Office for Health management

Facilitating management development for the health services in Ireland

Clinicians in Management:

A Review of the Initiative and Pointers to the Way Forward

Lime Tree Consulting
and Nixon Consulting

Foreward

The Office for Health Management commissioned this independent review of the Clinicians in Management Initiative. We felt it was appropriate at this time to get an independent assessment of this major programme in order to shape its future direction.

The Department of Health and Children requested the Office for Health Management to facilitate the further roll out of the Clinicians in Management Initiative in 1998. We have been working with the project teams in all of the second wave pilot sites since then to develop the necessary skills and understandings and to share learning and best practice across sites.

The findings of this review raise some important questions for all of us involved in this Initiative. It is plain that progress has been painfully slow and that the results have been mixed across the country. Whilst almost all seem to agree that there is a need to move on and progress this Initiative further, the slow rate of progress does not augur well for the future.

If this Initiative is to achieve the results it promises in terms of a more patient-focused service, with decision making being brought closer to the patient, it is evident we must address the obstacles currently impeding progress.

We must ask ourselves what are the next steps to be taken to provide the incentives to move forward at a more rapid pace? The authors of this review make a number of useful suggestions. It is clear that a more intensive input from all parties is required if we are to move on.

We in the Office for Health Management suggest that this review should provide an opportunity for us all to take stock and decide on the way forward.

Denis Doherty
Director

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1. Introduction

This report was commissioned by the Office for Health Management (OHM) and is the third in a series of occasional reports / briefing papers on the Clinicians in Management (CIM) Initiative. CIM was launched in late 1998 by the Minister for Health with the objective of giving key professionals - doctors, nurses and health and social care professionals - a greater say in the management, planning and development of health services in order to bring about improvements in the quality of patient care and in the effectiveness of the processes through which the services are delivered. OHM has had a central role in supporting this Initiative through training and development interventions and through supporting consultancy assistance in many hospitals.

In early 2000 the OHM, in conjunction with the Department of Health and Children, decided to evaluate the progress of the Initiative in order to glean best practice thus far and to enable future support to be targeted as accurately as possible. Therefore a survey to assess the progress of the CIM Initiative was commissioned and undertaken over the summer months. Thirty one hospitals throughout the country were visited (in the main in the Summer of 2000) and this report distils the findings from these visits into one comprehensive document.

The purpose of the report is to inform interested parties about the 'state of play' of the Initiative in Irish hospitals and to contribute to the progression of the involvement of clinicians through the identification of barriers to and enablers of progress.

The structure of this report is as follows:

- we outline the overall context in which the Clinicians in Management Initiative is developing (Section 2)
- the structure of the review process is outlined (Section 3)
- the key issues and observations arising from the review are discussed (Section 4) and,
- a way forward is discussed in terms of enablers and priorities (Sections 5 to 7).

Throughout this document the term 'clinicians' is taken to refer to all the clinical professional staff who are involved in service design and delivery. The term thus includes doctors, nurses and the range of health and social care professionals.

2. Clinicians in Management - Background & Context

This current CIM Initiative was formally introduced in Ireland in late 1998. Its introduction mirrored similar changes in other developed countries and reflects changes in the environment within which health services are being delivered. In general, these changes are focusing on clinical quality, patient satisfaction and value for money. In this context, experience elsewhere has shown that the better the working partnership between clinical and managerial colleagues within a hospital, the better the potential for delivering patient care of the highest quality.

The overall thrust, therefore, of the CIM Initiative is to gain the active involvement of the clinicians in all aspects of the management of the services which they provide - from strategy and planning through to the operational issues associated with delivery. There are many reasons why this involvement is seen as increasingly essential.

First, technological and clinical developments in medicine make it possible to develop and deliver services to support and treat a wider range of conditions than ever before. This fuels the expectations of patients and consumers. As a result, there is ever increasing pressure on resources and, consequently, priorities need to be shaped and re-shaped on a constant basis. In Ireland, the national budget for health care delivery has risen dramatically over the past few years and there is an increased level of scrutiny of the impact this additional spending is making or can be expected to make. Determining priorities and ensuring that best value is obtained from additional resources is a task which cannot be undertaken by administration alone. It requires the advice and direct management input from the clinical professionals.

Secondly, the expectations of the public with regard to what the health service should deliver are increasing, not only in terms of the range of services but also in terms of the quality and quantity of services, and of consumers' day to day experience of how services are delivered. Improvement and responsiveness in these areas can only come when the total team of professionals and managers in hospitals work in partnership with one another.

Thirdly, the complexity of many services and the increasing expectations of the different clinical professionals with regard to the roles which they play means that multi-professional team working is necessary if services are to be both effective and efficient. The necessary level of team working can only come about when the range of people involved in service delivery take collective responsibility for all aspects of what is delivered.

Fourthly, there is increasing scrutiny of the roles of professionals in the health service. Consumers are now less likely to treat medical professionals with the deference and uninformed respect that often typified these relationships in the past. Initiatives such as clinical audit and clinical governance are developing in response to this and should help to ensure that the quality of services matches international best practice. These developments will be very challenging for the clinical professions and are best developed from within the community of professionals who plan and deliver services. In other words, there is a developing quality agenda and this can best be facilitated by the involvement of clinicians in management.

In summary, no health service in the world can avoid taking hard decisions about resource allocation and prioritisation. Up to now, in Irish hospitals, the predominant model of decision-making could be said to be typified by individual or groups of clinicians

seeking to extend the clinical quality or quantity of care, and managers trying to seek the best compromise between

- what clinicians want for their patients,
- what can be afforded, and
- what is in the best interest of the relevant population overall.

This way of decision-making has led, in many incidences, to a lack of co-ordination in the short and medium-term planning for health care delivery. It has led to highly centralised (and distant from the patient) decision-making, and to high levels of frustration.

The thrust of the CIM Initiative is to delegate more decision making to clinicians in order that the difficult issues outlined in the points above can be tackled realistically based on productive interaction of clinicians and managers. From the beginning, it was recognised that there would be 'no one size to fit all', and hospitals were encouraged to explore and investigate different approaches to the involvement of clinicians. To date, the approaches which have been implemented include structural and infrastructural changes, changes to decision-making processes, changes to information and performance management, and changes to the way services are planned.

3. The Review Process

Each site which participated in the Clinicians in Management Initiative was offered the opportunity to be involved in the review and almost all agreed to participate. The objectives of the review were given as:

- to assess progress with regard to the involvement of clinicians in management in each CIM site,
- to decide on the best way forward, and
- to identify the support and development needs of each site, differentiating between those needs that are best addressed locally and those which can be met nationally by the Office for Health Management.

A team of six management consultants from various firms was invited to carry out the site reviews, with one consultancy day being allocated to each site. Early in the process the consultants met with the Office for Health Management and agreed a general checklist of issues to be covered during the reviews.

Following each visit the consultants produced a short report which was given to the hospital concerned as well as to the Office for Health Management. Towards the end of the process the six consultants met to discuss their overall findings and discuss how best the Initiative could be supported in the future.

Finally, when all the site reports had been received, two members of the consultancy team were invited to produce an overall document encapsulating the main themes and issues arising from the review and summarising / discussing the best ways of moving forward with this Initiative.

4. Overview and Key Issues

In this section we provide a broad overview of progress (4.1). This provides a backdrop for the more detailed discussion of a number of key issues and observations which arose from the site reviews (4.2).

4.1 Overview

As one would expect with a survey of over 30 hospitals, there was quite a variety of findings and quite a wide range of experiences. A small number of hospitals are still at the exploration stage and an equally small number are approaching full incorporation of clinicians into management. The most common development is the effort to make organisational structure changes in response to/ preparation for CIM - typically changes to the corporate (hospital) management structure and the introduction of smaller, more stand-alone units of management. Because of this variety it is not always easy to draw general conclusions or observations. However, in the main, the following themes emerged:

- there is a need for greater clarity about the authority, responsibility and accountability arrangements which will be needed at all levels within hospitals to enable appropriate and sustainable devolution of power to clinicians.
- much attention has been paid to structural change within hospitals, and this may be deflecting attention from the larger intended outcome of involving clinicians, that is, improved patient care. In some hospitals, communication needs to be extended and repeated to ensure that everyone has the same understanding of the purpose of the Initiative, in relation to both the means (such as structural change) and the ends (improved patient care).
- The introduction of new roles - such as Business Managers and Clinical Directors - has not been entirely smooth, and there is an ongoing need for clarification of these roles regarding operational and strategic management of Units and of the hospital itself.
- Different clinicians are involved to differing extents. In general, nurses are more involved formally than are doctors, and the health and social care professionals seem to have most questions about the nature of their involvement. With regard to the perceived benefits of clinician involvement in management, on the whole it is the doctors who most remain to be convinced.
- On the whole, the level of formal performance measurement and scrutiny of practice is very under-developed in Irish hospitals, thus making it difficult to capture the costs and benefits (financial and other) of changes to the way health care is delivered. In addition, there seems to be little comparison of practice within hospitals or across hospitals (using Irish or international benchmarks).
- Implementing changes to the way health care is delivered in hospitals will impact on resources, and one of the main stumbling blocks to involvement of clinicians (in particular, doctors and the health and social care professionals) is the lack of financial or human resources available to enable them to reduce their clinical workload and spend more time on service management.

4.2 Key Issues from Site Reviews

4.2.1 The Purpose of CIM and the CIM Agenda

In many of the hospitals the reasons why Clinicians in Management was being introduced was either not well understood or not well articulated. The purpose of the Initiative, in terms of anticipated describable changes in areas such as delegated decision making, service management and service quality tended not to have been effectively discussed or clarified. Managers certainly had the issue on their agenda and there was a belief that Clinicians in Management was a 'good thing'. However, often the benefits which the Initiative was meant to achieve were either poorly described or interpreted with some suspicion by the clinical community. There was a sense of Clinicians in Management being a centrally driven Initiative which the Minister had launched and, in many cases, there was an absence of real connections with the benefits which the Initiative could be expected to bring at local level.

As a consequence, there was a limited appreciation of how the Clinicians in Management Initiative should be developed in practical terms site by site. In general terms, most sites envisaged the CIM Initiative enabling two things:

- more clinician involvement in service design and delivery, and
- more clinician involvement in management of resources (people and money).

This was fine enough in so far as it went but more detail was needed to show how the CIM Initiative would enable clinicians to become engaged in these issues. For example, the management agenda for proposed clinical units needed to be better defined as did the types of decisions which clinicians would be enabled to make and the accountability frameworks within which they would be expected to operate. Also it is questionable as to whether the agenda as represented by the above two items is extensive enough. For example, there was little reference to the developing agenda of clinical quality (audit, governance, etc.) or to clinical performance (through benchmarking, the development of care pathways, etc.).

All of the above poses an issue about involvement. Clinicians tend to be people with a mind for detail. They want to know what they are signing up to. In the absence of a clear purpose and a well defined agenda it is probably not surprising to find that progress in developing the Initiative has been slow overall.

4.2.2 Management Involvement

The health services are dealing with many challenges these days. In addition to the day-to-day delivery of health care, there is the need to ensure that best value is obtained from the record amount of funding which is going into health. There are significant endemic staff shortages. There are major capital and service developments in many hospitals. Consumer expectations and advocacy are increasing. In addition, in the east of the country, the new Eastern Regional Health Authority is recently established and it (together with other Health Boards) is in the process of developing new working relationships with the voluntary hospitals. In other words, the environment for health service planning and delivery is becoming more

complex and there are new issues attracting the attention of the senior managers of hospitals every year.

The CIM Initiative at local level appears to fall, as mentioned earlier, predominantly on the shoulders of senior hospital managers to drive and to oversee. Implementing Clinicians in Management was on the list of their performance objectives. Additionally, many were intellectually convinced that this was the right way to go. They shared the frustration of clinicians with the bureaucracy and slow decision making of the 'system' and felt that it was time to connect those who actually spent the resources with the decisions and responsibilities which went along with this. They were convinced of the merit of the Initiative for patients (better service) and for staff (more involvement in the planning, decision-making and management of services). However, the range of pressures on these managers meant that it is becoming harder and harder for them to prioritise the Initiative. No hospital (in this Review) had full-time dedicated people at senior level charged with the management of this major change. The Initiative, therefore, was one of a competing set of priorities for senior managers. By their own admission, few could afford to give it the degree of attention it needs at this time. In addition, personnel changes at senior management level had occurred recently in several of the hospitals in this Review and this too had impeded progress.

The effect of this was that, in many instances, the Clinicians in Management issue remained at rather a 'headline' level with little detail mapped out showing how the change would impact upon roles, responsibilities, structures and the working ethos. For example, there was little evidence of detailed thinking about:

- the decision making powers that would be devolved to clinical units and what this would mean for the Health Boards and Hospitals in terms of 'letting go';
- the practicalities of Clinicians in Management on organisational and governance structures;
- the practical issues to do with enabling doctors to take time to undertake managerial responsibilities; and
- how the CIM Initiative could be used to develop the hospital's quality agenda.

That is not to say that managers were not making real efforts to engage clinicians with the Initiative. On the contrary, in many of the hospitals visited, real efforts were under way. Many were spending time and energy in selling the idea and endeavouring to get key clinicians involved. Some were tackling real obstacles such as changes to the nursing organisational structure which were necessary to facilitate the introduction of new management arrangements.

Overall a general observation from this Review and from experience elsewhere is that the introduction of Clinicians in Management requires a high level of focus by a senior person. He or she needs to give much time to 'selling' the idea and articulating its benefits but most of all, they need to build relationships with senior clinicians who over time become convinced of the benefits which can accrue from Clinicians in Management. The notion of Clinicians in Management is thus most easily taken forward when leaders emerge from within the clinical community as well as from within management.

4.2.3 Clinician Involvement

In several of the hospitals visited, it became clear that there are many different interpretations of the Clinicians in Management Initiative and, in particular, about what it is intended to achieve. Perhaps this diversity of interpretation is not entirely unexpected given that this is potentially the biggest change ever in the management of Irish hospitals.

By and large, it is also a change that is being driven within hospitals primarily by managers rather than clinicians, and the focus of attention has been on issues which typically fall within the domain of management - such as structures, resources, communication, and service planning - rather than on clinical quality (the domain of clinicians, by and large). As a result, many clinicians see the Initiative as something that is for and about management rather than about their involvement in the planning and delivery of service.

The overall perceptions which the different professional groups have about Clinicians in Management and its implications are summarised below.

Nurses

Nurses were divided in their reactions to the Initiative. On the one hand, there were those who perceived Clinicians in Management as changing the organisational structure and therefore changing the roles of many who were now in senior level positions. They feared the devolution of management to clinical units and the subsequent loss of the nursing hierarchy. This was compounded in some areas with a lack of permanent appointments at senior level over the past two years. Some hospitals had held off making permanent appointments when vacancies arose because they were waiting to see what the organisational structure implications of Clinicians in Management might be. As a consequence such hospitals had quite a number of posts filled by people on an 'acting up' basis. Now that many hospitals are at the stage when Clinicians in Management is being worked through in more detail, there is resistance from many of these who not only see their acting up post under threat but also see that the basic hierarchy is unlikely to remain in its present form.

On the other hand, there were nurses who were enthusiastic about Clinicians in Management and saw it as a mechanism for the nurse becoming much more fully involved on a multi-disciplinary basis at clinical unit level. They saw the scope for more active involvement in service design and in developing the quality agenda, and for developing a culture more supportive of innovation. In many of the hospitals where a team had been set up to develop Clinicians in Management nurses were playing a very active role.

Health and Social Care Professionals (HSCPs)

This group was drawn mainly from the therapeutic diagnostic professions (physiotherapy, occupational therapy, speech therapy, lab-technicians etc.) and in the main they felt a degree of threat from the Clinicians in Management Initiative. The threat came from two perceptions. First, they envisaged hospitals being divided up into semi-autonomous clinical management units and they feared that this would lead to the fragmentation of their professional groups. Secondly, they felt that as a group of related professions, they would have little influence at hospital level if Clinicians in Management were to be fully developed.

Most of the fears arose from the fact that the organisational models which would support Clinicians in Management on the different sites

had not been fully developed. In the absence of such clarity, the HSCPs feared that their influence at corporate level relative to the doctors and nurses would diminish. The lesson is to ensure that new structures are motivational for all the clinical professions who contribute to the treatment and care of patients.

Doctors (Consultants)

There was variable buy-in from doctors. The situation ranged from no real involvement in some places to very well developed involvement in others. In those sites where the Initiative was most advanced doctors were taking leadership for clinical units and working alongside a team often comprising a senior nurse and a 'business manager'. In other areas, there was little or no involvement from doctors. In some cases, this arose from lack of interest and in others it arose from practical issues such as the lack of time to take on additional management responsibilities. These were real problems in some hospitals where doctors had long waiting lists and felt that devoting sessions to management would only result in longer lists.

It was also observed that team work among doctors even in the same speciality was often undeveloped. Consultants were operating very independently from one another and there was little hard evidence of doctors in the same speciality coming together to discuss standards, service design, the use of treatment protocols, etc. One observation from this is that an initial target of Clinicians in Management should be to develop a greater sense of team-working among doctors in the same clinical area. Greater scrutiny of clinical performance and quality may well be a major driver for this in the future.

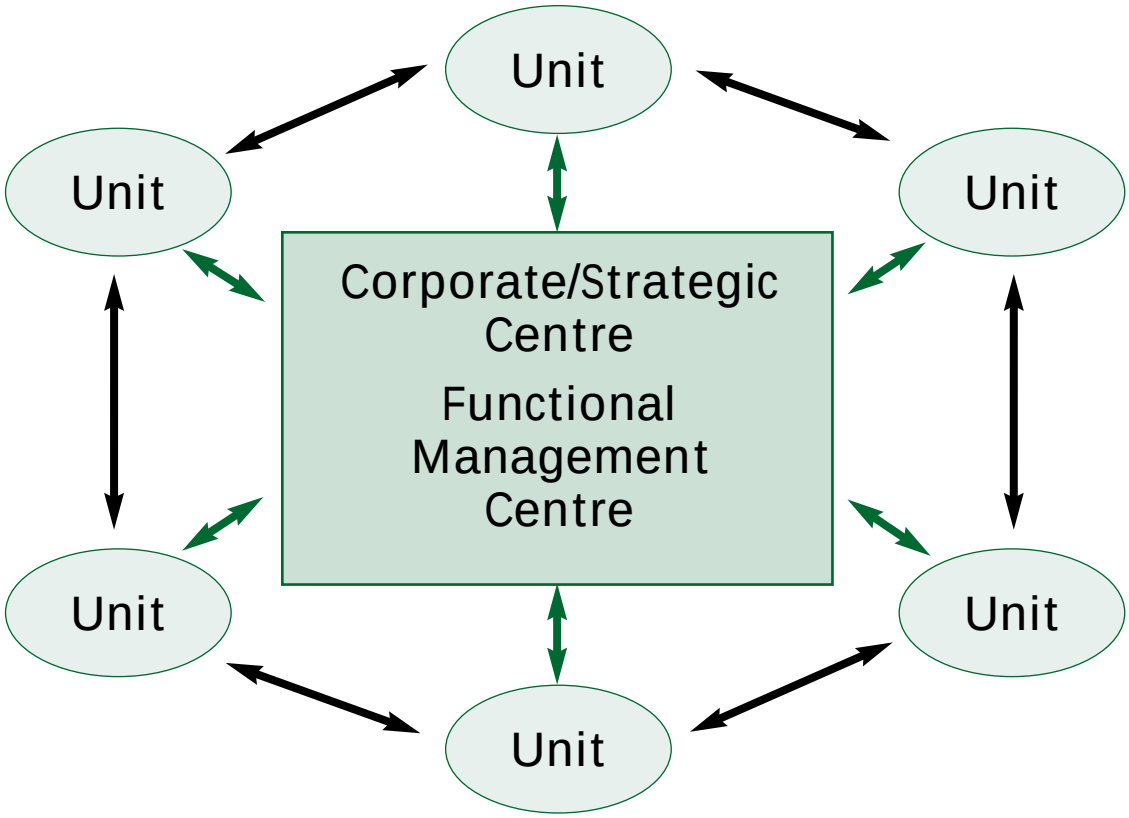
In addition, many consultants want firm evidence of the benefits for patients which have been derived from doctors' involvement in management and decision-making (in Ireland or in other countries). Time was also a significant barrier to the involvement of clinicians, especially consultant doctors and health and social care professionals. Some hospitals have used CIM development funding to pay for clerical and administrative support for these clinicians. In a very small number of cases, funding was provided to cover one clinician session (half-day per week) for the small number of consultant doctors who have taken on the role of Medical Director. Those filling such posts report that one session per week is insufficient to carry out the role properly.

Finally, in some sites Clinicians in Management has been taken up enthusiastically by a senior doctor and where this has happened, more progress has been made. There are several examples of this. The clinician with this interest becomes the informal leader of the medical community with regard to Clinicians in Management. The lesson is that hospitals need to work hard at getting a senior consultant committed to this Initiative and then to use him / her to guide the process as it seeks to gain the involvement of a critical mass of other consultants.

4.2.4 Structures, Delegation and Roles

Most of the hospitals which were visited were in the process of exploring or implementing some form of structural change to enable them to involve clinicians more in management. In general, hospitals had, for the most part, opted for a structure based on smaller "business units" (such as directorates, divisions, or units of management), usually around surgical, medical and diagnostic/ therapeutic groupings. The predominant model, in general, could be said to be based on a central 'hub', as depicted opposite in Figure 1.

Fig. 1: Predominant Form of CIM-related Structure



In general, the larger hospitals/multi-specialty hospitals were creating much higher numbers of units of management (up to 11 in the largest hospital) than were smaller/single-specialty hospitals. Where such units do exist, they are headed by a consultant doctor.

Staff in many of the hospitals which have introduced units of management remarked that they felt this development had contributed to their motivation and increased their involvement in the decisions to be made about the running of their unit. However, on the whole, it was those hospitals or units which had already introduced multi-disciplinary teamworking prior to the Initiative where most staff benefits were mentioned. Some clinicians were also unsure about their roles and the boundaries of their decision-making at unit level. Unit Nursing Officers were felt to be key posts but many UNOs were struggling with the 'matrix'-type working and reporting relationships which were emerging for them. The health and social care professionals, in particular, were worried about the implications for their services and for their professional development in the context of the introduction of smaller, stand-alone units of management.

Finally, it was noted that, in some hospitals at least, there was some confusion about how much power and control should be delegated from the centre to business units. As a result, the appointment of business managers to units was giving rise to some confusion over roles and responsibilities. The level at which

business managers were appointed also ranged quite a bit in different hospitals, suggesting that, in some cases, they were likely to play more of an administrative role rather than a management role in the unit. The level of functional support to units (in terms of HR, finance, IT, etc.) also needs to be clarified in many hospitals.

4.2.5 Measuring and Managing Performance

To an extent, there appears to be a chicken-and-egg conundrum in the implementation of the CIM Initiative in many hospitals in that their current systems and methods are not sophisticated enough to provide meaningful measures of performance - clinical, operational or patient satisfaction. This lack of transparency compounds the difficulty of not being able to adduce the benefits to patients of the Initiative.

To a great extent, the management information systems required to support devolved power (financial management, performance/activity measurement, etc.) are not yet well-enough developed to enable anything other than relatively centralised management. At a national and regional level, it seems that the one area of hospital performance which is most thoroughly scrutinised is 'living within budget' and, as a result, some hospitals are so fearful of budget overruns that they are unwilling to decentralise financial management until they are sure that clinicians will be appropriately responsible and corporate-minded in their decision-making. This is contributing to clinicians becoming frustrated because they feel that the structural changes remain somewhat toothless without a greater measure of local resource management.

The national agenda with regard to performance management (the collection of HIPE data) also appears to be largely driven by efforts to compare costs, rather than to improve clinical quality. For example, HIPE data in many hospitals are based on ward performance rather than clinician or team performance.

4.2.6 Approaches to Implementation

On those sites which have developed Clinicians in Management to a significant degree it is interesting to examine the experience of different approaches to implementation. There are two approaches in broad terms. One is to proceed with one or two units on a pilot basis and the other is to go for implementation across the board. The arguments for each are well rehearsed and indeed, for some hospitals, the pilot is the only approach available simply because there is not enough buy in from the clinicians to enable a whole scale implementation. Some experience does however suggest that caution is needed in the pilot approach. One danger is that the hospital develops two sets of management arrangements and processes, one of which is inside the mainstream of overall hospital management and the other of which is a management entity which operates to quite different rules. This has obvious dangers though these can be overcome by:

- maintaining overall authority under the General Manager and the senior team
- being very specific about decision making authority and responsibility from the outset
- binding the leader of the 'clinical unit' into overall hospital management structures thus balancing his / her role between the needs of the specialty and the needs of the hospital as a whole.

4.2.7 Other Factors

Teamworking

Those areas where there is a history or established practice of multi-disciplinary team-working and decision-making seem to be the areas most amenable to further involvement of clinicians. However, many of the reports from the hospitals indicated a low level of teamworking at specialty level. During the Review meetings, the management consultants looked for evidence of teamwork-ing in areas such as:

- service design
- service innovation
- development of the roles of the different clinical professions.

While there were good examples of team working in these areas, they tended to be isolated and there was little evidence of team working across entire specialties or groups of specialties. Indeed, as observed earlier, even the doctors in the same specialty area tended to operate on quite an autonomous basis. There was also evidence that the boundaries between nurses and doctors were very firmly drawn both in terms of role and in terms of influence. This ethos with its 'professional silos' is a major challenge for Clinicians in Management and strikes at the heart of the issue which is to change the culture in the hospitals away from a command / control ethos to one where teams work in a productive manner continuously improving the quality and design of the services which they offer.

The Size and Ethos of the Hospital

Progress in the CIM Initiative does not seem to depend particularly on one size or ethos. However, within this general picture some comments can be made:

- some smaller hospitals (circa 100 beds) already, in effect, have arrangements which ensure that clinicians are involved in the management of many service planning and operational matters. This may not be happening under the Clinicians in Management banner but the thrust of what is meant to be achieved under Clinicians in Management is in place at least at a basic level. Such places need to be encouraged to deepen what they now have rather than to engage in developing lots of new organisational structures and processes
- some hospitals under the direct management of health boards seem to be stuck in their implementation of the Clinicians in Management Initiative. Some have barely started while others are down the road to some extent but are not progressing as quickly as they might. There are many reasons for this but one is the lack of a clear new set of delegated authorities defining what devolution will mean in practice. Thus people are not sure what they are signing on to other than some general idea of more 'involvement'. In these situations, Health Boards need to be clearer about the end game which they hope to reach and this needs to be painted more clearly in terms of new roles, new authority levels, new structures and new processes, which, collectively, can be seen to offer real benefits to patients and to the different professional groups
- some of the hospitals have had a strong history of medical involvement in determining strategy and direction. Some of the hospitals with a religious ethos

would fall into this category. However, in some instances there is a discernible gap between this and what is intended by Clinicians in Management. The gap is two fold. First, the old model is medically dominated and excludes the other professional groups. Secondly, involvement is pitched at the governance / strategy level and not at the level of specialty management. In such institutions, there needs to be a rethink about the level at which clinicians can become involved and about the range of clinicians who can combine in teams to contribute to service management.

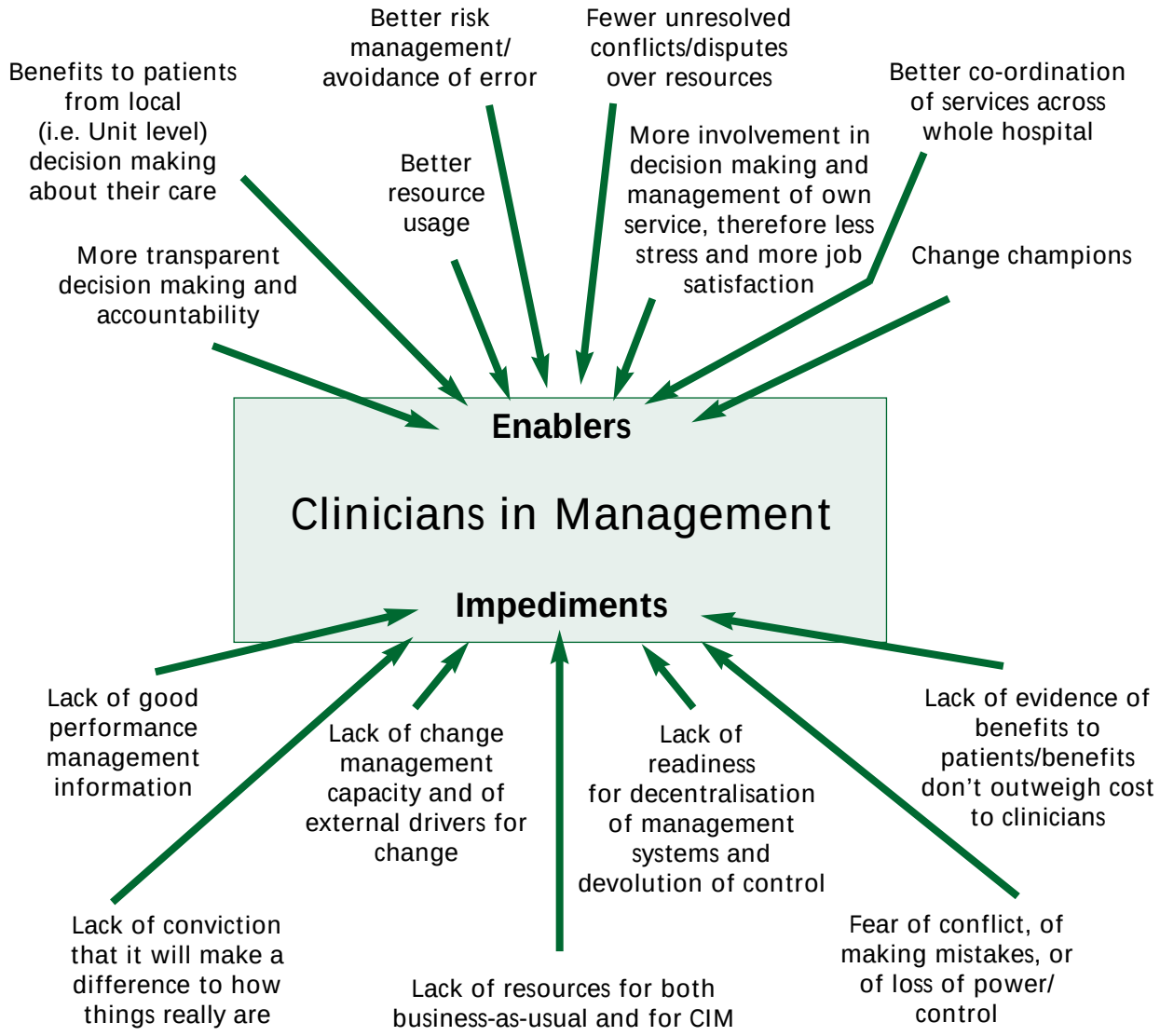
Having made these points, several hospitals have made progress with Clinicians in Management and have developed new structures, processes and roles accordingly. Not all have progressed at the same speed and all have hit a variety of obstacles. But those on the road to involvement of Clinicians in Management believe that it has brought real benefits to patients and staff alike.

5. The Way Forward - Managing Change

5.1 Overview

Clinicians in Management is, as mentioned before, one of the biggest potential changes ever to be tried in the Irish health system. It is more than structural change, it is also about changing the culture of the health service. In a change of this magnitude, there are, inevitably, potential winners and losers, and factors which will mitigate against the change as well as those which could or will facilitate it. The diagram below shows some of these factors.

Fig. 2: Clinicians in Management: Impediments and Enablers



Managing change is not easy and managing change in complex organisations is particularly difficult. Hospitals are probably the most complex organisations in any sector, given the criticality of their services, the mix of disciplines, specialties and functions, the high cost of providing service, the power distances within and between professions, and the fact that they are demand-driven to a significant extent. Added to all of these is that hospitals have been, overall, relatively steady-state organisations in the past. Whereas many clinicians are used to ongoing change within their discipline (due to the development of new treatments and treatment methods), in many areas, the relationships between clinicians (within their disciplinary groups and across them) has not changed much in the last 50 years.

Clinicians in Management is, amongst other things, an attempt to change the way clinicians work together (for the purposes of improving the efficiency and effectiveness of patient care). Very few managers or clinicians have been involved in changes as potentially broad and far-reaching as this one. In addition, the change is being introduced in 'real time' (i.e. alongside efforts to meet service demands which are higher that they have ever been in Ireland), and, as a consequence, very few managers or clinicians can devote dedicated, specialist resources to this issue. In other words, there is a question mark over the capacity for change management which the health services have to give to this Initiative at this time. These factors would not augur well for the introduction of change in any context or sector.

While much good work has been done it is probably fair to comment that the Clinicians in Management is in danger of losing direction and impetus. This is not unusual in initiatives which are designed to effect major change in organisational culture and organisational arrangements. In most long term change projects it is necessary to stand back from time to time and consider how to refocus the Initiative and give it new energy. In this context, there are a number of circumstances / actions (outlined below) which, if they could be brought about, would help give the Initiative new focus and impetus. In many ways they are a cumulative package.

5.2 Pre-Requisites for Change

In general, for change to occur within any system, there are a number of pre-requisites. A generic formula for the 'calculation' of the likelihood of change happening is: **Ch = (D x V x P) > Co**.

where **Ch** is Change, **D** is Dissatisfaction with the status quo, **V** is the power and extent of commonality of the Vision for how things might be better in the future, **P** is the degree of development of the Processes needed to get from where things are now to their future (better) state, and **Co** is the Cost (both financial and human) of changing. In other words, for change to be likely, the level of dissatisfaction, the power of the vision and the processes required to effect change must all exist and must outweigh the costs of changing.

Regarding the CIM Initiative, it is, in our view, questionable whether sustained change will occur, for the following reasons:

- Amongst the key stakeholders (the clinicians themselves), there does not seem to be widespread dissatisfaction with the way things are at present (or, if there is, they are not ascribing their dissatisfaction to their level of involvement with management);

- As mentioned earlier, there are several and diverse views on the vision of the CIM future (some clinicians - such as HSCPs and senior nurses - have expressed considerable fear about their future if there is to be greater devolution to units of management, and some clinicians see the future as one where management decision-making, whether involving clinicians or not, will interfere with their current relatively autonomous clinical and business decisions);
- The processes by which the devolution of power and its associated accountability will occur are, in many sites, only beginning to emerge, and
- There are costs to this change - some clinicians will lose autonomy, some are fearful of losing their professional solidarity, some may lose status, and many are trying to implement the changes in the face of uncertainty and in concert with the day-to-day challenges that the provision of hospital care presents to clinicians (thus making for longer working days and weeks for both managers and clinicians in several sites covered by this Review).

For these reasons, the management of change is one of the aspects of the Clinicians in Management Initiative which needs most attention at this stage.

5.3 Strengthen the External Drivers of the Case for Change

The degree of change in which people and organisations are willing to engage depends very much on the pressures which they perceive support the change in the external environment. In other words, people are more likely to change if they believe that the change will enable them to deal more effectively with the changing nature of the world in which they live and work. It is in this context that we note the relative absence of strong external drivers in the Clinicians in Management process. It is perhaps not that the drivers are absent but more that they are not being articulated clearly and strongly enough by those who have the vision to see the process implemented. The key stakeholders in the Clinicians in Management Initiative, i.e. those who may have to change most, are the clinicians themselves. At present, amongst clinicians, consultant doctors have by far the largest 'say' in the way in which resources are allocated. If the Initiative is to work, there will have to be some gains in it for consultants or, at very least, as little pain as possible. Consultant doctors are, of course, interested in improving the quality of care provided to patients but the problems often lie in which (consultant's) patients get prioritised for resources - in many hospitals, consultants, in effect, can operate almost as stand-alone businesses rather than as equal players in a corporate team.

It would be helpful, for example, to have some of the following drivers in place:

- political focus on ensuring that the budget allocated to health care is being spent most effectively by insisting on benchmarking performance in Irish hospitals with best achievement elsewhere in Europe. The downstream effect of this could be to selectively invest in those which perform most effectively, similar to the 'rewards' which hospitals can gain through HIPE. Such a focus would provide incentives for teams of clinicians at local level to take a more comprehensive ownership of all aspects of their services
- raising the profile of clinical quality through insisting on a more strategic approach to

clinical (multi-professional) audit and through a more transparent approach to the continuous supervision of clinical practice. These and other clinical management issues are on the agendas of hospitals elsewhere in Europe and will sooner or later climb higher on the agenda in Ireland. These issues should be on the government's agenda and doctors and other clinicians encouraged to take ownership of them. This would encourage clinicians at local level to become more closely involved in management as they sought to respond to a quality agenda which was being insisted upon by both government and citizen alike

- key leaders and others in the management of the clinical professions (especially medicine) taking a much more public role in pushing forward the Clinicians in Management Initiative. This could happen at a number of levels, for example, policy makers in the Department of Health and Children, Chief Executive Officers of Health Boards and the professional bodies and advisory associations.

These and other drivers of change would further raise the profile of Clinicians in Management and would make it explicit that there are benefits to be gained as well as penalties to be avoided through participation.

5.4 The Process of Change

The management of this change, like any change, has political and psychological dimensions as well as a rational basis, and a range of management styles - including both driving or applying pressure and winning hearts and minds - will need to be employed to ensure that real change occurs. In general, most hospitals in the Review were found to be relying on the 'hearts and minds' approach to influence change - this reliance was both by choice (managers do not want to impose this change as its imposition could create a lot of resistance) and by the relative absence of external drivers (as mentioned above).

Some of the other ways in which the management of the change could be complemented (so as to ensure that all three dimensions - rational, political and psychological - are addressed) are:

Rational

- Greater use of project management techniques - defining and scheduling the major phases and the tasks that are required to bring about change in the hospital/Board.
- Explicit clarification of costs and benefits, including evidence of patient benefits that have been derived in other hospitals.
- Mapping the change - clearly delineating the vision of the end point of the change, including what will be different and what will have stayed the same. This vision needs to be more than a "motherhood and apple pie" version of the change, it also needs to deal with practical issues such as how will decisions be taken and implemented at various points within the system, and with systemic issues such as how reporting relationships, financial management, performance management, etc. might look in the future. Of course, this version of the future is the starting point in the design of the change - the clinicians themselves may have other ideas on how the change could be effected.

Political

- Mapping the stakeholders - making efforts to show different stakeholders what the future might hold for them in the new structure/system, and dealing explicitly with power balances and 'winners and losers'.

Emotional

- Communicating constantly about the change and encouraging people to participate in the design and implementation of the changes to systems, structures, practices, etc.
- Dealing with fears, concerns and difficulties that individuals might encounter in their consideration and/or implementation of the change.

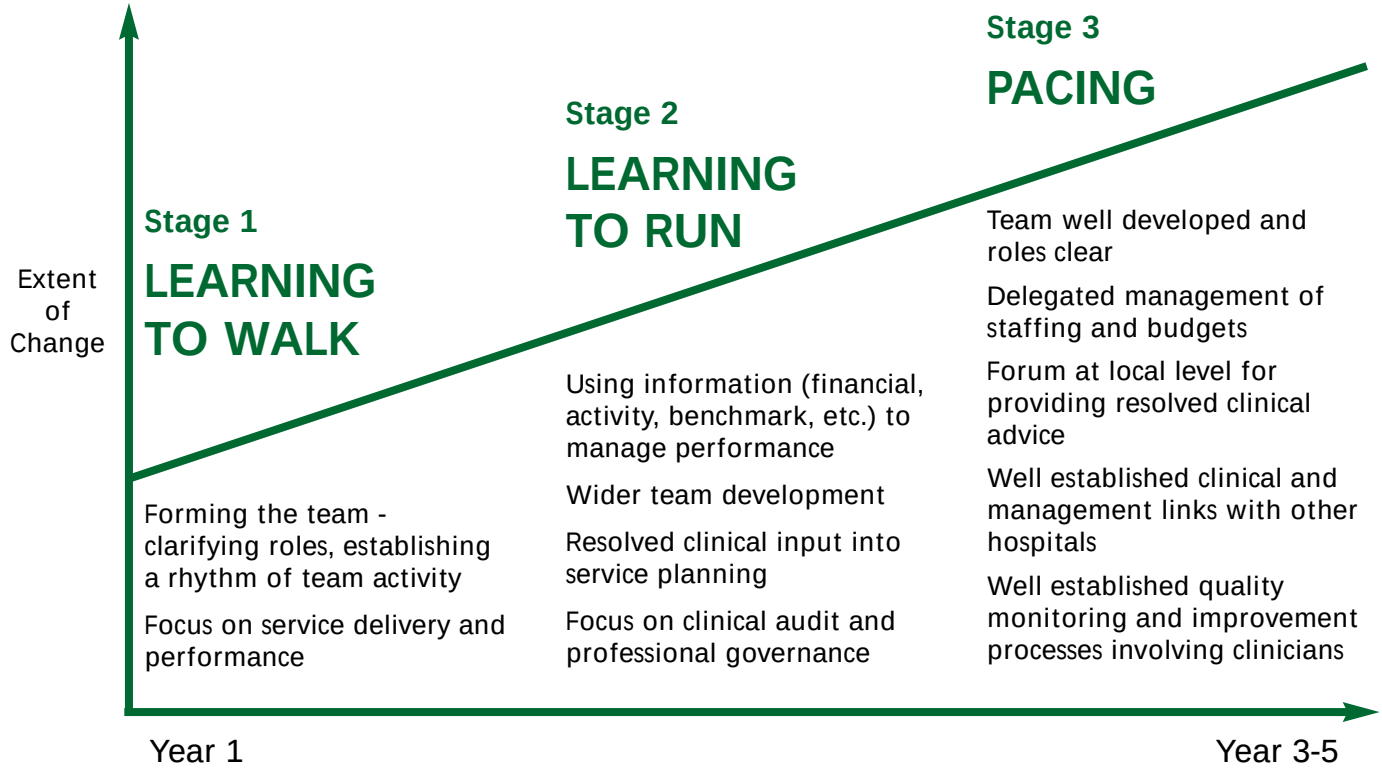
The change managers themselves (i.e. those managers or clinicians who are closely involved) should continue to meet regularly for the purposes of support and sharing of learning across comparable or similar sites/areas. Finally, given the rate of change in the general environment for Irish health services, a realistic estimate needs to be made of the amount of time it may take to fully involve clinicians in management - for some clinicians and for some systems, this may be the largest cultural change that they have undertaken in quite a while.

5.5 CIM: A Three Staged Approach to Implementation

One aspect of the review which stands out is the observation that many seemed to see Clinicians in Management in terms of structures and roles and therefore took a task approach to making the change happen. This is good insofar as it goes but it belies the complexity of the change which is being attempted. We would therefore argue that a more appropriate approach would be to see the change process first and foremost as a culture change and to employ change management techniques in the delivery of this. These techniques tend to place more focus on process issues (communication, involvement, etc.) than on the task issues of role and structure. It is our view that many of the hospitals would have benefited from the input of someone with the experience of making change happen in organisations which are staffed largely with members of the 'professions'.

This follows on from earlier comments and argues that one of the reasons for the limited progress is the lack of focus and lack of understanding of what is to be accomplished. It is therefore suggested that more thought needs to be given to defining the stages of implementation of Clinicians in Management. The diagram overleaf sets out a map showing a progression through three stages. The details of each stage could be debated but the usefulness of mapping out what is expected within agreed timescales is undoubtedly of benefit.

Fig. 3: A Staged Approach to Implementation



Leadership and Team Working

The diagram illustrates a three-stage development over a 3 to 5 year period and it suggests the need for the progressive taking on of responsibilities and freedoms. Broadly what is envisaged is as follows:

Stage One: the first priority should be the forming of a team of clinicians who will be responsible for the specialty or group of specialties.

The focus should be on :

- building team stability through clarification of roles
- establishing a rhythm of meetings
- developing a basic data set which the team will use to assist its management function; working with finance department to develop meaningful financial data
- developing relationships within the wider group of professionals in the specialty area
- taking responsibility for the day to day management of the people within the clinical area under the umbrella of overall hospital HR policies and procedures
- starting to make a difference by examining and improving service delivery processes and improving the patient experience of the system.

The key to success in stage one will be the ability of the team to form a cohesive unit supported by the exercise of sound interpersonal skills between team members

Stage Two: on the basis of a team where members now feel comfortable with one another the key developments in this stage would be:

- an examination of the performance agenda through benchmarking with similar hospitals elsewhere both within Ireland and further afield
- starting to take control of the clinical management agenda - audit, care pathways, etc.
- becoming established as the forum for service planning within the clinical area and developing processes for resolving conflicting development priorities between clinical areas
- building strong links throughout the clinical area through effective communications and responsive management of people and other resources
- starting to make use of regular monthly financial data to manage the affairs of the clinical area

Stage Three: this stage is not so much about taking on new responsibilities as it is about becoming well practised and proficient in exercising the responsibilities adopted in stages one and two. During this stage the team will be competently managing people and finances, they will be the recognised body for service planning in the clinical area, they will be taking initiatives to improve operational performance and clinical quality and they will be moving ahead on measures to improve patient experience of the system. The leader of the team will also be connected into the overall management body of the hospital and thus discussions at local level will be in the context of overall strategies and policies.

The detail of what is in the three stages is less important than the overall principle of careful mapping out the evolutionary change. Each site could develop such a plan suited to its own circumstances and stage of development.

6. The Way Forward - Enablers of Further Progress

6.1 Re-Balancing the Agenda

The management focus which seems to typify the Initiative to date needs to be complemented with a clinical focus. Very few of the sites had elaborate systems or procedures for developing this clinical focus, systems such as those designed to enable clinical or medical audit, quality and clinical governance, the development of care path-ways or other innovations in the way services are delivered which would benefit patients, or benchmarking against international standards of good practice. In other jurisdictions (UK and US, for example), changes in legalisation have driven much of the clinical development agenda (particularly risk management and governance) but, as yet, there is no similar external compelling force for clinicians to review their own performance in Irish hospitals, nor does there seem to be much explicit discussion of this agenda amongst the medical and health professions.

Perhaps it is time to look at the issue of involving clinicians in the 'business' of delivering health care in a slightly different way from the CIM Initiative, that is balancing the management perspective with a clinical one. The question needs to be asked: could hospitals and health boards achieve the same benefits to patients without incurring significant extra expenditure and without the need to involve all clinicians so heavily in the 'management agenda' at the present time? One way in which this might be achieved is to move the agenda away from clinicians in management and towards good governance (from both a clinical and a management perspective). The essence of good governance is that there is ongoing review of how the business is planned, managed and delivered. Given that the business of hospitals is, by and large, acute health services, the chief operations staff are clinicians and the governance of this aspect of the service is (rightfully) their responsibility.

Thus, a key transition for hospitals seeking to involve clinicians in management is some form of clinical audit/peer review of clinical quality and patient experience - these issues are much closer to clinicians than are the issues of management and accountability and, with the increasing emphasis on risk management and rising medical indemnity costs, there is, perhaps, more of an imperative for clinicians to take responsibility for these aspects of service. (Of course, the financial and human implications of service decisions are important too and need to be addressed at a later stage.)

6.2 Performance and Information Sets

There needs to be greater general discussion of the performance management agenda, from both the task and process perspectives. People need to know what outcome measures are available to help them capture the patient benefits and people also need to know who 'owns' the performance measurement system. Monitoring performance can be a highly political activity and there must be a good deal of trust, from both managers and clinicians, that the measures being used are fair and that the system enables balanced decision-making (across both resource and clinical management issues). Performance and management information systems need further development to enable transparency about clinician and Unit performance (many of the HIPE collection systems only enable the latter).

Devolved management units need good quality financial data and accurate activity / performance information. There was

generally a lack of movement on setting up these information sets. Even if one goes for a three stage evolution as suggested above, it is necessary to start developing the information sets in year one. Experiences elsewhere suggests that it takes a few years to hone the information into the shape which is useful to clinical units and is trusted by them.

6.3 Structures, Roles and Accountability

Structures

Many hospitals would seem to have spent a good deal of time in consideration of the structural issues which might enable them to involve more of their clinicians in the decision-making about resources and patient care and many have made huge efforts to introduce structures which enable decisions to be made closer to the patient.

However, in some of the larger hospitals where the number of units is in double figures, there is a possibility that the pendulum may be moving too far in the direction of local involvement in decision-making, as the 'centre' (which may be a hospital management team or a clinical director) may find it difficult or too costly to engage in the necessary operational and strategic transactions with such a large number of relatively stand-alone units. In addition, it is likely that very good care path-ways will be needed to complement large numbers of units of management to ensure that patients don't 'fall through the gaps' when moving between units.

Roles

One of the issues which arose most consistently in the Review meetings with the hospitals was the prevalence of uncertainty about the roles and responsibilities of both clinicians (doctors, nurses and health and social care professionals) and managers (general managers and unit business managers) in the 'new order'. This uncertainty is, to an extent, understandable given that the restructuring which has typified the Initiative in most sites is still at a relatively early stage and, as with the implementation of most change, not everything can be fully anticipated and planned in advance.

As yet, and these are early days for the implementation of the Initiative in most sites, it would appear that the scope of the unit business managers is relatively limited. As mentioned before, the predominant impression is that the business managers appear to be occupying more of an administrative role. There was little sense of business managers leading the 'business' of the unit in relation to analysis of customer care, performance standards and reviews, analysis of the 'market' (through epidemiology and changes in the external environment), or working in collaboration with other units or parts of the health system to achieve better care pathing or efficiencies.

Appendix 1 to this Report is an attempt to delineate the generic roles and responsibilities which the clinicians (doctors, nurses and health and social care professionals) and managers might play in units of management. The purpose of this sketching of roles and responsibilities is to encourage discussion and debate amongst those involved in the Initiative - it is not intended to be a comprehensive blueprint.

Accountability

Each site needs to define what it means by 'devolved management'. This needs to be defined in terms of the decisions which will be devolved to clinical units and, in turn, be relinquished at hospital, Health Board and Department level. The ideal end point should be defined and the pathway to that end point

described. Equally the implications of devolution on processes and procedures needs to be made clear if organisational confusion is to be avoided. This covers the full range of management functions - Human Resources, Finance, Service Planning, etc. Having defined the new arrangements, the organisation as a whole (clinical unit, hospital and Health Board) needs to be consistent in how these are operated. This is a critical element of reinforcing the importance of the clinical units to which responsibility has been devolved. So, for example, in a devolved clinical unit, it would be unacceptable for a senior member of staff to seek to get acceptance of a proposal at Hospital level if that decision was properly within the authority level of management at clinical unit level.

6.4 Skill Development

Local teams need new skills principally in teamworking and basic management techniques. There should be a commitment to support teams with such inputs during the first stage of their development. Training and skill development can also usefully be introduced at other levels (for example, clustering a few new units together in learning sets or providing master class type inputs on specific issues from a central source). Hospitals which wish to participate in such programmes should be able to demonstrate that they are actually at the implementation stage and not just thinking about it.

Many clinicians noted that they would like management training if they are to increase their involvement in the management of units, including training in financial management, human resource management and change management.

6.5 Clinicians In Management And Staff/Patient Benefits

Much has been written in the past about the benefits to patients through greater involvement of clinicians in management. However, not so much has been documented in detail about these benefits and there seems to be a significant level of scepticism amongst clinicians about:

- Whether significant benefits do actually accrue to patients, and
- Who benefits from the benefits? (i.e. if there are improvements in service this year through, for example, reduced costs and/or higher throughput, does this become the baseline for next year and, if so, are clinicians putting themselves on an upward treadmill when they already feel like they are working at full stretch in many cases?).

These issues have to be addressed openly and honestly. Their discussion might not persuade people, but at least it may contribute to the reduction of scepticism. People need to see evidence of the worth of the changes: the worth to patients, to the hospital and to themselves. Many hospitals have already gained benefits from the involvement of clinicians in management-benefits for patients and for the clinicians/staff, including the following:

- New services established and more beds opened (Waterford, St. John's Limerick);
- Access to OPD has improved (St. James's Hospital);
- Complaints have decreased (St. James's Hospital);
- There are joint problem-solving initiatives in

many sites involving a range of clinicians and covering a wide variety of issues (quality, bed management, theatre management, clinical audit, service planning, etc.). (Cavan Monaghan Hospital Group, St. James's Hospital, Waterford, St. John's Limerick, Portiuncula);

- Better financial control and alignment between corporate objectives and operational spending (Portiuncula) and reductions in expenditure on testing (Waterford);
- Better advance planning relating to the appointment of new consultants (James Connolly Memorial)
- New nursing management initiatives (rostering, clinical practice, cross-Unit communications, etc.) (Waterford, Wexford, St. John's Limerick); and
- Wherever progress on the CIM Initiative has been made, front-line staff felt they had a greater degree of 'say' and control over day-to-day decisions and service planning and communication across Units and between disciplines has improved.

The development of run-throughs of pre- and post-CIM decision-making might make it easier for people to see how things might work in practice (particularly if based on generic medical and surgical units). In addition, ideally, any development initiatives aimed at supporting the CIM Initiative should include opportunities for people to model what might happen in practice regarding decision-making and communication in their own hospitals under the new arrangements.

6.6 Dealing with Practical Obstacles

There are some issues which need practical solutions. There is a general vagueness about the time which a consultant would have to give to the management role if he or she were to accept leadership in a clinical unit. This issue needs to be addressed both in terms of the current reality and in terms of consultant contracts in the future. It is important for hospitals to recognise that this process will take consultant time and that this means time away from clinics, etc. Pragmatic ways need to be found to deal with these and the necessary resources (money, locum cover, etc.) provided.

Similarly, in some areas there are difficulties in migrating the current nursing structures to those which would be supportive of devolving management responsibility to a clinical unit. In some cases this has led to protracted negotiations. Again, practical solutions need to be found to deal with these issues.

7. Conclusions

Clinicians in Management is viewed by most hospitals as representing a major change in the way hospitals are managed in Ireland. In a health care world which is

- increasingly complex in terms of the range of treatments and services which can theoretically be provided
- under scrutiny in terms of value for money
- set in an increasingly well-informed and questioning society
- more and more subject to litigation

the imperative is to enjoin all the senior staff at hospital level (managers and clinicians) in determining priorities and in dealing with operational and planning issues.

This is primarily a culture change issue. The response to it, however, has been largely in terms of organisation structure. This is fine insofar as it goes. However, it is not enough. Success, in our view, will depend upon putting much more emphasis on three factors.

First, the process of introducing Clinicians in Management needs to be supported by a range of **change management** techniques. Properly applied, these will enable new structures and new roles to evolve.

Secondly, **the agenda** which the teams at hospital level are expected to address should be balanced to include issues which are of central importance to the clinicians - clinical quality, governance, evidence based practice, etc. These issues have a 'natural' professional focus for clinicians and, if they are adopted strategically at hospital level, they will enable doctors, nurses and health and social care professionals to exercise meaningful leadership within their professional areas.

Thirdly, the **skills and competencies** of those involved in Clinicians in Management teams need to be developed to enable them to work effectively in teams pursuing objectives in the context of overall hospitals' strategies.

Given that these three factors are given more emphasis, what practical steps could be taken to give impetus to the process? The benefits of Clinicians in Management could be drawn out more clearly to illustrate the positive impact upon patient care. Doctors from other hospitals who have made Clinicians in Management really work and who have lots of examples of benefits could be used to help build impetus and enthusiasm. On a local basis, hospitals could give the development more focus by allocating the bulk of a senior manager's time to lead and develop the change. The difficult resource issue of the time needed by consultants to play a meaningful role in specialty based teams needs to be addressed realistically. Once a development is agreed at hospital level, it could be managed more firmly through the use of simple project management techniques. These are all ways of giving more impetus and focus.

Finally, this document could be used as a mechanism to take stock with interested groups around the country and working through with them the practical implications of dealing with Clinicians in Management as a culture change issue.

Involving clinicians in management is not an option. We trust that this review will enable those who have been grappling with this issue for the last two years to take stock and re-energise and, where necessary, refocus their efforts in order to make further progress which will enable the hospital services provide care which is both of the best possible clinical quality and also is delivered in an efficient manner which is sensitive to the range of patients' needs.

Appendix 1

Clarification of Possible (Non-Clinical) Roles and Responsibilities

	HEALTH BOARD/SERVICE	HOSPITAL/CORPORATE	UNIT/'DIRECTORATE'
DOCTORS	• Working with colleagues to monitor trends in epidemiology and to plan for services in good time to meet population needs. Consideration of mix of care, cure and prevention/health promotion. • Liaison with GPs and discussions of community/hospital interface.	• Contribution to overall hospital service mix planning and resolution of resourcing conflicts, particularly inter-consultant conflicts of an operational and/or strategic nature. • Membership of corporate management team and/or hospital strategy group.	• If Head of Unit, development of a team approach to management of all clinical issues arising in Unit, and close collaboration with Business Manager to ensure continual quality improvement in patient services. • Audit of clinical service to ensure that standards are upheld and that Unit/clinicians' performance is comparable with national/international benchmarks. • Ongoing review of case mix in Unit to identify decision drivers, implications, costs and impact on other Units.
NURSES	• Collaboration with other Nurse Managers to ensure Health Board-wide management/ deployment of nurses to best advantage. • Workforce planning (need to clarify whether this is done is conjunction with Central HR or separately for nursing population). • Development of services according to population needs including management of hospital/community interface.	• Management of nursing to ensure it is best placed to contribute to delivery of clinically acceptable nursing services in most efficient way possible. • Contribution to corporate strategy and service planning (membership of management team). • Workforce planning (need to clarify whether this is done in conjunction with Central HR).	• Ongoing contribution to audits and reviews to identify best practice within Unit (within and beyond nursing).
HSCPs	• Working with colleagues in community to ensure that therapies are delivered in a way which strikes a balance between best for patient and most efficient use of resources.	• Ensuring appropriate attention to diagnostics and therapies in overall service planning and in case management. • Developing protocols - in conjunction with other clinicians - for diagnostics and therapies to ensure best balance between risk avoidance, cost and effectiveness.	• Working with other clinicians to ensure optimal management of each case and overall mix. • Working with colleagues to identify efficiencies in use of diagnostics and therapies.

Clarification of Possible (Non-Clinical) Roles and Responsibilities

	HEALTH BOARD/SERVICE	HOSPITAL/CORPORATE	UNIT/'DIRECTORATE'
BUSINESS MANAGERS	• In multiple-hospital Board, contribution to regional planning and development of optimal service offer.	• Pooling and sharing information on Unit performance to enable integrated service planning and management, and identification of cross-Unit conflicts and design/ re-engineering of processes to enable more efficient/ effective use of resources.	• Development of a 'business plan' for Unit (including public/private mix). • Development/ redesign of performance management systems to enable collection of data, comparison against comparable benchmarks, and review of performance drivers in case types. • Financial management of Unit (to the extent this is actually devolved) and feed forward of financial information to head of Unit/clinicians. • Identification of resourcing conflicts and, with Head of Unit, working to ensure appropriate resourcing levels for Unit. • Role of BM vis-à-vis HR management within Unit needs to be clarified.
OTHERS			• Raising awareness of areas where patient services might be improved. • Participation in system improvement processes.