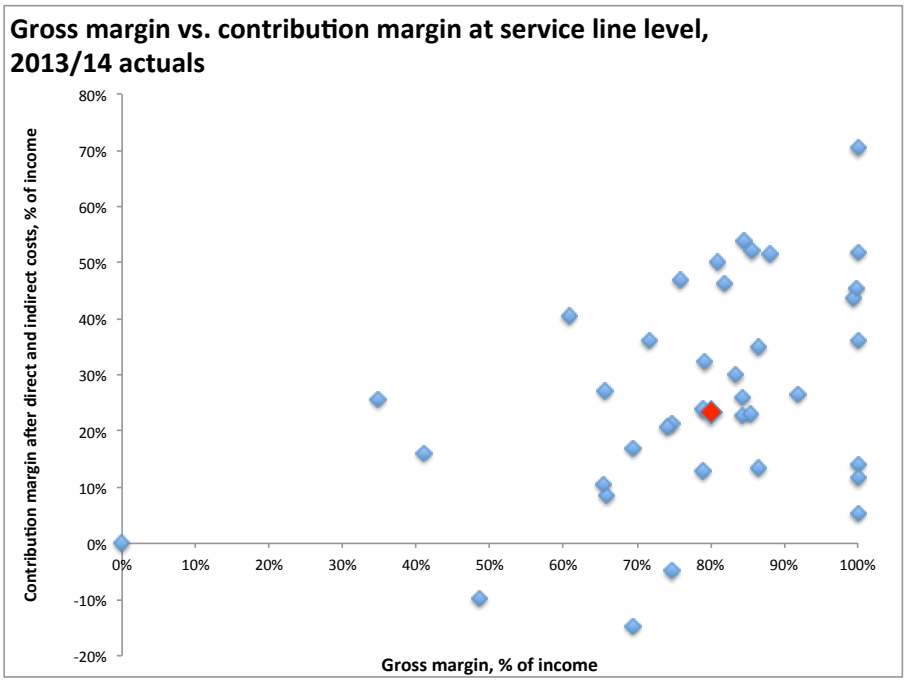
- Update Performance Framework to reflect new governance & assurance approach and clarify expectations incl. TMB to Board escalation - **October 2014 KG/KR** [from 17 Jul presentation].
- Develop a clear statement of expectations for monthly performance review cycle, in terms of meeting requirements, timing, participation, information inputs and meeting outcomes at service line, divisional and trust level (this should reflect the scale and complexity of the service line and so should not necessarily be a 'one size fits all' set of expectations).
- Clarify individual and team accountabilities for performance, particular between service line leads, SMT and divisional teams and role of Executive team (if any) in service line performance reviews
- Promote consistency of approach to performance reviews at all levels, even if frequency of meetings, allocation of time and range of metrics reviewed are customised to services.

3.3.2. Benchmarking and objective assessment of performance

The development of service line packs during the first half of 2014 was a step towards developing an evidence based assessment of performance and potential at service line level. However the use of internal and external benchmarks appears to be very limited and choice of benchmarks at trust level (e.g., Op costs per WTE, income per FCE) do not appear to be relevant or actionable at service line level. This is also supported by the relatively low score on self-assessment.

From observations to date, it appears as though most of the assessment of "performance" is focused on financial performance through SLR reports (particularly in terms of what reaches the board) but even here there are challenges of interpretation and which measure(s) best reflects what a service line can influence (e.g., gross margin, contribution margin, EBITDA - all in both absolute and % of income terms as well as actual level and variance from planned levels). The chart below shows that service line gross margin varies from 100% to around 30% (with average across service lines of 80%), whilst contribution margin varies from 70% to -15% (average 24%) with little correlation between the two.

Poor performance on certain key metrics is clearer (e.g., variance vs. budget, 18 week RTT, infection control, etc.). However, without an objective, holistic assessment of strong performance, it is not possible to develop



approaches to earned autonomy, or to develop effective or fair incentives and consequences. Furthermore it can lead to considerable frustration amongst service leads and, if compounded by an over focus on financial performance can lead to disengagement of clinicians in particular.

Recommendations:

- In line with recommendation in 3.1.3, Exec team (in consultation with divisions and service lines) should agree the process and criteria to asses performance and capability of service line teams. This should include the use of external and internal benchmarks and incorporate quality, safety, patient experience, efficiency, workforce and financial measures. Where necessary, quality (and other service specific KPIs) may need to be developed
- Significant variances compared to 2013/14 plan (or potentially 2014/15 YTD) on financial and non-financial KPIs should be reviewed to understand whether they were due to poor performance, external factors beyond the control of the service or a poor plan/ baseline and lessons should be applied to 2015/16 planning
- Regular use of benchmarking information should be promoted (e.g., through integrated improvement programme, through strategic planning process). This is likely to include improved use of existing tools such as Dr Foster as well as potentially joining other benchmarking initiatives such as those run by FTN and PLICS providers, and using publicly available sources (e.g., reference costs)

3.3.3. KPI development and performance tracking

Level 4 'best practice' implementation is described by the Monitor self-assessment tool as:

- "Sub-service line KPIs set and owned by front line staff / wards / teams."
- "How to make improvements against KPIs is understood by front line staff"
- "Performance is continuously tracked and communicated against the most critical measures, both formally and informally, to all staff using a range of tools"

Based on the evidence of documentation provided by the Divisions and the scoring of the self-assessment, the trust has some of these components in place but also a number of important gaps. There is evidence of sub-service line KPIs (e.g., Imaging modality within Radiology, different Therapy services within Therapies) but it is not clear how well these and the associated plan targets are either owned or understood by frontline staff and they

are not organised into a coherent view of sub-service line performance. There is a very long list of KPIs that are tracked and whilst this is in part a reflection of the complexity of healthcare delivery and the range of local and national targets and expectations, it does make focusing on the 'most critical measures' difficult. In addition, most are 'lagging' (rear view) indicators. However, the minutes and action points did highlight particular areas requiring improvement which were then followed up the next month. It will be helpful to identify KPIs that have been subject to improvement work and resulted in better performance to use in communicating the benefits of SLM and also to demonstrate that front line staff do know how to make improvements.

The completeness and timeliness of the performance tracking data also has shortcomings. SLR data in the February 2014 scorecard referred to November 2013 situation, whilst run rate data (and associated charts) had not been completed for a number of months (Feb 12 in the case of Radiology, Sep 13 for GUM and Jul 13 for Therapies). It was not clear from the documents how widely performance is discussed and whether the information is shared and used beyond the 6-10 people within each of the service line meetings.

The main 'tool' for tracking performance appears to be excel based 'scorecards' which are produced monthly for each service by different individuals. There is currently a lack of business intelligence tools, however deployment of the new PAS is due to improve this situation. The need for improved analysis and interpretation was also highlighted in a number of discussions.

A number of interviews highlighted the need to have consultant level (or equivalent) information available in a timely manner to support action planning and target delivery. The next section on Information management is a key enabler to effective performance tracking and improvement work.

Recommendations:

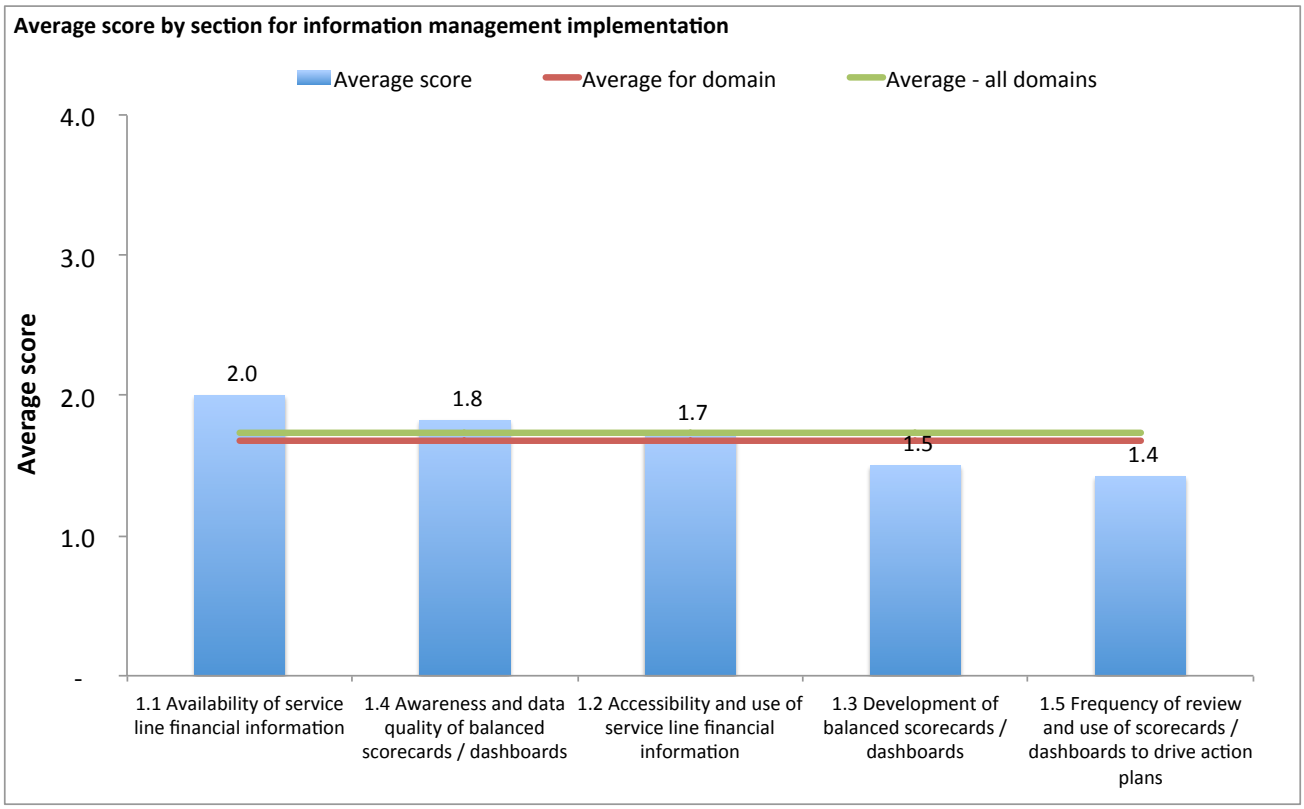
- KPIs should be reviewed by service lines and tested for relevance. Where possible a balance of leading and lagging indicators should be used.
- Performance should be tracked against prior year as well as plan, including use of run rate charts, to help services understand seasonality factors, trends, variability in performance and also reasonableness of plan levels
- Performance information across all domains should be integrated into a single 'scorecard', available at team level and aggregated up to trust level, to make understanding the interplay of the different domains easier and enabling a holistic view of performance. This is in line with the recommendation in 17 Jul presentation "Continue to develop Integrated Performance reporting in line with PAS implementation timetable – **October - JT".**
- The presentation of performance information should be consistent across the trust to improve efficiency of scorecard development, data processing, and information sharing. However, only metrics relevant to the particular service should appear on its scorecard.

3.4 INFORMATION MANAGEMENT

3.4.1. Availability, use and quality of scorecards and dashboards

"Further development is required to complete the balanced scorecards to a satisfactory standard"
Evidence from the divisions shows that scorecards are available for most services on a monthly basis and that these cover a range of activity, operational, workforce and financial indicators. In discussions it was also clear that these KPIs are actively managed - both in terms of performance and also ongoing relevance to services with new KPIs added and some old KPIs removed. However there were at least three different scorecards (an activity, income and costs scorecard, an SLR report, an excel sheet workbook covering Operational Productivity and Access and Quality of Care and Access, and then workforce measures which appeared in action notes indicating that they were provided at the meeting without documentation). There were also comments about the data used for meetings being more ad hoc *"what you can get on the day", "dashboards have not been produced in recent months due to time pressures in information team".* As such it is very difficult to gain a holistic view of performance or understand the interplay between the different performance domains.

A (large) number of KPIs also did not have a plan or baseline figure to compare current performance against and in discussion this seem to be either because the definition was still in development or that a trust wide target (e.g., for cancelled operations) had not been set and cascaded. There was also a lack of run rate charts as outlined above and, as a result, a lack of comparison with prior year (either in month or year to date).
Concerns were raised indirectly about frustrations at the slow speed at which identified issues with data quality or KPI definition were addressed *("the data provided is not accurate which means too much time is taken checking")* which was also reflected in the particularly low self-assessment score for development of balanced scorecards / dashboards.



The reports from each area were of a similar format but overall there was potential for greater consistency in presentation (and efficiency of production). Similar KPIs across different teams / sub-services also tended to be grouped together rather than grouping by team or sub-service. Monitor self-assessment also includes making reports available to patients and all staff as a component of best practice implementation. It is not clear from the work to date how far the trust has embraced this level of transparency, although one respondent to the self-assessment commented *"I personally am not sighted on service line management information".*

Recommendations:

- The trust should invest in a more streamlined, consistent and efficient trust-wide process for producing integrated performance scorecards / dashboards for teams or sub-services which can also be aggregated to service line, divisional and trust level. This would require a single point of accountability for pulling together all relevant data from the different departments (into a KPI database) and running the monthly scorecard production process.

3.4.2. Availability, use and quality of service line financial information

"Current provision of financial information is sporadic and variable in terms of quality"

Level 4 (best practice) implementation is described as "service line financial data is made available to all staff and published on a quarterly basis", however to be an effective management tool the data itself needs to be available in a timely and more frequent manner. Indeed level 3 is described as "service line financial information is actively monitored by the service line team to make timely interventions." The information also needs to be meaningful to service lines and supports services and this is particularly an issue for 'hybrid' units such as radiology and pathology that have some external income streams but the majority of the resource is deployed to support internal 'customers'. Under current arrangements these services show high contribution margins for their 'service line' component but then overspends on their budget statements. This overspend may be due to increased demand from internal customers which may be covered by corresponding external income streams but there does not appear to be a way to reflect this overspend accordingly. The absence of standard costs makes using the information for understanding root causes of variances harder to do.

There is also a lack of understanding of the current apportionment approach and a feeling that it has not kept pace with organisational changes. This reduces the confidence users have in the information provided. With the dominant financial control mechanism appearing to be more traditional budget statements, the importance given to (and interest taken in) service line reports appears to have been reducing over time. Timeliness is another important issue. As outlined above, a February scorecard had SLR data from November as the most recent.

Whilst training was provided when SLR/SLM was launched, and a slide pack from November 2012 indicated that some more recent training or awareness building has been undertaken, there does not appear to have been any refresher training provided recently or induction training for those new to service line roles. As such understanding of the system, the approach and the potential benefits is reducing.

Recommendations:

- The trust should consider making service line reporting the dominant approach to financial control but ensure it is fit for purpose across all 'performance units'. This would require it to be undertaken in a timely manner as part of month end process.
- The trust should update the approach to apportionment. This may be enabled by work on PLICS deployment (see below) but can also be done without PLICS. The work should be led by Finance but be informed by frontline staff. It should also be used to improve awareness and understanding of both the approach and the cost drivers of the organisation.
- The trust should re-start SLR specific training for those expected to work with the system (as part of a wider development programme for SLM implementation)

3.4.3. Development of Patient Level Information and Costing System (PLICS)

Level 4 implementation is described as "service line financial information is capable of analysis to individual transaction, patient or pathway level", which is only possible with deployment of PLICS. One of the actions from the 17th July presentation was "Obtain approval for PLICS, clinical ownership, and commence implementation – **September 2014 - JC".** The full business case and implementation plan are due to be presented to CDG in October with a key decision being whether to invest further in the existing Synergy system which provides current SLR reports or replace the system.

Whilst PLICS has the potential to provide an extremely rich set of data for performance and planning purposes, experience suggests it should not be viewed as the panacea for service line reporting. A number of trusts have deployed PLICS to augment their SLR, providing greater drill down capability and (in some instances) greater benchmarking potential with other organisations (e.g., benchmarking clubs such as those run by Albatross Financial Solutions). There is often a trade-off to be made between investment in PLICS deployment and maintaining and improving existing SLR mechanisms but both require improvements to apportionment approaches and promoting greater understanding of cost drivers.

Recommendations:

- The trust should consider the investment decision for PLICS in light of the overall approach to improving service line information outlined above. It should ensure that sufficient resource and attention is given to maintaining a functional SLR approach during PLICS development.

4. KICK STARTING IMPLEMENTATION

Section 3 includes a large number of recommendations and that these come on top of other recommendations and actions from recent reviews into governance arrangements and regulatory requirements. There is therefore a significant risk that this review fails to gain traction. To help kick-start implementation, this section covers four areas: design principles; priorities for action over the next six months; resourcing for the next phase; and an overview of how the programme of change could develop and be managed over the next two years.

4.1 DESIGN PRINCIPLES

To help test the robustness of the current organisation design and guide future changes, a set of twelve design principles have been developed based on the recommendations from section 3. These have been tested with the Executive and are set out below:

1. Performance units should be defined consistently across the organisation with a clear primary function (e.g., clinical service lines, clinical and patient support services, and corporate and other support services).

2. Each performance unit should control as much of the resource they require to deliver their services as possible and be able to be defined in terms of an aggregation of one or more treatment function codes and/or cost centres and/or other organisational codes.

3. Organisational layers should be minimised as far as possible. Where they continue to exist, their value add must be clearly articulated and understood by those above and below in the organisational hierarchy.

4. Each performance unit should have a named accountable lead and this should be consistent with budget holder / delegations. For service lines this should ideally be a clinician operating as part of a leadership (triumvirate) of doctor, nurse, and manager, supported and advised by peers from corporate support functions (e.g., FPM, HR, Clinical Governance).

5. Each performance unit should have named support from each corporate support function (Finance, HR, business support, Clinical Governance, Information etc.) even if this individual is shared across more than one unit.

6. The amount of funded leadership time and management support should reflect the scale and complexity of the service, and the degree of strategic challenge facing the unit. This allocation of time should also be dynamic over time.

7. All current performance unit leadership teams should be provided with tailored development opportunities to ensure they have the necessary skills, knowledge and behaviours to undertake their leadership roles effectively.

8. Decision making should take place as close to the front line as the nature of the decision and associated trade-offs, and the capacity of the decision maker allow.

9. All units, regardless of primary function, should be included in integrated strategy, planning, performance and risk management processes.

10. All units should have some form of monthly performance review supported by a balanced scorecard that reflects their contribution to trust objectives and targets as well as unit-specific goals.

11. Performance should be measured across a balanced set of domains (e.g., Safe, effective, responsive, caring, cost efficient, well-led) with a mix of leading and lagging indicators monitored regularly.

12. Financial performance should be managed on a contribution margin basis as soon as financial management processes allow.

Examples of how these design principles would apply are set out in Appendix A, with a framework for assessing relative performance of service lines set out in Appendix B.

4.2 PRIORITIES FOR KICK-STARTING "ORGANISING TO DELIVER"

To provide focus for the scarce organisational bandwidth available to engage with the development of service line management, three priority actions for the next six months are set out below:

- **Priority 1: Clarify organisation design by Christmas**
  Ask a sub-group of Medical Managers group to work with divisional leadership teams to run a service line 'fit for purpose' assessment to clarify organisational design and accountabilities and identify gaps or issues requiring Exec level involvement.

- **Priority 2: Get an improved performance management process in place by start of FY 2015/16 at the latest**
  Invest in informatics capacity to develop a single, trust wide process to produce monthly balanced scorecards for every operational unit (which can be aggregated to service, divisional and trust level) to be tested and ready alongside an agreed performance review schedule by start of new financial year.

- **Priority 3: Stress test plans at performance unit level using expertise and experience from across the organisation by end of January 2015**
  Run a 'peer review' process as part of the planning for 2015/16 whereby each unit presents their assessment of their service and their plans to support delivery of trust objectives for clinical and non-clinical colleagues to understand, challenge and support.

Further details about what would be needed to deliver these priorities are set out in Appendix C

4.3 POTENTIAL RESOURCE REQUIREMENTS FOR NEXT SIX MONTHS

Assuming that the focus of effort in terms of service line development over the next six months is on delivering the three priorities set out above, the following resource requirements have been identified:

4.3.1 Opportunity cost investments (i.e., no additional cash cost):

- New in post Head of Strategic Planning provides additional capacity and a focal point for coordinating implementation – proposal is that this would be sole focus of role for first 18 months

- Formation of a "Team of Deputies" to come together to ensure the implementation is embedded in existing structures and processes as quickly as possible (e.g., HR, Finance, Information, Governance, Nursing, etc.) - *requires commitment from departments to prioritise it sufficiently*
- Attendance and involvement of clinical staff in Peer Review sessions should be considered part of allocated management time / SPAs as far as possible, could also be considered educational.

4.3.2 Potential cash cost investments:

- Medical Managers sub-group may require investment of £3,000 - £5,000 to fund additional PAs for those involved so it is treated as a formal commitment not a voluntary contribution (non-recurrent)
- Investment will be required to develop a suitable KPI database and reporting tool (non-recurrent) – potentially £30-80k depending on level of customisation and consulting support
- 1 x WTE Information Analyst resource will be required to run monthly scorecard production process – this may be achieved through a re-alignment of responsibilities (recurrent)

NB. This does not include additional investment in people development to support organisational change as this needs to be aligned with existing programmes and actions.

4.4 LONGER TERM PROGRAMME OF CHANGE

Part of the project brief included setting out what successful development of SLM looks like for the trust over 6, 12 and 24 months. This has been summarised into three broad phase:

Phase 1 (Oct 14 and Apr 15): Removing ambiguity and using what is currently available consistently and at the right level. The key actions are included within the priority actions for kick-starting implementation. This phase will also highlight key gaps and issues that need to be resolved over the following six months but should mean that for the start of 2015/16 the organisational structure and accountabilities are clear, sufficient time has been allocated to leadership teams, plans and objectives have been set for all performance units and there is a trust wide process for tracking, reviewing and acting on an integrated set of performance information.

Phase 2 (Apr 15 - Oct 15): Making improvements and adjustments to organisational model based on early experience of revised model. The first six months of the new financial year will provide an opportunity to test the clarified organisational design and make iterations as necessary. Objectively assessed high performing services will start to emerge (or be confirmed) allowing piloting of changes to rewards, consequences and decision rights. This will be supported by a development programme for leadership teams. Increasing confidence in data quality and improved analytical capacity and business intelligence support should enable more evidenced based decisions and prioritisation, whilst developments of financial service line reporting (potentially enabled by PLICS) will be informing CIP opportunities. Preparations for a refresh of the strategic plan will have been undertaken.

Phase 3 (Oct 15 - Oct 16): Mature organisational model evolving as situation and needs change. Operational units will have gripped the issues of 'day to day' performance and be able to take an increasingly outward looking approach to the strategic planning process and their organisational design, reflecting the changing commissioning environment. Clinical leaders will be shaping the trust's strategy. The availability and quality of 'business intelligence' will have continued to improve and with it the level of 'pull' for information from operational units will have increased. Succession plans will have been enacted for some services, whilst the quality and responsiveness of corporate support functions will keep pace with the maturing service lines.

This is set out in tabular form in Appendix D, along with an outline governance structure for implementation.

Appendix A: Design principles

Design principle	What does it mean (examples only)	What doesn't change

1. Performance units should be defined consistently across the organisation with a clear primary function (e.g., clinical service lines, clinical and patient support services, and corporate and other support services).	• Anaesthetics is not a performance unit - it is made up of (at least) three performance units:
	  • Critical Care service line (which has a specific external income stream)
	  • Pain Management service line
	  • Theatres clinical support service
	• There will be "hybrid" units (e.g., Radiology, Pathology, Therapies) where there is some direct access or unbundled income but on the whole they are clinical support services
	• HR, Finance, Information etc. are all "performance units"
		• Resource should continue to be be shared where needed (e.g., some rotas)
		
		• Support services should be considered as important as service lines

2. Each performance unit should control as much of the resource they require to deliver their services as possible and be able to be defined in terms of an aggregation of one or more treatment function codes and/or cost centres and/or other org codes	• Wards will form part of service lines where they have a dominant specialty • Endoscopy may be part of Gastroenterology service line (depending on level of use by other specialties) • Some Therapists may form part of a service line • Single organisational hierarchy used consistently for all reporting (e.g., in ledger, ESR etc.)	• Shared facilities that are "owned" by one service line will continue to be available to other services • Heads of Professions will continue to have a responsibility for individuals within their profession (but they may not have direct line management / resource allocation authority)

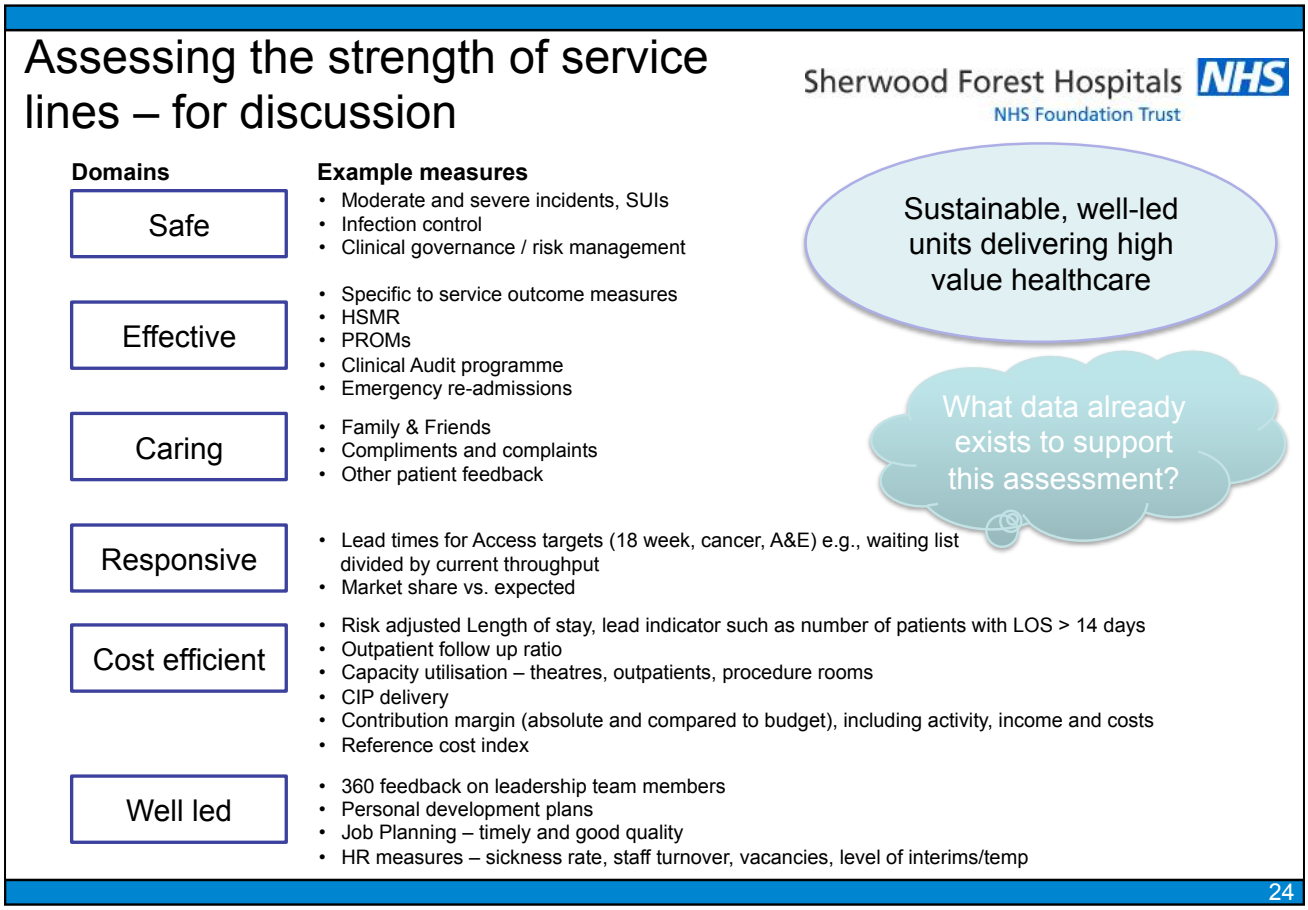
3. Organisational layers should be minimised as far as possible. Where they continue to exist, their value add must be clearly articulated and understood by those above and below in the organisational hierarch y.	• Flatter organisational structure - Executive closer to front line (e.g., Heads of Service may report directly to Executive)
	• Role and accountability of divisions needs to be considered
	• Head & Neck SMT becomes three service lines:
	  ENT & Audiology
	  Ophthalmology
	  Oral & Maxillo-facial surgery
	• Potential breaking down of Medical / Surgical boundaries (e.g., establish a GI unit across Gastro and GI surgery)
	• Questioning the value of having Paediatrics in Planned Care division
		• Need to maintain manageable spans of control whilst avoiding aggregation due to management convenience without clinical synergy / interdependency

Design principle	What does it mean (examples only)	What doesn't change
4. Each performance unit should have a named accountable lead and this should be consistent with budget holder / delegations. For service lines this should ideally be a clinician operating as part of a leadership (triumvirate) of doctor, nurse, manager advised by peers from Finance, HR, Governance	• An agreed leadership establishment providing a clear view on vacancies and forming basis for leadership development and succession planning • No more out of date distribution lists for leadership events • Budget holder accountabilities aligned with service delivery and quality accountabilities • Leadership team could (should?) also include FPMs and HR business partners	• Gaps in the establishment will still need to be managed • Appointed leaders will still need to have development opportunities to build their capabilities to undertake their responsibilities • FPMs and HR business partners should be viewed as peers of the leadership team
5. Each performance unit should have named support from Finance, HR and business support / Information even if this individual is shared across more than one unit	• Any unit - be it service line or support service - know who should be their first point of contact (even though this will be shared)	• The need for units to become increasingly "self-service" • The need to make difficult trade-off decisions about level of support provided to different teams
6. The amount of funded leadership time and management support should reflect the scale and complexity of the service and the degree of strategic challenge facing the unit and be dynamic over time	• Allocation of PAs (or equivalent) to meet needs of the task rather than building up size of service line to justify number of PAs • Number of PAs may change from year to year • Some Heads of Service may have 0.5PAs, others may need 3-4PAs	• Need to manage level of spend on management time
7. All performance unit leadership teams should be provided with tailored development opportunities to ensure they have the necessary skills, knowledge and behaviours to undertake their leadership roles effectively.	• Identification of individual and collective development needs • Development opportunities linked to succession planning • Outward facing component to access a wider range of perspectives on effective management and leadership	• Needs to build on existing development programmes
8. Decision making should take place as close to the front line as the nature of the decision and associated trade-offs, and the capacity of the decision maker allow	• Reduction in decisions that need Exec sign off • Less silo-based decision making - financial consequences of operational decision and service consequences of a financial decision both better understood and taken into account	• Performance units need to demonstrate they are best placed to make the decision and have capacity to make good decisions

Design principle	What does it mean (examples only)	What doesn't change
9. All units, regardless of primary function, should be included in integrated strategy, planning, performance and risk management processes	• Service lines need to actively involve their key support services in development of their plans • Support services have a role to help shape service line plans, whilst being responsive to needs of "internal customer" • Joined up planning better understood across whole organisation	• Support services - whether clinical or non-clinical - are integral part of planning new developments
10. All units should have some form of monthly performance review supported by a balanced scorecard that reflects their contribution to trust objectives and targets as well as unit-specific goals	• Exact nature of performance review will depend on level of earned autonomy and complexity of issues • Principle applies just as much to HR as it does to Orthopaedics • Support services will need to develop quality and operational KPIs • Scorecard production process needs to include **all** units	• Corporate support services should not be"let off the hook" because they tend to be directly managed by Exec Director • Importance of support services not overlooked • Flexibility to avoid one size fits all approach to reviews
11. Performance should be measured across a balanced set of domains* (e.g., Safe, effective, responsive, caring, cost efficient, well-led) with a mix of leading and lagging indicators monitored regularly	• Need to have consistent set of domains across the organisation • Need to develop KPIs to ensure balanced and sufficient leading indicators • Leaders of performance units assumed to accountable for all domains • Trust performance can be easily disaggregated to individual performance units • Updated performance reporting to the Board	
12. Financial performance should be managed on a contribution margin basis as soon as financial management processes allow	• A different approach to financial management, particularly service lines and clinical support services • Changes in costs will be considered with changes in activity and income • Clear understanding of the use of reserves and contingency at trust level	• Differential expectations on level of contribution margin recognising structural differences beyond control of units • Tight cost control • The ability to retain central reserves

Appendix B: Assessing performance of service lines

POTENTIAL PERFORMANCE DOMAINS



SERVICE LINE 'FIT FOR PURPOSE' ASSESSMENT CHECKLIST

1. Is service line (SL) clearly defined in terms of organisational building blocks (e.g., specialty code, cost centres, datix / other codes), Is there a further sub-division into 'operational units'?
   i. If so what is YTD budgeted and actual income and costs for those building blocks
   ii. If not, what are issues to be resolved?
2. Is SL the dominant user (>80%) of specific facilities (e.g., wards, treatment facilities)
   i. If so, has that resource been included in the definition of the service line?
   ii. If not, what is rationale for keeping separate?
3. Is workforce dedicated to SL or shared? If shared, who with and why?
   i. Medical workforce – consultants, other career grades, training grades
   ii. Nursing – specialist, other
   iii. Other clinical staff delivering direct patient care (e.g., Therapists)

4. Does SL have a leadership team appointed and in post (covering medical, nursing and managerial triumvirate)?
    i. If so what is the allocation of time and on what basis?
    ii. How long have the individuals been in post and what, if any, immediate issues or challenges in terms of capacity, capability and commitment need to be addressed?
    iii. If not, what plans are in place to fill the gaps and how are those gaps managed in the interim?
5. What is the division and SL's current understanding of in year performance issues across six domains of assessment framework (Safe, effective, caring, responsive, cost efficient, well led)?
    i. Does it have service specific quality KPIs?
    ii. Can it define three immediate priorities?
6. Does the SL have a clearly defined set of monthly meetings established to review performance and agree priorities?
    i. If yes, are meetings well attended and productive?
    ii. If no, what arrangements does the division have in place to manage performance?
7. What is the division and SL's current understanding of its strategic challenges and opportunities, including how it is perceived by commissioners, referrers and partners? Are any plans in place to address implications?
8. Is the division and SL clear on which (internal) services and support services it needs to work with most closely to deliver efficient and effective pathways and patient care?
    i. What approach is adopted for managing those links?
    ii. Does the other service / support service recognise its importance to SL?
9. How well do the corporate support services align with the SL structure?
    i. Is there a named contact / lead for each of the main corporate services?
    ii. Are there any gaps in support which SL feel need to be addressed?
10. Do the trust governance and internal management processes reflect the service line structure (e.g., cost centre mapping tables, budget holder delegations, internal reports)
    i. If not, why not? What actions needs to be taken to address this?

Appendix C: Priority actions - what's needed?

Recommendation 1: Clarify organisation design by Christmas - what does it need?

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- ☑ Time from sub-set of Medical Managers group to assess all service lines at least once, with potential to need to return to cross-cutting issues
  - 6-8 individuals (led by Medical Director, 2 x Clinical leaders from each of PC&S, EC & M, 1-2 x clinical leader from D&R, senior HR representative, Head of Strategic Planning)
  - Assume 4 hours per division (split out over 6 x 2 hour meetings probably)
  - Fall back meeting (or two) to cover cross-cutting issues / difficult links (e.g., additional 4 hours)
- ☑ Time from divisional leaders and service line teams to prepare for assessment (TBD – could be c 1 hour per SL)
- ☑ Time from divisional general managers to attend their division's SL assessments (e.g., 4 hours)
- ☑ Project resource to prepare and orchestrate meetings
- ☑ Time from Exec team to receive assessment and feedback from Medical Managers and to address non-service line specific issues (e.g., future of Divisional director role, Ambulatory Care structure, model for shared services)
- ☑ Time from corporate support to update systems, processes and information flows to reflect organisation design

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Recommendation 2: Get an improved performance management process - what does it need?

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- ☑ Dedicated scorecard manager / administrator with sufficient technical expertise for interface with data suppliers and scorecard tools and business experience to be able to interact effectively with internal 'customers' – ideally available during KPI specification and technical development of tools
- ☑ Investment in technical solution development – can be as basic as a customised MS Access database with MS Excel reporting tool initially with relatively low development costs
- ☑ Project time from data suppliers from across the trust to develop data extracts in line with KPI specification
- ☑ Time each month from each nominated data supplier to provide data extract to time and specification (should not be additional requirement from today as scorecard should replace some other data supplies)
- ☑ Time from key service leaders and executives to agree KPIs, including definitions, plan / target / benchmark levels and Red-Amber-Green ratings
- ☑ Project time to provide induction for internal customers of scorecards (likely to need to augment scorecard managers time)
- ☑ Commitment to streamline other (monthly) reporting and meetings to align with scorecard process as far as possible
- ☑ (Potentially) increased time in service line review meetings for at least divisional teams and possibly Exec members

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Recommendation 3: Stress test plans at operational unit level - what does it need?

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- ☑ Expectation setting as part of 2015/16 planning and budgeting process (e.g., planned kick off meeting in Oct / Nov)
- ☑ Development of a basic template for units to use to shape their thinking and output
- ☑ Time from teams to undertake SWOT and PESTLE analyses and develop considered plans to address weaknesses, risks and opportunities
- ☑ Some form of interim review by Executive (or divisional) team to steer and provide some 'grit' in the process (December?)
- ☑ Peer review presentations – likely to need c. 2 days in total but exact format needs to fit organisation – organised around clinical adjacent cohorts plus some impartial views (mid January?)
- ☑ Time from TMB (?) to consider feedback from peer reviews and implications for trust plans and priorities
- ☑ Data suppliers to provide information if requested by service line teams (alternative approach would be to use centrally produced 'fact packs' to inform service plans)

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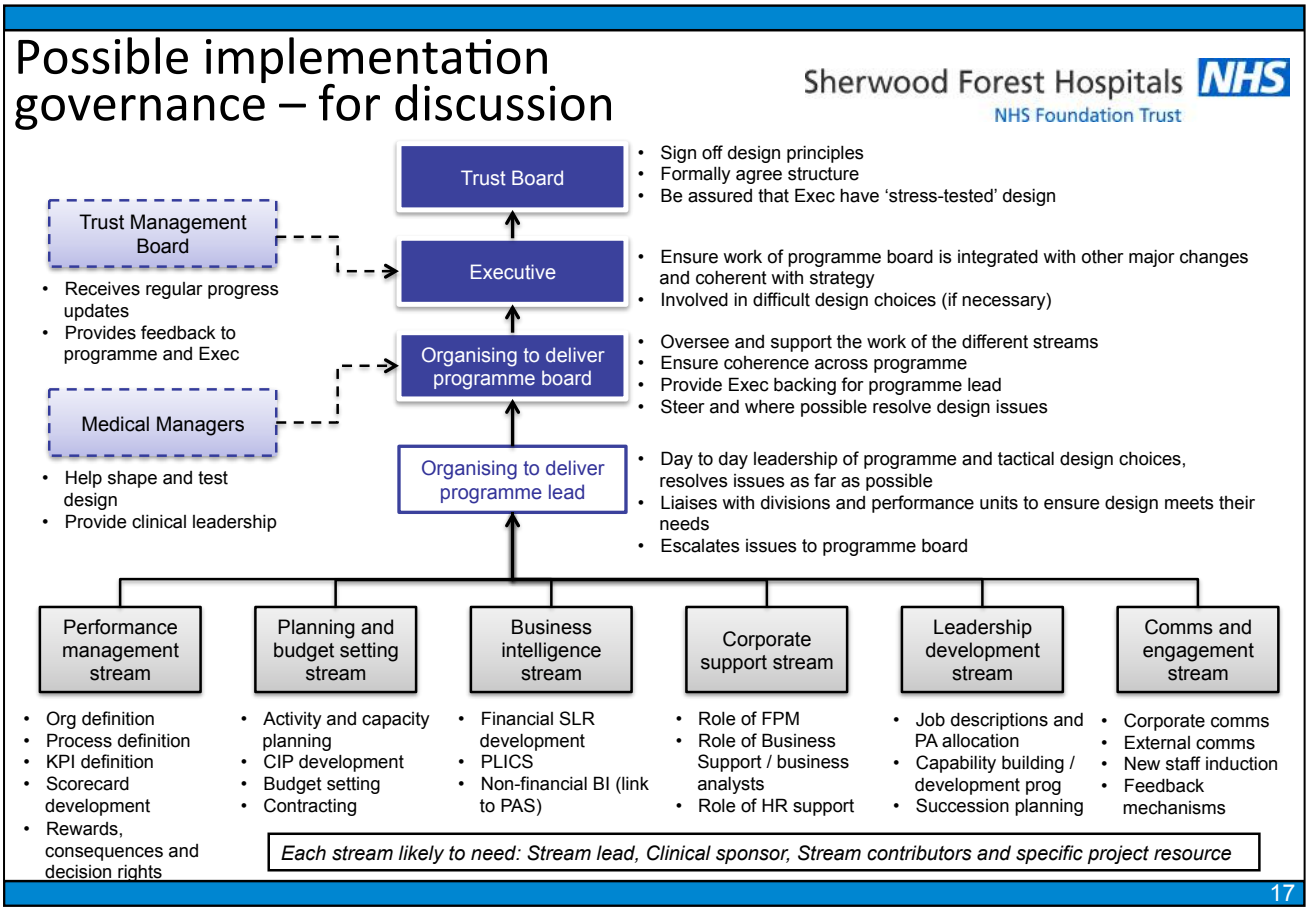
Appendix D: Programmatic implementation



What does successful development look like – for discussion

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	6 months (31 Mar 15)	12 months (30 Sep 15)	24 months (30 Sep 16)
Organisation model	• Org structure redefined in line with design principles • Service leadership teams clarified	• New org structure reviewed and iterated as necessary • Informed assessment of performance and leadership capacity completed	• Continued refinement of organisation model where necessary • Increased devolution of decision possible due to maturity of service lines
Capabilities & behaviours	• Head of Service job description agreed • Allocated time for leadership roles agreed • Basic role induction / refresher training complete	• Early piloting of changes to rewards, consequences and decision rights underway with 'high performers' • Development programme in place informed by initial succession plan	• Successful transition to new service line leadership teams in line with succession plan • Effectiveness of corporate support judged to have improved
Strategic Planning	• Board portfolio review completed • Divisional strategies for service lines for 2015/16 in place	• Preparations for service line led strategic planning process completed • Portfolio decisions enacted (or underway)	• Increasingly outward looking strategic planning process giving rise to new opportunities • Clinical leaders shaping trust strategy
Operational planning	• 2015/16 activity, capacity and budgeting process completed in line with new structure	• Service lines and support services take lead in operational planning, facilitated by divisions / corporate	• Well-established process for effective cross-unit planning ready for 2017/18 planning round
Performance improvement	• New performance management process ready to support delivery of 2015/16 targets	• Monthly performance review process working effectively at all levels • Issues identified are being addressed by transformation programme • Increasing confidence in data quality	• Increasingly dynamic approach to performance management to reflect maturity of services • Refresh of strategic objectives reflected in service line targets
Information management	• Balanced scorecards which aggregate from operational units up to board produced by monthly deadline	• Improved business intelligence function in place (technology and skills) • Revised costing and apportionment underway, including development of standard costs and PLICS implementation	• Level of 'pull' for business intelligence across all domains continues to increase • Capacity to support service lines able to respond to increased demands

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