DRAFT CASE STUDY

Cultural change around introduction of a Divisional Medical Director structure at Whittington Health.

1. AREA OF FOCUS

1.1 We revised operational management structure to give doctors clear management responsibility and accountability in medical management. From a previous traditional structure where Clinical Directors were in an advisory role to Director of Operations, we moved to a Divisional Medical Director role where the DMD leads each of three operational Divisions, each integrated across the ICO and each supported by a Director of Operations.

2. WHY?

2.2 This was to do with Trust Board understanding the fundamental role of doctors in delivering the ICO strategy. We see doctors as respected clinical leaders and trusted guardians of quality of care. By appointing Divisional Medical Directors we would have services led by consultants who were necessarily completely engaged in SLM and in identifying and delivering CIPs owing to their budget-holding responsibilities. This approach should safeguard quality of care.

2.3 Consultants as Divisional Medical Directors should also be well able to engage with their wider clinical teams. The new structure, involving 3 operational Divisions, each spanning community and hospital pathways replaced an older system that had included four hospital-based plus two linked community teams. The new structure was intended to facilitate true integration between community and hospital services, reducing boundaries and enabling transformation of clinical pathways.

3. HOW DID TRUST BOARD KNOW THE PLANS WERE ROBUST AND REALISTIC?

3.1 Whittington Hospital NHS Trust has a good track record of clinical engagement as evidenced by:

- Tribal study in 2009, involving survey of consultants at 30 Trusts, in which Whittington Hospital Trust scored highly on clinical engagement
- It is our custom and practice that the CEO attends Medical Committee regularly, and meets separately with the Medical Committee Chair. Medical Committee regularly has over 40 consultants present.
- Whittington Hospital has engaged in the Talent Management programme run by the SHA and has provided leadership development support for promising medical leaders, both internally and by supporting them to attend relevant external development opportunities such as King's Fund courses, Next Generation Directors' programme, BMJ/OU development modules and NHS Top Leaders programme.
- The Medical Director and existing Clinical Directors supported the introduction of the new management structure and the posts were appointed by competitive interview.

3.2 The model of operational Divisions led by Divisional Medical Directors has been shown to be effective in other Trusts, including some geographically close to the Whittington. The plan included further developmental work (internal and external) for the DMDs to enhance their skill sets.

3.3 The plan also included appropriate support for DMDs – each Division has a Director of Operations, a head nurse, and a lead for each of HR, Finance and Clinical Governance, so each Division is a Business Unit reporting to the Chief Operating Officer. Thus the person carrying budgetary responsibility (DMD) is closely related to the service work of the Business Unit.

3.4 Recruitment for DMDs, Directors of Operations and their supporting managers took place from the whole Integrated Care Organisation to demonstrate that the new Trust would be a coming together of equals, rather than an acute Trust taking over community services. This approach was felt most likely to deliver true integration.

4. ASSURANCES TO TRUST BOARD THAT THE PLAN HAS BEEN IMPLEMENTED AND DELIVERED THE DESIRED CHANGE IN CULTURE

4.1 There was competition for the DMD posts that confirmed the buy-in of senior clinicians. The DMDs were appointed in June 2011 and then each established Divisional Boards, Quality dashboards with Divisional Leads for Risk and performance dashboards. Divisional ownership of CIPs was an important feature in order to identify sufficient savings and maintain and enhance quality.

4.2 Each Divisional Board meets monthly and includes Clinical Leads as well as finance, HR and general managers. The Divisional Boards feed into the Senior Management Team that meets every fortnight and reports to the Executive Committee.

4.3 Transformational change, involving the remodelling of whole patient pathways between the acute and community parts of the Trust became possible through this model. DMDs were able to engage with a wide range of staff and use performance and quality information and data from service line reporting to build their strategy. The DMDs then presented their proposals at Board seminars to inform decisions made by the Board about strategic plans for the range of services based on quality and economic information and on inter-dependencies between specialties.

4.4 The DMDs' ownership of SLM has enabled them to help refine its measurements and apportioning of costs. This has led to consideration of disinvestment in certain non-profit lines that are not integral to the service.

4.5 The DMDs/Divisions have engaged with the work of the Quality sub-Committee of the Board. Each Division in turn comes to the Quality Committee to present their own information. They have taken ownership of quality metrics and developed their own local KPIs too. For example clinicians took the decision to focus on improving the care of the deteriorating patient and to agree a CQUIN on reducing out-of-critical care cardiac arrest rates.

4.6 CIPs proposed and agreed at Divisional Boards are then taken to the CIP Board for assessment of their broader impact. Every CIP proposed must include a statement regarding any potential risk to quality and this is

discussed among the clinical members of the CIP Board. If passed by CIP Board they are then subject to further scrutiny by a “star chamber” involving the CEO and Medical or Nursing Director to assess quality impact. It is a measure of the success of the DMDs that they have been able to identify appropriate CIPs, and the higher level reviews have not identified any specific quality risks not already identified within the Divisions. All Divisions plan to monitor the effect of implemented CIPs to mitigate against any unintended consequences.

4.7 In the first ten months of our new integrated structure DMDs and their teams have learned a lot about the wider organisation. DMDs and senior managers who have a hospital-based background are making specific objectives to visit their community services, and similarly those from community backgrounds are learning about hospital services. This broader understanding of the range and diversity of our services and areas of strength and weakness is feeding directly into ambitious plans for transformational change.

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