A picture of health

Service cost data in performance management in the NHS
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Stuart Wayment FCMA
CIMA Innovation and Development Specialist
1. Executive summary

The role of the finance function in NHS organisations has evolved beyond reporting costs to assimilating detailed and accurate data to support clinical decision making. Finance professionals are using better information to refine costing processes and provide insights that can add value at the front line of the health service. Through this process, service line reporting and management (SLR/M) and patient level information and costing systems (PLICS) have emerged as two principal techniques that are being adopted at various stages along the way.

CIMA’s previous report, Transparency and Accountability, using better data to drive performance in the NHS (2008), identifies areas where these techniques were complementary as well as exploring the challenges and benefits associated with each. Building on this report, CIMA has undertaken a survey to gain an understanding of how these initiatives have been adopted and whether they have successfully achieved their original aims.

The survey found indications of a widespread appetite for improvement, where 72% of organisations have implemented either PLICS, service line reporting or both. It also suggests that these latest initiatives are being driven by largely internal reasons. This compares favourably with our last NHS survey, In year financial forecasting in the NHS (2007), which found that there was a propensity to factor an element of ‘what was expected’ by the management hierarchy into externally reported forecasting information. These findings indicate that some of the commercial edge that has so far been lacking in the public sector is beginning to manifest itself through the latest reforms. In short, where organisations are doing these things, it’s because they see a commercial, or even clinical, advantage in doing so, rather than simply reacting to the compliance requirements of policy makers.

The survey identifies NHS organisations at different points along a journey towards better information. We find the majority of organisations at an early stage in this process, whilst some first adopters are starting to see the benefits of costing at the patient level. For others, where detailed patient data may be less readily available, the challenges of implementing an accurate costing system are greater, leading some to question whether ‘the view is worth the climb’.

The detailed survey responses are provided in section five. However, the key themes and messages emerging from the survey are:

- Whilst service line reporting and management has been implemented in two thirds of responding organisations, the uptake and use of patient level information and costing has been far lower, at just 17%. The majority have elected not to do costing at this very detailed level and instead rely on other methods.¹

Which costing method is used in your organisation?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>55%</td>
<td>SLR</td>
</tr>
<tr>
<td>28%</td>
<td>SLR and PLICS</td>
</tr>
<tr>
<td>13%</td>
<td>SLR and PLICS</td>
</tr>
<tr>
<td>4%</td>
<td>PLICS</td>
</tr>
<tr>
<td>1%</td>
<td>Neither</td>
</tr>
</tbody>
</table>

¹ Of those organisations not using PLICS, 61% are using end of year reference cost data, whilst 23% are using in-year costing systems such as theatre; pathology; x-ray etc.
Foundation Trusts are more likely than non Foundation Trusts to have adopted either or both of these methodologies. FTs, at 29%, are significantly more likely to have adopted PLICS than the non FTs at 7%. Similarly, we find 81% of FTs reporting use of service line reporting and only 62% of non-FTs.

Which costing method is used in your organisation?

- The type and size of the organisation did not affect responses significantly, however, we find Acute Trusts were more likely to have implemented PLICS than other NHS organisations.

- An internal desire to understand cost drivers and behaviours is far more important than any external pressures to do so, however where this motivation is present, it does tend to be initially championed by the finance department rather than embedded into the organisation wide culture.

- PLICS implementers were more likely than non PLICS implementers to be using the information to inform what we have described as targeted, or ‘differential’ cost improvement programmes.
Have you used your chosen costing method to develop differential cost improvement programmes?

- There is a unanimous recognition of the need and intent to improve on the quality of the data that underpins either of these methods of performance reporting and management.
2. Introduction

Costing of, reporting on and ultimately managing the services that it provides is a cornerstone of performance management for all organisations. A thorough understanding of how costs behave and are driven is a fundamental tenet.

The finance function in many NHS organisations has traditionally been seen as an overhead with a policing or control role. By rebalancing its traditional roles and encompassing both a control role as well as an empowering role it can move to a position where it is seen to be a value adding function.

The effectiveness of management decisions can be judged by the extent to which they make a positive impact. The added value that the finance function brings to decision making is in the provision of high quality relevant information to support decision making.

CIMA’s survey has been undertaken to assess how readily NHS organisations are implementing more advanced costing techniques, and crucially, whether they are yet able to realise the benefits of more detailed management information that can be derived from these systems.

Adding value through ‘differential’ cost improvement programmes

Performance management mechanisms are primarily intended to facilitate and promote improvements in efficiency. This can mean doing things differently or ‘working smarter’ to get improved value for money from the available resources. Indeed, if they are considered to be primarily cost cutting means then they are unlikely to achieve one of their often quoted primary objectives which is to achieve clinician buy-in.

One by-product of improved cost information however lies in the opportunity to develop more targeted cost improvement plans, which has the potential to reinforce rather than detract from this objective.

Traditionally many NHS organisations when faced with the need to implement a cost improvement programme (CIP) have taken a blanket type approach and imposed a savings target across the board. This approach is unlikely to foster a sense of ownership for what are already unpopular measures and are likely to detract from the achievability of the plan.

Armed with more robust and evidence based information it may be possible to develop more targeted improvement programmes, which for the purposes of this survey we have termed ‘differential’ cost improvement programmes. Such targeted plans can be seen to recognise and reward efficiency and so have the potential to be considered as more equitable.
3. Setting the context: 
the challenge of costing in the NHS

3.1 What is changing?

In the current economic climate, NHS organisations are more compelled than ever before to have a good understanding of how their costs are driven. Informed decision making based on a robust costing mechanism can help organisations to improve their performance; those organisations that achieve cost leadership can gain competitive advantage.

The NHS has been continually reforming to improve performance and is now in the process of implementing what is described as a four way reform – demand and supply side reforms as well as transactional and structural. The four categories of reform are explained below.

Framework for the reforms

Money following the patients, rewarding the best and most efficient providers, giving others the incentive to improve (transactional reforms)

More choice and a much stronger voice for patients (demand-side reforms)

Better care
Better patient experience
Better value for money

More diverse providers, with more freedom to innovate and improve services (supply-side reforms)

A framework of system management, regulation and decision making which guarantees safety and quality, fairness, equity and value for money (system management, or ‘structural’ reforms)

Source: Adapted from NHS: Health reform in England: update and commissioning framework, 2006
These four strands are interrelated and all have a significant impact on finance. Transactional and structural reforms are the two categories most relevant to the issues in this survey. This is because transactional reform encompasses the funds flow mechanism which includes payment by results and tariff (for significant elements of income flows) while structural reforms have a significant impact on the regulatory regime.

3.2 The regulators

The structural/regulatory regime change and the introduction of the concept of Foundation Trusts and a Foundation Trust regulator, Monitor, has had a significant impact on behaviours. At the current stage of the reforms, the service is part way through a migration for many, from Trust status to Foundation Trust status. As a result we see a position where a regulator oversees some of the bodies whilst the remainder are retained under the management of the Department of Health. Many of these aspire to the freedoms that come with Foundation Trust status and are working towards attainment of that position.

Funding and accountability relationships in the NHS

The Department of Health and Monitor are each championing improved performance based on a better understanding of cost and cost drivers, but each has a different approach. Monitor is promoting service line management through service line reporting, whilst the Department of Health is promoting the development of costing, and importantly information, at the level of the individual patient, through its patient level information and costing systems (PLICS) proposals. At this stage, as the split of numbers of organisations between FTs and non FTs approaches half and half, the NHS faces alternative options as to how it undertakes performance management.

At the heart of both these initiatives is the concept of better information to support improved decision making. CIMA has previously explored the role of the finance function in providing decision support to organisations in its *Improving Decision Making* suite of reports, where we find the management accountant’s contribution to decision making rests on ‘their ability to provide timely and accurate information efficiently’.

There may also be issues of organisational aspiration in play with some organisations making the transition from being managed by the Department of Health to moving towards regulation by Monitor. Although our survey finds that the main drivers behind the chosen approach are internal rather than external, it is interesting to consider whether the aspirations of non FTs to move to FT status might impact on their choice.

The introduction of Monitor with its risk based regulatory regime was viewed as heralding a far more commercial focus for health service organisations. It may initially seem surprising that the service line reporting and management initiative is less granular, and therefore less detailed, than the method promoted by the Department of Health. In reality, this is most likely to be a reflection of Monitor’s more principles based approach to regulation and oversight, which is largely consistent with the ‘comply or explain’ governance principles that are more often found in the private sector. Monitor does recognise the importance of the added granularity that is available from PLICS but also adopts a pragmatic stance that service line data is an achievable ‘stretch’ for the average trust, whilst data at other levels (such as patient or clinician) could be a natural progression from this point. The DoH approach is to consider costing at the most detailed level, i.e. at the level of the individual patient, to produce information that can then be consolidated upwards and reported in the most appropriate way.

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2 Whilst they may be seen as competing initiatives, the two methodologies are by no means mutually exclusive, with 77% of our PLICS using respondents also reporting use of service line reporting.

3 *Improving decision making in organisations – the opportunity to transform finance*, CIMA 2007
Monitor also points out that SLR/M are not mandatory and that having provided the principles and framework, it is for each organisation to decide whether or not these are adopted – something that Monitor refers to as a ‘demand pull’ initiative. It would not be surprising if Monitor’s recommendations provide a strong incentive for trusts to adopt service line reporting or management. Many organisations are still working towards the attainment of Foundation Trust status, and if Monitor did have cause to intervene in any failing trust, there would be a requirement to explain why a SLR/M approach was not being followed.

3.3 Funding issues

Another of the strands of the reforms, transactional reform, deals with how funds flow through the system. An underlying part of this is payment by results and the use of a centrally determined tariff for significant amounts of activity and therefore funding.

The NHS has seen real terms increases in funding over the last ten years but there is always a need to ensure effective use of this resource. As with much of the public sector, NHS resources are constrained in that whilst real terms funding has increased, the demands being made upon the service have also increased due to factors such as increased public expectation. Health spending is a frequent topic of political debate and to a degree has enjoyed a ‘ring fenced’ position which may help see it avoid reduction but in reality it is unlikely to see the real terms growth that it has enjoyed for the past decade. In the current economic climate, the need to drive efficiency is compounded by the constraints on public spending that will inevitably see at best reduced real terms growth for the sector.

As a consequence there will be a real need to do more, or better, for the same or less resource. The public sector may have been less immediately impacted than the private sector by the current economic crisis, but it is perhaps opportune that it had commenced on the path towards improved performance reporting with its current reforms. The added value that the finance function is developing will offer an opportunity for finance professionals to provide insight and analysis to support improved decision making.

Organisations that are able to develop a good understanding of their costs and cost behaviours and who are able to apply activity based management may be better placed to make the case for additional investment and services. These organisations might gain competitive advantage in their ability to develop or contract services, based on better data for informed decision making.

Finally the Department of Health has announced that over time it intends to move the basis of tariff from the previously used reference cost data to a new system based on quality assured patient level costed information. This may incentivise providers towards using PLICS by giving them the opportunity to influence tariff, and hence their income streams.
Cost leadership
Organisations that practice what Michael Porter described as a cost leadership strategy strive to be a lowest cost producer at a given level of quality.

The introduction of payment by results with its centrally determined tariff intentionally removed the element of price competition from Trusts, for significant amounts of their income. This removal of price competition was intended to simplify contract negotiations, support patient choice and at the same time encourage providers to deliver services at a standardised cost. This has resulted in an environment where organisations that are able to pursue a cost leadership strategy will have an advantage.

‘Implementing PLICS has enabled Guy’s and St Thomas’ to produce evidence based service line reports which are reported twice a year to review performance and help focus direction at the annual business planning round. These reports are also used by clinical teams to assess efficiency opportunities and inform future investment’.

‘Having accurate and reliable feeder systems allows the clinicians and managers to drill down from a high level specialty level service line report through to the actual resources used and income received by a particular patient or groups of patients at Guy’s and St Thomas’.

‘Guy’s and St Thomas’ has used PLICS to provide evidence to inform local pricing discussions with PCT’s. Our patient level costs for 2007/2008 have also been provided to the Department of Health to help inform the development of the future national tariff’.

‘The PLIC’s system at Guy’s and St Thomas’ also produces, as a by-product, reference costs for admitted patient care and outpatients and programme budgeting returns for the Department of Health’.

Jeremy Brinley Codd, Head of Financial Developments and Costing,
Guy’s and St Thomas’ NHS Foundation Trust
4. Our survey findings

This survey builds on CIMA’s recent report, *Transparency and Accountability, using better data to drive performance in the NHS, (2008)*, which looked at the key issues that organisations would wish to consider prior to implementing an improved performance management and information system. The report considered the interrelated initiatives of service line reporting (SLR), service line management (SLM), and the use of patient level information and costing systems (PLICS).

This survey has been undertaken with the following objectives:
- to establish the extent to which either or both of these methods have been implemented
- to understand the reasons why organisations chose the costing method
- to explore whether the intended benefits had been achieved or fully realised.

The survey was sent to all NHS organisations, from which, 53 responses were received. Responses came from a broad mix of both Foundation Trusts and non Foundation Trusts as well as smaller and larger organisations, (where small organisations have a turnover of up to £150m and the larger ones a turnover in excess of £150m).

Our findings show some interesting trends, whilst at the same time reflecting the relative maturity – or immaturity – of these programmes. One of the limiting factors with this research seems to be the ‘newness’ of the reforms, suggesting that in some cases it is too early to be clear about the benefits achieved.

Where we are now

Service line reporting, which developed into service line management was introduced by Monitor in 2006, with the earliest implementers of PLICS being slightly before that. Whilst we can therefore consider both as relatively new performance management tools, we find a much greater uptake in SLR compared with PLICS, According to our survey, as many as 66% of NHS organisations are currently using SLR, with a total of only 17% of organisations using PLICS.

Our survey and subsequent discussions clearly identify that data (both its quality and availability) are crucial factors that impact on the ability of organisations to adopt one or the other of these methods. It is also apparent that whilst data is often captured and maintained (primarily for clinical, rather than costing purposes), it is frequently held in disparate systems across the organisation. One of the key success factors is the ability to consolidate this and to enable its use for costing purposes.
Our survey also identified different treatments of overhead costs depending on which system was in place, with non PLICS sites being far more likely to include overheads in their costings whilst the PLICS sites were more likely to base their costings on the direct patient costs. This may be due to PLICS sites taking a view that direct cost data, as well as being available on a timely basis, is the element of the costs that is most relevant in terms of being able to manage expenditure.

How do you calculate your costs?

Non PLICS sites are far more likely to include central overheads in their costing, at 75% compared with 44% of PLICS sites.

Base: All those who do not use PLICS (44), Foundation Trust (15), Non Foundation Trust (27)
4.1 Emerging trends

4.1.1 Motivation for change
One of the clear messages from the survey is that organisations have decided to implement these costing and reporting mechanisms largely on account of an internal desire to understand and manage costs, rather than external compliance pressures. There seems to be a core driver, usually from within the finance directorate and at a senior level, but this may not have rolled out widely into the culture of the organisation as a whole. This is not entirely surprising, but does identify most of these organisations as still working towards attainment of their stated priority: to ‘achieve clinician buy in’.

Why do you intend to implement PLICS?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Very important</th>
<th>Reasonably important</th>
<th>Not important at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>To get clinician involvement/engagement</td>
<td>87%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>To improve profitability/efficiency</td>
<td>80%</td>
<td>13%</td>
<td>7%</td>
</tr>
<tr>
<td>To get measureable financial benefits</td>
<td>73%</td>
<td>27%</td>
<td>7%</td>
</tr>
<tr>
<td>To help manage services</td>
<td>67%</td>
<td>27%</td>
<td>7%</td>
</tr>
<tr>
<td>To improve data quality</td>
<td>53%</td>
<td>40%</td>
<td>7%</td>
</tr>
<tr>
<td>Natural progression from service line reporting (SLR)</td>
<td>47%</td>
<td>27%</td>
<td>27%</td>
</tr>
<tr>
<td>To improve benchmarking</td>
<td>40%</td>
<td>53%</td>
<td>7%</td>
</tr>
<tr>
<td>Previous costing method not successful</td>
<td>60%</td>
<td>33%</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>7%</td>
<td>13%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Driving clinician engagement was rated as leading motivation for adopting PLICS, with 87% of applicable respondents rating it as ‘very important’. Base: All those who are planning to introduce PLICS in the next 6 months (15)
The survey also looked at how the size or type of organisation impacted on the ability or appetite to undertake these developments. A key factor affecting an organisation’s ability to develop its costing and reporting is the availability of good quality data. This manifests itself in our survey findings as a more significant uptake of SLR/M and or PLICS within the Acute Trust setting, with lower levels of adoption amongst Mental Health Trusts and other organisations. Data quality for costing purposes remains a challenge, and the opportunities offered to improve data quality is rated highly by 53% of respondents as an important motivator. The reported strong uptake of SLR/M is also underpinned with a high level of frequent reporting, with 58% of SLR sites reporting on a monthly basis.

How often is SLR undertaken?

![Bar chart showing frequency of SLR reporting]

Service line reporting is undertaken more frequently than PLICS, with 58% of SLR sites reporting on a monthly basis.

4.1.2 Weak uptake of PLICS

Whilst service line reporting has been embraced and adopted by a large proportion of our respondents, the uptake of patient level costing has been less unanimously welcomed. This may be because it’s just more, or even too difficult. Or, it may be that organisations don’t see the incremental advantage of taking costing down to the level of the individual patient. Instead, we see organisations relying on other means to inform their SLR such as existing costing or even reference costs. When we asked those not using PLICS if they intended to do so within the next six months only 34% indicated that this would be likely.
This finding is at odds with the Department of Health’s snapshot survey that informed CIMA’s previous report *Transparency and Accountability, using better data to drive performance in the NHS* (2008). This internal survey suggested a far greater uptake in PLICS across NHS organisations. In 2008, the appetite for implementing PLICS seemed to be strongest amongst FTs, and whilst this is still the case, the uptake is at much lower levels than previously thought. These results might appear to be surprising given that PLICS as an initiative is being championed by the DoH which oversees the non FTs, whilst Monitor, the Foundation Trust regulator, has in the past promoted service line reporting but without stipulating that it should be supported by PLICS. However, there was a strong suggestion in the earlier figures that non FTs were increasingly aiming to adopt PLICS as well.

Our survey finds that non FTs were not only less likely than FTs to be currently applying PLICS, but also that they were less likely to be intending to implement it in the short-term. There are several reasons why this might be the case:

- it may be that FTs are the leading edge organisations who roll out best practice earlier
- it is possible that FTs see advantage to be gained from the additional level of granularity employed in PLICS
- or it may be a consequence of the fact that the Foundation Trusts are more data rich than the non FTs, thereby enabling the move to PLICS to be achieved.

![Foundation Trusts are more likely to roll out PLICS than non-FTs, with 40% of Foundation Trusts planning to introduce PLICS in the next six months against 33% of non-FTs.](image)

PLICS offers a sound foundation as an activity based costing methodology. It is also consistent with many of the key principles identified in the International Federation of Accountants, (IFAC) and Professional Accountants in Business, (PAIB) good practice in costing guidance. The low levels of PLICS adoption, both actual and intended, are therefore disappointing.

The survey also found that of those organisations not using PLICS, 61% of the respondents are basing their SLR/M reports on the annual reference costs exercise, whilst the remainder of those not using PLICS have developed a local costing system to support their reporting. Reference cost data has been widely held to be unreliable and so it is surprising to find so many organisations are still relying on it to underpin their reporting.
4.1.3 Getting value from PLICS

Overall, we found the majority of organisations not yet in a position to develop better informed and differentially based cost improvement programmes, with only 39% of all non PLICS using organisations reporting use of this kind of initiative. In organisations using PLICS, we see a different picture, with 56% of these organisations adopting these programmes.

As our survey shows, organisations choosing to implement PLICS rated ‘to get clinician involvement’, with ‘to improve profitability/efficiency’ and ‘to get measurable financial benefits’ as their top three reasons for implementation. These three reasons might initially and intuitively appear contradictory. The value of patient level costing is not limited to the opportunity to make immediate finance led cash savings. One of the motivating factors behind investing in PLICS is that the quality of PLICS derived data makes it particularly suitable for informed decision making.

The primary reason for implementing PLICS, ‘to achieve clinician buy-in’ could be seen as a longer view objective, where clinician buy-in could be increased if it could be demonstrated that efficiency was rewarded. This would contrast favourably with the blanket approach to budget reduction that has often been adopted and is frequently seen to be inequitable. Whilst only 33% of PLICS implementing organisations reported that there was a strong PLICS culture within their organisations, as an evidence based reporting tool, PLICS has the potential to appeal to clinicians. It is reasonable to expect the initiative to become more embedded in the culture as it matures.

If the full value of this information is to be realised, these objectives must be met and the detailed understanding derived from better information should be used to inform targeted cost improvement programmes. As we have identified most organisations as being at an early stage in the journey towards better information, it is not surprising that the majority of respondents indicated that it was too early to say whether the introduction of PLICS had achieved its intended benefits. Again, this is likely to be a reflection of the maturity of the initiative.

**To what extent has PLICS achieved these objectives?**

- Fully 11%
- Partially 33%
- Too early to say 56%
- Not at all 0%

Base: All who currently use PLICS (9)
4.1.4 The right information

One unanimous response concerned the quality of the data currently available within organisations. Whilst over two thirds of them described their information as either ‘quite’ or ‘very’ strong and over three quarters of them stating that they were either ‘quite’ or ‘very’ confident with the results, all PLICS implementing respondents said that they were taking steps to improve the quality of information used to inform their PLICS costings.

Data availability and quality was similarly a major issue when we looked at this area for our previous report. There are a wide spectrum of views, ranging from ‘let’s make a start with the data we have, even though we accept it might not be perfect’, through to ‘let’s work on getting the data right before we start to use it’. Undoubtedly, there is merit in both views. If costing is undertaken with poor quality data, it runs the risk of being discredited. However, by using existing data whilst accepting that it is possibly flawed, there is an opportunity to expose and then rectify any weaknesses. The middle ground is probably a good starting point but this will depend on the organisational appetite for the inevitable challenges that will follow.

4.1.5 ...at the right time

When PLICS implementers were asked about frequency of reporting, responses were markedly different to those given by the non PLICS community. Only a third of PLICS using respondents said that they reported results monthly with quarterly being the favoured reporting frequency. This may be a reflection of the additional complexity of reporting on a PLICS basis, or it might simply be that less frequent results are considered for other reasons to be optimal. Getting the best from the detailed data provided by PLICS is a matter of balance between reporting in time to act on the data without reporting so frequently that the process becomes a drain on resources.

4.2 Conclusion

Our survey paints a picture of an evolving position where the NHS is striving to improve its financial performance. Over the last ten years the NHS has consistently seen real terms growth in funding, yet only recently has it begun to manage to stay within its means. It is now in common with many areas of the public sector facing if not a stand still then at least a very real reduction in the level of growth it receives.

With current NHS reforms driving a more commercial focus, it is gratifying to see that organisations are choosing to adopt performance management tools that add value to decision making. This is consistent with CIMA’s own principles based methodology that has an emphasis on ensuring that appropriate methods are applied rather than imposing prescriptive or other guidance.
The vast majority of respondents cited internal reasons rather than external pressures as the reasons why they have either implemented or intend to implement these reporting mechanisms. In an environment that still is moving towards FT status as being the desired state, it may be that these results also show a willingness to please the potential future regulator, Monitor – rather than the former master the DoH – as the uptake of the Monitor promoted initiatives is significantly more than that of the DoH’s championed cause of PLICS.

Our survey results indicate that most NHS organisations are still at an early point in the journey towards the goal of assimilating better information to support decision making. With the recent, but wide-spread, introduction of service level reporting and management and PLICS, we find an increasing number putting the necessary costing structures in place to achieve this aim.
5. CIMA’s survey – methodology and detailed responses

5.1 Methodology

The survey was designed by CIMA’s NHS working Group and CIMA’s in-house team. It was carried out using an online questionnaire and circulated to a database of senior NHS staff.

5.2 Response rate

Responses were received from 53 NHS organisations in total, of which 40% were Foundation Trusts and 59% were non Foundation Trusts. Both smaller and larger trusts, (where small organisations have a turnover of up to £150m and larger organisations have a turnover in excess of £150m), were evenly represented. Most responses were received from finance directors or deputy finance directors in these organisations.

Q2. What is the budget revenue for your organisation in 2008/2009?

<table>
<thead>
<tr>
<th>Budget Range</th>
<th>Total</th>
<th>Foundation Trust</th>
<th>Non Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than £80 million</td>
<td>15%</td>
<td>14%</td>
<td>19%</td>
</tr>
<tr>
<td>£81-£150 million</td>
<td>30%</td>
<td>26%</td>
<td>33%</td>
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<tr>
<td>£151-£299 million</td>
<td>28%</td>
<td>26%</td>
<td>29%</td>
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<tr>
<td>£300-£499 million</td>
<td>13%</td>
<td>10%</td>
<td>13%</td>
</tr>
<tr>
<td>£500 million or more</td>
<td>13%</td>
<td>10%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Base: Total (53), Foundation Trust (21), Non Foundation Trust (29)
Q1. To what type of organisation do you belong?

Base: Total (53), Foundation Trust (21), Non Foundation Trust (29)

Q1. To what type of organisation do you belong?

Base: Total (53), Foundation Trust (21), Non Foundation Trust (29)
5.3 Detailed survey responses

Questions 1 – 3 related to background information about respondents, including job title and organisation.

Q4. Is service line reporting (SLR) used in your organisation?
The survey found over two thirds of organisations (68%), using service line reporting. When this number is analysed based on whether or not the organisation has Foundation Trust status, the split changes to 81% of FTs reporting use of service line reporting and only 62% of non FTs. The size of the organisation seems not to make a difference in this area with both the ‘smaller’ and the ‘larger’ trusts reporting equally that they carried out SLR.

Q5. How often is SLR undertaken?
Over half (58%) of respondents reported monthly. Non FTs (at 67%) were significantly more likely to report on a monthly basis than their FT peers (47%), but they also reported lower numbers falling into the less frequent reporting cycles of bi-monthly and quarterly. Only 8% of all respondents reported that they were doing annual service line reporting. The survey also found that the smaller organisations regardless of their status were able to report more frequently with some 63% of the smaller organisations responding that they completed monthly reporting.
Q5. How often is SLR undertaken?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Total</th>
<th>Foundation Trust</th>
<th>Non Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>58%</td>
<td>67%</td>
<td>51%</td>
</tr>
<tr>
<td>Bi monthly</td>
<td>47%</td>
<td>25%</td>
<td>73%</td>
</tr>
<tr>
<td>Quarterly</td>
<td>19%</td>
<td>24%</td>
<td>14%</td>
</tr>
<tr>
<td>Bi annually</td>
<td>11%</td>
<td>24%</td>
<td>8%</td>
</tr>
<tr>
<td>Annually</td>
<td>6%</td>
<td>6%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Base: Total (53), Foundation Trust (21), Non Foundation Trust (29)

Q6. Is patient level information and costing (PLICS) used in your organisation?

One of the most striking aspects of this survey concerns the extent to which patient level information and costing has been implemented, with only 17% of all respondents claiming to use this method. However, when this figure is analysed between FTs and non FTs it appears that FTs, at 29%, are significantly more likely to have adopted PLICS than the non FTs, at 7%. The survey also found larger trusts reporting higher levels of adoption of PLICS than smaller organisations.

Base: Total (53), Foundation Trust (21), Non Foundation Trust (29)
Q7. How do you calculate your costs?
When asked whether costs were calculated based on direct costs or if central overheads were included, the response regardless of status or size was notably weighted towards inclusion of central overheads.

![Bar chart showing the percentage of organizations calculating costs based on direct patient costs or including central overheads, with the breakdown for Foundation Trust and Non Foundation Trust.]

Base: All those who do use PLICS (44), Foundation Trust (15), Non Foundation Trust (27)

Q8. Have you used information derived from SLR/SLM/PLICS to enable you to develop differential cost improvement programmes?
61% of organisations were not using information derived from these reporting methods to influence differential cost improvement programmes. The result varied little across organisations of different status and size.

![Bar chart showing the percentage of organizations using information from SLR/SLM/PLICS to develop cost improvement programmes, with the breakdown for Foundation Trust and Non Foundation Trust.]

Base: All those who do not use PLICS (44), Foundation Trust (15), Non Foundation Trust (27)
Q9. If you are not using patient level information and costing (PLICS) what alternative costing methods do you use?
A sizeable majority of respondents said that they were using reference cost data to support their costing reporting. Many said that they use a number of different systems. When analysed in terms of size, the smaller organisations were more likely to use reference cost data than their larger peers (71% compared to 52%).

Q10. Are you planning to introduce patient level information and costing (PLICS) in your organisation in the next six months?
A significant number of respondents (66%) replied that they were not planning to introduce PLICS in the next six months. Again FT or non FTs responded remarkably similarly, with the smaller trusts more likely to respond ‘no’ compared to the larger organisations.
The next questions focused on reasons why organisations had or intended to implement PLICS.

Q11. Why do you intend to implement PLICS?
Those who had indicated an intention to introduce PLICS were asked what factors were important in that decision. The top scoring response was ‘to get clinician involvement’, with ‘to improve profitability/efficiency’ second and ‘to get measurable financial benefits’ third, although other factors such as ‘improving data quality’ were deemed to be ‘very important’ by more than half of all respondents.

Q12. Why did you implement PLICS?
When those that had already implemented PLICS were asked to rate the same factors by importance, the clear top placed answer was ‘to improve profitability/efficiency’. ‘Clinician involvement’ also scored highly (as it had for the previous question). Overall, the responses to this were broadly the same amongst those intending to implement as they had been amongst those who had implemented.
Q13. To what extent has PLICS achieved these objectives?
Asked whether the introduction of PLICS had achieved its intended benefits, the majority of respondents indicated that it was too early to say. No respondent replied ‘not at all’ and one FT said that it had fully achieved its intended benefits.

![Pie chart showing responses to Q13]

Q14. How do you calculate your costs?
This question asked those that had introduced PLICS if their costs were based on direct patient costs or if they included central overheads. The number who report including central overheads was much lower, at 44% than when the same question was asked of non PLICS sites, at 75% (see question 7).
Q15. What is the importance of the following factors on the introduction of PLICS?

Respondents who have implemented PLICS were asked to rank a range of factors that had impacted on their implementation. Financial position or deficit was ranked as either very or reasonably important by almost all of the respondents, placing it jointly the top factor by this measure, alongside ‘having a lead consultant.’ All of the factors rated as important were noticeably internal. External factors such as SHA encouragement were notably scored as ‘not important at all’ by almost 90% of respondents.

Other reasons cited by our survey respondents include:

‘The need for improvement in finance understanding the business’

‘Dissatisfaction with tariff construction’

‘Gathering evidence where tariff does not reflect cost’
Q16. What percentage of your turnover do you apply PLICS to?
This question looked at the proportion of turnover to which PLICS (where implemented) had been applied. The majority of respondents applied it to over 50% of turnover with the largest section being within the range of between 51% and 75%. It should be borne in mind that trusts will have revenue streams that are not patient related (such as research and development or training levies) that will by definition fall outside of PLICS and therefore 100% PLICS coverage is not to be expected.

![Bar chart showing the percentage of turnover to which PLICS was applied]

- 0% – 25%: 11%
- 26% – 50%: 56%
- 51% – 75%: 33%
- 76% – 100%: 0%

Base: All who currently use PLICS (9)

Q17. Have you used information derived from SLR/SLM/PLICS to enable you to develop differential cost improvement programmes?
When PLICS implementers were asked if they had used information derived from their costing systems to develop differential cost improvement programmes, the results were very different to the responses received to the same question asked of those that had not adopted PLICS. 56% of the respondents in this group said that they had used the information to enable them to develop a differential cost improvement programme. This compares to 39% of the non PLICS adopters which use the information in this way.

![Circle chart showing the percentage of respondents who used information derived from PLICS]

- Yes: 56%
- No: 44%

Base: All who currently use PLICS (9)
Q18. **What feeder systems are used in your PLICS?**

When considering the feeder systems that PLICS sites use it is apparent that a wide range of systems are in use and this might be one of the barriers to implementing this level of detail into costing. Whilst it appears that some respondents seem to have understood this question to have referred to which feeder system was primarily used in their organisation, the majority of respondents report using various systems. The highest rated system overall was the pharmacy system, reflecting perhaps one of the high cost drivers being drugs.

![Bar chart showing feeder systems usage](chart.png)

The following questions are designed to establish factors around ownership and organisational culture associated with PLICS.

Q19. **Who is responsible for the PLICS process?**

Responsibility for the PLICS process sits firmly with the finance director. The respondents to this survey were mostly at director, deputy or associate director of finance level and two thirds (67%) of respondents said that they had responsibility for the process.
Q20. To whom are PLICS results reported?
Responses to this question show clearly that PLICS, where used, is essentially an internal reporting tool and results are regularly taken to forums that include both clinical and managerial staff. External examples of PLICS reporting was rare although several indicated that the reports had multiple uses.

![Bar chart showing distribution of PLICS results reporting to different levels of leadership.]

- Service Line Managers: 44%
- Senior Management: 33%
- Board: 22%
- Directorate: 11%
- Other: 56%

Base: All who currently use PLICS (9)

Q21. How often are the results reported?
When PLICS implementers were asked about frequency of reporting, the results differed from those given by the non PLICS community. Only a third of the respondents said that they reported results monthly, with quarterly being the favoured reporting frequency.

![Bar chart showing frequency of PLICS results reporting.]

- Monthly: 33%
- Bi monthly: 11%
- Quarterly: 44%
- Bi annually: 11%
- Annually: 11%

Base: All who currently use PLICS (9)
Q22. Is PLICS used for reference costs?
The majority of PLICS implementers – two thirds – also use their PLICS information for reference costs purposes. However, one third do not.

Q23. Is there a strong PLICS culture embedded in your organisation, e.g regular benchmarking information; encouraged to identify efficiencies?
When asked about how strong the PLICS culture is within their organisation, the majority of PLICS sites responded that it was not strongly embedded.
Q24. Are you able to measure the benefits of using PLICS derived differential cost improvements?
Unanimously, respondents report that they have not yet been able to measure the benefits of using PLICS derived differential cost improvements. However quite reasonably the majority of respondents say that they are unable to measure this yet as it is ‘too early to say’.

Base: All who currently use PLICS (9)

Q25. How would you rate the quality of information used to inform your PLICS?
Turning to data quality, two thirds of respondents identify that the quality of information that they have used to inform PLICS is either ‘quite’ or ‘very strong’. The remaining third state that it is weak ‘in certain areas’ although no respondents say that it is ‘weak’.

Base: All who currently use PLICS (9)
Q26. Are you taking steps to improve the quality of information used to inform your PLICS?
All respondents said that they were taking steps to further improve the quality of their information. Steps being taken included auditing of existing information and systems as well as the introduction of new systems.

Q27. How confident are you with your PLICS results?
When asked to rate levels of confidence with PLICS results, a fifth of respondents rated this as high (very confident) whilst over half were quite confident. No respondents ranked this as ‘not at all’ with the remainder citing ‘too early to say’.

![Confidence levels chart]

Auditing data in response to clinician feedback
Development of PAS and data collection
Feeders, feeders, feeders
Installation of stock control and distribution cabinets identifying actual consumable usage to patients
New IT systems e.g pharmacy and theatres. Also use of barcoding
Systems improvement/introduction
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