Office for Health management

Facilitating management development for the health services in Ireland

Clinicians in Management: Introduction and Case Studies

Prepared by

first consulting group FCG®

Clinicians in Management: Background and Rationale

Putting clinicians at the centre

Put simply, *Clinicians in Management* heralds the biggest change to the management of Irish hospitals for many years. It aims to provide for balanced involvement in decision-making between doctors, nurses and allied health professionals, and to decentralise the responsibility for managing resources down to local units with their direct participation. In so doing, it aims to foster a stronger sense of equal partnership between the various professional groups within the hospital, with a common focus on improving patient care. It is designed with one purpose only - to improve the quality of care available to patients in Irish hospitals.

Providing for Collaboration Across the Professions

Clinicians in Management also recognises that the business of running a hospital is a complex one. Just as medical science is becoming increasingly sophisticated and specialised, so does the effort required to organise, deliver and audit acute health care services demand more elaborate and effective input from a broad spectrum of professionals. The management of health care facilities now requires balanced involvement from doctors, nurses, allied health professionals and others whose main role entails caring for patients, alongside colleagues responsible for providing support services such as finance, personnel and information technology. Managing a hospital effectively is now truly dependent on excellent collaboration between professionals across the organisation.

The "Clinicians in Management" initiative

Clinicians in Management is all about facilitating that collaboration, and about achieving balanced inputs to the management of the hospital from clinical staff. Recognising that clinicians make the vast majority of decisions regarding the use of resources within the hospital, the *Clinicians in Management* initiative seeks to formalise the reality by giving clinicians delegated authority within their own environment, and a real say in the running of the hospital - with the needs of the patients being at the centre of all management considerations.

Purpose of this Briefing Paper

This Briefing Paper, prepared by First Consulting Group, was commissioned by the Office for Health Management as an introduction to the *Clinicians in Management* initiative for professionals across the health services, with a view to providing a broad background to what is involved, and a variety of case studies from organisations which have already made significant progress in this area. It contains an overview of the critical success factors, the benefits which *Clinicians in Management* can deliver, and - through means of a management checklist - the main steps required by various organisations to bring the initiative to life.

Developing Local Solutions: Starting the Debate

It is suggested that each organisation should debate thoroughly the issues involved in implementing *Clinicians in Management* as no single solution will suit every organisation, and crucial decisions will have to be reached within each hospital as to the specific structures and management arrangements required to suit local circumstances. A key purpose of this Briefing Paper is to help initiate that process of local debate.

Next steps

The Office for Health Management has organised and will continue to facilitate workshops to help take forward the *Clinicians in Management* initiative. Following consultation with the Department of Health and Children and the OHM, individual hospitals have formed internal Project Teams for the implementation of the initiative, to decide on the specific management structures which might best meet local needs and reflect their own traditions, and to develop bespoke project plans for the introduction of *Clinicians in Management*.

Clinicians in Management: The Initiative in Practice

What does it mean in practice?

At the launch of the *Clinicians in Management* initiative in late 1998, Health Minister Brian Cowen stated that *"the key to survival and success is the capacity to respond to change*". The Minister went on to say:

> *How many times do we hear people on the ward or in the clinic saying "Nobody listens to the people who do the work?" Very often there's no reason why they can't make a contribution which would improve life for the patients and staff. However, they believe that they can't make these changes without going through some long bureaucratic process, full of people determined to stop them. Much of the change which needs to be brought about is to convince people that they can makes these changes themselves.*
>
> *The sense that you have the power and permission to change things is one of the main characteristics of successful organisations. As well as releasing creativity, it provides the flexibility to respond to changing demands and changing expectations.*

"the power to change"

Clinicians in Management is about giving key professionals in Irish hospitals a greater say in the management, planning and development of health services. It is about creating effective working partnerships between clinical, managerial and administrative colleagues to aim for a better quality of care for the patient. It is ultimately about giving healthcare professionals the power and permission to change things for the good of their own organisations and their patients.

How does it apply?

As the case studies within this Briefing Paper demonstrate, no single solution exists which will fit every organisation seeking to find a better way for involving its clinicians in the management of healthcare facilities and services. However, there are two essential elements seen across a wide variety of organisations which represent the core ingredients of *Clinicians in Management*:

- The creation of a management board for the hospital, responsible for taking key corporate decisions on both short-term and long-term issues, which contains significant and real involvement of clinicians
- The devolution of authority for the management of the business and the control of its resources to locally-accountable units, often referred to as clinical directorates or integrated management units (IMUs).

Time and again, the case studies show that where *Clinicians in Management* is seen to work effectively, it is because a proper working partnership of equals has been developed between the professions within the hospital (ranging from doctors and nurses to managers and allied health professionals), and because real delegation of authority has taken place, down to the level at which care is delivered to patients. Those organisations which lose sight of, or dilute, these fundamental principles, typically end up with cosmetic alterations to their management structures, but largely a lack of real involvement by clinicians in the running of the hospital.

What's in it for clinicians?

Where the initiative has been introduced successfully, it has indeed delivered real benefits. *Clinicians in Management* has been evolving within the United States, UK and elsewhere for the last two decades, and since the early 1990s has begun to be introduced into Irish hospitals by means of a pilot project. Whilst it does require those clinicians who have a key involvement to devote more of their time to business (as opposed to clinical) issues and to develop new management skills, the benefits obtained by those organisations which have already implemented the main features of *Clinicians in Management* include:

- Improvements in patient care through better targeting of resources
- More opportunity to focus on quality initiatives
- Introduction of audit in clinical care, with consequent improvements
- Enhanced opportunities for professional development
- Better efficiency and reinvestment of resources into patient care
- Improved and better-defined relationships between managers and clinicians
- Better cross-disciplinary working and a better collective "team" spirit
- More influence on top management of the organisation.

Key Quotations from those involved in the Clinicians in Management initiative

On clinician involvement at the heart of decision-making:

"Changes in management practices should encourage physician involvement; most of the costs associated with hospital care result from physician decisions. Given the traditional hospital organisational structure, with central supervision of costs but little control over decisions that affect them, a new management approach is in order."
Dr Robert M. Heyssel, Johns Hopkins Hospital, Baltimore MD, USA.

On the importance of having the power to change things:

"The sense that you have the power and permission to change things is one of the main characteristics of successful organisations. As well as releasing creativity, it provides the flexibility to respond to changing demands and changing expectations."
Mr Brian Cowen, TD, Minister for Health

On the differences between leadership and administration:

"We need leadership not administration - you should let people with degrees in hospital administration administer, and you should help set the strategy and measure the quality and ensure that it's there, and help translate to the community what it is we're doing, and especially help allocate resources: how do we decide from among the available technologies which ones we're going to adopt, and get your colleagues pulled together to help answer these questions."
Dr Peter H. Levine, UMass Memorial Health Care System, Worcester MA, USA.

On the connection between patient care and clinician involvement in management:

"This approach [Clinicians in Management] recognises that decisions to bring patients into the hospital, to prescribe courses of diagnosis and treatment, and to discharge patients generate the majority of hospital expenses. Decentralised management gives the institutional responsibility for these decisions to those who make them - the physicians. Management strategies aimed at reducing lengths of stay and controlling the use of ancillary services are then more likely to be successful because they are directed by physician-managers who can influence the behaviour of their colleagues."
Dr Robert M. Heyssel, Johns Hopkins Hospital, Baltimore MD, USA.

On clinicians entering the management process for the right reasons:

"There are some physician leaders who did it because they weren't good doctors and couldn't succeed in medicine, so they took some kind of low level administrative job… We want to get some good people to do this for the right reasons, because they can see that they can have some fun and influence their lives, and how medicine is practised."
Dr Peter H. Levine, UMass Memorial Health Care System, Worcester MA, USA.

Clinicians in Management: Steps Required For Successful Implementation

Core Features and Critical Success Factors

For those healthcare organisations which are implementing *Clinicians in Management*, the key question inevitably arises: What do we do next?

It is essential to understand that there is no "off the shelf" solution which fits every hospital, no model for *Clinicians in Management* which is universally applicable. As each organisation is different and faces different challenges, so does the approach to *Clinicians in Management* need to alter to reflect local circumstances, traditions, structures and needs. However, there are a number of core features which may be observed in those hospitals which have implemented *Clinicians in Management*, namely:

- Recognition of the fact that key decisions are typically taken at two levels - corporate and departmental - and that the hospital management process must aim to build effective linkages and flows between the two levels
- Decentralisation of services and delegation of authority to the lowest appropriate level (ie at or near the point of delivery of care)
- Management structures which focus on the patient rather than on professional hierarchies
- Recognition that clinical involvement will come from doctors, nurses, allied health professionals and others, in partnership to serve patient needs.
- Availability of good quality, accurate and timely information as a basis for informed dialogue and decision-making
- Trust and respect on both sides between clinicians and managers, and common focus on shared values, goals and organisational objectives
- Proper and clear definition of roles and responsibilities, both of individuals and of groups within the hospital
- Integration of the executive management of the hospital's business with the clinical / medical management of services
- Effective training and development plans for staff involved in taking on new managerial and resource management responsibilities
- Comprehensive team-building and organisational development exercises to improve cross-professional collaboration between staff.

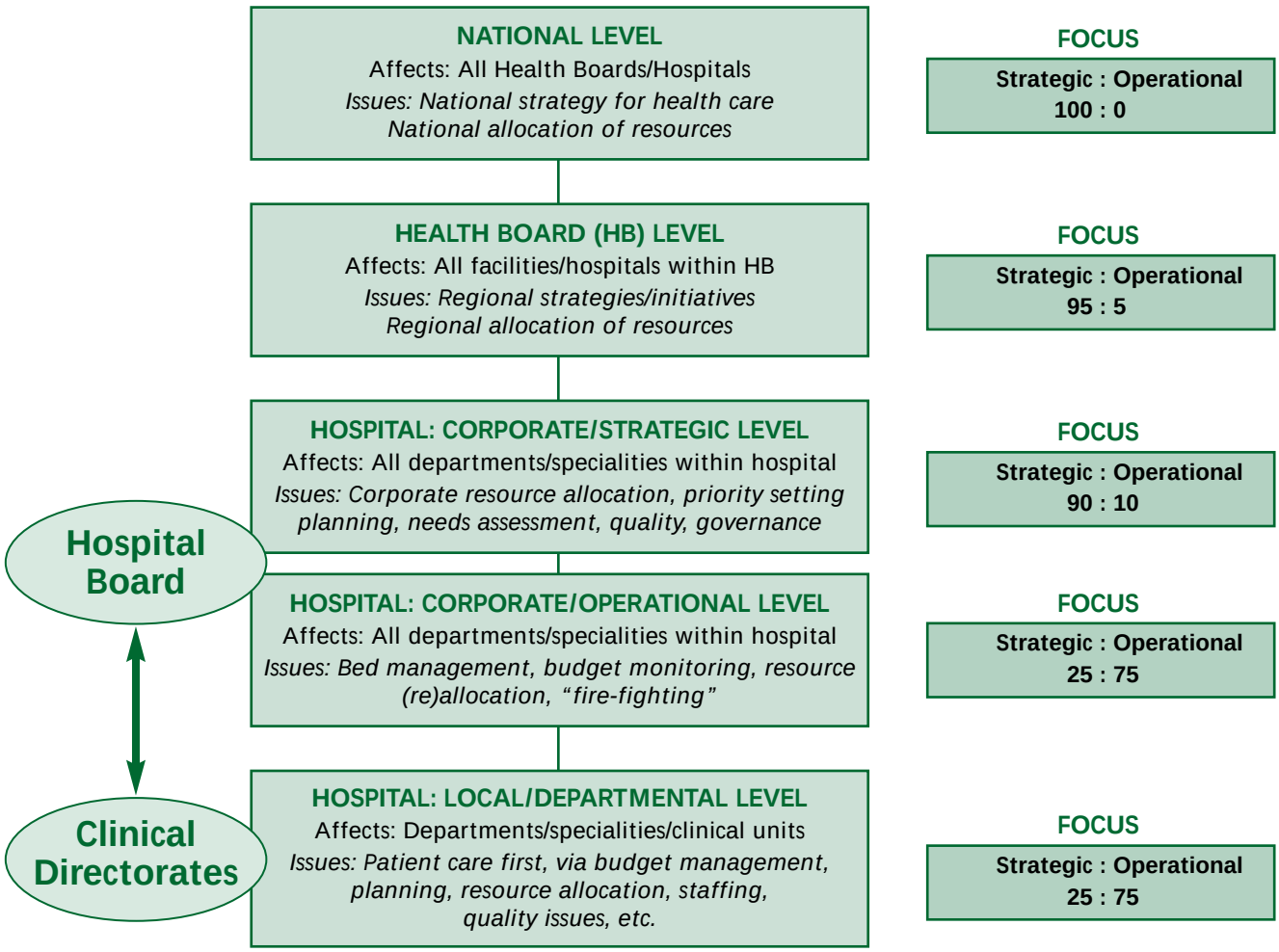
Different Levels of the Management Process

Those hospitals which have developed and implemented successful *Clinicians in Management* models have tended to recognise that the management process operates at different levels within a large, complex entity such as an acute hospital, as follows:

- At the corporate (hospital) strategic level, the need exists for the resources available to the hospital as a whole to be allocated fairly and effectively, with the total needs of patients assessed and decisions made accordingly (e.g. deciding in which specialty capital investment will be made)
- At the corporate (hospital) operational level, issues such as bed management need to get dealt with quickly
- At the local / departmental level, local decisions need to be made about resources within each specialty or department; for example, dealing with utilisation or locum cover, whilst personnel at this level also need to feed into the planning and resource allocation process.

In addition, within the context of the Irish health service, both the Health Board / regional and the national perspectives also need to be taken into account, providing further levels of strategic decision-making. This may be illustrated as in Figure 1 below:

Figure 1: Hospital Management Process



Corporate decisions: the Management Board

Although corporate decisions affecting the entire hospital may be represented as either strategic (ie major issues concerning the future) or operational (more routine or day-to-day matters affecting the whole institution), in practice it is often difficult to separate the two. An issue such as bed management may have an immediate need for a decision, but may well pertain to a longer-term problem concerning the services offered by the hospital. Accordingly, the best means of dealing with corporate issues is through a single management board, which consists of both clinical and non-clinical managers, with responsibility for running the whole hospital.

Integrated Management Units / The Clinical Directorate Model

An increasing trend as part of best practice is for the development of Integrated Management Units (IMUs) within an acute care setting. Typically, this approach brings together various professional disciplines (medical, surgical, nursing, paramedical, and business support) within a cohesive unit, whereby attention is focussed upon enhancing patient care, for example across a range of related specialties, with considerable flexibility and semi-autonomy with regard to priority setting and resource usage. Although the terminology is somewhat interchangeable, this approach has often become known in the UK and Ireland as the clinical directorate model (reflecting the original Johns Hopkins model). However, it should be noted that this describes a generic approach rather than a prescriptive model, and that different variations on the IMU theme (to suit local circumstances) may be observed.

Making it happen

As seen in the case studies presented within this Briefing Paper, the emergence of the IMU / clinical directorate model has provided a good opportunity for effective local / departmental decision-making, set within the framework of an overall management structure in which the clinical director has guaranteed input into the hospital's corporate decision processes at both the strategic and operational levels. That represents the theory, but what practical actions need to be taken to put these new management arrangements into place?

Creating the Hospital Management Board

Many Irish hospitals already have an established forum for consultants to discuss matters of concern, by means of a Medical Board or Medical Committee. However, the Hospital Management Board is a very different entity, one which brings together staff from a variety of professional and managerial perspectives, with the intention of debating and resolving key issues of service delivery and business strategy within the organisation. The principal tasks to be undertaken to create a Hospital Management Board are typically as follows:

- Determination of membership (which usually consists of the General Manager, Clinical Directors or consultant representatives, Matron/Director of Nursing, and a business manager)
- Establishment of a clear constitution for the Hospital Management Board and definitive terms of reference for its scope of operation
- Where Clinical Directors are not already in post, election of consultants to participate in the Hospital Management Board
- Determination of the business processes which will govern the hospital, and how the Hospital Management Board will work in practice
- Where appropriate, establishment of an operating model between the Hospital Management Board and the Health Board to which it reports, so that the roles and responsibilities of each are absolutely clear and that future disputes do not arise.

There will, of course, be different issues which arise within each organisation, and a detailed assessment of the needs of each hospital needs to be undertaken before the correct model for a Hospital Management Board can be selected, and subsequent choices made for the supporting business processes.

Creating Integrated Management Units

The integrated management model, which is currently in use within several Irish hospitals (albeit in different shapes and formats), entails the bringing together of specialties within one or more management units, in which the management of medical/surgical, nursing and business issues becomes more cohesive. The generally-accepted criteria for defining the scope of each IMU are:

- Whether the specialties are clinically compatible
- Their respective location (e.g. across several sites)
- Their size (both in absolute terms and by comparison with other units).
- Whether their resources are compatible (ie making sure that staff within the directorate are dedicated to the relevant specialties and not shared with other areas).

Dedicating resources to Integrated Management Units

In most cases where IMUs have been established, in the US, the UK, Ireland and elsewhere, it has been necessary to appoint dedicated resources to take responsibility for clinical management, for nursing management, and for the business management of the IMU, thereby bringing cross-functional collaboration to serve the interests of the patient. Typically, the integrated management model has tended to facilitate:

- The involvement of all senior professionals within the IMU in the planning of future service delivery, for example in determining resource needs and setting/agreeing service targets
- The management of all clinical activity within the IMU, within the budgeted resources, with the intention of aiming to achieve the targets set by the IMU
- The pursuit of quality initiatives, and attention being devoted to important areas such as clinical audit, risk management, resource utilisation review, setting of clinical priorities, etc
- Within the nursing profession, a separation of focus: typically, within the integrated management model, the Matron / Director of Nursing concentrates on nursing policy, standards and quality issues (i.e. management of nursing), with the operational management of nursing staff taking place within the IMU at arm's length (i.e. management of nurses).
- Congruence of goals and objectives between the hospital (at corporate level) and the IMU (at operational level), by giving the Clinical Director a formal role / presence in the corporate decision-making forum for the hospital (ie the Hospital Management Board)
- Semi-autonomy for the IMU, so that it becomes responsible for its own budget, resources, allocation of priorities, service planning, and quality initiatives, whilst nonetheless recognising that it is part of the corporate body of the hospital (ie semi-autonomy does not equal total independence)
- Greater transparency of decision-making, and greater involvement of staff within the IMU through creation of an IMU management team which reflects the different professional contributions and perspectives.

Bringing Integrated Management Units to life

The work required to bring IMUs into existence typically involves the following:

- Development of terms of reference, roles and responsibilities which are clearly understood by all concerned
- Deciding how IMUs are to be constituted (ie which specialties go into which IMUs)
- Development of proper business procedures and clinical management protocols for the IMU
- Training for all staff in new roles and responsibilities (particularly in budget management and related business issues)
- Determination of appropriate management information needs and reporting arrangements, and assessment of associated systems issues
- Appointment of a professional business manager (full-time or part-time) for IMUs to support the management effort of clinicians
- Development of quality mechanisms and framework for clinical management within the IMU (e.g. resource utilisation, clinical audit, etc).

Critical success factors for Integrated Management Units

Above all, it is essential that the integrated management model is implemented carefully and at a pace with which the organisation is comfortable, perhaps over a phased period to allow staff to become more accustomed to new roles.

Finally, it must be recognised that there are resource implications for any hospital wishing to introduce IMUs. In addition to the resources required for implementation, there is also a need for staff within each IMU to have time available for management purposes on an ongoing basis, in addition to their "normal" role (clinical responsibilities, nursing duties, etc).

Changes in perspective

Whether through the creation of a Hospital Management Board or the development of IMUs or clinical directorates, the *Clinicians in Management* initiative requires healthcare professionals to take a different perspective on their organisation from the one to which they are accustomed.

Consultants

Typically, the senior medical or surgical consultant will find that he/she spends more time on managing and competing for resources, on putting the case for the IMU, and on aiming to improve patient care through clinical audit and quality initiatives. Some of this will no doubt merely formalise existing practice, but it nevertheless does represent a departure from traditional methods of hospital management.

Nursing Directors

The role of the nursing director or matron will often change more radically, in that the introduction of IMUs frequently entails the local nurse managers within the IMUs becoming responsible for day to day staff management, with the nursing director assuming a more strategic role related to policy, standards and quality. The major functions of the nursing director include setting nursing care standards, reviewing nursing practice, directing the total nurse recruitment programme, overseeing the management of in-service and continuing education programmes, and reviewing and approving budgets and plans for the IMUs.

Allied Healthcare Professionals

Allied health professionals and other healthcare professionals will usually see their roles change more gradually, with a more managerial focus being grafted on to existing responsibilities on a part-time basis. Most commonly, the introduction of IMUs and more structured internal relationships gives allied health professionals a formal say in service planning, management and development, often for the first time.

Chief Executive Officers and Hospital Managers

As part of the changing culture, it is also incumbent upon senior managers to respond to the increased delegation of responsibility which *Clinicians in Management* brings about. As Hospital Management Boards and IMUs are formed and staff at the local level are given more direct responsibility to run the units for which they are accountable, Chief Executive Officers and Hospital Managers will increasingly find that their roles become less focused upon operational matters and issues of detail, as day-to-day management responsibility moves to devolved units. Instead, they will have a greater involvement in formulating policy, setting the standards and targets, and monitoring performance, whilst also providing whatever support and encouragement is required to help the Management Boards and IMUs become most effective. This demands some relaxation by CEOs of the "traditional" styles of centralist management, and the adoption of a more co-operative environment which reflects the new devolution of responsibility.

Business Managers

Finally, arguably the biggest change in perspective is that which all staff encounter through the availability of better, more accurate and more relevant information on their own areas, often made available through a dedicated business manager (or similar person) tasked to produce performance and financial information for the IMUs and for the hospital as a whole. Although it will generally take time to get the data and the supporting IT systems fully up and running, the growing availability of this information will change immeasurably the internal management debate, prompting - perhaps for the first time - hard decisions from informed professionals, on real issues, and based upon firm facts.

Clinicians In Management: A Management Checklist

Establishing the starting point

In many ways, the *Clinicians in Management* initiative draws together a variety of features which are part of today's management agenda in Irish hospitals, such as:

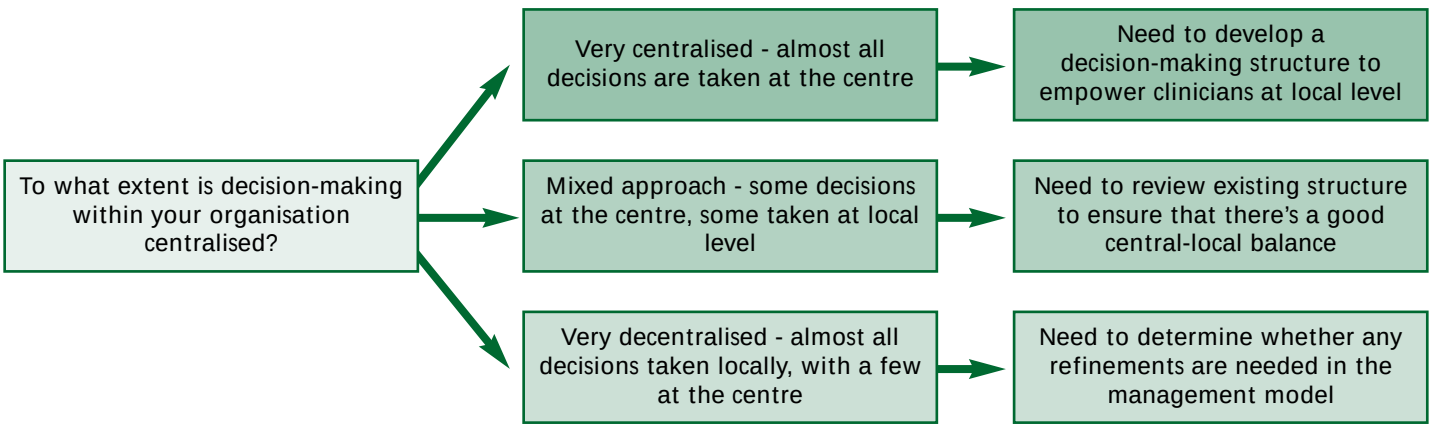
- Involvement of clinicians in the management process
- Accountability and decision-making
- Audit in clinical care and clinical processes
- Pursuit of gain for patients
- Empowerment of staff
- Improvements in management information.

Using the Checklist

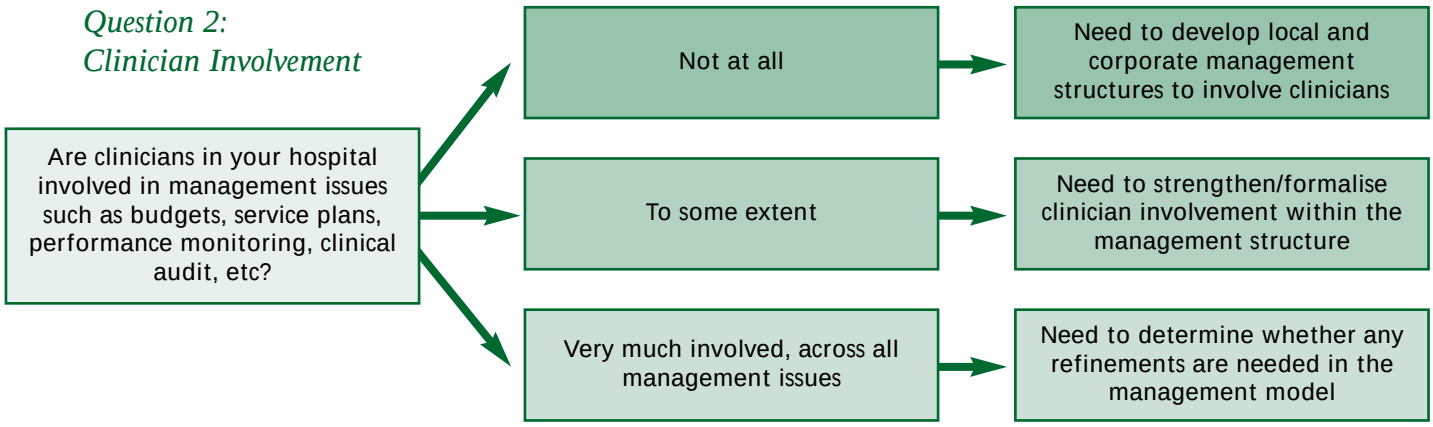
For many reasons - historical, organisational, cultural and others - it is to be expected that no two hospitals will be starting to implement *Clinicians in Management* from the same basis. No two implementation plans will be the same, as different issues must be tackled within each organisation, whilst the pace of change itself will depend upon such factors as the availability of resources, the quality of management information, and the existence of a clearly-thought out strategy for moving ahead. We suggest that each hospital should convene its *Clinicians in Management* Project Team, and if necessary a wider group covering the main professions or functions likely to be involved in *Clinicians in Management*, to work through the checklist. The self-assessment is to be completed by discussing each question, determining which of the answers best applies to your organisation, and finally agreeing how best the recommended solution may be incorporated within your implementation programme for *Clinicians in Management*.

With this in mind, the following management checklist is intended to provide a broad indication for each hospital as to the course of action which is most suitable.

Question 1: Existing structure

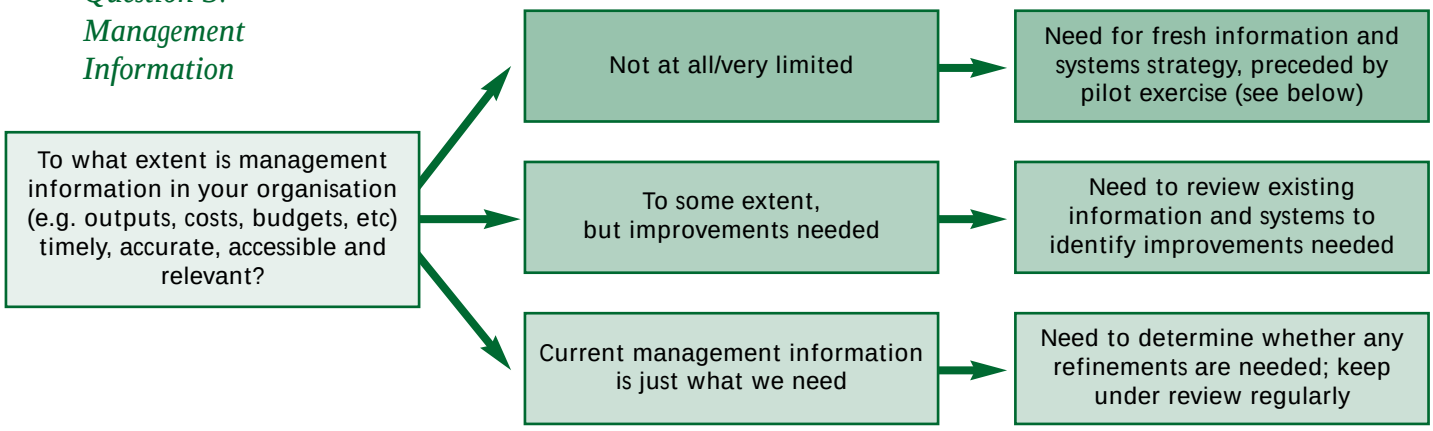


Question 2:
Clinician Involvement



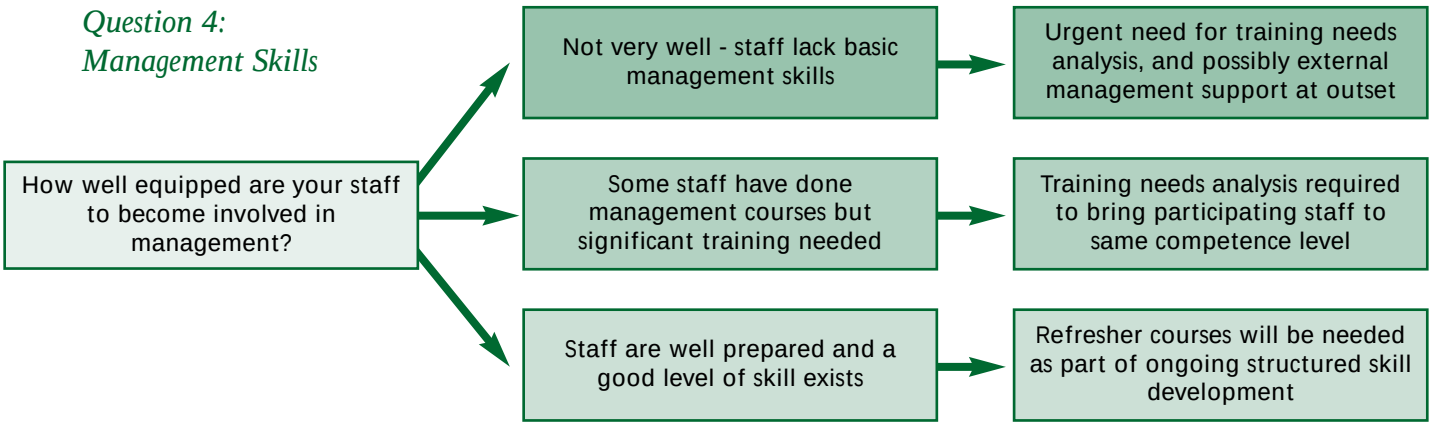
As this shows, hospitals need to be moving towards a management and decision-making structure which facilitates the involvement of clinicians, at both local (e.g. business units) and corporate levels (e.g. through a hospital executive board or committee).

Question 3:
Management
Information



The issue of management information and the supporting IT systems is often one of the most vexed questions within the Clinicians in Management initiative, but one that can be resolved by a progressive and measured approach. Whilst it is true that a fully developed integrated management model, for example, will require good quality, reliable and well-presented information on costs, outputs, staffing and so on, many Irish hospitals will not be starting their implementation of Clinicians in Management from that basis. Indeed, history shows that most other hospitals in other countries which have implemented Clinicians in Management successfully were in a similar position at the outset, and that they moved gradually - often over several years - to improve their IT systems, whilst simultaneously changing their culture, amending the way they did their business and made decisions, and working on the development of their information systems. In the early days, working to identify the information required, where it comes from, and how it can be extracted/managed, is more important than having the technology on hand from the outset. Those hospitals with most to change in terms of information and systems can make a useful start in this area by using manual information to help identify future needs, processes and systems, and can move progressively to that "end state" over a period which suits them.

Question 4:
Management Skills



The development and continuing strengthening of management skills is a critical component of the Clinicians in Management initiative, and hospitals will have mixed experiences in this regard: some may be able to benefit from the presence of staff with business qualifications and prior experience of clinical directorates, for instance, whilst others may need to build up their internal business management skills from scratch. In all cases, a structured approach needs to be taken through the establishment of a training needs analysis, a practically-focused training plan, and the roll-out of training, education and organisational development exercises to supply the organisation with the right skill set. The specific requirements for training and development will vary enormously from one hospital to another, dependent upon the issues they face, the nature of their response to Clinicians in Management, and the pace of change.

KEY LEARNING POINTS:

- Whilst there is no single model which must be followed absolutely, best practice should be observed when designing local solutions to meet local needs
- It is imperative to build in balanced clinician involvement from the outset, covering not just doctors but also nursing and allied professions in partnership with management and business personnel
- It is more important at the beginning to get used to dealing with financial information in broad terms, rather than to focus on the detailed numbers: moving towards a new culture takes priority
- Proper training and development of staff is essential, through a structured mechanism: staff are the key to making *Clinicians in Management* work

Clinicians In Management: Frequently-Asked Questions

Q: Is it essential that we have effective financial information systems before we can start to devolve budgets to Integrated Management Units?

A: Whilst it is important that good financial information is available, this can often be achieved in advance of new financial systems being implemented. It is more important to develop a proper rationale for the identification of costs and to agree how this is to be done, which can generally be achieved using existing information. A manual costing exercise will often be required, involving the analysis of financial data and decision-making on the apportionment of costs; these discussions should involve the clinicians who have responsibility for the services / resources concerned. The benefit of this approach is that it allows the evolution of devolved cost information and the surrounding processes, so that when new financial systems are introduced and costs are refined, the procedures for dealing with budget devolution will already have become established.

Q: How much time should be devoted to the management aspect of each job and how should it be balanced with clinical time?

A. One to two sessions per week may be made available to accommodate the management aspects of a new role. There will be times when the demands on people's time conflict. It is not possible to ensure that management issues crop up in management time and clinical issues in clinical time. Flexibility will be required, but staff should be disciplined enough to keep to fixed times if possible. Supporting personnel will be on hand to facilitate clinicians in their new roles: they should use them to best effect.

Q: How does the relationship between an IMU and the services it uses, like theatres, work?

A: There are a number of approaches which can be used. These range from informal agreements about the amount and type of services to be used with no direct link to budgets, to formal internal contracts where changes in activity have a direct effect upon each party's budgets. Which route is taken will depend upon a number of factors, for example:

- complexity of the services being organised
- information availability to support the process
- history - whether there have been problems over balancing resources in the past.

It is important to make sure that the route chosen helps in managing the process and doesn't get in the way by producing unnecessary paperwork or reducing the quality of the working relationship between the departments.

Q: Why should clinicians get involved in management?

A: Health is a clinical issue. If a clinician gets involved, he/she is able to represent the clinical viewpoint in making the decisions about how his/her hospital runs. It will mean that at times he/she may have to make hard management decisions. However, these decisions will at least be made taking account of the clinical views. It will take up time that he/she doesn't feel is to spare at present. On the positive side, clinicians who have got involved have been almost universal in saying that they have gained satisfaction from influencing the decisions and from making the clinical voice heard.

Q: What will clinicians have to support them in their management role?

A: There are a number of different models which have been used. Generally, however, they all have some element of full time general management support. The person doing this role may or may not have a clinical background. In addition, the management team will usually have some senior nurse involvement. Often this person provided the day to day operational management on the wards. Clinicians will also have some element of business or information support. This may be part of the IMU or may be a nominated person in a central department. The finance input is crucial to ensure that the information around the budget position is available and can be interpreted for the management team. Finally, clinicians should expect to have some additional medical input to the management team, usually in the form of another consultant or two dependent upon the specialties being covered. Between all staff, these professionals will make up a management group for each area. How this fits with the overall hospital management will vary from place to place.

Q: What are the main things a clinician needs to make sure are in place before he/she takes on the role?

A. The main thing a clinician needs to make sure is that he/she has a clear view of what is required. It may not be possible to have all the support in place from day one or all the information that is required or requested. If that's the case, then it will be reflected in the way the process will be implemented, the pace of change, and what will be expected of each participating clinician.

Clinicians in Management: Case Studies And Success Stories

1: JOHNS HOPKINS HOSPITAL, BALTIMORE, MD, USA: THE ORIGIN OF CLINICAL DIRECTORATES

The Birth of Clinical Directorates in the US

Johns Hopkins Hospital in Baltimore, Maryland, is widely held to be the first major hospital in the US to introduce a structured approach to involving clinicians in the running of the hospital, and in making corporate decisions rather than simply those related to caring for individual patients. Although the reasons for changing the culture in this way were perhaps more to do with solving an immediate financial problem rather than anything more visionary, the clinical directorate model devised at Johns Hopkins very quickly outlived the short-term difficulties which had brought it to life, and proved to be a big hit, both internally and with other American hospitals seeking to foster a better relationship between managers and clinicians.

A need for change

Johns Hopkins has a fine history of achievement as a major teaching hospital and centre for internationally-acclaimed medical research. The hospital's decision in the early 1970s to introduce a novel method of management stemmed from a need to cut costs in an informed and balanced manner, whilst maintaining its broad range of services. (The hospital then employed 1,300 doctors and 4,100 other employees, and had 1,000 beds.) Although most US hospitals have long enjoyed a level of funding not matched within Europe, commercial pressures have often demanded an immediate response from the corporations which provide healthcare services. Typically, US hospitals have tended to react to financial crises either by cutting costs across all departments, or by pulling in the reins and concentrating on those services which make the most money. However, for many teaching hospitals and other institutions with a tradition of public service - including Johns Hopkins - the opportunities to do the latter are often precluded by the organisation's mission and charter; they have to continue providing a broadly-based service.

Choices for change

When faced with the need to contain costs, Johns Hopkins recognised that it could not take an exclusive financial focus and simply shut down the care services which were not making money; instead, a more innovative approach was required. Johns Hopkins decided to attempt to break the mould in the delivery of its medical care (through reduced lengths of stay, more emphasis on day surgery, and more work being channelled through the Outpatients Department) and - for arguably the first time in the US - in its management practices.

New structures

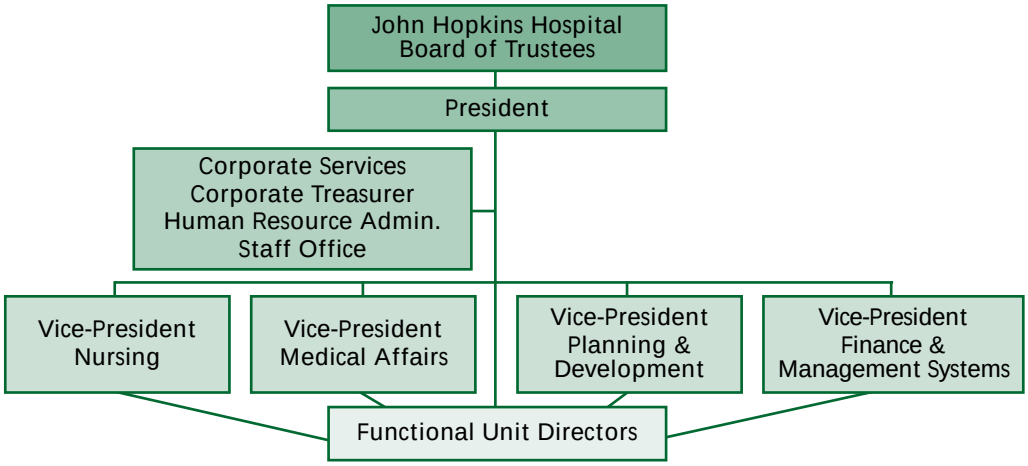
At Johns Hopkins, it was recognised that most of the costs within the hospital resulted directly from decisions reached by physicians. However, traditional management structures had placed the responsibility for budget management with the hospital's executive managers - few of whom had any clinical training. In fact, more than 80% of the hospital's costs were managed centrally prior to 1972. It became apparent that whilst this disconnect between budget responsibility and clinical decision-making persisted, the hospital would not be able to get proper control of its costs, or to make the right decisions about allocating resources.

Clinical directorates

The solution was to adopt a management structure which gave the physicians the responsibility for managing costs and controlling resources. For the first time, the new structures gave doctors significant and real input into the decisions affecting both the clinical and business life of Johns Hopkins, by moving responsibility for operations and finance to the clinical departments. In order to provide for a smooth transition, Johns Hopkins provided training to strengthen the management skills of the doctors, and developed financial and management information systems to provide the critical data needed to manage the overall institution and the integrated management units under the new model of governance and control.

Key Features: Corporate Structure

The new decentralised management structure introduced in 1973 provided for an effective split between policy and operations within Johns Hopkins, pushing accountability down to where patient care was actually delivered. In effect, the hospital became a "holding company" for a series of specialty hospitals referred to as functional units, which are discussed below. The overall management structure as introduced in 1973 was as follows:



The functional units included:

- Anaesthesiology and critical-care medicine
- Gynaecology and obstetrics
- Laboratory medicine
- Medicine
- Neurology
- Oncology
- Ophthalmology
- Pathology
- Paediatrics
- Psychiatry
- Radiology
- Surgical sciences.

Key Features: Functional Units

Within the Johns Hopkins model, considerable autonomy is given to a number of functional units, each of which has a specific clinical focus and is managed by a clinician, supported by a director of nursing and a business manager, with the three-person team being accountable for all direct costs, including staff, supplies, and services bought in from other departments of the hospital, including laboratory and radiology services. Considerable freedom is given to each unit as to whether they buy support services (such as catering or property maintenance) from other Johns Hopkins departments, or purchase from external firms, although this policy tends to help reduce in-house costs rather than result in work being contracted out. Central overheads which relate to the hospital are apportioned across each of the clinical units. Whilst considerable autonomy is granted to the functional unit managers, the over-riding requirement is for each unit to comply with corporate policy and strategy, with clinicians being very much at the centre of both operational and strategic decision-making.

Success Factors

The structures adopted by Johns Hopkins are widely regarded as being a success - they helped achieve much better cost containment than before - and as having heralded the introduction of similar models across the US. Five major features were seen as being central to their success:

- The executive managers within the hospital were willing to delegate the authority for decision-making and resource control to the doctors running the functional units
- The doctors themselves had to assume responsibility for managing a business for the first time, something from which they previously tended to shy away
- The overall process of change needed the acceptance and support of the professional nursing staff within the hospital, with nursing managers also receiving delegated authority to manage their own resources
- The development of management and financial information systems to support the decentralisation process
- The development of effective communication between the central unit administration and the decentralised functional units, and within central and functional areas.

The cultural changes experienced as part of this exercise at Johns Hopkins were probably the most significant of the entire programme, but it was demonstrated that the overall effort produced a more accessible management structure, reduced bureaucracy, and placed the overall responsibility for managing the hospital in the hands of those managing the care of its patients.

KEY LEARNING POINTS:

- Better control of costs and better decisions about allocating resources came about through forming effective professional and managerial links between budget responsibility and clinical decision-making
- The Johns Hopkins clinical directorate model entails a three-person directorate management team led by a clinician, supported by a director of nursing and a business manager, which is accountable for all service provision and resources
- Considerable autonomy is given to clinical directorate managers, so long as they comply with overall hospital policy and strategy
- Proper balance had to be achieved between the different professional disciplines participating in the clinical directorate model

Source: "Special Report: Decentralized Management in a Teaching Hospital", by Dr R M Heyssel and others, of Johns Hopkins Hospital, published in the New England Journal of Medicine, May 1984.

Clinicians in Management: Case Studies And Success Stories

2: UMASS MEMORIAL HEALTH CARE SYSTEM, MASSACHUSETTS, USA: ONE PHYSICIAN CEO'S STORY

Background

UMass Memorial Health Care, based in Worcester, in the central region of the US State of Massachusetts, is a not-for-profit health care provider organisation, with $742 million in revenue, two main hospital campuses and other facilities offering more than 700 beds, and 7,500 employees. Formed as a result of the 1998 merger of the University of Massachusetts Clinical System with Memorial Health Care, the newly-created UMass Memorial features a high level of involvement by clinicians in the executive management of the organisation, which is led by Dr Peter H. Levine, its Chief Executive Officer.

Balancing Inputs to the Management Structure

Early in the merger period which resulted in the coming to being of UMass Memorial, the Board of Trustees saw a clear need to ensure that there would be a truly inter-disciplinary team charged with the running of the organisations. As Peter Levine says, the Board wanted "no more loan eagles" but a more cohesive structure which provided for the best inputs across professional disciplines. The UMass Board opted for a management team balanced between business/finance people and medical leaders, and also decided to appoint an experienced physician manager as its CEO.

Choosing the Right Leader

Dr Peter Levine - who prior to the merger had been President and CEO of Memorial Health Care - had spent 25 years as a successful haematologist and oncologist in teaching hospitals before moving (with careful thought and perhaps some trepidation) into executive management. His rationale for changing roles was simple - as he had seen increasing complexity in organising the provision of care, and a proliferation of expensive diagnostic and therapeutic services which brought along resource problems, he had wrestled with solving what he saw as a core challenge: how does a hospital face technical and scientific developments, deliver them to an ever-demanding customer base, and keep teaching and researching going too?

Good (and Bad) Role Models of Clinicians in Management

When he was offered the opportunity in 1989 to become CEO of Memorial Health Care, Peter Levine pondered his decision and in so doing paid close attention to other physicians who had made the break into management. *"I found some good role models, and went around and walked in their shoes,"* he says. *"That, more than anything else was what convinced me I could do the job and have fun"*. On occasions, however, there were some bad examples which Dr Levine encountered. *"There are some physician leaders who did it because they weren't good doctors and couldn't succeed in medicine, so they took some kind of low level administrative job"* he says, acknowledging that the future of *Clinicians in Management* in Ireland should not be based upon such individuals: *"We want to get some good people to do this for the right reasons, because they can see that they can have some fun and influence their lives, and how medicine is practised"*, he encourages.

The Clinician Manager: Leadership or Administration?

As a doctor, Peter Levine was determined to ensure that his new CEO job would not be administrative in focus, but would be centred on leadership. His Chairman encouraged him to think in these terms: *"We need leadership not administration - you should let people with degrees in hospital administration administer, and you should help set the strategy and measure the quality and ensure that it's there, and help translate to the community what it is we're doing, and especially help allocate resources: how do we decide from among the available technologies which ones we're going to adopt, and get your colleagues pulled together to help answer these questions"*. This, of course, was central to the challenge with which Dr Levine had been wrestling for some time, and to solving

the implicit problem of managing healthcare delivery using complex resources in the most effective manner to enhance patient care and treatment.

UMass Memorial's Structure: A Balanced Model

Peter Levine and his Board of Trustees have worked hard to ensure that the management structure of UMass Memorial is well-balanced. To begin with, four of the executives in the top team of twelve are doctors, including a physician chief who works with departmental chairs on the allocation of resources. The Chief Quality Officer is a physician, giving focus to the excellence of care provided by UMass Memorial. In addition, there are four Nursing Vice-Presidents with a significant management role, including two who run major business units within the organisation (covering women's and children's services, and cancer services). However, the clinical expertise has been deliberately balanced with executives who possess organisational, business and finance skills, and Dr Levine readily acknowledges the essential role played by his Chief Financial Officer in the running of the organisation.

Ensuring Accountability Throughout the Structure

At UMass Memorial, the involvement of clinicians in management doesn't rest solely at the top level of the structure: Peter Levine and his colleagues have been keen to introduce a series of devolved business units, each with physician or other clinician leadership, supported by staff with business expertise. He offers an interesting vignette to illustrate the extent of progress in recent years.

An Orthopaedic Case History

In 1995, UMass Memorial was experiencing challenges in its orthopaedic services unit, with escalating costs of increasingly complex technology. Budgets were out of line, and orthopaedic surgeons were requesting equipment which the hospital could not afford. Investigation showed that the surgeons were using five different brands of hip and knee prosthesis, whilst standardising to a single brand could save $750,000 through bulk purchase from a single supplier. (Very similar issues applied to other major purchasing by UMass Memorial, such as pharmaceuticals.) In the 5% of cases where clinical conditions demanded a very specific product, the hospital could continue to buy prostheses from other sources. After some initial hesitation, the surgeons themselves elected to move to single brand purchasing, with the hospital offering financial incentives to allow gainsharing with the physicians, based on better financial performance and better patient satisfaction. This method places great focus on the need to do a combined good job on managing finance and on providing high quality patient care. Since then, the same incentivisation approach has resulted in major cost reductions in pharmaceutical purchasing, releasing more money for investment in new equipment and facilities.

Organisation-Wide Clinician Involvement

Peter Levine stresses how different things are now to previous management approaches: *"At first it is frightening to the clinicians, because someone's telling them what to do, and everyone's used to some extent to being a lone eagle and doing what they're used to doing, and they will level charges of 'cook book medicine' at you - but they're designing the cookbook... [but] they wouldn't now go back - they like their team meetings, and I don't think there's a physician in our place anymore who isn't part of some regular team meeting, usually once a week for a couple of hours, where the team will sit down together and compare notes on how they're managing illness within their pod of specialists, and it all goes very well."*

What's In It For Clinicians

Asked how he might help a hesitant physician to decide whether to become involved in the executive management process, and particularly to answer the question "what's in it for clinicians?", Peter Levine offers the following wisdom born of his own experience:

"The opportunity to control your fate. Don't agree to be an administrator. Doctors hate the word, I do too, and we're not trained to do it. Instead, depend on those people, learn what you can from them, and let them administer. The role for the physician, using their huge fund of knowledge, is to help allocate scarce resources, help lead their colleagues. The word is Leadership, with a capital L, and it's not so hard to learn how to lead - there are people who can teach that. It's not born, it's not innate, and there are all sorts of skills you can pick up that teach you how to lead. Leadership can be a lot of fun and you can wind up leading inter-disciplinary groups, with no more lone eagles. Teamwork is fun too."

Balance and Professional Partnership

He concludes with a reminder of the critical need for effective partnership between the professional groups involved in the running of a hospital:

"Unless you bring the physicians along, and unless they have the feeling that they have some input in a meaningful way and some control… the system will increasingly spin out of control because the technologies and the expensive interventions, whether diagnostic or therapeutic, keep coming at a faster and faster rate. Secondly, there's an absolute imperative that the physicians must understand… that they can't just independently order what they feel like ordering and have everyone pay for it forever. So both sides have something to say to the other which is important."

KEY LEARNING POINTS:

- Find some good role models and follow them
- Structure the organisation to balance input between clinicians and business people in the most effective manner
- Build a working partnership between professionals to help run the hospital in a cohesive manner
- Bring the clinicians along, and give them good opportunities for meaningful input and control

Source: interview between Dr Peter Levine of UMass Memorial Health Care System, and Shane McQuillan and Brent Hanson of First Consulting Group, July 1999.

Clinicians in Management: Case Studies And Success Stories

3: ST HELENS AND KNOWSLEY NHS TRUST: WOMEN'S AND CHILD SERVICES

The Organisation

St Helens and Knowsley NHS Trust, located in the Merseyside area of England, is made up of two acute and three community sites with in excess of 1000 beds overall. It became an NHS Trust in 1991.

Corporate governance

Until the beginning of 1997, the Trust operated a management system which consisted of Heads of Service leading the specialties. This resulted in a corporate management board that was very large, due to the number of specialty representatives. In 1997, a clinical directorate system was introduced which led to the establishment of five groups of specialties. In 1998, the Women's and Child Services Directorate was added, to make a total of six clinical directorates:

Clinical directorates

- Medical
- Surgical
- Mental Health
- Critical Care/A&E
- Women's and Child Services
- Specialised Services (including Burns and Plastics).

Each of these is led by a Clinical Director, supported by a General Manager, and the Clinical Directors attend the Trust Management Group with the CEO and the Medical Director, and a representative from the General Managers' forum. All General Managers from the directorates are part of another operationally-focused corporate forum.

Women's and Child Services

The Women's and Child Services Directorate covers paediatrics, neonates, gynaecology and obstetrics. It has an £8m budget with an establishment of 8.5 consultants. An interesting addition is that the directorate manages the community midwifery service run by the neighbouring Community NHS Trust, enabling the midwives to meet their continuing education and training commitments through a rotational scheme.

Former Nurse as General Manager

A Clinical Director, who is appointed for a period of five years with a two session per week commitment, heads the directorate. A General Manager - in this case a nurse who has made the transition to general management - and heads of service for paediatric and obstetrics/gynaecology support the Director. A central department within the Trust provides information support, and in addition there is a dedicated resource in finance. There is no separate business analysis support provided by the Trust, although the General Manager generally undertakes this type of work with support from the finance and IT departments. The directorate has a management board which meets on a monthly basis, and has input into the Trust's service contract process (ie agreements with the Health Authority "purchaser" for delivery of services).

Success criteria

The clinical director has identified the following as being key to the successful operation of the clinical directorate:

- The partnership with the General Manager is crucial. As the General Manger has a clinical background, being a former nurse, this is a particular advantage when dealing with clinically-based issues such as complaints. The problem is that although time is set aside for the clinical and management roles, it is rare that issues arise in these designated time slots, making support essential
- The right type of corporate support is necessary to supply the "management speak" in the service contract arena. The strength of the Clinical Director is in the clinical background, not the management background, emphasising the need for adequate support on a complementary basis.
- A clinical background is key to getting respect of the directorate colleagues. This Clinical Director has found that a management style of working together and encouragement has worked best with a group of clinicians not formerly working together.

KEY LEARNING POINTS:

- A clinical background makes delivering possibly difficult messages more acceptable for clinical colleagues. To date, this has worked in getting the right management decisions implemented.
- The directorate has been able to influence the service contracts which they have to work to. This means that through the clinical input, it is more likely that contacts will be realistic from a clinical delivery standpoint.
- A clinically orientated way of thinking is applied to issues. Currently the Clinical Director is exploring the possibilities of developing care pathways which cross the acute / community boundaries.

Source: interview between Dr C. R. Woodhall, Consultant Paediatrician, of St Helens and Knowsley NHS Trust, and Jonathan Burd of First Consulting Group, June 1999.

Clinicians in Management: Case Studies And Success Stories

4: ESSEX RIVERS NHS TRUST: SURGICAL DIRECTORATE

The Organisation

Essex Rivers is an acute Trust with around 800 beds, functioning on a number of different sites. The organisation became a “second wave” NHS Trust in 1992.

Corporate Governance

The hospital has a Management Executive which concentrates on the operational management, success and performance of the Trust, and the practical implementation of Trust Board strategy. It is chaired by the Chief Executive and comprises the executive directors and the six clinical directors.

Clinical Directorates

Before achieving Trust status, the hospital had in place a number of divisions making up a "cogwheel" advisory structure. Each one was chaired by a clinician from the relevant specialty and had a business manager, but there was no devolved budget and no management accountability. However, there was considerable merit in retaining this arrangement as these were formal groups of consultants from the same or similar specialties, who were meeting together to discuss service and practice issues. It was this structure that formed the basis for the development of clinical directorates which put clinicians firmly in the driving seat, enabling them to make major decisions which would affect their specialty and the care of their patients.

Surgical Directorate

The directorate has a budget of approximately £7.6 million, and, with the exception of gynaecology, manages all surgical specialties. The directorate has developed and evolved its activities over the last six years. It is run in partnership by a Clinical Director and a Business Manager, who are supported by advisors in nursing, finance and human resources. In practice, the Business Manager handles the day to day management, while the Clinical Director focuses on clinical issues. They meet once a week to discuss overall strategy and current issues. Support services are mainly provided by other departments within the Trust, and are managed by reflecting the requirements in the budgets at the beginning of the year to try and avoid the overhead of cross-charging.

Success Criteria

The Clinical Director identifies the following areas as being critical to being successful in the role:

- being able to speak for his colleagues
- being funded for the time the Clinical Director devotes to management, in this case one day per week
- having in place a Business Manager and working together as a partnership.
- having in place a support team of advisors in nursing, finance and human resources.

In addition the Clinical Director has found it important to be IT-literate, in order to understand and manage the budget and activity output from the information department.

Finally, as part of the process of providing for better clinical audit, the Clinical Director has successfully introduced an appraisal system for the 20 or so surgical consultants working in Essex Rivers NHS Trust, thereby using the clinical directorate model to enhance the provision of care to the Trust’s patients.

KEY LEARNING POINTS:

- Controlling the budget enables clinicians to make changes within the directorate that they consider beneficial to the care of patients, such as changing the structure of wards and staffing
- Putting a Business Manager in place, and providing dedicated support through nursing, finance and human resources advisors, was a critical component of the clinical directorate model
- The introduction of an appraisal system for the 20 consultants in the directorate has helped to enhance quality of care for the Trust's patients.

Source: interview between Andrew May, Clinical Director, Surgical Directorate, Essex Rivers NHS Trust, and Sandy Winyard of First Consulting Group, June 1999.

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