Service Line Reporting – Developing the Links between Finance and Performance

Introduction
Service Line Reporting (SLR) has recently gained prominence in the NHS as Monitor recommended it to both existing Foundation Trusts and applicants, many having gone beyond this to implement full Patient Level Costing (PLC) systems which I will also briefly describe.

In moving away from traditional NHS management accounting SLR attempts to rectify a fundamental shortcoming that tends to arise in that approach, namely a disconnection between the majority of Trust income, its application (expenditure) and what is achieved as a result (activity).

This briefing paper has been divided into three sections:
- Firstly exploring and defining SLR itself
- Then proposing utilising tools such as SLR to help give a fuller picture of performance
- Ending with an overview of the current position on SLR within NHS Wales

What is SLR?
To begin I’ll define SLR and PLC whilst contrasting with a more traditional NHS management accounting approach. From there providing a little more detail on SLR itself.

Traditional NHS management accounting
Although generalising the problem can be twofold, firstly income may not have a direct relationship with volumes of activity (‘block contracts’), and further expenditure budgets are often underpinned by historic ‘rolled forward’ allocations, having little relationship with either activity volumes or the overall service structure being provided. Secondly Trusts have tended to organise themselves on a specialty and functional department basis, with budget management accountabilities and processes reflecting this.

Advantage – Simplicity and often follows an organisations management structure.

Disadvantage – can lead to conflicting goals and priorities across interrelated departments / specialties.

Service Line Reporting
SLR creates a comparison of income and expenditure for a discrete service, broadly an aspect of a Trust that could in theory operate independently. In identifying income it is expected that this would have a clearly defined relationship with the activity undertaken.

Advantage – provides a link between activity and costs and in doing so significantly increases transparency for decision making and clinical engagement.

Disadvantage – an initial barrier may be defining income at a service level as commissioning to date in Wales has rarely followed this model. In England Payment by Results covers many aspects of a Trusts services and therefore largely overcomes this.

Patient Level Costing
Goes beyond SLR and assigns all costs to individual patients. In doing so can therefore report at an individual patient level as well as being aggregated to deliver SLR.

Advantage – financially and clinically having a common unit of measure, the patient, that can be compared at many levels e.g. between clinicians or with national benchmarks.

Disadvantage – shares income definition problem with SLR. Also complexity is inherent and therefore takes time and resources to both set up and maintain.
Further exploration of SLR

The two fundamental elements defining a SLR approach are:

- Business Units, being an aspect of the Trust that in theory could be separated as a business in its own right, having its own income flows, based upon a discrete group of patients, and the staffing, facilities etc to deliver this care.

- The application of the Income & Expenditure approach below the current annual task of reporting this at Trust level. A simplified example of an I&E statement is:

<table>
<thead>
<tr>
<th>Income</th>
<th>£</th>
<th>Act.</th>
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<tbody>
<tr>
<td>WAG</td>
<td>xxx,xxx</td>
<td></td>
</tr>
<tr>
<td>Private</td>
<td>xxx,xxx</td>
<td></td>
</tr>
<tr>
<td><strong>total</strong></td>
<td>xx</td>
<td></td>
</tr>
<tr>
<td>Direct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Staff</td>
<td>x</td>
<td>xx</td>
</tr>
<tr>
<td>Ward</td>
<td>x</td>
<td>xx</td>
</tr>
<tr>
<td>Admin</td>
<td>x</td>
<td>xx</td>
</tr>
<tr>
<td>Theatres</td>
<td>x</td>
<td>xx</td>
</tr>
<tr>
<td>Radiology</td>
<td>x</td>
<td>xx</td>
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<tr>
<td>Pathology</td>
<td>x</td>
<td>xx</td>
</tr>
<tr>
<td>Overhead</td>
<td></td>
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<tr>
<td>Estates</td>
<td>x</td>
<td>xx</td>
</tr>
<tr>
<td>Trust Board</td>
<td>x</td>
<td>xx</td>
</tr>
<tr>
<td><strong>total</strong></td>
<td>xx</td>
<td>xxxx</td>
</tr>
<tr>
<td><strong>surplus / deficit</strong></td>
<td></td>
<td>x</td>
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Key to note is that SLR takes this to a business unit level and crucially makes a definite link to the activity being provided [integration of disparate views]. So an example statement for a specific service (e.g. Orthopaedics or Maternity) could be constructed as follows:

Traditional budget management would probably have identified most or all of the direct expenditure areas to a service, reflecting it’s accountability and span of control. SLR clarifies the relationship with other support areas, the indirect costs that are crucial in delivering the activity that technically delivers the income for that overall service to operate.

Two fundamental requirements to deliver the benefits of SLR are:

- Engagement of clinical, managerial (Board and service delivery), financial and information staff throughout the organisation.

- Accountabilites and licence to act being modified to accommodate the service line approach.

In achieving these SLR can be delivered in many different ways, some approaches are noted in the next table. In moving down the table it becomes obvious that time invested in delivering SLR will increase, however the potential to engage is also likely to increase as a direct result of improvements to the consistency, quality and clarity of information.
<table>
<thead>
<tr>
<th>Method</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Retrospective analysis (once per annum)</td>
<td>Utilise annual reference costs</td>
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<td>Encourages benchmarking but utilises data that would vary between 9 and 21 months after the year it relates to.</td>
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<tr>
<td>Supplementary statements (delivered periodically)</td>
<td>Re-run the reference cost system in year (e.g. on quarterly data)</td>
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<td></td>
<td>Supplementation routine management accounts</td>
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<td></td>
<td>Develop a hybrid of the reference cost and management accounting systems.</td>
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<td></td>
<td>Supplements routine management accounts</td>
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<tr>
<td>Integrated into Financial Management and Reporting</td>
<td>Reset budgets based upon the SLR data and redesign reports</td>
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<td></td>
<td>Replacement to existing management accounts, should deliver consistency of messages</td>
</tr>
<tr>
<td>Integrated into organisation</td>
<td>Reorganise Trust management processes to reflect service lines.</td>
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<td>Authority to act being aligned with service (Service Line Management).</td>
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For further information Monitor have developed guides and toolkits for the development and presentation of SLR, which are available from [www.monitor-nhsft.gov.uk](http://www.monitor-nhsft.gov.uk).

**Utilising tools such as SLR to help give a fuller picture of Performance**

The following notes some potential benefits of SLR that could be delivered:

- **Transparency** (engagement) - in establishing a direct link between Trust income and the activities and costs incurred in delivering that income, SLR can be perceived as a more transparent and hence fairer system.
- **Efficiency** - where countries have based their funding systems upon activity (activity based funding) this has evidenced improvements in operational as well as financial efficiency.
- **Benchmarking** to stimulate change - this would be dependent upon the system but directly adopting an average or best cost to establish income levels gives organisations a comparison site in organisations that financially perform better.
- **Improve data quality** - by utilising the activity and financial systems more robustly it has been demonstrated that data quality has improved.

Beyond this the clarity of finances and a more direct link with actual clinical and operational performance links two of three key aspects of service delivery to patients, the third reflecting the quality of outcome. Within this relationship financial performance will often be a symptom of the other two.

![Performance, Quality, Finance](image)

To deliver SLR as a compliment to other national performance tools, the following may also need to be considered, appreciating that some represent a need to balance national prescription with local autonomy:

- **Service Lines/Business Units:**
  - For comparison between organisations at service level an agreement around service descriptions may be required, for example an orthopaedic service could fall into Orthopaedics as a service line, or Trauma and Orthopaedics or Musculoskeletal services etc.
Income:
- Having noted the general lack of connection with actual activity and indicative proposals for a capitation (needs) based allocation of funding to new organisations in Wales, actual income is unlikely to represent a robust basis for SLR.
- In finding a suitable proxy national costing data could be suitable but there is freedom at present, therefore organisations could select average, upper quartile, best or some other measure. Particularly if revising actual budgets, this would also need to balance to actual income levels. Thereby performance against income is likely to be reported differently across Wales. Reporting against multiple bases is feasible but clarity and consistency of message may suffer.
- There may also be a desire for stability within mechanisms and therefore trends within income data may be utilised rather than an individual year itself.

Expenditure:
- For new organisations that will combine former Trusts, who are used to reporting by type of expenditure, Healthcare Resource Groups (HRGs) and Programme Budgeting groups, with LHBs who utilise Programmes of Care as well as Programme Budgeting categories. A consistent measure or segregation of expenditure may therefore be required.
- To note Gwynedd LHB have developed a tool to view the whole of an LHBs expenditure that can be analysed/compared below LHB level.
- Through comparison with income, organisations could report the controllable elements of a service, i.e. before apportioned overheads, or the full surplus / deficit of that service.

Activity:
- Delays in achieving fully coded activity could represent a key issue. Turnaround time in Wales is considerably longer than England, where the majority of activity data is expected within four weeks of period end.
- Proxies and other forms of activity data may therefore be required for acute services.
- Poorer quality or lack of nationally defined activity in other areas, such as community, are also of considerable concern.
- The inconsistency extends to other tools such as operating theatres. Here minutes are reported to costing teams around Wales in several different ways, e.g. the time a patient enters theatre to leaving recovery area compared with ‘cutting time’ and this often focuses upon time utilised rather than time allocated – i.e. wastage ignored and can thereby distort the presentation of a specialties relative efficiency.

Utilising SLR to support target setting and as a basis for investment decisions.

SLR and NHS Wales
Jeff Buggle, in having had some experience of this approach in former English role, has been keen for Trusts in Wales to progress SLR. Plans from all Trusts are due by the end of November, detailing how they will deliver SLR for the new organisations from 1st April 2009 (first reports being due at the end of the first quarter). Therefore a clearer picture will emerge early December and increasingly so from that point onwards towards April.

As noted the annual Reference Cost returns can be utilised as a basis for SLR. Of note within Wales are:
- The strengthening of the regime and reconciliation processes to improve the quality, consistency and comparability of this data.
- The development of key cost pools within admitted acute areas, driving a strong link between the reported costs and the key cost drivers (at present the total is analysable to ward, theatres, prosthetics, pathology, radiology, drugs and critical care pools). This is not nationally prescribed in the English system and becomes a fundamental element in linking systems to implement PLC.
- A national annual snapshot version of SLR was piloted from the 2006 / 07 Reference Costs and has been widely shared. This exercise will now form a part of the annual Reference Cost process.
- An update to the casemix grouper (HRG version 4) is presently under review, this could deliver increased clarity and segregation within acute aspects of expenditure. Also allowing efficiency benchmarking with English data that is produced on this basis.
Work is also underway to explore other systems that may prove complimentary in non-acute areas, such as the Gwynedd LHB tool mentioned above where work is also underway to develop a programme budgeting version as well as linking to available outcome data.

As noted proposals are developing around a capitation based method of funding allocation, if this is implemented there may be an increasing need to understand and compare the resulting expenditure. SLR could aid at local levels in defining the gap between the funding and it’s use, as well as benchmarking opportunities to address negative gaps. At a national level it can support other performance measures in financially quantifying performance gaps and tracking performance over time.

Mark Bowling
Programme Manager
Financial Information Strategy
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