CARE WITHOUT BARRIERS, SENIOR MANAGEMENT STRUCTURE

DISCUSSION PAPER

1. INTRODUCTION

1.1 Care without Barriers, the Board’s proposals for a single integrated NHS organisation in Highland, was adopted following consultation in October 2003. Implementation is on-going following on from the formal integration of the Board and Trusts into NHS Highland on 1st April 2004.

1.2 The Board asked that the arrangements be kept under review. Indeed, in respect of Direct Health Services (DHS), arrangements were agreed for an interim year as work on clinical integration progressed. However, the appointment of Paul Martin to the post of Chief Nursing Officer for Scotland and Richard Carey to Chief Operating Officer for Grampian necessitates a review of progress now and decisions regarding the replacement of these two key individuals. Further, the retirement of Dr John Wrench later this year permits consideration of Public Health within this context.

1.3 Throughout June, I have had the opportunity to take soundings from a number of colleagues. The vast majority of colleagues I have spoken to say they are keen for the Board to move to restructure quickly. It is not seen as essential or desirable for there to be a prolonged period for reflection or consultation before deciding on a way ahead.

1.4 The views of our Non Executive colleagues have also been sought, and generally these have been found to be consistent with what other colleagues have told me. In essence, our Non Executive colleagues are keen that we should move ahead to reorganise the areas where there is opportunity to do so, but that this should not compound the impact of change which has already taken place. There is also acceptance of the need for modernisation, but with the proviso that there is effective Portfolio Working to make this more accountable. Non Executive colleagues also feel that there is the need for further clarity and understanding about the roles and position people have on the various committees to ensure that good Governance practice prevails, and as such, the opportunity to refine the roles and remits of the committees must take stock of the overlapping areas. Finally, there is a feeling that there is still some duplication that the Board need to address over time in order to ensure full integration.

1.5 I thank colleagues for giving me their time - this has been an immensely valuable exercise. The following paper is my précis of what I heard. As well as the findings I have suggested some options for wider discussion and consideration.

2. FINDINGS AND OPTIONS

2.1 My first consideration was the question of leadership and management capacity within NHS Highland, and succession planning.
2.2 The integration of the Board and Trusts has enabled us to streamline how we do business. However, the complexity and scale of the agenda facing us is as great as ever. The two Deputy Chief Executives carry a considerable share of the workload. As individuals they are highly respected and very effective. However, NHS Highland is now one organisation with executive capacity drawn from a combination of the former Executive Teams supporting three separate organisations, the two Trusts and the Board.

2.3 Capacity is an issue at middle and lower grades throughout the organisation, and especially in acute services. As a result, Directors are also drawn into operational matters squeezing their ability to provide strategic leadership and adding to the workload pressures. This environment does not facilitate effective delegation. Further there is limited scope for middle managers to contribute as fully as they might to modernisation and redesign. Within Corporate Services this is being addressed through the integration of the previous Trust and Board services which has provided the opportunity to make most effective use of available capacity. The same approach now needs to be adopted as part of the work to integrate the clinical services of DHS. In this way capacity needs to be built throughout the organisation.

2.4 As a general comment, there has been a lack of attention to succession planning. This is a national problem not helped by the cessation of the management trainee scheme and exacerbated locally by the relative stability of the workforce and lack of opportunities. More consideration needs to be given to our organisational design and policies if this is to be addressed.

2.5 In respect of specific responsibilities, there is broad agreement for the need for clear and accountable leadership for service delivery at Executive level i.e. a Chief Operating Officer for DHS. This a crucial role for the Board and needs to focus on driving forward the process of clinical integration across primary and secondary care, and establishing the Community Health Partnerships (CHPs) and Specialist Services Unit as robust operational units. A focus for the role should be to ensure a clear and effective framework of delegation to these operational units and performance management of Direct Health Services as a whole. The post holder could provide leadership for modernisation and redesign projects alongside other Directors and the Board Chief Executive.

2.6 General Managers have been established and appointed to the Community Health Partnerships providing more senior operational management capacity than hitherto. Consideration is now being given to establishing the supporting management infrastructure within CHPs to ensure they can function effectively. The same consideration is being given to the Specialist Services Unit by managers within the unit. Although this work is not complete, one option being considered is the establishment of a General Manager post for Specialist Services to mirror the CHP posts. Also reporting to the Chief Operating Officer this would provide clear management accountability on the acute side, without Directors being too drawn into day-to-day management. The Board has already established the Non-Executive members of the DHS Committee as CHP and SSU chairs. Thus managers and Non-Executives work in partnership to lead the delivery of direct health services. The diagram below illustrates the point:
2.7 There is a strong desire to see modernisation as ‘everybody’s business’: it cannot and should not be divorced from the operational role. Overall leadership can be assumed by the Board Chief Executive shared between Directors and Managers on a project-by-project basis. Staff throughout NHS Highland can contribute as capacity allows. There is though, a need to tightly manage the agenda – to ensure we are doing the right things and that we are doing the right things well. The Corporate Team has already assumed responsibility for the Modernisation Plan. There is a need to invest at project management level to ensure that the work of the Corporate Team, and the time of staff leading and contributing to projects, is used most effectively, and that agreed actions are followed through and delivered.

Options for discussion:

i. Should we establish the post of Chief Operating Officer, accountable to the Board Chief Executive for the delivery of Direct Health Services through CHPs and the SSU?

ii. Should we establish a Specialist Services General Manager post alongside those in the CHPS, or are there other ways of providing operational clarity and accountability for this significant area of service? Would this allow scope for capacity building and succession planning within SSU?

iii. Do we feel the Board Chief Executive and Directors can provide the leadership for modernisation rather than make a specific senior appointment for this purpose?

iv. Should we seek to recruit the best possible candidates from the open market for any new posts, or seek dispensation for an internal recruitment process in the first instance thereby creating the potential for further opportunities for succession for next in line managers
2.8 I also took the opportunity to reflect on the vacant position of the Director of Public Health as part of this process. This is an important role for the Board and is the clear executive lead on health improvement, driving forward the Scottish Executives ambitious agenda in this regard. The advances in the health of the population that we are striving for can only be achieved through collaboration with community planning partners, and within the NHS through closer working with operational units especially CHPs. Formal arrangements for Public Health input to CHPs are now being established as part of a health improvement network across the Highlands.

2.9 Public Health could contribute further however, and provide greater leadership in respect of service development, redesign and strategic planning.

**Options for discussion:**

v. Should we appoint the DPH with, a) current responsibilities, b) with a wider service remit or c) with a reduced management role and focusing on leadership for health improvement through partnership working?

2.10 I have considered other aspects of the senior management structure. The ‘interim year’ was designed to allow the arrangements within DHS to evolve and be considered further in the light of experience. An issue is the clarity of accountability in the interim structure. The resignations of the Deputy Chief Executives have initiated the review of their responsibilities with options already set out in this paper. This leaves the position of the Medical and Nursing Directors. Although new roles have only just been established, there is a view that these, even as interim roles, may not provide the clarity of leadership and accountability to best serve either the Board or the post holders. Any proposals for change will need to be considered according to the Board’s Organisational Change Policy.

**Options for Discussion:**

vi. Should we move now to appoint to single Medical and Nursing Directors for NHS Highland, or wait for the interim year to run its course?

vii. The post holders would be responsible to the Board Chief Executive in respect of their corporate Board responsibility but to the Chief Operating Officer for leadership of the clinical service. How would these accountabilities best be reflected in line management arrangements?

2.11 The Board has also asked that the committee structure be kept under review and this has also been considered alongside the foregoing matters.
2.12 The Chair of the Area Clinical Forum has led a piece of work to review the clinical advice to the Board. The detail of this is currently being discussed within the Board’s advisory network but it is appropriate to consider the broad principles here.

2.13 The overall premise of this work is that the clinical advisory structures need to develop into an integrated mechanism to support the new NHS systems in Highland. The Board needs well-informed, competent, consistent and coordinated advice and that this needs to be dynamic and proactive as well as reactive to the Board’s agenda. The proposal is to bring together existing advisory mechanisms – the Area Clinical Forum, the Clinical Planning Group, Executive Clinical Directors with a partnership forum and public engagement perspective into a single Clinical Advisory Network for NHS Highland. This will impact not only on the Board’s agenda, but also on DHS and service redesign and, where appropriate, ensure that the Highland clinical view is fed into national considerations. Further this forum could take on the function of the Board’s Redesign Committee, chaired, as it would be by the Boards Non-executive clinical director. This group could report directly to the Board rather than through the Improving Health Services Committee. Indeed, in the light of the recommendations below, the DHS Committee could subsume the role and function of the Improving Health Services Committee.

2.14 One specific objective within Care without Barriers was to ensure clarity of decision making within NHS Highland without duplication and unnecessary bureaucracy. At a corporate level this has been achieved through the establishment of the Corporate Team replacing the previous Board and Trust executive teams and operating on behalf of the Board to deliver the Board’s strategic agenda. From an operational perspective the key building blocks are the CHPs and SSU and whilst further clarity is required to establish actual delegated authority in the light of the Scottish Executive’s guidance and Board policy, the principles are becoming clear. What are less clear are the distinct roles of the senior management team within DHS and the Board’s DHS Committee. Without a clearer distinction there maybe a danger of confused accountabilities and ineffective governance. The DHS Committee as currently constituted is made up of Non-Executive Directors, Board Directors and senior officers. This could be seen to combine governance and management. An option would be to reconstitute the Committee as a Board Committee of Governance with Non-executives holding the service to account for the delivery of outcomes agreed in the health plan, for financial performance and for the operational components of staff, clinical governance and patient involvement.

Options for discussion:

viii. In principle, should we pursue the proposals to bring together clinical advice to the Board into a single forum? Could this take on the role of the Board’s Service Redesign Committee as set out in Partnership for Care? How should the forum best discharge a responsibility to oversee the huge redesign agenda? What is the best way of ensuring appropriate Non-Executive involvement in redesign?

ix. Should we establish the DHS Committee of the Board as a Committee of Governance or are there other ways of achieving clarity of accountability and avoiding duplication?
x. Is the work of the Board’s Improving Health Services Committee subsumed by these options?

2.15 Finally, I sought a sense of how long we should take to consider these issues.

Paul Martin leaves at the end of August and Richard Carey at the end of September. This leaves us a little time to reflect but not a lot. Generally there is a feeling that too much uncertainty is not helpful and that we should ‘decide and get on with it’, after all, consideration of structure is only one aspect of creating a successful organisation. Although the possibility of interim arrangements were contemplated, and may be necessary, in general the preference was to firm up on proposals as quickly as we could.

Options for discussion:

xi. Is it possible to firm up on these options for a decision at the August Board meeting or should we take longer to make sure we get it right? What further process should we embark on?

In general:

xii. Will the sort of options discussed here improve the ability of NHS Highland to lead and manage the huge change agenda we face? What else should we be contemplating?

xiii. Do they introduce clearer lines of accountability and make it easier for the Board to be more effective in its role of strategic leadership and performance management?

3. NEXT STEPS

3.1 These thoughts have been formed quite quickly and in discussion with a limited number of people. I am keen to hear views from anybody with an interest in making NHS Highland as effective as possible. In the first instance I would appreciate any comments on the options and questions floated in this paper by the 19th July. This will then allow me to report to the Board on 3rd August, either with final recommendations on these matters or proposals for a further period of discussion. Any comments right up until the Board day would be welcome though. Please let me have your thoughts in whatever way suits – come and see me, ring me, email or write, or invite me to a team meeting – contact details below:
I look forward to hearing from you.

Roger Gibbins
Chief Executive
July 04